INSTITUTE OF PSYCHOSEXUAL MEDICINE

N E W S L E T T E R

No. 10

Editor: Dr. Katharine Draper,
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Dear Doctor,

January, 1978.

Enclosed with this tenth Newsletter you will find the Agenda for the A.G.M. and the Secretary's Report. I emphasise "tenth" because we are approaching the time when the founding officers of the Institute will retire, according to the constitution, and we hope that others will come forward to assume their responsibilities.

1. MEETINGS

FUTURE

(a) The A.G.M. will be held at:

5.0 p.m. on FRIDAY, MARCH 3rd
in the MARCUS BECK LIBRARY, ROYAL SOCIETY OF MEDICINE,
WIMPOLE STREET, LONDON, W.1.

It will be followed by a clinical meeting at 8.0 p.m. in the WEST HALL on:

"Technique or understanding? Dangers of getting in a rut".

Speakers: Dr. Joy Herman, Dr. Alexandra Tobert, Dr. Pru Tunnadine.

Members wishing to dine at the R.S.M. should 'phone and book their own tables.

(b) A weekend symposium will be held at Birmingham University, September 1 - 3rd, 1978.

PAST

(c) A clinical meeting was held in the Marcus Beck Library at the R.S.M. on Friday, December 2nd, 1977. Dr. Eleanor Mears read her paper on "An analysis of the work of twenty-five members of the Institute". We cannot give her paper in full while it is waiting publication elsewhere, but I am grateful to Dr. Hinshelwood for the account of the meeting given in Appendix A.

RELEVANT

(d) International Congress of Psychosomatic Obstetrics and Gynaecology. Rome November 13 - 19, 1977.

A number of our members attended the conference. Dr. Tunnadine has given us "Some Impressions" (Appendix B1.) and papers were presented by Dr. Margaret Blair and Dr. May Duddle (Appendix B2 & 3).

(e) Balint Society Since our work is so closely allied with that of the Balint Society, we feel that our members would be interested to receive the advance notification of the 4th International Conference, enclosed with the Newsletter.

2. ACCREDITATION

The Accreditation Panel met on December 3rd and Dr. Coombs, Dr. King, Dr. Rogers and Dr. Williamson were passed for specialist work in the field of psychosexual medicine.

3. COUNCIL NEWS

Miss Valerie Thompson has, at the request of the Council, agreed to become Publications Editor, and has already been busy editing the reports of the two weekend meetings. She has sent me the following message:

"I would be delighted to receive any copies of publications produced by members of the Institute in recent years on illustrating or elaborating on our particular method of work in any environment whatsoever. This will form a concentration of knowledge as we progress and the Council hopes that ultimately some of the work may be published as proceedings of the Institute in ways to be determined. I hope to be inundated with such contributions if they are addressed to me at 81 Harley Street, London W1N 1DE."

Miss Thompson will be assisted by Dr. Pasmore and myself. Since the last Newsletter we have received a copy of Dr. Morag Bramley's paper "Short-term psychosomatic treatment of sexual problems" published in the British Journal of Venereal Diseases Vol. 53, No. 5, October, 1977, which was mentioned in the discussion following Dr. Mears' paper.

All other Council News will be given in the Reports of the Officers at the A.G.M.

4. RESEARCH

The workshop for twenty-five doctors who will take part in the Pilot Study will take place at Margaret Pyke House on Friday, January 27th, and we will carry a report on this in the next Newsletter.

The Committee are still in correspondence with the Nuffield Foundation.

5. ERRATUM

Apologies to Dr. Brown for the misprint in Newsletter 9, page 3, item 10 "Study Tour". Those who join Dr. Brown for his study tour will go to CHINA (not clinics) and anyone interested should write to Dr. Brown, 90 Darley Road, Gravesend, Kent. The Study Tour will have a special emphasis on Family Planning and attitudes to sexuality.

6. ONE-DAY INTRODUCTORY COURSE - Margaret Pyke Centre.

A number of these courses have been held and we are grateful to Dr. Liz Miller who has written an account of the course she attended for the Newsletter (Appendix C).

