Psychosexual Components of Therapy - Ref258

with Gillian Vanhegan

27th September 2022

TRANSCRIPT

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Steven Bruce

Good evening and welcome to the Academy for another evening of great CPD and as always, I am delighted that you can be with us tonight. This evening's topic is a little unusual, perhaps for us as manual therapists, but it came about after one of our previous speakers, you might remember him the orthopaedic consultant, and hip specialist Simon Marsh, invited me to join him at the Royal Society of medicine for a talk by Matthew Syed. Now I went down with half a dozen Academy members. And during the pre-talk drinks, I got into conversation with John Vanhegan, who is another eminent orthopaedic consultant and someone who has a long history of working with manual therapists. And that was great fun and all very well, but I also met his wife Gillian. And it struck me that what she does also has real relevance to us, in particular to the communication between us and our patients. Now, Gillian's also a medical doctor, and long, long ago, she was an obstetrician, but she now specialises in psychosexual medicine. She is in fact a fellow of the Faculty of Sexual and Reproductive Health Care at the Royal College of Obstetricians and Gynaecologists, and she's a member of the Institute of Psychosexual Medicine. And she's going to be telling us how a bit of psychosexual knowledge might help us do our jobs better, and make sure our patients get the best care possible. So, Gillian, good evening, it's fantastic that you've taken up the invitation, you've made this trip up to the backwoods of Higham Ferrers, and you even brought your eminent orthopaedic consultant husband, John with you, you squirrelled him away in the gallery, so he can't watch you on the show.

Dr Gillian Vanhegan

Feels better.

Steven Bruce

How does it feel to be talking to osteopaths and chiropractors about sex?

Dr Gillian Vanhegan

Well, what I'm really trying to talk about is to get the message over about what happens in the consultation and in the examination because I think we're coming from the same place where we are very, I suppose honoured to be able to touch people's bodies. And when you touch somebody, you're not only touching them physically, but you're touching them emotionally. And that can awake many, many past experiences for patients.

Steven Bruce

Which is why I think this is going to be so relevant to everybody who's watching. However, before we get started, can I just remind you, as I always do, about the value of sending in your questions, we don't have the option this evening of live video questions. But please don't be shy. Let's have your thoughts and your queries throughout, on the chat lines on Facebook and on the website. And I know Julian is going to do her best to answer those questions. So Gillian, let's start off with whatever the heck psychosexual therapy or medicine is because I suspect there's a bit of confusion in many people's minds about that.

Dr Gillian Vanhegan

Yes, well, perhaps it helps if I say how it started for me and where I came from. I started my medical career in sexual and reproductive health, contraception, talking to people about unintended pregnancies and so on. And I began to realise in what seemed to be fairly straightforward consultations, there was

something going on for some patients that I had to get in touch with and understand. Perhaps if I tell you about one of the patients who pushed me into training and psychosexual medicine, it was years ago, and I was doing a contraceptive clinic. And it seemed very straightforward. The next girl, in her 20s, just wanted another six months of the pill. Easy I thought, getting towards the end of the clinic, lovely. Bit of blood pressure, weight, everything okay? Yeah, fine. I took the pills down from the cupboard, and I put them in the bag and gave them to her. And it was one of those moments, holding the door handle. And we all say that when it happens, and it really, really does. And she turned around and she looked at me and she shook this packet of pills at me. And she said, I don't know why I'm taking these. I think I'm just doing it for my boyfriend's sake. I don't enjoy sex. In fact, I might be gay. Boom, boom, out through the door. Doctor sitting thinking, wow, what happened there? There were obviously lots of feelings, lots of questions. What could I do for this woman who actually I never saw her again. But that sort of interaction that happens every now and again, between practitioner and a patient is what makes you think about, I'll change my career.

Steven Bruce
And it's funny you say that because it was only a couple of shows ago, when somebody then said, you know that the strange things will come out just as the patient's leaving the treatment room, and you've got no time left to talk about it. And effectively, you're saying, oh, well, that's very interesting. Goodbye, but my next patient is waiting. As a result of this, have you learned how to spot those signs much earlier in the consultation, do you think?

Dr Gillian Vanhegan
I hope I have, but even so, if you get a very defended patient, and they're so defended, so defended, and they're so afraid of showing their vulnerability, they're not actually going to let go of that until they feel safe in moving out of the door. And this is why a lot of people if they go to see a GP with a very sensitive problem, will often choose the locum in the general practice, because that's someone you don't necessarily have to see again. And you can maybe offload what we call transference in psychotherapy world, offload a whole lot of stuff onto that locum. And then they won't see them again. And I think it's the same feeling for patients who see us, you know, they test us, don't they, they come in, they see how they get on with us. And then just at the end, they think, yeah, he or she is okay, maybe I can share this awful secret about abuse or rape or whatever terrible things people have locked away inside them. And so yes, I mean, you asked, do I spot it earlier on, I very much hope so because I observe patients, not just when they arrive in the room, and I'm sure it's the same for you in your practice, you know a bit about the patient before they come. And maybe the effect the patient's had on other people, like your receptionist, or whoever, they may be an annoying patient who, well, you think is annoying, because they've changed their appointments a lot, and they've shifted things down the road. But actually, you're already slightly warned that that patient might not be ready to come, there might be something they're putting off. And then you can use that as an observation when they arrive. Sorry you couldn't come sooner. And, you know, I wonder why it's taken you a little while to come.

Steven Bruce
Of course, there's a big difference isn't there between what you do and what we do, because, by definition, people are coming to you for either psycho or sexual or both problems because of the nature of your profession. With us, they're not coming for that reason. So they aren't expecting to talk to us about

such intimate problems. And I was also thinking, as you said, what you did that, often, we've said, you know, when a patient comes to see you, they assume they're your only patients, so they don't mind taking all your time and everything else. But when they come with a very sensitive problem, I suspect one of the difficulties they have is that they think they're the only person with that problem. So explaining it to the GP or to someone like yourself, or even, perhaps more difficult for someone like us, they think I'm the only person with this problem, and someone's going to laugh at me or they'll feel that I'm strange in some way.

Dr Gillian Vanhegan
Yes, I mean, you've absolutely hit on it there. I see a lot of women with vaginismus, which is one of my real specialties, and sure because what you're working with is muscle tightness, and spasm and so on. And in vaginismus, the woman has that uncontrolled vaginal spasm, which is quite unconscious, there's nothing she can do about it. And it makes difficulties in relationships and so on. And so, really, that is stopping people getting inside her both emotionally and physically. So that's where we need to be able to find out what's happening. Now, I got to that because you said people know what they're coming to see me about. It hasn't always been so and so I've been in the same situation as you are, because they've been coming for a swab. They've been coming for a smear test, and not to talk about a sexual problem. And that's when I've picked up problems from certain people. And that's what I feel could work very well in osteopathy, because you're touching the patient, you're talking to the patient, and they might not have come to talk about this deep-seated sexual problem. But in whatever manipulation, whatever you're doing with them, it can awaken something in them that they'll then start to talk about.

Steven Bruce
I'm not aware of having treated any patients with vaginismus, it's probably because they wouldn't have talked to me about it. A because I'm a man. And B because I'm not the sort of therapist who think they would talk to about it. What sort of physical problems would be associated with that, that they might be coming to us with? An obviously there was a psychological element, and that will impact on their healing process. But what else might they have going on that might make us think there's possibly a problem like that?

Dr Gillian Vanhegan
Well, they'll be massively somatising their problem, whatever their vaginismus was due to if it was due to abuse or some terrible thing they witnessed or whatever. So the amount of pain and the amount of muscle spasm can involve quite a lot of the body. And in extreme cases, it's really involving the thighs, and the whole sort of pelvic girdle as it were, and abdominal muscles. So it'll be a woman with a huge amount of tension in that area that's not from a sports injury or something like that, and finding it, and you can work with them, but they'll find it very difficult to let go of that protective spasm that they have.

Steven Bruce
How would you suggest someone broaches the subject, how do you give the patient the opportunity to talk about something like that, something so personal?

