INSTITUTE OF PSYCHOSEXUAL MEDICINE

N E W S L E T T E R

No. 11

Editor: Dr. Katharine Draper,
29 High Street,
Chipstead,
Sevenoaks TN13 2RW.

May, 1978.

Dear Doctor,

This Newsletter is the first to be printed on the electric Roneo that has been given to the Institute by one of our members, Dr. Roland Freedman, and its first message is to record our thanks. The Roneo is also being used to print the transcripts of Advanced Seminars.

The Minutes of the A.G.M. which accompany this Newsletter, contain most of the news, but this section includes notice of events since the meeting in March. We also have a good collection of contributions from members.

1. MEETINGS

FUTURE

(a) The WEEKEND MEETING will be held at

the GOLDEN VALLEY HOTEL, CHELTENHAM, September 1st - 2nd.

THEME: Use of Institute Training in Different Medical Settings

Friday

2 p.m.	"Roots"	Dr. Pasmore
	Problems in Subfertility Clinics	Dr. Hughes (London)
	Requests for Abortion	Dr. Coles (Bristol)
	TEA	
	Youth Advisory Centres	Dr. Hinshelwood (London)
	Anxieties in a VD Clinic	to be arranged
	Group Discussions	
7.30 for 8. p.m.	DINNER - by courtesy of Wyeth Laboratories Dept. of Postgraduate Education.	

Saturday

9 a.m.	Counselling HM Prisons	Dr. Roberts (Kent)
	Genetic Problems	Dr. Williamson (Southampton)
	Vasectomy Counselling	Dr. Filshie (Nottingham)
	Group Discussions	
	COFFEE	
	The Doctor's Vulnerability - Three case studies by:	Dr. Lisle (London) Dr. Gilloy (London) Dr. Coombes (Leeds)
	LUNCH	

2.15 p.m. In Gynaecological Out Patients Departments — Miss Thompson (London)

SUMMING UP BY CHAIRMAN

Director of Training - Her Aims and Difficulties — Dr. Tunnadine (London)

TEA

Members of the Institute are asked to put forward their ideas for future training and development of the work of the Institute.

5 p.m. - 5.15 p.m. CLOSING REMARKS BY THE CHAIRMAN

We are grateful to Mr. F.A. Patterson, Dept. of Postgraduate Education at Wyeth Laboratories, who is undertaking the administrative arrangements, and members will hear direct from his office. The cost will be approximately £30.

It is regretted that unforeseen difficulties have led to a change of venue, but we hope that this will not prevent anyone from attending. Arrangements are already in hand so that the preference for a University, expressed by Members at last year's Meeting, can be implemented.

(b) A clinical meeting will be held at the Royal Society of Medicine on Dec. 8th 1978.

(c) The A.G.M. followed by a clinical meeting, will be held on March 30th, 1979.

PAST (d) The A.G.M. was held in the Marcus Beck Library at the R.S.M. on March 3rd 1978. At the clinical meeting that followed Dr. Alexandra Tobert and Dr. Prudence Tunnadine spoke on "Technique or Understanding? The Dangers of getting in a rut". I am grateful to Dr. Robina Thexton for the account of the meeting given in Appendix A.

2. NOTICE FROM THE TREASURER - DR. FAY HUTCHINSON - URGENT

"Following my report at the A.G.M. in which I explained that rising costs were not going to be met from our subscription income in the next year, the Council has discussed ways of increasing our income, and agreed that it would be necessary to raise subscriptions from 1st September, 1978. The rates have remained fixed since the Institute was founded, and I hope that we will not have to increase them again in the next year or so if all our members continue, and make arrangements to pay in September 1978. The different rates are as follows:

1. Covenanted Subscriptions will remain in force until their 7 years expire but some associate members who have covenanted for £3. and are now full members should increase the covenant to £5. If any other member would like to increase their covenanted subscription to £10. p.a. please do so!

2. Full Members subscription Ten pounds p.a.
i.e. existing full members, and in future those accredited by the panel.

3. Associate Members Those not accredited by the panel, Five pounds p.a.

4. Subscribing Members Ten pounds p.a.

I am including new Bankers Orders and Covenant forms. If they can be completed, and returned to me before 1st September, 1978, this will be extremely helpful.

Training Account It has been decided to use a separate account to fund training seminars, and pay the administrative costs of setting up the new seminars. Each seminar should be self-financing - therefore the fee may vary, depending on the number of members and frequency of seminars. A registration fee of £5. will be paid by each new member when a seminar is set up to help meet the administrative costs, in addition to the first terms fee.

Some Advanced Seminars are now being held weekly, and the cost is increased to £30. a term. It has been suggested that some members may find this difficult to meet, particularly if they have to give up sessions to attend. If this is the case, they are asked to write a confidential letter to the Treasurer, to see if we can make any adjustment.