? A PATRON SAINT FOR THE INSTITUTE

I was examining a Cypriot woman who had been referred from a sub-fertility clinic, with vaginismus. "My Mother", she told me, "had 'trouble' for 15 years after the birth of her first child. Then she had a dream - a vision almost - of St. Andrew. He was doing ..... what you are doing (examining her). After that she was better".

I hope there will be a good attendance at the A.G.M. to discuss the important issues raised in Dr. Blair's report.

Yours sincerely,

Katharine Draper.

KATHARINE DRAPER

APPENDIX A.

Barbara G. Hinshelwood.

Members of the Institute of Psychosexual Medicine met on Friday 2nd December with Dr. Main in the chair to hear Dr. Eleanor Mears read her paper. This is a retrospective study, over one year, of the work of 26 members of the Institute. Tables of the results were circulated to all present, and we shall be able to read the full text when the paper is published.

Dr. Mears was stimulated to write her paper after Dr. Bancroft's Oxford study was published in the British Medical Journal in 1976, Vol 1, p. 1575-7 The Paper is written as a comparison with this study and uses the same diagnostic classification. This classification completely ignores the neurotic interaction and the subjective feelings of the psychotherapist, which some doctors found too restrictive to cope with.

Thirty-two doctors volunteered, and twenty-six actually took part in the study, a similar drop-out rate to patient attendance, it was noticed. Of 1828 patients 160 failed to keep their appointments and 129 were inappropriate for various reasons. Altogether there are 1373 completed cases, including couples. Patients received an average of 3.7 sessions of treatment, 48% being dealt with in 1 - 3 sessions. The longest duration was 38 sessions, and still in treatment.

Patients were treated in sessions which were conducted as studied in seminar training. Dr. Bancroft's team were all psychiatrists. His patients had 1½ hour diagnostic sessions initially, then the treatment which followed was mainly behaviour therapy using techniques advocated by Masters and Johnson, with co-therapists.

Dr. Mears discussed her results, and the difficulties of assessing results of this work. There was a substantial improvement in 65% of cases, effected in a mean of 2.5 hours per case, which were favourable results in this comparative study. She concluded by posing a number of questions.

Is there a most satisfactory type of clinic? Seminar trained doctors work in a variety of places:- health clinics, infant welfare, F.P.A. (free of fee-paying) privately, hospital psychiatric or gynaecology, etc. How important is the individual doctor's approach; the length of sessions, spacing of sessions?

How do we end treatment, and how do we view those patients who drop out? And when we are assessing success, what are we aiming for? Perhaps we, and our patients, all have different criteria.

In the combined study the proportion of women to men was very high, while in Dr. Bancroft's study it was about 50/50. Do women more readily accept failure and find it easier to seek help, or is it that women more readily use clinics staffed by women, or men avoid clinics staffed by women?

It seemed that the sexual presentation was the primary problem in about 50% of cases, and secondary to some other disturbance in the other 50%, but there are insufficient statistics as yet on this. This is an area Dr. Mears would like to pursue further.

The discussion that followed was very slow to actually pick up any of Dr. Mear's questions. A lot of time was spent discussing where the paper should be published and to whom it is directed, and we then talked about the value of such a paper. Should time be spent on statistics and classification of symptoms etc. when our way of working does not usually involve these concepts.

A lot of pessimism about our work seemed present towards the end of the meeting and Dr. Main had a few workds to say on it in summing up. Doctors are on the whole more pessimistic than patients and their relatives. Does our pessimism come partly from working with patients who need a container to project their own uselessness into? The Institute must get together in seminars and organise publishing its work. This carefully prepared and excellently produced paper of Dr. Mears is a very favourable reply to Dr. Bancroft's Oxford study. Maybe we need it for our own morale.

APPENDIX B.

