

# 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 18  
October 1980

Dear Colleagues

As my suntan from Hawaii fades and the excitement from the York Residential Weekend subsides, I settle down to write the Newsletter to you and to share some of the feelings that have resulted from these very different but stimulating conferences.

In June, 8 members of the Institute travelled via Los Angeles to Hawaii and during our stopover we took part in a symposium of Family Planning Workers arranged by Los Angeles Regional Family Planning Council. On the morning of this symposium, panic set in because members who were speaking were lost in an unknown hotel in Los Angeles. As I was the only one who knew where the symposium was being held and I did not know where the rest of my colleagues were staying, I had a very bad half-hour while detective work was done and the lost were eventually found!

Our presentations were enthusiastically appreciated by our fellow workers in the field of Family Planning and the members of the Institute have an open invitation when visiting LA to speak on some other topics. Our programme included Emotional Aspects of Contraception, Sterilization Counselling, the Relationship of Vaginal Infection to Contraceptive Methods and also a short presentation on how the Institute developed. There was much responsive laughter when Robina Thexton described coitus interruptus as stopping off at Los Angeles on the way to Hawaii!

Of Hawaii, our memories are of sunshine and swimming and companionship, exotic drinks and interesting food. We ate sucking pig roasted in the sand and drank rum based cocktails and bought colourful jewellery and clothes. The scientific content of the Conference was unfortunately a disappointment because it was too diffuse owing to the multiplicity of disciplines present. Our therapeutic approach to contraception really had little in common with that of the pharmacists and sociologists and educationalists who made up the audience. Socially we enjoyed each other's company, but probably more was learned on the beaches than in the lecture halls. Members pooled experiences of such conferences may help us to present a conference in the United Kingdom which avoids some of the pitfalls. Your executive committee is at present giving some thought to this. If you have any comments or suggestions, perhaps you would like to get in touch with Dr Tunnadine or a member of the executive committee.

Our own residential weekend at York University was well supported the programme was based on understanding the way that Institute members are using their training and the self imposed boundaries that exist in their work. At times there was conflict among the members about these boundaries and whether training should be diversified. I felt that the expression of this hostility openly within secure relationships was not unhealthy or destructive and from these conflicts a mature Institute can emerge. One institute member has written to me about this and the letter is printed later. We appreciate very much Dr Barnes planning of the programme and there were many congratulations interspersed with the criticisms. Are there any other comments forthcoming from members which may help the programme arranger for next conference?

The beauty of the campus at York was marred by the weather and some of us wore blankets from the beds as protection from the cold as we walked through the grounds from one building to another - which created a slightly bizarre atmosphere and I know at least one member who slept in most of her clothes. Next time we shall probably remember to pack our hot water bottles.

The York Conference was the last occasion at which our good friend Mr Pat Patterson will be with us. It was indeed a blow for us all to hear that he is leaving Wyeth in the near future and will therefore no longer be involved with NAFPD or the Institute of Psychosexual Medicine. He has been a devoted and generous friend to us all these years and we are so sorry to see him go, but of course, we do all wish him the very best for the future within his new job and his future life. With him goes our gratitude and affection.

Full reports of both these conferences and the Berlin Conference follow later in the Newsletter.

The 1981 Residential Weekend will be held at the Golden Valley Hotel, Cheltenham, which will happily provide central heating should the autumn be chilly.

Members who have not already received registration cards for completion will be receiving them soon. Please remember to fill these in and return them in order that your curriculum vitae as far as Institute training and work is concerned may be recorded. An increasing volume of enquiries is being received from doctors, patients and even the British Council in Mexico, and therefore up to date information about doctors is very important.

Yours sincerely,

Rosmarie D. Lincoln.

I. FUTURE MEETINGS OF THE INSTITUTE

- (a) The Annual General Meeting of the Institute will be held on Friday, 20 March 1981 at the Royal Society of Medicine. The meeting will be at 5.30 pm with a buffet supper to follow and a speaker at 8.15 pm.
- (b) The Residential Weekend Meeting is to be held at the Golden Valley Hotel, Cheltenham on 19 and 20 September 1981.

II. NOTICES OF OTHER MEETINGS

- (a) The British Psycho-Analytical Society are holding a one-day course on Saturday, 22 November 1980 entitled "Basic Psycho-Analytical Concepts". Speakers will include Miss Rose Edgcumbe, Colin James, Christopher Dare and Murray Jackson. Tickets are £12.00 and are available from the Secretary, Institute of Psycho-Analysis, 63 New Cavendish Street, London.
- (b) 5th World Congress on Medical Sexology - to take place in Jerusalem in June 1981.
- (c) 2nd International Congress of Andrology will take place in Tel Aviv in June 1981.

NOTICES, ARTICLES AND CORRESPONDENCE FOR  
THE NEXT NEWSLETTER MUST BE RECEIVED BY  
THE EDITOR BY 31 JANUARY 1981

### III. (A) NON-EJACULATION PRESENTING IN PSYCHO-SEXUAL CLINICS

A PRELIMINARY REPORT - first published in "British Journal of Sexual Medicine" - Rosemarie Lincoln & Robina Thexton

#### Summary

In a study of 22 men unable to ejaculate in the vagina, 2 methods of presentation were found: 12 patients (Group A) wanted treatment to increase their own sexual pleasure, while 10 patients (Group B) came essentially because their wife wanted them to produce sperm in order to have a baby. Group A patients were all subsequently able to ejaculate in the vagina, while Group B did not do so within the follow up time of the study.

Other common findings in the total series were:

There was a high incidence of twinning and sibling rivalry - the proportion of twins was 13 times the national average; childhood resentments at the mother's inability to give the patient full attention because of the rival; early lack of support from the father; a relationship with the woman doctor which appeared to reflect the need of such a patient to stimulate and promise much and give pleasure to, yet ultimately disappoint women.

#### Introduction

Little has been written about non-ejaculation. In 11 years, Masters and Johnson (1970) had only 17 cases of ejaculatory incompetence in therapy. Kaplan (1974) reports treatment combining psychotherapy with behaviour therapy, but admits to lack of hard data to support the efficacy of this approach. "Problems of Fertility in General Practice" (1953) states that treatment is extremely difficult.

The study was made in fortnightly research seminars of the Institute of Psychosexual Medicine to understand male sexual difficulties and develop techniques for dealing with them.

19 women doctors working in the field of contraception and sexual medicine were led by Dr Tom Main, a psycho-analyst experienced in Balint group training Methods and in psychosexual medicine. The doctor/patient relationship was particularly studied for its revelation of the characteristics of the patient, the responses he evoked in the doctor and his response to her interventions. We have no information of the kind of doctor/patient relationship which might arise between such patients and men doctors.

We defined non-ejaculation as inability to ejaculate in the vagina. Some patients could ejaculate with masturbation but not in the vagina; with others, masturbation in various ways, often 'non-touch', led to ejaculation; some ejaculated only with oral stimulation; some did not ejaculate at all and never had nocturnal emissions.

#### Patients and Methods

Our patients were referred from: General Practitioners (5), Sub-fertility clinics (5), Family Planning clinics (3), Gynaecology department (1), Venereal Disease department (1), College Medical Officer (1), through the Press (1) and self-referred (5). We

excluded some cases from this study where non-ejaculation was only one symptom in a severe general psycho-pathology and in none of the cases included could the non-ejaculation be attributed to physical illness or drugs.

The doctors had all previously been trained in the listening technique first described by Balint (1957). They avoided direct questioning, conducted an unstructured interview and listened for unconscious fears and fantasies using their individual and variable skill and experience. The doctor studied the "here and now" feelings between herself and the patient in order to gain and offer insights; and the response of the patient to the suggestion of genital examination was noted as a possible 'moment of truth' (cf vaginal examination in women (1970). Contraception and Sexual Life).

### Clinical Findings

#### 1. Presentation Two groups emerged.

Group A (12 patients) In contrast to Group B, Group A actively sought help for themselves, going to considerable lengths to find it - and variously consulting general practitioners, psychiatrists, urogenital departments, ministers and counselling services. They wanted sexual pleasure and orgasmic release for themselves.

Group B (10 patients) These men were pushed into coming by their wives' doctors, or brought by their wives, 7 of whom desperately wanted a baby. A significant phrase used was "I cannot satisfy my wife", ie the wish was to please or placate the wife rather than to seek personal pleasure in sexual fulfillment. In 6 cases the wives did most of the talking and demanded that their husbands be made to ejaculate. The concern of all these patients was fertility, not pleasure.

2. Wife/Patient Relationship The men could maintain an erection in prolonged and active intercourse, although some tended to become bored eventually. They were proud of this ability, but had little appreciation of the vagina or of shared feelings. The wives were sexually responsive and most had multiple orgasms early in their marriages; but eventually they began to feel that something was not right. One wife said "He doesn't seem to be making love to me - he does it as a duty, it is a bit of a chore". In general, the wives began to want their husbands to find pleasure in them and they desired sperm, both for their personal pleasure in it and for the chance it gave them to conceive. A number were concerned with AIH, this having been mentioned by a referring doctor. The unconscious hostility behind the non-ejaculation of these apparently innocent, dutiful, but thwarting husbands became clear to the members of the seminar only slowly, who then recognised the inhibitions of honest aggression in these men. One doctor described her patient as 'pulling his punches'.

3. Relation to Parents and Babies A few men spoke openly of their distaste for fatherhood, and once the doctor was thus alerted she became more sensitive to less overt declarations of this distaste and noticed their ambivalence towards having a baby. It was sometimes linked with ideas of fathers as shadowy or inadequate figures who had walked out on mother, had died or had been away from home, leaving unsupported by masculine identifications to advance their roles from being mother's son to a father. Despite a conventional and proper declared wish for a child, the problem had sometimes come

into the open only when the wife stopped the pill, or when non-ejaculation only occurred at the fertile time of the month.

In general, the patient saw his mother as being unappreciative of his wish to be valued by her, not attentive enough of his commitment to her, but requiring him to adapt to her wishes and orders, a mother to be placated by a resentfully obedient son.

4. Twinning and Sibling Rivalry An unexpected finding was that 7 of the 22 subjects were born as a twin. The present incidence of multiple pregnancy is artificially inflated by the successful treatment of infertility. However, in the early 1940's there were 244 live offspring of multiple births for every 10,000 of all live births. This means that the incidence of twins among these 22 patients was 13 times higher than expected. This is highly significant (Poisson's Test:  $P = < 0.001$ ).

All but 2 of the others had brothers and sisters of whom they had been jealous. In order to gain maternal approval when young, they had hidden their resentment at mother's 'neglect', had sought to be good appeasing children, yet had never felt they could please their mothers enough because of the rival. These men were unsure that what they had to offer was of value and they did not value or enjoy being themselves. A few openly declared their fear of fatherhood and their rivalry with any baby to come; and the need to be the woman's one and only was sometimes astonishingly clear; and from gross examples the doctors learned to recognise this need in more subtle forms. One man bluntly put it: "I don't want to share my wife with anyone else". Another only resented the (easily interpretable and symbolic) thought that his train set in the spare room would be removed if a baby came; and yet another made beautiful dolls houses, chiefly for his own pleasure. It seems likely that many of these men are unconsciously ambivalent about having children as a consequence of jealousy and sibling rivalry when a child. This hypothesis gains scientific status from the unexpected finding of a high proportion of the men who were born alongside a twin-rival.

5. Doctor/Patient Relationship The man was invariably agreeable, obedient and apparently collaborative in the interview with the doctor, and raised her highest hopes that she could help this 'poor man'. She felt powerful and valued and was pleased by her patient for several interviews. She then became frustrated at her inability to get anything relevant out of him. Trained to be perceptive about her own role, she then noticed how she had sometimes been turned into an all clever demanding woman, and now saw her early 'poor man, I am sure I can help him ejaculate' as false optimism, engendered by a man whose potency lay in making the woman want him and then with-holding himself from her.