Assessment by the Panel In the past, members of the Panel have given up a full day for this, without payment. With an increasing number of members presenting for assessment, we are now making a charge of £20. for assessment, and if the candidate is successful, £10. to register as a full member.

We are making enquiries as to the possibility of getting friends to help finance our training programmes, to try to keep the costs down.

I would be grateful if you would attend to any changes in your subscription now.

P.S. I have two subscriptions paid in the name of Dr. C.E.J. Shaw and Dr. Unsworth. If you answer to either of these aliases, please let me know, so that your membership may be credited."

3. ACCREDITATION

The Accreditation Panel met on March 4th and Dr. P. Brown, Dr. S. Buck, Dr. D. Morgan and Dr. I. Trail were passed for specialist work in the field of psychosexual medicine. Dr. Carol Butcher has been appointed Penal Secretary and those who wish to apply to appear before the Panel should write to her at 59 Wimpole St., London, W.1.

4. RESEARCH

a. PILOT STUDY A workshop to launch this study was held on 27th January. I am grateful to Dr. Heather Mountford who has written a lively account given in Appendix B.

Already 11 cases, representing 88 years of non-consummation, have been enrolled into the study.

b. NUFFIELD STUDY A workshop has been arranged to launch this study on October 6th at Margaret Pyke House. The doctors who have gained experience in the Pilot Study will take part. Meanwhile the committee are working on the final details.

5. CORRESPONDENCE

i) S.A.R. Films These films have had considerable publicity and been the subject of a correspondence in N.A.F.P.D. I am sure members will be very interested to read the reactions of a group of seminar members which has been sent to me by Dr. Jane Berry (Appendix C1.)

ii) Training Dr. Elphis Christopher has written to propose a system of Tutorials (Appendix C2.) and I would be interested to receive replies for the next Newsletter.

6. PSYCHOSOMATIC MEDICINE

Those who walk the tightrope of psychosomatic medicine need to be aware both of the rare cases where a somatic disorder can present as a sexual problem, and of the emotional consequences of disease. I am grateful to Dr. Houghton who has prepared the summary of a paper on "Sexual Dysfunction in Patients with some Neurological Disorders" (Appendix D1.). We are also pleased to include a paper by one of our new Subscribing Members, Dr. Lawrence Goldie (Appendix D2.) on Psycho-sexual Problems in the Treatment of Cancer.

I am sure some of you must have met patients in these categories and I will be pleased to receive any relevant case studies for the next Newsletter.

7. BRITISH ASSOCIATION FOR COUNSELLING have written to the Institute offering to send a copy of their brochure to all members. Those who are interested should write to the B.A.C. at 20 BEDFORD SQUARE, LONDON, WC1B 3HU.
Telephone no. 01-636-4066.

8. NEW MEMBERS

A list of New Members, Subscribing Members and changes of address is given in Appendix E.

The following quotation seems relevant to our way of working:-

"..... a scruple of accuracy which I retained until I had reached the age at which I realised that it is not by asking him questions that one learns the truth of what another man has had in his mind".

Can anyone identify it? The answer will be given at Cheltenham where I hope we will enjoy a large gathering of members.

Yours sincerely,

KATHARINE DRAPER

APPENDIX A.

"TECHNIQUE OR UNDERSTANDING. THE DANGER OF GETTING IN A RUT".

Dr. Tobert and Dr. Tunnadine

An account of the clinical meeting, at the R.S.M. on March, 3rd, 1978.

Dr. Main introduced the 2 speakers, who first met each other in his basic seminar in January 1960. They have collaborated on many occasions, but on this occasion had not discussed beforehand how each would approach the subject.

Dr. Tobert defined technique as a 'method for achieving one's purpose'. The purpose is to help people whose sexual drive has been lowered by fears of various kinds:- of exposure of the body, or of emotions, of demands made on them of mess, smell, of their own bodies or their partner's body, of the propriety of pleasure.

The method of helping was searched for in seminars - aimed at clearing away the emotional problems which are detractive from the patients sexuality. It only offers treatment after understanding of the problems has been achieved. The patient has built up barriers of protection from anxieties and she can't express her feelings through these.

The vaginal examination is a parallel of the exposure of intimacy which takes place with a partner.

Dr. Tobert finds she uses this 'tool' less, but talks about it more. It is useful in cases of non-consummation, dyspareunia in young married women and primary frigidity.

She finds that in cases of secondary frigidity, she needs to have more information about the life happenings which brought to the surface old emotions not properly worked through, now causing conflict.