THE INTERNATIONAL CONGRESS OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY

B.I. SOME IMPRESSIONS OF ROME, 1977 Prue Tunnadine

The Vth International Congress of Psychosomatic Obstetrics and Gynaecology met for a week in November. To exchange the dank terminal for the Cavalieri Hilton in sunshine couldn't be bad, but the infinite variety of that magical, cynical, truly eternal city claimed of course much of the delegates' dedication. As to work, our own Prof. Norman Morris was an admirable President. Dr. Tom Main chaired a session with elegance and aplomb and rushed off to lead seminars around Italy. Professors Arthur Crisp and Jim Watson (with Christine) psychoanalyst Laurence Goldie, our Margaret Blair and May Duddle and others spoke admirably for "G.B." and we beat Italy, at Wembley, on the Wednesday, though not well enough, annoying the waiters! The English-spoken contributions, even allowing for language difficulty, were with few exceptions of a high order in relation to others. Encouraging to find our efforts so ahead in sophistication, especially in psychosexual medicine; but sad so few of us there to boast, for some papers our most basic trainees would hardly think worth reporting.

But three halls full of continuous ten minute papers are no way to judge or learn; no way to appreciate the fruits of painstaking original work. Slides whizz by; translators scream "slow up", chairman scream "shut up". Is this necessary? All the "Management of labour" cults were there, Leboyere and Kitzinger and the dedicated and reputable and the frankly lunatic fringe. R.D. Laing's film "Birth" centred this debate; a savage attack on medical interference. Too savage perhaps as it goes on to suggest women have a monopoly of tenderness; not true in my experience. But it will surely provoke many another heated exchange as it goes the rounds.

Did we learn anything new? Not much. But we had the town band and a banquet in a Palazzo and a party at the Embassy and an audience with the Pope (who I gather congratulated those who offered themselves on being <u>against</u> contraception etc!) And we had Traviata and one of life's magic moments in the St. Cecilia's ensemble's exquisite musical clowning. And we had the pasta and the plonk - and the Pieta. And colleagues who had been mere telephone voices became friends. For me, that's what these conferences are about.

APPENDIX B2 PSYCHOSOMATIC PELVIC PAIN Dr. Margaret Blair

When pelvic pain is largely or wholly psychosomatic it can be demonstrated to be an expression of anxiety, and this anxiety is usually about femininity and feminine functions. The pain is used, consciously or unconsciously as an attention seeking mechanism to express feelings of:-

1. Fear and uncertainty
2. Guilt and regret
3. Anger

The most common conditions that these feelings are associated with are:

1. Menstruation
2. Intercourse
3. Abortion
4. Childbirth and motherhood
5. Hysterectomy

Puberty with the onset of menstruation is a time of adjustment to developing sexuality and to all its implications. For many this is a natural procedure but for some it is a time of great difficulty and anxiety with a reluctance to accept the feminine role. This can manifest itself in dysmenorrhoea unamenable to

prescribed remedies or operative intervention. It can also be a pointer to further problems as many of these patients go on to have trouble with intercourse, difficult pregnancies and labours ending with forceps delivery or Caesarean Section. Often this sequence is not predicted but only looked at in retrospect, whereas if the psychological problems of these young patients presenting in their early teens had been looked at, at the time, much of their future pain and trouble might have been prevented.

Non-consummation occurs much less frequently these days but the following case is an example of the use of psychosomatic pain to draw attention to anxieties about intercourse. The patient, aged 22 had been married for 3 years. She had had a series of minor complaints which gradually became localised to pelvic pain severe enough for her to faint and be sent home from work on several occasions. She was sent to a gynaecological clinic where it became obvious at once that she had severe vaginismus. She would not let anyone near her - the pain was much too severe - before anyone touched her. She was sent to a psychosexual problem clinic with the message that she would probably need a hymenectomy but it might be worth while trying psychological methods first. After much difficulty she did allow examination with one finger and was able to express some of her fantasies and fears. These fantasies were mainly about pain and damage in the form of tearing and splitting. Eventually she was able to examine herself which was a great relief to her. Much later she was able to consummate her marriage and is now considering pregnancy. Most important in the present context is the fact that her pelvic pain served its purpose and has now gone, having been used to call attention to the area of her difficulties which she was unable to express in words.