6. Special Interests Masters and Johnson (1970) reported 5 of their 17 to be anxious products of severe religious scruples, although they did not state what would be the norm. 4 of our 22 couples were keen church workers; in others, the men were interested in good, clean healthy sports like football (5), or solitary sports (gliding and fossil hunting) or ones which took them out at night (coarse fishing). These activities were enjoyed more than time with their wives.

7. Findings and Fantasies at Genital Examination Doctors have little difficulty about requiring genital examination of a man when his complaint is somatic, eg hernia. But with this psychosomatic complaint they felt ill at ease over ordinary examination. It was only as they became freed by insight from the patients sexualising of the interview that they retained their professional rights to examine. Now they noticed how some patients took off some of their defences as they removed their clothes and could express simple fears. "It looks smaller today" or "I think I am rather small". One patient revealed that he could not look at his genitals in a mirror and that his feeling about them as he looked down was derogatory; one almost fainted with anxiety about retraction of the foreskin when the doctor put out her hand to examine his penis; another revealed his castration fear of damage to the glans especially if rammed into a vaginal spasm.

Two patients had been troubled with bed-wetting and 2 had adult urinary problems, inability to urinate in public toilets alongside others. A few had enjoyable urinary or sexual fantasies of a vengeful or triumphant kind in which height was important. One, high up, urinated on those below; another climbed a ladder to get shoes from a shelf, but looked down at a naked older woman. He fell on her and had exciting intercourse (but he did not ejaculate); another told how he could ejaculate only when travelling on top of a bus. These fantasies seemed to reverse and abolish the childhood humiliation of being small and impotent and of being watched while urinating.

#### Outcome

Of the 22 men studied, 12 men were enabled to ejaculate intravaginally with 2-6 sessions. These were Group A who had sought help for themselves and their own pleasure. In contrast, none of the remaining patients who formed Group B were changed. These seemed only to have come at someone else's request, usually their wives' and sought nothing for themselves. Interestingly, Group A patients having ceased to appease woman and enjoying their own new powers for themselves, they gave the woman doctor little or no credit for the improvement. One reported he was cured only because his wife had "crossed her legs"; another, "she was not as wet as usual", a third said he had cured himself with a book which described movement during intercourse; a fourth said he had cured himself by stopping masturbation. The doctors, of course, became wiser as the work proceeded and increasingly came to see their early optimism as diagnostic of the patients' stimulation of women, and their later sense of being ignored, as diagnostic of the patients' new sense of owing his prowess to nobody but himself.

An important element in the therapy appeared to be the ability of the woman doctor to respect, listen to and understand what the man had to offer; to resist the collusive temptation to be eager and confident or to instruct him; and to interpret events in the doctor/patient relationship as these appeared. She also had to be able to accept the man's needs to get and own potency rewards for himself; to tolerate as a mother would his son, his pride in his own achievements and his 'taking her for granted' with a selfish lack of appreciation of her help; and to act as a humble co-worker with the patient, not as an all-knowing doctor whose delight is an obedient graceful one.

The co-operation of Group B was initially very satisfying but eventually proved to be spurious, and disappointed and annoyed both wife and doctor. It was not true co-operation but mere obedience of a passive kind, hiding grudges and fears and hostility. Their intercourse was more apparent than real, whether sexual, social or medical. These men were troubled in themselves, and might have been accessible to therapy, but for the fact that they had not really sought treatment and did not want it, and the absence of motivation was in our series, decisive. Any attempt to encourage or persuade these men to accept therapy merely created further false obedience. Technically we therefore conclude that the way the doctor is approached allows an early assessment of the motivation.

However, even now that seminar doctors are aware of this, they are in enthusiasm tempted to ignore this knowledge. Group B men with their capacity to give great initial satisfaction to women, can still raise the highest hopes, even in doctors who are alert to their significance, and this is a wry and humbling route for arriving at a poor prognosis!

#### EXAMPLE I Clinical Type A

Mr Love is a company secretary and his General Practitioner had referred him to a psychiatrist who had been unable to help, and so Mr Love asked again to be referred to the psychosexual clinic of the Family Planning Clinic which had prescribed the pill for his wife before their marriage 6 months previously. He made his own appointment there and he and she walked in together. He was short-haired, 26-year-old wearing a neat polo-necked sweater and his wife appeared relaxed and pleasant.

He began: "I want help because I cannot ejaculate. I have always been good at everything, especially sport and I am so surprised that I can't do this." His sport was football.

During the first consultation, doctor and patient talked about relationships with mother, younger brother and previous girlfriends and the doctor noticed that she frequently felt uncomfortable because the patient put her down. At one point he said "I think you are talking a lot of rot!" The doctor asked the wife to wait outside and now the patient revealed himself as less worried about non-ejaculation than about inability to urinate in a public toilet with others present. This had begun at 14 years and now inconvenienced him in business life. He had never told anyone, not even his brother, because the latter might tell his mother and she would think him "silly".

He had never masturbated but had had nocturnal emissions during dreams of intercourse with a woman, which were far more exciting than during actual intercourse. He naively thought that this was due to the blanket rubbing him. The doctor accepted all of this - his talk of urination and his dream ambitions for intercourse - without censorship or surprise. The fact that he could tell her about these secret matters indicates something of his feeling that the atmosphere was to be trusted as one that held no scorn of him.

The doctor discussed his need to hide his urinary troubles from mother's scorn and his need to keep his doctor ignorant and powerless. (With hindsight, we may also notice that it was only after his wife was outside that he could tell the doctor of urinary blocking). He apologised for his keeping the doctor at bay but retained an air of denigration of her work.

The atmosphere in the second interview was different, and the doctor noted their mutual feelings of being more at ease. By the third visit the patient was impatient to tell of having intercourse on the hearth rug; when his wife had returned, slightly drunk, from her office party. She had been less inhibited and he had not felt so much watched by her; he let himself go and had ejaculated. The doctor likened this to a nurse's intuitive need to leave a patient alone with a urinal in bed for a considerable length of time. Mr Love said he would come again, after a longer interval. "Then I will feel free, like the patient in hospital".

He returned two months later and said: "It's all been good since last month when it clicked into place." Now he wanted intercourse all the time.

His explanation for the cure was that he had read an American novel which made him realise that the man should move in and out during intercourse and he had not done this before. He attributed this naivete to never having masturbated and to being disinterested in sex. The doctor felt that there had previously been an inhibition of aggressive movement.

The therapeutic technique was: taking him seriously, listening for, accepting and talking about underlying anxieties of the person, not the symptom, and commenting on these as they appeared in the doctor/patient relationship.

He had come early in marriage, had owned the problem, had no pre-occupying wish for a baby, but sought pleasure. He refused to be belittled and dared to denigrate the woman doctor and she had accepted his aggressiveness calmly and without retaliation and had discussed it in the doctor/patient relationship. He put her in her place, ceased to fear her supervision and in his new freedom had experimented and found out what he could do, whether or not she watched him.

#### EXAMPLE II Clinical Type B

"The Old Rocker" He was referred by the subfertility clinic which his wife had attended. He came obediently but without personal enthusiasm, accompanied by his dowdy 30-year-old wife. Also aged 30, scruffy, pudgy, nervous and stammering, he, at once, asked if he could smoke. She did most of the talking and said that during intercourse he had never ejaculated, but became bored and exhausted while she had several orgasms. She blamed his mother, who was a domineering woman in both their eyes. His father was away from home having left the mother. His brother was much more successful than this patient, being a diplomat in the Far East.

When seen by himself he said that only once had he ejaculated in the vagina of a "Bird" he had taken for a ride and "laid", when he had been one of a gang of Rockers on motor bikes. Later he had learned that she was under 16 and police had investigated the matter.

He gave a history of tormenting sergeants in the army by dumb insolence, and of laughing at and frustrating any senior who made demands on him. He used similar frustrating techniques on his wife, for instance asking her to dress up in black undies, but then saying that she did not excite him. She was a religious woman, employed caring for handicapped children and she responded by mothering him for his childish behaviour. He felt like another handicapped child.

During intercourse, when he almost reached orgasm, he described a feeling of being in a yoke, and was more excited by masturbation with fantasies about penetrating a black woman from behind and then he would be able to ejaculate.

After leaving the army, he had an unsatisfactory job record, was always in trouble with authority and made poor relationships with bosses. He had given up a previous girlfriend to placate his mother in a hostile way. The patient had no clear ambitions to be a father himself, although, in an ambivalent way, he was surprised and delighted with his high sperm count in his semen. This man's hobby was making dolls' houses for his own pleasure.

A reluctant patient, he gave the doctor some interesting facts, but gave little or nothing of himself. Plainly not happy in his marriage, nor with his mother, nor with his doctor, he was a spurious collaborator with all three. Guarded and resentful of intercourse as a demand, he appeased women and resented their dominance. He moved out of the area because of employment difficulties and, perhaps typically, slid out of a therapy which had been undertaken in somewhat childish (apparent) obedience to his wife.

The final outcome of therapy is unknown.

#### EXAMPLE III Clinical Type B

"The Young Pretender" This 29-year-old Director and owner of a small, recently established firm, came to the clinic by himself, under his wife's pressure, because she wanted a baby. Initially he appeared confident and handled the interview in a skilled social way. He had been a virgin when he married a year previously, but he did not tell his wife, who was a divorcee with one child. Intercourse had been marvellous and his wife said that he was a super lover because she achieved multiple orgasms. He himself did not ejaculate but had pretended to do so until she began to wonder why she did not get pregnant and then he had to confess.

The doctor mentioned his apparent need to please only his wife and he replied that his wife too had remarked that he could never ask for pleasure for himself. He was anxious with the doctor and could not use certain sexual words (eg masturbation and homosexuality) unless prompted by the doctor who thus found herself putting words into his mouth, almost an active sexual expert soothing a humiliated and passive child who was trying to keep his dignity. He said "I hate to say this, but I think it must be psychological" and "It's not as though I'm a mummy's boy". He may have been referring to his pain in the interview when he remembered his pains of being teased at public school for ignorance about the facts of life. His general manner was that of a vulnerable boy who giggled with anxiety.

At the second visit he said the trouble was that his wife's vagina was too big, but was quite unable to consider that this might be a statement not only about sexual organs, but about comparative sexual appetites and capacities.

He had masturbated since he was 20 years old, with frequent pleasurable ejaculation, but also guilty anxiety. He was trying to stop because he felt that all would then be well. When he failed to keep the next appointment the doctor noticed her disappointment and anger, and her non-too-well founded idea that she could help this

man if he would come again. Later he did come, saying that he had hit his wife after a row about him not doing things. He had left her for a 'cooling off' period (which mirrored his behaviour with the doctor). Of his open aggression with his wife he said "It isn't cricket." He was unaware that cooling down aggression by absenting himself from wife or doctor contained its own disguised aggressiveness. He failed to keep his next appointment and did not reply to an enquiring letter.

He gave the doctor an interesting time but frustrated her as a frightened child frustrates a keen teacher. His social manners were a disguise for anxiety, weakness and vulnerability. His need to placate and please and obey women was a cover for hostility based on terror of them. Obedient in intercourse, his non-ejaculation was more than his wife could bear. Similarly he could incite his doctor to high expectations and then disappoint her.

This man of promise did not seek the doctor himself but was sent by his wife and he "obeyed" her.

-o-0-o-

(B) INSTITUTE OF PSYCHOSEXUAL MEDICINE - Dr Joan Coombs

The Institute of Psychosexual Medicine is a learned body which seeks to develop understanding of psychosexual medicine by doctors through seminar training.

