



Institute of Psychosexual Medicine

President:	Dr Tom Main	Secretary:	Dr K. Draper
Treasurer:	Dr F. Hutchinson	Editor:	Dr R. Lincoln
Director of Training:	Dr P. Tunnadine	Chairman of the Council:	Dr M. Blair

Newsletter No. 17
June 1980

Dear Colleagues,

The counter attraction of the sun drenched balcony in Malta and the attendant companionship has delayed the Newsletter by one week, but because of my seminar training I feel less guilt ridden and ascribe my feelings to "belonging to the human race."

The feeling associated with the Institute news at present is its growth in stature. The DHSS grant for training of Leader doctors is a tribute not only to our negotiations led by Dr Prudence Tunnadine, but also to the concept of our training methods which allow individual doctors to develop techniques to work with individual patients in the hope of the development of understanding, with the potential for change of attitude and behaviour.

Associated with this growth is a need for a record of the curriculum vitae (as far as Psychosexual Medicine is concerned) of all doctors who have taken part in the training of the Institute. For this purpose Dr Deman, the registrar, will keep a filed record of all doctors who have attended seminars run by Leader Doctors of the Institute. The majority of these doctors are Members or Associate Members but there are some working in the field who are not. In both cases it will be helpful to have this record available when a doctor is seeking employment in posts in Psychosexual Medicine.

Application for Membership of the Institute should now be made to Dr Fay Hutchinson, the Treasurer. Membership entitles the doctor to attend meetings and to receive the Newsletter (provided the annual subscription is paid!). The newsletter now costs over £1.00 per copy to produce.

Another item of good news is that 8 of our members will attend the International meeting in Hawaii - 5th International Conference on Venereal Disease, Family Planning and Human Sexuality, 24th June - 1st July, 1980. Several Institute doctors are presenting papers. En route for Hawaii we are also presenting a symposium in Los Angeles. The programme will include:

1. Sterilisation Counselling - Dr Ann Smith.
2. Psychosexual Aspects of Contraception - Dr Robina Thexton.
3. Vaginal discharges and their relationship to Contraceptive Methods - Dr Morag Bramley.
4. Gynaecological Case Study - Dr Joan Coombs.

The next Newsletter will contain reports of both these meetings - Hawaii and Los Angeles.

I should be grateful for clinical material for the next Newsletter which should reach me by early October.

The programme for the Residential weekend in York looks very interesting and I hope that it will be very well supported. The venue at York University is delightful, even if the beds are rather narrow and the facilities rather spartan compared with the luxury of Cheltenham!

Yours sincerely,
Rosemarie D. Lincoln

I - FUTURE MEETINGS OF THE INSTITUTE

a) Residential Meeting of the Institute at York University: 13th and 14th September 1980.

Theme: The expanding Field of the Institute Work; its boundaries and its special strengths.

Programme: Saturday, 13th September. Chairman: Dr Tom Main.
Dr Margaret Blair - Defining the Boundaries.
Dr Mary Rees - Discussant. General discussion from the floor.
Dr Alexandra Tobert - Extending the Boundaries.
Dr Jill Tattersall - Discussant. General discussion.
Dr Wendy Roles - Couples.
Dr Pru Tunnadine - Discussant. General discussion.
Dr Jean Pasmore - The Use of the Institute Technique in Marital Therapy.
Dr Carol Stuart Morrow - Discussant.
Some insights learned by the Huddersfield Seminar during the past year. General discussion from the floor.

Sunday, 14th September. Chairman: Dr Margaret Blair.
Dr Tom Main - The Institute and Psycho-analysis. Debt, differentiation and development.
Dr Roland Freeman - Discussant. Discussion with all speakers on the platform. Questions may be put either in writing or from the floor.
Recognition under Section 63 applied for.

b) Workshop for Institute Leader Doctors is to be held at the Golden Valley Hotel, Cheltenham from 4.00pm on Friday, 24th October till 5.00pm on Saturday, 25th October 1980. This is to provide the opportunity not only to discuss administrative problems but also to be a day of intensive leadership seminars.

II - NOTICES OF OTHER MEETINGS

1. The British Psycho-Analytical Society are holding a day conference on Saturday, 5th July 1980 entitled "Psycho-analysis and Women". Speakers will include Juliet Mitchell, Dinora Pines and Enid Balint. Tickets are £12.00 and available from the Secretary, Institute of Psycho-analysis, 63 New Cavendish Street, London.
2. 6th International Congress for Psychomatic Obstetrics and Gynaecology 2nd - 6th September 1980 to be held in West Berlin.
3. 5th World Congress on Medical Sexology - to take place in Jerusalem in June 1981.
4. 2nd International Congress of Andrology will take place in Tel Aviv in June 1981.

III - ARTICLES

a) Post-Natal Loss of Libido: Its Understanding - Dr Alexandra Tobert

Loss of libido after childbirth is reviewed in consideration of the patient's feelings about herself as a woman, as a mother, and as a wife. The patient's feelings about the baby as a reminder of other significant babies in her life are discussed. A few examples of cases are presented. Briefly the foundation of psychosexual therapy for such cases is outlined.

Among patients who present with secondary frigidity, the largest single group comprises those women who regard the birth of a child as the turning point in their sexual life. In many cases inquiry suggests that loss of libido exists as a remnant of an earlier post-natal depression or as the concomitant of one which has settled into an on-going chronic state. In to-day's climate, sexual unhappiness may be a symptom readily presented when a woman has failed to return to a state of well-being months or even years post-partum, and is ashamed to continue to complain of tiredness and tearfulness. A story emerges of a miserable, unapproachable woman trying hard not to be perpetually bad-tempered and a puzzled rejected husband, together unable to offer their child the emotional sustenance on which its future well-being depends.

The treatment of the frigidity overlaps and may even be found to have coincided with the treatment of the condition as a whole.

The life histories of these women have, of course, all the diversity of human experience, but there are some persistent patterns which may occur singly or in combination. The need to search for understanding of the individual remains always paramount. Only upon basic assumption may some areas which require exploration be suggested.