However, as is to be expected she still has doubts about her feminity and from time to time has aches and pains in the legs or chest which she presents as doubts about her oral contraception, but she is now able to add "but I expect it is all due to my problems really, isn't it?

There are many patients who have been able to allow consummation but then present with dyspareunia. Often these patients are extremely reluctant to admit that the pain can have anything but a physical basis. Their medical advisors, taught to exclude all physical causes before labelling any pain as psychosomatic, collude with the patient, give creams and pessaries, cauterise the cervix, do Ds and Cs and laparoscopes and the patient's conviction that there is something physical causing the pain is reinforced. An example of this is a patient who presented with dyspareunia and thought she had something inside her causing the pain which she felt in her vagina at the time of intercourse. She was investigated and nothing physical was found. She took time to accept that her pain was not physical but psychosomatic but was eventually able to say that she had a feeling there was something in the way as twice she had thought she was almost reaching an orgasm but had stopped her husband as she did not know whether the feeling was pain or pleasure. She went on to say that she did not know what to expect and expressed the fear that to go on and have an orgasm might make her feel degraded or silly.

In this case the patient was able without very much difficulty to relinquish her pelvic pain which had, as in the first case, served the purpose and had drawn attention to the anxieties which she could not at first express in words - namely, her fears of orgasm.

Unfortunately not all patients are able to accept as readily as this that their pain is not physical.

Patients requesting termination do not usually present with pelvic pain - they present their difficulties in the form of an unwanted pregnancy. That in itself should call attention to their problems, but if these problems as well as those associated with the termination, i.e. the mixed feelings of guilt,

relief and regret, are not understood and worked with they may need to develop psychosomatic pelvic pain - and some do this.

The puerperium and the months that follow is another period in the patients' lives in which their feminity is strained. In their inability to adjust to the role of partner and mother, pelvic pain often attributed to damage and stitching, is presented and again it needs to be understood. It is often an expression of anger and resentment against the partner who is often thought to be getting off too lightly with no added pain, strain and responsibility.

Hysterectomy is for some patients a very painful process as the uterus apart from being functional is symbolic and represents a large part of the patient's feminity. She may have had trouble with it for years, pain, bleeding, and a determination and expressed wish to have it all taken away, but, when it is taken away the pain persists. She was ambivalent, and taking away the uterus still leaves her with her problem which was her inability to accept her feminity completely. This is what has to be understood and worked with if possible. It is often very difficult to do this and it can be more difficult after hysterectomy than before.

In conclusion, it should always be born in mind that pelvic pain may be not only physical but psychosomatic and much time can be saved and trouble avoided if both are looked at together. While physical examination and investigations are being carried out an attempt can be made to look at the patient as a whole and see what she is trying to express by her pain.

APPENDIX B3.

RESPONSE TO ORGASM BEFORE MARRIAGE IN PATIENTS WITH VAGINISMUS

May Duddle.

(An Extract - The treatment and results are given in the British Journal of Psychiatry 1975. 127, 169)

Patients with vaginismus have usually been assumed to be neurotic and frigid - unable to respond to any form of sexual stimulation.

To test if this is correct and to try to discover more of the etiology of this condition I decided to compare 3 groups of women; a group of 32 presenting at a sexual dysfunction clinic with unconsummated marriage due to vaginismus; a group of 35 married women attending at a day hospital with a diagnonis of neurotic illness, and a control group of 50 women attending a clinic for contraceptive advice and with no history of vaginismus or mental illness. The birth control clinic was, incidentally, running alongside the sexual dysfunction clinic in the same premises.

The patients with vaginismus formed part of a series previously reported (Duddle 1975). They had been married from 3 months to 15 years and had never managed to have intercourse. They were a consecutive group referred to the clinic from a number of sources for this problem and there was no selection of cases. In 5 couples the husband had some degree of impotence and in 2 premature ejaculation, which further contributed to their difficulties.

