Psychosexual medicine: Why me?

This article describes how a particular approach to sexual difficulties allows a useful therapeutic relationship with patients to be developed. Combined with an understanding of the dynamics encountered in the genital examination, it is possible for any interested GP to engage in psychosexual work. The Institute of Psychosexual Medicine has been training GPs and other doctors for over 40 years.

The GP curriculum and psychosexual problems

**Professional module 2.01: The consultation in practice** requires GPs to:
- Understand the wider context of the consultation: this means perceiving that your patient is a person; a belief that the sick patient is not a broken machine; and that ‘health’ and ‘illness’ comprise more than the presence or absence of signs and symptoms.

**Clinical module 3.08: Sexual health** requires GPs to:
- Take a sensitive, non-judgmental and person-centred approach to handling sexual health problems.
- Understand that sexual health problems have physical, psychological and social effects.
- Understand and take into account cultural and existential factors that affect the patient’s risk of having sexual health problems and also their reactions to them.
- Be sensitive to the social stigma that is often associated with sexual health problems, even for some healthcare professionals.
- Be able to describe common presentations of sexual dysfunction and sexual violence and abuse, including covert presentations such as somatisation (physical symptoms).

Some GPs encounter many patients with psychosexual problems and some only a few. Some GPs are reasonably happy to refer patients with psychosexual problems to counsellors, relationship therapists or clinics that specialise in erectile dysfunction, gynaecology or mental health issues. For other GPs, a lack of provision leads to an expectation that they should themselves be able to assist. A minority of GPs develop a special interest in psychosexual problems.

The time-consuming study required for training in psychosexual medicine is not desirable or appropriate for all GPs. However, GPs do not require specific training to be effective in helping patients manage psychosexual problems, and it is important for any GP to understand what may be going on when a patient does engage in accessing more specific help. This article aims to encourage those who have an interest in psychosexual medicine; it describes how a brief, focussed consideration of psychosexual problems using a disciplined model of holistic concern combined with insights obtained from physical examination can lead to very significant changes in the level of a patient’s happiness.

**Development of psychosexual medicine**

The first descriptions of psychosexual problems occurred in the early-1900s, in the context of a biomechanical model of sexual abnormalities and deviancy. Later, the impact of psychoanalysis created a practical understanding of the unconscious mind and a new means to assist patients. The initial description of psychosexual medicine was as a type of applied psychoanalysis performed by...
doctor psychoanalysts. Its new and better description is brief interpretive therapy or simply psychosomatic medicine applied to sexual disorders. There are many overlapping themes between psychosomatic (body/mind) doctoring, patient-centred care, narrative medicine and holistic medicine, and these themes have gradually moved up the GP agenda; requirements related to person-centred care are now listed in the RCGP curriculum (see Curriculum Domain 2: Being a GP). For a recent review of Patient-centred care published in InnovAiT, see Dhamba, Griffin, and Kinmonth (2015).

In addition to the more general requirements, the specific key tenets of psychosexual medicine have evolved from work carried out in the early-1970s, when groups of interested doctors joined seminars under the lead of analysts Dr Michael Balint and his colleague, a psychiatrist, Dr Tom Main. Case discussion and analysis rapidly led to two consistent findings:

1. That a deep understanding of the doctor–patient relationship in a group setting is crucial in being able to make effective interpretations
2. That an intimate examination, such as happens in general practice, gynaecology and sexual health settings, can be a moment of truth, at which the doctor understands the underlying fears, defences and fantasies that have hitherto prevented the patient from finding an answer to their problem

**Psychosexual problems in everyday practice**

Most people will encounter psychosexual problems at some stage of life. The third National Survey of Sexual Attitudes and Lifestyles (Natsal-3) recorded 42% of men and 51% of women who had had sex in the preceding year as having experienced significant sexual difficulties lasting 3 months or more. As shown in Fig. 1, this was serious enough to distress 10% of men and 11% of women (Mitchell et al., 2013).

GP s are used to helping patients experiencing sexual problems; for the majority of these cases it quickly becomes clear whether the matter is organic or psychological in origin. For example, a man who experiences erectile dysfunction after deep pelvic surgery usually needs a physical form of help, whereas a woman who loses desire in a relationship, but intermittently rekindles interest in different circumstances, has a psychological or relationship problem. Indicators such as the speed of onset and persistence of the problem in different situations can help to distinguish between physical and psychological causes.

