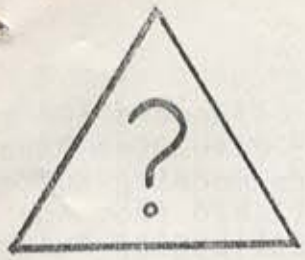


INSTITUTE OF PSYCHOSEXUAL MEDICINE

N E W S L E T T E R

No. 15. October, 1979

Dear Colleagues,

It seems as though the past few months has been a time of great growth for the Institute, both numerically and in stature.
During 1979, nearly forty new members have joined, and the network of seminar training has extended. Unfortunately, the requests for Advanced Leaders cannot yet be fully met.
It is rewarding for the Institute and particularly for Dr Tunnadine that the D.H.S.S. is taking a serious interest in our training methods. This interest may prove beneficial in a more practical way ultimately. You will notice in the correspondence that your secretary, Dr K.Draper, has written to the D.H.S.S. on your behalf clarifying the training standards expected from all members. It is felt that individual doctors should negotiate with their own Districts or Areas on matters of status and pay, using the circular references quoted in Dr Draper's letter when appropriate. There is great disparity in the way in which different Areas regard doctors who work in Psychosexual Clinics or who do specialist work in ordinary family planning clinics - Specialist session rate is being paid to some doctors. An advanced letter MD9/79 is appended showing recommended sessional rates.
The Cheltenham weekend was well supported and enjoyed, a report follows later in the Newsletter. There are several other dates for your diary. In June 1980 we hope that we shall be participating in an International meeting in Hawaii. The Institute has been asked to be one of the sponsors of this meeting and some members are hoping to present papers. If there are sufficient numbers of delegates a demonstration seminar may be given. Dr Carol Stuart Morrow has written to me about this in our correspondence section. Why not make Hawaii a stop-over in that long projected holiday of a life-time, or fulfill the great expectations of Aunt Agatha in Wagga Wagga?
Dr Margaret Blair, Chairman of your council, is busy with the 'archives' of the Institute to tell you or to refresh your memories about the Grass roots and this will be the Star article in the next Newsletter and so watch for the next thrilling instalment!
The Editorial Committee is reading all the previous publications of members in order to consider indexing them and whether any form of re-publication is possible. Please let us have a reprint of any paper which you have published.
I am grateful to all those contributors who have put their work and ideas on paper and sent contributions to the Newsletter and I hope that some other members who are "resting" at present will send me material for the next one.

I. Notices of Future Meetings :

17th November, 1979 - A one-day course "Working with Offenders : some practical and Psychological Issues" To be held at 63 Cavendish Street, London between 9.30 and 5.00. The fee of £12 includes morning coffee and afternoon tea. Admission is by ticket only, available from the Hon Secretary, Public Lectures Committee, British Institute of Psycho-Analysis, address as above. Cheques to be made payable to the Institute of Psycho-Analysis.

17th & 18th November, 1979 - Leader Doctors Workshop, Birmingham.

7th December, 1979 - "Working with the Handicapped and those who care for them" Dr Fay Hutchinson. To be held in the Marcus Beck Library at the R.S.M.

28th March, 1980 - Annual General Meeting of the Institute in the Marcus Beck Library at the R.S.M. at 4.30 p.m.
- "Defences against Pregnancy" - Dr Blair and Dr Howard at 8.15 p.m.

13th and 14th September, 1980 - Residential meeting at York University.

II. Training :

Now that Dr Tunnadine's book "Contraception and Sexual Life" has been reprinted it is suggested that all Family Planning trainees are recommended to read it as part of their training.
Research Seminar : Dr Tom Main's Research Seminar is in the process of being reconstituted and any member who is interested in joining it should contact him. It is to be held weekly at the West London Hospital.
Basic Seminar : There are a few vacancies in a basic seminar held at the Margaret Pyke Centre alternate Wednesdays starting on 10th October. Please contact Dr Carol Stuart Morrow, 59 Wimpole Street, London. Tel : 4862274.
Assessment Panel : Associates wishing to be assessed by the accreditation Panel for Membership should contact Dr Carol Stuart Morrow. Panels are being held in December and January.

III. Correspondence :

1. a) Letter from Dr K. Draper to Dr M. Tate, Senior Principal Medical Officer, D.H.S.S., Alexander Fleming House, London.
"The Council of the Institute of Psychosexual Medicine have asked me to bring the training regulations and criteria for accreditation of Members to your attention.
"Members of the Institute have met varied responses from different Authorities when they have negotiated contracts for work in psychosexual problem clinics. Although many members have been graded Senior Clinical Medical Officers (according to HC(PC)771) or for "Specialist Sessions in the Community" (according to HC(PC)78 12), others have had difficulty in gaining recognition for their training. I, therefore, enclose a copy of the Training Regulations and Criteria for Accreditation.
"The institute was formed in 1974, to take over the seminar training in psychosexual medicine which developed in the Family Planning association, when the N.H.S. assumed responsibility for Family Planning. The recent development of training in this field has meant that all Areas are not aware of the standard of our seminar training."

b) Reply from Dr J.S. Metters, Senior Medical Officer to Dr Draper.
"Thank you for your letter of 24 September addressed to Dr Mary Tate.

I have been asked to reply as I deal with the subject. It may be helpful if I explain that I also deal with maternity, gynaecology, contraception, abortion and genetic counselling. Thus you will see why psychosexual medicine is one of my responsibilities.

"It was helpful to have the latest training regulations and criteria for accreditation of members of the Institute. By the same post I received a copy of the proceedings of the Institute's meeting held at the Golden Valley Hotel, Cheltenham in September, 1978. I have not been able to read this through completely yet but shall be doing so shortly.

"I also noted the points you made about the difficulties some Institute members are having over gaining recognition for their training. I will send a copy of the training regulations to my colleagues who deal with medical manpower.

"I hope you will contact me if there other matters concerning the Institute which you would like to bring to the Department's attention."

c) An Advance Letter MD 9/79 has been sent by the D.H.S.S. to Administrators of Regional Health Authorities, Area Health Authorities, Secretaries of Boards of Governors, Family Practitioners Committees.
Date. 8.10.1979
Reference. B3/150/71
by the assistant secretary - D.A. Birch.
The fee for regular sessions as Consultant or specialist work
(WEF 1.4.79.) £26.10
Doctors conducting sessions concerned with patients with marital difficulties: -

	W.E.F. 1.4.78	W.E.F. 1.4.79
Full session (1½ - 2½ Hrs)	£17.30	£21.60
Short session	£14.15	£17.60

2. Letter from Dr P. Shirley-Quirk :

"In connection with the work of the Research Group I recently asked the Elmer Holmes BOBST Library of New York University for a computer printout of all the papers published in connection with non-consummation. It turned out that consummation, non- or un-, is not in the computer's dictionary, so the keywords vaginismus, dyspareunia, impotence, frigidity were fed in, together with psychosexual, psychotherapeutic, psychosomatic techniques, etc.,

"Both Medical and Psychological Data-banks were searched for worldwide papers on these subjects back to 1967. The result should prove a valuable source of reference and we hope Institute members will make full use of it. Please give full details of the subject required and be prepared to pay a fee to cover the cost of photocopying and postage."

