

DIARY OF EVENTS 1981 - 1982

INSTITUTE MEETINGS

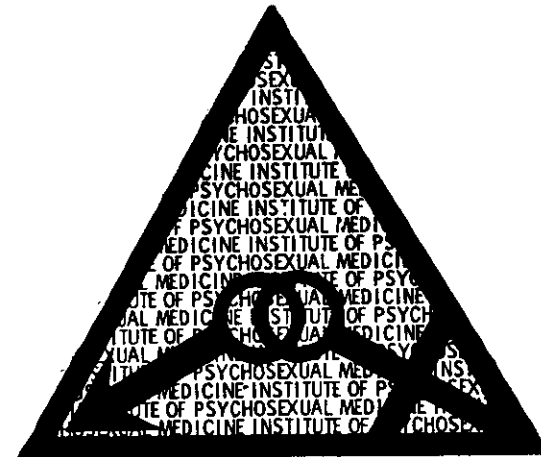
1. Residential Weekend to be held at the Golden Valley Hotel, Cheltenham, From Friday, 18th (at 5.00 pm) to Sunday, (after lunch) 20th September 1981.
2. Annual General Meeting To be confirmed
3. Institute of Psychosexual Medicine - International Conference: 7th-10th July 1982 at the Hotel Metropole, Brighton.
4. Residential Weekend Autumn 1982 Nottingham

OTHER MEETINGS

1. British Psycho-Analytical Society is holding the following one day lecture and discussion courses:  
6th June 1981 - "Self-Destructive Acts: A Psycho-Analytical Approach"  
4th July 1981 - "The Mind of the Child - Development and Assessment"  
Details from 63 New Cavendish Street, London, W1.
2. 5th World Congress on Medical Sexology Jerusalem. June 1981
3. 2nd Congress of Andrology. Tel Aviv. June 1981.
4. International Symposium on Fertility Control. 1st-3rd June 1981 in Tunis, Tunisia.

Newsletter 19

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**Institute of  
Psychosexual  
Medicine**

INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No 19

May 1981

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Dear Colleagues

Our President Dr Tom Main celebrated his 70th birthday in February. There were festivities with his family and also some of the "golden oldies" of the Institute at that time, but the AGM was the first opportunity that we had to formally congratulate him on his youth and vigour and to thank him for all the years of work and wisdom that he has given to all his seminars and the Council of the Institute. The warmth of affection which we feel for him was clearly expressed by all the members who were able to attend the meeting and by the many contributions to the presentation gifts - a picture of Richmond, and books about birds and (no, not bees!) but fishes. Dr Tunnadine expressed our love and gratitude and our very best wishes for many more happy years. There is a commemorative photograph of Dr Tom Main available (details for obtaining one are given later in this Newsletter).

Another step in the evolution of the Institute - the First International Conference. This is to be held in Brighton in July 1982 and the first announcement about this is enclosed with the Newsletter. Members who have participated in other conferences have become increasingly aware of the real interest of other doctors in our training and work, and, on the other hand, the very limited opportunities for presenting the work to appropriate audiences. Research studies by Institute Members which have resulted from prolonged and painstaking work in seminars, are valuable and often unique (for instance the prospective study on couples seeking vasectomy).

There is often a reluctance by our doctors to present or to write about their work and previously it has been difficult to find a publisher for the papers which have been written. Editors seem to be more interested in statistics and control studies rather than papers about understanding human beings. Brighton will give us an open forum in contrast to Institute meetings which are for members only. Quite a celebration!

At the AGM Mrs Nancy Raphael suggested that there might be a change of the name of the Institute to include the word "training" but many people felt that the Medical Profession and public had just begun to recognise our name and perhaps this was not the time to make changes.

The Registrar again stresses that all members of seminars should be asked to complete the registration cards of their training and employment in Psychosexual Medicine. There is no other way of proving which doctors have participated in Institute training because some doctors do not become members.

Please read the letter from Dr Elphis Christopher concerning the needs of SPOD for doctors interested in sexual counselling for the disabled.

The Newsletter has again changed shape and its present format should be more economical as well as giving more concise reference information. I hope that you will all feel that it is an improvement.

Yours sincerely,

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Residential Weekend: Friday, 18 September - Sunday,  
20 September 1981  
Golden Valley Hotel, Cheltenham.

Provisional Programme

Friday:

2.00 pm Council Meeting  
5 - 6 pm Business meeting for all Institute Members  
7.00 pm Sherry reception and Hot Buffet Supper  
8.30 pm "Use of videotapes in Training"

Saturday:

Three papers about the problems seen in Obstetric practice. "Studies in Doctors seeing patients presenting with male impotence."

Sunday:

A selection of papers on work in the Institute.  
"Celebration of Cases."

Cost for Three Days: £59.00

FOR DETAILS OF OTHER MEETINGS - SEE BACK COVER

MESSAGE FROM THE TREASURER - DR JANE BERRY

I have now taken over as Treasurer from Fay Hutchinson. I regret that there will be some unavoidable delays in making payments, clearing cheques etc during the next few weeks while all accounts are transferred. I must apologise for any delays which do occur. I will do all I can to minimise inconvenience to Members.

Membership Subscriptions Please note that the rates for Membership of the Institute changed at the AGM on 20 March 1981. The new rates are:

Members	£15.00 per annum
Associate members	£10.00 per annum
Subscribers	£15.00 per annum

It would be a great help if Members could amend their Banker's Orders accordingly - as soon as possible - before the subscription is due. This will reduce the number of reminders that will have to be sent and therefore keep the costs incurred in collecting subscriptions to a minimum.

May I remind Members who have covenanted annual payments to the Institute for a 7 year period, that it is now possible to make an additional covenant to cover the increased membership subscription, if you so wish. New covenant forms are being prepared and I will send them to Members on request.

Where to contact me My address is:

Rose Cottage  
Gilbert Street  
Ropley  
Nr Alresford  
Hampshire SO24 0BY  
Tel: 0962-77 3233

I hope to get the financial affairs of the Institute running smoothly again as soon as possible following the change of Treasurer. Please don't hesitate to contact me with any queries or problems which arise.

## ARTICLES

### A. THE GOSSAMER GROUP - DR BARBARA DEVEREUX

In the Autumn of 1979 amongst the adverts and bills in the post came a letter from the Postgraduate Secretary of our Health District - the 'Coastal Strip' - inviting any doctor interested in a 'Balint -type' series of meetings to get in touch with him. As a result, eight General Practitioners and I (then part-time GP, part-time Family Planning) met for an exploratory meeting in the common room of a group practice in Great Yarmouth, three of whose partners were present, together with a Clinical Psychologist (male) who works locally, and a University Student Counsellor (female) from the University of East Anglia to act as 'facilitators'. It was decided to meet fortnightly for ten sessions and the members agreed to make it a commitment.

The 'facilitators', who had already been asked to attend the group, were to be paid and some of the first session was spent discussing how the group should run, and whether it was necessary to have these 'experts'. As I was used to seminar training and also had some experience of group-leading myself, I felt that we could probably manage alone - but found it difficult to express these views, partly as I was the only other woman present and did not wish to appear to be pushing the female counsellor out; also, partly because one or two of the GPs expressed fear of the group situation and wanted the security of recognised leaders.