3 examples were given:-

A woman who had post partum depression and loss of libido, hadn't connected her symptoms with her child's congenital dislocation of the hip and her own hospitalisation with the same complaint from the age of 10/12 - 2½ years. She needed to work through again the anger and anxiety she felt then. Another woman had loss of libido since her baby was born 10 years before and hadn't connected it with her own mother's death when she was pregnant. A third woman of 41 years was sexually happy until she reached the age her mother was when she died. "I always dreaded that I would die then too", and when this fact was uncovered in the interview she improved.

A great many postnatal women need help - they have a lingering depression and are looking after their babies without joy - the birth has re-awakened old feelings which need to be resolved. They may feel they themselves were not mothered enough, or had been jealous when another sibling was born. The present sexual problem is the way in to get help for the wider personality problem and Institute doctors need to have skills to look at this.

Dr. Tunnadine defined the Institute technique in a different way, as a special use of the doctor/patient relationship in the here and now and a special use of the genital examination. Human sexual behaviour is the expression of one's attitude to oneself and to one's partner and changes from moment to moment and over the years - if patients can think how they relate to the doctor in the here and now they learn how they are relative to their partner.

The vaginal examination is useful where patients are learning about sexuality - where their difficulties are to do with distorted early relationships they need psychotherapy rather than sexual therapy.

Institute doctors are not 'mothers' or 'fathers' to patients, but caring authority figures and we must note how they deal with that. The Dr./Pt. relationship involves rapport, acceptance, permissiveness and also bad feelings from time to time.

For instance if we are trying to be a better 'mother' to a male patient, we may miss his difficulty, which is that he hates peaceful, good women. Moment of Truth was first described by Hemmingway as man's confrontation with himself. In the unguarded moment of the expectation of examination, feelings and fears are revealed. These are of exposure of private parts and what this means to the patient, of penetration, or of challenge to performance.

It is useless to reassure a patient if you haven't understood what it is that lacks assurance.

Dr. Tunnadine has a mental check list to note how the patient behaves with her, and it is special and unique to her as it would be to other doctors who bring their individual personalities into the interview.

She had started her talk with an amusing caricature of the original so called 'F.P.A. technique' used to help frigid women in clinics.

In the discussion which followed the two warmly received presentations, several useful points were made.

Dr. Bacher welcomes the fact that the Institute technique allows us to be <u>ourselves</u> treating the individual patient.

Dr. Barne likened it to polaroid spectacles, to see better below the surface, different people see different things, and make different uses of it. Each individual uses his own skill, is sincere and true to himself.

Dr. Tunnadine added that on the bad days when we are not at our best, this is useful if we can watch the patient's reaction to it.

Dr. Tobert is glad that patients, like our children, give us more than one chance but we mustn't waste their time, so we must continue to modify and improve our technique.

The indefinite fact is the outcome of treatment. The precise art is to notice how it is going.

Dr. Goldie commented that it is necessary to have a precise technique to use, so that how you yourself are feeling that day doesn't sway the treatment.

Dr. Main added that it is not what you do to or for a patient, but what you do with them. By the time the doctor understands what is going on, the patient does too. You get to understanding by listening - you start off by being ignorant but willing and the technique is altered by the setting in which you are working. We must keep technique in the thought area of the mind.

Dr. Freedman felt that you should not put patients into categories - ask more questions of some than others.

Dr. Tobert replied that to classify saves time and with secondary frigidity if you can find out the essence of the shifting equilibrium, when they were happy before, you can do a short cut.

Dr. Tunnadine concluded by saying a lot more needs to be understood, especially about the technique of examining men and the different levels of communication if you examine them standing up or on a couch.

Robina Thexton.

(Both speakers are preparing their papers for publication later)

APPENDIX B.

A REPORT ON THE WORKSHOP FOR THOSE TAKING PART IN THE RESEARCH GROUP'S PILOT STUDY ON NON-CONSUMMATION.

Dr. Heather Mountford

On Friday 27th January, those of us who had agreed to participate in the Research Group's Pilot Study on non-consummation, met together for the first time at Margaret Pyke House in order to learn our tasks.

This pilot study has been launched by the Research Group because of pressure within the Institute of Psychosexual Medicine to get some of it's work published. This pilot study is being financed by money donated by individual members of the Institute. One cannot doubt the dedication, hard work and thought which has gone into the preparation of this study by the Research Group and are grateful to them for what they hope to do for the benefit of the Institute.

We began at 10.30a.m. - twenty-five of us, desks in rows, instructors on the platform. Katharine Draper introduced the study. The definition of non-consummation is to be, "the failure of any penetration of the vagina by the penis in the present relationship". We are to study only those whose non-consummation is of fours years duration or more or if an N.H.S. Consultant, Marriage Guidance Counsellor or sex clinic has been involved in unsuccessful treatment.