3. Note from Dr [illegible] Bromley :

"The research committee would be grateful for the assistance of an Institute member to house and to make available to members a computer print-out and photocopied articles on subjects relevant to our work, and to keep these references up to date."

4. Note from Dr Carol Stuart Morrow :
Honolulu, Hawaii. 24th June - 1st July, 1980.
The Institute is acting as a sponsor to the Vth International Congress on V.D., Family Planning and Human Sexuality, in Honolulu next year. A party will be attending from the Institute and we hope that some of you will submit papers for presentation and that we will demonstrate a typical Seminar at work.
A round trip can be arranged to be away 10 or 14 days, including 3 - 5 days in Los Angeles for approximately £550.- £650. First class hotel, with bed only. Obviously most of this would be tax deductable for the self-employed Schedule D payers.
If you are interested, please write to Dr Carol Stuart Morrow, 59, Wimpole St, London. W1. Tel: 486.2274, stating :

1. Name and Address
2. If you have any ideas for a paper
3. How long you prefer to be away
4. Whether you would like a few days in Los Angeles as part of the trip. (The air fare is already included.)

This is not a Committment to attend but would help with planning a group party trip with minimal possible costs i.e. Maximum numbers for a group.

5. "Dear Editor,

"Enclosed are a few thoughts about the Symposium at Cheltenham :

My Initiation into the Institute of Psychosexual Medicine

"Having been an Associate Member of the Institute for approximately 2 years I decided that I simply must attend their Symposium this year. At the last moment the Gynaecologist, for whom I work, decided to send me to the NAFPD Symposium on Infertility as this is the type of work I do in my capacity as his Clinical Assistant.
I was delightfully surprised, on arriving at Cheltenham, that I was also about to live in luxury for 3 days in addition to learning how to better my skills.
The NAFPD Symposium passed off on Friday with interesting lectures and discussions but it was with a little trepidation that I waited for Saturday. Had I, I wondered, been doing the right thing for the last two years or had I, in spite of attending Dr Coombe's seminar, failed miserably to realise what I should have been doing? I felt the moment of truth was at hand.
Dr Turnadine's talk on the Vasectomy Research Seminar proved interesting as did the case histories presented by Lt. Col. Bradshaw and Dr Sheila Corrin. I felt I could identify easily with Dr Corrin, as vasectomy counselling is also part of my work. So far so good!
The study on Non-consummation as a research project with statistical explanation fascinated me as until then I certainly did not think it was possible at all to evaluate one's work. However it began to look a little disturbing when it was found to be impossible to put the patients fantasies into the computer and it will be interesting to see at the end of the study whether a true evaluation is possible or whether the most one could say is that an attempt has been made to evaluate the work scientifically but that it is not possible to cover all aspects.
The following session after tea demonstrated the role of the Seminar in Psychosexual Medicine. The cases which were presented showed how the dynamics within the group enabled the doctor in charge of the case to use the expertise of the groups in the doctor/patient relationship. This, plus the Sunday morning session, at last made us realise what psychosexual medicine really means. I was full of admiration for all the speakers for the way in which they could demonstrate how in each case the doctor/patient relationship had been used to overcome the patients problem. I felt we should all have worn T-shirts with CONCEPTUALISE written across our bosoms to make us more aware of our methods of treatment.
In conclusion I can only say that I have never before attended a medical meeting when I felt there were 120 doctors with so much understanding and empathy with the needs of their patients and at last I felt very proud to be an Associate Member of the Institute of Psychosexual Medicine."

Lorna M. Sykes
Senior Clinical Medical Officer
Kirklees Health Authority
Huddersfield.

Note from Dr Fay Hutchinson :

Family Planning Association Sex Education Courses.

I know that in the past many of you have taken part in some of the courses run by the F.P.A. Education Unit, and found it to be valuable work. In recent years, less use has been made of doctors on the courses and more emphasis has been placed on experimental work. The education unit is now entering a new phase, and is expecting to develope new courses for the cases of the mentally and physically handicapped, as well as courses for teachers, social workers, youth workers and pharmacists. I have been involved in some pilot courses for the handicapped and found them challenging and rewarding, as one's seminar training and experience of group work is valuable in coping with the fears and anxieties that may be released during the course, as well as being able to give factual information.
Mrs Freda Parker, who is the Director of the F.P.A. Education Unit would like to hear from any doctors who are interested in working on these courses. They will take place in the Regions and not just based in London. In service training will be given, and modest fees are paid. If you would like further information, please write to:

Mrs Freda Parker, Director of FPA Education Unit
Margaret Pyke House
27 - 35 Mortimer street
London W1N 7RJ

IV. Register

a) Here is a list of new members who have joined since Newsletter 13:

