

ASPECTS OF THE CONSULTATION

Hidden agendas: psychosexual aspects in consultations

Jane Botell

Introduction

It is 9 o'clock on Monday morning and the doctor or nurse has just returned from 2 weeks' leave. The first patient on the list looks straightforward and should give a quick start to the morning's work. This might be:

1. At the family planning clinic: a repeat prescription for the contraceptive pill.
2. At the genitourinary clinic: the results of sexually transmitted infection screening.
3. At the general practice surgery: a couple, the woman for a repeat of her hormone replacement therapy and the man for a sick note and a repeat of his antidepressant medication.

Could all three patients have hidden agendas buried beneath these seemingly innocuous requests? We might not anticipate any of these to be a calling card for:

1. "I've gone off sex with my current boyfriend because I fear letting anybody get close to me again, in case I repeat the hurt of past relationships."
2. "Sex feels dirty; I must have an infection."
3. "Sex hurts me. He is losing his erection. We both still feel grief over the death of our only child born in my mid-40s, and now time has run out to have more children."

Is this our job?

Surely we are not expected to deal with this in addition to all the other tasks in our busy professional lives, particularly if the patient only offers the symptom covertly and seems to want it to remain hidden? Wearing our physical hats, we would take note of erectile dysfunction in the male patient, as it could be the first indicator of later cardiovascular disease. What of the other complaints? Are these symptoms really hidden? Why has this patient changed her contraceptive method so many times? Why has this patient asked for repeated investigations when the results always come back negative? Why has this couple attended the surgery so often in recent months, consulting with all the partners at different times? Patients with many consultations and unresolved complaints should raise our suspicions of a hidden agenda.

Why are we not solving the problem?

The health professional is left feeling impotent to help. Frustration and anger grow, and we feel that we could cope if only the patient would express their complaints in the conventional open way. We appear to be unable to hear the unspoken word, read between the lines and we ignore the inconvenient clues. We don't have enough time: there is only a 10-minute consultation.

Is it time or are we too scared to enter areas where we feel out of our depth, unfamiliar, untrained and overwhelmed? It feels as if we are exposing ourselves, our lack of expertise, our vulnerability and our weakness. If we acknowledge to ourselves our own feelings of uncertainty, even before knowing the facts of the history, we can allow patients to complete their narrative. This allows an insight into the inner world of our patients more quickly and more deeply than any painstaking 'question and answer' style of consultation led by a controlling health professional following his or her agenda of preconceived ideas and generalisations.

What can we offer?

The study of the doctor-patient relationship is the cornerstone of the everyday work of the doctor trained by the Institute of Psychosexual Medicine (IPM)¹ whatever the nature of the consultation or presenting symptom. The method is based on the methods of brief focused therapy developed by Balint, Malan and Main.²⁻⁴ Removing the protective coat of the hidden agenda through listening, observing, feeling, interpretation and reflection of all the clues present in the consultation allows for its emergence into the conscious. This can be scary for patient and doctor alike, and no more so than at the clinical genital examination.

This area is not called 'private parts' for nothing. It is as if the very clothing of the patient serves to protect him or her from further exposure. For some people, such examinations can prove invasive and even violating. Sensing the prospect of physical and psychological discomfort, the patient withdraws. Both patient and doctor want to run away. The patient hurries the doctor to get on with this intimate examination, the doctor starts making jokes or talks about unrelated topics, anything to dissipate the uncomfortable feelings that seem to be engulfing the consultation. Unintentionally, the doctor has fallen headlong into difficult territory and the hidden agenda. Learning how to tolerate this discomfort and even learning to use it as a therapeutic tool can be rewarding.⁵

The question remains: Should we proactively search for something that is so well hidden? Without the patient's consent, I would say you should not. It is hidden for a reason. To go uninvited would be tantamount to abuse. Acknowledge to the patient there seems to be a problem and offer a space in which to explore it if the patient is motivated to do so. There can always be another opportunity, particularly in general practice.