Dr Gillian Vanhegan
Well, I haven't really told you the way I work, the way I work is using interpretive psychotherapy. And it's looking at the consultation and the examination and seeing directly what's happening between you and the patient, and interpreting it back to the patient. So it's no good thinking, oh, this woman's enormously tense, she's very difficult, she's very defended. So you'll have to think of the nicest way of saying that to her. I notice, you find it really difficult to relax that part of your body, I wonder why that might be. And I often play the really stupid doctor, because that's the best thing that'll make people talk. You know, I really don't understand why this is happening. And sometimes they'll then think, well, always in psychosexual medicine, the patient has the answer, actually, because you can never, never generalise, not all people, nobody's the same as the next person. And that makes me think of what you were saying about people think they're the only one. The question I think I'm asked most often, is, have you ever seen anyone like me before? You know, this problem I have, the fact I can't have a baby, because I haven't had sex with my partner, you know, and they think that they're the first person I've seen with that problem. Whereas I could write volumes of patients I've seen like that, absolutely. So it's then saying to someone, well, why do you think you're the only person? What is it that's happening for you? And drawing them out in that way.

Steven Bruce
That's getting into how you do your work, it's not how I think the chiropractors and osteopaths watching this evening, they probably wouldn't want to go into those depths unless they're trained in some way as a psychotherapist. I was just wondering, as you was saying there, what guidance you've got to our audience who are constantly being told that they mustn't cross boundaries, particularly sexual boundaries, and so even having a conversation like that they might be worried would lead them into professional difficulties with our governing bodies.

Dr Gillian Vanhegan
Exactly. That is a concern always, for all of us. Of course, I don't know exactly what your governing body says but I have the JMC guidance, College of Obs and Gynae. I have to offer a chaperone for a start, as you do, yeah. Having a chaperone in the room will often tamp down a bit on what the patient wants to say, because they might be ready to talk about something to you, to me. But if there's a third person in the room, they might not feel so comfortable. And I've had patients say, go into the examination and I'll go, you know, would you like to have a chaperone, and there'll be someone who's perhaps traumatised by an episiotomy or something, scar, and they'll go, it's bad enough that you're going to look at it, doctor, I don't want another person in the room with me. But the chaperone is really good protection for us. I think what you have to be very careful about is only interpreting what the patient is telling you, so that you're not going outside the boundaries. It would be ridiculous to ask intimate questions about something. But you can feel what the patient's telling you. And I can say, it seems that you're telling me that sex is a bit uncomfortable for you, you know, in the way that your patients are telling you that their muscles are a bit tight. So you're not saying, do you do this, do you do that? It's not that kind of therapy. It's just getting people to open up by observing what's happening to them and their body.

Steven Bruce
I'd be fascinated to know if anybody watching this evening, if whether you've had patients who have perhaps unexpectedly opened up to you about this sort of problem. But going back to what you were

saying about chaperones there, Gillian, we did a show some time ago with a lady called Sandra Harding and Sarah Tribe, and their physiotherapist who talked about, how to apply the guidelines, and they said that there are strict regulations over who can be used as a chaperone. Now, I don't know whether that applies to you. But they said that for physios particularly, they're not allowed to use family members. Is that the same in your line of work?

Dr Gillian Vanhegan
Absolutely.

Steven Bruce
So who do you use?

Dr Gillian Vanhegan
In fact, I'm very lucky that mostly when I ask people, if they want a chaperone, they say no. But in fact, you should have a trained person, a nurse, an HCA, a receptionist who's been trained, I was Medical Director of the Brook Centres for 21 years, I did all the chaperone training there. And they didn't have to have medical knowledge as such, I could train our receptionist just in the understanding of what procedure, say I was putting in an intravaginal device or something for a patient, so long as they understood the procedure and what the patient might be expected to say. They would be able to assess what the doctor was doing, that the doctor wasn't taking too long or doing unnecessary examinations and all those kinds of things that the GMC would hear about, but never use a family member. No, no, no, no.

Steven Bruce
Is that sort of training available, we wouldn't need that sort of detailed knowledge of medical procedures, but is that sort of training available to receptionists in our clinics, chiropractors and osteopaths?

Dr Gillian Vanhegan
I would imagine that on the NHS website, you would find some online training or maybe even some face-to-face training. I don't specifically know of one. But that's where I would start.

Steven Bruce
It's quite rare for most osteopaths and chiropractors to do intimate examinations. But nonetheless, we are asking people to undress to their underwear, and we are touching their bodies. And so you know, it might be appropriate. It's always appropriate to offer a chaperone, particularly to someone of the opposite sex. But it would be nice to know that we've covered some ground, ticked some boxes and had proper training for those chaperones.

Dr Gillian Vanhegan
Yes, it has to be, they really do have to be trained.

Steven Bruce
Because they need to know how to behave when they're in treatment room.

Dr Gillian Vanhegan

Yes. Now, what I never want is a chaperone who's up the head and chatting away about where they went on their holidays, or you know what they're going to have for dinner. Because that's taking the patient away from thinking about what's happening. And it's really important that the patient's focused on whatever therapy they're having, whether it's, what you're doing and what you're teaching them to do exercises and things that you might give them, or what I'm doing, it's really, really important, so you want your chaperone trained, that of course, they're going to be nice and polite and kind to the patient, but not necessarily divert them from what's going on. But the reason why I say please don't use a partner, member of the family...

Steven Bruce

Patient's family, we're talking about here.

Dr Gillian Vanhegan

Patient’s family is because and I come across it so often, I'm thinking of a couple I'm seeing at the moment, in which case I saw them on Zoom. And they want to get pregnant. This might sound like I'm going off the subject, but I'm not. They want to get pregnant and talking together. Fine. Oh, we don't really have any problem. No, we haven't ever had sex no marriage. No, but you know, oh, no, no, and on the go. And there isn't anything we can't talk about in front of each other. Finally, finally, I've managed to separate them and see them one at a time. And of course, one of them has been deeply traumatised by something that happened in the past, which he's not going to talk about in front of his wife. So the same thing applies when you have somebody into your consulting room. There's someone there going, oh, yeah, it's fine. Yeah, whatever, I'm her partner, but they may not necessarily feel that they can open up. I mean, yeah, I can think of lots of times when it really hasn't worked. There was one time in Brooke, when a girl came in for an emergency pill, a morning after pill with a young man. And I have so learned, and we know, don't we, we say hello, I'm Gillian and I'm the doctor who are you. And for some reason that day, I didn't do it. And in they came and sat down. And I made that awful assumption that he was her boyfriend. And talking, talking, talking about things and turned to him and said, of course, you'll always use condoms from now on. And he went, what? I'm a mate, he said, I'm not her boyfriend. So you have to make before you talk in front of anyone else in the room, you have to make really, really sure who's sitting there.

Steven Bruce

That reminds me of when I was in training, actually, I can distinctly remember, I don't remember who the practitioner was, but the student came out of the treatment room with the lady he'd been working on, and started to explain to the gentleman she'd come in with what was going on, she wasn't as intimate with him, he had nothing to do with her whatsoever. He just made the assumption that they were together because they came in together. Where we're gonna go from that. You mentioned, he had a problem, so I perhaps made the stupid assumption that most of your patients or all of your patients were women.

Dr Gillian Vanhegan

No, they're not. I see men who have erectile problems, or ejaculation difficulties. And in a way, I think men are more difficult to work with.

Steven Bruce
My wife would agree.

Dr Gillian Vanhegan
I think it's that thing about men maybe not talking as much as women do, not having the words perhaps to express the feelings so much. To give examples, I mean, middle aged man with erectile problems, and everyone will assume that, oh, you know, maybe he's getting hypertensive or diabetic, all the things that can happen, and he has all the blood tests done. And his GP says, no, no, no, everything's fine. Absolutely fine. And he's just saying, no, I can't get an erection, hopeless. And it's only when you begin to talk about the situation, that maybe he's just lost his job. He's not feeling like a man anymore. His grown-up children can't afford to move out of the house. So they are having sex in the next door bedrooms. And I always feel it's like the stags in the forest. You know, you see those nature films, where there's the old stag and the young stag comes along, and they lock horns. And eventually the old stag, goes limping off into the woods. And I feel this is so sad, because this is what's happening for this man. And until we're able to talk about it and give him back a bit of confidence and a bit of manhood and a bit of you know, and the erections will come back because they're not physically caused. So yes, I do see a lot of men, I see young men, I see young men who develop either premature ejaculation or erectile problems, when their wives, partners, whatever, start to talk about starting a family. And they can be that, oh, yes, we want to have a baby. We want to have a baby. But actually, on his own, I'm thinking of one particular lovely bloke in his 20s, on his own, who just sat there and cried about his childhood and how it just wouldn't be right to bring another child into the world. And so that sort of emotion had affected his physical performance so that he couldn't at that moment bring another child into the world.