Shirley Toogood - 31 Kendal End Rd, Barnt Green, Birmingham 45
Helen Murrell - 6 Tredwell Close, Bromley, Kent
Peter Scales - 108, Chislehurst rd, Orpington, Kent
Brian Spencer - 14, Woodlands, Darras Hall, Ponteland, Northumberland.
Aileen Powell - 52, The Boulevard, Worthing, Sussex
Gillian Wandless - 31 Ashfield Rd, Leicester.
Ann Worler - 49 Moor Crescent, Newcastle [illegible]
Roger Whatley - 496a Settington Rd, Melksham, Wilts.
Vera Smith - 6, The Crescent, Long Benton, Newcastle-upon-Tyne
Hilary Davies - Shouls Park, Norton Canon, Herefordshire.
Rose Newsom - 11 The Footpath, Coton, Cambridgeshire.
Barbara Robson - 40, Thornton Road, Wimbledon SW19
Henry Shapiro - 395 Harehills Road, Leeds.
Joan Kirkland - Westholme, Westgate, Otley, W.Yorks.
Kathleen Bowen - Little Blakes, Shelsley Beauchamp, Worcester.
Monica McLaren - Bohereen, Bath Rd, Nailsworth, Stroud, Glos.
Jean Bowie - 167 Bishop Rd, Bishopston, Bristol
Mary Stewart - 7 Rossland Crescent, Marton, Middlesborough, Cleveland
Gwen Leavesley - FPA of Western Australia, Woonwarra House, 233 Adelaide Terrace, Perth, Western Australia, 6000.
M. Bingham - 16 Lower Quay, Fareham, Hants
Sheila Green - 5 Ruffield Close, Winchester, Hants
Barbara Smith - Beechwood, Waddington Rd, Clitheroe, Lancs.
Carole Brown - 4B Chapel Road, Dersingham, Kings Lynn, Norfolk.
Delia Bickerton - Fellside, Pantymwyn-Mold-Clwyd.
Marion Birch - 46 Grey Road, Liverpool 9.
Vera Giles - Fair View East, Mill Lane, Main Hill, Liverpool, L[illegible]
M. Graham - 19 Beehouse Lane, Grappenhall, Warrington
J.M.de la Hoyde - 39 Kiln Rd, Fareham, Hampshire
Marjorie Hooks - 93 Whitefield Rd, Stockton Heath, Warrington
Shivkuman Pande - 152 Jubilee Drive, Liverpool, L7
E. Waring - Tunglin, Burton Rd, Lt. Neston, S.Wirral
Sally Waters - 49 Bower Mount Rd, Maidstone, Kent.

b) Medical Directory

When Members of the Institute submit details of their qualifications to the Medical Directory or similar publications, please will they give information of their membership.

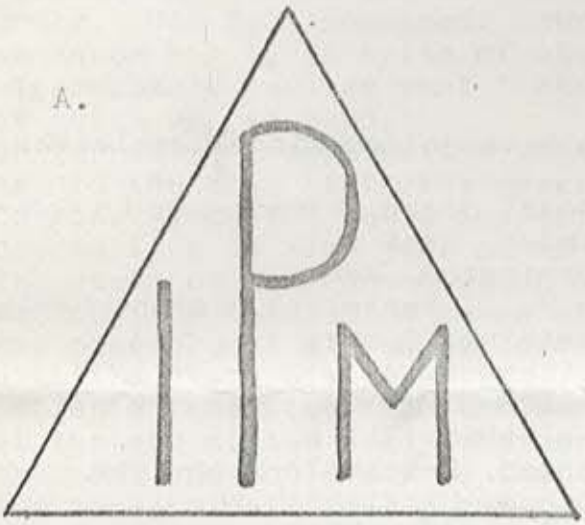
c) Enclosed with your newsletter is a copy of your entry on the Institute Register. If it is not correct, or if your telephone number is not included, or if it is not coded 'M' or 'A' (member or associate), please would you return the amended slip with corrected or additional details to:

Mrs Fiona Beresford-Frye
"Newholme"
The Street
Brampton, near Buxton
Norwich
Norfolk NR10 5AA.

V. Symbols

Additional designs for symbols have been sent in by members. Now which shall we use? Comments and votes, please.

A.

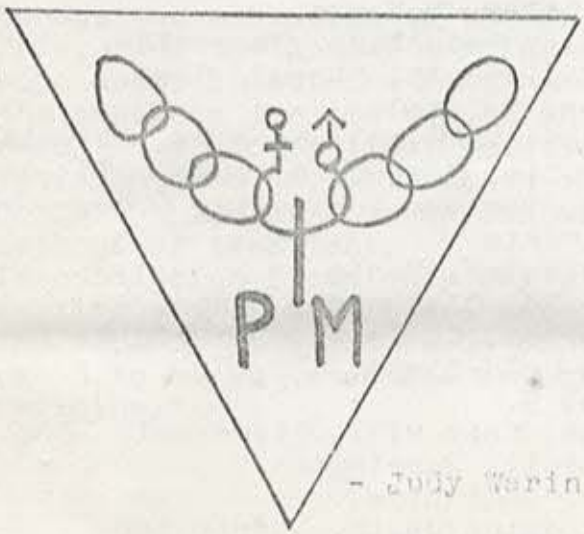


Submitted by
- Nadine Lincoln.

B.

- David Delvin

C.



- Judy Warin

Yours sincerely,

Rosemarie D. Lincoln

ROSEMARIE D. LINCOLN

'The above symbol is of a broken chain, the broken link forming a ♀ with male and female facing each other across the gap, including the letters I.P.M. and enclosed in a triangle - symbolic of many things!' J.W.

I. Reports of Meetings

Report of the Residential Meeting held at the Golden Valley Hotel, Cheltenham on 6th and 7th October, 1979.

By Dr Robina Thexton.

Session I. Dr Margaret Blair was in the chair. "Psychosexual problems revealed during medical consultations requesting sterilization."

a) A personal account of the Vasectomy Research Seminar - Speaker: Dr Pruedence Tunnadine.

The seminar was set up to do a pilot study to understand requests for vasectomy - 10 members reporting freely their next 20 cases - and forms were filled up. A year later follow-up letters were sent out and where necessary visits were made.
Some of the patients were well adjusted with stable relationships and no psychopathology - but there were also:

1. men who had to be in charge of the contraception and couldn't trust the wife to do it
2. men who dealt with their angry, frigid, wife by placating her and opting out, passively aggressive - determined to have a vasectomy.
3. those belonging to "The Michael Parkinson Set" - groups of men who all came along together - as from a fire station or men's club - among them there was sometimes one who didn't want it done, but didn't like to stand out and say so.
4. men whose wives used it as a punishment for too much sexuality - to put an end to it.
5. the "Escapers" who felt they should not procreate because the world situation is too threatening and the population explosion must be curbed.
6. Those who had had enough children and wanted time to enjoy themselves.

The doctoring comprised understanding the marital interaction and doing a careful physical examination to exclude pathology (a terratoma of the testicle and fibroids in the woman were picked up and the operation done was not a vasectomy.)
The doctor complied with the request and said 'lets talk about whether it is the best thing for you.' The patient's feelings were respected and sometimes it seemed unnecessary to delve too deep. It became clear that they should not make a decision to have an irreversible operation while in a crisis of marital upset or after a termination or death.
The doctors looked for couples with a good relationship and a good love life, where man and woman agreed the man should have the operation; and helped them to air any anxieties and expectations first.
In the discussion Dr Pullen asked if there is any way of identifying the men who afterwards are unwilling to bring in semen specimens, as if they dont want to be told that they are sterile.
Dr Tunnadine agreed there were men like this and reported some last minute pregnancies in the research group as if couples were uneasy about the finality of the operation.
Dr Powell asked what particularly was the physical examination for?