The patient's feelings about herself as a woman

There are some unhappy women for whom all feminine functions are burdensome from menarche to menopause. Painful menstruation, symptomful pregnancy, difficult births, problems of child-rearing, all form a sad progression towards a suffering middle-age. Times of physiological transition become crises of emotional instability. Pre-menstrual tension, post-natal depression, menopausal misery occur singly or coalesce into a pattern.

Frigidity in all its many manifestations, temporarily or persistently, may take its place in the symptom complex of troubled femininity. In terms which do not explore, but at the same time do not deny or contradict the analytical understanding of early childhood development, femininity may be likened to an heirloom which requires to be handed on from mother to daughter in an unconscious, intangible ceremonial. Many patients describe how mother died or departed, or lived unloving or unloved or unfaithful or how she refused to come to her daughter's wedding or to help with the baby.

Thus there is an interruption of the psychological ceremonial and a break in the continuity. In differing ways and for differing reasons the heirloom of femininity was not offered or not acceptable and the daughter is left bereft and unable to function in wholeness. One deeply troubled woman had been describing her demanding, unsupporting mother. When asked about her grand-mother she said, despairingly, "Like my mother, only worse."

The patient's feelings about herself as a mother

The demands made upon a woman by a new baby inevitably draw upon her emotional reserves. Hopefully, these reserves have been laid down in childhood, restocked from fulfilling relationships throughout life, and consistently replenished in marriage by a loving husband whose affection she is able to accept and to absorb. It is one of the tragedies of post-natal loss of libido that a woman finds herself compelled to reject sexual love and tenderness at a time when she needs it most. There are among this group of patients many women who have not themselves passed through an experience of mothering which they are then able to re-enact for their children. They are faced with the emotional parallel of trying to feed a baby from an empty breast.

Heather is 26, plump and pretty. She has been married for seven years and has two daughters aged 4 years and 18 months. She came to me because since the birth of her second child, she has lost all interest in sex, feels miserable and realises that her marriage, which had before been warm and happy, both sexually and generally is deteriorating. She is also worried because she finds herself readily loving to the baby but short-tempered with her older child.

We talked. Gradually, understanding has begun to grow. During her second pregnancy her parents had separated. Logically, she thinks that this was a good thing because they had fought all their lives, but to her surprise she found herself very upset and her parents constantly on her mind both in the present and in memories of her childhood. She describes her father as a drinker and a liar and her mother as a nagger. Many incidents emerged of her mother's coldness and lack of sensitivity to the feelings of her family. Neither parent offered physical affection. Heather is the oldest of three girls. Much had been expected of her regarding sensible adult behaviour. She felt very responsible for her sisters. She depicts with modest pride the contrast both materially and emotionally between her squalid childhood home and the home which she and her husband have created, and she is terrified now of spoiling it by her coldness to her husband and her irritability with her older daughter. She was particularly shocked when she heard herself saying to her husband "Get off, it's my body, not yours" in the same tone which she had heard her mother use, when as a child she pulled the blankets over her head so as not to hear her parents quarrelling.

She has come to see that her childhood provided a poor foundation for her adult femininity, but that her own quality of personality had been sound enough to overcome these handicaps until at the vulnerable time of her second pregnancy her parents separation had disturbed the balance. She also believes that she is treating her older daughter as she felt that she had been treated herself, by denying her the opportunity of being a child.

Sexually and generally things are getting better, but the process of rebuilding her confidence in herself still needs more time.

The patient's feelings about herself as a wife

It is a sad feature of our culture that the daily life of a woman running a home and looking after a husband and children is regarded by some - men and women - as a relegation to a backwater of life and outside the swim of things.

For women who have gained status and satisfaction from their working lives, the restrictions imposed by a new baby can readily lead to a jealousy of the freedom apparently enjoyed by the man of the house. This is particularly likely where there has been an earlier competitiveness with men and a consequent sense of having lost a battle. Sexual activity may then lose its quality of joyful sharing between equals and become instead an imposition to be resisted. It is these women who often make use of those expressions of bitterness and resentment which have become a part of our language. "He takes me for granted, he only wants me for sex." "I feel used." "He has the best out of life - men always do." "Sometimes I give in."

The patient's feelings about the baby as a reminder of other significant babies in her life

There is a group of women for whom their own baby represents, on an unconscious level, a younger sibling who aroused feelings which could not be expressed or resolved. It is almost inevitable that an older child should feel jealousy and anger, often of great intensity, towards a new baby, but it is not easy for parents, particularly those who have not read the psychology books, to love and support a child through such feelings which must then be repressed and covered by "good" feelings. Sometimes depression results, but commonly there is the development of a personality which is self-disciplined, hard-working and orderly and which functions fully and effectively. Vulnerability lies in situations which provoke dependence or guilt.

Against such a background, the arrival of a baby, with the accompanying relaxation of defences, may re-awaken the old repressed feelings and result in all or part of a post-partum symptom complex of depression, withdrawal from offers of affection, anger towards the child, and intense anxiety. Not only are these symptoms distressing in themselves, but the contrast they provide to the earlier personality leads to the further distress of self-condemnation.

Clare was a young teacher who was seen when her first baby, Emma, was 8 months old. She had been clinically depressed almost immediately after Emma's birth and had

been treated with antidepressants. She had improved and was now looking after her baby very well, but she remained tense, anxious and tearful and had lost all her previously healthy sexual feelings. Above all, she was deeply distressed by the feelings of resentment and occasionally near violence which she had experienced towards Emma. "That isn't me," she declared.

She had taught, with evident effectiveness, until she was seven months pregnant. Emma was a much wanted child. Her husband was also a teacher who proved to be unfailingly loving although much absorbed in his own work. She spoke with deep affection of her own mother and of her happy childhood. She had one sister, 3 years younger, who had been a sickly, crying baby. Clare has few memories of her early childhood but often said that she was thought of as being a very good child.

