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# The physiotherapist in a psychosexual consultation

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**Abstract**
Psychosexual medicine is the application of psychosomatic medicine to sexual disorders. Emotional factors are not always experienced at a conscious level, and may present as physical problems in patients. Psychosexual medicine is a brief form of therapy, and the use of psychodynamic principles within a consultation may create a moment of awareness for the patient that can result in understanding and change. Physiotherapy, which was established as a profession in 1894, involves the creation of a therapeutic alliance between the patient and the physiotherapist, who work together to achieve rehabilitation and restoration of function. The key skills of listening, observation and touch are used to develop a trusting and empathetic consultation. Physiotherapists working in the field of pelvic health in the broadest sense, which includes women's and men's health, and pelvic floor dysfunction, routinely conduct examinations and physical assessments that require a high level of trust and intimacy. An understanding of and further training in psychosexual medicine can help physiotherapists to use the consultation and examination to raise patients' awareness of the emotional factors if they present with a sexual problem or reveal one over the course of the conversation. This insight may help patients to acknowledge hitherto unexpressed emotions, and begin the process of change and health acquisition.

*Keywords:* physiotherapists, psychosexual medicine, therapeutic relationship, touch.

## Introduction

Psychosexual medicine is the application of psychosomatic medicine to sexual disorders. The term "psychosexual" refers to the mental, emotional and behavioural aspects of sexual development or activity, or the physiological psychology of sex. Psychosexual dysfunction is a disturbance of sexual functioning that may be caused by an individual's mental and emotional difficulties concerning sexuality rather than physical disorders.

The Institute of Psychosexual Medicine (IPM) was founded in 1974 by doctors already working in seminar groups under Dr Tom Main, a psychoanalyst, who helped to create a type of brief therapy that could be used by doctors treating clients with sexual disorders. Before this, Michael Balint, another psychoanalyst, had held meetings with general practitioners to discuss aspects of the doctor–patient relationship, and concluded that "some of the people who, for some reason or other, find it difficult to cope with problems of their lives resort to becoming ill" (Balint 1957, p. 18). The understanding grew from this that emotional factors present in the consultation are not always experienced by the patient at the conscious level, and that the application of psychosomatic medicine might facilitate an awareness: a "lightbulb moment" in which insight is gained and recovery made possible over a short period of time. The underlying cause of a problem presented in a consultation may be physical or psychological, or a mixture of the two. Attitudes, anxieties and fantasies revealed in the consultation and physical examination are highly relevant to the sexual problem.

The IPM offers training for doctors and allied health professionals that gives them the opportunity to acquire the skills they require to practise psychosomatic medicine in a psychosexual consultation (Box 1). Those wishing to train with the

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**Box 1.** Institute of Psychosexual Medicine (IPM) training*

- Seminar-based training takes the form of a group led by an IPM seminar leader (and involves a minimum of between six and eight participants)
- Training consists of 12 h per term, three terms per year over 2 years
- An introductory term is an option
- Cases are presented and discussed so that participants can acquire psychosexual consultation skills
- A case logbook is presented prior to the diploma examination, during which two cases will be discussed in a *viva voce* with two sets of examiners
- Ongoing training is encouraged; for example, attendance at further training sessions and biannual clinical meetings

*Further information available online (www.ipm.org.uk).

IPM need to be seeing patients who have been referred with sexual problems, and be established in the practice of genital examination as part of their assessment. Physiotherapists working with patients with vaginismus, dyspareunia, orgasmic disorders, pelvic pain, erectile dysfunction, ejaculatory disorders, and sexual problems reported by those with pelvic floor dysfunction and prolapse would be particularly eligible for this additional postgraduate training. A history of sexual abuse may also lead to psychosexual disorders.

## The psychosexual consultation

The key components of psychosomatic medicine in a psychosexual consultation are:

(1) *Observation and listening.* Where the atmosphere of the consultation is understood more clearly, including how the client presents, what is said and not said, and the significance of "Why now?"

(2) *Awareness and interpretation of the clinician–patient relationship.* Where understanding and using the feelings experienced by the clinician or patient arising in the consultation may enable the latter to become aware of sexual problems not yet experienced at a conscious level. This will involve the use of a psychodynamic approach, including components of transference and countertransference, and an awareness of the significance of psychological defences.

(3) *The use of the genital examination as a psychosomatic event.* The patient believes that his or her problem has a physical cause, and will expect to be examined to help "identify the problem". Discussion about the examination, and an awareness of the feelings that emerge as part of the examination can help to identify unexpressed difficulties and anxieties, which can be used in turn to help the patient gain insight in a safe and therapeutic environment.