1. To exclude pathology.
2. To notice moments of truth and allow anxieties to be aired such as "What will they actually take away?"

Dr Law said men's reactions to examination varied from showing no feeling, to being embarrassed and even fainting.
Dr Barne exemplified men's anxieties when telling of a patient who signed the consent form but failed the operation appointment. 9 months later he re-appeared and re-signed the form, but went to the lavatory and disappeared again.

b) The role of an army gynaecologist in Sterilization consultations.
Speaker: Lt.Col. James Bradshaw.

Lt.Col. Bradshaw described his work. His patients are army wives and soldiers for whom he does vasectomies, and non army patients who attend his psychosexual session held in Woolwich. He does about 100 Pomeroy sterilizive operations and 50 hysterectomies annually. Though they have been counselled by their G.P.s, he had enough time to also counsel each couple.
Statistics on a slide showed that some of the patients who complained to him of general unresponsiveness in sex and who had had tubal ligation, or hysterectomy or vasectomy, blamed either the husband or the doctor for their symptoms. He described a corporal's wife who was referred by her GP for sterilization - her real problem was that since the birth of her baby less than a year before, she couldn't bear her husband to touch her. She reported to Lt.Col.Bradshaw a traumatic adolescence when her mother died and father hanged himself, and he felt the request tobe sterilized was a rejection of motherhood because she felt inadequate as a mother. The doctor treated her difficulty with herself and her body and her frigidity was cured and she was not sterilized.
A second woman was described who was 38 and a telephone operator supervisor - a cold woman who had never liked intercourse - she and her quiet husband had three children from his first marriage and 2 of their own and she requested sterilization - They were not complaining about their poor sexual life, and after the operation, it was the same, neither better nor worse.

c) Vasectomy Counselling in a Community Health Centre.
Speaker: Dr Sheila Corrin

Dr Corrin sees the couple noting answers to questions about contraception like the wives who complain of 'Having done it all up to now' - and discovers puerperal depressions, often never diagnosed or treated.

Dr Corrin suspects problems if they reply in certain ways to her questions - the problems may be impotence, premature ejaculation or loss of libido. Sometimes the patients are not motivated at that time to accept help with the problems uncovered. Mrs H was 29 and drab. Her bus driver husband was 36, lively and wanted sex all the time. They wanted no more children, having two daughters already. Dr Corrin saw the wife on her own and helped her understand how she envied her their 'easy life' and felt dissatisfied with her role as a woman. She needed to disappoint her husband her husband and consciously stopped herself reaching orgasm when they had intercourse. He had a vasectomy and the patient was surprised he hadn't suffered at all and was "just as bad as before" !
Mr and Mrs L came together, but he did all the talking and said he wanted her off the pill, so he should have a vasectomy but was worried that he couldn't get erections or any sensations in his penis. Dr Corrin listened to his long and complicated sexual history, making interpretations and the impotence improved, but he didnt have a vasectomy - it was as if in the request for one, he was really seeking help for impotence and he got it.

Dr Blair in summing up at the end of the morning, thanked the speakers for their carefully prepared papers and suggested that further study around hysterectomy would be rewarding to improve counselling before it, and follow-up care afterwards.

Session 2. Dr Prudence Tunnadine was in the chair.

a) 'Prospective Study of Non-Consummation'
Speakers: Dr Bramley, Dr Brown, Dr Draper and Dr Kilvington.

Dr Draper said the committee had met 43 times and held 2 all day workshops and a working week-end. It had designed a form to collect the facts and raised funds.
Dr Kilvington showed the form with a top enrolment page, a page for personal facts about the woman and another for the man, and a fourth for the outcome of treatment. 20 doctors sent in every case they met until 30th September, 1978.
Dr Bramley showed slides of statistics - the figure which stands out is that 50 couples were enrolled and 62% consummated in 6/12.
Dr Joe Brown said that this is the only prospective study in the world for non consummation. There have been 20 retrospective studies. It aims at finding what success there is in using interpretation of the Doctor/Patient Relationship in cases of non consummation and whether the time spent in therapy is reasonable.
The institute doctors have not been made impotent like the husbands and patients with symptoms lasting 8 - 11 years have been cured. Interpretative therapy has worked even in social classes 4 and 5. The importance of the vaginal examination as a psychosomatic experience has been underlined in this study. Those coming as couples had a higher success rate.
In answers to questions from the floor, the speakers replied that the problem was solely attributed to the male partners in 2 cases, and that in 3 cases the hymen was intact. Problems about follow-up were discussed and whether the number of 'defaulters' might invalidate the study. The fact that the prognosis was better when there was vaginismus was noted, revealing the problem as one of difficulty with body relationship.

b) 'Insights gained in Seminars'
Speakers : Dr Doreen Anderson and Dr Margaret Gill.

Dr Margaret Gill described a case of non-consummation. The patient had been married 6 months but was too tense to have interccurse. She controlled the doctor and after 3 visits she failed to come again - making the doctor feel she hadn't managed the right balance of support and exploration of feelings but felt it is the patients privilege to stop treatment if she wants to.
The seminar sometimes gives a blinding flash of insight, but more often a slow understanding of cases which comes by worrying away at them. It trains doctors to discipline themselves to work at difficult ideas.
Dr Doreen Anderson described a case of non ejaculation where she treated the wife, who was the real patient. When the doctor accepted the anger and sadness of the woman who wanted sex for herself, the husband who was away working as a chef on an oil rig, got better and at the next visit the wife reported that they were now enjoying intercourse and planning a pregnancy. The seminar had helped the doctor identify the real patient and sit with her, listening and accepting.
Discussion followed about the woman's change to radiance and also the suppressed aggressive feelings of the doctor which denied the patient the opportunity to talk about it within the doctor/patient relationship.

Dr Tunnadine summed up the 2 cases presented by saying:

1. We would all like to be nice, accepting doctors, but we must recognize our bad feelings.
2. The non-ejaculating husband was drugged along by his wife but the successful treatment of her difficulties made him better in absentia on an oil-rig.

Session 3. Dr Jean Parmore was in the Chair.

'The use of the Doctor/Patient Relationship in the treatment of Psychosexual problems following childbirth.'
Cases were presented by: Dr E. Holdsworth, Dr J. Tisdall, Dr A. Smith and Dr J. Yorsten.

A brief description of each case follows with some details omitted to preserve the confidentiality.