Results

These are some of the results I obtained:

Age at Menarche The neurotics had a slightly later age at onset of menstruation but the control and vaginismus patients were identical, suggesting that later sexual maturity is not a factor.

Age on Marriage The age on marriage was very similar although the controls were an average 2 years younger for both males and females - perhaps patients with both neurotic illness and vaginismus are more reluctant to marry.

Domicile The vaginismus patients were more likely to have come from an urban background - to have been brought up in a town - possibly with less access to the knowledge of sexuality in animals easily acquired by country children.

Education Levels Education levels varied a little with less of the vaginismus patients going to grammar school than the other 2 groups, but more going on to college. For some reason less of the neurotic patients had gone on to higher education - perhaps because of problems connected with their illness.

Sex Education They were all asked now they first learn about sex. The answers were not dissimilar, although for some reason again the neurotic patients varied - none said they first learnt at school and only 2.9% learnt from books, but controls and vaginismus patients were very similar.

Religious Denomination Concerning religious denomination, again vaginismus patients and controls were very similar with more Anglicans and less Catholics than the neurotics.

Religious Practice Religious practice varied more - both vaginismus and neurotic patients being either more devout or more inactive than the controls. This does seem to cast doubt on the idea th t religious teaching, by increasing sexual guilt, contributes to the problem as Ellison (1968) has suggested.

Eysenck Personality Inventory Vaginismus patients and their spouses were asked to complete Form B of the Eysenck Personality Inventory which gives scores for neuroticism and extraversion, and they were compared with scores for a general population.

Although the scores were just inside the normal range the patients were at the extreme edge of this for neuroticism and under it for extraversion, although their spouses were remarkably normal. There seems to be a particular personality pattern in this type of patient - the women often being a stubborn type who dislikes submitting and she usually seems to choose a gentle husband who will not, as it were, rape her (Friedman, 1962, Mayer, 1932). This passive-aggressive personality type came out more clearly in some work done by Cooper (1969) than in this study.

Experience to Orgasm Before Marriage None of the results so far as significant but one remarkable difference showed in their response to questions about their total experience to orgasm at the time of marriage. 71.9% of patients with vaginismus had had orgasm from some form of stimulation prior to marriage, and only 66% of controls and 65.8% of neurotics. This took into account that some of both neurotics and controls had experiences orgasm in intercourse before marriage.

Masturbation was similar for all, but many more of the patients confessed to having achieved orgasm in dreams and more had petted to orgasm. Commonly these couples go on for years achieving sexual satisfaction by mutual masturbation, and it is only when they desire a family that they ask for help and then may go back to their former practice afterwards even if they do achieve penetration.

This does seem to demonstrate that these patients are reacting normally in the 2 stages of intercourse described by Helen Kaplan (1974), disorders of which produce most of the sexual dysfunctions. They respond to sexual arousal, the first, or, vasocongestive phase of intercourse innervated by the parasympathetic system, and they also respond to orgasm, the second, or, orgasmic phase innervated by the sympathetic. The only thing they cannot allow is actual

penetration and to attempts at this they respond with acute anxiety - even with panic - producing spasm of the muscles of the lower part of the vagina and sometimes of the thighs also. In other words, they demonstrate phobic anxiety to penetration.

Experience to Orgasm before Marriage

	Vaginismus (n = 32)	Neurotic (n = 35)	Controls (n = 50)
Premarital Intercourse %	0	25.7	24.0
Masturbation %	28.1	31.4	28.0
Dreams %	40.6	28.6	26.0
Homosexuality %	0	8.6	4.0
Petting %	56.3	28.6	40.0
Total	71.9	65.8	66.0

In summary then, these patients with vaginismus usually react normally to the vasocongestive and orgasmic phases of intercourse, but exhibit phobic anxiety to penetration, and treatment aimed at overcoming this is usually successful.

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APPENDIX C.