The Institute arose from the needs of family planning doctors who sought to develop greater skills of doctoring in order to help their patients. Every request for contraception represents a request from the individual for a sexual life. Contraceptive practice is inseparable from psychosexual medicine. In recent years contraceptive medical practice has become much more relevant to general practice, gynaecology, obstetrics and psychiatry. Many doctors in these fields have sought to develop their insight into sexual problems by seminar training and the application of skills has broadened.

In the early days problems for seminar study were usually female orientated, although working with the case would often lead to the understanding of a distressed man whose partner had presented "the problem". Men are more likely to present with psychosexual distress to the general practitioner and this has altered the kinds of problems studied in seminars.

A basic training seminar usually includes 10 to 12 doctors who meet for 2 hours once a fortnight during academic terms. There are usually 6 seminars in each term and the basic training group meets regularly for a minimum of 2 years. It is expected that each doctor should be engaged in medical practice which provides clinic encounters with patients who have sexual difficulties, either directly presented or indirectly presented under the cloak of other symptoms. One of the aims of the basic training seminar is to develop the ability of the doctor to recognise the presentation of psychosexual distress. The patient may feel that offering up a physical symptom is the only way of communicating to his doctor regarding his emotional distress. Some would argue that the patient is right, particularly those doctors who do not regard the emotional component of the patient's pain to be the business of the doctor. However, there are many doctors who wish to practice "whole patient medicine".

The offering of the symptoms as a "visiting card" may have much broader implications in medical practice and be relevant covert communications with regard to a wide range of disturbances from "baby battering" to "granny battering".

Seminar members are expected to present their own clinical material for discussion in the group, a naked experience for any doctor, but one which the individual members and the group as a body become accustomed to. Trust and tolerance develops which allows the work of the group to continue. Examples of cases studied include contraceptive problems, many gynaecological problems and the emotional sequelae of gynaecological operations and indeed any operation such as mastectomy, colostomy or vasectomy which can change the patients body image and evaluation of self.

Much of the work studied includes such sexual problems as in the female non-consummation, failure of arousal, failure of orgasm and loss of libido. In the male, commonly presented problems are those of non-consummation, premature ejaculation and retarded ejaculation and emotional factors contributing to impotence and loss of libido. The role of the doctor in doctor patient discussions regarding termination of pregnancy, tubal ligation and vasectomy is also studied.

Although the study group confines its material to sexual matters, the value of the doctors sensitivity to the patients conscious and unconscious communications has wider use in doctoring. Many doctors find the insights gained in the training seminar enhance their skills in other ways. Some doctors notice a reduction in their prescribing habits, the more accurately they perceive the patients problem and the more accurately they dispense the drug "doctor". Some have even found incidental benefits in their committee work and other interpersonal transactions.

At the end of 2 years of basic training most doctors will have received an introduction to psychosexual medicine. Most suitable doctors will have developed enough understanding and skill to diagnose problems and an awareness of how to help their patients in the ordinary course of their work. Hopefully they will have learned how to avoid iatrogenic sexual distress in their patients. They will also have developed the ability to assess suitable cases for treatment in the primary care setting and to identify cases which need referral. Probably most cases do best in the setting in which the case is presented, that is the setting selected by the patient and with the doctor of his choice. Sadly many "cases" are lost by referral; the insolubility of the problem being endorsed by the rejecting referring doctor.

At the end of the introductory period of training, there will be some doctors having sufficient talent for the work and sufficient motivation to wish for further specialist training. On the recommendation of their basic training seminar leader, they may then continue to study ways of developing their skills in an advanced training seminar.

#### The Advanced Training Seminar

There is no time limit for advanced training. The group may, in fact, meet more frequently than the basic training seminar as the degree of involvement in the field of psychosexual medicine is often more intense. The supply of clinical case work is more copious and the expectations of the members of the group are often increased. The

increased fluency of the work dictates the pace and weekly meetings may be relevant.

On satisfactory completion of advanced training, doctors may apply for the Institute's examination by panel. The aim of the examining panel is to assess the candidate's competence to undertake specialist work in psychosexual counselling. The examination is in 2 parts. During the first part the candidates and the panel members all participate in a seminar in which cases brought by each candidate are studied. Later in the day individual candidates face the panel and discuss a second case brought for scrutiny. The panel seeks to assess the doctors ability to understand factors in the doctor patient relationship, and the doctors sensitivity and insight regarding the communications within the doctor patient relationship. Attention is also paid to the doctors use of the physical examination of the patient and the potential therapeutic value of this psychosomatic event in the doctor patient setting. It is important that the doctor demonstrates to the panel the ability to select cases appropriate to this approach and to identify patients who for one reason or another cannot use interpretive therapy.

Successful candidates are issued with a certificate of competence in psychosexual medicine. This is rarely achieved with less than 5 years of in-service training. A doctor who has satisfied the examining panel and who is in possession of this certificate would be competent to accept referrals from other practitioners and agencies.

The prime object of the Institute of Psychosexual Medicine is to provide training for doctors and to maintain standards by the training of trainers and also by the accurate assessment of potential members through examination by panel.

It is not within the scope of this account to define the skills and insights learned in training. Nor would reading about the seminars described by authors be a substitute for the actual vivid experience of the living moments with patients and in the training seminar. Most of the formal training of doctors provides them with knowledge and teaches them the appreciations of such knowledge. Much of the work of doctors, particularly general practitioners is concerned with psychosomatic elements of disease. For these, the traditional tenets of medicine are not applicable and different skills are required. The psychotherapeutic approach to emotional problems is the more valuable to the patient. Psychotherapy is a personal skill that cannot be taught. It is a skill which can only be acquired by an active process of learning through living and also involves some change in the doctor based on insight. Such learning can only be acquired gradually by painstaking study and honesty.

Up to 1980 the Institute in-service training has involved 1,000 doctors. In 1974 there were 200 trained doctors. Since then at least another 500 have applied and started training and about half of these are general practitioners. From the original nucleus there are now over 40 doctors who have developed sufficient skills to become trainers in their own areas.

There are no short cuts in psychosexual medicine. Patients expect their doctors to understand their minds as well as their bodies and the links between the two. Perhaps by understanding both and recognising their interdependence, we will enhance our doctoring and find greater satisfaction in our craft.

(C) PSYCHOSEXUAL SEMINARS FOR NURSES - Dr Joan Coombs

Having resisted requests to give lectures to nurses on psychosexual problems for some time, I finally agreed to run a short series of seminars instead. Some time after the first group disbanded I was asked to lead another group of nurses and the following is an account of the experiences of the second group.

The aim of the series was not to make nurses into psychosexual experts. It was hoped that the group could study the working relationship a patient can have with a nurse and the special ways in which this relationship can be of value to the patient. It was hoped that an awareness of the relevance of sexual problems would begin to develop and that the seminar members might begin to feel more comfortable with their patients' communications and able to listen sensitively.

The seminars were conducted on similar lines as those for doctors in the Institute of Psychosexual Medicine. There were 12 group members and myself the leader. Some members worked only as family planning nurses, some were health visitors, some were both.

The first group had been disconcerted by the non-teaching method of study of clinical experiences. They had expected a didactic approach from the leader and were irritated and bewildered. Although the method of study had been discussed at the first meeting the irritation of the group members impeded the work of the group for some time. As the series was only planned as a short one I felt time had been wasted.

In order to avoid wasting time in this way I arranged a pre-seminar interview between each prospective member and myself. This allowed us to discuss the aims of the group and the method of study. It also allowed us the opportunity to appraise each other and to strike up a rapport which seemed to facilitate the work. One interviewee decided the group was not for her but subsequently attended.

Each meeting lasted for 2 hours from 12 till 2 and we met fortnightly for 7 sessions. A sandwich lunch was provided which did not interrupt the work much. The meetings were very well attended.

My impressions of the work of the group were favourable. I felt that they very quickly adapted to the mode of learning that we had adopted and they kept the aims of the group in focus. There was a wealth of clinical encounters to study and a large proportion of the members contributed cases and events. All the membership was active in discussion. It was interesting that almost all the cases presented were ones in which the relationship with the nurse was of value to the patient. Perhaps this was due to the patients' view and rapport. Patients often feel less intimidated and safer with nurses than they do with doctors.

Although nurses do not examine, diagnose and treat patients, this was no impediment to the therapeutic value of the transactions they did have with their patients. Those nurses working in family planning clinics were occasionally able to report "cap cases" in which learning to use a cap had provided valuable insight and communication regarding sexual difficulties. This was of great value to the rest of the group and deepened their understanding.

One health visitor regularly brought cases that she and the GP were both working with. The GP was very interested in the group and encouraged his health visitor to present cases.

In order to assess how far the needs of the members were met a questionnaire was given to each member and all but three completed it; 4 family planning nurses, one health visitor, 5 were both.

The first question was "Do you meet patients who have psychosexual problems in the course of your work?" - they all did. Most of them answered "Yes" but three answered "Occasionally." These were all family planning nurses.

The Group were asked "What were your personal expectations of attending seminars" - the responses ranged "to be able to recognise problems," "to gain further insight", "to find out what psychosexual problems are", "to receive formal instructions and appropriate therapy". Several members expected to find benefits from group discussion and the understanding of other attitudes.

To the question: "Did you find the pre-seminar discussion with the leader helpful or not" 7 answered "Yes". 2 observed that it prepared them for the non-teaching method of learning. One member did not reply to this question and another did not attend the appointment. One member answered "No" to this question. She was a family planning nurse who only saw cases occasionally and felt that the role of family planning nurses is limited as they do not have close enough connections with patients. The group did not seem to meet this person's needs at all. She hoped to identify patients quicker so that they could be referred to a psychosexual clinic quicker. She would have preferred "more teaching" and had no wish to attend more seminars.

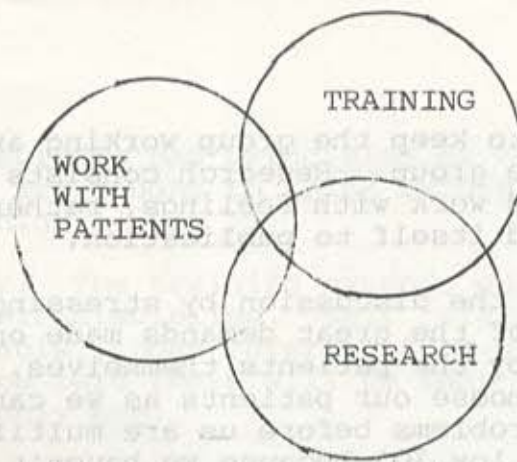
When asked "How did you find the 'non-teaching' learning process in the seminar", one replied cryptically that the "success depends largely on the character of the people present". Two observed that it was not as helpful as they would have liked. It is interesting to note that neither of these members presented any of their clinical work for study in the group. 3 commented on how difficult they had found the experience initially but then found it appropriate. Three were enthusiastic about the method of study finding it a "most useful way of learning" and one member noticing that the process of listening and learning and the unstructured interview was particularly appropriate to the field of work.

-o-o-o-

#### IV. REPORTS OF MEETINGS

##### (A) Report of the Weekend Conference held at York on 13 and 14 September 1980 - by Dr Robina Thexton

Dr Tom Main was in the chair for the first morning and Dr Margaret Blair presented a paper 'Defining the Boundaries' of the Institute's work. She explained graphically:



The Institute provides a special training for special work, which depends on work with patients and with research and all are inter-dependent. The tools used in this work are understanding, and interpretation when pertinent, of the Doctor/Patient Relationship; understanding the facts known to the patient, and also his fantasies about his body, and about his sexuality; also understanding the use of the physical genital examination. There is a difference between psychosexual therapy and psychotherapy or marital therapy but always the doctors' interpretations, and timing of them, and the picking up of non verbal clues are important.