The 1980 sessions ran largely on the basis of a member bringing the case history of a patient whom he had found 'difficult' for whatever reason, followed by group discussion of the doctor-patient relationship. Interpretation of the feelings aroused in the doctor and in the patient and his family were discussed, with increasing insight by the group, and occasional meaningful intervention by the 'facilitators', but several members -

especially one Scottish doctor - felt still that their contribution was expensive and at some sessions must have been "about fifty pence a sentence"! We began to know each other better and to come to terms with our own hang-ups, and it was interesting that one member felt that he could express and expose himself more freely on the one night when his younger partner was unable to be present. He, in fact, revealed a fear of dominant women affecting his doctor-patient relationships, and dating from his upbringing from babyhood by two Scottish school mistresses. Several doctors found that they had fixed ideas of the roles which men and women ought to play and found themselves, for example, becoming angry at a woman who retired to bed too easily, instead of caring for the family (? because they would like to be able to opt out as easily?), and there was considerable discussion of the emotions of anger, love and pity which patients engender and how we react to them.

The group disbanded after the ten sessions (about Easter time) with a strange sense of achievement and loss.

In the Autumn of 1980, a letter was again circulated to all General Practitioners, suggesting another series, and I realised that my decision to attend again was partly because I felt the need to support the only other female member (the Student Counsellor). It is interesting that I felt protective, for she is well able to look after herself - but strangely, we all felt that sometimes the 'facilitators' were the least sure of themselves in the group - possibly because they were expected to be 'experts' and also were different, in not being doctors.

This series of ten sessions is taking place in the Medical Education Centre, and five of the original group are attending, with three GPs who are new this time. The room and the group are both smaller, on 'neutral ground', and we seem to be reaching deeper levels of discussion and interpretation. As

with the other group, I find myself at 52 just the oldest - a new experience for me - and several of the GP members have done their Family Planning training in our clinic ('though in this group, I in no way feel an Instructing Doctor).

It was felt that the group needed a name, if only to put as a heading to the list of those claiming mileage on Section 63, and as we hope to increase our awareness of factors in the doctor/patient relationship, we soon took up a bright suggestion of 'The Gossamer Group' - for greater sensitivity!! We seem to have used shorter incidents with patients as introductions this time and have found fruitful material in interpreting why one person's hackles rise when addressed as "Doc", or by first name, discussing roles and expectations - male, female, doctor, patient, and why it is difficult for doctors themselves to go sick. We have spent some time on whether all illness is a need to opt out and subconsciously chosen by the patient, and how much doctors need patients, as patients need doctors. The handling of emotions with dying patients - 'involvement' and to what degree, men's vulnerability in showing sympathy to women, patients' need to produce 'non-genuine' symptoms, the use of touch and our own boundaries on this (eg acceptable to hold a woman's hand during childbirth, but not as soon as the baby is born), and the exploration of psychosexual factors in many consultations. I found myself being accused of the role of rescuer when I felt that the group were leaning too heavily on one doctor in the presence of his partner, who was new to the group, and we discussed whether it was necessary to know something about each other to function well in the way that one member felt he could relate to a patient better if he knew something about his background. For example, he knew little about the female counsellor, whether she was married, divorced, separated or single; as she had referred to her children but he noticed that she did not wear a ring. Another member said that he felt it unnecessary to know personal details but the female

counsellor shared that this questioning made her anxious, because she sensed disapproval from one member in particular who had not realised that his strong views must come over as threatening to his patients. We have discussed tears and a man's feeling that tears were a sign of weakness, and what our own needs are, and what we want from the group. After seven meetings we are still not sure - each one taking or giving what seems appropriate to him (her!) and increasingly recognising group excitement or depression, collusive flight or distress, and our own strengths and weaknesses in relation to the clinical material.

The biggest pitfall is slipping into generalisation, as on the occasions when this happens the group ceases to have value. After about two hours the Psychologist attempts a summing-up, after which we go for a quick drink to unwind. (The evening is known by my long-suffering husband as my "night out with the boys").

The nine-mile journey each way for the Lowestoft three affords more time for review, and sometimes the most pertinent comments of the evening! I think that the skills slowly learnt in seminar training can make a particular contribution in such a group, but the loyal attendance of busy GPs means, I think, that everyone has come to recognise the value of learning "extra sensitivity" in the doctor/patient relationship.

The East Anglian 'Coastal Strip' recommends Gossamer Groups to other areas!

B. BEREAVEMENT COUNSELLING  
SOME EXPERIENCES WITH A COUNSELLING SERVICE

DR PAT ROBERTS

Long, long ago as the newest and most junior houseman in the hospital, I was given the task of telling a mother that her small daughter had died. She had been a particularly beautiful child, suffering from tuberculous meningitis the course of which we had been powerless to arrest. I remember saying how sorry I was and that tears had sprung to my eyes as she squeezed my hand - before turning to walk back along down the long hospital corridor, drawing her shawl more closely round her shoulders.

I felt totally inadequate, very young and inexperienced in face of her grief. Sister was not impressed by my performance and I wondered desperately what a proper doctor would have said.

Many years later, when attending a series of talks and discussions on Bereavement, a senior medical officer speaking of his own difficulties asked what my "little stock phrases" were for breaking the news to dying or bereaved patients. I found that I still had none.

There are no easy words of comfort and most people continue to feel ill-at-ease in the presence of the bereaved.

Much of the difficulty appears to lie in our reluctance to come to terms with the inevitability of our own death and dying. When in 1966 Michael Balint decided, with a group, to study the doctor-patient relationship with dying patients, doctors were slow to discuss their feelings and it was over a year before the seminar started seriously to present cases.

As well as reminders of mortality, the seminar considered the doctor's helplessness or impotence in the face of terminal illness and death, the

significance of separation anxiety evoked by the situation and the manner in which such anxieties had been handled in the past. Balint's message, as always, was for the doctor to take his cue from the patient, to listen to his needs - to what was said and unsaid. By far the most important part of counselling the bereaved consists of listening.

Freud has described the double standards whereby we can acknowledge death for others but not for ourselves and during World War I, suggested that in our civilised attitude to death we were once again living psychologically beyond our means. "Would it not be better," he said, "to give death the place in reality and in our thoughts which is its due and to give a little more prominence to the unconscious attitude towards death which we have hitherto so carefully suppressed?"

Lindemann, Gorer and others have since done much to increase our understanding of grief and mourning and remove existing taboos, but it is significant that thanatophobia, or specific anxiety about death, has still almost no description in psychoanalytic literature, suggesting defensive needs on the part of psychiatrists themselves.

At all events, it is important to have thought realistically about our own death and to have considered carefully the possible loss of someone close and dear, before undertaking the support of another's bereavement. It is advisable also, if not essential, to have resolved any personal grief before attempting to help another with their grief-work. It is otherwise impossible to behave with complete integrity, when faced with agonised attempts to deny chaos and disaster. The temptation will be to join in make-believe and collude in pain-avoiding pretence that life can go on as before.

TRUST

Integrity is vital to bereavement counselling. The mourner needs to feel safe - the familiar landmarks in his assumptive world have been shattered. His

supply of basic trust will be greater or less, according to his life's experience, but he must find something reliable to cling to if he is to survive.

Erikson, quoting from Webster's dictionary, defines Trust as "assured reliance on another's integrity" and further paraphrases the relation of adult integrity and infantile trust by saying that healthy children will not fear life, if their elders have integrity enough not to fear death. One can be reminded of this when supporting a widow, reacting in child-like panic to an uncertain future, but trusting enough to share her regressive and very dependent feelings and behaviour.

