

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER

Editor: Dr. Katharine Draper,
29 High Street,
Chipstead,
Sevenoaks TN13 2RW.
September, 1978.

No. 12

Dear Doctor,

It was good to enjoy such a gathering of colleagues at Cheltenham, and to hear of the work experiences of the speakers, who were brave enough to share their striving and vulnerability. Such a large audience was daunting but I hope the angst was rewarded by the appreciation they received.

The expansion of the Institute is reflected in this Newsletter, which is largely taken up with a report of the meeting and recent developments in training and accreditation. Dr. Pasmore "Roots" have grown to a flourishing tree.

1. MEETINGS

FUTURE

- (a) A clinical meeting will be held on:
FRIDAY, DECEMBER 8TH, 1978, at 8.15 P.M. at:
The Royal Society of Medicine (Marcus Beck Library)
1 Wimpole Street, London, W.1.

DR. J. GILLEY will speak on "REACTION TO RAPE".
Recognised under Section 63 with zero rating.

- (b) The A.C.M. will take place at 5.00 p.m. on
FRIDAY, MARCH 30TH, 1979, at the Royal Society of Medicine,
and will be followed by a Presidential Address at 8.00 p.m.

- (c) The Weekend Meeting will take place at:
the Golden Valley Hotel, CHELTENHAM, on October 6th & 7th, 1979.
Dr. Barne will be pleased to receive suggestions for topics.

- PAST (d) The weekend Meeting took place at the Golden Valley Hotel, Cheltenham, on September 1st and 2nd, and was attended by over 100 members. I am very grateful to Dr. Robina Thexton and Dr. Gill Hinshelwood who have each taken responsibility for one day's reporting and provided a full account for those who could not be with us (Appendix B.) A full transcript will be circulated by Wyeth Laboratories.

2. COUNCIL NEWS

A Meeting of the Council took place at Cheltenham on the morning of Friday, 1st September, at which all members were present.

As a result of these discussions, and the response to her talk, Dr. Tunnadine has sent me a Report which is given in Appendix A1. This contains important proposals to which merit close attention, as well as news of future seminars.

The system of accreditation was reviewed and the accreditation Secretary has sent a letter and report so that all members are fully informed of the discussions (Appendix A2.).

It was decided that there should be a Registrar to relieve executive members of some of the routine work. The duties would be:

- i. To keep a record of new members and take charge of the Register.
- ii. To keep a list of Trainees and encourage them to join the Institute.

Dr. E. Deman, 20 Beaumont Street, London W1N 1FF.
has agreed to be Registrar.

The Council is considering proposals for a Court of advanced leaders but meanwhile it was agreed that Dr. Hana Backer should be recognised as an Advanced Leader.

The Council received a report on the pilot study on non-consummation and the Nuffield project and this is given in Appendix A3.

3. PUBLICATIONS

Dr. Valerie Thompson must be congratulated on her work of editing and collation which made possible the eventual circulation of the transcripts of the weekend meetings at Bournemouth and Durham. We must again thank Mr. Paterson of Wyeth Pharmaceuticals for funding this work, which is appreciated by all our members.

Dr. Eleanor Mears has written to tell me that her paper on an analysis of the work of members of the Institute has been accepted by Public Health and will be in the September issue - but this is delayed 2-3 months by a strike! I had hoped to enclose a reprint with this Newsletter, but hope it will be ready for January.

4. CORRESPONDENCE

I have received a reply to the letter published in Newsletter No. 11, Appendix C1. on "Viewing of S.A.R. Films by Seminar Members". The letter is given in Appendix C, with a comment by the original group.

5. DR. MICHAEL BALINT

During a discussion, at the Wyeth Dinner, of Dr. Pasmoro's paper "Roots", several members said that although they know Michael Balint's books, they would like to know more about the personality who had been able to "switch on the light in a dark room" for the members of his original seminar.

With limited time and resources I have collated a short account in Appendix D. If any member has personal recollections that they can add to this I would be pleased to receive them for the next Newsletter.

- 6. A list of marriages, changes of address and new members is given in Appendix E.

We hope that the suggestions for research groups, weekend workshops, and individual supervision will receive support and can be implemented soon. Meanwhile I would like to remind members that I have always hoped that the Newsletter could be used for the discussion of ideas and accounts of interesting case studies and would welcome contributions for the next issue.

Yours sincerely,

KATHARINE DRAPER

APPENDIX A.

COUNCIL REPORTS

1. REPORT FROM DIRECTOR OF TRAINING

Dr. P. Tunnadine

It seems clear from the response to my talk at Cheltenham that there is substantial demand for intensive refresher or continuation training among experienced doctors, though many are unable to commit themselves to further prolonged group work. I am exploring suggestions as to how this need may be met, especially far from London. While informal "support" groups have tended to "fizzle out" in the past, skilfully led research groups on specific new topics have been real "think tanks" and growth points of new knowledge. The specific suggestions offered from the floor were as follows:

1. With reference to Dr. Christopher's letter to this Newsletter, many felt they might wish to avail themselves of occasional personal supervision sessions, for difficult cases, if such were offered at the going rate (which at present would be in the order of £10. per hour) while rejoining a regular seminar was impossible. To this end, I should be grateful to hear from those leader doctors who are prepared to be so consulted, so that a list may be prepared and published. Clearly individual arrangements would have to be finalised on a one to one basis.
2. Leadership training might be offered to the leaders emerging from groups set up informally in the first instance. At present this could be arranged but they would have to finance the trip to the Workshop themselves. There is however some hope on the horizon that the training of leaders may get financial support, in which case workshops outside London may become possible. Alternatively experienced leaders might visit such groups on a roving basis. Concentrated group workshops of a day or weekend, either in addition to or consecutive with other meetings, at which doctors who look for refresher stimulus would work intensively, preferably with a leader they had not worked with before. This too is being explored for next year and your response would be appreciated.