Case 1. Dr E. Holdsworth. was doing a family planning session with a trainee doctor, when a well dressed 25 year old mother with a beautiful baby complained that the pill was putting her off sex and she hadn't had intercourse for three months. She wanted however, to stay on the pill. The only trouble was that her husband demanded sex. The doctor had seen this woman before as she had often called in with complaints since going on the pill a month after her baby was delivered by Caesarian Section. This had been done at 36 weeks because of a breech presentation. The doctor felt she had to defend the pill, and felt as if she was being tested. In this interview with the trainee present she also felt tense and bewildered and the patient had caused a commotion in the clinic with the baby and lots of shopping bags.
When asked to say a bit about her life, the patient recounted how she left home to do a job in a seaside hotel when she was 16 years because her father was so strict and kept her in. She enjoyed several sexual relationships until 3 years later when her parents separated and she went home to live with her mother. After a short time she met and became engaged to her husband and a house was bought which needed a lot of renovation and this left no money for fun, so she broke off the engagement.
Here the audience noted the symbolic connection between the patients desire for vaginal pleasure but lack of commitment to spend effort to improve - (she resented the money needed to renovate the house.) After a while, however, she wanted him and went to live in the half renovated house. She was happy to find she was pregnant and enjoyed intercourse until 6 months when she 'switched off'. She told the doctor sharply that it wasn't nice to continue as it might have hurt the baby. 2 weeks after delivery, with some trepidation, she had started again and enjoyed it, but at 6 weeks she felt so tired she refused and now her husband was fed up. At the same time the baby was admitted to hospital and she spent many days there having tidied up at home first. When she returned at 10 p.m. she was too tired to have sex. Since the baby was discharged she was fully occupied looking after him.
The doctor commented that the loss of libido coincided with the baby's illness and that she had been concerned with that and the housework and hadn't considered her husband's need to have his place in the family. Then she picked up all the shopping and helped the patient to the door with an 'accepting' gesture saying 'It seems that your needs for a home and a baby are met, but not your husbands'
Two weeks later the patient phoned to say she only needed pills and not to come, because things were all right again.
The audience was asked to discuss the Doctor/Patient Relationship during this successful therapy.
Dr Zucchi said she was tidy, had to have her house and relationships just right - including her relationship with the doctor whom she controlled, but the doctor got to grips with her and was able to keep her head, not collude in the overwhelming nature of baby chores and say 'What about your husbands needs?'
Dr Rosalie Taylor said - She came in burdened with baby and shopping, you received and accepted her so she could communicate with you.
Dr Parmore asked how the presence of the trainee affected the interview. It had made the whole encounter difficult.
Dr Gilley said that the final communication, as always, was so important, helping her with the shopping and pointing out about the husband.
Dr Tisdall: The doctor began not liking the patient, who was annoying.

Empathy came when she appreciated the burden. Then the vulnerable but well defended patient was able to accept help. Originally the doctor was annoyed, responding to anger in the patient, but later responding to the cry for help.
Dr Montford: The patient had failed in childbirth and had a Caesarian section, but the doctor shared the guilt and burden.

Case 2. Dr Tisdall. A serviceman's wife who had a demanding 6 month baby, was referred by a social worker because of marriage problems. She and her husband, who was overseas a lot, were not communicating. The doctor felt that joint therapy would be best, but the husband wouldnt consider coming. So the wife came and was drab, unfeminine and rather assertive. She reported losing interest in intercourse during her first pregnancy. She felt resentful that she had had to give up her career while her husband had an exciting life. The doctor felt she would enjoy herself in a feminist group! She missed her home which was in the commonwealth and told of her father having committed suicide when she was two years old. Sometimes she now wanted to commit suicide herself. She was one of triplets, and got herself noticed by being difficult as a child, and wanted to shock her mother into controlling her - but this didnt happen. She complained a lot about her husband not being sufficiently supportive - but she missed him and wished his letters were warmer. The doctor suggested he might be defending himself because he felt rejected. She complained bitterly about all things English.
The patient went on to tell of an earlier pregnancy during her 3rd University Year - the baby had been adopted and she had grieved over losing it. The doctor interpreted her conflict about being pure mother, or sexual woman, or still being a daughter, not a wife. She came twice and then phoned to say that she was happy again.
Factors in this case were conflict between mothering and career roles; she was still an unhappy little girl inside who wanted to be different and was anxious lest her bad feelings would drive her husband away when she really wanted him to cherish her. She got from the interviews permission to let the husband do this - the doctor allowed her to be less than perfect and in this case it was the patient who used the patient/doctor relationship as though finding that mother could accept an angry little girl.
Dr Tisdall felt that all the complaining was the adolescent aggression coming out late.
Dr Dacher said that when she arrived presenting her drabness, it was all the badness inside showing and the doctor accepted this and gave her a second appointment and an opportunity to charge.

Case 3. Dr A. Smith was in her G.P. Surgery when a 26 year old woman came to register - she didnt want to see the doctor, just to register, she said and she shouted at her two noisy children, who got more noisy. The doctor said she liked to meet new patients, and asked a bit about her - she was 26 years old and her husband was 28 and she reported being happy to have had a tubal ligation and hysterectomy. She looked bedraggled with shoulder length greasy hair. 3 weeks later she came for advice about an itchy vaginal discharge and the doctor cleared the surgery of movable, breakable objects so that the naughty children could do no harm. The patient objected to the request to get up on the couch - she just wanted a prescription. The doctor insisted and said "Have you been examined before?" and the answer was "Yes, when I was pregnant and I know it is going to hurt."
She held her knees together and there was vaginismus and also monilia. The doctor said "Does it hurt when you are with your husband?" She replied "Intercourse is awful, like Hell, since my last baby a year ago. I havent had a climax since and I've no interest in it." Her eyes were wet with tears and she was uncomfortable showing her distress.
The doctor said "It is also painful emotionally - we'll make another appointment." The patient said "What for?" and the doctor felt she