Steven Bruce
I don't imagine my own experience is unusual, but for men sexual performance is such a measure of your manhood that I imagine that it's something that, it's very difficult for people to talk about when there's a problem. I don't know if it's the same for women, because obviously, there are lots of things like this, which are a measure of your femininity as well, aren't there.

Dr Gillian Vanhegan
Women will talk more easily, and women have access to more health professionals, I always feel in their lives there, as well as seeing the GP, they might have a midwife, a health visitor, people they talk to, and then they will talk to their women friends more easily. Men don't. And I did do a study once about the difference between my NHS practice and my private practice. And in my private practice, I saw far more men than women. And it was the other way around in the NHS practice. And this was because men kind of felt they had to pay to be listened to, it was lacking value in themselves. And feeling, I've absolutely got to pay for help about this. And yes, they won't necessarily talk to their mates down the pub, because it's not manly.

Steven Bruce
No, no, quite. And we've had some comments come in. Actually, Ali says that when he's using cranial techniques, and I think you probably know what I mean by cranio sacral therapy. Very gentle stuff. He said, it's very common for people to start talking about problems in the area. In the area I imagine he means the area we're talking about now. Because it's a very calming, intimate, I think cranial is a much

more emotional process than structural osteopathy, or chiropractic. Simon says he finds when he does diaphragm releases that patients will quite often talk about sexual problems. And it's a bit of a tricky tightrope to walk in how best to respond. What's your guidance? And what should we do if if the patient raises that sort of topic?

Dr Gillian Vanhegan
I think that an osteopath would be absolutely right to say, I can see that's a problem for you. It's something you're worried about. I'm not trained in this, but we'll find somebody who is. And then probably they should know anyone in their area, GPs or clinics who've got people who are trained in psychosexual medicine.

Steven Bruce
So it's fairly common, is it, to find somebody who is qualified?

Dr Gillian Vanhegan
Not so easy, not so easy. There are areas of the country that do not have enough trained people. I'm part of the training committee of the Institute of Psychosocial Medicine. And we often look at the map of the UK. And we try and move our training into areas which are great big, not hotspots, whatever the opposite to hotspots are, where you don't have enough therapists, we move in and do training there, because sadly, of course around big cities, you're more likely to find a therapist if we're talking Manchester, Liverpool, Newcastle, London, Bristol, you know, I can think of therapists in all those places I've just mentioned. But if you're perhaps not too close to a big city, you might have more problems, unless you've got a wonderful GP who's gone off and done training.

Steven Bruce
If you're not going to pay privately for this, presumably you've got to go first your GP in order to get referred? Is that a barrier to people actually going through this process?

Dr Gillian Vanhegan
Yes, I mean, every decade, we have what's called NATSAL, which is the National Audit really, of Sexual Attitudes and Lifestyles. It's a study, you might even have been sent one yourself because they're doing one at the moment. It's done every 10 years, there's a bit of slippage because of COVID. So the figures are still the 2010 figures, because we haven't got the 2020 figures. But those show that only 10% of people with sexual problems will go and see someone and the majority of them will go to the GP first. That's why we feel that we need more and more GPs to do our kind of training.

Steven Bruce
I was going to say how well versed are the GPs in getting people to go to the right places afterwards. What would the GP's response be, have they got a little array of drugs or other things which they can give to a patient because they assume that they know how to fix the problem or would they immediately say, no this is a psychosexual medicine problem. You need to see a specialist.

Dr Gillian Vanhegan
Of course it will depend on the GP, some who will be very empathetic and will want to send the person to the right sort of therapist, counsellor. I mean, there are many ways of treating sexual problems, there's

CBT, there's sensate focus. I just happen to do the Institute of Psychosexual Medicine method. But you could have a GP who's just a drug hander outer, especially to a male patient, because they're very few medications for men. But yes, they might just be handing out Viagra, Cialis, whatever, to the patient without looking at what's happening for the man and why he needs to be taking it. And of course, we know a lot of people are cured by putting Viagra in the bedside table and never, never taking one, but it's there. But that's not necessarily so and they probably do need to talk about their problem. So it does depend on the GP that you see at that moment is what I'm saying.

Steven Bruce
I think from what I quickly read of this before, while we were talking there, this is quite a heartwarming story, because John says he recently had a female patient who came in with knee problems. And on his case history taking the patient had Raynaud's and PCOS. I was very careful with my questioning and felt that the patient would at some point want children, I suggested visiting a colleague of mine for other treatment. Following week she came back and told me she'd spoken to her family and said, I think I found someone who can help me. I felt that I'd succeeded, says John, in helping her with a long-standing problem.

Dr Gillian Vanhegan
Well, it's lovely that she was able, I don't know how he got on to the PCOS from her knees. But it's wonderful.

Steven Bruce
Well, I suppose, I'm speculating here that actually as part of his case history taking, he will have gone through the various systems and said, is there anything I need to know about? And we've had some, I think we've had several two or three shows on PCOS here because we need to know what the signs, symptoms are. And also just point people in the right direction when they come to us with problems. Marianna says, given the opportunity for online consultations now, although it's not ideal, would it be possible to do a consultation with a psychosexual counsellor that way, if there was a dearth of practitioners in the local area? So do you do online consultations?

Dr Gillian Vanhegan
I do, yes.

Steven Bruce
Are they as effective?

Dr Gillian Vanhegan
We were, of course, driven into it by COVID. And also, I was driven into doing my teaching by zoom, I have a number of groups around the country who I teach, doctors and physios and nurses. And so there is a huge difference between what you get on a zoom screen and what you get in a room. Because we're always looking at the body language and how the person, for example, I saw a man on zoom the other week with problems. And at the very end of the half an hour on Zoom, he said, actually, I've got a spastic leg, spasticity in one leg. And I was horribly bullied at school about it. And I looked at him and I said, if you'd been walking into my consulting room, we might have been able to talk about that right at the

beginning of the consultation. So, of course, a zoom consultation or a phone consultation or whatever is better than nothing. But face to face is absolutely you get so much more. There was an another young man, who luckily I was seeing face to face. And he was tense and his hands were held really tight, tightly. And I said to him, you're so anxious about this, interpreting what was happening. No, no, I'm not. I said, just open your hands for a minute. And he opened his hands. And he was practically bleeding across his palms from the nails that he had stuck in. Now, if that had been on Zoom, I wouldn't have seen his hands. I wouldn't have been able to use that and just draw that out for him. So yeah, as I say, if if you haven't got somebody in the area, then it's better that the person talks on Zoom. But certainly, sexual problems usually are helped by a physical examination as well. So at some point, the patient would have to see somebody face to face.

Steven Bruce
Because we ourselves were sort of pushed into doing more online consultations during the COVID problem, which, when you're doing what we do for a living thinking, manual therapy is quite hard to do that way, but you can achieve a lot. But of course, as you say you miss out on that body language aspect of the consultation, don't you? And I suspect that whether the problems are psychosexual or not, if a person's got emotional problems of any sort, it's going to have an impact on how well they were recovering from whatever their physical injury, might even be causing their physical injuries. Whoever knows. Claire says, this isn't something that comes up very often for us. But when it does, it's bound to throw practitioners, and maybe leave some of us saying things that aren't really part of our training, because we don't know what to say. Can you suggest phrases that we can use to be supportive, but to prevent us ending up in a hole?