As for today, our prime purpose was to learn how to fill in the forms that the group had devised in order to acquire all the necessary information about a case. We were told that we must accept the form as it stood and that it had been designed to fit in with ordinary clinical practice. We were told that today six cases were to be presented - real cases dramatised and enacted by the research group. We would also have a script. For each case we would fill in a form and the forms would be collected and marked. By the end of the day it was hoped that some uniformity of answers would be produced. Rapidly and with great efficiency Morag Bramley explained the form - 0 = None, x = Unknown, (1) = Yes, (2) = No. It all seemed very confusing.

Case 1 began. Enter Mrs N., housewife, wife of Army Colonel. She has written to her G.P. saying that she wishes to "explain" her husband's impotence. Mrs N. " - You see it is my husband who is so hopeless, I am at the end of my tether". With prompting by the doctor, the story of a tough, dominating woman emerges. Enter Colonel N. who tells his story. We come to the end of the first appointment. The second appointment is a week later - the story further unfolds. Mrs N. is examined, weeps, is becoming more relaxed, more vulnerable, showing the soft core of femininity beneath the hard exterior. It is now two weeks since the first visit and we must fill in Form I. We are confused - the case is confused. There are questions, discussion, dissension. The form goes away to be marked. We keep a copy and are told the "right" answers.

There are questions again, discussion, disagreement. Time is getting on and we must get on with the case. The next three visits are enacted, consummation is achieved but the result is less than perfect. What went wrong? We have three more forms to fill in; one for her, one for him, one for the final outcome. There are details of upbringing, religion, education, obstetric history, sexual experience, sexual information, fantasies. Does a passing reference to parental separation necessarily mean emotional upheaval? Does being an Army Colonel mean further education or wasn't he at Oxford so does he have a degree? What is her fantasy about her vagina? Is it (1) too small or (2) possible pain?

In the next room Form I is being marked. There is a chart with our marks on it - black is right, red is wrong. What are we <u>meant</u> to say? We are told the answers - questions again, disagreement. The forms are collected again. Coffee comes round but we mustn't stop. Time is getting on and we are on to Case 2 which we must finish before lunch.

Lunch is excellent, kindly provided by Ortho Pharmaceutical. We bring our coffee to our desks and start on Case 3. The actors change their parts

- doctor, husband, wife, narrator. It is the sleepy hour, the case is difficult but suddenly it's getting easier - we rattle through the forms. On to Case 4 - encouraging comments come through from the next room - there's more black than red on the chart now. Confidence grows as the sky darkens outside. Then, reprieve! Case 5 is our last case. We can do Case 6 from the script at home. No cheating this time. No neighbour to crib from.

The end of the day. We are fairly tired but then so must our instructors be too. It's been interesting - never boring, quite exciting in a way, trying to get it right. We've even learned quite a lot from the cases although sometimes they've been a bit facile, too easy. Will we be able to apply what we've learned to our own cases? At least we are stimulated - longing to start.

Anyway, what will it all add up to, this Pilot Study, this first piece of research to come from the Institute? How will the results be evaluated? Can these bare forms ever mean anything when the colour, the flavour, the feel of the case is all gone? We will be interested, even informed. But will it show others what it is we have to offer, what good if any can we do? Not only for the sake of the Research Group but for the sake of the Institute of Psychosexual Medicine let us wish this project well.

APPENDIX C1.

VIEWING OF S.A.R. (SEXUAL ATTITUDE RESTRUCTURING) FILMS BY SEMINAR MEMBERS

The members of the past Winchester and present Alton Seminars held a showing of the S.A.R. videotapes made by the Multi-media Resource Centre of the National Sex Forum, San Francisco.

Our purpose was to try and assess the relevance of these films to work with patients with psychosexual problems and to our method of training.

It appears that these films are being increasingly used for teaching purposes without adequate assessment and we would like to make the following comments.

1. Quality

Technically the quality of the videotapes left a lot to be desired. There was interference and poor colour definition.

2. Content

The overwhelming opinion was that all the tapes dealt with the function of the sexual organs and almost completely disregarded feelings and relationships.

Although these films obviously intended to show explicit sexual functioning, the photographic techniques used caused confusion and thwarted this aim. Techniques such as superimposition and the over-enthusiastic use of dream-like photographic sequences were responsible for this confusion.

To sum up, we feel that the philosophy conveyed by these films is fundamentally different from our own and is centred on the bodies and organs rather than the feelings of real people.

Delia Aitken	Jane Berry	Mare Laxton
Ros Anderson	Margaret Blair	Ruth Lever
Helen Arthur	Mavis Conway	Joan Pasmore
Eva Banky	Dee Howell	Elspeth Williamson
		Jessie Yorston.