wanting to be rejected, but walked to the appointment desk.
A week later the patient came and was able to talk about herself. She had become pregnant at 16½ years and her parents made her marry the father - a school friend, who used to get drunk and batter her. She became depressed, had a divorce and her son, born when she was 17 went with the father, because she rejected him.
At 22 years she was pregnant again and feared a repetition of the previous disasterous relationship - but her boyfriend went with joy - he had had mumps and was afraid he'd be infertile. The patient was overjoyed to see how pleased he was. She had another son and afterwards they used sheaths and were very happy. After her third baby she asked to be sterilized and it was done on the third day - a patient in the same ward had an episiotomy which broke down, and this caused her to feel that her husband would tear her open when they resumed intercourse. Her periods became heavy and her G.P. suggested the pill but she didnt want it and nagged him and her husband into allowing a hysterectomy. After this her scar was sore and she never had a climax again. She went to her G.P. who referred her to the Marriage Guidance Council - but she became fed up with them when they told her to mimic a climax. The husband's job now took him to London in the week and he was staying away over the weekend because of the tense no intercourse situation. When he is expected home she tries to be responsive 'but when he arrives I just rag' she said. The doctor said "Do you want to break up?" and the patient looked so sad at the thought that the doctor was able to say "That makes it so painful for you?"
The patient broke down and went and in the same way as she had felt happy to see her boyfriends tears and real feelings, now the doctor felt happy. 'I made him agree to the hysterectomy and now I want another baby. I was wrong - how can I climax when there is no chance of a pregnancy? It is right that it hurts me, as a punishment - it would be hard to admit to him that I was wrong' The doctor pointed out that when her husband had cried he was able to share his feelings of fear of infertility - could she share hers with him now?
6 weeks later she came back, unrecognisable because her hair was permed and her children well behaved. She had plucked up courage and told him and he had burst into tears, and she too, and then they made love. He changed his job and moved back home.
This case bears out the 2 rules that sterilization should never be done at the time of a crisis (such as childbirth) and there should be adequate pre-hysterectomy counselling.
Dr Watkinson felt this therapy was successful because the doctor acknowledged the emotional pain, respected it and allowed the patient to feel on equal terms.
Dr Rosalie Taylor said that the doctor was aware of her own feelings towards the woman and used them.
Dr Friedman said that the woman's aggressive presentation might have made the G.P. reject her, but she took the message and made the diagnosis.
Dr Hinshelwood said she had improved with containment and understanding and time - the quality of sharing was almost unconscious.

Dr Jessie Yorston : Case 4. A 24 year old woman was referred to the psychosexual session by her G.P. because in reply to his question, she said she didnt enjoy intercourse. Her 25 year old husband was surprised and pleased that she had asked for help. She had been a dental receptionist before she married 5 years ago. 6 months after her marriage she became pregnant with twin boys who died - she hadn't been allowed to see them and she was kept in isolation in the maternity hospital and she felt very envious of the other mothers. She had completely shut off her sad feelings. The doctor felt overwhelmed with sadness at this remark. She had been advised to get pregnant again quickly and when she did, she felt angry and had to have forceps when she was delivered of a 9 lb boy. She felt that boys caused pain and she wanted to reject him.

International Conference - "Caring and Counselling" S.P.O.D.
University of Sussex, 10th - 13th July 1979

A Personal View.

by Dr Jane Berry.

Seventeen countries were represented at the Conference, delegates were from many different backgrounds and many of those attending were themselves disabled. Apart from the latter, there were social workers, nurses, some doctors, "counsellors" of all types, occupational and physiotherapists and others concerned with the rehabilitation of the newly disabled, there were teachers and those working in the field of mental handicap.

On the first evening, the introduction to this three day residential conference was a game called "They Ought to be Grateful". Everyone was asked to role play from a given script. The able-bodied were given the roles of disabled people or their relatives and the disabled played the parts of Social Workers, Housing Officers, Marriage Guidance Counsellors, Lawyers, Doctors and Doctor's receptionists, and even F.P. doctors dealing with psycho-sexual problems! It proved to be a friutless task to get help in "Carrington" - "A debased little market town within 60 miles of London " - which in fact consisted of two Halls of Residence on the university campus and the surrounding grounds. Queues, frustrations and barriers to seeing people who could help, were the order of the evening, and it became apparent that it was simply chance if one was in the right place at the right time to get help. Someone had obviously observed Family Planning Doctors in detail as the doctor who concerned herself with psychosexual counselling remained closeted in her consulting room for the duration of the game seeing one patient!

This imaginative, if slightly chaotic, introduction to the Conference gave some insight into the isolation and frustrations of the person seeking help; although after the first half-hour it became slightly boring and predictable and I for one sought out people to talk to about work, which surely was one of the main aims of meeting together.

In her Ministerial address to open the Conference, Lynda Chalker, Parliamentary Under-Secretary of State at the DHSS, announced a £25,000 grant from the DHSS to increase the work of SPOD in the information and training field. We heard that the new Government was committed to the prevention of disability and rehabilitation. The Minister made a plea that the disabled should not be set apart but that they should receive specially directed help.

For the next three days papers followed each other every ten minutes. was little if any time for questions and discussion and this was to the dis of everyone.

We first heard a paper on "The Growth and Efficacy of the SPOD Advisory and Counselling Service 1975-79". When the sexual difficulties presented by the 'client group' were described, it struck me forcibly that these problems were the very same problems that present to us at any of our clinics in the Health Service:- doubts about sexual potency and capacity, problems about self-image, doubts about attractiveness to peers, etc. These patients were being presented as a 'special group' with special problems but were really just patients as usual, camouflaged by their physical disabilities. I had to keep reminding myself how easy it was to be deflected from a consideration of the patient by the feelings engendered in the doctor by the disability and its associated physical problems.

Dr. Wendy Greengross spoke about "The difficulties encountered by able-bodied professionals working with disabled clients". She presented the audience with some ethical dilemmas - should a third person be introduced into love play between a couple with physical disabilities, to enable them to achieve intercourse ? should surrogate partners be arranged ? should couples needing residential care have children ? what are peoples rights and responsibilities if they have physical disability? Unfortunately, there was no time for discussion of these points.

A part of the Conference which gave me most stimulation was the presentation of some most interesting papers on the problems of sex education in centres for mental handicap, and for ESN students. We were priveleged to hear Winifred Kempton, who has pioneered sex education programmes for the mentally handicapped in the USA and to see some of the teaching material she has developed for use with mentally handicapped children and adolescents. Max and Della Fitzgerald of the USA gave a paper on "The Sexual Implications of Deafness", their thought provoking paper vividly pointed out the effects of deafness on sexual activity. In contrast a paper from the U.K. entitled "The Deaf and Dumb in Family Planning Clinics" would have disappointed most F.P. Doctors by its superficial treatment of the subject.

So it went on, paper after paper, from "The loss of sexual ability prior to heart attack" to the problems associated with multiple sclerosis, sexual life after mastectomy, sexual life after spinal injury, after ileostomy, etc. etc. By the last day I was becoming more and more dismayed by my own irritation. I think this irritation arose because many seemed to be seduced into working with the facts of the disability and not with the whole person. How easy it seemed to be to be tempted into generalisations and the more comfortable consideration of

helpful gadgets and sex aids, rather than looking at the painful feelings of the patients. Maybe at some future SPOD Conference this year's absence of Institute members could be remedied and a paper could be submitted which demonstrates the use of the methods and skills developed during our training in work with the handicapped individual. I think that we have something special to offer in this field.