The significance of the genital examination is one of the key differences between psychosexual medicine and psychosexual counselling, although there is much overlap between the processes regarding the understanding and use of psychodynamic principles in the consultation.

The components of the psychosexual consultation mentioned above show a great deal of similarity to the underlying principles of a physiotherapy assessment, where the key skills of observation and listening, being aware of the how the patient is engaging with the physiotherapist, and the use of a physical examination will enable a diagnostic evaluation to be made and subsequent treatment to be established.

A commonality exists between the physiotherapeutic and psychosexual consultation: the establishment of a therapeutic relationship and the skilled use of touch are key components of both.

Physiotherapy began as a profession in 1894, when four nurses seeking to avoid being associated with unscrupulous providers of massage treatments formed the Society of Trained Masseuses. Further development in the 1900s, when the Incorporated Society of Trained Masseuses became the Chartered Society of Massage and Medical Gymnastics, raised the professional status of practitioners and gained the organization a Royal Charter (CSP 2017).

Key to the development of the profession was the desire to legitimize therapeutic touch, and in doing so, the core skill of physiotherapy stressed a body-as-machine approach that "emphasized the primacy of an anatomic, biomechanical, and kinesiological view of the body at the exclusion of 'other' ways of understanding the reasons for illness or injury (subjective, personal, social, or spiritual, for example)" (Nicholls & Holmes 2012, p. 456). Professional autonomy also progressed with the advent of physiotherapy treatment without medical referral in 1978, and physiotherapists becoming fully independent prescribers in 2013.

In consultation, the physiotherapist does indeed create an independent therapeutic alliance with the patient, and where touch is concerned, the issue may be how to maximize the therapeutic possibilities of the encounter while retaining a dignified separation (Nicholls & Holmes 2012). A study presented at the 2015 World Confederation for Physical Therapy Congress in Singapore identified that physiotherapists were less explicit about the use of touch as a communication tool, and suggested that increasing the conscious awareness of the value and impact of touch might enhance the relationships and connections they make with their patients (Hiller *et al.* 2015).

The members of POGP specialize in the field of women's and men's health, including pelvic health, pelvic floor dysfunction, continence and obstetrics. Issues of intimacy and stigmatized conditions make consultations potentially challenging; the use of touch and retaining a dignified separation require careful consideration. The guidelines produced by the Chartered Society of Physiotherapy (CSP) for pelvic floor examinations emphasize the need for professional boundaries during intimate examinations and treatments, limits that are established by ensuring rigour in training and working within the individual physiotherapists' scope of practice (CSP 2012). No mention is made of the potential therapeutic benefit of such a procedure, or the necessity of further training in order to fully understand the potential gains that can be made by this area of physiotherapy. The CSP states that: "The physiotherapeutic role of pelvic floor examination, assessment and/or intervention is to address the movement, performance and function issues relating to the pelvic floor complex" (CSP 2012, p. 5).

A recent study has explored the significance and meaning of touch in the practice of physiotherapy within the framework of a phenomenological enquiry (Bjorbækmo & Mengshoel 2016). Phenomenology arose from the disciplines of philosophy and psychology, and seeks to understand what is experienced regarding a phenomenon by those directly involved in undergoing it. Thus, reality is socially constructed through the interaction of individuals assigning meaning and interpretations to their perceptions and experiences (Nathan 1999; Bowling 2014). This allows the subject of touch to be explored in the real world, as experienced by those involved in giving and receiving it. Bjorbækmo & Mengshoel (2016) highlighted the existence of language and practice intimating touch, including palpation, massage, non-verbal skills, bodywork and embodiment. They concluded that touch "opens the way for a trustful, respectful co-existence between therapist and patient [ . . . ] in whose silent, leisured pace there are healing possibilities" (Bjorbækmo & Mengshoel 2016, p. 19).

The body has been the subject of much discourse in the social sciences, and the Cartesian mind–body paradigm is often cited. Traditionally, physiotherapy has adopted a biomechanical approach in which objectivity, reason and logic enable normal and abnormal to be the defining characteristics of the function of the body. Embodiment as a theory applied to physiotherapy practice emphasizes an orientation towards the whole person. Nicholls & Gibson (2010) suggested that the three components of an embodied view of health and illness are: an awareness of the objective reality of the illness; an orientation to the subjective meaning given to the person's lived experience of health and illness; and a consideration of the social institutions (i.e. political, social and structural) that mediate people's experiences and behaviours. These authors added that physiotherapists are indeed working with an embodied view of health and illness despite their training, not because of it (Nicholls & Gibson 2010).