Dr Gillian Vanhegan
Yeah, no, as I sort of said earlier, I think you'll acknowledge the patient's pain. And you say, I see this is a really uncomfortable area for you if they started to talk about a sexual difficulty. You're in pain and difficulty about this. But I will have to refer you to someone else who will be able to talk to you about it. So I know, I have doctors, when I'm training them they say, oh, that consultation was so awful. I feel so dreadful. I just, you know, didn't do the right thing and all that. And I say to them, well, where do you think that came from? And of course, that's been massive transference from the patient. We've all come out of consultations, feeling we could just sit down and weep, but the patient's breezed out. So I think if you're empathetic, acknowledge pain and say you will find them help. That's the best that you can do for your patients.

Steven Bruce
Keith has said that a lot of guys talk to him about erectile dysfunction following prostate issues, and medication by the GP like finasteride or self-medicated testosterone with Viagra or similar. He thinks the clinic is a safe space with no judgement, but he might not know the answers, but he can listen and signpost. I think that's what we're hoping to get from this, is we're not expecting to become therapists like yourself, but we want to know how to signpost people in the right direction. And it did make me think earlier on, somebody earlier on sent in the observation, Jason, he said that what you've described sounds like motivational interviewing. And you said that you do your practices based on what the Institute of Psychosexual Medicine says. But you also mentioned cognitive behavioural therapy, what actually is the difference between motivational interviewing, CBT. And what you do?

Dr Gillian Vanhegan

CBT is very problem focused. It's very much relearning. I think it's far more useful for things like people with OCD, or people who want to give up smoking or that kind of thing. I have sent patients who can't use my sort of interpretive psychotherapy, some people can't use it, they can't process it, or they won't use it. And over the years, I can think of probably four or five, who I've sent to a CBT therapist, a cognitive behavioural therapist, because they will be on a different level, they will be giving advice, they'll be giving homework, what they do, the next time the patient comes along is check the homework and have you done this and have you done that. Whereas if a patient says to me, what shall I do before I see you again, that immediately will go back to them? What do you think you should do? And if they want to do some exercises or something, then certainly, they can. But we're not didactic, we don't give instructions like that. So that's the difference between us.

Steven Bruce

So what's the mechanism involved in this? How is it effective?

Dr Gillian Vanhegan

It's effective because as I say, it's the patient who knows where their problem's from, however deeply, deeply, they've buried it right down in their unconscious. And it's when you put back everything they're saying or doing that they begin to get it to the surface. I mean, on a very mundane, silly level. There was a woman the other day, who had booked a slot from 11 to 1130. Or someone had booked it for her. And I sat at my desk and she didn't turn up. Time's going on. time's going on, and I'm doing other bits and pieces. Finally, with five minutes of the consultation left, she comes in. And she's holding a cup of hot Starbucks coffee. Of course, I feel angry, but you don't get angry. I said, what is happening here? You don't show anger. You acknowledge anger in yourself. But you interpret what's happening. And I said to her, I feel you don't want to be here, which was the kindest way I could say, I'm really annoyed about this. And she said, no, I don't. She said, my husband made this appointment, because I don't want to have sex with him. And off she went on one about how her husband was exactly like her stepfather now, very controlling, wanting her to do this, all about washing up and cleaning and stuff and stuff and stuff. And she poured it all out in five minutes. And then she sat back. And she was very funny. She said, wow, she said, can I see you again? She said, and by the way, he's paying for my appointment she said, don't tell him I was 25 minutes late, just charge him for the half an hour. But it's, how did I get to that? It's observing what's happening and seeing and pointing things out to patients so that they think, yeah, I didn't want to be here because of him and this and that and the other. So it's a simple interpretation.

Steven Bruce

It must be a horrible process for a lot of patients where they have a problem, which they can't or don't want to admit to their partner or their family, and probably their friends, especially if they're men, perhaps, and so constantly internalising all of this and presumably worsening the problem in the process.

Dr Gillian Vanhegan

They are and that's probably why a lot of them end up with you guys. By the time they've internalised all of that, they're rigid. You know, you can imagine the musculoskeletal pain they're in. And that's why I think it's really important that as you're working with people, I think they will come out with difficulties that they're burying.

Steven Bruce
Robin has asked how you separate the psychosexual from sexual dysfunction caused by poor physical fitness?

Dr Gillian Vanhegan
That's a very good question, isn't it? I think it's so straightforward to begin with history and examination, isn't it and assessing somebody's physical state. I have known some people with severe physical problems, who do not have sexual difficulties, because of the way they've learned to adapt, and their partners adapted and so on, and things are fine. I had a group of neuro rehab doctors that I was working with up in Newcastle. And they had really interesting cases of people who'd had strokes and all kinds of neurological conditions and MS and so on. And they wanted to know how to help these patients who had a mixture of profound physical problems, which were leading to sexual problems, and you really can help people like that, but I think he wants to know how you tell the difference. Well, it's in the history and examination and finding out how physically well or unwell somebody is.

Steven Bruce
And we have a question from French Claire, bonsoir Claire. One patient I saw was a young male patient who said during the case history that his libido was very low. I wasn't aware at the time that there were such practitioners a psychosexual therapist, it's very eye opening, do patients have to get a referral from their GP?

Dr Gillian Vanhegan
Some clinics take self-referrals, some do. Yes. And sometimes there are health advisors, or doctors or nurses in sexual health clinics who've done training, and you can walk into an open access clinic like that and see somebody without going via the GP.

Steven Bruce
I suppose we could find that out in our own clinics, couldn't we? We can Google sexual therapy clinics or practitioners and find out whether they take referrals.

Dr Gillian Vanhegan
Exactly.

Steven Bruce
Somebody that the machinery has named Interesting Creation, because it does this. I don't know whether he isn't or she is an interesting creation but says that they had a 54-year-old patient who announced as she finished, as he finished treating that she had been raped by her uncle at the age of 10. I didn't know how to respond, how would you respond to something like this?

Dr Gillian Vanhegan
You see, this is really interesting. This is why I thought it was important, this session because that practitioner has touched that patient and in whatever way they've touched them, it's just open that locked door from the past. I would say, if it wasn't me, the osteopath was not trained, I would say, have you ever talked to somebody about this before? And would you like to? And definitely find her a counsellor because

child abuse that's locked away for that length of time causes so much internal pain and must have over her life caused sexual difficulties, I would imagine. We were doing the exams a couple of weeks ago, and I'm an examiner, it was a membership exam, and there was a physio taking the exam. And our exams are oral, not written papers. The people come along, they have a logbook of cases, we literally throw dice and choose one of the cases. And the physiotherapist presented a wonderful case of a really controlling woman who wanted the couch moved and all kinds of things and the physio was thinking what's going on for this woman, you know, what is going on for her. And she'd come to have pelvic floor exercises, so that she'd be able to have sex, which she hadn't been able to do for some time. And she was really awkward and really difficult, but the physio hung in there. And the woman got up on the couch and she said, I had a terrible delivery 14 years ago with my daughter. And in the delivery room, somebody said, that's been used a lot. So the woman immediately thought this was a personal comment on her. Presumably, the doctor or midwife or whoever it was, was probably talking about an instrument that needed to be thrown out or something that had been used a lot. So that seemed to be enough to have traumatised that woman. But, in fact, at the end, when the woman was dressed again, and patients do feel safer when they're dressed again, got off the couch, got dressed, and she said, actually, my daughter's 14 now, and I was raped when I was 14, and my daughter's going to the same school where I was raped. And so she'd held that in for the whole of her life since she was 14. She'd never talked to anyone. But now that her daughter was 14, the whole horror of it was coming back to her. And luckily, our physio who's done our course and knew how to start working with her. But that is the kind of thing that comes up.

Steven Bruce
Does this mean that your course is open to osteopaths and chiropractors?

Dr Gillian Vanhegan
We're certainly open to gynae physios who do pelvic floor work. If there are osteopaths who are doing genital examinations, certainly it would work. Yes.

Steven Bruce
All osteopaths are trained to and I can't speak for chiropractors, but I imagine it's the same, however most elect not to do that unless they're going to specialise in that area of medicine, of physical medicine. But it's interesting to know that the opportunity might be there for them.

Dr Gillian Vanhegan
The opportunity's definitely there. I mean, our gynae physios have been totally brilliant. We opened up to allied health professionals about five years ago, I think it was and they bring so much to the Institute and really interesting cases.