From: Dr. Elphis Christopher,
35 Wood Vale, N.10.

Dr. Psychosexual Clinic
North Middlesex Hospital.

To: The Editor,
Institute of Psychosexual
Medicine Newsletter.

I should like to propose that the Institute give serious consideration to the setting up of a personal tutorial system similar to that run by the Marriage Guidance Council. The purpose of this would be for the benefit of trained psychosexual doctors who have a case that they would like to discuss immediately rather than wait for a seminar (that is, if they are attending one).

I felt the need of a personal tutor recently with a rather difficult case which I am sharing with a marriage guidance counsellor who, in fact, consulted her tutor for help.

The case was one of non-consummation of 6 years duration. The couple (Jewish, in their 20's) had attended a marriage guidance counsellor for 1 year prior the wife's referral to me by her G.P. (a woman doctor F.P. trained). The husband had left the wife and had had an affair to reassure himself about his potency. The wife had sought help from the G.P. after listening to a radio programme on sexual problems, which mentioned that marriages could be annulled on the grounds of non-consummation.

Both husband and wife had attended the first interview (the husband had returned hoping that something could be done). The wife cried during the entire interview - the tears appeared to be both defensive and controlling rather than of sadness. She adamantly refused to be examined. I felt it would be less threatening for her to let her take control and recommended the use of dilaters (something I rarely do) on the basis of avoiding the 'battle of wills' about examination in which she could defeat me as she had done her husband.

In subsequent interviews to which they both came a picture emerged of the wife as an indulged only child of unhappy parents. The father was considerably older than the mother who had had numerous affairs. They frequently argued and when the wife was 14 the father had told her about mother's behaviour which shattered her idealised image of her mother. A suggestion that sex for her meant becoming wicked like mother met with little response. The husband came from a close knit but troubled family with a grandfather who ruled like an Old Testament patriarch. He (the husband) felt angry that his own father could not deal with this. Thus both had 'impotent' fathers. During interviews the couple vied with each other for attention like rivalrous children - the wife continued to cry and the husband constantly corrected my interpretations inferring that I had not understood (and, indeed, perhaps I had not!) I felt that he could not express his true feelings towards his wife (the anger and resentment for making him impotent) and that he really needed someone for himself (much as I felt during our interviews!) He always had to maintain the role of protective Prince Charming towards his wife. He accepted my offer to refer him to another marriage guidance counsellor and saw her regularly. (I also kept in contact with the counsellor). Meanwhile the wife cried less at interviews and had managed to pass two dilaters and requested that she show me this. She also asked me to examine her. When I attempted to do this, she shivered and shook and said that my fingers were sharp (like her husband's penis) and when I tried to enter further, screamed hysterically, "I can't, I can't". She refused to examine herself.

At the last interview (the 7th) she came in announcing that she had thrown her husband out because she could not cope with "the tension". If her husband made sexual advances they were like "an experiment" to see if he felt

anything. He called her filthy names and said she'd never let anyone into her 'hole'. She resented his work. (He was a successful businessman involved with construction and building!!) and she dearly wanted revenge upon him. She blamed the break-up of her marriage on the first counsellor they had seen together, attacking her honesty and integrity and maintained that she was trying to get her husband away from her. Suggestions that it was really me and the other counsellor with whom she was angry (the mothers who took men away) were denied. At this interview, the tears shed seemed to be a mixture of anger and real sadness for herself. She left saying that there was no point in returning as her husband had left her and gave me a look of pitying contempt (her 'revenge' on me?).

This couple seemed to have embarked on a collusive marriage - her the fragile princess 'sleeping beauty' and him the protector Prince Charming. Once insight into this was gained by him, particularly the intense underlying anger which they both felt began to be expressed. However, her defences which seemed largely hysterical were very strong and did not, perhaps could not, allow 'penetration'. She seemed unable to trust and be vulnerable and could only relate to others by manipulating them. Both carried much anger and disappointment with their own parents which they brought to the marriage. I am uncertain whether I have really understood this case, or whether I really appreciated what was happening between us and would have greatly valued support/discussion with a tutor during this time.

Do other doctors feel like this? Obviously, if a tutorial system is set up consideration will need to be given to who the tutors should be (leader doctors, senior Institute doctors?) and payment for the tutorial (whether through the Institute or on an individual basis).

APPENDIX D1.

"SEXUAL DYSFUNCTION IN PATIENTS WITH SOME NEUROLOGICAL DISORDERS"

Synopsis of a paper presented at Montreal, 1976, International Congress of Sexology, by P.O. Lundberg, M.D. Department of Neurology, University Hospital, Uppsala, Sweden.