Various workers, notably Colin Murray Parkes, have described what happens when someone is bereaved and the formidable double task facing the mourner, of accepting the reality of the loss and yet holding inside himself the memory of the lost partner, who will remain part of his regained autonomy.

The emotions aroused in the grief work are disturbingly painful for the sufferer. They are distressing, too, for the helper who has to tolerate this pain, listen to endless repetitive and self-recriminatory attempts to make sense of the situation, but unable to satisfy the longing or restore the loss. He is able only to reassure the mourner that these bad feelings are normal and to allow a safe climate for their expression. He may be tempted to say that, against all the odds "time will heal", but this phrase (albeit true) is usually found to be as intolerable as the pain.

The counsellor may be met with anger, hostility, irrational or demanding behaviour and without awareness and respect for the mechanism used to cope with the pain - both by himself and the mourner - he may react negatively or settle for collusion.

Disbelief and Denial are instinctive initial reactions to any major sudden change (good or bad).

A widow, told of her husband's collapse in the super-market, while she was at home with a cold, replied, "It can't be him. I only spoke to him an hour ago".

They are not only basic healthy defences but essential, if the initial impact is to be survived without massive shutting-off of emotions. The implications of such a traumatic loss as bereavement, can only be assimilated gradually in piecemeal fashion, at the mourner's own pace. Dissociation enables intolerable feelings to be split off temporarily from time to time, to allow for recovery or coping with day to day living.

One widow describing how she "could not take it in all at once", talked of "parking" the more painful bits to "come back and think about them later", a useful device. Unfortunately, in her case a further bereavement prevented return, leaving sad areas of uncompleted mourning. Another said "There were so many other people to comfort, I had to postpone thinking about myself until I went to bed".

Used wisely, these defences act as "mitigators", letting us down gradually as we do our reality testing but, if too efficient, denial and repression may result in little grief work being done. The bereaved may become impoverished emotionally and unable to form new ties. Ill-health, neuroses, depression or irrational behaviour may develop and the subject left vulnerable to the danger of reactivation by future losses or crises.

A young policeman called on a widow, in the middle of the night, to tell her of a fatal accident. He asked to speak to her husband and when she explained that she was a widow, he burst into tears. His own mother had recently been widowed and he, as the policeman son, had coped efficiently with no sign

of weakness and no opportunity to grieve. The widow made tea for them both and for his friend in the co-car - which she found to be a strangely therapeutic exercise. As he left he said kindly, "Go to bed now and have a good night's sleep. There's nothing you can do until the morning".

"I told myself I would do it better this time - I would cry like they said. It's no good though, I still feel locked up. Some things go too deep for tears! Sometimes I think I just can't let myself believe it". This young mother's second baby had died of gastro-enteritis, her first being still-born. One year after the death of her baby she became deeply depressed and suicidal, seeking in-patient treatment in a psychiatric hospital. Her childhood had been spent in various children's homes.

#### ANGER & GUILT

The anger which recurs to varying degrees throughout the grieving process is regarded as normal by Bowlby and is probably an inevitable component. It is not always recognised by the mourner, although the angry behaviour may be readily observed by someone outside the situation and will be picked up in the doctor-patient relationship. If it leads to angry tears and self-pity, the mourner may be steered at this stage towards positive change and the tears become useful grieving. All too often it is suppressed and denied.

Many with religious beliefs find it particularly difficult to acknowledge, feeling extremely ashamed of the angry reactions - even of such healthy protest as, "Why should I be bulldozed by fate? It's not fair!" There is guilt over the use of the word "loss", if the loved one has been taken to a better place and much reassurance may be needed and permission given to grieve for the human deprivation. Religion and faith are, without doubt, valuable supports if they are not used to block the grief work and those with a belief or blueprint for living do better than those without.

A very personal distress, difficult to bear or share, is caused by guilt - yet the counsellor will have to share it many times over. It may be thought of as anger directed against the self which can, of course, lead to depressive illness. The widower who thought "It was just another headache" and the young widow who had "a row about nothing the morning he died" carried intolerable burdens, relinquished only slowly - as do many who castigate themselves, irrationally, for imagined failures and omissions.

Both guilt and anger are disturbing - even frightening to live with and are frequently projected as blame on to others - God, the hospital, the GP, the partner who has deserted them by dying.

Two widowers, who had both received ECT for depression, with minimal results, greatly improved after ventilating their resentment at wives who had "gone and died" on them, just as they were coming up to retirement. One had worked hard to alter house and garden in preparation for the shared leisure years ahead, while the other had long been saving for the World Cruise he had always dreamed of.

A case of mutual projection of guilt and anger, made more poignant by separation, is illustrated by the history of Harry, aged twenty-two years, and serving a sentence for manslaughter - following a fight in defence of his brother, in which an innocent bystander had been killed. Towards the end of his sentence he became morose and withdrawn and on being granted parole, staged a suicide attempt. This was reported as immature behaviour and certainly on meeting him, it was not difficult to accept that he was the youngest in the family. He complained of feeling confused and "switched off" - "unable to remember things", but there was abundant evidence of suppressed anger. He wanted to return to his mother's home rather than to his wife. "I might be angry with her or come home tired from work and just go to sleep. This would look mean - would be wrong after all she had been through."

It transpired that, in their three years of marriage, his young wife had two miscarriages. Then followed the cot death of their much-prized two-month old son while Harry was on remand. "Just one of these things", he said. "I don't blame nobody". However, he had heard that she might have been drinking and "she was young to be a mother" at eighteen. Gradually, he expressed his grief over the baby's death. If he had been at home would it have happened? His remorse, over the fact that his uncontrolled aggression had resulted in the death of another young man and caused pain to the victim's parents, was deep and genuine. Less easy to share, were his fears that something destructive about him had been responsible for killing one man and three babies.

It seemed likely that his wife might be feeling equally unsure over her femininity and mothering. Although she declined the offer of a joint visit, a very caring probation officer confirmed this. The couple, with no opportunity to share the pain, had each projected their anxieties on to their partner.

Harry started by asking for mothering. He wanted to escape from adult and masculine roles and a situation which was too complex for him to handle. He slowly matured, however, and went out to his wife - although with continuing psychiatric oversight.

#### DEFENSIVE ACTIVITY

Flight into action can be the counsellor's escape from the intolerably slow pace of grieving. "It's time you asked for an anti-depressant - or go on a holiday". "Why don't you move near your daughter? She would be easier in her mind". Doing something relieves the strain and distracts from the pain - even making cups of tea! Doctors prescribe or mourners seek relief in frenzied activity.

Rita's father died when she was five years old and her beloved grandmother when she was eight. She suffered a further major loss at fifteen years with the death of her step-father from a brain tumour. Her mother took flight on each occasion,

involving herself in the needs of others and overlooking those of herself and her child. Later pathological grief reactions developed in both. Mother now travels widely on behalf of an international charity, while Rita has sought love and reassurance from a succession of inadequate and disappointing young men - frequently terminating the relationship before she might suffer rejection.

Daisy had considerable insight into her behaviour. "I was rushing about when he was ill to keep me from thinking. Now I seem to run around looking for something all the time. I wish I could find it - I might settle". On another occasion she said, "I was all right as long as I kept thinking about me - even me when he was gone. I went to pieces if I thought how he felt".

This same widow idealised her husband's memory, his courage, his planning for her future. He had arranged to have the house painted outside and planned the next year's allotment before he died. They had done a lot of "worry work" together. "I wish I was like him and could carry out all the things he would have wanted". She sat in his rocking chair as she talked and her six year old son came to join in the conversation, wearing his father's shoes.