Advanced training The two London Advanced groups on Wednesday mornings (Dr. Tunnadine) and Thursday afternoons (Dr. Main) are now fully subscribed, unless an occasional drop-out vacancy occurs. However, several doctors are on the waiting list for a new group which could begin in the New Year under the leadership of Dr. Jean Pasmore on Tuesday afternoons if there is sufficient demand. It is vital therefore that any doctors completing their basic training in the near future who are recommended by their leaders to proceed; or any doctors who have not earlier had the chance to complete their advanced training; should get in touch with me as soon as possible. As usual, final selection is the responsibility of the leader.

2. LETTER & REPORT FROM THE PANEL SECRETARY

Dr. Carol Stuart Morrow.

A meeting was held on 8th August 1978 of the Institute Executive Committee with those Members who had been invited to sit on Panels at various times. The reason being a feeling of dissatisfaction throughout the Institute, in particular from Panel Members, about the appraisal or examination system for accreditation to Membership and receipt of the Certificate.

Three questions were discussed:-

- (a) Is the present method of appraisal which consists of
 - (i) A seminar by examinees followed by individual interviews with the Panel.

(ii) Seminar leaders report - the best method to obtain a Certificate?

(b) Who should be the examiners

(c) Who should elect the Panel?

(a) The System

Many methods of examination were looked at, including those used by the Royal Colleges. We considered:-

(i) Sending examiners to the examinees own seminar for appraisal in situ - this was dismissed as impractical administratively.

(ii) Progressive reporting with 1 to 2 yearly progress reports by seminar leaders. It was felt that this put too much work and responsibility on the leaders.

The ultimate conclusion, reached after hours of discussion, was that there is no perfect examination appraisal system and that we should do our best with the present system.

(b) The Panel Members

After much discussion it was felt that the Panel should not be a changing body but that they should be elected and hold office for 1 to 2 years to introduce conformity to standards set. It was felt that with repeated experience, it would be much easier for the Panel to make decisions. The Panel should be separate from the Council and their decisions should be final.

It was suggested that the Executive should propose to the Council their suggestions for Membership of the Panel and that these suggestions should be put to the Institute at the Annual General Meeting, for their approval.

It was felt that this would remove pressure from failed candidates and take away pressure which some Members had felt when decisions of the Panel were questioned to them.

The meeting recommended that the Panel should be composed of three people:

(a) Advanced Seminar Leader or Institute Analyst.

(b) Junior Seminar Leader.

(c) A Member, not a Seminar Leader, taking sessions on psychosexual medicine.

The people suggested were:-

(a) Dr. Jean Pasmore - substitute Dr. T. Main.

(b) Dr. A. Tobert.

(c) Dr. G. Hinshelwood.

A substitute would be required for the occasions when Dr. Pasmore's seminar members presented themselves to the Panel.

The term of office was not decided, but 2 years was suggested since there are only 2 to 3 Panels per year, with 4 to 5 candidates per Panel sitting. It was suggested that the Panel Secretary should both organise and attend all Panel sittings, in what capacity apart from 'hostess' was not decided.

The criteria as outlined in the document on training are:-

1. Ability to understand vaginal examination as a psychosomatic event and to use these findings therapeutically.
2. Ability to understand the contribution of both the doctor and the patient to the doctor-patient relationship.
3. Sensitivity to unconscious elements in the patient communications.
4. Perception of the doctors' own individual strengths and weaknesses as clinicians.
5. Ability to accept cases appropriate to this approach and to recognise unsuitable cases such as those with deep-seated pathology or personality disorder and those who cannot use interpretive therapy.
6. Some knowledge of the psychodynamics of emotional development.

Candidates should know what the criteria are.

Ways should be devised by which the criteria could be examined.

Candidates should be told why they had failed.

FOOTNOTE

A Panel has been suggested for October/November 1978. Would Advanced Seminar Leaders advise me of people who are ready, whom they wish to come before the Panel.

I would remind all candidates that there is a fee of £30. to be paid. This comprises £20. Panel fee, since the Members of the Panel are now paid £25. each per Panel sitting and £10. Institute membership for successful applicants.

Dr. Carol Stuart Morrow M.B. Ch.B.
Panel Secretary.

APPENDIX A3.

RESEARCH GROUP REPORT

Katharine Draper.

1. Pilot Study

The Pilot Study which was launched in January has now enrolled 44 cases who have either been unable to consummate for over 3 years, or have been previously treated by an N.H.S. Consultant. Recruitment to this Study will cease on 6th October, and six months will be allowed for treatment, after which the results will be collated. This Study has been carried out with the funds subscribed by members of the Institute, and with at least 44 cases it will provide material for a preliminary paper.

2. Nuffield Project

A workshop will be held at Margaret Pyke House, on October 6th for 20 doctors who have taken part in the pilot project, and further case studies have been prepared for training in completing the Study forms.

A psychiatric social worker, who has had experience in marital therapy, has been engaged to carry out the independent assessment which was the condition of the Nuffield Grant. She has had experience of research work and appreciates that she will not carry out any treatment with patients, while the group feel that she has a warm personality that will not be threatening.

APPENDIX B.

REPORT OF DAY 1 OF INSTITUTE OF PSYCHOSEXUAL MEDICINE MEETING AT
CHELTENHAM, SEPTEMBER 1 & 2.