It proved necessary to work slowly to help Clare to accept her own aggressive feelings which had appeared so out of place in her kindly childhood home and too frightening in their intensity to be expressed towards her sister.

She has recently had her second baby and says that she cannot believe that she could feel so different and so warm and patient towards a baby.

Pregnancy is a time of particular vulnerability and the impact of events which occur at this time is likely to be of deeper and more long-lasting significance.

Mourning during pregnancy imposes a conflict which is sometimes almost insoluble. No way may be found to accommodate both the appropriate sadness and gladness except the denial of all feelings. Depression will almost certainly follow.

There are among patients who present with secondary and particularly post-partum frigidity, many who have suffered a bereavement.

Margaret was a woman of 30 who presented with total loss of sexual feeling. She thought that this had been present throughout the nine years of her married life, but on further inquiry it emerged that she had been happy in the early months of her marriage but then her mother had died just before she realised that she was pregnant. She had not been able to tell her of her pregnancy and had grieved that her mother had not known of a longed-for grandchild.

During treatment she talked little about sex, but much about her childhood and her mother. To her surprise she discovered a re-awakening of her sexual feelings.

Treatment

As in all psychotherapeutic procedures the foundation and the framework of treatment rest upon the doctor/patient relationship. Within this the patient will be able to express her feelings and verbalise her thoughts and memories, so that her story will unfold of its own accord. Diagnosis and treatment will proceed at the same time, as doctor and patient gain insight and understanding together. Within this setting it is hoped that the patient will find a renewed sense of her own femininity and her capacity for self-expression, and be able to use these to enrich her sexual life. The focus of treatment remains circumscribed and progress is often achieved with surprising rapidity.

b) An Age for Concern - Dr Prudence Tunnadine

For both men and women the menopause can be a difficult period of life. Whether it may be a time of new challenges, rich freedoms and opportunities, or whether a "change" for the worse, may to some extent be influenced by the attitude of the doctor. Ultimately it will be decided by the attitudes of both doctor and patient.

Life begins at forty - or does it? For those with the inner zing and outer trappings of a Mae West, perhaps. For most of us and our patients, more likely is a scream

for her namesake the life-saver. How should we regard the menopause? Certainly as a natural and inevitable phase of life - for men as well as for women perhaps. Certainly, most doctors would agree and most women hope, not as a disease. Yet the 'dis-ease' it may cause - physical, mental and emotional - can have profound and tragic effects if poorly understood. It may affect not only the woman herself but those around her; not least, often, her doctor. To respond, as we often do, with "It's your age dear. You'll just have to live with it" may contain an element of truth, but is grossly inadequate in terms of preventive medicine. Preventive? Of what? Let us begin what could, when complete, be a long list. Dry vagina leading to recurrent infection; increase in prolapse and cystitis; menorrhagia leading to surgery or repeated investigations; night sweats leading to requests for sleeping pills; depression, headaches, anxiety states and despair leading to frequent surgery visits. These are only a sample of the way this, in just one woman, can affect the doctor. For the woman herself, all these, plus frigidity or dyspareunia threatening marriage at the most difficult time with children leaving home, sense of confidence and purpose for the future in doubt; not to mention husband likely to be at his own most vulnerable crossroads, needing, often, his own extra reassurance that the young lion in him is not now on the downhill slope. So, social implications too; on marriage, on the vital "nest-quitting" stage for the young, needing their independence blessed securely; needing least of all warring parents and a weepy unstable nagging mother.

We are wise, in the face of the known statistical dangers of oestrogens, to be cautious about dishing them out in the absence of demonstrable deficiency, in a fruitless fantasy quest for eternal youth. On the other hand, unnecessary investigations and surgery have a measurable mortality too. So does walking across Oxford Street and so do many of the other slightly hazardous exciting pastimes which make living full enough to be called living. And so do misery and despair - we should not be so anxious to control barbiturates if they did not also give undesirable effects. How, then can busy doctors steer a rational course in what, we fear, could be a real Pandora's Box of work load should we open a chink in the door. For truly we can say of 'menopausal anxiety' in both men and women, "There's a lot of it about". As one who has the time, interest and rashness to open that door, I find women present broadly in three ways. Some of the men come also; more, I suspect, covertly and with less obvious presentations, to their general practitioners. A word about them later.

Quest for informed discussion

Those of us trained in psychosexual medicine tend to be suspicious of a request for information. Why, we ask ourselves, when for example a young woman expresses ignorance of her body or the nature of normal sexuality, has she been unable to discover herself in this broadly literate and informed age? Can she emotionally allow herself to know? Should we then wonder similarly when a woman asks what to expect of her menopause? Clearly there is some element of anxiety which we ignore at our and her peril. However this area is truly one in which some ignorance is appropriate and rational. Little of authority is written, and old wives tails are rife. Just as these women as adolescents really did receive less factual information and blessing about sex than their daughters in general do today, so their mothers had little help with their own "change". Today's menopausal women often actually experienced the effects of their own mothers' floodings, flushes and frustrations in their home life. So they want to be prepared and do better, and some anxiety not to repeat the disasters is reasonable. Today they dare to ask.

Having first been alert to any communication of excessive panic and explored it if required, we are left with many women who just need their questions answered. What can we say? First I think, that we cannot predict how any individual will proceed, but that we can monitor the process by regular checks, including hormone estimations where necessary, and deal with problems as they arise accordingly. This response is in itself much relieving of anxiety. My own view of hormone replacement is, rightly or wrongly, quite clear. To dish out uncontrolled oestrogens in a futile quest for eternal youth and in the absence of symptoms is irresponsible and foolhardy. To

attempt to adjust demonstrable imbalance which is actually causing problems seems to me reputable preventive medicine; to withhold it, having balanced the risks, as illogical as withholding insulin for diabetes or thyroid for myxoedema. How can a general practitioner assess measurable imbalance? Only, with accuracy, by blood levels or daily smears over several menstrual cycles - not feasible. We can however get a rough guide from a cytologist experienced in the matter from the routine Pap. smear, repeated if necessary at one or two stages of the cycle.