The idealisation and identification helped this family and, although the phase lasted many months, Daisy has now, in her own time, branched out into a successful cottage industry and is making her own decisions.

Two widows, who were friends, had kept their husbands' ashes by their bedsides for many weeks. In one case, the casket was gradually moved downstairs and progressively towards the back door as the grief work proceeded, in a manner which the helper felt was symbolic. The other casket sat by the telephone and great exception was taken if anyone held a jovial conversation over the remains. Were these examples of mummification?

It is not always easy to assess the progress of reality testing. One must constantly seek for "attunement" - picking up the mourner's anxieties, monitoring the use made of the defences, of which more than one may be in play. Has the widow with four children really not taken it in, or is she one who finds it difficult to weep in public? Has she, indeed, the time or opportunity? She may do much of her grief work at night, or on waking early in the morning with the knowledge that "something terrible has happened, that isn't going to change and that life will never be quite so good again". One has to listen hard, sometimes to know.

Mr Brown's recent involvement with the Year of the Disabled could be premature flight, or might prove a positive outlet for caring feelings which need to be used and valued. A redistribution of the libido? A Japanese mother whose baby died a cot death, steadfastly refused to show any outward sign of grief, talking only of superficial matters. The nursing staff felt helpless and hopeless and finally angry that she would not "let us help her at all". Her behaviour was what she felt expected in her culture and she did, indeed, grieve very deeply in private.

Grief work is neither logical nor tidy in its progress and must not be hurried. Each individual proceeds at his own pace and in his own manner - nor is there any set time for recovery "as from the measles". The counsellor has to help the mourner to complete the task, not only to accept and survive the loss but to go forward with a new identity and, hopefully, renewed strength.

Frequently in clinics and surgeries, patients are encountered whose symptoms stem from unresolved anger, guilt or from poor self-esteem resulting from incomplete mourning. Apart from factors of personality and the timing of such crises in an individual's life-history, there seems often some environmental deficiency - an absence of anyone who care or with whom grief could be shared.

## BEREAVEMENT COUNSELLING

Could a bereavement service help? Was it really necessary in this most inevitable of life's crises? If so, did this imply failure on the part of family, friends, the "caring" professions and the community at large? With a view to discovering more about this I went, some years ago, on a course for professional workers on Bereavement, organised by Cruse. This national organisation for the widowed and their children was founded in 1959 by Dr Alfred Torrie and now has branches throughout the country.

By this time I had been widowed for many years and was surprised to find myself still unduly sensitive on two counts. One was the recurrent use of the generic term 'widow' - suggesting collective anonymity. ("Widows crack under the strain" was one less fortunate phrase!) The other was what seemed like constant and reproving reference to 'unresolved grief'. Intellectually and as a doctor I, of course, accepted what these very caring people were saying, but emotionally as a widow I rebelled. Was it realistic or indeed desirable, that any major grief should ever be entirely resolved or forgotten? Even the sadness had been a valuable experience.

These were discoveries I made about myself which have proved useful since. I find I can now talk freely and protectively about our widows or even my widows. Is this true acceptance?

The very excellent course led to my involvement, with other professional workers, in establishing a counselling service on lines proposed by Cruse to cover a wide area, both urban and rural. We made a slow start. Local doctors and clergy expressed doubts over the wisdom of segregating the bereaved in this way and we had our own uncertainties. Although the newly trained professional counsellors had few referrals, publicity brought many lonely people to the Social Evenings. There were problems here, too, with meeting-place and entertainment. Expectations were disappointed. We did not always please. Was this related to bereavement, we

wondered - that nothing would ever be quite right again? Few widowers came.

The Social Club has now settled to a united supportive group, with a constant attendance of twenty to thirty, and our fears that this might become inward-looking and collusive have not been realised. The environment is safe. Confidences can be shared over such behaviour as taking a pillow to bed or crying through the night, as can problems of disorganisation and indecision. Brief individual counselling is possible, but most work is done between the members at the valuable level where one human being cares to listen and give comfort to another, whose anxieties he can understand. Above all, other widows and widowers can be seen to have survived.

From time to time, talks and discussions on practical and emotional aspects of bereavement are held, but for the most part the aim is purely social. It is difficult to socialise on your own, particularly if you have been used to a partner taking you off by car or by the arm and the widows and widowers who come to the club, about six to twelve months after their bereavement, are ready to take their first steps into the outside world again. Many friendships are made which become lasting, perhaps leading to joint activities, expeditions and holidays. They are a robust and independent group, rejecting the idea that they need professional help, clearly accepting that mourning is not a sickness or a weakness but a job to be done - and strong in the conviction that widows are the best people to help widows. The fact that I am a doctor is occasionally helpful, but frequently it is irrelevant and at times I have felt that I have carried all the blame and anger directed against doctors since time began. The GP "who was marvellous when hubby was ill, but has forgotten me now", is regularly attacked. An example is Dorothy May, whose husband died of a bladder cancer. She continues to attend the surgery with daughter Jenny, who suffers recurrent urinary infections. "You

know", she said, "I've been nine times since Christmas and he's never once asked me how I feel. I expect I would tell him I'm all right, but he should know how anxious I am". Some, I am glad to say still value their doctors.

We continue to watch our members through psychosocial transitions when they may be vulnerable, such as anniversaries, house-moving, children leaving home or getting married. One confided in distress after her daughter's wedding, "I behaved like a real mother-in-law. I don't know why I felt so bitchy and upset". Others have called well-tried defences into action again. "When it came to the move I felt quite numb and sat there shaking. I just couldn't believe it. I just couldn't go. In the end the new people arrived before I had left". Another who later became very depressed, related how after moving house she "rushed straight off to stay with my daughter - just like I did when her Dad died". Two have had mastectomies, several have become redundant and one became agoraphobic after her only son married. In general, this Social Club does act as a BRIDGE as intended, and we are pleased when members take up other interests. A few, it must be confessed, have become life members - welcoming newcomers and just avoiding the temptation to become professional widows. The Club can also give permission to stop grieving.

Our most faithful and constant widower looks after all the ladies, moves the tables and sees to the locking-up.

Younger widows have been frankly horrified at so many over sixty who, although motherly, bring home the possibility of lonely years ahead. It has been found much more valuable to meet in small groups, in a home setting, which allows for more intimate sharing of their confusion, fatigue, loneliness and despair - the almost physical feeling that half of themselves has been wrenched away "leaving a hole in the side which must be filled".

They badly miss feeling desirable, attractive and valuable, the shared confidences and humorous anecdote. Now with so much to cope with in a dual role, they wish to feel dependent again. The dominant role, if previously sought, no longer holds attraction. They can freely talk about their sexual feelings - sometimes ashamed that they still have these longings which might shock the neighbours or, perhaps filled with anger at the deprivation.

Linda used to ring her counsellor regularly between two and four o'clock in the morning, to unload pain and resentment that parental figures were still alive and having sex, while her vital young husband had been killed. This had been the most successful area in a very stormy marriage. Her mourning followed a rather dramatic manic-depressive pattern, involving the working through of earlier unresolved crises - alternating testing and abusive behaviour with tearful clinging and dependence. She reacted destructively to a number of well-intentioned suitors and was amazed, but grateful, to find that her counsellor had survived when eventually this phase was resolved. The counsellor can act as a mother-substitute for the very young bereaved, whose adolescent conflicts are still too recent to allow discussion of sexual needs or dependency problems with surviving parents.

