DIARY OF EVENTS – 1981 and 1982

Institute Meetings

Annual General Meeting Friday, 19th March 1982
5.00 – 6.30 p.m. Royal Society of Medicine
Buffet Supper at 6.30 p.m. and Clinical Meeting at 8 p.m.
Speaker: Helen Manning (E.N.T. surgeon trained in Psychosexual Medicine) on "Cut off your nose to spite your sex."

International Conference 7th – 10th July 1982
To be held at the Hotel Metropole, Brighton.
Programme included on page 5

Leader Doctors Workshop 24th – 26th September 1982
To be held at Nottingham University.

Other Meetings

International Society for Psychosomatic Gynaecology and Obstetrics, 23rd and 24th November 1981 at the Royal College of Physicians. "A new generation of psychosomatic research."

8th – 12th March 1982. Meeting at the Royal College of Gynaecology.

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INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 20
November 1981

CONTENTS

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Vice-presidents	:	**Professor Norman Morris** **Dr James Carne** **Dr. Robert Gosling**

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INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 20
November 1981

Dear Colleagues,

"Meanwhile in laid-back California" runs the headline in the Observer, reminding me of the peaceful 'yard' in Los Angeles where this editorial was originally written (the original was lost in the mail.) This newspaper article describes the latest escape into tranquility in California. For £8.00 an hour one can float naked in the dark in a man-sized, sound-proof, plastic box called a "tranquility tank" containing ten inches of water and a strong concentration of Epsom salts.

Lilley, the inventor of the tank, claims that it helps people to find 'a new inner security and integration of themselves on a deep and basic level.' A chaise longue by the swimming pool in the Autumn sunshine was O.K. for me!

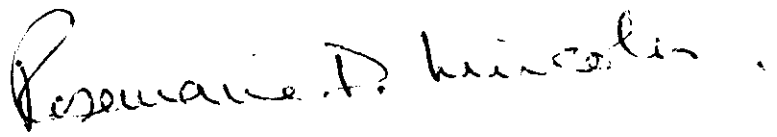
Plans for the International Conference at Brighton are going forward well and it has been decided to combine this meeting with our annual residential one in order to create a firm financial basis on which planning can go ahead and also to ensure that Institute members will have the opportunity of attending with the other participants who may have had different training and hold different views and therefore interesting encounters will result. Early registration gives financial advantage so obviously it is to be recommended that members make up their minds as early as possible. Accommodation will be available in Hotels and in the University with an appropriate differential in the cost. Details about this and a draft programme are printed later in the Newsletter.

The Residential Weekend at Cheltenham on 19th – 21st September was well supported, with about 140 members attending. It was very much enjoyed. There was a warm atmosphere, climatically and emotionally, and the scientific content was research orientated. The papers on problems presenting during pregnancy and postnatally showed evidence of the enormous amount of understanding and learning that is needed in this field. The gynaecologists present at the meeting were enthusiastic that more members of the obstetric teams in hospitals are becoming aware of and more sensitive to the presentation of psychosexual problems while patients are under their care.
It would be helpful to know for future planning why other members were unable to go to Cheltenham. Finance? Time? Lack of interest in the programme? – May we have some feedback, please?

The next event on our calender will be the Annual General Meeting on Friday 19th March, 1982 from 5.00 – 6.30 p.m. followed by a buffet supper and speaker, Helen Manning on "Cut off your nose to spite your sex" (insights of an E. N. T. surgeon trained in psychosexual medicine) at 8.00 p.m. This will take place at the Royal Society of Medicine. It is to be hoped that the A. G. M. will be as well supported as it was last year.

The number of Associate Members of the Institute is growing quite rapidly and we are lucky to have the help of Mr Ronald Trowbridge, as an Administrative Assistant to Dr Jane Berry, who will be able to keep our records of membership and addresses in an orderly way.

Yours sincerely,



Rosemarie D. Lincoln
Hon. Editor

NOTICES FROM OFFICERS

Notice from the Secretary – Dr K. Draper

It has been decided that next year there will not be a weekend residential meeting in September, but that this meeting will be combined with the International Conference being held at the Metropole Hotel, Brighton, from July 7 – 9th 1982. The Registration fee will be lower for those who book before the end of February.