Second, we may tell them that for many women there is a stage well before the oestrogens themselves begin to become unstable, when she may ovulate less regularly. This may result in irregularity, menorrhagia and perhaps above all, an increase in premenstrual tension, and is likely to require progesterone or an adjustment in her "pill" dose, rather than oestrogen. A common terror for women at this stage is that the emotional instability of the premenstrual phase will worsen as the "change" progresses; that they may even go mad.

Thirdly, we may explain that when the time comes that the oestrogens themselves begin to fade, the periods merely get less and less frequent and heavy, and simply fade away without any problem at all. In this case contraceptive precautions may be discontinued after a full two years of amenorrhoea (one year if she is over fifty) and that, with a sigh of relief, is that! Only if the periods instead become increasingly heavy or frequent, is medical or surgical intervention likely to be required. Even then hormone control is often sufficient. We may add that the only symptoms which can be guaranteed to respond to oestrogen replacement are hot flushes and night sweats, and dry or shrinking vagina. These are not universal concomitants of the menopause, but are not to be despised when they occur. They can truly wreck the sleep, the lovelife, and above all the sexual and social morale, at this vulnerable watershed time.

And finally, it is worth stating positively, for most are shy to ask but all wonder, that the only reason why sexual life should suffer is that she feels it will. Indeed for many women the relief from fear of pregnancy and responsibilities of motherhood should ensure the best time of their lives in this respect. If a woman cannot allow herself this freedom she must be helped by careful counselling before, as so often sadly happens, frigidity, depression, marital breakdown, and despair follow.

Request for gynaecological or contraceptive advice

In addition to the issues described above, in otherwise healthy women, the most subtle and difficult decisions in this age group involve fibroids, hysterectomy, sterilisation, and of course the dreaded "pill". For many women with menorrhagia, unlikely to want more children or to bear them safely if they do, hysterectomy would seem to answer all questions and have the added merit that the hormones may then be treated on their merits. It is again becoming quite fashionable in some areas to perform hysterectomy in such cases, often indeed in much younger women, almost as a sterilisation or "contraceptive" procedure. Many women find it a great relief. Certainly where fibroids are present there is good justification for this, since to give hormones whether as oestrogen replacement for systemic symptoms or the pill for cycle control and contraception, may encourage their growth and only delay their recession after the change. However, many would question, in the absence of such considerations, whether any major surgical procedure should be done lightly, and some women have added emotional and irrational attachment to their uteri - or rather what they symbolise in terms of their feminine self-image, which cannot be discounted for their future emotional health. Whatever the good reason for hysterectomy, it is important to discuss these aspects, if psychosomatic repercussions are to be avoided. Further, and despite the apparent conclusions about the nature of female orgasm of Masters and Johnson, some women have to re-learn sexual technique after hysterectomy. If they are not forewarned it can have a disastrous effect on them and their partners to discover, when intercourse is resumed, that as one couple put it to me "it has gone". Sadly this well-publicised

research has, it seems, emphasised or given "scientific" credence to a self-evident fallacy. The idea that intercourse has no sensation to lead a woman to orgasm beyond that produced via the clitoris is clearly an old wives tale to the many women who have had any good fortune in the matter; perhaps it is better called an "old doctors", or now an "old clinical psychologist's" tale. Many women, and their partners, are accustomed to the pleasurable sensations of pressure on the uterus and surrounding structures as an integral part of successful intercourse. This is specially true perhaps with the kind of "full pelvis" which goes with a uterus that is likely to need removal. A nicely tidied up "empty" one feels totally different for both. I have met several couples whose happy sex lives fell apart overnight with this dismay. Of course the capacity for orgasms is not gone, though the crisis of confidence makes it so. It is a vital part of pre-hysterectomy "counselling" to explore how much of her sexual fulfilment rests on these internal pressure sensations, which usually include most importantly the pressure/movement of the cervix/anterior fornix/bladder area. If so, she must be warned to relearn her intercourse sensations concentrating on the muscles and other tissues of the introitus.

Assuming the uterus is to remain, what of contraceptive advice? This is a time when most women are well - one might say anxiously - motivated towards really effective contraception, but all the methods may have snags. The diaphragm or sheath may lose their charm at an age when a spontaneous love life is so important to the flagging sense of being a "bright young thing" in both partners. The IUCD may be tiresome if the periods are already heavy, and when every late one brings a pregnancy panic. We need of course, as with contraceptive patients of any age, to remember that a fully confident couple will cope with any method, and choose on purely practical grounds. But the fical pill, for all its hazards, remains the only 100% certain non-surgical method we have so far, and to refuse it in all cases above an arbitrary age line needs more careful thought for the individual. No patient and no doctor can be unaware of the statistical risks of thrombo-embolic disease, and no doctor should be unaware of the extra-risk factors. They are widely reported not only in the medical press but in every Sunday paper and every hair-dresser's magazine also.

Against these we do well, in otherwise healthy women, to balance the good news. Among this we should weigh the certainty, the cycle control, the stabilising hormone effect, the decreased flow, the avoidance, perhaps, of surgery, and not least the peace of mind and sexual confidence. I meet many women who openly claim that for them the statistical risks are outweighed by these other benefits. Having put the facts squarely before them, it seems to me as a doctor that it is their right to choose. One patient put it nicely to me "You can't guarantee I won't walk under a bus either. And if I'm worrying about getting pregnant or getting old, I'm maybe rather more likely to do just that!"