12.9.78 Robina Thexton.

DR. J. PASMORE, a member of the very first psychosexual seminar, gave the first talk. Her title 'ROOTS' was appropriate because from that seminar, led by Dr. Michael Balint, has grown this large training organisation with seminars taking place all over the country.

She outlined the way women doctors were working in the post-war period; keen to keep their part-time jobs in family planning clinics, being exploited by seeing 50 patients at a session and training doctors at the same time, the sole aim being to stop unwanted pregnancies. Birth control was not generally accepted as respectable, nor was extra-marital sex, patients were of working class origin and the unmarried were not seen. Caps and sheaths were the only methods given, but sexuality was not voiced and non-verbal pleas for help were ignored. The work of Helena Wright and Joan Malleson opened up acceptance of women's right to enjoy sex, and some family planning doctors started listening to complaints (e.g. about a husband, which they realised was a request for help with frigidity). Those doctors knew a lot about a great variety of caps and also of vaginas and heard feelings about them expressed during examination and searched for training in this field. In late 1959, Nancy Rafael backed a suggestion to ask Michael Balint to lead a seminar. His approach was like "a light switched on in a dark room". From that first seminar has grown the wide understanding of psychosexual problems in both sexes. Of its ten members Dr. Margaret Blair, Dr. Sylvia Dawkins and Dr. Rosalie Taylor were in the audience today. Various publications resulted: A Pilot Study in the B.M.J. Virgin Wives, A Paper on Frigidity and Sexual Discord in Marriage.

The doctors were aware of a change in themselves and increasing skill in using the Dr/Pt relationship in treatment.

There were complaints by lay F.P.A. staff about the first special psychosexual sessions in clinics as they took time and money away from contraceptive services.

The next development was a Leader Doctor's Workshop led by Dr. Main and with the support of this, the seminar members started groups outside London, and the work grew.

The second paper was by DR. HUGHES who spoke of using SEMINAR TECHNIQUES IN SUBFERTILITY CLINICS. His aim is to obtain pregnancies for his patients, and he uses the interactive nature of the consultation watching his involvement with the patient. He works in a male infertility clinic at the Royal Free Hospital, at another in the East End and in private practice and notices that the cause of the azospermia may vary in each place according to different accompanying problems (e.g. premature ejaculation and impotence and medical illness). The seminar training helps him to recognise covert signs, to take time over the consultation and bring the patient back again and again. He recognises the pressure on a man required to produce sperm in a container, or for a post coital test, and of coitus by calendar. He listens, rather than intervenes, and keeps asking himself; what is happening in the interaction? He uses humour because interviews should be enjoyable for the doctor and are therefore more relaxed for the patient. He is aware that patients need careful explanation of what is being done and why, and what are the results.

Attending seminars has helped him to make some sense of the mass of chaotic unconnected material presented to him.

In the discussion following, Dr. Coles took up the point that patients complain that results of treatment are not explained - perhaps some prefer hope to knowledge - Miss Valerie Thompson outlined a scheme whereby in-patients are told on 4 occasions what has been done to them, to get over their difficulty in absorbing it.

Dr. Taylor suggested that patients want to stick to their fantasies of what has been done.

Dr. Main commented on the link between infertility and the need to be told things. The sanction to be adult (and a parent) is not obtained by some. When they cease to feel like 'robbed infants' they can function in a world of adults.

Dr. Pat Thompson, mentioned emotional causes of infertility exemplified in her patient who had never menstruated and wanted, without success, a baby in a stable sexual relationship. She decided to marry her partner, still did not menstruate, and 9 months later was delivered of a baby.

Lt. Col. Bradshaw regretted that investigations take so long that patients become distressed by timed love making. Dr. Margaret Blair suggested that delay is sometimes brought about by the patients themselves, being indicative of their ambivalence towards pregnancy.

Miss Thompson hopes that medical research will continue to find reversible physiological causes for some cases, at present labelled emotional.

Dr. Main noted that Dr. Hughes attempts to form a relationship of equality with his patients which enhances work to find causes of infertility. We also have to consider the needs of patients never able to have a pregnancy.

In the third paper, DR. COLES from Bristol described how seminar training has taught her to watch and listen to what is really being said by PATIENTS REQUESTING TERMINATION OF UNWANTED PREGNANCIES. Such a counselling service differs from psychosexual work in several ways.

1. There is only a short time to arrive at an understanding - so she first arranges the termination and then discusses it - thus the patient relaxes and talks more freely about what she thinks she wants.
2. A decision must be made - there is no opportunity for the patient to shop around for a therapist she likes, or to postpone or opt out of treatment. Nor can the doctor - leaving the patient with the wrong outcome. Patients are so bombarded with advice, it is difficult to reach their real feelings.
3. Patients are ignorant about procedures and risks of abortion and need information.

Dr. Coles notes who makes the appointment and whether the patient comes by herself, comes in alone or (for instance) with mother. The girl who brings her mother is telling the doctor she isn't old enough to cope. If she brings along her partner, has he come to support her, or has he been dragged along?

Dr. Coles gets at their real feelings by asking what was their immediate reaction to confirmation of pregnancy (momentary pleasure, horror, what will mother think etc.) But the doctor must listen as well to parents and relatives - they will be living with the patient afterwards. When the girl is under 16 years and the parents must know, the presence of a counsellor is supportive to her. The woman who wants the baby but her partner does not,

needs help to work through her resentment and understand her search for and affection. There are also the women to whom it seems to mean nothing to end a pregnancy.

Dr. Coles recognises her interaction with all patients who perhaps make her into a practical doctor or protective and maternal, or angry. She interprets this, and also thinks why the pregnancy happened at this time and what the future contraception will be.