Steven Bruce
Osteopaths in England are classified as allied health care professionals. I don't believe that chiropractors and osteopaths in Scotland are not I believe, it's so weird vagary system, would that mean that chiropractors couldn't even consider going for training?

Dr Gillian Vanhegan
If they're allied health professionals, if they do physical pelvic examinations, and they are signed up to their professional body, they are very welcome on any of our training. We have an online 12-hour training, which is called an introductory term, which is a mixture of talks delivered by people like me and others, but also mixed with case discussions. So that's online, and if somebody likes that and finds that it talks to them that it's something they can work with, and that they're seeing those kinds of patients with those sorts of difficulties, then they can join one of our seminar groups, which meets for 12 hours every term and work towards say doing our diploma exam, takes about two years training to get to diploma level.

Steven Bruce
That might be of interest to people who do specialise in this area.

Dr Gillian Vanhegan
Certainly, if there's anyone out there...

Steven Bruce
Is it expensive?

Dr Gillian Vanhegan
It's 260, 250 pounds a term, I think.

Steven Bruce
So the answer is no, it's not expensive.

Dr Gillian Vanhegan
And the introductory term's 250, but they have changed lately. So I'm saying 250, it might be 260. Yep.

Steven Bruce
That's interesting. So we obviously will put up the details of your own website at the end of the show, and we'll make it available to people later. Is that all they need if they're interested in that avenue?

Dr Gillian Vanhegan
Yes, certainly get in touch.

Steven Bruce
I don't know if you wouldn't be overwhelmed with people suddenly emailing you saying, please, can I do the training?

Dr Gillian Vanhegan
No, that would be absolutely fine. We'll find places for all of them. I promise you.

Steven Bruce
It struck me listening to you a moment ago that one of the values of discussions like this is trying to prepare people for things that they haven't thought of might happen in clinic. And it's the same with first

aid situations. But we actually we had an osteopath on the show well over a year ago now before COVID, I believe, and he was talking about techniques to resolve stress in patients. And one of the ladies, a local lady who volunteered to become a patient, and he'd done his stuff on her. And then we asked her, do you mind if we asked what the stress was? And she said, she'd been raped. And I don't think I'm easily dumbstruck. But I thought, I really don't know what to say. We were on camera live. And I thought, Christ, that's a brave thing to have admitted to in that forum. But even if it had been in my own clinic on my own, I would have been taken aback. And I'm hoping that what people might take away from this is, just bear in mind the possibility that someone could come out with this sort of information and have something in mind that you're gonna say.

Dr Gillian Vanhegan
Yeah. So I think what you did there was a bit shocked and drawback. I think what we have to do is, say you move towards someone and say, you're very brave to have shared that with us. And hope that we can find someone to help you.

Steven Bruce
That would be the opposite of what I'd have thought, if a woman has just admitted in my treatment room, she's been raped, the last thing I want to do is move towards her because I would think that might be exactly the wrong thing.

Dr Gillian Vanhegan
Yeah. But what you did in that moving away, was putting your feelings about rape and how awful it was and all that. And really, what you want to do is empathise with her bravery and talking about it. But I see what you mean. Yes. I mean, I'm not saying you go very close. But instead of drawing back, maybe just lean forward a bit.

Steven Bruce
We might actually be physically touching somebody when they admit something like that. And who knows? Well, again, on this sort of communication, Anita says, what kind of language should we use to signpost the patient to a service such as yours, or services within the communities that deal with these issues? Just so the patient is attending the right clinic?

Dr Gillian Vanhegan
Well, the language is, isn't it, you seem to have a difficulty in your sex life, in your sexual life. We need to find someone who can help you and the clinic will, and just ask them, do you have a therapist who deals with sexual difficulties? Yes, I mean, I have heard patients referred to me who don't know what they're coming for, because the person sending them hasn't been brave enough to tell them. And also, I've had patients turn up with GP referral. And I've learned now never to say, your GP says you've got such and such, because they'll go, no. And now think I've got the wrong person in front of me. It's much better to say to the patients, what's your problem? How can I help you with that kind of thing? Because yes, words are difficult, aren't they? They can be misconstrued.

Steven Bruce

Yeah, they can be misconstrued. And, you know, obviously, one of the consequences is that we do something which is prejudicial to the patient's wellbeing. But also, a lot of people will be worried well, if you in any way give the wrong impression to the patient, it's a perfect opportunity for a complaint to the General Counsel. And then we're in front of what we call the Professional Conduct Committee, I think is Medical Tribunal for you, isn't it? But yeah, that is a horrifying process when all we're trying to do in almost all cases is help the patient, that's all we're interested in. I was thinking a little while ago, you were talking about chaperones and who we should and shouldn't or can and can't use as chaperones. I presume you must come across situations where there is an unwanted chaperone, where a partner has insisted that they come in with the patient or someone else is with them. And how do you go about dealing with a problem like that? Because you probably want to get rid of them so they can talk freely.

Dr Gillian Vanhegan

It's interesting, you should say that one of the trainees in my Cambridge group was presenting a case, when I say presenting case, they're telling us about a case, the case isn't there. And she was telling us about this 26-year-old girl who had been brought to her gynae clinic by her mother. And the mother was staying there, even for the examination and everything. And we're all sitting there going, you have to get the mother out of the room, you have to see the patient alone. It's really difficult the accompanying person. Because we're working at Brook as I did, for all those years, I had a lot of mothers who brought their young daughters in and sat because they wanted to know what was going on, which immediately made it very difficult for me to ask questions and assess whether they needed contraception, whether they needed morning after pill, what they needed. So I developed the thing of, well, the GMC is very hot on confidentiality, and I'm afraid every patient has to have a confidential consultation. I'm sure if there's anything your daughter would like to tell you afterwards, she will and remove the mother or the boyfriend or whoever it is from the room, because it really will impede what's going on.

Steven Bruce

And you can't ask the patient, can you, because in the presence of their mother, let's say they're not going to admit they don't want their mother there.

Dr Gillian Vanhegan

Exactly, that's so difficult, so difficult. And the mother will say, oh, she wants me to stay. She wants me to stay. I said, well, I'm really sorry, from a professional point of view, I have to see her alone, which is, you know, you have to have that sort of tricks like that to do it.

Steven Bruce

I don't know if there's something that you've ever come across, but reading one of Adam Kay's books, very funny man. But he said that in one of his obstetrics clinics, in the lady's lavatory, there was a sign saying, if there's something you need to talk to us about confidentially, particularly sexual abuse, or whatever else, put one of these little stickers on your case notes. And we'll know when you go back into the room. And he cited one case where a woman came in there were dozens of things all over. And they were desperately trying to get rid of her husband, it turned out it was their little daughter while she was in the loo who was sticking the notes on.

Dr Gillian Vanhegan
I remember that episode on television.

Steven Bruce
Oh, I didn't see that on television, but I read about it.

Dr Gillian Vanhegan
Sometimes in the loo, there's a thing that says, if you need to talk to somebody about something private on your own, ask for Annie or something.

Steven Bruce
We've got that in the pub. But of course, it's a big notice. So everybody knows that's what you're doing. It's become such widespread knowledge that it's hardly confidential anymore.

Dr Gillian Vanhegan
Go to the bar and say I want to speak to Susie, they'll go oh, they've got a problem.

Steven Bruce
All the heads will turn, and the conversation will die in the bar. Turning back to our questions, Simon says, how do you self-protect when patients bring up situations that reflect your own experience?

Dr Gillian Vanhegan
Ah, right. Well, psycho analysts have years and years of analysis, which they pay for, they know themselves inside out. Doctors, we don't go through that process. So we are expected to know our own internal trigger points and deal with them if they come up in the consultation. And I agree, it is very difficult. And I've known some of the people I've trained one person I'm thinking of in particular, who had lost a child. And really difficult for her, if that came up, when a patient was talking about a problem, you know, because she's obviously going to think about her own trauma. But you really have to set that aside and listen to the patient. And think what it means to the patient, because it'll mean something different to the patient from what it means to another person. But we haven't had analysis or endless psychotherapy, no.

Steven Bruce
Do you yourself have to go through counselling to make sure that you're okay, after all the stuff that you must hear.

Dr Gillian Vanhegan
We have what's called supervision.