Over 70 members have already completed the tear off slip on the leaflet that was sent with the last Newsletter, and they will receive the full Programme in November, with plenty of time to take advantage of the reduced registration fee. Anyone else who wishes to receive the Programme and Registration Forms should write to:

Conference Secretariat,
Caroline Roney Medical Conference Organisers,
100 Park Road,
London NW1 4RN Tel: 01-723 6722

It is appreciated that the timing and increased cost may be difficult for some, but many members felt that they would like to take part in this first open meeting, when there will be an opportunity to discuss our work with other doctors who are interested in psychosexual medicine. The name 'Conference' cannot be changed, as it is already on the leaflets etc., but the meeting has been designed as a workshop. The papers introducing each subject will be brief, and time will be spent in groups during each session, so that there will be plenty of opportunity for exchange of ideas as well as for our guests to experience the seminar situation.

Notice from the Referral Secretary – Dr M. Gill

Many thanks to all those members who have sent in their clinic details on the yellow forms. They are very useful indeed, If you have not sent details, please do so, as I would like as many as possible.

REGISTRAR – Dr Elizabeth Deman has been relieved of this office now that registration has been incorporated into the work of the Administrative Assistant to the Honorary Treasurer – Mr Ronald Trowbridge of 6 Dunsells Close, Ropley Alresford, Hants SO24 0DN Tel: Ropley 2439. Mr Trowbridge will be in touch with members from time to time on purely administrative matters connected with membership and subscription. The Institute would like to express great appreciation for all the work that Dr Deman has given to this complicated task.

Notice from the Director of Training – Dr Prudence Tunnadine

1. **D H S S Grant**
We are still awaiting final news as to whether this will be extended and therefore some hope remains.

2. **Seminars**
New Basic Seminars are being arranged in Nottingham, Taunton, Bradford, Leeds, Exeter, West London, Bath, Margaret Pyke, Pontefract, Maidstone and Diss.
Advanced Seminars with vacancies : Sharpthorpe, Salisbury, Exeter, Guildford and West London.
A **new Advanced** Seminar will take place in Nottingham if there is sufficient demand.

Interested doctors are asked to contact the
Director of Training for further details.

3. **A New Information Sheet** about the training the Institute offers is being printed and will be available shortly for members to use.

4. **Accreditation Panel**
The accreditation panel members now consist of:
Dr A. Tobert, Dr B. Hinshelwood and Dr R. Thexton.
The reserve member is Dr S. Lucas.
Dr Judy Gilley is the panel secretary.

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

Colonel James Bradshaw – Duchess of Kent Military Hospital, Horne Road, Catterick Garrison, North Yorkshire.

Dr Mary Griffen – 39 Trewsbury Road, Sydenham, London SE26.

Dr Gillian Wakley – 'Holly Lodge' Lynch Crescent, Winscombe, Avon BS25 1AS

Four more candidates have presented themselves to the panel and accreditation will be published in the next newsletter.

5. **Research : The Nuffield Study**
Dr Bramley reports on research into treatment of Non-consummation.
The report of the Pilot Study was published in the British Journal of Obstetrics and Gynaecology Vol, 88 No 8, p. 819 to p. 824, August 1981, under the title 'Brief Psychosomatic Therapy for Consummation of Marriages.'
The figures for the Nuffield Study are still being analysed.
a) Out of 112 reports on couples, the Psychological Social Worker differed from the Doctor on only 3 occasions and there were special reasons for this.
b) Out of 159 couples, 60% consummated at 6 months. Twenty months later 68.5% had consummated. The true figure will be higher than this as patients entered towards the end of the study had less time for extra treatment after the six months was completed.

c) The mean duration of symptoms of presenting couples was 4¼ years.
d) The mean age for females was 25½ years and the median was 25 years. The mean age for men was 28 years as was also the median.

Provisional Programme of the International Conference
Brighton, 7 – 10 th July 1982

Wednesday 7th July 1982
Introductory papers on Training will be given by the President, Dr Tom Main and the Director of Training, Dr Prudence Tunnadine.