The therapeutic relationship between physiotherapist and patient was explored in a review by Besley *et al.* (2011) in which she identified eight key themes: patient expectations; personalized therapy; partnership; physiotherapist roles and responsibilities; congruence; communication; relationship/relating factors; and influencing factors. Additionally, Josephson *et al.* (2015) examined the contribution of evaluative language to the therapeutic relationship with a qualitative study of consultations in primary healthcare and a hospital setting. Her findings suggested that patients engage from a clinical and interpersonal perspective, but physiotherapists are more focused on their clinical tasks, and more comfortable with using language that is congruent with progress and the achievement of clinical outcomes. It may be that the physiotherapists are not always at ease with acknowledging their patients' or their own feelings in a consultation, which might be a result of anxiety that "control" of the session will be lost.

Physiotherapists who have experience of "difficult" consultations have acquired the skill needed to manage the emotions in the room, allowing the patient to feel heard and themselves to display empathy.

The IPM training builds on the ability of an experienced practitioner to make therapeutic use of what is in the room. As described by Freud (1900), "free-floating attention" is the ability of the physiotherapists/practitioners to hear what is being said overall, while being cognizant of the non-verbal language of their patients, and aware of the feelings and thoughts being generated in themselves. It is the use of these emotions and feelings that can be so powerful for patients, who may not know either that these exist or the extent to which these contribute to the problem being experienced.

A psychosexual consultation may include:

- awareness of how the patient presents, the relevance of prior communications and detail about the manner in which the patient joins the consultation;
- the use of open questions to encourage dialogue and sufficient time for free flow of the discussion (closed and direct questions may stifle important information and emotions);
- the use of reflection, silence and wondering with the patient to facilitate the feelings to be expressed (e.g. "I wonder how it feels for sexual intercourse to hurt so much?");
- detailed questions about sex to encourage the patient to express the problem and hear the reality (e.g. "What happened the last time you had sex?" and "Has sex ever been enjoyable?");
- observing the emotions in the room, and by verbalizing them, helping to make the less conscious more conscious;
- asking what the patient thinks will be found on genital examination and how they feel about having one (attention will be paid to how the patient is during the examination or why they have declined one);
- tolerance of not knowing the answer (the physiotherapist learns to allow for there not being a solution in that moment); and
- helping patients to be aware of the feelings that have been generated in relation to their sexual problem that may help them to identify the possibility of insight and change (e.g. "It sounds as if you might be afraid that I might think you are exaggerating" and "You seem to find this very difficult to talk about, but are smiling").

The use of transference and countertransference is key to the psychosexual consultation. Transference is the experience of feelings, drivers and attitudes towards a person in the present that are a repetition of reactions to a significant person from the past. Countertransference is where the practitioner can use the emotional response felt as a key to understanding emotions and anxiety held in the patient's subconscious. This use of empathy can help the patient to acknowledge hitherto unexpressed emotions.

Defences are strategies that are not under voluntary control that are used by the ego to protect itself. These usually develop in childhood, and may become unconscious and unhelpful in adulthood. The most commonly mentioned defences include:

- repression – unconscious blocking of unacceptable thoughts or rationalization of feelings;
- intellectualization – thinking about events in a cold, clinical way;
- avoidance – refusing to deal with the unpleasant situation;
- denial – outright refusal to acknowledge the situation/event;
- projection – casting our own unacceptable qualities onto other people;
- conversion (somatization) – an emotional response is converted into a physical symptom;
- regression – reversion to earlier patterns of behaviour; and
- displacement – attributing feelings to people who are less threatening.

Defences in a psychosexual consultation will be manifested by the patient and the practitioner. The ability to identify the defences being exhibited will contribute to an understanding of what is going on in the room. The experienced practitioner will also know when not to make the defence strategy overt and share the emotion felt. The defence exists to protect, and it may be that what lies behind the defence is too painful to tolerate knowing at this stage.

The management options for a psychosexual disorder are illustrated in Fig. 1.

## Case study

A 28-year-old woman was referred to the present author for vaginismus. She had been in a relationship with her present partner for 4 years, and had had previous short-term relationships. There was no history of any problem with sex with any of her partners.