Dr Blair likened working with the patients defences to peeling off the outer skins of an onion, meanwhile acknowledging the underlying anxieties. It is a skill which can be learnt, but it cannot be taught. The patients must be selected carefully, and also the focus of the work. They should be people who function normally in most areas of their life but have a small area of difficulty which is the psychosexual problem. The doctor/patient relationship should be fairly superficial - a deep relationship including interpretation of dreams is outside the boundary. Therapy is aimed at change in the patient and not in the environment.

The patients come for help with libido, vasectomies, hysterectomies, etc and many have upset body attitudes and we now talk of a psychosomatic body examination rather than only a vaginal examination.

We should eliminate unsuitable patients for therapy:-

1. Those with a low IQ unable to communicate verbally.
2. Other cultures (especially with language difficulties).
3. The psychotic patient.
4. Heavily defended patients.

These patients are unable to recognise and make use of interpretations. With other patients changes can be made which may free them to progress. The training for this work is in regular seminars studying cases: Basic, Advancing and Leader Doctor Workshops.

Unsuitable doctors for this training and work are:-

1. Those with no understanding of feelings or of the unconscious.
2. Those who joined the seminars with wrong expectations.
3. Those who cannot listen, but only teach or preach.
4. Those whose own neuroses get in the way.

After training - doctors understand - and use therapeutically the physical examination, and are sensitive to the patients unconscious communications, and are able to select suitable cases, and to make use of the doctor/patient relationship.

They are not qualified by the training to do group therapy, family therapy or to treat the unconscious.

The Leader Role is to keep the group working and to understand the relationships in the group. Research consists of honest reporting a frank discussion and work with feelings, rather than facts and this does not easily lend itself to publication.

Dr Mary Rees opened the discussion by stressing that we must know the boundaries because of the great demands made on us by referrers, by our colleagues and by the patients themselves. In counselling clinics we cannot choose our patients as we can in family planning or GP settings. The problems before us are multifactorial - do we have to exclude some (ie low IQ) because we haven't yet enough skills to help them? Should the training be extended to include discussion of group dynamics, use of video tapes, having a trainee sitting in with an experienced doctor as she works?

Should the Institute provide maintenance seminars for those who have completed the training? Should there be more seminars for nurses? We must write about and publish our work.

Dr Williamson: There is a point when we have to stand on our own feet and not need a support seminar.

Dr Griffith: If the patient remains heavily defended, surely it means we have failed.

Dr Blair answered that these were the patients we should refer on.

Dr de Carteret: All psychosexual problems spring from early experiences and are to do with the unconscious. Can we harm them by working superficially?

Dr Shaw: I would welcome other methods of learning - use of two-way mirrors, studying the dynamics of the group.

The answer to this point was given as: Intensive case examination is not a teaching method, but a method for doctors to train themselves, not identifying with other doctors but keep their eye on the focus.

Dr Anne Smith pointed out that low IQ patients do have feelings and we can work with them to a limited extent.

If doctors prove to be unsuitable, the group decides and makes its feelings plain but some thick skinned doctors need to be told to drop this work. In the same way we have to learn to terminate therapy if we have started with an unsuitable patient.

Dr Corran: The psychosomatic examination has extended from the original vaginal examination to include male genitalia, and breasts, etc.

Dr Dewsbury: Some patients are not suitable for Institute methods but we can help them better than people without that training.

Dr Pasmore: As doctors we cure rarely, help often and comfort always.

Dr Montford: We should keep within our boundaries but we have a responsibility to get the patient better and sometimes we have to resort to other methods.

Dr Main: The Institute has principles of treatment but no particular method. Doctors are taught to think before they act. Our main function is training.

Dr Rosalie Taylor: The training extends our horizons and teaches us discipline and self-discipline. Self referred patients from clinics are usually suitable, those referred from outside often not suitable. Patients should be told there will be many interviews and not expect to change after only one.

Dr Blair: We must not accept everyone referred - if unsuitable some must be rejected.

Dr Main concluded by saying that personal experiences from individual doctors differ - and if we all branch out on our own, our own blindneses recur. As individuals we may change, but we need to meet together to be disciplined to stay that way.

The Second Paper was titled 'Extending the Boundaries' and was given by Dr Alexandra Tobert.

We are challenged, she said, to respond as fully as possible to our patients, within the limits of our skills and time, because there are such numbers of patients needing our help. The patients who used to go only to GPs, gynae clinics and psychiatrists are now, more suitably referred to psychosexual clinics. We must make a diagnosis aligned to the patients needs. Our skill can be used with flexibility but without distortion.

Dr Tobert does a clinic in a big city hospital and often has a psychiatric registrar sitting in with her and this disturbs the interaction of feelings but the patients accept it. In 6 months there were 45 sessions with 328 patient visits - 51 men and 74 women were seen. The average number per session was 7.2 - sometimes 11 patients were seen, and this was too many, therefore the ones who came at the end were not getting enough attention. The number of times they came varied between 1 and 15. The doctor always offered a second appointment to talk it over if she had to say "I can't help you". Sometimes she says "Let's have 6 weekly meetings and see where that takes us". The patient feels the validity of their claim for sexual help. They can be grouped as follows:

### Frigidity

1. A circumscribed problem in a healthy personality.
2. Problems with femininity, as mothers, wives, etc - based on emotional distress over a sexual complaint or physical symptoms.
3. Patients with panic reactions - the anxiety state causing enormous distress - they have an unconscious block and need wider psychiatric help.

### Secondary Frigidities - the majority group.

The doctor says "Tell me about yourself" and looks for the trigger that produced the frigidity - if it appears the prognosis is good.

The trigger, or echo of the past, is a short cut into treatment. Post partum patients often show deep discontent, and no focus of joy. There is a loss of libido, and it may last up to 5 years. Some presen

with a physical symptom such as pelvic pain, dyspareunia, vulval soreness or menstrual problems. The body is expressing the feeling which cannot be expressed verbally.

Some patients are mourning for a parent, a child, the loss of their uterus or fertility.

### Impotence

We are treating men with impotence and seeking to learn more about it. Secondary impotence has a trigger - we watch for a clue in the personality which shows in the doctor/patient relationship - such as anger, or excessive co-operation, inability to lose control. There are also non-emotional causes: depression, physical illness and scare stories. We must do tests: serum prolactin, testosterone levels, LH and FSH. We unearth a startling amount of psychopathology during the consultations but we should stick to the focus for therapy.

Dr Tobert gave 3 case histories to illustrate these points, and the hard task of understanding the individual.

Dr Tattersall opened the discussion by agreeing that in the provinces there are vast numbers of patients needing help. We have to take short cuts as there is a shortage of time and doctors to see them. The patient brings his own expectations to the clinic, and he is the one who has to have enough motivation to change, for therapy to be effective.

Dr Main pointed out that we had heard a paper from a compassionate doctor with sophisticated skills of how she works in her own setting.

Dr Bradshaw tries to pick out at the antenatal booking when he takes a history, which woman are at risk of post natal loss of libido - it is necessary to understand the individual patient.

Dr Andrew said that we must be prepared to listen to what our patients want to say about the spiritual side of their lives.

Dr Tobert agreed with Dr King from Northumberland that it would be valuable for gynaecology staff to understand the Institute's work. Dr Coombs has to treat patients with iatrogenic psychosexual problems not present before gynaecological treatments, but developing from it.

Dr Freedman quoted Lord Cohen - there are 3 things in medicine, "diagnosis, diagnosis and diagnosis" and Dr Main later preferred "Examine the problem, examine, examine"! Sometimes, Dr Freedman went on, we don't cure our patients, but we understand them and help them to live with the problem.

Miss Thompson reminded us to always check out absence of organic causes. It is necessary sometimes to work fast, but to know when to tolerate and interpret silence and give time where necessary. We must accept the problems ourselves because if we refer patients - they may not choose to go.

Dr Main concluded the discussion by the comment that we all have fond hopes of great skill and success - in the end we have to do the best with what we've got - a parallel to most marriages!

Dr Wendy Roles gave the third paper - "Couples"

She contrasted working in a one to one relationship with a patient with seeing a couple and having a male colleague with her.

The usual way of working involves:

1. Transference to the doctor of feelings, hostile or otherwise, which have arisen in previous relationships and need to be interpreted and understood. We look for evidence that the patient sees the doctor as representing an important other person.
2. Recognition and understanding of the feelings of the doctor about the patient.

It is difficult to understand an individual's intrapsychic complaint if the partner is present - but Kaplan states that it is not always necessary to resolve the underlying conflict to achieve improvement in sexuality. We have to understand why we see couples - is it accepting the fact they came together, or is there anxiety in separating them and obscuring ownership of the problem. Who has brought who and why?

Dr Roles started seeing couples some years ago to test out Masters & Johnsons theory that there is no such thing as an uninvolved partner in a relationship where there is sexual inadequacy. Sexual response represents an interaction between 2 people and the marital relationship is considered as the patient. The criteria for accepting couples which Dr Roles uses are:

1. A good relationship, not a marriage in name only.
2. Absence of psychopathology or neuroses.
3. Good motivation of both partners.
4. Willingness to make a contract to attend regularly over a period of time.
5. The disturbance appears to be interpersonal rather than intrapsychic, ie secondary frigidity or impotence where the behaviour was determined by pathological transactions which might be altered by changes in the system.

With both partners present, the focus is on the dynamics of the relationship in the here and now. Transactions are noted and interpreted and attitudes and behaviour observed. Ventilation of feelings is inevitable. One partner cannot remain emotionally detached since confrontation by the other or by the therapist undermines the defence.

Patterns of blame and scapegoating are looked at. One therapist can observe what is happening when a dialogue is taking place between the other therapist and a patient - perceptions and understanding are compared afterwards.

Dr Roles and her co-therapist Dr John Rogers book people for 6-8 weekly sessions - the interview is unstructured, and behavioural techniques are sometimes used; sensate focus, genital pleasuring, squeeze technique, discussion about orgasm, erection, penetration - instructional sheets may be given. These techniques are used as a focus for interpretive work and for examination of the relationships.

We watch for:

1. Positive feelings - the degree of warmth and affection with the relationship - intimacy, sincerity and honesty.
2. Negative feelings - hidden anger, resentment and blame. Is there fear of closeness?
3. Motivation - who wants to improve, who brought who and why and why now?
4. Complaint - who is complaining and what does the partner feel?
5. Expectations - do they differ? Is there conflict between the needs for self-fulfillment and the need to please the partner, eg the ability to achieve orgasm.
6. Communication - is the couple close or out of touch? Who holds the stage and who is passive?
7. Sexual Attitudes and Inhibitions - are they due to parental influence or in response to the partner?
8. Collusion - who owns the problem and who is denying it?
9. Dominance - who makes the decisions and controls?
10. Dependence - are dependency needs being met? Is power wielded from a position akin to passive resistance?
11. Boundaries of the relationship - exclusion or inclusion of children, in-laws, careers, hobbies, pets.
12. Games and Pay-off. These using transactional analysis terms are:
  - (a) Kick Me. The role of the Victim, with a need to be punished or rescued.
  - (b) Uproar (havoc) a fight between the couple to promote hostility leading to withdrawal and wounded feelings - resulting in avoidancy of intimacy because this is the threatening situation. This is revealed when sensate focus is used.
  - (c) Rape. The woman who seduces men to reinforce her feeling that men are beasts.
13. Projection - the despised and unwanted bit in one partner is projected onto and carried by the other.
14. Doctor/patient relationship:
  - (a) Transference - we note how each partner relates individually to us - antagonism is noted - it can be in response to an interpretation in the here and now, or as an echo of a hostile relationship in the past.
  - (b) Friend in Court. Each partner relies on the therapist of the same sex to support and translate feelings.
  - (c) Counter transference. The doctors feelings to each partner are discussed afterwards.