Thursday 8th July 1982
Papers to be presented:-

"While I'm here, Doctor, I don't suppose it matters, but. . . . . " Dr R. Freedman
"What can you say to young people today?" Dr F. Hutchinson
"We've never managed intercourse." Dr H. M. Bramley
"I cannot understand why I cannot ejaculate, I'm so good at everything else." Dr R. Thexton and Dr R. Lincoln

Friday 9th July 1982

"It was such fun until our Johnny came along" Dr A. Tobert
"I'm impotent – can you give me some pills?" Dr J. Berry and Dr J. Yorsten
"Shall I bring him with me next time, doctor?" Dr K. Draper
"I don't want to get pregnant – I do want to get pregnant" Dr E. Christopher
"I want an abortion, doctor" Dr M. Blair
"Our family is complete – will sterilization mean the end of everything, doctor?" Dr P. Tunnadine

Saturday 10th July 1982
Plenary session. Reporting back from groups and general discussion.
Summing up. President.

Free communication sessions will be held on Thursday and Friday (5.15 – 7.00) and participants are invited to submit papers on topics concerned with psychosexual medicine lasting for 10 – 15 minutes for presentation and discussion in these sessions. The papers should be sent to the Scientific Committee, 111 Harley Street, London W1 before 1st May, 1982.

ANNUAL GENERAL MEETING
19th March 1982, from 5 – 6.30 p.m.
At the Royal Society of Medicine

There will be a Buffet Supper at 6.30 p.m. and a Clinical Meeting at 8.00 p.m. The Speaker will be Helen Manning: "Cut off your nose to spite your sex." (Insights of an E. N. T. surgeon trained in psychosexual medicine.)

There will be a Memorial Concert
for
Dr Pat Shirley-Quirk
on
Saturday, 14th November 1981
at 8.00 p.m. in
High Wycombe Parish Church.
Gabriel Faure's Requiem will be performed.

The President of the Institute will be represented by Dr W. Roles.

REPORTS OF MEETINGS

Residential Weekend, held at the Golden Valley Hotel, Cheltenham. 18th – 20th September 1981

Dr Robina Thexton

A business meeting preceeded the scientific programme. The opportunity was taken to introduce the members of the council to the Institute members and to describe the role of each.

The International Conference at Brighton in July 1982 was discussed and it was decided that this should be combined with the annual Residential Weekend in order to ensure adequate financial backing. The registration fee which would include all meals but not accommodation would be approaching £90. Increased numbers attending might reduce this sum. Accommodation would be at the Metropole Hotel, or smaller hotels or at the University. Members were encouraged to make sure that there was adequate local publicity about the Conference.

A buffet supper followed a sherry reception kindly provided by Wyeth.

Scientific Programme

The Use of Videotape in Training

Dr Elspeth Williamson from Southampton described the making of five videotapes for teaching GP trainees, junior housemen and medical students. The aim was the recognition of psychosexual problems. The patients were role played by Family Planning nurses and doctors, trained by the Institute, took the parts of the interviewing doctors. The tapes had five different themes.

1. Frigidity in a woman who was resentful of the feminine social role. The by-phrase was "I am a zoology graduate and he earns less than I did. I resent his enjoying intercourse when I don't."
2. Difficulty in finding any suitable contraceptive method in a woman aged 48. "Don't you think it's time we slowed down, Doctor?"
3. Difficulties about pelvic examination and expectation of vaginismus. Two different clinical approaches were shown.
4. Youth Advisory Interviews. A girl and her mother and also, a girl alone.
5. Impotence in a 45 year old man whose daughter had just left home to go to university.

These tapes had been used successfully in group discussion. Dr Roland Freedman showed tapes which he had made for teaching purposes and the following questions were posed after the conclusion of the tape.

1) List the occasions when the doctors behaviour was inappropriate.
2) How could it have been different and why?
3) Give suggestions for improving the interview.

An Institute doctor was present. Actors were used as patients and briefed minimally.

The clinical encounters represented:

1. The complaint of a vaginal discharge and the doctors failure to listen.
2. A request for giving up breast feeding and the explanation of the patients fears about being tied to mothering.
3. A pill problem revealing difficulty with intercourse and the attempt to explore fantasies about the Pill.

The doctors did have difficulties themselves in front of the TV cameras!
Cost £300.

A brief discussion followed on the question of the usefulness of tapes in training. Their use as a trigger for discussion was thought by most members to be acceptable.