The author and his colleagues have investigated sexual dysfunction in the hypothalamo-pituitary axis, temporal lobe epilepsy, multiple sclerosis and peripheral neuropathies.

The sexual history is corroborated by interviewing the partner. Clinical examination involves noting the body hair distribution, skin pigmentation, genital examination including testicular volume in men, and presence or absence of galactorrhoea. Neurological examination is particularly directed to the lower segments of the spinal cord, including five genital reflexes, the pelvic musculature, and genital sensation as assessed by a biothesiometer (an instrument for assessing vibration sense in the skin and mucosal areas). Further investigations as appropriate, include hormonal assays, skull x-ray and tomography, lumberpuncture and myelography, E.E.G., E.M.G. of pelvic muscles, visual fields and seminal samples.

1. Hypothalamo-Pituitary Disorders

This group was the largest in the original paper. Of 65 males with tumours in the cellar region, 48 reported decreased or absent libido and potency. While this was the initial symptom in 20 patients medical advice for this reason was sought by only one.

There was less sexual insufficiency, eleven out of 21 patients, with a small intracellar tumour (these tumours will usually present with visual field defects due to pressure on the optic chiasma). A larger supracellar tumour caused insufficiency in 37 out of 42 patients (probably due to impairment of hormonal absorption due to pressure on the hypothalamo-pituitary portal system).

19 tumours produced hormones. Sexual problems were seen in 5 of 11 cases of acromegaly and 7 of 8 prolactin producing tumours (these are often successfully treated with bromocriptin). Clinical hypoandrogenism was found in most cases and testosterone levels correlated well with sexual function.

75 women showed similar patterns of decreased libido, reported in half the cases of acromegaly and all but one of 19 patients with hyperprolactinaemia. 90% had amenorrhoea, which was usually the presenting symptom. Low serum oestradiol levels correlated well with sexual insufficiency.

An absent response to intravenous LH-RH was seen in both sexes.

2. Temporal Lobe Epilepsy

Focal manifestations of a fit might include genital sensations and orgasm itself very rarely precipitates a fit. Erection difficulties were felt to be due to reduced level of androgen metabolites as anti-convulsants induce liver enzymes. (Shades of anti-convulsant oral contraceptive interactions!). Medication with carbamazepine or benzo diasepines sometimes improved libido and potency.

3. Multiple Sclerosis

Transient dysfunctions occur early in the course of the disease but may persist later. Men frequently have impotence, although genital manipulation may result in erection when fantasies failed, whereas women tended to complain of lack of lubrication, and both from paraesthesias. Symptoms tended to correlate with concomitant bladder

disturbance and impaired perspiration. There was no sexual association with the ocular and cerebellar type.

4. Peripheral Neuropathies

When due to diabetes mellitus, partial impotence apparently involves up to 50% of men and has a poor prognosis. Disturbed sexual response and lubrication difficulties afflict women. Abnormal electromyography of the pelvic musculature can be shown.

Local Nerve Lesions

Lesions of sacral nerve II or III gives ipsilateral impairment of sensivity in the penis, scratum, vulva and vagina, but does not cause impotence or anorgasm (rarely a bilateral impairment, due to a disc hernia or arachnoiditis may cause failure of erection or ejaculation). Pain will normally be the presenting symptom and may be very intense at orgasm. (These patients may need help post-operatively to regain satisfactory sexual function).

Helga Houghton

APPENDIX D2.

PSYCHO-SEXUAL PROBLEMS IN THE TREATMENT OF CANCER

Lawrence Goldie, M.D., D.P.M.,
F.R.C. Psycho.
The Royal Marsden Hospital,
London, SW3 6JJ.

A young man who discovered that he had multiple sclerosis realised that his doctors were suffering when they had to face him. His diagnosis was acute embarrassment caused by the doctor's attempt to compensate for a hard and unglamorous life by preserving 'a God-like aura' he thought that the doctor's difficulty was in admitting that he is dealing with a disorder about which he is largely ignorant and he feels that he cannot help.

This also applies to the doctor when faced with problems that are presented as 'sexual' emotional problems have always been there but it is now the fashion to cite them as 'sexual' which is rather like saying that someone with cyanosis has a skin colouration problem. The doctor feels that he is in an embarrassing position if he thinks that he ought to know more than his intelligent patients and he falls back on personal experience, anecdote and bluff.

The embarrassment is even more acute when the patient is having problems that are the result of treatment - impotence replaces omniscience. If the disease is cancer the choice of what to say seems to be between sounding a death-knell by using the word 'cancer' or describing 'treatment' and its effects, which is like a life sentence - being condemned to live with everything that makes life worthwhile, stripped away. It is to be noted that people who present us with very difficult problems, particularly problems that we feel we could not 'live with' or 'solve' .... tend to get very badly treated. Like a pariah or like someone cursed, the patient responds to the expectations of the community and this includes the doctors.