Conclusions The opportunity to shift between Institute one to one therapy, marital therapy and behavioural therapy is valuable - but do the fantasies remain buried? Drs Roles and Rogers feel it is difficult to understand and interpret what is going on in a foursome, but they have a lot to offer the couples and are confident in the value of their work.

Dr Tunnadine opened the discussion - re-iterating that if you see couples in this way, it is totally different from the one to one relationship. Our training enriches us and helps us to find the essence of the work - the patient is whoever comes, we must be prepared to think, examine and discuss new situations with colleagues as Dr Roles has done.

Dr Suri: If the problem is in the relationship, the Marriage Guidance Council is the right place for treatment.

Dr Rogers: It is impossible to separate relationship therapy from sexual therapy. Working in the FPA produced the 'tool' of the Doctor/Patient relationship to use with women patients. Now we get men and couples and we must have new 'tools'.

Dr Main: Calling in the partner used to be a way of dodging what was under your nose. The dangers we must watch for are:

1. The individual may not himself grow.
2. The internal world is ignored.
3. We move from one system of thought to another and back again.
4. We retreat from our own anxieties.

It may be secretaries who arrange for couples to come and doctors accept the situation out of cowardice. Changing systems of working is a defence against the awkwardness of sticking to one system, ie arriving at a sticking point with one individual and moving into the relationship instead.

Dr Blair: We need more training and research about seeing couples.

Dr Tunnadine: There seems to be myth that there is a strict rule: that we continue with the traditional way of therapy and do not see couples.

Dr Roles: In 1976 a survey of all her cases showed 25% cured, 25% slight improvement, 25% remained the same, 25% dropped out.

Dr Elder: We try to look at the doctor/patient relationship and use it therapeutically - when seeing couples it is diluted, so we pull in other techniques, like behavioural ones.

Dr Berry: Surely behaviourist methods are techniques and we need our individual skills to use them.

Dr Rogers: The projection that goes on between a couple is an added concept to work with over and above the doctor/patient relationship.

Working with a co-therapist is a training system - we learn from each other and work faster. We sometimes have completely different views, we get stumped, we argue and try to understand.

Dr Jean Pasmore next presented a paper The Use of the Institute Technique in Marital Therapy.

She outlined the differences between the Institute technique - studying the doctor/patient relationship in the here and now - with the bodily sensations and symptoms and fantasies about these; and, marital therapy which she had practised for many years at the Cassel Hospital Richmond. There she worked with one marriage partner and a colleague worked with the other one, then the therapists met afterwards with a psychiatrist and discussed the interviews. It was a limited form of psychotherapy.

Dissatisfactions due to discrepancies between expectations and reality were revealed. Therapy involved understanding the defences and resolving the conflicts which were exposed.

The defences showed as: - perhaps - fear of dependence, the denial of the need to depend on anyone in all areas of life, but most in the sexual field. It was necessary to undo the tangle when "women won't and men can't". Also to identify the interaction between members of the family. The emphasis, however, was on the internal conflicts in the partners "What happens between these 2 people"?

Unsuitable patients were excluded as soon as possible. There were those who were too disturbed, too defended, or unable to use interpretative therapy due to intellectual or cultural reasons. Also unsuitable were those needing long term support, which was not available in the setting.

The focus was the presentation of a psychosexual problem in an otherwise normal life.

Motivation is vital and both partners must own their own distress. In a crisis presentation the distress is acute. There must be sincere concern for the other partner who is separate and individual. The aim was to establish satisfactory sexual intercourse and then each could develop in his own way. This was achieved by acknowledging and relieving immediate anxieties. The causes of anger were exposed, communication restored; guilts, fantasies about the other partner were explored, fear of weakness or aggression discussed. Eventually the man could enjoy his own potency and the woman her femininity.

With 2 therapists seeing 2 partners separately, there were 2 diagnoses of 2 individuals. Patients were free to show their feelings of anger of tenderness, concern and need. Sometimes only one partner was seen. In this short term work, it was essential to keep the focus: which was to understand the defences against the physical, emotional and social roles of the male and female. Then it was important to recognise the time to stop and allow patients: "To use life to grow from". (Winnicott)

The vaginal examination was not always used, if the trouble was mainly with the relationship it might be a main focus, where the fear was of pain and fear of penetration and loss of control. The timing of physical examination varied.

It was not so much an Institute technique that was used as an Institute attitude of mind - to explore, evaluate and test the validity in seminars. We use all the knowledge gained from our own experience of the doctor/patient relationship and indeed from life itself.

Dr Audrey Jones opened the discussion by re-stating that we need flexibility to expand our work. Perhaps we need maintaining seminars to keep in touch with new ideas, to discipline ourselves to work out at the end of a session, exactly what went on in it. If one of our tasks is to restore communication between 2 people - we must wonder why they could not do it. How can we recognise when to stop therapy and let the patient grow.

Dr Main said, when doctors are sensitized, more human distress is revealed - it is not that we stir up discontents. He had been the supervisor when Dr Pasmore was doing Marital therapy and he remembered when patients said: "It's not my problem, it is his or hers". Then a moment came when it was said "I'm not so splendid - I realise I've denied my problem all along." The third doctor - the supervisor - had to stop these moments. It is rare for one human being to be understood by another, let alone by 2 more people.

Dr Draper asked if it depended on the therapist or the patient whether a couple or an individual be seen. Dr Main answered that treatment should be according to findings in the patient rather than preferences or predilections of the doctor. The technique is: listening, understanding, making deductions which are interpreted back to the patient. Every case is a research, but it is difficult to write down what went on - so there is a dearth of statistics.

#### Some Insights learned by the Huddersfield Seminar during the Past Year by Dr Joan Coombs

In this paper Dr Joan Coombs agreed that there was a difficulty in persuading doctors to write about their work and her seminar members had not managed to do this, so she, the Leader, had to talk about them instead. She had asked them to produce some work resulting from the therapeutic use of sensitive, intelligent listening and understanding. They were Family Planning Doctors doing special sessions; who sought to enhance their skills by group study. A 'trawl' was done by the local authority in 1976 and this group was formed - with the addition of 4 male general practitioners - who did not attend regularly and later gave up. Dr Coombs wonders if she didn't cherish them enough!

These women doctors seemed to work by being surrogate mothers to their patients, sometimes a Madonna and child mothering and sometimes a chief cook and bottle washer doormat kind of mothering. This quality of mothering was identified as sometimes a model of femininity, and sometimes to educate and give information. The patient-child felt significant and cared about and received temporary nourishment which allowed growth. There was no shortage of cases and they often were mothers with inadequate bonding to their children resulting in child abuse. As rapport was established with the doctors, feelings were expressed, and the doctors, acutely perceptive, had gut responses but also conceptualised their insights. There was a constant supply of difficult patients, but the doctors never gave up - accepting their patients and making successful relationships with them. The pace with which the patients make adjustments varies.

Some impotent were reported, but the majority of patients were frigid women, who were unsatisfied with mothering, were unloved and unvalued and suffered day to day rejection - some had been abandoned as babies, sent to unloving foster homes and now had only a blank

relationship with a TV set! They claimed emotional compensation from their husbands, who could not provide it. They had unrealistic expectations of their relationship with their children, whom they could not allow to be unruly, and their own anger came out as child abuse. Then they punished themselves by withdrawing from sexual pleasure. The doctor shared their bad experiences and understood their fantasies about their genitals, that they were too small, belonged to others or something was missing. The use of the genital examination allowed observations to be made. The doctors had to guard against over-protecting these patients and keeping them too long - and they learnt how to be banished from the lives of patients who could own their improvement without being constantly grateful. The women became happy in their lives as well as in sexuality.

Dr Anderson felt they had been less successful with their male patients, except that their unsureness in itself may have put them on a level with their patients who may have found it therapeutic.

Dr Jones wondered why the seminar members had not written up their cases.

Dr Tunnadine said that, on the whole, we don't write about our work because it is very difficult to do so.

Dr Main said that one case written in depth is worth more than 100 trivial ones. To a woman, a baby is an extension of herself, and her hatred of it is also irritation with herself. We have heard women say "You horrible little monster" about her own baby. A lengthy report of one case would throw some light on this. This group of Huddersfield doctors had been able to identify with patients wanting to batter babies.

Dr Anne Smith said increasing numbers of our cases are men; how can we get skills to help them? Dr Coombs replied that intelligent, brave listening is the only way. Dr Main commented that the anxiety about curing impotence stops doctors thinking about it. Dr Barne said that men sometimes want a magic answer and resist talking about feelings.

Dr Tunnadine: Baby battering is a symptom as impotence is also a symptom but we treat people and if our patients of any culture are asked what race they belong to, we only need to know it is the human race.

Dr Friedman: Why do women doctors have different feelings about men's problems?

Dr Coombs: Men only comparatively recently started presenting themselves.

The Institute, its Psychoanalysis, debt, differentiation and development by Dr Tom Main

On the second day, Dr Blair took the chair and Dr Main spoke on this subject.

Freud thought of psychoanalysis as a technique of Investigation - using free association, noting all details, with no emphasis on any particular utterance. Then inferences are made - response of patients to these is listened for, it is a scientific investigation of the

unconscious. A mother thinks why her baby may be crying and then she acts - no words need be spoken. In psychoanalysis there are words but the order and the 'music' is listened to as well.

From this emerged the concern that the underlying pain may awaken a patient's memory for certain facts and something can then be done with the facts. Hypotheses are made - but some of these are discarded. When they can be confirmed, then you get theory.

Psychoanalysis is a body of theory which has to be tested, confirmed from facts and re-tested from the body of knowledge developed a method of treatment. Insights gained by a patient make a difference to him and investigation of the unconscious requires the collaboration of the patient who has defences and resistances. These have to be traced to their origins but also respected. It is not an advising or telling method of treatment, but finding out a joint investigation involving collaboration. There is no consoling, moralising or judgement - just a search for the truth. The truth may be painful and unwelcome. An analyst must be compassionate about pain and time his interpretations to relieve anxiety - otherwise it gets frozen.

It seemed that feelings for the analyst might get in the way. Then this transference was found to be a valuable source of information because the feelings transferred to the analyst were an echo of past feelings about others. The analyst too has feelings which cloud judgement - he may for instance be too sympathetic to think. This too is a valuable source of information and is called counter transference. It also became an area of study.

In a doctor/patient relationship, our presence counts and contributes to the atmosphere built up between 2 people. It is unique to these 2 people. A psychoanalyst has free floating attention and listens to everything whereas the psychotherapist selects what he listens to. A GP selects what he examines of the patient before him, because he cannot examine everything. The patient also selects what he says. They also select where they go for help, eg an alcoholic goes elsewhere.

We need patients who can talk logically and have the capacity to communicate. We are concerned in the Institute with whole people with whole relationships. We do not get deeply involved.

The psychoanalyst becomes the principle object in a patient's life. In psychosexual medicine the setting is variable but during analysis there is always the same room, couch and chair, unvarying - no secretary and this sterile field lends to concentration. An Institute interview is contaminated by outside life and the doctors are concerned with a particular task.