Steven Bruce
That's the term I was looking for.

Dr Gillian Vanhegan
We have group supervision, which is very, very useful. And all the people in the group will tell you what you've done right and what you've done wrong. They're all your colleagues. And it's very helpful because

it opens the case up, because you can get a bit channeled with a patient, you can be going down one path, but there could be another path over there that you haven't quite opened up to. And I've noticed people in these sorts of groups being quite defensive about their own patients. You know, if somebody in the group says, well, maybe that guy was gay. Did you ask him about that? And then go no, no, I'm sure he wasn't. And they'll protect their patient from any other thoughts. But that's how we work. We take our cases to the group of peers, to a peer led group.

Steven Bruce
Eva's made a very good point here. She says at the end of the day, osteopaths, for the most part, are not also trained counsellors. And so something which often seems to be forgotten. And I agree there because there are occasions when I think many practitioners are drawn into offering advice in areas where they aren't experts. And as Eva says here, there's nothing wrong with a friendly conversation, but it is about acknowledging our professional limits when things get into specialist areas such as this. I suspect, again, I'm thinking in my own approach here. Maybe it's a male thing that if a woman particularly opens up to something like this, there's a desire to be protective and to solve the problem. And that might lead people into thinking that they should offer more advice than they perhaps are capable of doing.

Dr Gillian Vanhegan
No, I mean, the whole thing of knowing our limitations. And referring on, I mean, I know my limitations if somebody is becoming more of a psychiatric case, because our sort of therapy works for someone who's psychologically, if anyone's normal, psychologically normal. But if somebody is at all paranoid, deluded, schizoid, then that's limitations. And I would refer them to a psychiatrist, because I'm not a psychiatrist. We've all got our boundaries.

Steven Bruce
Right. We've been sitting down for a very long time. And I promised our audience, there'll be a practical component. And we've got a patient in the studio this evening, who has very severe sexual difficulties. Do you think you could offer us anything around the treatment table that might be useful?

Dr Gillian Vanhegan
Right, yes, let's go and have a look.

Steven Bruce
Let's go over there. Now, this particular patient has rather predictable sexual difficulties, loss of use of the limbs and so on. I think the audience were expecting that I was going to lay on the table.

Dr Gillian Vanhegan
No, Resusci Anne's here just to give the message really, that when you walk into your consulting room, it's something you're doing every day, we get blasé about our own environment and what we're doing. But this patient, bless her, may not have been in this situation before, certainly not with someone they don't know. And as you mentioned earlier, might have to be taking clothes off different parts of their body. I'm really interested in the way people respond to an offer to be examined. In our case, sometimes they'll go absolutely no, no, no. And you know, there's no consent. You can't examine someone. You may get the sort of patient who, there's a soliloquy, I've heard it so many times. Oh, doctor, this is awful for you,

having to examined me, I haven't had a shower, I haven't had a bath, I'm awful, I'm dirty. It's terrible for you. So I'm kind of feeling a bit defensive when patients say that because I'm thinking, it's my job, I'm doing it every day. And I realise that that is coming from them. And I'm wondering why they're thinking a part of their body is not good. And so I'll put that back to them and say, oh, that's interesting. Why do you feel that that's not a really nice part of you. And that's when you get people talking about abuse, abortions, guilt of all different kinds. And I don't know that it applies so much to what you're doing, but we very much observe the way the patient's lying on the bed. Are they the person who's got the blanket up here, absolutely defended, tucked under their chin, terrified about you examining them. Are they the kind of person who's really in the fetal position up against the wall?

Steven Bruce

Yes, we will probably tell a patient to lie in this position or prone or on their side, but they might well have a towel over them. So the opportunity is there for them to be protected with that covering I suppose.

Dr Gillian Vanhegan

Yeah. So just be, I'm sure you are...

Steven Bruce

I say tell them, we'll ask them to lie prone, we don't tell them to do anything.

Dr Gillian Vanhegan

Yeah, so just be aware of how they're feeling about the situation that they're in. And often, we were talking about chaperone training. When I train chaperones, I say to them, now, how would you feel if I suddenly said to get up on the bed, and you know, you wouldn't have your underwear on, you'd just be lying on the bed, and they suddenly realise what it's like. And for us, it's walking around in the patient's shoes, as we say, it's feeling what the patient feels.

Steven Bruce

For 90% of patients, it's not usually a problem, because they know what to expect when they come to see us. But I've often wondered, you might have a towel over a patient or whatever. But as you're waggling a hip around like this you are, inevitably, the patient may feel that they're exposed, even if you're looking at them and talking while you're doing this. Generally, with something a little bit less flexible than that, as I said, for 90%, it's not going to be a problem. But maybe just there will be somebody for whom that's a particularly sensitive thing to be doing. And we'll get the sort of feedback that you've described.

Dr Gillian Vanhegan

Yeah. So I think really, that I'm sure as osteopaths, you'll be aware, if somebody is not comfortable with whatever you're doing, especially around their lower regions. And I think the patient to look out for as well is I've seen very disarming, overexposed patients. And that is an awful feeling, if you come around the curtain, and they're really overexposed, probably haven't put the paper or a towel or whatever it is over them and they kind of, I feel, oh, I could just pick up the leg and drop it, you know, they're cut off from the waist down. And with those patients, I don't start examining them. I say exactly what I've said now, isn't it funny, you don't seem to be joined to the bottom parts of your body, you seem to be very distracted from the waist down. And very often you'll get a story then of abuse. And the only way they could cope

was by not feeling anything. And they also might be looking at the wall not looking at you. Because they kind of don't want to be there. And they get a bit childlike about it, and they'll turn away.

Steven Bruce
I once had a patient, an elderly lady, I think she was in her 80s. My routine was to say, after the case history, I'd say, would you mind undressing to your underwear, we are required to leave the room while they do that, and knock on the door and come back in. And this lady undressed to nothing but her stockings and suspenders, which was a complete shock to me. And I wasn't quite sure whether I should say for God's sake, put the clothes back on or just pretend that this was perfectly normal. I chose the latter route, because I didn't want to embarrass the poor lady. And as quickly as possible, gave her a towel. But it's a choice of language or interpretation of what we say is interesting, isn't it?

Dr Gillian Vanhegan
No, absolutely. When things like that happen, you have to think why did that happen?

Steven Bruce
Well, it hadn't occurred to me to think there might be a reason why that happened. I just thought this was an elderly lady who's you know, she's nothing was going to faze her.

Dr Gillian Vanhegan
Yeah, I mean, sometimes patients say that, don't they? I've had six babies, everybody's seen everything, they do that kind of thing. But maybe she was of that school. But also, it is worrying that somebody is quite so overexposing so quickly.

Steven Bruce
We're not going to get much out of Annie here, but are there, do you think, when a patient comes to us, and very often we're going to see them in their underwear, we'll be talking, we've got a long time, usually about half an hour to talk to them about their problems, would you say there's a category or are there groups of patients were there are red flags, just flags that say, this is someone who we might want to consider as having psychosexual problems. What are the cues, verbal or otherwise? Or you know, or physical? I mean, self-harming perhaps, maybe that's a cue.

Dr Gillian Vanhegan
No, I'd start right from the beginning, you leave the room or if you've got a curtain around the bed, or whatever it is, how long they take to get ready. Whether it's really difficult for them, because I've known patients when I've taught, golly, it's taking her a long time to get ready. And that is because there is something she's holding back on. So it starts right there. And there was one woman once, I finally went round the curtain, and her clothes were absolutely beautifully folded at the side of the bed. Normally people take the things off and chuck them down. But even her tights were folded and at that moment, I didn't know what that was about. I thought she's been wasting time of it. But actually, she hadn't been examined for a very, very long time. And it was because she was afraid that she actually had cancer that she was rotting away inside which she absolutely didn't have but that was what her fear was. And I realised that all this beautiful clean underwear had been hiding what she thought was a terrible thing going on inside her, which wasn't. So it's right from the beginning things like that. But then as I say, in the

way they're lying on the bed, it's a red flag. If they're being very, you know, and obviously, you're not going to proceed if you feel uncomfortable. And there have been times when patients have said to me, go on, go on, examine me examine me, and I've gone no, because it's not right. And you will get that feeling from a patient who's been abused or whatever, and you feel uncomfortable in your own self.