In the discussion it was decided that such counselling is needed for every termination case and also for male and female sterilisation. Some surgeons appreciate the counsellors work as they do not want to do it themselves.

Dr. Halifax agrees with the woman's right to decide as this allows her to stop being infantilised.

Dr. Hutchinson worries about some gynaecologists who feel they have the right to decide.

Dr. Main commented on the woman's altered relationship with her own mother when she becomes a mother herself, and the grief which may need working with after a termination.

DR. GILL HINSHELWOOD then read a paper about THE USE OF SEMINAR TECHNIQUE IN YOUTH ADVISORY WORK. Firstly, seminars had helped her value her skills learned in hospital and general practice and family planning clinics, in psychiatric work, through reading and lectures and memories of her own adolescence and child rearing. In Camden, where the London Youth Advisory Clinic is situated, there are many agencies offering help to the young. She therefore, looks beyond the requests presented in the clinic and asks: Why this patient at this time, here and with this problem? She told of a patient requesting contraception well over the usual age of clients - Dr. Hinshelwood remarked that perhaps she was asking to be treated as a youthful person, uncertain of her sexuality and the patient valued the opportunity to talk of her sheltered childhood, staying at home to care for her mother, recently deceased, and her wish for, but fear of having a sexual fling.

Dr. Hinshelwood sees here patients as wanting to discuss some aspect of their involvement with the tasks of adolescence which are:

- to reach an appropriate level of education and decide on a career.
- to separate from parental dependence.
- to relate to a peer group.
- to reach physical maturity and be fairly satisfied with the result.
- to form a mature sexual identity and make a satisfying heterosexual relationship.

The seminars have helped her to identify and then help these young people confused and unable to cope with these tasks, by listening without giving guidance or direction - thus giving the person the safety to dare to look at the distress and confusion. It is also cheering to recognise cases where there is no distress, and just provide practical help. The initial contact in this clinic is with the more experienced workers, and this is important.

A couple who were referred by a G.P. for a sexual problem had already been treated by 5 others - By listening and observing, Dr. Hinshelwood realised that his impotence was due to physical illness (malaria) and sent him into hospital, but the girl needed several visits to talk of her lack of confidence in her femininity.

Seminar training has helped Dr. Hinshelwood resist identifying with the parents, treating the client as a vulnerable child and resist liaising

with other workers about a client. A social worker telephoned us about a girl saying "Please help her with her sexuality, it is worrying us". The girl in the clinic interview showed good management of her sexual life, remembering to take the pill and so on. She resists the temptation to direct the patient in the way the other adults in his life would want, and only looks at the Dr/Pt relationship, never comparing, never referring to theory or generalising. Seeing them as the individuals they are is not made easier by the pressing urgency with which young people beg to be reassured that they are like all the others.

Sticking to the discipline learned in seminars stops 2 major pitfalls, allowing youngsters to harbour and develop a grudge which they make responsible for all the misfortunes of life, such as a wicked stepmother or bat ears; and allowing a situation where one or both feel that salvation lies only in the doctor, denigrating the contribution that all the other people in his life have made.

Dr. Griffiths asked why the task is development of a heterosexual relationship. Dr. Hinshelwood said "It is the norm", to which some audience members said "Hear, hear".

The doctors working in the centre were varied in age - Dr. Coles thought it good that they might be seen as alternative parents.

Dr. Tully enlarged on the example of the girl whose social workers tried to stop her having sex, but as the clinic doctor accepted her sexuality, the girl showed her mature side and stopped rebelling.

The clinic expects responsibility and the clients respond with it.

Dr. Main noted that adults suppress their adolescent shocking behaviour but the adolescent acts it out.

Dr. Kilvington said that much discipline is needed to resist the temptation to become a loving mother and Dr. Skrine added there is pleasure in having practical things to do, like examining a patient or writing a prescription.

DR. MITFORD, a G.P. from Northumberland spoke last, of THE USE OF THE INSTITUTE TRAINING IN GENERAL PRACTICE. It has revolutionised his dealing with all his patients and trainee doctors - he can relate better to them.

There are advantages counselling sexual problems in a general practice - the patient feels comfortable in the privacy, the G.P. knows the background and can foresee the difficulties because of this. Most patients bring their physical illness and then say "Oh by the way" and he gets them back to discuss what they really want to say. He doesn't find the vague complaint of pelvic pain or vaginal discharge so common.

The initial contact is in a routine surgery and he makes a further appointment also in the usual surgery hours so the patient can feel it is a usual complaint and gets attention quickly. Dr. Mitford follows up as often as necessary and has learnt how to bring treatment to a close when nothing further can be achieved. He has worked for a year since leaving the seminar and now would like to join a support group to make further progress.

He gave examples of happy outcomes to counselling and then one where he failed to help a dominant woman and her small impotent husband. There was no worthwhile on going relationship and he tolerated the wife's disgust at his not prescribing potency pills.

Dr. Mitford has met cases of impotence where the cause was severally gout, deep vein thrombosis, diabetes and carcinoma of bronchus. A physical cause must be watched for.

In reply to Dr. Bullough's query he said he gives 7½ minutes to the initial enquiry and then 30 minutes in subsequent appointments.

Dr. Williamson asked if there is difficulty when you have knowledge of the absent partner.

Dr. Main said that Dr. Mitford makes the most of opportunities for seminar technique in general practice but this is different, not better than, other venues.

The audience broke into small discussion groups twice on Day 1. The group I joined discussed the papers - memorable points were "Is heterosexuality the norm?" and "how can support groups be organised for those who need them" ?.