The sequence of events and the outcome of cancer and its treatment is felt to be so predictable that other members of the victim's society isolate 'victims' who can <u>then</u> be denied all basic emotional and material support. We hate the 'victim' who asks for something that we cannot supply, for example "help", "comfort", "reassurance" and "hope"; we hate the victim who presents us with a dreadful, full of dread thought ..... this could happen to us .... Like the harbinger of bad news he is likely to get maltreated. Thus it must be made clear from the outset that though we name our diseases differently

- the curses, the death curses in our society and in the African and Aboriginal societies have the same effects and the same origins.

Both in primitive and sophisticated society words are needed for the transmission of curses (and their opposite). Words can be used like missiles to destroy an object, a name can be given which destroys the object so named .... as it did in former times when Tuberculosis was a disgrace and was called 'Consumption' and Lepers were persecuted. Words can also be used to isolate, as when we use a secret language, it happens in medicine when we use special words for 'contempt' - producing diseases like Hysteria and Syphilis.

In almost indecent fashion we may refuse the patient (particularly with cancer of the sexual organs) decent intercourse; the physical treatment being interposed to prevent intimacy. Thus physical treatment is proceeded with, keeping patients at a distance, in an emotionally cold sterile atmosphere. Nobakov describes this beautifully in his book "An invitation to the Beheading". The charming, understanding man, who does not want to be frightening turns out to be the executioner. At the end he urges his victim to be "good" and co-operative so that the beheading goes smoothly and painlessly for both of them. It sounds like a homosexual seduction until the victim at the very point of putting his head on the block realises that he can just get up and walk away. It also happens, perhaps all too rarely, with patients and "specialists".

The patient being isolated, is avoided as a suffering being who must be touched by the transaction, the intercourse that uses words to express and acts to substantiate, the willingness to take from and share another's suffering, thoughts, hopes and loves.

In native societies it is obvious who the victim is, and, that they do not survive - their societies and their doctors .... the Witch Doctors' ..... treatment. In our society it is more difficult to identify the process and the victim and considerable strength of character and independence is needed to survive 'the treatment'.

For example, a young woman of twenty-two years had been on a physiotherapy course before she got married and, after her first baby was born she knew, before her first consultation, that she had cancer of the clitoris. In fact she told the surgeon what she had before operation. When she first went on to a ward in a general hospital the nursing sister was so dismayed and angry that she knew her diagnosis that she wanted an enquiry to find out who was responsible. At a later date she saw another doctor for radiotherapy and he infuriated her by his condescension and contempt in trying to persuade her that she was mistaken in thinking that she had cancer. She was so hurt and mortified that she refused to attend that hospital again.

During one of our discussions she was saying that 'patients' as it they were different from herself, should be told the truth, and she stopped short as she realised that <u>she</u> actually had cancer. Transiently she felt like everyone else, that she was discussing something that happened to other people. Her father had died when she was twelve years old, of cancer of the lung, and her mother had been told not to let him know. The patient said that her mother still felt remorse and guilt because she had obeyed, you might say allowed herself to be seduced and this condemned him to an imprisoning silence. I was originally asked to see her because it was thought that she would be depressed and in need of help <u>because</u> she knew all about her disease.

She was on a ward for very ill patients and coming from another part of the country she had few visitors so that for the most part no one spoke to her at length. We talked and with moving frankness and without reproach she discussed her life. She was sad but not persecuted or resentful. She obviously could have managed her pain, discomfort and relative isolation without me, but she left me in no doubt that she felt better for having someone to share, be affected by, her feelings and thoughts. She was a sensitive integrated and interesting person and it was a privilege to speak

to her. She never complained of a lack of sex (or a lack of love) the difficulties with intercourse were in those around her.

The prognosis in cancer has been transformed by chemotherapy and radiotherapy, particularly in the Lymphomas and the Leukaemias. These diseases occur in young people most commonly. In adolescents and twenty to thirty year olds the treatment itself produces problems such that the patient often feels that death or the disease is to be preferred to the treatment and the life that follows it. The adolescent betwixt the dependency of childhood and mature independence suffers most. For a young doctor in or just out of the trials of adolescence these can be the most trying of patients; the most annoying, with their persistent questions; and they may be those he is most likely to want to avoid.