Steven Bruce
And the patient who seems completely uninterested in their own welfare, they've come to you because they're in pain, but they don't seem interested in their health, their physical fitness or anything or maybe they're obese or whatever else. Would you be thinking, well, maybe there's a reason for that.

Dr Gillian Vanhegan
Yeah. Somebody who just doesn't respect themselves or yes. I'm sure that you pick up on that kind of thing. And maybe you send people off to exercise and things and they come back and haven't bothered. Yeah, they're not involved in the process of getting better. And as you say, that can be some deep seated thing that's depressing them, holding them back, that their treatment's not going to progress unless they become involved.

Steven Bruce
Yeah. Well, I think there's probably little we can do to help.

Dr Gillian Vanhegan
Yes, no, poor Annie. I feel the need to cover her up.

Steven Bruce
We'll take a few more questions from the audience. Somebody has asked if we can mention the hand signal, that means you're in trouble. Open hand that closes finger by finger to a fist? Is that something you're familiar with?

Dr Gillian Vanhegan
No, that's really interesting.

Steven Bruce
I remember, it wasn't that, but I'm sure there was a different hand signal as well, which was known to some people, now I'm guessing what's been described is somebody who does that as a way of showing that there's a problem, presumably, when there's someone else in the room, and they want you to know about it.

Dr Gillian Vanhegan
I'm afraid that one's completely passed me by.

Steven Bruce
Whoever sent that in, can you give us a bit more detail on that? Because I do remember it, but not well enough to talk about who came up with that particular hand signal, you know, when it's used and so on or how people know about it, you didn't know, how would the public know.

Dr Gillian Vanhegan
And I've never seen anyone actually doing that. No, not that I've been aware of, terrible to think there might have been a cry for help. But I haven't seen that.

Steven Bruce
Yeah. John says, have you ever had a male patient come to you and say that he can't climax. John's had a patient who told him this and wanted help, and it seemed that he could have intercourse, but he couldn't climax and this was becoming an issue for him. He treated him with acupuncture and unfortunately, never got to see him again. What would your advice be? We don't know what he treated him for with acupuncture, whether he was actually addressing that issue.

Dr Gillian Vanhegan
Yes, men who don't ejaculate, it's not that common a problem. But it's quite kind of heart sink problem. Because they are men who, how can I put it, they, perhaps deep in the unconscious need to let down a partner, male or female. I had one man with this problem, who sits in my head forever, probably saw him 20 years ago who had a really lovely partner. And he could not ejaculate. He could ejaculate with masturbation; he couldn't ejaculate with his partner. And when I began to really find out what was going on, he was a very well to do, very successful. I luckily can't remember what he did, because I want to keep him anonymous, but he was very successful. Everything was going fine. But he could absolutely cry about his childhood and an alcoholic mother, and there didn't seem to be anyone else to look after this woman except for him, even as quite a young child. And he described about changing bedsheets and things that were not very nice. And that was his memory of all this mess and awfulness. So he didn't want any mess in his life. And he didn't want mess involve another person. And that was what his ejaculatory problem was about. I mean, the best way, I've not seen that many because it is a fairly unusual problem. But the best way of treatment is by, if they can ejaculate with masturbation involving that in life with their partner, so that they can get closer and closer to maybe intra vaginal ejaculation.

Steven Bruce
But of course, it would help to go and see someone like yourself, wouldn't it?

Dr Gillian Vanhegan
It's essential, I would say it's not a problem that tends to go away without treatment.

Steven Bruce
It's certainly not a problem that I would feel competent to advise on, even given what you've just said.

Dr Gillian Vanhegan
There's been a bit of research in the institute, but we all agree that they are quite difficult patients to deal with.

Steven Bruce
Really. I've been informed, on the website, before we came on earlier, there's a lot of chat that goes on that I don't see that doesn't get sent to me, because it's not the questions. And there's been quite a few people asking whether this topic is relevant to us as manual therapists. But lots of people are saying that

they've had patients bring up sexual topics, as I said earlier on. The great thing I'm thinking about this is that we need to be prepared for those possible, sudden and unexpected comments from patients. And I genuinely, I think this is really relevant to what we do, because it's all part of how we can communicate, interpret problems, which may be unusual for us and refer in the right direction.

Dr Gillian Vanhegan
I think it's really a shame that some people don't think it's relevant. Because I'm just afraid that if somebody did try to open up to them about something, they're a bit of a closed door on this one. Maybe for whatever reason, they don't want to go there themselves.

Steven Bruce
I'm smiling slightly, because we're about to get a guest appearance in the back of the studio off camera from someone who's going to demonstrate the hand signal that we're talking about. Right, and we are being shown that the hand signal is this, thank you for that, Justin, coming out of the gallery to show us that. But the bigger question is, how many people would know about it?

Dr Gillian Vanhegan
Where does it come from? Who started it?

Steven Bruce
I'm fascinated to know that.

Dr Gillian Vanhegan
Yes, that's what we need to know.

Steven Bruce
Yeah. And of course, if you of all people haven't become aware of that, then it would be surprising if lots of patients knew about that hand signal. But anyway, we do know. So, it's called the cry for help signal. But I still don't know who has actually deemed it to be a cry for help signal.

Dr Gillian Vanhegan
Well, I'm glad I've learned that tonight. I'm really pleased, because if ever I see it, now I know.

Steven Bruce
And similarly, of course, I've been reminded of it. How you would do that discreetly in a treatment room, you'd have to do it somewhere out of sight of whoever it was you were trying to conceal it from.

Dr Gillian Vanhegan
Yes, if they were sitting at the side, the way you've done it now it wouldn't, yes.

Steven Bruce
It's a bit like asking for Muriel at the bar, because if you know about it, then they probably know about it. So yes, Lou says over the last 10 years, I've had a male patient who I thought was joking when he said I've fallen off my heels again. In the last three years, he/she has come out as being transsexual, should

I have spotted this. They're so much happier. It's disappeared. They're so much happier now and back problems are far less. But did only let them down by not tweaking that they were trying to tell me something. It's easy to beat yourself up about things that you didn't know at the time, isn't it? And I'm I'm very bad for having a fairly jocular approach to things. And if someone said I've fallen off my heels again, I might think oh, yeah, okay, you've injured your ankle and I wouldn't think twice about it.

Dr Gillian Vanhegan
But he was obviously trying to tell him or...

Steven Bruce
Yeah, or expected him to know. But as you say, up until that point, it would seem that it's been concealed, because allowing that emotion to come out, allowing that statement of your sexuality to come out seems to have helped with resolving the other problems. So it's definitely relevant to us as a professional, isn't it? Deborah says the hand signal came from Canada. Well, that's handy. Alex says, I'm interested in the dynamic of a patient that has always over shared about their sexual kinks. Not in an inappropriate manner coming on to me way, but just in a, surely everyone experienced this isn't this and talks about it way. It transpired they were molested as a child. And I was wondering if that had any bearing on their over openness about it, and talking about it wanting to explore their pain kinks with random dating app people?

Dr Gillian Vanhegan
Yes. I mean, in a way, that's kind of what we were talking about by overexposure examination. It's overexposure by talking, isn't it? They're disinhibited and all this has happened to them, and that's why they want to talk about it. And I think they want somebody to ask them how they feel about it because it's often when somebody pours out a whole load of stuff like that, you sort of think, oh yeah, right. But really, you want to know why they're doing it and what they feel about.

Steven Bruce
I suspect there are quite a few osteopaths and chiropractors, and possibly physiotherapist, and so on, if someone started talking about their sexual kinks, as it was described there, they would say, I'm sorry, I'm not prepared to talk about that. And that's appropriate in this discussion. But actually, that might be the wrong approach, it might be that they need to talk about that. And they need for someone to ask them why.

Dr Gillian Vanhegan
Yeah, I think I'd say, I wonder why you're bringing that up now. Pretty straightforward thing, isn't it?

Steven Bruce
I imagine that some women might be very worried that it is a come on, whereas men would be perhaps less worried.