In this age group the deaths have all been untimely and unbelievable shattering. Two young husbands were found dead in bed by the children, another killed in a senseless explosion. Severe problems with guilt and anger have been worked through, backed up by individual counselling but sense of humour still prevails and there is plenty of positive thinking as the grief work progresses.

#### CHILDREN

For those with dependent children, there is also a Parent's Circle. Cruse has always given special consideration to the bereaved child, stressing how easy it is to overlook the grief of children while concentrating on their parents. In the past the

tendency has been to remove them from the scene, ostensibly to shield them from the pain, but at the same time protecting adults from the poignancy of the situation. Yet children must be allowed and helped to express their feelings to the best of their ability.

The Parent's Circle aims to support the mother or father in this task - which may be difficult to cope with in view of their own burden of grief. In fact, with a mother preoccupied with mourning and, perhaps, a new job as breadwinner, the bereaved child may appear to lose two parents.

Bowlby has compared the separation anxiety of childhood with adult mourning and has demonstrated that bereavement and other loss situations may reactivate infantile fears of death and separation. It is known that small children who are unable, fully, to grasp the abstract concept of death, may harbour guilt and fear lest they were in fact responsible for this appalling event; and that guilt and angry feelings may be repressed and turned against themselves or directed against the surviving parent - testing this parent's powers of survival with provocative and unreasonable behaviour.

It is extremely hurtful and exhausting to cope with this alone, or to be told that you, "can't have given Daddy enough to eat or he wouldn't have died." But if not understood and worked through, these anxieties remain infantile and repressed and are not accessible to reality testing and modification as the child grows and learns.

Such patterns may indeed persist into adult life as in the case of John, who complained of depression and loss of libido. He remembered, vividly, his anger and desolation at his father's funeral - nobody had thought to console him as they supported his weeping mother. He provoked and criticised his wife, whose attempts to resume her career in medicine recalled his resentment at his widowed mother, having by necessity to work and becoming

"bossy and detached", depriving him of much of her time and loving. He felt himself inadequate and too young to satisfy or support the women in his life, but demanded excessive attention. This brought the couple to a psychosexual clinic.

Erna Furman has emphasised that there can be no peaceful deaths for the parents of young children. Whenever we merely say "his parent died", we leave out the inevitable horror and tragedy that such a death entails. The parents of some of our children suffered particularly violent deaths. One young father was destroyed by a bomb, and as no member of the family was able to identify the remains, the question in all their minds was, "What was in the box?" at the time of burial. Their mother encouraged them to draw their phantasies which they compared together, and the whole family was greatly helped by the exercise. Other children were, for a long time, alarmed by the sound of ambulances and the sight of red blankets.

Suicides, deaths overseas and ambivalent relationships have led to anguished grieving for surviving partners, causing problems of emotional neglect for their children. The Circle, which has two professional leaders - a man and a woman - not bereaved, is a place where the joys of child-rearing can be shared as well as the difficulties, but parents are supported in the expression of their own negative feelings in order that they may better tolerate those of their offspring. It does seem that the surviving parent is the best person to help the child with his bereavement if they can. Even if, to further quote Erna Furman, "a professional person can express it better or say it more beautifully", the parent will be with the child more constantly and can give support or answer questions at the moment this is needed. The aim of the Circle has been to help the parent to do just that.

Recently, with few counsellors, it has been necessary to work with small groups, but inevitably our most important counselling is on an individual basis, when we visit people at home or with their families. Contact has sometimes to be maintained by telephone, if the distance is great, but useful supportive work can be done this way.

We are rarely called in until after the funeral, when family and friends depart and the numbness and shock begin to wear off. Strangers are not usually welcome in the early stages, but we have been involved with one elderly lady who lived entirely alone - just to provide human contact and make cups of tea. The village took over at night, taking it in turns to sleep in the house. As she bolted the door at half past eight at night and rose at five in the morning, it represented considerable personal sacrifice but a wonderful community experience.

A death in the family affects all the members and we frequently have to help a bereaved person to see that the awkward behaviour of in-laws may be due to their grief over a relative whom they have known longer than the surviving spouse. Equally, we all know that sibling rivalry can persist even to the grave-side and possibly beyond. "It's all very well for you, you've only known him thirteen years. I've known him since he was a little boy". This comment was made to a widow at the funeral by her father-in-law's secretary.

Many others outside the immediate circle may be affected also, resulting in angry reactions or hurtful avoidance which increase isolation. Kindness, however, is to be found in unexpected quarters and a sense of humour can be all-important. It certainly came to the rescue of a farmer's widow when informing their cowman of her husband's death. "There's no-one more sorry than me Ma'am," he replied, "It's the third employer to die on me in eighteen months." He lived in a tied cottage. This quickly brought home to this family the fact that they were not alone in their loss.

We have seen relatively few widowers, the older group tending to be deeply depressed and lonely, while the younger widowers have problems with child-care and have been better supported by their friends and colleagues. We have to learn more about their needs. Increasingly, we are called to support the families of dying patients or those with long-term illness and this is now an important area of our work.

For practical advice, we have a panel of professional advisors and we also man a weekly Bureau where help ranges from sympathetic listening to the completion of incomprehensible forms. How do you fill in Husband's Name? Does one write "the late", or append "deceased"? Such problems can seem insoluble in the early days of widowhood.

#### COUNSELLORS

Our counsellors are trained and work under supervision, with a consultant psychiatrist as advisor. None of our last group of trainees were professional workers. All were widowed members who now felt able and ready to use their experience. The aim has been to develop their natural skills of listening and sharing pain, and to enable the use of their knowledge of bereavement as Cruse counsellors or in their places of work and roles in the community. One ideal model would seem to be that of a widow, now a trained counsellor, who works in a local post-office on her housing estate, where she handles the pensions and allowances. She meets widows early in their bereavement and has arranged small self-help groups which are visited in turn and who can call for help at any time.

We plan to extend our training programme, hopefully with an on-going seminar and a study of those at special risk. We certainly need more helpers. It is impossible, with the resources at our disposal, to reach everyone who seeks our help and to fail them must only increase their feeling of isolation and despair. This particularly applies to those who have had the need to ask an impersonal national organisation for support with their personal suffering.

Not everyone, of course, needs counselling nor, in the event would they necessarily turn to such a service. Many who do approach us need quite brief assistance and can profit from very limited help. Given space and time to grieve, the majority accomplish their task and are free to go forward with renewed strength and a new identity. A Cruse widow put it beautifully: "I never could have believed it. I still love him but differently. I can see he was part of making me the way I am now - but I am a new person." She had extended her personality and developed new skills. While retaining valuable memories, she had triumphed over her grief and grown through the experience of her loss.

Another Institute member, Dr Trevor Zutshi, was also involved in the formation of this Cruse branch and has since contributed to the training programme.

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Cruse. National Organisation for the widowed and their Children. Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR.

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## REPORTS OF MEETINGS

### A. REPORT OF ASMT CONFERENCE

DR MORAG BRAMLEY

The Association of Sexual and Marital Therapists held a conference at Holly Royde College, Manchester on the 27th and 28th February 1981. The title was "Recent Developments in Research in Sexual and Marital Therapy". There were 75 Conference Members.

Dr Martin Cole of Birmingham presented a paper which described the characteristics of patients with erectile difficulties and then discussed the result of sex therapy using male and female surrogate partners.

One hundred and fifty patients requested surrogate therapy. One hundred and fifteen were considered suitable. Teenagers and those over 50 years old were excluded as they were considered to have a poor prognosis with surrogate therapy.