A sort of psychotherapy is done by many disciplines - bank managers, GPs, solicitors, clergymen. The latter particularly help with the mourning processes. The field is limited by the setting - if it is a bank, the talk is of money. The training is in the art of listening, keeping quiet, letting the patient lead and we follow. Analysis goes at the patient's pace. - there is no time limit. In the Institute we want quicker results. We are not concerned with scholarship and knowledge, only skills of listening and interpreting. To learn we have to do. To work with our patients we are ignorant doctors who listen to each new patient, who needs a relationship with us and a moment of discovery with us. Each time there is fresh thinking. Trainers with new groups have fresh interest to make observations.

Hierarchical Promotion happens like this: A new idea is enjoyable. Others try the idea and teach it. The idea becomes the rule and the right thing to do - but it started as just a useful idea. An example of this is the Trooping of the Colour. The foot rule discipline was once necessary to get troops formed into battle lines. It is now obsolete, but taught for discipline only. Similarly a vaginal examination is sometimes useful - we must guard against it becoming a rule.

Like psychoanalysts, we do not teach doctors, but we train ourselves, in groups - the group respects the truth and does not disgrace a doctor who takes a wrong step. To begin with we talk about patients and then learn to talk about patients and their doctors. The aim is the liberation of both to be themselves.

We recognise the nature of suffering, and we are ready to investigate it rather than shut it out. We do not reassure - we offer an idea rather than consolation. We get at the truth of the professional life of the doctor - the blind spots, prejudices, cowardices, evasions, predilections. We should not be over anxious nor complacent. The 'internalisation' of the training experience acts as a model of behaviours to be used with a patient. This system is unique and we owe it to Michael Balint.

New techniques of training grow out of new demands, such as the telephone seminar between Dr Main and the Newcastle Advanced Group. We must study new things - how to help male patients and couples. Some we will be able to help and some not. As long as we try to understand before we act. Our selected patients are not neurotic, but healthy, with one area of pain. We do not work at great depth. In groups our professional ego can become more sensitive, so we understand more, more troubles are revealed to us and we do not get an easy life, but an interesting one!

In the Institute study of non-ejaculation, the women doctors felt they could help these men - the optimism and interest of the doctors was a characteristic of the men's relationship with women. This was a research finding and all our work is research, with a unique doctor - a unique patient every time. It is with living people and it gets killed by measuring it. The oral tradition is the best way of passing on knowledge - as mothers tell their daughters about mothering.

Dr Friedman opened the discussion. He was struck by the similarities between our work and psychoanalysis. We are incritical of our patients and select them - each individual patient is studied but it is hard to write down how the doctor changes and how the patient changes. Should we superimpose on this other methods of sex therapy?

Rosalie Taylor commented on a difference to psychoanalysts who never touch the body - we apply body communication to understand fantasies.

Dr de Carteret: As mothers, we all do psychotherapy in bringing up our children, but sometimes we have blind spots - the more we know, the more we realise the harm we may do - we need more training in this work. David Malan's book Individual Psychotherapy and the Science of Psychodynamics already mentioned by Dr Blair teaches a lot about it.

Dr Main: But we have to act on it ourselves and get better at it ourselves by doing it. When we don't understand our patients we give something like behaviour therapy and the doctor gets out of the

difficulty. When you are up a gum tree you run for your life! But we must stick with the difficulty.

Dr Roles: There is a 4 year course in psychotherapy at the Tavistock which at least one of our members has completed.

Dr Shirley-Quirk: Yes, I have - we studied people's anxieties rather than learn theory - the more sensitive we became the more trouble we found.

The last session of the conference was devoted to general discussion.

Dr Tunnadine noted the feeling of some members that there should be more teaching and support in the Institute - perhaps they can get together in groups and support each other - the only way forward is to struggle on; "fall flat on your face", pick yourself up, understand what went wrong and carry on differently.

Dr Roles: Getting people to examine themselves, is a sort of behaviour therapy and that is accepted.

Dr Tunnadine: But we only suggest it if they have expressed fantasies which they can only come to terms with by confrontation with the reality by self-examination, we don't suggest it apart from this.

Dr Rogers: The Institute could be a forum to study other methods of therapy.

Dr Tobert: We are not taught things; we learn.

Dr Blair: We can look at other sorts of treatment if we report it honestly in a seminar.

Dr Rogers: I would welcome groups set up to measure the effect of other treatments.

Dr Smith from Newcastle: In our seminar we asked for formal teaching and had a term off for lectures by experts. We later discarded this method of learning and went back to reporting and studying cases.

Dr Main: New doctors start with primitive technique and then they develop. The Institute is not a rigid body confining these doctors. When a psychiatrist worries about what the coroner will say if the patient dies - he is really worried about what he will think of himself - not having been through enough, etc. Harsh judgements come from within ourselves.

Dr Griffiths: Understanding a negative counter transference is a way in to knowledge of the patient. Why and how it arises - it handicaps the work, but so does the positive counter transference.

Dr Main: The work is difficult. If you want an easy life, you won't get it!

Dr Griffiths: Are the words love and hate irrelevant? They haven't been mentioned.

Dr Main: We are interested in these emotions, and have mentioned compassion, anger, hating babies - but we tend to refer to a love affair these days as a 'relationship'!

Anonymous written question: Should I be doing a 3 year psychotherapy course?

Dr Main: Yes, if you want to be a psychotherapist - if we study other things, we become therapists in the field we study - but this Institute is the only one of its kind in the world.

Dr Suri: Why do female doctors feel uneasy with male doctors? I don't.

Dr Roles: The doctor feels the man's hostility towards women and has to work through it.

Dr Coombs: When women doctors use the basic listening approach with men they become easier with them.

Dr Parry: It is difficult when men come who have no partner at present.

Dr Tobert: They are bringing their fears and doubts about themselves - the essence is to understand these.

Dr Elder: In future conferences could we have case presentations? This could be a celebration of our skills. The doctors here have a lot of living clinical material - we could gain by discussion of individual cases. In seminars we report cases as they go along - in a conference we could have a completed case. None of us have perfectly treated cases - this would not matter.

Dr Thexton: Last year at Cheltenham there were vivid cases of post natal loss of libido. It was possible to use knowledge of other cases when I next met one presenting this way.

Written question: How does an analyst manifest compassion and how does he contain his feeling so the patient does not feel let down, rejected, hurt and upset?

Dr Main: This will occur, human fantasy being what it is, the patient sees the analyst at he sees him. The analyst accepts the negative feelings and tries to think what it is about.

Example: When a holiday is near, patients get angry and are in pain about partings. The analyst intervenes to put the patients in touch with the pain.

-o-0-o-

#### EDITOR'S NOTE

The reporting of the conferences is verbatim and is written as understood by the reporting doctors.

We apologise if the speaker feels that the meaning is not conveyed as they had intended.

Confidentiality has been respected and a few omissions have been made to ensure this.

## EDITOR'S NOTE

The full report of the Proceedings of the 1979 Conference at Cheltenham are very much delayed but are kindly being printed as usual by Wyeth and will be circulated as soon as they are available.



# HAWAII

FIFTH INTERNATIONAL CONFERENCE ON  
VENEREAL DISEASE, FAMILY PLANNING AND HUMAN SEXUALITY

(B) FIFTH INTERNATIONAL CONFERENCE ON VENEREAL DISEASE,  
FAMILY PLANNING AND HUMAN SEXUALITY - Dr Robina Thexton

Eight members of the Institute of Psychosexual Medicine and a Family Planning Nursing Tutor were the only British participants at this Conference, apart from Dr Malcolm Potts, who came on the last day to speak on 'Worldwide Family Plannint'. The conference was held in Honolulu from 24 June to 1 July and was sponsored by the Institute of Psychosexual Medicine, Planned Parenthood of Canada and Pharmacists' Planning Service, USA.

The venue was idyllic, most of staying at the Hilton Hawaii Village, where the lectures also took place in a huge air-conditioned conference centre. They started at 8 am in 3 different rooms, no paper being longer than 20 minutes. After a coffee break there was a plenary session until 12 noon, and between 1.00 pm and 3.00 pm there were further papers and workshops. An abstract of each paper appeared in the handbook, so that it was possible to select what one heard, but inevitably this meant missing some papers which one would have liked to hear.

The titles of the papers were varied, eg "Promoting a National Condom Campaign", "Sexuality Workshop for Men only with a Female Leader", "An Assessment of Education and Information Activities in an American Family Planning Program". Some had confusing jargon titles, eg "A Social-psychological/social-structural Framework for Understanding Adolescent Intercourse and Contraceptive Behaviour". This particular paper was read in a monotone, with confusing visual aids! The British papers in contrast were refreshingly concerned with work actually done with patients rather than studies carried out from statistics and questionnaires.

Dr Morag Bramley from Sheffield gave 3 papers - the first about psychosexual problems revealed in STD Clinics, where the infection was due to an extra-marital affair because within the marriage sex had gone wrong. Dr Bramley had treated the 4 men whose case histories she described, by conducting an unstructured interview, facilitating discovery and interpretation of the patient's fantasies, interpretation of the doctor/patient relationship, and use of the genital examination as a psychosomatic event, enabling the man to voice his feelings about sexuality.

Dr Bramley's second paper described a study she carried out which suggests that women taking oral contraceptives are protected from trichomonas vaginalis infections, although more prone to yeast infections. Her third paper was a study of haemophilus vaginalis in a family planning clinic. 522 women had vaginal specimens taken at enrolment, as had 380 who returned for an anniversary visit. A heavy vaginal discharge and offensive odour was common when haemophilus vaginalis was cultured. The significance of the findings and the indications for treatment were discussed.

Drs Rosemarie Lincoln and Robina Thexton gave a joint paper describing a study of 22 men who failed to ejaculate during intercourse with their wives. To understand the psychodynamics of this symptom, Institute of Psychosexual Medicine doctors met fortnightly over 2 years and reported their unstructured interviews with these men during which unconscious fears and fantasies were listened for. The 'here and now' feelings arising during the consultation were used, both in understanding and interpretation. Physical examination of the genitals sometimes provided a 'moment of truth'! Among these men 7 were born as a twin (13 times the expected incidence of twinning) and all but 2 of the others had siblings of whom they had been jealous. There had been resentment at the mother's inability to give the patient full attention because of the rival, and early lack of support from the father who in many cases had left home or died. The relationship with the woman doctor appeared to reflect the need of these men to stimulate, promise much and give pleasure to women, yet ultimately to disappoint them. They could not at a sub-conscious level tolerate the idea of a baby - another rival - and their wives did not, of course, become pregnant. 12 of them got better during the course of the study - they were those who had come by themselves, asking for treatment to gain orgasm and increased pleasure. The other 10 were not cured in the 2 years (though some of these eventually achieved ejaculation). They had been brought by their wives who wanted them to produce sperm for a pregnancy.

Dr Prudence Tunnadine led the British group in a demonstration seminar for the study of psychosexual problems. Those who came to this workshop were workers in this field in many different settings in the United States and Canada.

In the evenings we were able to dine in exotic restaurants, attend a Polynesian feast with entertainment by hula girls and fire-dancing men, sail round the bay on a sunset cruise, and frequently bathe in the warm blue water on Waikiki Beach.

It was good to meet so many enthusiastic workers in the field of human sexuality, not only from North America, but also Thailand, Mexico, Peru, Kenya, Australia, Malaysia and Saudi Arabia. The whole trip, which included lecturing to the Family Planning Division of the Department of Obstetrics and Gynaecology of University College of Los Angeles on the way, and a sight-seeing tour of San Francisco on the way back, was packed with interesting experiences.

(C) THE BERLIN CONGRESS - Dr Judith Dewsbury

The 6th International Congress of Psychosomatic Obstetrics and Gynaecology was held at The Reichstag in Berlin in September. When asked to write a report of the conference I readily agreed, but once home in my "working mum's" role I found it hard to squeeze the task in between the demands of patients and family. But then this was the theme of the conference - "Women in a changing society".