When assessing patients with psychosexual problems, it is important to check for the presence of mood disorders, such as depression, and consider concurrent issues such as premature menopause, testosterone deficiency, hyperprolactinaemia, diabetes, or thyroid dysfunction. As many medications have side effects that can affect sexual function, a review of their use should be undertaken. That the symptoms of erectile dysfunction often act as a warning about potential arterial disease or diabetes must be borne in mind. For a more detailed account of the varied psychological presentations and the options to manage physical problems, see the InnovAiT article by Rolfe (2010).

**What psychosexual problems can be addressed in general practice?**

It can be unhelpful to place firm diagnostic labels on a patient who is unhappy in their sexual life. On the other hand, some terms have a clear interpretation. Boxes 1 and 2 illustrate the types of cases that may (or may not) be initially managed in primary care.

GP s, as human beings, vary in the degree to which they wish to hear psychosexual demands during busy daily work. The problem is that although there may be appropriate services to which a patient may be referred (for example, mental health services, an understanding urologist, gynaecologist or specialist nurse), sex is always a sensitive area of a person’s life, about which the GP frequently has important knowledge that patients prefer to keep at a confidential level. Recognising such a wish is part of respecting autonomy. One can offer referral; however, we are required to be honest in sharing our understanding of expected success. The practitioner who knows the patient best will very often be the most-effective therapist.

Additionally, in primary care, a doctor trained in psychosexual medicine has the important advantage of also being able to address the medical and surgical aspects of a problem. These aspects are due to the frequently observed relationship between psychosexual problems and illness, surgery, childbirth, and the ageing process.

Psychosexual doctors usually work with individual patients and aim to be brief. One meeting can achieve

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**Figure 1.** The prevalence of sexual difficulties (lasting 3 months or more) and distress in people who had sex in the preceding year.
Expertise that may be sited in specific clinics (e.g. an erectile dysfunction clinic in secondary care) or in the community in sexual health services. In some areas, it can be difficult to access psychosexual services, or they may not exist at all.

As for the case of community services, hospital-based provision for psychosexual problems tends to be variable. In many cases, hospital-based clinicians will refer patients to community services for non-medical psychosexual counselling. However, in some specialist areas (e.g. urology, genitourinary medicine, obstetrics and gynaecology) the multi-disciplinary team may include a doctor or nurse trained in psychosexual medicine, and even if this is not the case, patients can at least benefit from having their case considered before being referred to a non-medical counsellor.

Commissioning, with an emphasis on cost-effectiveness as well as clinical effectiveness, is shaping the provision of psychosexual services in England. It is common practice for local authorities to commission non-medical counselling services, in order to lessen the burden on health services. Although such services can be effective, they may also be problematic as, although non-medical counsellors may have training from the College of Sexual and Relationship Therapists or the British Association for Counselling and Psychotherapy, they are not always an appropriate option for patients whose problems cross the boundaries of the body and mind. Such patients may have psychological problems closely intertwined, triggered and/or perpetuated by previous illnesses, surgery, adverse medical experiences, childbirth and health-related major life events.

The role of the GP in this context is to understand the services available within his or her locality, and the problem with which the patient is presenting. This knowledge will enable him or her to decide where the patient would be best seen, and by whom.

Community and secondary care provision

The Department of Health’s National Services Specification (Department of Health (DoH), 2013) encourages integrated services for sexual health. However, the provision of psychosexual services tends to vary to significant extents across the UK. What is available is often dependent on the historical interests of local clinicians in acute and community trusts, and the availability of resources, resulting in pockets of local expertise that may be sited in specific clinics (e.g. an

### Box 1. Problems that may be addressed in general practice.

- Vaginismus, loss of libido, difficulties with orgasm
- Non-consumption and dyspareunia
- Erectile dysfunction, ejaculatory problems and other penile problems
- Chronic pelvic pain or genital pain, recurrent discharge with or without a physical cause
- Emotional and psychosexual sequelae of sexually transmitted infections
- Contraceptive-related problems (including the inability to use any method), repeated requests for termination of pregnancy, effects of miscarriage
- Vasectomy and sterilisation requests with a hidden agenda of sexual problems
- Emotional and psychosexual effects of medical and surgical interventions, including miscarriage and termination of pregnancy
- Psychosexual sequelae of sexual abuse
- Sexuality, cancer and terminal care
- Effects of ageing, disability or illness on sexuality
- Psychosexual problems related to infertility and ending of fertility
- Difficulties following childbirth

### Box 2. Problems unsuitable for management in general practice.

- Long-standing psychiatric conditions
- Severe personality disorders
- Some patients with gender dysphoria, fetishes and sexual addiction

More than five meetings would be unusual. This is in contrast with talk-based psychological therapies, which generally involve longer courses of treatment.

What makes a doctor effective in dealing with psychosexual problems?