Dr Gillian Vanhegan
Yes, yes. And I think I'd say to them, you know, do you feel this is something that you need to talk about with somebody, I'm not trained, or whatever the osteopath would say.

Steven Bruce
More about the hand signal, Wikipedia says the distress hand signal was a hand signal to indicate distress, that goes without saying and need a rescue. The Canadian Women's Foundation devised a signal for help that women could use secretly to indicate that they were at risk of domestic violence. And so needed assistance. Knowledge of this signal then spread through social media such as tik tok, obviously, didn't spread far enough. What if you don't have a group of peers, life can throw all sorts of curveballs and when you come up against details of abuse that reflects your own, how do you manage?

Dr Gillian Vanhegan
When you come up against abuse that reflects your own?

Steven Bruce
That's Simon's comment, yeah.

Dr Gillian Vanhegan
So he's saying that he's had some trauma in the past.

Steven Bruce
That's what I inferred from that comment.

Dr Gillian Vanhegan
Yes. I don't quite understand what he's saying. And so if he comes up against somebody who wants to share their experience of abuse? Is it that he doesn't want to?

Steven Bruce
Yes, this is the challenge that you said we would face with questions, isn't there that? Yes, we kind of need sort of rapid feedback on exactly what's meant by that. So Simon, if you want to come back and be more specific, then that would be lovely. But if not, then we might have to pass on that for the moment. Anita says do you have a psychosexual therapist attached to cervical smear clinics?

Dr Gillian Vanhegan
Wonderful question. Over the years, I have done a huge amount of training with nurses who take cervical smears. Because it can be a really traumatic event for women, mostly, it's fine, I hasten to add, mostly, 90% of the time fine. But for some women, it will reawaken some awful experience, and they're quite traumatised by it. I don't think I've got time to go into it very deeply. But I have had a number of patients over the years, just the fact of having a cervical smear has caused huge sexual difficulties. So I think yes, I don't know that there are actually therapists attached with the clinic, but you can hope that you'll get someone taking the smear, who's been trained to understand the emotions behind it. It's not just the fact of physically taking a smear. And that's it. There's a lot more that goes with it.

Steven Bruce
And I was just trying to find a question that I saw a moment ago, in the meantime, Justin said, he's going to put the information about the hand signal into the credits. And of course, I'll share all the links and

things that we've talked about this evening. And that business of the handshake, the signal in the email that I send out tomorrow.

Dr Gillian Vanhegan
Thank you to the person who brought it up.

Steven Bruce
Yeah, it's one of the things I've discovered about, a lot of very eminent consultants, like yourself who have come on this show is that they're not in the least bit phased when some new information comes across as part of the show. And it's great, isn't it?

Dr Gillian Vanhegan
I love a bit of new information. I want to learn something every day, yes.

Steven Bruce
Have you got any takeaway points for us as we wind up the show, because we're coming to the end as you know.

Dr Gillian Vanhegan
Well, the takeaway points from me is that I've been really interested in the questions. I really admire the people who've said about the occasions when patients have brought up the problems that they've got, and that so long as everyone realises that if you're touching a patient and as you say, cranio sacral, whatever it is, it just might bring up a problem for that patient. And yes, don't go over your boundaries. But make sure that you know somebody in your local area that you can refer that patient to if they want help with whatever the problem is.

Steven Bruce
I think I would add to that, if I may., and I do this virtually every person who comes on the show is to emphasise to our audience that, for God's sake, write it in the bloody notes. Because it will be easy to think when someone says, talks about their sexual kinks, or someone put it early on, well, that's nothing to do with the treatment, but for self-protection, as well as anything else, I would want it in the notes that they had brought this subject up and what I've done about it, because it's one of those nasty areas, which could lead to difficulties.

Dr Gillian Vanhegan
Yes, absolutely. We have to be playing a bit of defensive medicine, defensive osteopathy, these days.

Steven Bruce
Simon has, I'm going to echo what you said, Simon, very bravely, has come back into this and said, yes, I've been abused in the past. And when patients mentioned their abuse, I find it painful to remember my own experiences and not take on the patient's pain.

Dr Gillian Vanhegan
Yes, which is what we were saying earlier, it's being able to go with their feelings about their pain, which is difficult if he's still got very vivid feelings about what happened to him.

Steven Bruce
I imagine by the fact that Simon is open about this, that Simon has actually probably taken on some counselling himself to be able to get to this stage. And let's hope that anybody else in that position would do the same. Because yeah, keeping stuff inside can't be good. Steve says, I'm reading a book called You Just Don't Understand Women and Men in Conversation by Deborah Tannen, a very informative book. Again, we'll put that we'll put a link to it in the email that we send out tomorrow. And as a final point, I guess, Pippa says that, I think going back to smear tests, she's heard that you can ask the nurse to use a smaller speculum if it's painful.

Dr Gillian Vanhegan
Yes, yes, of course you can, you don't let people do things to you without saying how you're feeling? Yes.

Steven Bruce
Is it worth me asking about, there's been a lot of information recently about lowering the age at which smear tests take place or are offered? Is there value in smear testing early do you think?

Dr Gillian Vanhegan
I've always been a supporter of earlier smear taking, yes. And in fact, I've been around a long time. And when I first started, at Brook, we used to take a smear a year after a girl had started to have sex. So when you think about it, there were 16 and 17-year-olds having smears in those days, which was way too young. But 25 is a bit old. There are a lot of things that can happen with a wart virus before you get to 25. I don't want to frighten people out there. But I would support slightly earlier smear taking.

Steven Bruce
So useful advice again for our patients. Gillian, we've had 417 people watching who have been logged. So it's been a it's been a good number for this evening show. So thank you, again for giving up your time to talk to us about this.

Dr Gillian Vanhegan
I've enjoyed the interaction and the wonderful questions.

Steven Bruce
And I have no doubt that it's very relevant. So that's all we've got time for this evening. As I said, we've got over 400 people watching. And many thanks to all of you watching, particularly those who shared their questions and their observations with us, as CPD, maybe it's a little bit out of the ordinary, but it does address a key element of our requirements, which is the need for effective communication. So more to the point, if it enables any of us to spot even just one patient in need then personally I think it's going to have been worthwhile. And I suspect it will apply to many more of our consultations. So before I go, again, let me thank all those involved, Gillian, of course, thanks to you, in particular, for sharing all your expertise this evening so freely, it's been a huge pleasure. But also to the team behind the scenes. Justin

and Paul in the gallery behind me, Ellie behind the camera there, Claire and Becky and Ruth who have been handling your questions so effectively. And if things have run smoothly this evening, then of course, it's all down to the work that they're doing, as I say very much behind the scenes. Quick look ahead. Thursday this week, I've got a lunchtime show with Trudie Avery, and she's going to be talking about a very different aspect of communication. How you can use your website, your branding, your colours to encourage confidence in patients and potential patients, Trudie is known as the logo lady and I'm smiling, when I rehearsed this, I kept calling her the Lego lady. She's not a Lego lady, logo lady, and it's going to be a great opportunity to get some free advice on the more subtle aspects of marketing and how that can affect your practice. Thursday lunchtime, 10 past one until five to two, our normal timings. Next week, Monday the third I've got Pippa Cossens in the studio for a lunchtime session on managing chronic pain. Now Pippa has been on the show before and she's a very experienced osteopath with a special interest in fibromyalgia, amongst other things, but she's also a sirpa practitioner, and she's going to be sharing a very useful pain management resource with us. So look forward to that one. Wednesday, the fifth I've got an evening show on paediatrics with a chiropractor, Mike Marinus The topic is going to be the treatment of unsettled babies, but I'm pretty sure it'll range far and wide, especially if you think about the difficult issues, we have surrounding actually telling anybody that we can treat this sort of thing. And, of course, there's lots more in the pipeline, but I'll stop at that. If you'd like to look further ahead, check out the calendar page on our website. There's lots in store, from migraines, to mindfulness to thyroid problems, as well as regular lunchtime case-based discussions. And I think there's one of those coming up on the 12th of October. That'll be the next one. That's it for this evening, though. Time for you to relax and for me to take Gillian and husband John currently in the gallery off to dinner. Hope you've enjoyed the show and I hope to see you on Thursday. Goodnight.