Saturday 19th September

Dr Main, our President, opened the morning session with a short presentation: the Institute began as a corporate body of doctors studying techniques of training and research. This involved listening and thinking about clinical problems which the doctor experienced – the approach is the same with patients – studying the irrational and unconscious elements. With a patient there is a

mutual unconscious relationship and particularly over the genital examination. The patient has to understand his own feelings, thus gaining understanding of his relationship with others. The doctor and patient are joint investigators, humble co-workers, each is ignorant but willing.

The successes of the Institute are that it organises Basic Seminars and Advanced Seminars; it has a corporate identity and holds learned meetings. It sends out a regular Newsletter, and there are maintenance seminars, leader doctors workshops and a research seminar. The work carried out by administrators must be acknowledged.

What of the future? The number of members is greater than the number of trainees. The trainee is an independent doctor – he has to do the work. Independent thinking is the aim of all training – but he relies as well on members of his seminar.

After training, do their skills remain at the same level or go up or down?

– they need to give and get critical comments
– not lose touch with the unconscious
– not cease spotting the doctor/patient relationship.

There is always a danger of **Hierarchical Promotion of Ideas.** This means ideas leaving the tentative area where there is uncertainty and arriving in the area of **knowing** – they become imperative. A move from one end of the ego to the other.

Example Trooping the Colour ceremony – now a beautiful ritual, was once a technique of getting soldiers on to a battlefield forming a British Square; marching and counter-marching now has no function.

Ideas suffer this fate when they are believed mindlessly. Management consultants find archaic procedures still practised – which are not adaptable and thoughtful. The **automatic** way of working economises on **thought,** but is less painful. Under **anxiety** people cease to think and fall back on hierarchical ideas. They rush in with mindless activity in order to get away from pain. We all fail in this way.

People do it because it is **there.**

Example: They ask patients questions rather than let **them** talk. We saw this under the anxiety of the Doctor/video relationship.

Instead we should listen and draw conclusions.

We turn to books and adopt questioning and telling techniques when we abandon listening and thinking. Trainees are the same – they lapse into teaching. **Thought is the first casualty of anxiety.** The Institute tries hard to stand anxiety in patients and conduct humble joint enquiry – the ignorant but willing pair – doctor and patient. The Institute gets trainers to **think** about seminars – to investigate rather than run away from difficult problems.

Dependence is a danger. Trainees must be independent. **Not** belonging to a seminar is good. But there are isolation dangers – too much anxiety of too many patients leads to reversal to certainty, and modifying techniques to suit circumstances – we offer books, telling, explaining, teaching. If frightened, insights can

be used for teaching rather than thought. We must get down to the ground floor and work **with** our patients, willingly.

Some doctors increase their skills after they have finished training some lapse backwards and do the same thing with all patients. We must encourage members to have it **both** ways – freedom to return to seminars after, say, two years. Give them opportunity to get in greater depth and steadily improve.

New and different kinds of patients are coming and with each new case we must be a beginner – not seeking expertness, but freshness of technique. Each formal maintenance seminar must write and publish. New findings will emerge in doctoring technique, in the business of understanding the sufferings of patients.

Morning Session – Chairman – Miss Valerie Thompson

Detecting Psychosexual Problems in the Antenatal Clinic

Colonel J. Bradshaw

Colonel Bradshaw began by declaring his awareness that the faint signals of anxious patients may often be missed, in the 'cattle market' atmosphere of the busy antenatal clinic. Pregnancy sometimes triggers off symptoms of sexual difficulty. Some women cannot convert exciting premarital sex to enjoyable sex within the marriage relationship. Some try to awaken libido with a lover, and some settle for duty rather than pleasure. Other women fail to anticipate the inevitable demands of a three way relationship and the responsibility of the baby. The emotional traumas associated with childbirth may be great.

Case Studies :

A blousy 21 year old German Woman who was the daughter of a Prussian General was married to a British Infantry Corporal. Late in pregnancy everyone was aware of her anxiety which seemed to result from her feeling of being in the doctors power. She had a Caesarian section and following the birth she had poor libido and also had vaginismus. If she did have intercourse she suffered from nightmares. She resented all doctors.

An analysis was made of 204 cases of sexual difficulty following childbirth in order to try and understand whether prevention might be possible.

a) Those with existing sexual problems.