Then, what of sterilisation at this age - and for whom? Now that the laparoscopic technique is available, many women who are quite certain they want no more pregnancies no matter what, will find this an admirable solution. It will have no beneficial effects on their periods or hormones; but at least the latter, as with caps, hysterectomy or IUCDs, can be treated henceforth on their merits. Admirable hormone replacement though the pill may be for many, it is in a sense a blunt instrument and the subtleties of cyclical preparations can more easily be monitored if the contraceptive issue is out of the way. But we must remember we are thinking of only a few years ahead, and I have met a number of cases in which either man or woman has been sterilised, back again for either pills or hysterectomy for other reasons. Rationally whether the man or the woman should take the step decided upon should be simple. It is a marginally simpler operation for the man; but it is the woman who would have to carry any further pregnancy. Thus, perhaps, it is she who in the event of some family disaster would be less likely to wish to resume fertility. Again, if "counselling" has been adequate, couples are perhaps the best judges themselves, but we must be aware of unconscious elements in their moti-

Psychosomatic elements

The menopause, for both sexes, is above all a psychosomatic event. It is a tragedy of human blindness that more than half a century since Freud, I cannot make that statement without an apology. I mean of course that it is an event in which par excellence the mind and emotions affect the body and vice versa. Yet, sadly, the very phrase "psychosomatic event" associates for doctors and patients alike the idea of "It's your nerves dear" and "You're imagining it", from which it is but a short step to hints of malingering and "pull yourself together". Doctors are apt to regard it so; more importantly, so do patients, and thus find physical pretexts and visiting cards in their help-seeking, of which they are already half ashamed. Having given some account of the rational factual anxieties of women and how they may present, we need to watch for those who may be specially vulnerable to emotional problems about this inevitable stage of life. For all of us it is the end of our fertility. For us all, though it need not be, it is feared as the end of our youth; certainly of our sexual youth. We may identify people who may be specially vulnerable in these respects.

First there are many women, and not only Roman Catholics, for whom their sense of active permissible sexuality is closely bound up with their maternal feeling. For such the idea of a continuing sexual life for its own sake may be difficult and need help. Others, who have enjoyed their sexual lives hereto, may find that as their young reach adult sexuality, they somehow feel they are "old enough to know better"; as though while just permissible for mothers, certainly not for potential grandmothers, it is the children's turn now. Thus, again, a failure of sexual confidence at a bad stage when the need for its reassurance is great. And others still, having completed their mothering task, which seemed unconsciously incompatible with the "sex for fun" aspect, may for the first time feel free to ask for help with the quality of their sexual lives, under the guise of some menopausal problem. "Is it too late" to be a woman in this sense, they are saying. It is well if we can help tell them no; for with husband's themselves at the crossroads, a frigid wife often tips the scales to otherwise unnecessary infidelity or marital warfare. Somatically this syndrome often leads in turn to an extra stormy menopause with all the investigations and treatments which that may, unnecessarily if the basic problem is understood, involve.

Another group of women who may be at special risk emotionally are those who have used their sexuality differently: those who have separated their sexual lives from their maternal feelings. This would include career girls, lesbians, and mistresses, perhaps of married men. After a lifetime of contented rational choice, often of fulfilling work and sexuality, it is suddenly too late to change their minds about fertility. Not that they would. Yet the long suppressed uncertainties, barely ever conscious, may now make themselves felt in somatic symptoms or depression. Some get "accidentally" pregnant and however wise the termination in practical terms, we are very unwise to allow them to take the hasty final solution lightly and without careful pre- and post-abortion consultation. They may also present with menopausal anxiety or depression. Some may request sterilisation or hysterectomy, which may in practical terms be suitable, in an unconscious wish to "kill off" finally the regretful "what might have been". Psychosomatic therapy may solve this; surgery certainly will not.

Another group of women of this age who may be vulnerable are the wives of men who are "youth orientated". This brings us briefly to the problems of men of similar age. For many it may be considered to be the end of an era. By this time, in worldly terms, most men will have achieved as much as they aimed to do, and many will feel sad that they may now be going downhill. Specially vulnerable are those, and thus, so are their wives, whose sense of confident manhood has been centred on their still being young men. This is reflected in academic or business ambitions achieved, in sporting prowess now "over the top", and perhaps particularly in the admiration of younger women. For such, their wives' tantrums of frigidity may be the incomprehensible last straw. Equally, their wives, who because of their husbands attitudes, begin to feel no longer important or desirable, are more likely to become apathetic.

In my practice most men coming to see me present with sexual anxiety. This may take many forms: secondary impotence; impotence only with their wives (or with their girl friends); recurrence of earlier tendencies to premature or retarded ejaculation. None of these fit into the tidy performance-orientated classification of "sexual dysfunction" therapists. All suffer some sort of anxiety which is reflected in their sexual affairs. The anxiety may be about ageing; about failing to please; or even due to anger and resentment over these things. Some men can relieve their feelings simply by hitting a golf ball; others less philosophical unconsciously add to their natural ageing processes. Such men are usually not too difficult to help. Some psycho-therapeutic skill is required and it may be necessary to explore earlier reasons for their vulnerability to these crises and stresses of middle age. During consultation invariably reflect stresses in other aspects of their lives are invariably discovered, very different from the simple "sensitive focus" or "squeeze technique". In many men psychosomatic problems are expressed in other ways in addition to sexual difficulties. Similarly women frequently present emotional problems in the form of gynaecological difficulties, and I suspect many men whose chief problem is truly a crisis of confidence in their virility, present to their family doctors with other more respectable symptoms. In many social groups it is more difficult for a man to admit fear, especially sexual fear, than for a woman.

c) The Panel - is it really an ordeal?

Dr Carol Stuart Morrow describes what actually happens at a Panel, for the benefit of prospective Candidates ...

The Panel usually sits at 111, Harley Street in a relaxing private flat. Candidates usually arrive and meet in the kitchen for a cup of coffee before the "Ordeal". At about 11am a seminar is held with the Candidates and the Panel members all participating. Everyone is asked to bring a case for this purpose. The Seminar usually lasts for one and a half to two hours. This is followed by a break for lunch, after which the Candidates come back individually at one hour intervals and present and discuss a different case of their own with the Panel. Those who live farthest away are usually seen first. Each Candidate is advised by the Panel at the end of the interview whether they are being recommended to the Council of the Institute for membership. Some days after this a certificate is sent to each successful Candidate which then enables them to take special sessions in psychosexual counselling.