On presentation, the subject revealed that she had experienced pain for 9 months. Penetration was difficult and painful, and sex frequently had to be abandoned. She was keen to know what the problem was. Her gynaecological swabs and

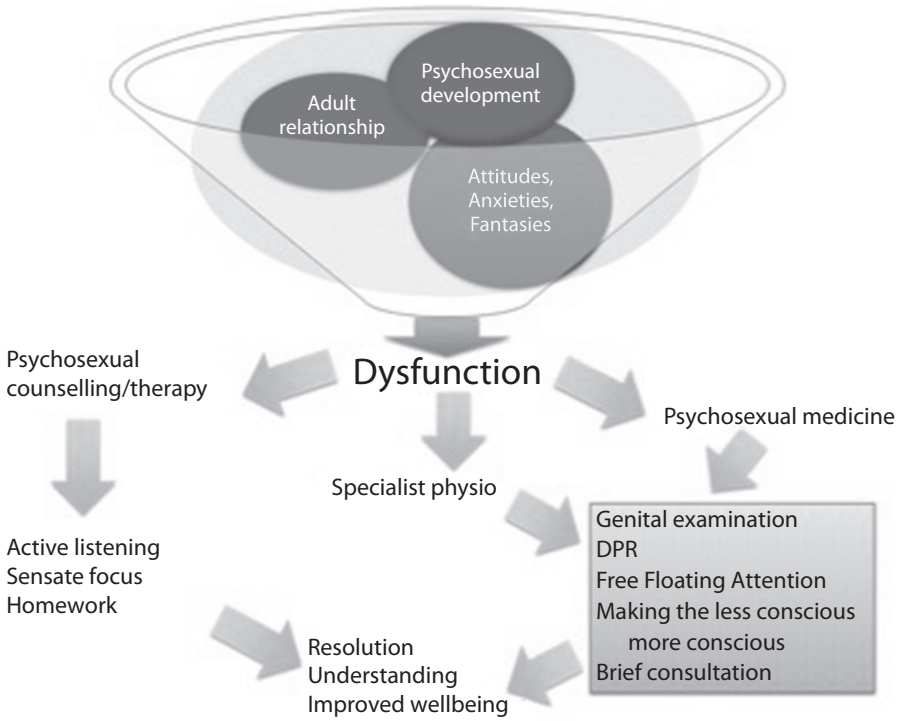


**Figure 1.** Flow chart showing the management options for a psychosexual disorder: (physio) physiotherapist; and (DPR) doctor–patient relationship.

tests were normal. She used tampons with no difficulty or pain.

Before the examination, the subject was asked, "What do think I will find on examination? Are you happy to be examined?" She said that she was "anxious" about having an "abnormal" vagina. She relaxed for the examination and showed no obvious discomfort. There were no difficulties with the insertion of one and then two fingers, and no areas of discomfort caused a need for withdrawal. She said afterwards that she was relieved that there was "nothing wrong".

In the consultation, the present author said the following:

- "Sometimes this type of problem does not have a physical cause."
- "I was able to examine you easily and comfortably, but I can feel that you are anxious and find this very difficult."
- "Are you able to enjoy having sex with your partner. When does the difficulty arise?"

The subject then mentioned that she is now in a serious relationship, and her partner wants marriage and a family. What might that mean for her?

The consultation then explored her feelings and beliefs in relation to family and marriage. She remembered that her mother had had severe postnatal depression when her younger sister was born, and she mentioned a feeling of loss and abandonment at that time, when she was very small.

The present author made the following proposition: "I wonder if thinking of babies takes you back to a time when you felt very anxious and vulnerable?"

This triggered a lightbulb moment: "I think that perhaps I am scared of having children because of how I felt at that time," the subject said. For this patient, her subconscious feelings related to having children have been expressed psychosexually in the form of the physical problem of pain on penetration. She is now able to deal with her emotions, and has returned to a satisfying sex life.

## Conclusion

Physiotherapists already have sophisticated communication skills, and even without formal training, will acknowledge that they are aware of the non-verbal components of their day-to-day consultations. Additionally, many are conscious that some patients "transfer" their emotions during a consultation, and they can be left feeling ineffective and heavy-hearted. The IPM training for physiotherapists who work with sexual disorders offers an additional skill to manage those consultations in which the physiotherapist–patient relationship and the feelings in the room are the currency of the therapeutic alliance. It is not about training to become a different clinician,

but instead, allows for the possibility of shifting the scope of practice to include a psychodynamic approach to the consultation. Key to this is the use of the genital examination as a psychotherapeutic event. As the public and professional awareness of the role of the specialist POGP physiotherapist grows, the use of touch may be employed with increasing awareness of the potential role that it has for adding to the embodiment dimension of physiotherapy. The confidence that patients have in the touch of a physiotherapist may help to make the psychosexual consultation, following additional training, a natural adjunct to the work of the specialist physiotherapist.

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