However, as health professionals we are in the privileged position to examine both the minds and bodies of our patients. If we use our physical or psychological skills in isolation, and in so doing actively neglect the other aspects, we provide a disservice to our patients. If we find a patient's blood pressure is raised, we try and understand the reason, considering possibilities that seem right to us and to the patient. Perhaps a patient asks for sleeping pills. He knows the reason for his insomnia: the pain in his arthritic hip. The analgesics and non-steroidal anti-inflammatory drugs are no longer helping. Hip replacement is offered as the obvious solution but the doctor is confused by the reluctance of the patient to take this course of action. The patient has the answers in

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ASPECTS OF THE CONSULTATION

response to the doctor's puzzlement. He reveals he cannot be away from home because he has a disabled wife and does not want to leave her.

In the same way, when a sexual problem is overtly or covertly presented, it represents a symptom of underlying dis-ease sometimes of physical origin, sometimes of psychological origin but more often a combination of both. It is therefore equitable to try and understand and to peel away the layers of obstruction but only as far as it is acceptable to the patient. The patient remains the expert.

Why do patients hide their inner agenda?

There are as many reasons as there are patients. For some, their inner self seems so messy they believe others would run away from the turmoil if it were to be exposed. If they do not love themselves, how could others love them? For some, the lead weight of internal pain seems so massive that there is no room to let anybody else inside, whether sexually with a partner or through therapy with a health professional, or so huge there would be nothing left of themselves if the weight were to be removed. For others, their external self feels so repulsive that they no longer feel a woman or man, let alone a sexual one – perhaps after a hysterectomy, mastectomy, vulvectomy or ileostomy. A man presenting to his cardiologist after coronary artery surgery might prefer to ask his cardiologist about physical treatment for his erectile dysfunction rather than acknowledge and address his feelings of vulnerability and mortality since his cardiac episode.

How do patients hide their inner agenda?

Sometimes they do so in unexpected ways. I might not have picked up in a routine clinic visit that sporty socialite Simon or muscle man Martin or mini-skirted, voluptuous Melanie Veronica, all had hidden sexual symptoms well camouflaged by their contradictory external appearance.

Why does Mrs Smith always bring her children to the clinic when attending for a smear and Mrs Jones seems to have perpetual periods? Are they trying to tell me something? Mrs Evans is so flirtatious I make sure I have a chaperone in the room when I examine her. These women are hiding behind children, symptoms and behaviour.

Men can hide too. Mr Smith brought his sandwiches into the consulting room. He was a very busy professional and really could not stay long. Mr Jones brought his mobile phone, and asked whether I minded if he conducted a conversation with his site engineer while we chatted. On calling Mr Evans from the waiting room, he peeped from behind the broadsheet newspaper that was effectively covering his face. I saw terror in his eyes. He later confessed: "How could I expose my vulnerability to a woman, that's my problem with my wife".

Why do couples come together to consultations? Some use it as a smoke screen. The doctor may be confused in deciding who is the patient. Is one hiding behind the other? Does one of the couple put all the blame on the other? One of a couple may use the appointment of the other to address his or her own problems as though he or she cannot acknowledge the problem directly.

Relationships with the same patient but at separate consultations can change. If Angela had been an easy patient to be with before I might wonder why had she dyed her hair, bitten her nails and no longer looked me in the eye at the next appointment. Was she screaming inside for me to notice the effect her termination of pregnancy had had on her, just like she was trying to tell her partner (who wanted to carry on as if nothing had happened)?

Mr Brown is always so angry that I can't find any space to ask him about his sex life, Mr Green seems too timid to have one and Mr Grey is just too sad for me to open up anything.

I have already highlighted multiple presentations and unresolved problems as indicators of hidden agendas; all can be subtle defences and disguises keeping the doctor out and the patient's feelings in. This can affect the genital examination. Suggestion of a pelvic examination for a presenting symptom of vaginal pain can produce such effective barriers from the patient that the examination does not take place at all. The normally competent health professional is transformed into the negligent doctor who misses an invasive cervical cancer.