Nearly 1,000 participants from 50 countries attended and between them read over 150 papers. There was an impressive opening ceremony with music, held in the Philharmonie Concert Hall. This was followed by a panel discussion by 10 distinguished female scientists. It was fascinating to hear them and later to talk to them and other men and women all over the world and to realise that, despite often quite marked cultural differences, the mechanism of illness induced by social stress and changing roles was not just a local but an international problem.

Australia had great cultural and generational conflicts at present, said Dr Dennerstein, a female psychiatrist, with a 40% influx of immigrants after the war, half of their total population was under 25 years old. Women were not comfortable in their new executive roles, confusing assertion with aggression. They were unable to cope with society's expectation that they could be as sexually responsive as men. Their husbands too felt equally threatened as they saw their previously dominant male marital role undermined. Consequently Australian men were now commonly developing sexual problems.

It was sad to see how the previously happy go lucky primitive communities developed modern ills as they became more wealthy and westernized. Dr Kreimer of Peru told how they had now introduced regular lessons in "Childbirth without pain" to their schools and colleges, as even the very young girls were conditioned to expect great discomfort and had a positive fear of child birth; a far cry from their grandmothers, who happily delivered in the bush and carried on working afterwards.

This was my first international meeting. I found it exciting and a great privilege to meet so many people, some of whom has previously just been household names. Inevitably the more valuable discussions certainly the most memorable, seemed to take place when we were most relaxed at the various informal gatherings; at the generous wine reception after the opening ceremony, during the happy dinner cruise on the Wannsee (when further fear and excitement was added by an East German gunboat, which seemed too interested in the ship carrying all the executive members of ISPOG, including Professor Norman Morris and his family) and at the intervals of the New York ballet performance some of us attended.

Drs Margaret Blair and Fay Hutchinson were the only Institute members I met there. We had all visited East Berlin and were keenly aware of the strong contrast between the glamour and wealth of West Berlin and the drabness of the Eastern Sector. From the windows of Auditorium C, behind the Berlin Wall, we could see 4 manned gun towers - a constant reminder to us all of the value of freedom.

Mr Elliott Philip discussed the effect of gynaecological surgery for cancer on woman's future sexual activity. He suggested that it should be the doctor's responsibility to raise the discussion at follow-up and stressed the need for adequate pre-operative counselling, to cover both the true nature of the disease and operation to be performed. 20% of women who had a mastectomy avoided sexual activity because of guilt over their body image. This could be reduced by counselling. Ugly abdominal scars and loss of body hair from chemo therapy also disturbed the women's innate and not unhealthy feminine narcissism. After hysterectomy and other genital cancer operations patients needed to know when it was safe to resume sexual activity and to be advised on the use of lubricants, and perhaps for the need for daily digital stretching. Similarly, Professor Willi of Zurich emphasized the need to counsel both partners before and after operative procedures of this nature.

There were many papers on the problems of termination of pregnancy. The West Germans have only recently introduced legalized abortion and were going through the same emotive and practical problems that we had faced in the past in Britain.

One was left with an overall impression that British psychosexual counselling and family planning is of a high standard. Psychiatrists at the conference seemed to have great insight into their patients problems but to me, much of their interpretation was highly speculative and unsupported by evidence. It was a privilege to have attended this conference and I was greatly impressed by the sensitivity of the contributing European obstetricians and gynaecologists, so many of whom said "we must listen more to our patients".

#### (D) THE GYNAECOLOGISTS' DILEMMA - Dr Anton Dewsbury

The Berlin Conference contained a most intriguing Balint workshop of perhaps 40 participants on the 'Emotional situation of the gynaecologist'. Perhaps I should add that in this group most of the gynaecologists were middle aged men. It was suggested that the gynaecological examination was in many ways a sexual act, or at any rate had sexual implications. These gynaecologists admitted feeling obliged to suppress this emotional reaction. But, it was pointed out, gynaecologists who suppress their sexuality are also likely to suppress their emotionality and so be less effective at a psychosocial level in helping their patients.

There was an attempt to minimize the sexual content of the internal examination by some discussion of whether children who came with their parents should be allowed to watch. Some felt they liked young girls to be present for their education and thought that the children found it interesting. "After all, the examination is not unpleasant". Another described the gynaecological examination as an "aggressive act" from which children should be barred.

A psychiatrist listening to all this suggested that the gynaecologists should ask themselves what took them into this career choice. He said that if you were to ask psychiatrists what led them to their choice of profession they would say that they had had trouble with their souls. So what of gynaecologists? One had chosen out of gratitude to mother who had escaped serious gynaecological illness, another was bored by men's illness and a third enjoyed the company of women.

So the topic arose of how these male gynaecologists should deal with the emotional vibrations created by their patients. Should they repress them or express them? Should one hug the woman who cries when you tell her she has cancer? The wife of a gynaecologist sprung up to describe this as a very threatening situation! It was agreed that sexual feelings had a part to play in the consultation, as did feelings of helplessness or aggression. But that one can identify too much.

The women in the audience pointed out that the men had falsely presumed that the examinations' threat lay in the hint of sexual pleasure. One woman said that she felt like a prostitute when she was being examined and another felt aggressively towards her examiner. The palpable hostility of the female moiety of the audience spoke volumes, and it seemed likely that some of these women had mistaken the suppression of feeling in their examiner for rejection and felt angry and alienated by the experience.

"Yet", as one gynaecologist remarked, "if I deal feelingly with the problems of my patients all day, I return home sexually busted". What does one do with these primitive feelings which have been evoked? It was not always appropriate to reflect them back to the patient, but even more disastrous to take them home. Was this, several asked, the role of the Balint Group - to defuse these feelings? It was the best solution that emerged.

Several of the younger women in the audience asserted the need for more women gynaecologists, because women had often experienced similar psycho-social crises to their patients. The implication that this would remove the potentially sexual and aggressive nature of the gynaecological examination is, in the author's opinion, unrealistic. These forces may be changed or reduced but still remain. Indeed the denial and repression of the young women in the audience contrasted fascinatingly with the over-zealous honesty of the male gynaecologists.

(Editor's note: Dr Anton Dewsbury is not a member of the Institute but he had accompanied his wife to Berlin and we felt that his report might be of interest to members).

(E) CASSEL HOSPITAL DIAMOND JUBILEE CONFERENCE - Dr Jean Pasmore

This conference was held in July at Gypsy Hill Training College and was generally regarded by all concerned as an outstanding success. Some 200 professionals attended - doctors, nurses, psychologists, child psycho-therapists and many psychoanalysts. The majority were in residence for all the 5 days, but a number attended for one of the days only.

The scientific programme on the conference theme of the use of psychoanalysis in health care was subdivided into daily themes of:

Monday	The Therapeutic Community - its theory and development
Tuesday	Structure, Process and Dynamics in Health Care Institutions
Wednesday	The Application of Psychoanalysis in the Training of Health Care Workers
Thursday	Research - Ideological and Methodological Issues
Friday	Psychoanalysis and the Core Experience of Clinical Work in Health Services.

Introductory papers on each day were read by distinguished invited speakers and further related papers followed. At the end of each day several papers described various aspects of Cassel Hospital work in simultaneous workshops.

Besides the many distinguished speakers there were some especially notable visitors - Countess Mountbatten of Burma, who addressed the conference on Friday; Dr Gerard Vaughan, Minister of State (Health) who assured us of the future of the hospital; Professor Baroness J McFarlane, professor of nursing at Manchester University who chaired the discussion on "The Nursing Process and Psycho-social Nursing"; Dr John Horder, the President of the Royal College of General Practitioners, and the Mayors of Richmond and Kingston.

Many interesting papers were also given by Staff of the Tavistock Clinic and Institute which also celebrated its Jubilee this year. This social events included a reception on the first evening, a party at the Cassel Hospital on Tuesday and the Conference Dinner on Thursday. These gave delightful opportunities for old friends and colleagues to renew acquaintances formed at the Cassel over the years and to meet members from many overseas countries attending the conference.

Dr Main's address on the opening morning traced the history and development of the hospital and emphasised the link with the Cassel Family throughout all its stages. This family atmosphere characterised the conference also, allowing the participants to disagree and argue against a background of steady allegiance to the ideas and interests which lie behind the ethos of the hospital and owe their origins to psycho-analysis.

While various papers throughout the week contained many ideas of interest to the Institute - those of Thursday and Friday were particularly relevant.

Dr Malan spoke of the work of Dr Davanloo, which he saw as a landmark in psychotherapy. Professor Wachtel gave a most interesting account of the relationship between Psychoanalysis and Behavioural Therapy - and Dr Hildebrand developed a theory from a study of Psychotherapy in the 'Older patient' that there is after middle life a revival of the classic sexual roles.

Enid Balint spoke on the doctor/patient relationship in the 1980s emphasising that the use of this was the essential element in Michael Balint's work with General Practitioners. She quoted Professor Loch "The doctor's aim is to help a suffering patient by understanding him. This enables the patient to enlarge his capacity to understand himself".

In Dr Wilson's introductory address he spoke of the plan for an Institute of Applied Psychoanalytic Studies to be based on the Cassel Hospital Site, which would be funded from other sources than the source funds of the NHS. This would allow the Postgraduate Training and teaching function of the Hospital to expand and develop as befits its importance.

## V. TRAINING

### (a) Seminars

A few vacancies exist in seminars in various parts of the country and interested associates and members of the Institute should contact the Director of Training, Dr Pruedence Tunnadine, 111 Harley Street, London, if they would like to join a seminar.

#### Advanced Seminars

There are vacancies in Dr Main's seminars in Newcastle, Guildford and Sharpthorne - and in Dr Tunnadine's seminars in London, Leeds and Bromley.

#### Leader Doctors Seminars

Are held in London by Dr Blair, in Newcastle by Dr Main, and in Leeds by Dr Tunnadine.

#### Leader Doctors Workshop

Dr Blair now runs the Leader Doctors Workshop in London on alternate Wednesdays.

#### Nurses

Several nurses training groups exist led by Institute members and there are two nurses groups led by Doreen Clifford. Another trainee nurse leader will start soon.

### (b) Formation of New Study Groups - Dr Pruedence Tunnadine

At the York Conference the need of trained doctors to meet both for mutual refresher support, and for the "postgraduate" study of specific topics was again aired. Again I expressed my own hope that such doctors would get together at their own initiative to do this, and where possible to make some attempt to collate and publish their findings. I reiterated that the Institute cannot be directly responsible as a training organisation for such independent "postgraduate" initiatives - nor should it wish to own them - but that our leaders are individually willing to consider requests for assistance in such projects should they be made. I was delighted that several such projects attracted response. Among the names of those interested were included some with accreditation in leadership, so it may well be that even this central support may be unnecessary. Those who signed on for these topics, and those of the membership absent from York who would be interested, are asked to get in touch with the convenors concerned as soon as possible.

1. A refresher seminar for trained doctors to meet in central London on Tuesdays from 5 pm - topics to be decided by the membership once met. Please contact Dr Jane Kilvington, 122 Marshalswick Lane, St Albans. Tel St Albans 53156.
2. A group to study experiences in Rape Counselling to meet in north London. Please contact Dr Judy Gilley, 24 Brookland Hill, London NW11. Tel 01-458 1348.
3. A group to study the treatment of couples. Please contact Dr John Rogers, 11 Turner Road, Slough. Tel Slough 22495.

4. A group to study the treatment of men suffering from impotence. There was a large response to this project. A number of those interested seemed to live in the Midlands and North. Dr Margaret Blair would be available to lead a research/study group if enough were able to meet in London. Please contact her in the first instance. Those from the Midlands/North included some with leader experience. Once the full demand can be assessed, it may be that 2 or even 3 such groups might be planned for the geographical regions involved. (The Water Butt, Cooks Lane, Walderton, Chichester. Tel Compton (W Sussex) 335).