Central to psychosexual medicine is the need to identify the blocks and phantasies that prevent a patient from helping themselves. Sometimes a phantasy may be an unconscious misunderstanding relating to self-esteem, such as attractiveness, or the effects of a damaging past experience. By recognising the evidence obtained in the doctor–patient interaction, the doctor may feel confident in interpreting this in a useful way. At other times, a patient’s deepest fears and difficulties only become apparent during the genital examination. Using such understanding is a complex matter that requires a highly skilled approach.
The key to effective management of psychosexual problems is the doctor–patient relationship. The features that make a practitioner effective in nurturing this relationship are the same whatever the environment. McWhinney and Freeman (2009) identified three core elements of person-centred care and these correlate with the ‘essential conditions’ of the psychologist Carl Rogers (Rogers, 2003), namely that any therapist should practice with unconditional positive regard and that doctors engage more effectively with patients if they are honest in the doctor–patient interaction.

In all areas of general practice, personal skill, a willingness to listen, and preparedness to engage with distress determines how useful we are as individuals and how effectively we can alleviate suffering. Holistic doctors treat the body and the mind, seek psychosomatic understanding and are prepared to acknowledge the emotional state of a patient, recognising the effect the patient has on the practitioner. Recognising that effect is required both to deliver safe patient-centred care and to maintain professional boundaries (General Medical Council (GMC), 2013). In addition, any doctor to whom a patient presents with a psychosexual problem receives the compliment of trust in the hope of help. We must respect that trust.

Case study 1.

A 64-year-old man in his second marriage asked if his recently lost erections were best accepted and sex put on the ‘back burner’. He thought that his wife would prefer that outcome. His arterial and diabetic profile was unblemished. The GP offered sildenafil and it worked, however, the patient returned saying that he would rather let it be. He said, smiling, to the doctor ‘You remember my late wife. She would have told us that it’s no use crying over spilt milk’. The doctor felt the sadness, wondering if it was about delayed grief for her death or some more recent event. The doctor made a simple reflection ‘You do not seem to be smiling inside. Something is holding you back and making you sad’. The man paused, stood up as if asserting his strength and said ‘No, it’s not me that’s sad; it is my son that this marriage has hurt. Leave it with me’.

The GP respected his wish to deal with the problem alone. Later the GP was cautiously encouraged to hear that sex was back on the agenda.

In the example described in Case study 1, the patient did not want to undergo detailed questioning about his sexual history. He valued being able to identify the source of his distress and that the doctor both understood his situation and recognised that he could deal with his own life. Whether a patient’s distress is recognised depends on the personal characteristics of both the patient and the doctor.

The psychosexual consultation

A GP may identify a psychosexual problem during the course of a consultation, separating it from other issues and think of it as something to address immediately, also performing a genital examination if appropriate. With another patient, it may be more efficient to acknowledge the limited amount of information that can be obtained in 10–15 minutes and either offer to see him or her again or think of a referral to another agency. There are particular skills that are of considerable use during a consultation.

As GPs, we have a solid grounding in consultation skills. We try not to interrupt the narrative. We treat the patient as the expert. We respect autonomy. We attempt to establish the real reason for the attendance, take a history, examine, and then try to form a shared realistic plan. In addition to this, true understanding of a psychosexual problem requires an evidence-based appreciation of the doctor–patient relationship. The evidence requires a careful analysis of how the relationship develops between the two participants. The following skills add to those expected of every competent GP.

First, we pay particular attention to how the patient made the appointment. We note their manner, dress, approach, language and their demeanor as they enter the room. This can give indicators to what is going on. Dress can indicate self-esteem. Language gives clues to resentment or emotional dependency.

Second, if the patient knows most about their problem, then this means that the doctor is no longer the accepted expert. Is the doctor prepared to adopt a position of ignorance? It is easy to agree with this approach, however, it is very difficult to adopt that position. By trying to not to know, you gain the huge advantage of keeping your mind open to the unexpected and entering into the patient’s world.

Third, we must accept the limitations of asking questions. If all you do is ask questions, then all you will receive is answers. You will not gain understanding. Thus, when it comes to the history we may have to unlearn the mantra that a good detailed history is useful. What is useful is to listen rather than talk.

Fourth, although we wish to ease distress, we must not reassure unless we are certain it will be useful. Reassurance can be a dangerous process. If the patient has correctly understood the facts and findings, if they create a coherent understandable whole, then they will be naturally satisfied. A doctor has to be alert to the fact that when feeling tempted to reassure, he or she may in truth be seeking to reassure himself/herself. It may also mean that the doctor has detected that the patient is not feeling the same degree of ease as the doctor.
Reassurance here is tantamount to telling the patient that they are mistaken. Beware. The need is to understand what the discrepancy is, and to ensure that, after better understanding, the patient is content.