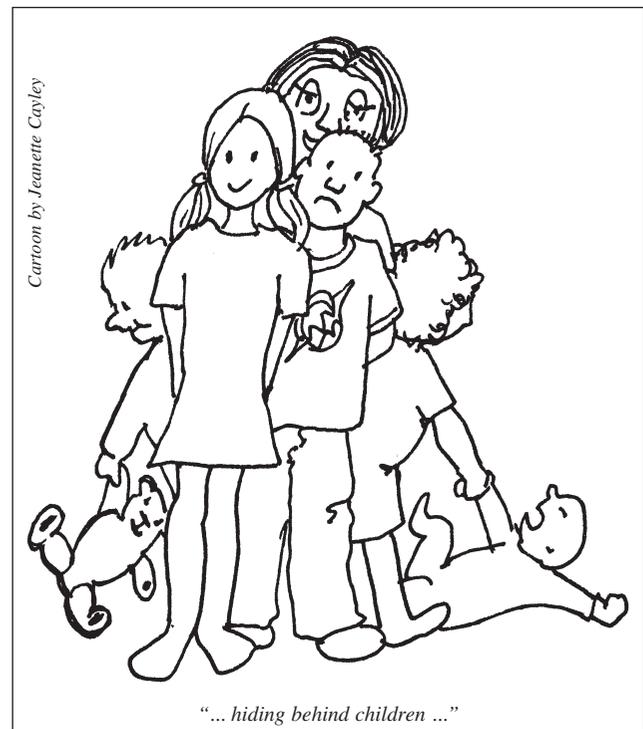
Saving time by spending time

In order to arrive at the real agenda of our patients we need to let them be the experts, not impose our expertise on them. One focused consultation could provide long-term benefit for doctor and patient. The hidden agenda might not all be revealed at one session but teased out over several short consultations. The process can be cost effective. Consider the expense of protracted investigations for pelvic pain, the origin of which might not be physical. Expensive fertility investigations may be arranged for the couple that has never been asked about consummation. Those holding the purse strings should be made aware that time spent exposing the hidden agendas of patients in the short term can be cost effective in the long term.

Medicine: art and science

This work is the art of revealing that which is concealed. We need to be aware that there could be something concealed behind the appearance, the presenting symptom, the referral, the behaviour, the speech, the silences or the feelings of our patients and be prepared to open the door to its revelation.

Medicine is both a science and an art. However, as doctors we often like to stay within the science zone where we can feel safe and comfortable surrounded by



ASPECTS OF THE CONSULTATION/NEWS ROUNDUP

statistics, quantitative studies, physical investigations and prescriptive treatments. We need to step out into the art of medicine; the one that existed before the technology was in the ascendant. Then doctors had to rely on observations of what was heard, seen, felt, smelt and tasted. Now the science of medicine has prevailed. We are called upon to produce quantitative, evidence-based research. What place there for the comments of patients, "a weight has been lifted", "I feel free for the first time in my life", "I understand now" and "I have choice"? Do phrases from the doctor such as "I study the doctor-patient relationship" make any sense at all within such rigid evaluation criteria?

What our patients need are both arms of medicine at the same time. They are not mutually exclusive.

Our patients have physical bodies, intellectual minds and feeling hearts. In recent times, doctors have concentrated on the first, given limited acknowledgement to the second, and run away from the third for fear of exposing too much of themselves and fearing boundaries might be crossed. As a result we have neglected a powerful diagnostic tool – the feelings in the doctor – as generated by a particular doctor-patient relationship in the here and now of that consultation.

Medical schools are now redressing the balance: emphasising consultation skills alongside physical examination, investigation, diagnosis and treatment. There is more of a holistic approach to medicine. In the evaluations from a group of medical students I had been addressing on the subject of psychosexual medicine, two extreme responses stood out. One said, "What a waste of time" and the other, "That was great, how can I train in this field?" Whose patients will benefit most?