There followed a reception, giving welcome opportunity for conversation and renewal of old friendships and an appetising dinner.

Dr. Main concluded the evening by thanking Mr. Paterson of Wyeth Pharmaceuticals for his help and by recounting amusing anecdotes about patronage.

DAY 2

Dr. Gill Hinshelwood.

Saturday had a very full programme. Dr. Main chaired the meetings and he welcomed Dr. James Carne, Vice President, to the day's events.

COUNSELLING IN HER MAJESTY'S PRISONS, was the subject of the first paper. 18 months ago DR. PAT ROBERTS was invited to work in a prison, dealing with men who presented with psychosexual problems. It was a daunting task. Her first patients were very much test cases, including men who stabbed their wives, a rapist and incest offences. While we in our ordinary clinics have to work hard to get at phantasies, such men acted out their phantasies which were larger than life. Dr. Roberts found the men very truthful about their feelings, which were often devastatingly painful feelings of physical inferiority. She finds the seminar discipline very helpful in coping with the pain that men reveal in quite an explosive way after much denial and repression has taken place. Men imprisoned for sexual offences are frequently persecuted and victimised. This may well fit in with their wish to atone. The child offenders are often the most abused in prison society. Her sessions with them give an opportunity to express their grief, for their feelings of sexual inferiority are total. There is often amnesia about events around their offence and Dr. Roberts finds the training helpful in relieving this. Homosexuality is rife among inmates and we learned of the many reactions to this state of affairs.

After the necessary period of atonement for the offence, prison does not really seem the place for many of these men. In the prison population, between the frankly psychotic, and the ESN, there is a large grey area where men may be forgotten, or helped.

GENETIC COUNSELLING CLINICS was the subject of DR. WILLIAMSON'S paper. Dr. Williamson entered the field of genetic counselling when it first became a specialist entity, from a paediatric background. She did her seminar training after starting her clinic. This is very much the marriage of an exact science with a humanity. Dr. Williamson outlined the categories of patients referred to her clinic.

Patients referred following a pregnancy disaster such as an abortion, stillbirth, neonatal death and congenital abnormality form one large group. Another group are those who present following a childhood disaster. These

patients had an apparently normal child, later found to have a physical or mental handicap. The questions invariably asked of the doctor are: Why did it happen? Why did it happen to me? Will it happen again? and in these questions there is an enormous amount of hurt and anger to cope with, because they are so terribly upset and cross with themselves.

Dr. Williamson illustrated her paper with a very moving case history of a young couple. The wife's first statement was "I've had an anencephalic". She described the tense and unhappy time surrounding the birth, and her awful fantasies about the "monster" she had delivered but never seen. She had no picture of her child as having anything human, such as limbs, or a sexual identity. The couple felt they couldn't have sexual intercourse after what had been inside her. We saw pictures of the baby dressed and undressed and were posed with the question, should parents see their baby? dressed? or undressed?

Parents who are the carriers of abnormality have enormous guilt and those who carry recessive diseases feel like lepers. Sometimes this can lead to a suffocating collusion in a marriage, keeping it together in an unhealthy way.

Those couples who are poor reproducers also tend to get referred to a genetic counsellor. There is rarely discovered a genetic reason for this and mainly the counsellor is helping with feelings in inadequacy.

Finally the vital questions the doctor finds she's interested in - why do these people come when they do come, often years after the letter of introduction was written? Statistics are not of interest to the patient, who wants help and discussion of a family crisis.

We were very fortunate that DR. BROWN volunteered to speak about VASECTOMY COUNSELLING at the last minute. In place of a planned paper Dr. Brown presented his audience with a range of controversial ideas surrounding the issue of vasectomy. Some of these are his own worries and thoughts on why he himself doesn't conduct a clinic - is it circumstances, or is it more unconscious avoidance of something he may find distasteful?

Dr. Brown quoted many of the generalisations about the men, their wives, and their relationships. He demonstrated how in individual cases when pain, hopes and fears can be expressed such generalisations count for very little. It is the seminar training that gives help and encouragement with this approach.

DR. LISLE and DR. COOMBS presented CASE HISTORIES ILLUSTRATING THE DOCTORS VULNERABILITY. Dr. Lisle's patient, a 25 year old, frail little girl with kyphoscoliosis, had had two unsuccessful relationships to men with upsetting perversions and was experiencing difficulties in her third relationship. She manipulated to get her own way in sessions, cancelling planned appointments and turning up unexpectedly in routine clinics, demanding much time spent on her. Thus Dr. Lisle's sessions were 'perverted'.

Dr. Coombs presented a rather frightening, highly intelligent woman who came with her husband. Her complaint was lack of orgasm, and her rather silent man was held responsible for this. He couldn't get into her rhythm. Dr. Coombs identified very much with the man and felt the woman's scorn reducing her skills.

There was a lengthy floor discussion following these two case histories. What is vulnerability, can it be mobilised as a strength? Do doctors who fear it so much retreat into a non-relationship.

After lunch MISS THOMPSON spoke about GYNAECOLOGY OUT-PATIENTS.

Miss Thompson, a consultant gynaecologist at the Royal Free Hospital, has included a psychosexual counselling session in her O.P. commitments for ten years. She described her colleagues reactions to this. She has some very challenging patients referred to her, such as those who have had extensive, unrewarding medical examinations, and more recently, young people with anorexia nervosa, and those requesting cosmetic surgery to their genitals. Also to this session come women with pelvic pain and chronic discharges. Her Institute training helps particularly with these women in making decisions about investigations, and helps to keep the waiting list down. As consultant gynaecologist Miss Thompson has many responsibilities - to her waiting list, her colleagues and the hospital, and it is important to realise when she has reached the limit of her skills, and how to stop, or refer on.