May I reiterate my delight that we are at last achieving the freedom to deal with these longstanding dissatisfactions by making these initiatives and demanding help with them, rather than, as for so long, waiting for that mythical animal, the faceless "Institute", to thrust them upon us!

5. Will doctors interested in forming a new Study Group on a Wednesday once a month, in London, contact Dr Rosemarie Lincoln, Idlehour, 67 Yarmouth Road, Thorpe, Norwich, Norfolk. The Wednesday would coincide with Dr Blair's Leader Doctors Workshop.

(c) Panel

Dr Robina Thexton has been appointed Panel Secretary in place of Dr Carol Butcher who is expecting a baby.

The Ordeal - Dr Anne V Smith

I am putting pen to paper in the hope that I give Dr Morrow more panels to arrange.

I sense among my own peers a tremendous reticence to put themselves to the Panel, yet superficially they say "Yes, I would like to put myself forward. Yes, I shall apply" - and nothing happens. In my opinion we can only move on in our work with increased awareness of ourselves and patients if we open ourselves to constructive criticism at seminars - and Panel Assessments.

My ordeal began at 6.30 am one cold December morning. Frank played taxi driver and took me, our son Peter and my friend Pat to the station for the 7.35 am train. BR and my companions did their best to muster my spirits but a little voice kept haunting me "How did you get yourself into this situation?" I half hoped that BR would come to the rescue and delay me so that I missed the seminar - but no - exactly on time I reached Kings Cross and was whisked by a London cabby to Harley Street, dumped unceremoniously on the pavement and left with a turmoil of thoughts as my family were conveyed to the zoo!

In fear I rang the bell and was ushered upstairs to the 'relaxing, private flat' - only someone had forgotten to tell me to relax! The coffee was welcome and good but the well meant words of "Relax, it's not an ordeal!" made me laugh inside. Just imagine me saying to a patient who is frigid "Relax, it's not going to hurt".

After a few minutes my companions in 'ordeal' arrived and we sympathised with each other. It helped to know they too were apprehensive.

The great moment arrived and we were shown into the living room to meet Our Panel. What a relief to see 2 faces that I had seen before. After brief introductions the seminar began - everyone participating. Each candidate was asked to present an ongoing case, so in 1½ hours we worked through 3 cases. I personally found that the concentration needed for the cases from people that I did not know made me mentally exhausted. Strangely the most relaxing episode was my own presentation. I find it so easy to lose myself back in time as though I were once again with that patient and the people with me in the room became, dare I say, less significant and less threatening.

With a great feeling of relief we were released once more to the outside world to search for lunch. That lunch hour passed pleasantly but too quickly to allow a proper post mortem! (By the way, Eileen and Doreen, if you are reading this, I have not forgotten the drinks I promised you - see you in York.)

After lunch back to face the Panel - solo. I felt distinctly sorry for myself having to face them alone. Again we had a seminar. I felt at the end of my case and discussion that the flesh had been picked from my bones and I was left feeling naked - exposed to the world. Yet something in me said they have done their job well. They now know my capabilities, my weaknesses as well as my strengths and if they do not like what they see I cannot do anything about it.

While the Panel debated their verdict I was asked to wait in the kitchen and to make myself a coffee. Such was my exhaustion that even that simple task was too great for me. A few minutes passed and I was asked to return. With smiles all around I was told that I would be recommended to the Institute as a Member. The relief of tension was tremendous and I flew along the street to find a telephone in order to share my news with Frank.

Later that evening 3 tired figures wended their way back to Newcastle - 2 tired from the zoo, the park, London buses, Madame Tussauds, etc and one exhausted, yet satisfied, from facing the Panel.

So I say to all associate members, yes the Panel Assessment was an ordeal, but one well worth experiencing.

When one of the seminar leaders informed my group that I was now a member, I overheard one person say "Anne? Has she passed the Panel? Really? Huh! If she can do it so can we." Well, if you are reading this get off your chair and GO AND DO IT! Talking is not enough. Let us have some positive action from our associate members and then we can get on and develop our work to the full.

(d) The Panel recommended to the Council that the following doctors should be accredited as full members:

Dr Ian Calvert - The Martins, Vicarage Street, Painswick, Glos.  
Dr Barbara Devereux - 6 Glebe Close, Gunton Church Lane, Lowestoft, Suffolk.

Dr Margaret Gill - 10 Peterswood Hill, Ware, Herts.  
Dr Judy Gilley - 24 Brookland Hill, London NW11.  
Dr A Morgan - Three Queens, 1 Deep Street, Prestbury, Cheltenham.  
Dr Rena Sampson - 27 Oakleigh Park South, London N20.

## VI. CORRESPONDENCE

(a) A letter has been received from Dr Geraldine Howard of The Garden House, Warren Park, Kingston Hill, Surrey, in which she points out that when publishing articles on Psychosexual Medicine, Journals are reluctant to publish the names of seminar members who have contributed to the research upon which the article is based. Dr Howard feels that it is important that work developed from a seminar should have general recognition although it may be written by a single author. She suggests that we might make this clear to the editors of Medical Journals.

(b) A letter has been received from Dr Jessie Yorston of Luibeg, Gardiners Lane, Romsey, Hants.

Here is a modified extract from a letter which I wrote to the programme secretary after the York Conference. Perhaps other people who attended the conference might like to put forward their views.

I have been a member of the Institute for several years and am convinced of the value of its training methods and I attend each conference in the expectation that these will increase my knowledge and understanding of the work which I am doing in the speciality - otherwise it is wasting time. Maybe it was my own fault that I gained no further insight from this year's conference, but I do not really think so because I met many others feeling the same way. I have become unhappy about it and if the majority of the members felt dissatisfied is it not possible that there is something wrong with the direction of the Institute?

It is true that the Institute is in its infancy, but infants should be allowed to develop and not remain attached to their mothers apron strings. Adolescents have to find out for themselves by learning and by gaining experience from others, by making mistakes, and by experimenting with ideas. Surely this is what we are trying to do. Certainly I am seeing couples when appropriate and I am not always confining myself to the one to one relationship, and I am occasionally using some behavioural techniques, in conjunction with the skills learned in seminar training. It works, so why are we inhibited in discussing this and actually learning from it?

What I should like to see at future meetings is a reasonable proportion of outside speakers working in the field of psychosexual medicine who use other methods; in order that we may learn and exchange experiences and views - surely we have enough confidence in ourselves to do this in the open? I should also prefer a different chairman at each session so that various views may be more fully expressed.

Also that some time should be spent in small groups where perhaps more constructive thinking can be done.

Yours etc.

VII. BOOK REVIEW - Miss V Thompson

TEXTBOOK OF SEXUAL MEDICINE - R C Kolodny, William H Masters and Virginia E Johnson. Little, Brown & Company, Boston, Massachusetts, \$18.95

---

Kolodny, Masters and Johnson have combined their expertise in Medicine and Sexology to provide a balanced guide to the recognition, understanding and treatment of both the biological and the psychological impacts on sexuality of various medical and surgical conditions.

The size of this book should not intimidate as good print, generous spacing and 2" (5 cm) top and left lateral margins make for easy reading. References and Index are also commendable. Diagrams and illustrations are clear but there is a confusing transposition of figures 9.5 and 9.7 under their inappropriate headings.

Of the chapters on the sexual implications of specific illnesses, those on diabetes mellitus, alcoholism and chronic renal failure are outstanding in value to any physician. The sexual impacts of pregnancy and infertility and the implications of various methods of contraception, gynaecological disorders and surgery are well covered and a chapter on sex and the oncology patient includes a description of the implications of drugs currently used to treat cancer. An exhaustive list of the sexual effects of both medically prescribed and illicit drugs is also of obvious value.

The topics of sex and the handicapped, homosexuality, transsexualism, and in particular, rape, are sensitively presented.

25 years of clinical experience and research at the Masters and Johnson Institute provide a base from which the Authors define their concepts and methods of sex therapy, culminating in a final chapter on the practical management for sexual problems. Written for the clinician who is not a sex therapist, it offers advice on how to approach diagnosis and assessment, whether and when to make referrals and how to undertake forms of patient counselling that stop short of sex therapy.

What does this book offer members of our Institute apart from a useful source of information on known effects of disease on human sexuality?

Firstly, Chapter 19 gives a clear description of Masters and Johnson's concepts of sex therapy and it is interesting to see that they only regard sensate focus as a component of therapy. The psycho-therapeutic relationship takes priority and many of our accepted concepts are recognised by them, for example, the need not to know.

They too use the doctor-patient relationship for understanding but justify conjoint therapy, ie treatment of husband and wife simultaneously, as they see that it is the relationship between them that is in therapy.

Chapter 20 deals with male sexual dysfunction and it is of interest to find that they feel they see few cases of relationship problems. Their cases are predominantly organic in origin, yet they are able to state that most men with impotence have normal levels of testosterone, suggesting that most instances are of psychogenic, rather than biological, origin.

Chapter 21 on female sexual dysfunction stresses the importance of a careful vaginal examination (done by a female doctor) and its therapeutic value but fails to integrate interpretation and makes no recognition whatsoever of fantasy formation.

They tell us that, whilst orgasm occurs naturally in women who have had surgical excision of the clitoris, the specific neurophysiological mechanisms of orgasm are not known and also that the precise relationship between hormones and sexual behaviour is not clearly understood at present.

I was left with a feeling that, whilst we could learn some useful facts from the book, they could certainly learn much from us when they discuss why some patients respond and others fail to do so in the otherwise commendable final chapter.

#### VIII. NEW MEMBERS (ASSOCIATE)

- Dr Z Osman - 8 Loveday Road, London, W13 9JS.  
Dr Gillian Cardy & Dr Ian Cardy - 'Leaze Cottage', Watsons Court, Melksham, Wiltshire, SN12 6JX.  
Dr Anne Shaw - 109 Eastcote Road, Pinner, Middlesex, HA5 1ET.  
Dr F V Griffiths - 6 Oakfield Street, London, SW10 9JB.  
Dr Bernard E Ryan - 13 Montford Close, Horsforth, Leeds, LS18 5SX.  
Dr Althea de Carterat - 38 Mulgrave Road, London, NR10 1BT.  
Dr Pam Elder - 1 Mandeville Drive, Surbiton, Surrey.  
Dr Patricia Brooks - 18 Emanuel Avenue, Acton, W3 6JH.  
Dr Christopher Sage - 4 Lansdowne Terrace, Twyford, Berks, RG10 9DY.  
Dr K E Schopflin - "Lime Tree Farm", Snow Street, Roydon, Diss, Norfolk, IP22 3RZ.  
Dr S A Bolt - The Medical Centre, The Hythe, Southampton, SO4 5ZB.  
Dr P C Gupta - Dept of Genito-Urinary Medicine, Scunthorpe General Hospital, Scunthorpe, Humberside.  
Dr Magdy K Ishak - Queen Elizabeth Hospital, Gateshead, Tyne and Wear, NE9 6SX.  
Dr Jean Bowie - 167 Bishop Road, Bishopstone, Bristol, BS7 8NA.  
Dr D P Feeney - "Bixter", Cade Hill Road, Stocksfield, Northumberland.  
Dr Anne Rowene Lakin - 57 Cambridge Road, Middlesborough, Cleveland, TS5 5NL.  
Mr Elliot E Philip - 94 Harley Street, London, W1N 1AF. (Subscribing Member)

#### Change of Address:

- Dr Ruth Skrine - now of Castanea House, Shaun Castle Lane, Bath, Avon. Tel: 0225 65440.