

[Ventegodt S.](#) **Every contact with the patient should be therapeutic.**

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Letter to the editor
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Every contact with the patient should be therapeutic

Repressed shame syndrome results in low self-esteem, low genital self esteem and sexual dysfunction often with pain. When it comes to gender and sexuality shame is undoubtedly the most destructive feeling. Even more destructive than open shame is the repressed shame that live its secret life in the tissues and inner space of the body, especially in the pelvic and genital area. The sign of repressed shame is the appearance of an unappealing bodily “energy”. If the genital tissue holds on to shame, the patient will feel her genitals somewhat “dark”, “dirty” or even “disgusting”, and the physician can often relate to this experience from the quality of the tissue – from completely healthy to somewhat disturbed and out of balance. A low genital self-esteem is often connected with general sexual dysfunction like lack of desire, anorgasmy, or pain, either during intercourse or chronic, often in the form of primary vulvodynia [1,2].

Interestingly the “repressed shame syndrome” in my clinical experience can be cured by simply giving acceptance to the patient’s body, sexuality and genitals. Every contact with such a patient can and should be curative, as there are plenty of possibilities to give acceptance to the patient, both through conversation and physically. Orally the acceptance can be the assurance that the genitals look completely normal and sound and physically the acceptance can be given in the way the genitals are touched during the pelvic exam [3]. Not giving the acceptance needed by the patient can lead to very negative experiences of the pelvic examination, which seems to be directly traumatic to young woman in some cases [4].

In the Research Clinic for Holistic Medicine in Denmark we have made the simple experiment of giving such accepting psychological and physical contact to 20 woman with severe sexual dysfunction. We noticed that 56% of the woman experienced an immediate and radical improvement [5]. We used the explorative phase of the pelvic examination as the occasion to give the acceptance that the woman needed. We experienced that when the issue of repressed shame was addressed in the session it seemed to be integrated right away. Just confronting the shame and understanding its irrationality is often enough to make it disappear. We noticed that the repressed shame resulted in what is now often called psychoform and somatoform dissociation, meaning that the patient has difficulties in connection through mind and body to another person, including the partner. By integrating the shame we can help the patient close this gap in contact, immediately improving self-esteem, genital self-esteem, and sexual function.

Most interestingly, sexual problems like lack of desire, anorgasmy, chronic pelvic pain and primary vulvodynia is also often cured when the repressed shame is

integrated, giving substance to the hypothesis that primary vulvodynia and the related pelvic-pain disorders are originally caused by repressed shame disturbing the tissue that is holding on to it. A tendency to chronic recidivant infection and reduced immune resistance in the genital area might also be related to repressed shame.

There is a severe problem in the traditional distinguishing between examining and treating a patient. Every contact with a physician can result in a major impact on the patient's understanding of life and disease – a fundamental philosophical impact that is very curative if positive. Every contact must be used to improve the patient's understanding of responsibility for health and quality of life. Every close contact to the patient physically or mentally must be used to close the gap of somatoform and psychoform dissociation. Every contact with the patient about gender or sexual issues must intent the processing of repressed shame and other emotions that are capable of giving the patient severe sexual problems. Only by using every opportunity can we improve the general state of sexual functioning. An area where about one in two or three have significant sexual problems[6].

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