So far Miss Thompson does not feel her psychosexual contribution is particularly valued or understood by her colleagues, but sees hope in new generations of medical students. She invites them to be unobtrusive observers, except in first session, and they make valuable contributions. At first she was unable to say whether seminar training helped her cope better in general gynaecology O.P., it seemed to just make life more hectic. But on later reflection she believes it does help, especially facilitating short cuts.

THE DIRECTOR OF TRAINING - HER AIMS AND DIFFICULTIES. DR. TUNNADINE gave an energetic account of her work in this capacity, and the work of the training committee.

She has many requests from doctors wishing to train and from groups already formed needing a leader, and one easily defined role is to marry the two, and help doctors get to the right group. Dr. Tunnadine is frequently asked how to set up groups by local authorities, and increasingly is requested by the Home Office, D.O.H., media etc. to talk about the Institute, its training and professional standards. In 1974 there were 200 trained doctors and since then at least another 500 have applied and started training. With this explosion it means that the Institute is rather short of leader doctors. To meet the demand co-leaders and leaders workshops are conducted to help doctors with clinical skills learn to be leaders and to support them in a vulnerable situation.

A further demand is from already qualified doctors who wish for further seminars. These must utilise doctors of the highest skills.

At 4.15 p.m. DR. MAIN and DR. TUNNADINE invited the audience to put forward their ideas for FUTURE TRAINING and for DEVELOPMENT OF THE WORK OF THE INSTITUTE.

Regulations of the Institute for training and qualification have been defined and printed and are available for members to read. We have at present a certificate of competence in psychosexual medicine. Many ideas were raised about further training for members. Should these be support groups or challenge groups? Leaderless groups could form and meet for discussions on a regular basis. A share-a-leader scheme was suggested, that is, a peripatetic leader visiting groups in rotation. There was also enthusiasm for workshop weekends conducted on seminar lines. A further idea was the provision of consultants who could be approached privately on an individual basis for difficult cases.

We need to introduce our ideas and skills to untrained people. Clinical expertise and leader skills are quite separate and to become a leader may need as intensive a training as the membership training.

Members are advised strongly to watch and use the Newsletter to see how these suggestions are taken up.

How much is money and its lack a drawback to furthering our aims? Members are urged to approach CHC's who may influence AHA's and Post-graduate deans of Universities.

DR. MAIN SUMMED UP THE CONFERENCE. He reminded us of the pre-roots, Freud, who influenced Ferenczi, who in turn influenced Balint. These were among the first people to study systematically the unconscious, and the latter two to have an interest in wider technical application of the knowledge. At this point Dr. Main paid tribute to Dr. Sylvia Dawkins, one of Balint's first seminar members, and a pioneer in the field. All the early workers used their skills first and foremost in a family planning setting, with its special opportunities for gaining access to phantasies. These workers are stamped with the sincerity and integrity of pioneers and it is most important to preserve this quality. Dr. Main then paid tribute to each of the speakers in turn and emphasised that such qualities are present in the Institute today.

Patients choose the setting that suits them and it is not necessary or desirable to have only one door, the all-embracing G.P., so long as patients entering different doors encounter equally sensitive and competent doctors. Rather than a psychotherapy technique, which can lose value with the passage of time, there is a good deal to be said for the seminar discipline to be considered as a philosophy concerning doctor-patient relationships.

Dr. Main concluded the weekend by paying tribute to the Monckton Fund and Mrs Nancy Raphael; Wyeth Pharmaceuticals, especially our friend Mr. Paterson, who has been with us throughout, unobtrusively ensuring our maximum comfort. Our thanks too, to Dr. Barne, for all the hard work planning the conference and organising the speakers. Also thanks to Dr. Fay Hutchinson, for the hard work organising a recording of proceedings. The hotel service was excellent and many voted to return to Cheltenham next year.

APPENDIX C.

CORRESPONDENCE

The University of Southampt.
Faculty of Medicine.

We write in answer to the communication in Newsletter No. 11 which gave the reaction of a group of seminar trained doctors to SAR (Sexual Attitude Restructuring) video tape material originating from the National Sex Forum, San Francisco.

Some issues raised in your letters call for comment and clarification. We also wish to explain what leads us to the view that the SAR films currently available do have some value.

It is not clear from your letter under what circumstances the viewing took place, though you imply that you looked at the films objectively to assess their possible use as a training or therapeutic tool. In that sense you may not have had the kind of experience the film makers intended. These films provide a graded exposure to visual data about the range of sexual activity practised in our society to allow viewers to locate and examine in discussion their personal responses.

You speak of the 'philosophy' of the films yet our perception was that the films offered a whole range of behaviour patterns without attempting to promote a particular orthodoxy and that this was fully in accord with the rationale of the film makers.

When you comment that the films seemed to focus on bodies and sexual organs rather than on relationships between whole persons with feelings, you imply that the films ought to have under-written the relationship between sex and love. To have done this would surely be to have used the films to promote one specific value in human sexuality and this is expressly what the films did not set out to do.

May we suggest that some of the negative feelings which the SAR films inevitably and understandably evoke in viewers have in this case been displaced in the unanimous message of disapproval your letter to Dr. Draper represents.

Our response to SAR films represents the by no means undifferentiated views of the undermentioned psychologists, doctors, social workers, counsellors and educationists associated with the treatment of sexual dysfunction and the development of sexual medicine as a speciality in this area.