The following doctors passed the Panel in February:

Dr Anne V. Smith - 6, The Crescent, Long Benton, Newcastle upon Tyne.
Dr Eileen Bedford - The Surgery, Penine Avenue, Riddings, Derbyshire.
Dr Doreen Anderson - 4, Newstead Road, St. Johns, Wakefield.

IV - REPORTS OF MEETINGS

5th Annual General Meeting held at the Royal Society of Medicine on Friday, 28th March 1980.

"Defences against Pregnancy" - Drs Margaret Blair and Geraldine Howard.

Dr Howard and Dr Blair described two couples with whom they had both worked with the individual partners.

The Accountant and the Opera Singer

The presenting symptom was impotence with the overt request for a baby. They were in their late thirties and had been married one year. Dr Howard saw the couple together. She was a large, dominating woman dressed in black and said that she desperately wanted a baby before she got too old; her own mother was 38 when she was born. She said that she had married her husband for love and had given everything to the marriage. The husband was small and kept a finger

over his mouth. He said that marriage had not changed his life at all. His ambivalence towards fatherhood showed up when he said that he could not make another visit for seven weeks. He eventually managed to get a full sperm count done but did not attend the doctor again. Dr Howard felt that in many ways the wife was the patient and needed help for herself and so she referred her to Dr Blair.

The wife's visit to Dr Blair: She told the doctor that she felt rather despondent after the joint interview. She expressed a fear about the difficulty of committing herself to marriage and fears lest it should not succeed. A.I.H. was then discussed and the wife's reluctance to pay for fear that if they did this would make it go wrong. The patient made difficulties about keeping the temperature chart and appeared to be using delaying tactics revealing her ambivalence.

She failed to keep her appointment and then suddenly reappeared in June and Dr Blair was able to discuss with her the need to control all situations. She arrived unexpectedly in the middle of clinic, agreed to A.I.H. from which she became pregnant. Later she miscarried. She then returned with more semen and A.I.H. was repeated. When she returned one month later to report that she had failed to conceive she was able to discuss her depression about the miscarriage and was far more able to share her sad feelings and to become a little more dependent on the doctor. In fact Dr Blair felt that she had been able to work with this outwardly rather formidable lady opera singer.

The Second Couple - The Solicitor and His Wife

This young man aged 26 was seen by Dr Howard and requested a vasectomy. (He had previously made this request before marriage). He was 5 feet tall and wore a pin stripe suit and carried a brief case. They had been married a year and he said that he could only achieve intercourse once a week without becoming impotent. He had always wanted to be sure of having no children because he felt that he had suffered so much from his own parents. He remembered his mother being very strong and his father weak. He often did not ejaculate and he felt that his wife was out to trick him. He pursued solitude and music and did not wish to share these with his wife.

The wife was seen by Dr Blair. She was enveloped in a cloak and did not use her husband's name. She feared dependence and rejected motherhood. She remembered the strife between her own parents. For several years she only lived part time with her husband and then they bought a house together and eventually married. She was afraid to take the pill because of various anxieties.

Second visit of the husband alone: He reported that his wife had been much impressed by the husband's interview! He said that if she had a baby it would be hers and would not disrupt his life. He said now that he was impotent and agreed that it was his subconscious antagonism to having a baby and that he could not accept children like himself. Dr Howard referred him back to Dr Robert Shields who had been treating him previously and with whom he had obviously developed quite a lot of insight into himself.

Second visit of the wife to Dr Blair: She failed to keep one appointment and later reappeared without her cloak! She had stopped the pill because she had run out of supplies and the husband was using a sheath. The impotence had disappeared. Dr Blair interpreted her risk taking behaviour and was able to discuss her difficulty in accepting the dependence of a baby on her. She had not yet learned to tolerate the baby within but her defences were somewhat lessened by talking to the doctor.

These two couples used a variety of defences against pregnancy, impotence, failure to ejaculate, failure to keep a temperature chart, difficulty in keeping appointments, objecting to the cost of A.I.H. The true reasons for not wishing for pregnancy was hidden behind noble sentiments.

V - PUBLICATIONS

The Editor has not received any information of current publications and we should be very grateful if you would let us know of any articles published in books or journals.

The British Journal of Family Planning published in April carried an article about the history of the Institute entitled "From Conception to Early Maturity."

VI - CORRESPONDENCE

a) Dr Jo Brown writes from the Elm Street Clinic, Ipswich:

Dr Dr Lincoln,

Thank you for a very clearly printed Newsletter No. 16.

Relative to symbols I think I too am a dissident like Dr Morrow.

Relative to the provisionally chosen symbol -

- i) why does it all appear in the 'dark' when we aim to shed light on problems?
- ii) are the two symbols just 'pecking' and is true sex in flight to the dark corners of the triangle?
- iii) or is the 'pecking' a start to drag deeper sex from the dark corners?

If we are to have this symbol could it be altered to show some 'lightening of darkness' or is it intended to stimulate members fantasy interpretation?

Yours etc,
Jo Brown.

b) The Secretary has received a copy of the Memorandum No. 44 on the Laws on Incest in Scotland (April 1980) from the Scottish Law Commission, which has been published for comment and criticism. Anyone who would like to read the Report, and possibly send comments, should write to the Secretary, Dr K. Draper, 29, High Street, Chipstead, SEVENOAKS, Kent. TN13 2RW

VII - TRAINING NEWS

There are a few vacancies in Dr Main's Seminar at Sharpthorne.

There is a new advanced Seminar being arranged in Yorkshire to be led by Dr Tunnadine on a Wednesday. Interested doctors should apply to Dr Joan Coombs - 13, Holly Park, Huby, Near Leeds. Tel: 0423 74391.