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1. Contributions from Members

THE DOCTOR'S DILEMMA

by Dr Elizabeth Deman.

The Cheltenham meeting, where the use of the doctor/patient relationship in the treatment of psychosexual problems following childbirth, was so movingly illustrated by case presentations, prompted me to draw attention to the difficulties for the patient and doctor to discuss feelings in the clinical environment of the post partum visit to the hospital. All the patients discussed presented with psychosexual problems months and sometimes even years after delivery. How could the patient have made her anxieties known sooner? How could the doctor have made the patient recognise her needs earlier?

It goes without saying that our objective (to use the current jargon) is to make a diagnosis in the light of the patient's presentation. This is where the doctor may run into difficulties because of the patient's expectations.

The six weeks post partum visit is an opportunity for the patient to confirm that her reproductive organs and appendages have reverted to the non-pregnant state. The discussion focuses around resumption of menstruation, cessation of vaginal discharge, elimination of problems of micturition and bowel movements. Contraception is offered, decisions sometimes being affected by the method of infant feeding e.g. progestogen only pill being suitable for breast feeders etc. In fact the patient expects from the doctor at the post partum visit an assessment of the physical state of her body. The emotional needs can easily be confused by focusing entirely on the genitalia by both the patient and the doctor. However, anxiety associated with sexuality can be diagnosed during history taking and at the time of examination. The patient may be able to verbalise complaints about a sore perineum or vaginal dryness; "it is normal for the vagina to be much larger once you have had a baby." Discussion about methods of birth control can sometimes give the patient the opportunity to air anxieties about sexual problems. Puerperal illness presenting with agitation over the baby, loss of sleep, listlessness, exhaustion, depresssion and loss of libido will also occasionally be seen at the post partum clinic. However, this is rare because the family doctor will usually have been summoned and initiated appropriate treatment earlier in the post partum period.

The doctor is forced to come to a hasty differential diagnosis. Is the patient's complaint:

(a) physical, i.e. residual trauma associated with the birth,
(b) emotional, i.e. adjusting to her new state as a mother coping with baby's, her own and her partner's needs,
(c) psychosexual - and if so has the problem resulted from this pregnancy and delivery or is it of long standing and has it only been highlighted by the present situation,
(d) finally is the patient suffering from a puerperal psychosis.

The therapeutic technique of the doctor/patient relationship can be demonstrated in the type of sexual problem which is of post partum onset and is associated with the pregnancy and delivery. Diagnosis at this stage can prevent the onset of a chronic problem which is immensely rewarding for the patient and doctor. The following case study illustrates this type of situation:

This patient presented with soreness down below and a story of any attempted penetration causing excruciating pain which spread from the vulva to the pit of her stomach making intercourse impossible She was genuinely deeply distressed and warned the doctor that examination would be impossible. Inspection of the perineum revealed a healthy vulva; the episiotomy scar was healed and there was no evidence of residual trauma. While listening to the patient the doctor was able to insert a finger high up into the vagina without causing pain. The patient was moved to angry tears, amidst sobs, she reported that several times since the birth of the baby she would see the doctor putting his enormous hand and arm into her, and wake up screaming with terror in the middle of the night. This would then recall the midwife saying "it's time to cut her" - it had seemed like hours before she was stitched up after the delivery and again she remembered how the nurses had told the doctor or student not to stitch her up too tightly. She now felt that the vagina was probably sewn up and that behind it there was an enormous gaping wound from her vagina and uterus into her stomach. The relief which spread acros her face having verbalised this private nightmare is indescribable. She was eager to confirm for herself, after the doctor had examined her, that she felt quite normal inside.

The doctor's dilemma is illustrated by the following case study where the patient is unable to acknowledge that she has long-standing sexual problem . Mrs. 'A' is a representative of the Hampstead, very demanding, quasi intellectual set, who before she is even called into the consulting room makes the nurses' heckles rise. At her first visit she was rather over weight. This was accentuated by wearing a clinging jumper suit. She had pretty hair caught attractively together by a clip at the back. She was full of complaints which were explained in an eloqueht, flowing, gracious manner. She revelled in the audience of medical student and two trainee nurses. She made the doctor aware of a teasing quality in her opening remarks - "since coming home I have had constant backaches; of course I have still got piles; I can never continue to breast feed; when will I regain my normal figure? I am swimming daily and I have restarted yoga classes."

As is the normal practice at the clinic we then went on to discuss birth control before the physical examination. This brought forth a flowing account of how this has always been a problem - the pill makes her migraine worse; the two coils fell out within a month of insertion (this seemed to amuse her immensely) - they can't stand those rubber things - she is very fertile and adores babies (this being her third) but her husband says enough is enough. None of the children were really planned since all forms of birth control are unsuitable for her. She even went to great lengths to explain to the students how the injection would not be possible for her because she has heard that it causes weight gain and affect migraine. She really gave an entertaining account of her love life. We found ourselves all laughing and highly amused. She revelled in holding the floor. She was reluctant to undress and be examined but knew routine of old and made no fuss. Although she did not verbalise the request the doctor sensed that she would prefer no audience at the examination,especially as she had commented on her obesity which she was clearly sensitive about. On the couch she said "although the vagina seems to be too large I can always feel the episiotomy scar for up to two years post partum". She exhibited vaginismus on examination although she persuaded the doctor to fit a copper 7. She returned after a month and defiantly announced that she had bled for a week after insertion of the device, had

chronic backache, had still not had a period although she is bottle feeding the baby and feels quite sick at the thought of examining herself.

On examination the coil was expelled and it was agreed that if the pregnancy test was negative we would refit the coil. The doctor was conscious of the battle going on between her and the patient when any attempt at exploring feelings was tried.

A month later she returned and said that since leaving the clinic last time she had had a persistant migraine, felt very tired and bled for four days after removal of the device. She said she didn't feel pregnant and her husband wanted her to be sterilised. However, she felt she wasn't ready for this. She refused to take durex away with her and announced she would return for coil fitting at the end of her next period. She insisted that she wanted her haemoglobin tested and this turned out to be 14 grms and she failed to turn up at her following appointment.