The extent of consensus among us may be summarised as follows:

1. We feel that everyone who intends to work in a context where treatment of sexual relationships is part of the task, should have early opportunity of exploring his or her own attitudes, values and inhibitions about sexual behaviour. In this process SAR films can play a useful part.
2. Where films are used in training or in treatment it is imperative that adequate time be made available to discuss the reactions of those present and that the event be conducted by persons already very familiar with the film content and in handling of group feelings.

3. There may be a case for using films with clients and this should be seen as part of the process of learning and of 'desensitizing' or 'permission giving' which we regard as an important part of therapy. There is no question of advocating an indiscriminate use of film in treatment though the judicious use of films in selected cases and for a specified purpose may be appropriate.

It is for this last reason that we stress the importance of a multidisciplinary approach to treatment within our clinics.

- | | |
|----------------------|---|
| Daphne Crawford | Social Worker |
| Frank Campbell | Catholic Marriage Advisory Council (C.M.A.C.) |
| Ray Charlton | Marriage Guidance Council (M.G.C.) |
| Prof. John Dennis | Dept. of Human Reproduction
Southampton. |
| Peter Exon | M.G.C. |
| Rod Holland | Clinical Psychologist |
| Kay Howard | M.G.C. |
| Dr. Judy de la Hoyde | M.G.C. |
| Dr. Michael Perring | Lecturer in Psychosexual Medicine
Southampton. |
| Margaret Rose | S.R.N., C.M.A.C. |
| Natalie Spector | M.G.C. |
| Joy Tennant | S.R.N. |

Comment from the Group Concerned.

We were trying to assess whether the SAR films had a place in the Institute's methods of training and practice.

It is difficult to see how the films contribute to our use of the Dr/Patient relationship, which is the basis of the Institute's method of working.

The work and thoughts of Michael Balint have had a profound effect on the practice of medicine in this country, not only through the development of seminar training, with which we are all familiar, but more widely through his emphasis on the part which only the general practitioner can play in the treatment of patients who do not have a "localizeable illness (1)". It is surely this altered respect for the work of the G.P. that has led the bright young trainees that we now meet on courses to choose general practice as their preferred medical career, and this in time should affect the quality of care offered many. His ability to conceptualize and analyse the doctor-patient relationship, and the "dose of the drug doctor (2)" should enable something precious to be preserved that was in danger of being lost because it could not be programmed into a computer.

It would be presumptuous, in the context of the Newsletter, to give more than a brief account of his life and some aspects of his personality. Talking to those who knew him the universal impression is of his vitality and continued questing, his lack of small talk and his love of dialectic. In preparing this I was astonished to find that the author of the descriptions of the subtle interactions between doctor and patient, trainer and trainee (3), had only come to Britain in 1939.

Dr. Main was a close colleague of Michael Balint and has given me permission to reproduce his obituary (4).

"When he died at the age of 74 on the last day of 1970 Michael Balint was at the height of his working powers. He held major offices, as current President of the British Psycho-Analytical Society, editor of the Mind and Medicine Monographs, and Visiting Professor of Psychiatry at the University of Cincinnati. He was in active psychoanalytic practice, and training and researching with medical students, psychoanalysts and general practitioners. He was planning yet another teaching trip both to the United States and to Switzerland, and was at work on a new book concerned with psychoanalysis.

He was held in high renown in the world of psychoanalysis, while among medical psychologists none in his life-time was so eminent. For nearly half a century he had poured out contributions to the literature of psychoanalysis and medical psychology - seven books and well over 100 papers, some translated into several languages. His professional life had been lived eagerly and vigorously, and he had enjoyed and enriched his two professions and medicine and psychoanalysis.

He was born in Budapest, the son of a Jewish general practitioner. His brilliance showed early and at 15 he was coaching his school-fellows. His life-long love of classics, people and language (he spoke French and German as well as Hungarian and English) began at school but his earliest ambition - to be an engineer - sprang from an equal delight in the exact sciences of physics and mathematics. He began the study of medicine in 1914 but soon postponed it for war service until 1916, when he was wounded and demobilized. Then he qualified as a doctor in 1920 and married in 1921. Because of the anti-semitism of the Horthy regime he left Budapest for Berlin that year and worked as a research chemist and biologist. In Berlin he and his wife began to train as psychoanalysts,

but Balint's twin interests in people and in scientific exactitude were already clear; at the very time he was treating his first psychoanalytic patients he became a Ph.D. in biochemistry.

In 1924 he returned to Budapest and completed with Ferenczi his own psychoanalysis begun in Berlin with Sachs. He owed openly to Ferenczi a life-long imaginative interest in Doctor-patient relations and early object relations, and to pure science he owed his discontent with inexact observation and his determination to distinguish observable fact, subjective fantasy and theory.

In Budapest he practised and taught students of psychoanalysis, directed the Budapest Psycho-Analytic Clinic and began seminars for general practitioners, but as the years passed racial intolerance grew in Hungary, and again in 1939 he emigrated, this time to Britain. He began work as a psychoanalyst in Manchester, took a British medical qualification and became an M.Sc. in psychology with a thesis on early infancy. At this time his wife Alice died, leaving him with their son John, now professor of medicine at Albany Medical School. He became consultant to the Northern Royal Hospital, directed two child guidance clinics in Lancashire, and remarried.

After the war he moved to London, worked as a psychoanalyst and became consultant to the Tavistock Clinic. Following a divorce from his second wife, Edna, he married Enid, and with her began his famous research-cum-training seminars for general practitioners. In 1950 he was Scientific Secretary to the British Psycho-Analytical Society and a member of Council, and during the 1950s was an active member of the Medical Section of the British Psychological Society, being in 1955-6 its chairman and a member of the Council of the British Psychological Society. In the years that followed he worked vigorously and happily at his two interests, psychoanalysis and medical psychology.