Such work with patients can never be taught in a didactic lecture form. It is a skill learnt from our experience of working with individual patients and their unique stories, presentations and feelings. Training is available from the IPM¹ or under the auspices of the

British Association of Sexual and Relationship Therapists.⁶

Summary

The hidden agenda of the patient needs to be acknowledged, the reason for the concealment needs to be respected, and the practitioner needs to offer a space into which the hidden agenda can be safely revealed. The patient and the health professional can then study and understand the real agenda.

My conclusion is taken from a recent *British Medical Journal* Endpiece:⁷

God, surgeon, medicine, patient

*Hippocrates in his Aphorisms, as Galen writeth sure,
Saith, foure things are needful to every kind of cure,
The first, saith he, to God belongeth the chiefest part,
The second to the surgeon, who doth apply the art,
The third unto the medicine, that is dame nature's friend
The fourth unto the patient, with whom I here will end.*

Statements on funding and competing interests

Funding. None identified.

Competing interests. None identified.

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- 6 British Association of Sexual and Relationship Therapy. <http://www.basrt.org.uk>.
- 7 Baron JH. From Clowes W, *A Profitable and Necessary Booke of Observations, For All Those that are Burned with the Flame of Gun Powder*, London, UK: Edm. Bollifant for Thomas Dawson, 1596. *BMJ* 2005; **330**: 455.

News Roundup

Pharmacist refuses to sell emergency contraception

A couple from Wales are expecting their first child after a pharmacist refused to sell them emergency contraception. The reason the pharmacist gave was her 'high morals'. Under the Royal Pharmaceutical Society's (RPS) Code of Ethics and Standards, which all pharmacists are expected to follow, a pharmacist is allowed to refuse to sell or dispense drugs because of their religious beliefs or personal convictions. Following on from the reports in the USA regarding pharmacists refusing to dispense contraception, this poses a very serious issue for health professionals in family planning in the UK. A doctor who refuses to provide health care on moral grounds has the duty to refer on to an appropriate colleague who will provide the service. A spokesperson for the RPS told me that their code of ethics states that: "before accepting employment a pharmacist must disclose any factors which may affect their ability to provide services. Where pharmacists' religious beliefs or personal convictions prevent them from providing a service they must not condemn or criticise the patient and they or a member of staff

must advise the patient of alternative sources for the service requested".

Source: <http://www.rpsgb.org.uk>.

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

Calcium and vitamin D associated with reduced PMS

Premenstrual syndrome (PMS) may be reduced by a high intake of calcium and vitamin D. Researchers in the USA have published a case control study in women aged 27-44 years. A total of 1057 developed PMS over 10 years of follow-up and 1968 did not. Calcium and vitamin D intake in their diet was measured at three time points by a dietary questionnaire. Women with the highest intake of vitamin D were 41% less likely to develop PMS than women with the lowest intake. A high calcium intake was associated with 30% less PMS.

Reference

- 1 Bertone-Johnson ER, Hankinson SE, Bendich A, Johnson SR, Willett WC, Manson JE. Calcium and vitamin D intake and risk of incident premenstrual syndrome. *Arch Int Med* 2005; **165**: 1246-1252.

Reported by **Henrietta Hughes**, MRCGP, DFFP
GP, London, UK

Liability for contraceptive failure

A court in The Netherlands has recently ruled that 15 women who became pregnant while using Implanon® for contraceptive should receive compensation for their pregnancy. The court has yet to decide whether the manufacturer (Organon) or the doctors who inserted the devices are to blame. The doctors' case rests on the correct insertion and usage of a faulty device; Organon argues the opposite. The cases have been brought against 13 individual doctors and two cases against Organon. The damages could be considerable since they would pay for the upbringing of the child until the age of 18 years. In all of these women no trace of the Implanon device was found in their bodies when they checked after becoming pregnant; this was confirmed by blood tests. Whether this was due to the device being expelled unnoticed through an unhealed wound or by faulty insertion is not known.

Editor's Comment: Inserters of Implanon devices might want to add to their record of insertion, if they do not do so already, that they confirmed the presence of the rod in the arm after the procedure.

Reference

- 1 Sheldon T. Doctors and company to be held liable for contraceptive failure. *BMJ* 2005; **330**: 1467.

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