VIII - NEW MEMBERS

Dr Mary Morley - 'Cleve Cross' Selborne Road, Croyden, Surrey. CR0 53Q
Dr Valerie Ann Hall - 77, Moorside North, Fenham, Newcastle. NE1 9DU
Dr Jennifer Peebles - 'Park House', Hampton Court, Surrey. KT8 9DA
Dr Catriona Reid - 16, Darlington Place, Bath. BA2 6BX

MINUTES OF THE FIFTH ANNUAL GENERAL MEETING
OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE

Held at The Royal Society of Medicine on Friday, 28th March, 1980.

The Meeting was attended by 20 Members and Associates

1. Apologies for absence were received from Doctors:-
Tunnadine, Tisdall, Aktar, Ford, Freedman, Zutshi, Darlane,
Herman, Thompson, Coombs, Thexton, Roberts, Brown, Lyons.
2. The Minutes of the Fourth Annual General Meeting were agreed and signed.
3. All matters arising were on the Agenda.
4. Presidents Report

Dr. Main reaffirmed that the principle function of the Institute was to train doctors in the study of the doctor patient relationship through Seminars. To support this aim it was necessary to have a qualifying body; meetings to exchange ideas, and research, in Seminars, to study new problems, e.g. abortion and vasectomy. The aim is to study the techniques used in these new encounters, not to study the conditions, and become experts on medical topics. The demands of training in basic techniques; training Leaders; and publishing a Newsletter lead to an enlarging bureaucracy, which could lead to a risk of being distracted from the central aims. It was a temptation to become a body of knowledge, not to study the plight of doctors and how they were being used by patients, to remain ignorant in the face of the patients need for a clever doctor. There was therefore a need to have a separate body to observe the work of the Institute from a distance, and examine the evolution of trends within the Institute, which should be called the Scientific Committee.

5. (a) The Secretary's Report

The Secretary reported on events which had taken place since the written report was despatched.

- i. Dr. Barne would like to resign as Programme Secretary, but would continue until after the September Meeting. Her resignation was accepted with regret and she was thanked for all her work.
- ii. Doctors Blair, Tunnadine and Draper had attended a Meeting at the D.H.S.S. on 14.3.80 which was called to discuss the provision and accreditation of "Counselling Services" in the area of Family Planning, abortion and psychosexual medicine. Further meetings were planned.
- iii. The National Marriage Guidance Council had called a conference to discuss 'Marriage Matters' at the Zoo on 28.4.80. The Executive would attend as a delegation.
- iv. The Institute had been approached by the B.B.C. about participation in a programme called Matrimonial Monday about marriage counselling services.

The Secretary's Report was adopted.

MINUTES OF THE FIFTH ANNUAL GENERAL MEETING
OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE

Held at The Royal Society of Medicine on Friday, 28th March, 1980.

The Meeting was attended by 20 Members and Associates

1. Apologies for absence were received from Doctors:-
Tunnadine, Tisdall, Aktar, Ford, Freedman, Zutshi, Darlane,
Herman, Thompson, Coombs, Thexton, Roberts, Brown, Lyons.
2. The Minutes of the Fourth Annual General Meeting were agreed and signed.
3. All matters arising were on the Agenda.
4. Presidents Report

Dr. Main reaffirmed that the principle function of the Institute was to train doctors in the study of the doctor patient relationship through Seminars. To support this aim it was necessary to have a qualifying body; meetings to exchange ideas, and research, in Seminars, to study new problems, e.g. abortion and vasectomy. The aim is to study the techniques used in these new encounters, not to study the conditions, and become experts on medical topics. The demands of training in basic techniques; training Leaders; and publishing a Newsletter lead to an enlarging bureaucracy, which could lead to a risk of being distracted from the central aims. It was a temptation to become a body of knowledge, not to study the plight of doctors and how they were being used by patients, to remain ignorant in the face of the patients need for a clever doctor. There was therefore a need to have a separate body to observe the work of the Institute from a distance, and examine the evolution of trends within the Institute, which should be called the Scientific Committee.

5. (a) The Secretary's Report

The Secretary reported on events which had taken place since the written report was despatched.

- i. Dr. Barne would like to resign as Programme Secretary, but would continue until after the September Meeting. Her resignation was accepted with regret and she was thanked for all her work.
- ii. Doctors Blair, Tunnadine and Draper had attended a Meeting at the D.H.S.S. on 14.3.80 which was called to discuss the provision and accreditation of "Counselling Services" in the area of Family Planning, abortion and psychosexual medicine. Further meetings were planned.
- iii. The National Marriage Guidance Council had called a conference to discuss 'Marriage Matters' at the Zoo on 28.4.80. The Executive would attend as a delegation.
- iv. The Institute had been approached by the B.B.C. about participation in a programme called Matrimonial Monday about marriage counselling services.

The Secretary's Report was adopted.

Dr. Main then spoke of the details of the Scientific Committee, and there was some discussion of the way in which it would monitor the work of the Institute and supervise standards. The President would propose names for the Committee.

Mrs Raphael said that it was important that there should be no changes when all the amendments were re-written as one document. It was agreed that this should be presented for ratification at the next A.G.M.

Dr. Shirley-Quirk said that she felt the Institute training should be recognised by the working party of psychotherapists. It was agreed that the Council should make representation to the working party.

(b) Director of Training

The report was adopted.

(c) Treasurer

The Treasurer reported that a grant from the D.H.S.S. had now been received. There would be £1,000. this financial year, and £7,000. in 1980. The grant was for the training of Leaders for the whole country, and would be used to fund Leader doctor seminars, and Leaders Workshops. Dr. Tunnadine was thanked for all the work she had done to secure this grant.

The fee of £350. for the Accountant was agreed. The accounts were presented. and explained by Dr. Hutchinson.

The report was adopted.

(d) The Editor

The Editor reported that the printing of the Newsletter had greatly improved the presentation and saved secretarial time. She would be glad to receive contributions for the next Newsletter.

The report was adopted.

6. Reports from the Secretaries

(a) Panel

Dr. Butcher reported that the Panel had met once on 12.12.79. and three doctors had been assessed as being 'fit for work in psychosexual medicine'. She was concerned that more doctors had not applied to go before the Panel, although some had made preliminary enquiries. Several advanced leaders reported that their seminars would be completing next Summer and the members would be ready to go before the panel.

