INTEGRATING MEDICAL AND PSYCHOLOGICAL TREATMENT FOR SEXUAL PROBLEMS: THE PSYCHE AND THE SOMA

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INTRODUCTION

This year marks my 40th year as a doctor. What I plan to do is take those 40 years of experiences, which upon reflection are wide, very varied and turbulent, and to use them as a metaphor depicting the integration of medical and psychological treatments, the need for it and what in my view still has to be achieved.

One always remembers the first day as a doctor. I was appointed to one of Sydney's largest teaching hospitals and was rostered on extra duty on my first evening in the Emergency Ward. Fully expecting to make some sort of brilliant diagnosis that first night, but instead amongst the usual pedestrian fare one sees in Emergency, I saw a woman in her thirties. I can't even remember what her presenting complaint was but it was something fairly minor. However during that consultation she obviously sensed she could talk to me and out of the blue, she shifted gears and said, "Doctor, I've never had an orgasm."

Our six years of formal medical training had not prepared me for that question, let alone the answer. The only time sexuality was mentioned concerned pædophilia and bestiality during our Psychiatry lectures in 4th year. However, I had seen this lack of coverage of human sexuality in our course as deficient and downright weird. I had taken upon myself to read T.H. van de Velde's "Ideal Marriage"[1] in 3rd year, a book which by that time in all the history of book publishing was second only in sales to the Holy Bible. So, I was able to muddle through with that patient and not back away from the answer. In retrospect, that incident that very first night on duty influenced my life, and kindled my interest in sexuality, sex therapy as well as the sex education of health professionals and general public alike. I decided there was a rôle I could play, a contribution I could make to my chosen profession. Then I made the next discovery.

No one listens to a junior or senior intern or house officer! I had to wait until I was awarded my MRCOG in 1970 to give me the credibility I needed. Upon returning to Australia from my postgraduate work in England, I started to raise the consciousness of my specialist colleagues and the Profession at large towards our responsibilities regarding the sexual difficulties of our patients. After all, if there is no sexual function, there is no Obstetrics & Gynæcology. I'm not referring just to the obvious topic of Obstetrics, but there would be no miscarriages, abortions, STD's, contraception and far less abnormal cytology & colposcopy, hysterectomies and repairs as examples. Our whole specialty depends on sexuality.[2]

I persuaded the Editor of the Australian & New Zealand Journal of Obstetrics & Gynæcology, one of the world's mainstream O&G journals, to accept the first article

ever on sexuality in 1974.[2] Then I badgered the Professor of O&G at Sydney University to include questions on sexuality in the Final exam, which for my sins he made me construct. He was persuaded by my argument that the medical student will only learn something if it is examinable. Students have so much to learn that if a subject is not examined they perceive it can't be important. I did the same thing for the MRACOG exams. However these 40 years have taught me many things, and in this context, when it comes to tackling their patients' sexual dysfunctions and difficulties, I still find resistance amongst my colleagues. I have reached the conclusion that in the same way we can't all be equally comfortable with major gynæ cancer surgery or microsurgery, IVF techniques or delivering babies, not every one is comfortable with sexual counselling. I will return to this subject in my concluding remarks. The best example I ever had was having driven into the car park of my medical centre one morning about 20 years ago, a fellow obstetrician & gynæcologist was also arriving. We had gone through medical school around the same time, we were friends and had even socialised in our student days. He asked me if I was "still doing…" he couldn't even get the word out after about three attempts, so I helped him by saying, "Sex therapy?" and he said, "Yes". I said, "I cannot see how one can divorce the whole of O&G from the sex act," and he replied, "I do my best to."

I have pondered other positive and negative medical influences in those formative years of mine. One of the "giants" in Gynæcology was T.N.A. Jeffcoate, and his "Principles of Gynæcology"[3] was our major text on the subject. Sir Norman really impressed me because on Page one of his very first chapter was a heading, "Psychosomatic and Sociological Aspects of Gynæcology". He dealt with all sorts of important aspects of the art of gynæcology. Some he labelled "trivial" but still worthy of mention. There were tips the like of which I never saw in another text at the time on pain, cancerphobia, the pelvic examination, getting the patient to relax and so forth. As good as this chapter and the book in general was however, there was a sentence I'm sure all women would scoff at upon hearing it. On the subject of the vaginal examination Jeffcoate stated, "Insert and withdraw fingers slowly to avoid any erotic stimulation."