Chemotherapy besides being, for many, very unpleasant is also very intrusive. It is prolonged and has to be repeated in an irregular fashion sometimes as an inpatient, sometimes as an outpatient. The patient cannot plan anything far ahead, or far from the hospital. They cannot plan firmly because the laboratory results on the day of attendance will determine if the patient stays in hospital for treatment or goes home. The changes currently occurring in chemotherapy and radiotherapy have altered significantly, the outlook without surgery, so that many mutilating operations are now felt to be no better than medical treatment. Though chemotherapy, for example, has greatly increased the period of survival and the numbers surviving the consequences of the treatment may be devastating, besides disrupting married life or a career at a period when there are few resources, patients are rendered sterile, impotent and hairless.

One young man with Hodgkin's Disease felt that he could not stand another course of chemotherapy as each of the previous two were thought to be the last and as they had not been told the consequences of treatment he and his wife were angry and suspicious. His wife's disappointment was associated with a severe and generalised dermatitis. Their every exchange became destructive and at home he would crucify her by making impossible demands on her whilst she tried to comply, bearing in mind his precarious physical state. But the worst burden for her, was the enforced sterility, the dead, unborn babies inside her; forewarned they could have tried to conceive or banked sperms before treatment started. Their intercourse ceased to be lovemaking and reparative. Understandably young doctors may omit to mention or emphasise <u>all</u> the consequences of treatment and ensuing nausea, malaise, infertility, loss of libido and loss of hair becomes painfully apparent and if not forewarned the patients pick it up bit by bit, shock by shock, from other patients and their relatives seen at different stages of treatment. The treatment may have been 'successful' or the best that can be done. After treatment of breast cancer or brain tumour the patient may be left feeling sexually handicapped and unattractive. A brain tumour may be removed with little prospect of recurrence but with the tumour the patient may lose his or her potency in every sense, being unable to work and live independently.

One young man, an executive with a new house, a wife and two children, became fat and unable to do more than sit around at home demanding tea, becoming enraged when his grossly impaired memory was questioned. It was not possible to treat him, but his wife and the children were seen as they tried to cope with the nightmare of a father who existed in effigy but not in spirit.... a 'neomorph' beyond suffering and beyond recall. He has now no sexual problems, but his wife has problems and no guiltless way of resolving them.

One very ill young man and his wife described how they saw a film taken a year previously in which he appeared. He was shocked to realise how much his appearance had deteriorated, and she was angry at the statistical presentation which showed improvement in treatment by quoting the improved percentage chance of survival. One could agree with her in feeling that

every patient is in a series of one and the most brilliant odds are no consolation to the loser. They had been students living together and when the illness was discovered they got married. She asked for a consultation because her husband had relapsed into complete dependence upon her and she did not know how to help him recover his potency. No one cared to know their frustrations and here was an ironic contrast between the present concern with sexual inadequacy in physically normal people and the lack of it with regard to patients whose physical expression of love is made difficult or impossible by treatment.

In line with the current misconceptions which confuse sex with love he felt despondent because he could not do what he thought that a man should do .... he was physically weak and he felt sexually inadequate. It became a matter of mobilising his resources in joint interviews to show him that there were many things he could still do in a manly way - making decisions and looking after his wife's needs even if he could not implement them physically. He could do his best which was what his stalwart wife wanted. He bore his illness from then on with fortitude until a sudden relapse into unconsciousness preceding his death. His wife was courageous, tough and unusually mature. She had known that something was amiss. She could easily have taken to the mothering role that her husband put to her but she was fighting for something else. She knew he was dying but she would not give up trying. She was persistent in wanting her husband to find himself, and his independence so that he could match her strength before his died. In this she succeeded - their intercourse succeeded!

"Psycho-sexual problems" do arise in the treatment of cancer and my intention is to urge you to discover what they are and where they may be located - in the patient or in the spouse; in those who 'treat' or those who are treated; in the past or in the present.

There is nothing good or bad intrinsically in past events. The presence of chronic and life-threatening disease is potentially good or bad according to what it evokes. A review of relationships may be instituted in the process - they may be as I have shown, creative but it may also be destructive as when the spouse of a patient - apparently without previous sexual problems becomes promiscuous and cruel, or the parents of a child with leukaemia become unfaithful, fall out of love or divorce one another.

Succeeding in a psycho-therapeutic endeavour with patients in these straits may be a bitter-sweet experience of admiration and pain. There is a beautiful French film of an area where elephants go to die. One of the females was dying, she tottered and the bull elephant nudged and pushed her to support; she sank to her knees and frantically he pushed grass into her mouth, trying to feed her. As this did not revive her, he then mounted her trying to have intercourse with her. He became frantic as she sank into lifeless immobility and it was then after some time before he could leave her.

In this confused world of misprision and misleading words it is as well to let the elephant show us what is 'good-natured' and wherein lies the pain of true 'psycho-sexual development'.

APPENDIX E.

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