His many psychoanalytic writings cover a wide spread of interest from aesthetics to criminology, from early infancy to old age, and are a memorial to his determined questing and his unceasing curiosity about the meaning of human experience. They show him as a master of his craft, concerned to wed skill and science. He had an abiding interest in the way clinical technique, clinical observation and theory reciprocally influence one another. His interest in early ego states and early object-relations never ceased, and he treasured the clinical situation as their place of revelation. It was the psychoanalysts' sensitivity or insensitivity of response that decided their clinical fate, and so he sought that psychoanalysts should be highly informed but free from theoretical certainty, innocent and wide-eyed in their work with patients, and thoughtful about non-verbal mental influences. He was therefore much sought after as a stimulating undidactic supervisor who could help and allow the student to develop his own gifts.

In the field of medical psychology he undertook a major creative synthesis between group dynamics and the training relationship as an object-relation, developing and testing his ideas in practice and so producing the 'Balint Method' of training seminars, in which the trainees are not taught but are required to think and to become personal researchers about doctor-patient relations. He and they showed how these relations decisively affect illnesses and the outcomes of treatment. This novel contribution of psychoanalysis to pedagogics was developed with workers in the Family Discussion Bureau, which he and Enid founded, with doctors from the Family Planning Association (whose present 17 seminars are founded on his methods), and above all with general practitioners. After some preliminary papers on the group dynamics of training and on the doctor-patient relation, he published in 1957 his historic book THE DOCTOR, HIS PATIENT AND THE ILLNESS.

It had an immediate effect on general practitioners all over the world, for it offered them now hope and challenge and with its emphasis on 'whole-person medicine', changed for all time the very perspectives of general practice. Within a few years doctors in Britain and in various other parts of the world were meeting together to pursue research-cum-training seminars by the methods he described. First the Dutch and Americans, and then the French, and later others made contact with Balint and required him to meet their trainers in regular international conferences. They sought him to conduct seminars in their own countries, and began to publish books which recorded their own new findings, about illnesses and the techniques of general practice which their new insights allowed. His other works in medical psychology, his innovating seminars in brief therapy, his studies with co-workers on the effects of training, his book with Enid on psychotherapeutic techniques and his many addresses and published papers, were illumined by his familiarity with the unconscious transactions between people in various settings and situations, and are a model of applied psychoanalysis.

Michael Balint experienced little of the common conflict between thinking and feeling, for he delighted in both; creative thoughtfulness about feelings - his own and others' - was his life. He was that rare creature - a scholarly sensitive man of action. His delight in others, his capacity to give and earn love, his enjoyment of vigorous argument, and his gentleness with people, together with the high skills that gave him such safety in mental adventure made him an exhilarating and lovable friend."

To fill in the picture let me include some extracts from Dr. Sutherland's obituary (5) which also gives a reference to an essay on his work.

"He joined the staff of the Tavistock Clinic in 1948 and remained until 1961, when he had to retire on reaching the age limit. He soon revealed to us his way of relating to groups of colleagues, a characteristic that became so familiar in later years to hundreds of general practitioners, social workers and others. When the task appealed to him, he communicated an infectious enthusiasm in tackling it. Possessed of a sharp intellect and a wide knowledge, he picked out themes which he wanted to pursue. He then worked at them with stimulating clear-sightedness, and often with results that had the stamp of genius. Once he adopted a project, he would eagerly seek colleagues to share it with him, but the pressure of his own creative thought at times made others feel he was too dominating. He was assertive by British standards, yet he himself would often joke about his Hungarian qualities. It was an essential part of this assertive quality that he liked others to challenge him in the same way. There was certainly not a trace of malice in him, and he had a great sense of fun. When he was being more than usually critical of my own efforts in getting him the facilities he needed, we would invariably end in good humour, often with a reference to the Hungarian proverb, "If you have a Hungarian for a friend, you don't need an enemy."

His first major contribution to the improvement of therapeutic skills in the mental health field was his work with the Family Discussion Bureau from 1948 to 1953. This unit was created by a group of social workers whose leader was later to become his wife. Balint at once saw that the accounts of marital and family interactions he was presented with had to be conceptualized in a new way, and, by dint of strikingly persistent work with this group, he was able to transmute his insight into skills of a high order for his colleagues. This unit set a model of work which has had

a very wide influence in the Probation Service and throughout social work in general. It was from this work that he moved over to the general practitioners to fashion with them corresponding skills.

As a contributor to psychoanalytic thought, Balint may well be rated in the future amongst the first-rank original minds after Freud and his immediate circle. He published several books and many papers on basic psychoanalytical theory. An appraisal of his work would be a major task, though an excellent starting point is to be found in the essay by Masud Khan (Int. J. Psycho-Anal., 50 (1969), 237-248).

Balint was a rich human being who enjoyed life, who gave generously to his friends and colleagues, and who has left a legacy in his writings that will be an inspiration for many years to all those concerned with psycho-analysis and with mental health. While he never learned to adapt to committee work, his provocative attitudes were never destructive; his challenges and impatience were part of his zeal in sharing his genius. "

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- (5) Sutherland, J.D. (1971) Obituary of Michael Balint. International Journal of Psycho-Analysis 52 331.

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APPENDIX E.

Marriage

Since her recent marriage the Panel Secretary (Dr. Carol Butcher) is now Dr. Carol Stuart Morrow. Her practice address remains 59 Wimpole Street, London, W.1.

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