Technology has brought us many true advances in our specialty. Any woman now of reproductive age knows she can go to her local supermarket and buy a home pregnancy test kit. A prescription is no longer necessary. It was only as recently as around 1963 when such kits came onto the market. Prior to this the technology available to measure hormones including sex steroids, was extremely crude, therefore inaccurate. In fact, every pregnancy test before 1963, and for a few more years until the new kits became commonplace, meant a female mouse had to be sacrificed each time. Concentrated urine from the woman was injected into the mouse's belly. One day later the mouse was killed, the abdomen slit open and if the ovaries appeared hyperstimulated, that was a positive, the so-called Ascheim-Zondek or A-Z Test. In 1974, David Abramovich, an expatriate Sydney Professor of Obstetrics and Gynæcology then in Aberdeen reported a study measuring maternal testosterone levels during pregnancy.[4] By then radioimmune assays had revolutionised hormone physiology. He observed that maternal plasma testosterone levels rose to a peak around 18 weeks' gestation and this was especially so if the

woman was carrying a male fetus. However, in the discussion at the end, he concluded, “There do not appear to be any clinical implications in this rise.” I criticised this conclusion in a guest editorial on sexuality in pregnancy.[5] I cited this as a good example of the difference between a researcher and a clinician. All Professor Abramovich had to do was observe and speak to these women during their pregnancies. In many women carrying males, by the time they are at the 18 week mark, their faces are erupting with acne instead of the traditional “peaches and cream” complexion, their scalp hair if not actually full of dandruff, becomes oilier and curls tend to fall out. Bodily hair such as axillary, pubic, on legs and abdomen increases. Often they note a heightened libido and sexual responsiveness, some partners telling me it has never been so high thus far in their entire relationship. These are all testosterone effects begging for clinical observation. Once more, women reading this who have given birth to babies of both genders will often reflect on these words and agree with the observations.

Sir John Dewhurst was also one of our great teachers and his lectures were always a treat in their clarity, erudition and wisdom. He was a world authority on childhood gynæcological disease, and his monograph, “Female Puberty and its Abnormalities”[6] is a classic work. I had the pleasure of attending a lecture of his in Sydney on the subject of the adrenogenital syndrome, which dealt as you can imagine with ambiguous genitals and congenital abnormalities. One of his slides showed an endocrinological schema with the pituitary at the top, and all the endocrine glands in anatomical position beneath down to the ovaries and genitals. Arrows started at the pituitary and all pointed towards one of the lower glands and the genitalia. He avoided any discussion of the tomboyish or sexual behaviour in these girls. I stood up and asked a question afterwards. I made the observation that all of the arrows in that particular slide pointed *downwards*. I asked Sir Jack about arrows which should also be pointing upwards from the genitalia towards the brain and what his thoughts were. He could not answer that question at all and fobbed me off.

I had started to meet world famous sexologists from around 1976 and at the beginning of 1978, I passed another milestone, when I visited the Department of Psychiatry and Behavioral Science, School of Medicine of the State University of New York at Stony Brook. This was during their heyday with so many famous sexologists on the one campus. Some had heard of my work with apareunia due to vaginismus. I was enjoying an 83% success rate in its management. It was wonderful to confer with them. New textbooks were being published and here was I meeting the various authors. An important book came out in 1979 that addressed finally some of the imbalance between conventional studies of hormones on behaviour and the less-studied and less-understood effects of behaviour on hormones.[7] This opened new avenues of thought for me. Then followed a very productive phase. I was teaching, training, counselling, treating and in 1983, I was appointed to the Board of SSSS (The Society for the Scientific Study of Sexuality), and from 1985 to the Board of WAS (The World Association for Sexology), both for several years.

With this kind of background in my post-graduation years, it is clear why I would be attracted to Psychosomatic Obstetrics & Gynæcology. I absorbed these concepts

well known to psychotherapists, but absent from our mainstream specialist medical literature. To this day I am also still actively involved in obstetrics. I graduated at a time of major change in my specialty. Childbirth was no longer the dangerous pursuit it once genuinely used to be for mothers and babies. [Nowadays due to the altered medicolegal climate, obstetrics is more hazardous for the obstetrician instead!] I met the new gurus such as Frédéric LeBoyer, Sheila Kitzinger and Michel Odent who showed us there was an effective, far gentler, less-invasive way to go. Similar changes were occurring in gynæcology. Innovations such as the contraceptive pill and other hormones, ultrasound, microsurgery and laparoscopy facilitated more conservative approaches. Nonetheless, I have always contended that since, unlike any other doctors, we obstetricians & gynæcologists are responsible for managing problems associated with every major *rit de passage* of women ranging from childhood through adolescence, "marriage", pregnancy up to the menopause etc., how can the **primary approach** to the management of such problems be with the knife or a "magic bullet"?

Many doctors haven't learned the very real therapeutic but time-consuming value of just listening and talking to patients/ clients; that doctors themselves are just as valid a medical instrument, as described by Balint.[8] A patient of mine who was a surgeon's receptionist told me once of a lady who came out from the consultation saying to her, "I feel so much better now." At the morning tea break she dutifully told her boss what the patient had said. He replied, "But all I did was talk to her." Some people just do not get it. One of my pet hates is being told by a patient/ client that previous therapists have told her either, "It's all in your head", or after a pile of tests and scans have been performed, "I can find nothing wrong with you", leading the woman to think her medical attendants believe she is imagining the symptoms.