Fifth, we must not guess or make assumptions. We can guess that a jaundiced patient with a palpable gall bladder is likely to be seriously ill and assume that we will need to get it urgently assessed by a specialist; however, managing psychosexual problems is different. There are fewer common causes than for purely physical conditions and the way forward for every individual is different. Even for those that are 100% psychological, the pattern of listening, timing of examination, opportunities to make useful reflections, and interpretations is unique. Compare Case studies 2 and 3, written to illustrate that a similar presenting symptom (pain on intercourse) can have two completely different unexpected causes.

**Case study 2.**

A GP felt stuck trying to understand why a woman, after refusing smear tests, revealed that she had never used tampons, had sex or ever touched her genitalia. A nurse had said that her introitus and vagina were small. Attempting an examination caused a complete spasm of the adductors, pushing the doctor away. However, the patient wanted the doctor to keep trying. ‘You are gentle’, she said. ‘I wish I had met you years ago’. The doctor felt that the patient was asking her to provide mothering and that the patient did not want to let her go. As time passed, the patient began to talk about a very strict religious upbringing leading to terror of any sexual activity. She had a patient boyfriend, whom she was terrified of losing.

Later, as she began to touch herself, she described a ‘block in my vagina’. The doctor interpreted her own response that although she would like to be able to take the block away she could only be the patient’s doctor, not a different mother. The patient had to decide when she was ready to let go.

They both shared the understanding that the block was muscle spasm.

**Case study 3.**

Another woman who was unable to have sex came to a doctor, explaining that she thought she had vestibulitis and vaginismus. Indeed, the symptoms of tenderness to cotton-bud pressure in the posterior fourchette seemed to confirm this diagnosis. Her medical notes were thin and she had no other medical problems.

The doctor was pleased that the patient had done some research to understand her problem and quickly offered referral to a joint Gynaecology/Dermatology Service with a special interest in vestibulitis. The doctor explained that he was not sure whether the appointment would be at the Gynaecology or Dermatology Clinic. The patient became unusually agitated and the doctor knew something was wrong. He said ‘I can see it is important for you to know exactly where the appointment will be. We need to understand that’. There was a long pause and he could see her struggling to say something. Eventually she talked about a secret termination of a pregnancy she had had 3 years ago when away at university. Although the counselling and procedure staff were understanding, she fainted just before leaving the ward and the nurse who had to stay late to help frightened her by saying that after a termination she should not use tampons for a very long time. Much later, and back in her hometown, the patient did use a tampon at the end of a period, however, it hurt trying to remove it. She waited 5 days in increasing embarrassment before going to the Accident and Emergency Department to have it removed. It had become offensive. She hurried from the building hoping she would never have to go back.

Over three appointments she decided to tell the story to her partner and did not come back for follow up.

You cannot assume that all patients with vaginismus will have had similar experiences to those described in Case studies 2 and 3; however, sexually repressed parenting and clumsy hospital procedures are well-known causes. The key to the successful resolution of both of these cases was the doctor correctly identifying where the doctor–patient relationship changed. In the first case, the doctor recognised her own response to a need for mothering. In the second case, the doctor detected discomfort in making an appointment that at first neither he nor the patient understood. Recognising the change in the relationship was in each case the decisive moment in beginning to recognise and resolve the patient’s problem.

Finally, when assisting a patient proves difficult, the GP needs to consider how well he/she understands the relationship. They may need to sit back and ask themselves what really is going on, perhaps reflecting on events and performing a reappraisal that can assist both the GP and patient in achieving a clearer understanding. Making reflections in the consultation is a skill addressed in GP training. Once one can identify and be aware of one’s skills, reflection and interpretation are useful tools (see Case study 4).

**Case study 4.**

A GP was consulted by a woman who complained of leaking small amounts of urine during intercourse and seeking a referral to a hospital specialist. It had made her
The doctor–patient interaction, including where and defines the dialectic of the Institute of Psychosexual any curriculum) are an essential part of training and patient interaction (rather than books or adhering to Seminars, with an emphasis on studying the doctor–practice and critical self-examination. This is the under-

The atmosphere became awkward and the doctor felt that the patient wanted him to get on and refer her without further ado. She did not want further questioning or examination. The doctor wondered if the problem was bladder instability and he was considering whether to utilise the local direct GP access to bladder studies. However, he knew that a referral required him to have excluded obvious abdominal or pelvic causes. He sat back thinking about the relationship that felt like an older woman telling him to be quiet and do his job without questioning.