Thirty-two surrogates were used. Of the 25 female surrogates, 12 were married, 8 divorced, 1 separated and 4 were single. Of the 7 male surrogates, 4 were married and 3 were divorced.

Twenty-two patients out of 115 showed some improvement as assessed by Dr Cole at an interview. Only 26% (30) patients reported back after 6 months of surrogate sessions.

His conclusion seemed to be that successful results in patients with sexual difficulties and no regular partner could be doubled by the use of surrogates.

It depends what "success" means as loving, caring, unselfishness, long term commitment and faithfulness in relationships were not mentioned.

Dr John Bancroft of Edinburgh described a piece of sophisticated research into erictile ability. He used erotic film stimuli in the laboratory with a device fixed to the penis which measured penile pulse amplitude and penile circumference increase. He tested the responses to erotic films of a) normal men; b) impotent men; c) diabetic men. He found that normal and impotent men had a rise in blood pressure of 20 mm Hg during the erotic films, while diabetic men had an abnormal rise of 30 mm Hg. The quickest change in penile dorsal artery pulse and increase of 10 mm diameter of the penis occurred in normal men, next in impotent men and the slowest changes were in diabetic men.

When each group experienced a second similar test, the penile pulse change was larger and penile size increased much more quickly in groups a) and b) and was much less in the diabetic impotent group.

Dr Jim Barnes of Dublin described an invention for the treatment of non-consummation and vaginismus, called the Whistling Rocket.

He helps this type of patient to use dilators after some discussion of their problem. Two to 12 hours are spent using these. Dr Barnes hopes that the whistling dilator will decrease the time spent. The patient will be aware of the amount of vaginal muscle tension by the amount of noise produced when the dilator is inserted. The patient's aim is to produce no noise and a relaxed vagina. The whistler comes in 6 graded sizes. Vaginal examination and fantasy exploration were not mentioned as part of this therapy. It is interesting to note that the preliminary study on non-consummation done by members of the IPS showed that patients who had a relaxed vagina on initial examination were more difficult to treat than those showing vaginismus.

Dr Sue Golombock from the Maudsley Hospital gave an account of a diligent study of a comparison between 37 children of 27 single lesbian mothers and 38 children of 27 single heterosexual mothers. The mean age of the children was 9½ years.

The 27 heterosexual mothers lived alone with their children as did 9 of the lesbian mothers. Twelve lesbian mothers lived in couples and 4 in shared houses. Twenty-seven of the children knew the lesbian tendency of their mothers.

The results showed no difference in gender identify or evidence of homosexual orientation in the lesbian mothers' children as compared with the children of heterosexual mothers but the children had not yet reached teenage years.

Most lesbian mothers wanted their children to be heterosexual. These children had more contact with their fathers than the children of heterosexual single women.

Dr Golombock concluded that at present the lesbian mothers' children - whether living with lesbian couples or alone with their mother were at no disadvantage compared to children living along with heterosexual mothers.

Dr Golombock also discussed the Maudsley sexual function questionnaire. It has 28 questions to be answered by patients before and after treatment. Male and female questionnaires are different. In spite of modifications, it was still found to be a very inaccurate instrument to determine the outcome of treatment.

Dr Keith Stoll of London described a retrospective study of the interaction of sexual dysfunction and marital interaction. By the end of the paper it was not clear which was the chicken and which was the egg.

Professor Jim Watson and Dr Bea Brockman from Guy's Hospital discussed long term outcome of sex therapy.

Of 154 couples presenting, 42 showed improvement in sexual function and in their relationship; 8 showed improvement in either sexual function or relationship but not in both. Thirteen were thought to be unsuitable for treatment and of the remainder many defaulted after one or two sessions.

Enormous effort and diligence was put into long term follow up which proved extremely difficult and had disappointing results.

The conference organisers had chosen a warm comfortable location, but the best of the conference was the friendly conversation and exchange of ideas that took place at meal time and between sessions.

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B. ANNUAL GENERAL MEETING HELD AT THE ROYAL SOCIETY OF MEDICINE ON FRIDAY, 20 MARCH 1981

Dr Tom Main introduced the speaker Mrs Enid Balint, whose late husband Michael Balint, led the original Seminar composed of Family Planning Doctors. Several members of the seminar were present at the AGM, Dr Margaret Blair, Dr Alison Giles, Dr Jean Pasmore, Dr Rosalie Taylor. Mrs Nancy Raphael was associated with its organisation in the early days, and there were several other invited guests, Dr James Carne (vice President), Mrs Shendon and Mrs Simon, Dr Stephen Pasmore and Dr Jack Norell.

Mrs Enid Balint gave a paper on Female Sexuality and here follows a summary of the ideas she presented, reported by Dr R Lincoln.

Mrs Balint began to speak about how women became differentiated from men in order to become women and even to enjoy being women.

It involves a discussion on how they became able to respect and care for men and themselves and their joint children and also how they may be able to be cared for by their men; it is very difficult for women to accept the mutual interdependence which is involved and also to abandon the need to care for their mothers.

The main focus of this paper was the early conflicts in women's lives which hinder these developments. Most important of all, the conscious and unconscious feeling that they must (but cannot) satisfy their mothers in caring for them.

In analysis of women it is found that they feel the need to be the most important caring person in their mother's life, but to enjoy fully being a woman they have to change. This is not only separation from the mother, but also giving up the compulsion to satisfy this, and to accept dependence on a caring person who is a man, and so can be a father to their children.

She also talked about the importance of physical body pleasure and she quoted case histories which illustrated the ideas about which she was talking.

There is a difficulty in differentiating sexual biological needs from those that are determined by early relationships. Women need to differentiate themselves from men for biological reasons and for reasons that have to do with human relationships and ego needs. The interaction between biological, psychological and environmental can be observed in individual women. Her fantasy life reveals the meeting point of biological drive, her instinctual life and the consequences of the relationship with her environment. The little girls development into a woman depends on how her body-needs and her environmental-needs co-incide and how they interact with her fantasy life.

She has a vagina and a clitoris and she develops fantasies which are uniquely feminine. The little girls own body feelings are more likely than her

mother's expectations to make her do what she does with a doll, a train or any other toy. It is difficult to differentiate between the little girl's need to hold something which arises out of her body feelings, and not out of her relationship with her mother, whose nipple she holds in her mouth and who holds her in her arms. If all goes well these interact and womanhood develops. A little girl may hold a train or a blanket as though it were a baby.

If the early body feelings are hindered, castration anxiety is difficult to overcome, but it is more important to dwell on the fantasies which arise out of what a little girl has, rather than what she has not. What happens in the environment to children and adults is such a matter of chance. One cannot blame people for what happens; the mother may be depressed, the father absent at a particular time or there may be a death or move of house.

The importance of the Oedipus complex cannot be overestimated because each individual has to resolve a complex conflict involving three people and not two.

The child is familiar in the unconscious mind with the mother's relationship with the father, at the same time she internalises her own relationship and experiences with her mother. Her husband and her father are part of her inner world, also in discussing the baby's relationship with the mother, it depends also on the mother's relationship with her husband. The mother is a wife, even if widowed or divorced.

If a mother is not in touch with her man, her mother's identify as a wife and mother, she will be unable to help her little girl to differentiate from a man and have a man to care for her and her children. Where there have been hindrances in development, it may be difficult for the girl to use one man, both as a mate and as a father of her child.