Now I turn to the crux of the integration of medical and psychological treatment for sexual problems. I have learned that medical practitioners do not have all the answers, but then in fairness neither do psychologists or all the other "*-ologists*", but that **together** we can find so many of the answers. Whereas psychotherapy offers much for orgasmic sexual dysfunctions, sexual phobias and such like, medical practitioners are very appropriate when it comes to pain associated with sexual functioning, be it before, during, or after. Since **pain** is the commonest symptom which brings clients/ patients to see a doctor, more doctors need to learn that different clients/ patients perceive, evaluate and act upon given symptoms differently which in turn make them behave in differing manners, dubbed *Illness Behaviour* (IB) and *Abnormal Illness Behaviour* (AIB) (Pilowsky, 1978)[9]. Singh (1981)[10] then showed us that clients/ patients may well exhibit AIB, but that it also matters what kind of doctor treats what kind of patient/ client, and that *Abnormal Treatment Behaviour* (ATB) may be exhibited. Further, I learned of concepts of Somatisation (e.g. Ford, 1986[11] & Lipowski, 1987[12]), and then an extension of IB and AIB, Pain Behaviour, (Tyrer, 1986)[13].

I am adamant that any person presenting with a symptom consistent with dyspareunia, (which in turn can be female or let us not forget male dyspareunia), cannot be managed solely by a psychologist or psychiatrist. A critical, sexologically-

oriented examination of the genitals and/or pelvis needs to be made.[14] We health professionals cannot exist without each other. As evidence of this, in my own management of apareunia due to vaginismus, my "pet" specialty, and the supreme example of a psychosomatic condition, many uncured still-apareunic women have come referred to me via psychiatrists and psychologists and I have been successful in helping them achieve not only intercourse, but to accept their vagina as a normal organ and to enable women to insert creams, tampons, etc as any "normal" woman can. There are cases where no amount of psychotherapy, guided imagery, hypnosis etc helps overcome such problems compared with *in-vivo*, *hands-on* techniques. Yet I am the first to point out that if I am the primary referee and the woman is severely emotionally upset, there is no way my services can be helpful, nor should I even try, until I refer such cases for psychotherapy to reduce this background of psychological baggage. In some of these cases, my services aren't required thereafter. In vaginismus the psyche is willing, used to be willing or maybe it wasn't ever willing, but the soma is saying a definite "No!". We have the chicken or egg situation here. Has the fear of penetration/ pain/ mutilation etc led to this condition, or, have painful, unsuccessful attempts at intercourse or other negative factors such as a past history of incest or rape, painful vaginal examinations and other negative experiences with **doctors** led to the involuntary pain behaviour and apareunia? It is a two-way street. At the 5th International Congress of Psychosomatic Obstetrics & Gynæcology in Rome in 1977, I was the first person in the world to point out that we doctors are equal to rapists as regards ætiological factors in preceding apareunia due to vaginismus.[15]

I have come to learn that the word "pain" is a form of "currency" used by patients to mean various things, but above all, it is a cry for some sort of help. Each of our medical specialties, of necessity representing a narrower band of medical knowledge hived off from the entire medical "cake", has its own "currency" to describe pain syndromes within that specialty. Such "currencies" include fibromyalgia, chronic fatigue syndrome, irritable bowel or bladder syndromes, muscular and migraine headaches, premenstrual syndrome, chronic pelvic pain, or finally — vulvodynia.[16] For example, the classical words, "Not tonight dear, I have a headache," of course is not a dyspareunic pain, but it is a "currency" or code, a subtext.

As an obstetrician & gynæcologist, my bias is towards women, but then, this is the realm of most dyspareunia. The principles apply equally to male syndromes such as anismus and proctalgia fugax. I have always held the view, based on long experience with very positive outcomes in patients, that whereas the patient/ client may say, "Doctor, I don't enjoy sex because it hurts", I respond, "*Au contraire*, sex hurts because you don't enjoy it".[17]

The previously mentioned advances in hormonal physiology and hormone use for treatments represent another medical area. Prolactin, testosterone and allied assays in both sexes yield therapeutic information, and testosterone therapy in women is something I have used judiciously over 35 years with good effect in the minority of women I see who are suitable candidates. There is a myriad of so-called "natural" remedies out there including œstrogens, gestagens, DHEA, DHEAS, wild yam,

phyto-œstrogens and so forth. One of the real problems with these compounds is that individual doctors do not know the exact composition of what the women are taking, and there are genuine concerns about uniform quality control and uniform efficacy of batches.