IMPRESSIONS OF AN "INTRODUCTION TO PSYCHOSEXUAL MEDICINE" COURSE

"20th October, 1977. Dr. Liz Miller

A course entitled "An Intoruction to Psychosexual Medicine" will be held at the Margaret Pyke Centre, London. This is a one day introductory course suitable for family practitioners and family planning doctors interested in the recognition and treatment of psychosexual problems." Thus ran the advertisement in the British Journal of Family Planning, July issue.

Although I had by then completed a year of Basic Seminar training I had joined my group in their third term, and felt that I had somehow missed out on basic information. This seemed the ideal solution.

The 20th October found some fifty doctors, composed of a good scattering of General Practitioners, Community Medicine and Hospital Practitioners, gathered at the Margaret Pyke Centre. I discovered that this was the second such course to be run by the centre, and that these are very much in the nature of an experiment. Feedback from the participants was a vital part of the proceedings, and we were therefore given Evaluation Sheets to complete by the end of the day.

Basically the day was divided into morning and afternoon sessions. First we considered what were the problems and how to recognise them, and in the afternoon the various methods of treatment were discussed. After tea we split into seminar groups for case history discussion.

Dr. Barbara Law was the first speaker in the morning on More Common Psychosexual Problems. I gave her top marks for a clear concise outline of the problems which are presented to us, illustrated in her lively inimitable style.

Dr. Fay Hutchinson then gave us a fascinating itinerary of Recognition of Problems, concentrating on the indirect and therefore hidden presentation. I mean, did you for instance know that a complaint of irritation of the eyelids could be a psychosexual plea for help? I didn't. I can now add, on good authority, irritating skin complaints to my list of more obvious presentations and confidentally ask my patients "Well, and who would you like to be scratching?"

We then saw the Chernicks film "Sexuality and Communication" which some of you may already be familiar with. Produced by Ortho in Canada it is a beautiful balance of sound sense and humour. I did however find the likeness of the female Doctor to Princess Anne, even to the fact of being pregnant, most disconcerting. Nevertheless definitely recommended.

After lunch we started our consideration of methods of treatment with a Psychiatric Approach presented by Dr. O.S. Frank, Consultant Psychiatrist at Westminster Hospital. I had expected to hear about Freud, the Oedipus Complex and transference, but was disappointed on that score. Instead, we looked at marital disharmony and the personalities involved in relationship failure. Not for Dr. Frank the five year in-depth analysis, but a very 'practical' approach, with a set number of sessions (say six) agreed upon with the couple, after which progress was reviewed and decisions made. I had been ready to admit a fair ignorance of psychiatric methods but Dr. Frank showed me aspects of the psychiatrists approach of which I was quite unaware.

Dr. Elphis Christopher outlined the, dare I whisper it, Behaviourish Method (Master and Johnson) and I am sure that she cleared up a lot of confusion in peoples minds. Most doctors outside our Institute have heard of M. & J. and I'm sure have wondered quite where they fit into the picture. Mention them to a member of the Institute and you may get the impression that you've said something "not quite right".

"But what DO you do then?" This was answered very well by Dr. Carol Butcher in the last lecture on the Balint Analytical Method. I was glad to hear her emphasise to us that after a one day introduction we would not be equipped to rush home and start treating all our patients. As doctors we're trained to expect an easy answer, a few lectures on the subject, then off you go and treat illness X, perhaps read a book for a more detailed step by step guide. I heard people asking " ... which book should we read?" ..... and remembered the same question asked by myself a year ago.

An excellent course. The day seemed much too short -- but in retrospect perhaps this was just right - enough to really whet one's appetite and make one want to find out more. I'm obviously biased, being already a convert, but I think, and hope, that this was how others felt.

I would like to put to you very strongly the idea of a course of this nature being run as a pre-seminar introduction. Perhaps it could be a pre-requisite for Basic training but I'm not so happy with that idea, being opposed to any form of rigid selection. Suffice to say that I found the course very interesting and would have welcomed the opportunity to have attended at the beginning of my Basic training. For me some things would have been much clearer much sooner, but that's just one doctor's point of view, one person's impressions of an "Introduction to Psychosexual Medicine".

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