It is important to the child that the parents seem to satisfy each other. We have to be in touch with three generations.

It is important to understand caring relationships and the ability to accept dependency, (and not react against it). Dependency may seem as over compensation for aggressive feelings in parents and children but it is an important part of the mutual dependency, which is an essential for emotional maturity.

Both the little girl and the little boy have problems to solve as a result of dependency. A woman receives and gives pleasure with her whole body. The fear of showing dependent needs or being over dependent is very strong nowadays. People are ashamed of it. This may arise from an unsatisfactory relationship in infancy when dependency is inevitable, though denied and repressed when it feels unsafe.

The genital orgasm plays an important part in a woman's feeling of well being and self esteem but it is only part of a good caring relationship between a man and a woman.

There were several questions from the floor which were answered by Mrs Balint. Dr Main thanked her and summed up by saying she had sung one of his favourite songs: "A child is brought up by the mother and the father and although that is true, a child is also brought up by the husband and wife and there is great importance to the child in its awareness of the kind of relationship between these two people. The awareness of her mother's dependence on her husband is an important development in the ego growth of the girl. It is a model of dependence that can be set by some mothers which is not frightening or endangering, but common sense."

PHOTOGRAPH OF DR TOM MAIN:

These may be obtained from:

Tara Heinemann - 54 St Maur Road, London, SW6  
Tel 01-736 3729 or 01-589 8420

Size 10" x 8" costs £1.20 & size 7" x 5" costs 75p

Please include 20p for postage and packing.

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C. SEMINAR AT THE POLICY STUDIES INSTITUTE  
1st APRIL 1981

DR R LINCOLN

This seminar was held at the time of publication of a report by Isobel Allen called "Family Planning, Sterilisation and Abortion Services".

This was a research project for the DHSS in two towns in England - one in the North and another in the South. Patients, doctors (GP and clinic) and nurses were interviewed.

Dr Geraldine Howard and I attended this meeting at which there was considerable emphasis on the need for adequate counselling in Family Planning and also understanding of the Psychosexual needs of patients. A further study is being arranged to look at the present situation about counselling and training.

The book is available from the Institute of Psychosexual Medicine. Price: £4.00.

## TRAINING

### A. LEADERS WORKSHOP: CHELTENHAM - November 1980

Twenty-eight 'leader' doctors gathered together for two days to share experiences, successes and difficulties.

Dr T Main was unfortunately absent due to illness and so the workshop was held without his special leadership, but fortunately the group emerged as not being too dependent on him. Dr Tunnadine reported "We missed Tom's touch of analytic class, but we are a viable outfit, able to take responsibility for our own work with vigor and excitement."

She paid tribute to the skill and calmness of Dr Margaret Blair taking over the leadership.

One policy question which was debated was as to whether Institute leaders should officially undertake training of groups of workers other than doctors. It was decided that the Institute should only offer information about doctors who were trained leaders, and should not undertake the training directly. Members felt that there had been a consolidation of skills and valuable exchange of ideas, since not all leader doctors can attend the two existing workshops - in London and one in the North. Doctors Blair and Tunnadine led the discussion groups and the topic included co-leadership (advantages and difficulties) and assessment training in their local Family Planning Clinic under the supervision of certificated instructing doctors.

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### B. FORMATION OF A NEW STUDY GROUP

1. A group to study the doctor/patient relationship when the patient is a male and the doctor a female is being held at 27 Oakleigh Park, South Whetstone on alternate Thursdays, starting 5th March. Would any doctors interested in joining

please contact Dr Jane Kilvington on 0727 53156 (122 Marshalswick Lane, St Aibans, Herts).

2. A group is being formed to study Rape Counselling. Please contact Dr Judy Gilley on 01-8834893 (57 Leopold Road, London, N2) if you are interested in joining. Those who may have contacted Dr Gilley previously should ring her at the above number, which is her current one.

Details of all existing seminars can be found inside the back cover.

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### C. Would any

Accredited doctor like to see patients in the Marital Clinic at the Cassell Hospital, Richmond (appointment arranged to be convenient) in return for supervision - which is on a Wednesday afternoon. No salary payable. Please contact Dr Margaret Blair in the first instance. (address inside front cover.)

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D. The panel recommended to the Council that the following doctors should be accredited as full members:

Dr Elizabeth Deman - 20 Beaumont Street, London.  
Dr John Peniket - 106 Stround Road, Gloucester.  
Dr Mary Rees - 31 Court Lane, London, SE21.  
Dr Lorna Sykes - Dunganth, Southgate, Honley, Huddersfield.

Dr John Munro - 42 Old Elvet, Durham, DH1 3JF.  
Dr Margaret Cooper - 2 The Monar Close, Shincliffe Village, Durham, DH1 2NS.

Dr Beryl Tulley - 6 Falcondale Walk, Westbury on Trym, Bristol, Avon.

E. RESEARCH:

The Nuffield Study

Dr Morag Bramley reports that at present 77 out of 123 cases studied have now consummated. 15 are continuing in therapy and 31 have defaulted.

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CORRESPONDENCE

A letter has been received from Dr Elphis Christopher, Senior Medical Officer, Enfield and Haringey Area Health Authority, Haringey District Community Health Office, Tottenham Town Hall, 359 High Road, N15 4RY. Tel: 01-808 1000 extension 308.

Dear Dr Lincoln

I am writing to ask if any Institute members are interested in counselling the disabled with sexual difficulties. As those who attended the SPOD (Sexual Problems of the Disabled) Conference in July 1979 will be aware, there is both great need and few resources of help for such problems. At a recent council meeting of SPOD (of which I am a member) concern continued to be expressed by this. Many requests come to SPOD from professional workers who wish to obtain help for their clients and there is a shortage of trained people to refer them to. Obviously, doctors who wish to help the disabled may not wish their names to be given to SPOD but perhaps they could give the names and addresses of the clinics in which they work. SPOD could then give these to professional enquirers. It would seem to me that the disabled are in great danger of having their sexual function seen in isolation as a mechanical performance and having their feelings ignored. This is where the Institute training would be so valuable. If any doctors are interested, perhaps they could write to me directly.

Yours sincerely

PUBLICATIONS

1. Pilot Non-Consummation Study

The report of the pilot non-consummation study has been provisionally accepted by the Journal of Obstetrics and Gynaecology, who wish to expand it.

2. If Mims and the other journal from which the articles were taken are in agreement, a booklet called "Themes in Psychosexual Medicine" will be published shortly.