Forty years ago, impotence was considered about 97% psychological and around 3% medical in ætiology. Nowadays our expanding knowledge places the mix at around 50-50. Sexual surgery is performed in some cases of impotence, for penile enlargement or penile correction as in Peyronie's disease. Transsexual surgery, vaginal repairs and labioplasties are examples of other surgical managements.

I have left the pharmacology of sexual dysfunction until last, because this represents a subject, which now is an area with only two sides. The other two sides are expanding exponentially and we don't know yet where the borders will end. Brain chemistry will unravel more secrets as the years go by and lead the way to newer, more targeted drugs. Another area of great promise is with the use of fMRI's and PET scans as well as I imagine technologies we haven't even dreamed of yet. Nevertheless, for now we must remain aware of the unwanted side effects of our expanding pharmacopœia upon sexual function. The reverse situation, drugs that enhance sexual function is also engaging our attention. The use of Viagra-type drugs by men has not lived up to expectations with large numbers of them now not refilling their prescriptions. I know that many sex therapists became dismayed when traditional forms of counselling went by the wayside as men sought a "quick fix" and embraced Viagra whilst continuing to smoke and drink heavily, not look after their diabetes or eat the wrong foods. As the American author, poet and philosopher Ralph Waldo Emerson once said, "Men wish to be saved from the mischiefs of their vices, but not from their vices."

CONCLUSIONS & SUGGESTIONS

Male and female Desire, Arousal and Pain continue to be the big treatment issues in the management of sexual problems. There is no doubt that the consciousness of all doctors, be they general practitioners or specialists of varying types, regarding their responsibilities towards clients'/ patients' sexual difficulties needs to be raised on a continuing basis.[2] I used to think once or twice was enough. As we become more aware of pain behaviours and in turn of more effective pain management, several of our textbooks will have to be rewritten. This will take a long time from now before such new concepts and treatment modalities percolate down the line to young doctors and psychologists. It is clearer to me now after 40 years that **special doctors, not all doctors,** will need to be more aware of clients'/ patients' sexual difficulties in the same way you can't expect all psychotherapists to be comfortable with managing sexual dysfunctions. It is also patently clear that neither psychologists nor doctors have all the answers. *Together* we will get somewhere. In fairness to my medical colleagues, there is so much to learn and this mass of material is expanding like the "big bang" over the years. In the words of a former Editor of the Medical

Journal of Australia, the explosion in the numbers of journals and specialised textbooks means that more and more smaller groups of people end up talking only to their fellows, and thereby lose out in knowing and benefiting from what is happening in the rest of medicine.[18] In view of this, I have come to realise that the ideal doctor, one who knows a reasonable amount about everything, and who has clinical skills to match, is an unrealistic pipe dream today. Gone are the days when life was a lot simpler and the town's only GP handled everything quite competently.

"The farmer and the cowman should be friends," states the song in "Oklahoma". I believe we should accept the reality that we need each other and cannot work in isolation from each other in our field of sexual function and dysfunction. In mentioning "special doctors" in this context, I would like to see that in a group practice of GP's for example, at least one of the partners has extended his/her training into counselling skills. As regards obstetricians & gynæcologists, we need a new type, not a new subspecialty. In the same way we have a pædiatrician and pædiatric surgeon, a neurologist and neurosurgeon, a cardiologist and cardiac surgeon, a thoracic physician and thoracic surgeon, a nephrologist and urologist, a rheumatologist and orthopædic surgeon; in other words two specialists in the same field but one is at the non-surgical, diagnostic end of the spectrum, the other at the surgical, we need a new breed of gynæcologist who is at the non-surgical end of the spectrum. Having said previously that the gynæcologist is the best medical specialist to manage certainly the physical aspects of women's sexual problems, we need such men and women to concentrate on the diagnostic and counselling aspects of our specialty, a "gynæcological physician", as it were. This is the niche where I have come to see myself. I am not a trained psychologist but I know that what I do is **psycho-therapeutic**. I am happy to leave the IVF, microsurgery, urogynæcology and cancer surgery to others with those important and ultra-developed skills.

Finally, I would like to see sexual difficulties experienced by men and women treated with more interest and concern by doctors equal to the level of concern among our patients. It would be a big help if these new textbooks that need to be written add some novel integrative tables into their teaching. In other words, in the same way we are taught perspectives such as the ocular, cutaneous or arthritic manifestations of disease, I believe we should see new tables devoted to the sexual consequences of systemic disease.

We doctors need a **biopsychological model** rather than the traditional medical illness model in the management of sexual dysfunctions.

In July 1982, I spoke here in Brighton at the 1st International Conference of the Institute of Psychosexual Medicine. The late Tom Main chaired my session. It is an honour and a thrill to be asked to speak at only the second international sexology congress to be held in the UK.

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