However, she made an appointment some time later and brought her husband along to discuss tubal ligation with clips. She had now had two periods since her last visit, having very severe backache during the period and severe migraines. The doctor found herself explaining the procedure of tubal ligation to this intelligent, intellectual couple. They seemed to want drawings and diagrams to illustrate what was involved in the procedure. They insisted that they wished to see the professor to discuss tubal ligation further and agreed that she might try a coil while being put on the waiting list. Incidentally, they had had no intercourse since the delivery nine months previously. So far, they have not been back to the clinic. The doctor felt that she was being controlled by them. There was great warmth in the doctor/patient relationship and the doctor was frustrated in attempts to take care of this couple, for whom she felt immense sympathy.

Such a case study illustrates how couple can manipulate the doctor and may subsequently become emotional casualties who find their way to psychosexual clinics when it is sometimes too late.

It would be interesting to hear from colleagues how they cope with such situations.

A SERIES OF SEMINARS DEALING WITH THE APPRECIATION OF PSYCHO-SEXUAL PROBLEMS FOR NURSES AND HEALTH VISITORS

by Dr Joan Coombs.

There were 12 applicants and the series of seminars was well attended. It was not possible to interview the group members individually to discuss the aims of the seminars prior to the first meeting, so this was done in the group at the first meeting.

AIMS OF THE SEMINARS

1. To allow the group members to develop some insight into sexual problems either directly of indirectly presented to them during the course of their work with patients.
2. To allow the members to come to terms with some of their own anxieties and 'hang-ups' so that they might become more sensitive to the patients.communications and heightened awareness of problems.
3 To facilitate the interaction between the nurse and the doctor in the clinic setting so that thedoctor is aware of the communications made by the patients to the nurse prior to the consultations.
4. The aim of the seminars was not to make the nurses therapists.
5. It was suggested by me that the work done by the group should be on their own encounters with patients in the course of their work. This was not popular with the group who were hoping to be taught.

Work Done

In spite of the reluctance of the group to work on their own encounters with patients, this method of learning seemed to work fairly well and there seemed to be a fair supply of clinical events to discuss from the majority of the group.

Towards the end of the series of seminars this supply dwindled and there was much pressure on the group leader to produce her own case material and start to teach. This pressure rightly or wrongly was resisted and was followed at subsequent seminars by a further supply of clinic events to discuss.

Composition of Group

There were 9 Family Planning Nurses and 2 Health Visitors and one member who was a Health Visitor and a Family Planning Nurse. There was a nucleus of consistently active members of the group. There was a fringe of members who became more active as the course proceeded and there was a periphery of one or two 'sleeping partners' who contributed nothing to the discussions. The health visitors were very active in the group and produced the most difficult cases and were obviously under much greater pressure from their patients than the nursesin family planning clinic settings. They also seemed to feel more isolated and unsupported when confronted with problems.

Questionnaire

A brief questionnaire was circulated and there were 5 responses. They were anonymous but I suspect the most active group members responded to the questions asked.

1. As a result of these seminars have you managed patients in a different way?

   Three replied that they had, they recognised the need to listen rather than advise.

   One said she hadn't come across problems but perhaps might perceive them quicker and with more understanding.

One felt that she needed more experience and did not respond to patients any different than previously.

Three members observed that they felt they would be more sensitive to the indirect presentation of sexual problems.

2. Would continuing seminars deepen your understanding and enhance your technique of dealing with them?

All five answers 'YES'

3. How did you find the new teaching learning process used in the seminar?

Two observed very difficult at first as they were waiting for laid out guidance rules.

A section of the questionnaire was headed 'any other comments'. Included were the following observations

1. As nurses in family planning clinics we do not always come across problems or if we do we have not the chance to discuss them with the patients fully'.
2. Conditions in clinics generally do not allow the family planning nurse to be helpful. I feel I might be more aware of existing problems but unlikely to be of major help in any but early difficulties.
3. I was somewhat horrified at the feelings expressed by some members .(These feelings were unspecified).
4. - We have to pass patrients pn to doctors whose attitudes may be different to ours. I.e. disinterested in patients' sexual problems.

All 5 responded to questionnaire. Wanted groups to

One other group member responded verbally that she had found the group useful and wished to continue. The way in which the remining 6 group members regarded the seminar remains in doubt.

The dimpressions of the leader were mixed. Certainly many of the members seemed to be more comfortable regarding listeninf to and talking about sexual problems than they appeared to be at the commencement of the rro group. As the series of seminars proceeded the group seemed to develop a tolerance to its anxiety regarding sexual matters which allowed more accurate and honest discussion in the group. Neither of these changes may have affected some group members though particularly the silent non-participants.
Recurring throughout the series was pressure by the group on the leader to teach and this seemed to be linked with the groups anxiety and with the anxiety produced in the reporting nurse by the expectations of the patients.

It may be that a sequence of seminars is not an appropriate way of introducing nurses to the valuable role they can play in helping patients come to terms with sexual difficulties. There was pressure by the organisers to provide a series of lectures. This was resisted by the seminar leader. Perhaps some of the anxiety and some of the difficulties encountered by the nurses was better understood in the seminar.

It would be interesting to hear if the Institute members have had experience of similar projects.

AGREED. (a) The Executive should prepare a paper examining the issue of outside speakers for discussion at the next Council.

(b) The need to define the Constitution and committee procedure, and the roles of the officers should be studied by the Executive and put before the Council.

(c) The Executive should study the difficulty felt in presenting their work to Meetings and report to Council.

7. Other Business

(a) Dr. Lincoln had received a letter suggesting that there was a lack of facilities for psychosexual medicine in Devon and Cornwall.

AGREED. This may be a suitable area for a Training Day.

(b) The Secretary reported that the three Vice-Presidents had been asked to join the Council for dinner at Cheltenham on 5.10.79. All had refused but expressed a continuing interest and sent good wishes to the meeting.

AGREED. They should be asked to dine with the Council at the Institute's expense before a London meeting.

8. Date of Next Meeting

The next meeting of Council will be held at 3.30 p.m. on Friday, 7th December, 1979 at 111 Harley Street, London, W.1.

Please will officers and secretaries send reports to the Secretary by Thursday, 15th November, 1979.

Katharine Draper
Secretary.

Applications are invited from accredited members of the Institute to run a weekly Psychosexual Clinic at 33 St James Road, West Croyden - this is on Tuesdays and appointments are made between 6.30 - 8.00 p.m. inclusive.

It is anticipated that another Psychosexual Clinic, at the same centre, will become available early next summer. Wednesdays, with appointments made between 1.30 - 3.00 p.m. inclusive.

Current Sessional Rate is £21.60

Please contact Dr D. P. Richards
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