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NEW MEMBERS

- Dr N Campbell (A) - 79 Manor Road, Worthing, BN11 4SI  
BN11 4SL  
Dr P M Mitchell (A) - The Surgery, Scurlage,  
Reynoldston, Swansea  
Dr John Peniket (M) - 106 Stroud Road, Gloucester,  
GL1 5JP  
Dr B S Naru (A) - 168 Runnymede Road, Ponteland,  
Newcastle upon Tyne  
Dr N Dave (A) - 7 Wimpole Road, Stockton-on-Tees,  
Cleveland  
Dr Catherine Nash (A) - 24 Bathurst Road, Norwich  
Dr H Arthur (M) - "Apple Trees", Dauntsey Lane,  
Weyhill, Andover  
Dr Bridget Friedmann (A) - 15 Highbury, Newcastle-  
upon-Tyne  
Dr Pam Taruba (A) - 105 Cavendish Avenue, London,  
W13 054

NEW ADDRESSES

- Dr Maureen Brocklebank - Limefield, 590 Chorley  
New Road, Lostock, Bolton. Tel Bolton 41691  
Dr Judy Gilley - 57 Leopold Road, London N2  
Tel 01-883 4893  
Dr John Limbert - 508 Selkirk Avenue South,  
Thunder Bay, Ontario, Canada, P7E 1T4  
Tel 8076234777

Dr Kath Chrispin - Walnut Tree House, Chilham Lees,  
Canterbury, Kent, CT4 8AU. Tel Chilham 452  
Dr Jennifer Rich - 27 York Road, Bowden Value,  
Altrincham, Cheshire. Tel 061-928 0722  
Dr Gillian Wakley - Holly Lodge, Lynch Crescent,  
Winscombe, Avon. Tel Winscombe 3257  
Dr Christopher Sage - 40 Summerville Road, St  
Andrews, Bristol

The Editor apologises for not including the names of the members of the seminar with the article on non-ejaculation in the last Newsletter and these are included herewith:

Dr C Butcher, Dr R D'Arcy Hart, Dr J Dewsbury,  
Dr K Draper, Dr E Falle, Dr J Herman,  
Dr G Howard, Dr F Hutchinson, Dr B Law,  
Dr S Lucas, Dr H Montford, Dr P Roberts,  
Dr W Roles, Dr P Shirley-Quirk, Dr R Skrine,  
Dr Alexandra Tobert and Dr Prudence  
Tunnadine.

#### OBITUARY NOTICE

We record with sadness the death of Dr  
Pat Shirley-Quirk.

#### LIST OF INSTITUTE LEADERS

Dr Doreen Anderson, 4 Newstead Road, Wakefield,  
Yorks  
Dr Hana Backer, 1 The Parade, Whitchurch, Cardiff  
Dr Islay Barne, 37 Beaconfield Road, London, SE3  
Dr Margaret Blair, Waldron Cottage, Harrow on  
the Hill, Middx  
Mr Morag Bramley, Greenhills, Back Lane,  
Hathersage, Near Sheffield  
Dr Muriel Broome, 30 Warren Road, Reading, Berks  
Dr Edna Clitheroe, The Warren, Main Street, Old  
Humberstone, Leicester  
Mrs Doreen Clifford SRN, (address to follow)  
Ham, Surrey (c/o Dr Pasmore)  
Dr Joan Coombs, 13 Holly Park, Huby, Near Leeds  
Dr Margaret Cooper, County Hospital, Durham City  
Dr Sylvia Dawkins, 13 North Terrace, Parsonage  
Street, Cambridge  
Dr Dorothy Davey, 12 Millington Road, Cambridge  
Dr May Duddle, 7 Lostock Hall Road, Poynton,  
Cheshire  
Dr Katharine Draper, 29 High Street, Chipstead,  
Near Sevenoaks, Kent  
Dr Desmond Dunleavy, Dept Psychological Medicine,  
RVI, Queen Victoria Road, Newcastle Upon Tyne  
Dr Roland Freedman, 1 The Grove, Gosforth,  
Newcastle Upon Tyne  
Dr Jean Grey, 9 Hall Meadow, Hagley, Worcs  
Dr Elizabeth Gregson, Priory of St John, Wells,  
Somerset  
Dr M Joy Herman, 10 Grimsdyke Crescent, Arkley,  
Herts  
Dr Valerie Hall, 77 Moorside North, Newcastle  
Upon Tyne  
Dr Fay Hutchinson, 45 Mornington Road, Woodford  
Green, Essex  
Dr Jane Kilvington, 122 Marshalswick Lane, St  
Albans, Herts  
Dr Rosemarie Lincoln, Idle Hour, 67 Yarmouth Road,  
Norwich, Norfolk  
Dr Shelagh Lucas, Forest Lodge High, Ongar, Essex  
Dr Tom Main, 6 Sherwood Close, Lower Common South,  
London, SW13

Dr Helen Manning, Blundells Farm, West Monkton,  
Taunton, Somerset  
Dr Eleanor Mears, 71 London Road, Sleaford, Lincs  
Dr Heather Montford, Cardinal House, The Green,  
Hampton Court, Surrey  
Dr Dorothy Morgan, AHA, Powys Divisional Office,  
The Watton, Brecon, Powys, Wales  
Dr Carole Stuart Morrow, 59 Wimpole Street, London  
W1  
Dr J S Munro, 42 Old Elvet, Durham, DH1 3JF  
Dr Joyce Neill, 31 Upper Lisburn Road, Belfast,  
N Ireland  
Dr Betty Orton, Beach Hill, Bitton, Near Bristol  
Dr Jean Passmore, South Cottage, Ham Gate Avenue,  
Ham Common, Surrey  
Dr Denise Pullen, 10 Charmandean Road, Worthing  
Sussex  
Dr C Pat Roberts, Rory Cottage, Taylors Lane,  
Trottiscliffe, Maidstone, Kent  
Dr John Rogers, 11 Turner Road, Slough, Middx  
Dr Ann Smith, 6 The Crescent, Longbenton,  
Newcastle Upon Tyne  
Dr Mary Smith, Briarly, 14 Enville Close, Newport,  
Gwent  
Dr E Sandeman, 33 Meols Drive, Hoylake, Cheshire  
Dr Ruth Skrine, 49 Woodcote Grove Road, Coulsdon  
Surrey  
Dr Shirley Snead, Beaufort Lodge, Lilleshall,  
Salop  
Dr Robina Thexton, 41 Hillcroft Crescent, London  
W5  
Dr Jill Tattersall, 38 Cherry Tree Road, Sheffield  
Yorks  
Dr James Templeton, Dept Psychological Medicine,  
Southern General Hospital, Glasgow  
Dr Alexandra Tobert, 32 The Rope Walk, Nottingham  
Dr Prudence Tunnadine, 111 Harley Street, London  
W1N 1DG

## SEMINARS

Any doctors interested in joining the following seminars should contact Dr Prudence Tunnadine at 111 Harley Street, London, W1N 1DG for further details.

<u>Name of Leader Doctor</u>	<u>Place</u>
<u>Leader Doctor Workshops:</u>	
Dr Margaret Blair	London
Dr Tom Main	Newcastle upon Tyne
<u>Advanced Seminars:</u>	
Dr Tom Main	2 in London 1 in Newcastle & 1 in Guildford
Dr Prudence Tunnadine	Leeds
Dr Alexandra Tobert (proposed)	Nottingham
<u>Basic Seminars:</u>	
Dr Joan Coombs	Leeds
Dr Doreen Anderson	Wakefield
Drs Jill Tattersall & Morag Bramley	Sheffield
Drs Ann Smith & John Munro )	The North East
Drs Margaret Cooper & Valerie Hall)	
Dr E Sandeman	Liverpool
Dr Dorothy Morgan	Cardiff
Dr Rosemarie Lincoln	Norwich
Dr Jennifer Tisdall	Plymouth
Dr Ruth Skrine	Bath
Dr Robina Thexton	Southampton
Dr Fay Hutchinson	London
Dr Shelagh Lucas	London
Dr C Pat Roberts	Maidstone
Dr Helen Manning	Taunton
Dr Joan Coombs	Bradford
Dr Katharine Draper (proposed)	Ashford
Dr Eleanor Mears	Sleaford
<u>Continuation Research Seminars:</u>	
Dr Shirley Snead - Stafford,	
Dr Jane Kilvington - N London,	
Dr Jane Berry - Winchester.	
Dr Islay Barne - Bromley	
Dr Judy Gilley - N London.	