(b) Programme Secretary

Dr. Barne said that there had been a weekend meeting at Cheltenham, October 6-7th and two clinical meetings at the R.S.M. in London. She asserted the reluctance of Members to put themselves forward to give papers, and the need for Group Leaders to approach Members of Seminars who had ideas for discussion.

(c) Research

Dr. Bramley said that the 50 cases in the Pilot Study had been reported at Cheltenham. The paper had been refused by the Lancet and was being submitted to the B.M.J.

There were now 107 cases in the Nuffield Study. There had been some difficulties with the Psychologist, who had not yet seen 50 cases, and enrolment would stop when she had reached this number.

(d) Publications

Papers published by members were still being collected and read by the Committee.

(e) Registrar

There are now 174 Members, 94 Associates and 3 Subscribers which is a small number compared to those attending seminars. The Registrar sends lists to the Editor, who has all the information from the recent corrections. Enquiries will be made of a cheaper way of producing an up-dated Register, which should differentiate full Members, and be available for distribution.

(f) Referral

Dr. Gill was taking over from Dr. Backer, who would be abroad next year, and was thanked for her work. Dr. Gill had received 23 enquiries since before Christmas.

Dr. Blair thanked the Officers and Secretaries for their work during the year.

7. Election of Council

The following doctors were proposed for the Council:-

Barne, Berry, Blair, Bramley, Coombs, Deman, Draper, Hutchinson, Lincoln, Morrow, Thexton, Tunnadine.

It was proposed that Doctors Freedman and Thompson and Mrs Raphael should be co-opted.

Their election was proposed by Dr. Kilvington and seconded by Dr. Backer and carried unanimously.

8. Dr. Main thanked Dr. Blair for her work as Chairman of Council.

X - ACCOUNTS: 31st December 1979. Chartered Accountants: Brewer & Co.

INCOME & EXPENDITURE ACCOUNT
FOR THE YEAR ENDED 31ST DECEMBER 1979

	<u>1979</u>		<u>1978</u>	
<u>INCOME</u>	<u>£</u>	<u>£</u>	<u>£</u>	<u>£</u>
Subscriptions received	1,825		1,326	
Tax recoverable under Subscribers' Covenants	<u>187</u>	2,012	<u>188</u>	1,514
Donations		15		15
Bank Deposit Interest		92		21
Income Tax Repayment Supplement		9		-
Sale of Regulations		<u>-</u>		<u>13</u>
		2,128		1,563
<u>Less Expenditure:</u>				
Hire of Hall	125		110	
Secretarial Expenses	565		350	
Printing and Stationery	30		88	
Training, Net Expenditure	381		91	
Newsletter	221		149	
Accountancy & Audit	331		162	
Travelling Expenses - Council Meetings	33		112	
Bank Charges	1		6	
Sundry Expenses	63		14	
Depreciation: Office Equipment	<u>19</u>	<u>1,769</u>	<u>3</u>	<u>1,085</u>
<u>Excess of Income over Expenditure</u> <u>transferred to Capital Account</u>		<u>£ 359</u>		<u>£ 478</u>

THE INSTITUTE OF PSYCHOSEXUAL MEDICINE

NOTES ON ACCOUNTS

31ST DECEMBER 1979

	<u>1979</u>		<u>1978</u>	
	<u>£</u>	<u>£</u>	<u>£</u>	<u>£</u>
1. <u>MONKTON FUND</u>				
Balance at 1st January 1979		4,746		4,617
Donations		100		1,100
Fees		-		189
Transcript Receipts		178		-
Bank Deposit Interest		174		26
Income Tax Repayment Supplement		8		-
Loan Interest received		53		96
Loan Interest accrued		<u>115</u>		<u>120</u>
		5,374		6,148
<u>Less Expenditure</u>				
Travelling Expenses - Advanced Seminars	852		549	
Research Group	-		129	
Secretarial Expenses	941		707	
Sundry Expenses	<u>6</u>	<u>1,799</u>	<u>17</u>	<u>1,402</u>
Balance at 31st December 1979		<u><u>£3,575</u></u>		<u><u>£4,746</u></u>
2. <u>RESEARCH FUND</u>				
Balance at 1st January 1979		2,200		883
Donations		<u>3,868</u>		<u>4,089</u>
		6,068		4,972
<u>Less Expenditure</u>		<u>3,422</u>		<u>2,772</u>
Balance at 31st December 1979		<u><u>£2,646</u></u>		<u><u>£2,200</u></u>

THE INSTITUTE OF PSYCHOSEXUAL MEDICINE
BALANCE SHEET AS AT 31ST DECEMBER 1979

	1979		1978	
CAPITAL ACCOUNT	£	£	£	£
Balance at 1st January 1979	1,784		1,306	
Add Excess of Income over Expenditure for the year	359	2,143	478	1,784
<u>Monkton Fund</u> (Note 1)		3,575		4,746
<u>Research Fund</u> (Note 2)		2,646		2,200
<u>Creditors</u>		287		248
		£8,651		£8,978
 <u>Represented by:</u>				
<u>Office Equipment:</u> at Cost	40			
Addition in year	67	107	40	
<u>Less: Depreciation to date</u>	33	74	14	26
 <u>Cash at Bank:</u>				
Capital Account	1,869		1,818	
Research Fund	30	1,899	230	2,048
<u>Cash in hands of Agents</u>		2,616		1,970
 <u>Debtors</u>				
Income Tax Recoverable		187		188
Loan		300		-
		5,076		4,232
 <u>Monkton Fund</u>				
Cash at Bank	1,406		2,477	
£2,000 Local Authority Yearling Bond	2,000		2,000	
	3,406		4,477	
Accrued Interest	115		120	
Income Tax Recoverable	54	3,575	149	4,746
		£8,651		£8,978

DR K. DRAPER) HON. SECRETARY
DR F. HUTCHINSON) HON. TREASURER