He reflected to the patient ‘I would like to offer you the best services we have. I understand that you would be more comfortable if I just write a letter, but if you let me understand more it will help us both’. After a pause, she softened and said ‘I knew you would want to examine me. I just could not bear the thought of wetting myself in the surgery. It makes me feel like a child’.

Later, the doctor was able to interpret that further. When she told him that her boyfriend was significantly younger than she was, the doctor could reflect ‘So that makes your problem even more upsetting’.

Training in psychosexual medicine

Training in psychosexual medicine comprises little book learning, as this is of limited value. It is necessary that facts about sexual physiology, human behaviour, the law, and many other important matters are known and doctors are expected to read around these subjects. However, although the learning of theory is essential, what a doctor requires to be able to work effectively is understanding and skills. The message from Socrates to the present day is that interpersonal skills result from practice and critical self-examination. This is the under-lying principal of how a doctor learns the skills of psychosexual medicine.

Seminars, with an emphasis on studying the doctor–patient interaction (rather than books or adhering to any curriculum) are an essential part of training and defines the dialectic of the Institute of Psychosexual Medicine (IPM). A GP attending seminar training will learn from the group and their own understanding of the doctor–patient interaction, including where and when it is suitable to continue or if referral or withdrawal should occur. There are no rules or checklists to understand the reason for a particular symptom.

Doctors attending seminar training bring cases for confidential discussion and analysis in groups led by a qualified leader. These are similar to Balint groups. Importantly, they also concentrate on the dynamics encountered in the genital examination and the understanding gained from the examination. Patients do not always receive a genital examination; however, this is part of an assessment of the majority of those with psychosexual problems. The IPM clearly defines safeguarding considerations and chaperone policies.

Over the period of seminar work, the doctor comes to understand that the feelings analysed in the room come primarily from the presented patient. However, understanding the reactions of the group and the characteristics of the doctor are also important. This assists the doctor in being able usefully to interpret at follow up what may be behind the patient’s difficulty and pass responsibility to the patient about whether or not they feel ready to make changes in their lives. Sometimes the group and the doctor realise that psychosexual medicine will not help and referral or withdrawal is in the patient’s best interest. Although any personal problems of the doctor are not up for discussion, training can lead to small but significant changes in the doctor’s practice that is also useful in other spheres of medicine.

Seminar group training is available all over the UK. Doctors, nurses and some specified allied health professionals can join one for a short or longer period. The IPM has the largest number of doctors in training of any body offering a professional underpinning in psychosexual work.

Those in training can work towards qualifications by examination. The first of these is a Diploma, which is the gateway to further training for Membership of the IPM and it can allow individuals to receive referrals if they are working under recognised supervision. However, it is only when a doctor is trained to Membership level that they are fully qualified to take referrals and manage patients either in a specialist clinic or alongside general practice work. Members attend continuation seminar groups and require IPM recertification every 5 years.

Those interested in training in psychosexual medicine should contact the IPM (see References and Further Information). It is possible to attend a study day, a short introductory course, or join a training group and work towards a formal Diploma or Membership by examination. Those who are interested are encouraged to first arrange an initial discussion with a training group leader.
What will I gain from training?

If the only tool you have is a hammer, you tend to see every problem as a nail.
Abraham Maslow

GPs often find that they encounter psychosexual problems with increasing frequency during their early years of practice. If this is not the case for you, then perhaps you should question why, considering the 10% identified as being distressed in the Natsal-3 survey.

If you find problems that frustrate you in trying to access suitable help for your patient elsewhere then consider gaining skills yourself. As a GP, you have a head start in developing useful therapeutic relationships. Group work improves understanding of what really goes on in relationships, in conflict and the unseen. Frustrations with secondary care become clearer and easier to challenge. One becomes more effective in meetings and practice planning.

A golden spin-off from psychosexual training is its impact in other areas of individual practice. One begins to see consultations in a new light. Confidence in one's own psychiatric care improves. 'Heart-sink' patients become less problematic. You become a better judge on how and when it is best to disengage. Even if a formal qualification in psychosexual medicine is not appropriate, you may wish to consider a short attendance at a psychosexual group or study day, you could be surprised at how valuable you find it.

Key points

- Listening and allowing the patient to be the expert is more important than taking a structured history
- Understanding the doctor–patient interaction allows a doctor to offer insights into a patient's sexual life
- The genital examination sheds light on how the patient feels about their sexuality. It may be a decisive moment

Beware when tempted to reassure
Training for doctors, nurses and some allied health professionals is available all over the UK. Visit: www.ipm.org.uk

References and further information

- IPM. Website: www.ipm.org.uk; telephone: 0207 5800631

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