A bossy school teacher of 29 had conceived without having had intercourse. She had been told at her first pelvic examination that she was too small and had vaginismus and could not consummate. A psychiatrist had failed to help her and she controlled the obstetrician too. She had a forceps delivery and had the baby fostered so that she could go back to work and regarded men as 'walking companions'. She was no better after delivery and opted out of treatment and became pregnant again.

b) Those with a predisposition to problems.

The reality of childbirth may be very different from some womens cosy expectations. Episiotomy and foetal monitoring may be shattering experiences. Gwen

Rankin of the Natural Childbirth Trust was quoted as saying "New babies result in passionate and overwhelming new feelings which are not always delicate and ephemeral".

Questions at the first booking visit may help to detect vulnerable people — such as;

1. Past history of emotional trauma eg. T. O. P.
2. Fears of the future eg. foetal abnormality, difficult labour, vagina too small, pain in labour.
3. Libido and orgasm, continuation of intercourse during pregnancy?
4. Is husband to be present or not during delivery and the reasons for this decision.
5. Intention to Breastfeed — ? guilt about sexual arousal during breast feeding.
6. Observations of the reaction to vaginal examination.

It was noticed that 9 women out of 43 had vaginismus and 4 of these admitted that they did have a sexual difficulty. Four of these women did not wish to breast feed.

Three examples were given of patients whose problems were detected and treated during the antenatal visits and Colonel Bradshaw emphasized the importance of being aware at this time and then further discussion can take place at the postnatal visit.

The Case of Patients with a Known Abnormal Pregnancy

Dr Frank Johnson
Consultant Gynaecologist & Psychotherapist

Dr Johnson described the case of a 35 year old primiparous woman who had conceived after 11 years of infertility due to endometriosis. She was treated and conceived and when she had an ultrasound scan she was found to have twins. Then blood serum showed very high alpha feto protein and later scanning showed one twin to be anencephalic.

She had at first been delighted to be having twins, but on discovering that one was abnormal she felt hurt. thought life was unfair and stabbed in the back. She could not forget the abnormal baby and felt depressed and unable to face other people. The doctor explored her fantasies of deformity and her feelings of incompetence as a woman. She went home and talked to her husband and cried. At the second visit she could begin to think about the normal baby and she did not want to be shown a photograph of the condition of anencephaly.

At 29 weeks she was admitted to hospital for bed rest and was put in a single room because she could not talk to the other patients. She felt that life was not fair, but she could cope alone. She was afraid that the abnormal baby would take all the nutrition from the normal twin.

Dr Johnson said that he tried to answer her questions directly and also allow her to fantasise. Ultrasound was used to allay her fears about the normal baby. The husband did not want to talk to the doctor.

At Delivery

The normal twin was delivered first and the husband was present and there were warm and happy feelings. Neither parent could look at the abnormal child and the priest came and baptised and touched the baby. When the doctor met the husband by chance in the toilet he talked for 40 minutes. He had lost his father nine months previously. The next day the mother was sad about the deprivation for her baby of a companion and the doctor suddenly found himself saying "People sometimes regret that they haven't looked at the abnormal baby". It burst out and he regretted having said it but suggested they make the funeral arrangements. The mother did not go but later wished that she had been there to comfort her husband.

At the post natal examination she was on cloud nine, but expressed anxieties about facing life at home. She wished to be sterilised. Once she expressed regrets at not having seen the anencephalic baby and she reported that her GP had said that he would not have let her see it. She felt depressed and tearful. The doctor interpreted to her that she could not fully accept that she had an abnormal child. She changed her mind about sterilisation but complained that intercourse had been painful. Questioning whether that might be due to the sheath or the episiotomy, the doctor said "Intercourse is no fun because of all your painful experiences." She resented the husbands comment that she would not have been able to cope with two babies. An interpretation was made to her about her need to be able to manage by herself.

In another month she was no longer preoccupied with with her loss and was happy on the minipill. She was given an opportunity to return if she should wish to.

Summary

Ultrasound may create an added problem by showing up the abnormality of a foetus early. Decisions have to be made and feelings understood. This patient mourned early and was helped by the fact that her obstetrician and psychotherapist were the same person. He was able to explore the fantasies, and answer the questions with an organic basis. The conflicts have emotional and organic components.

Dr Johnson hoped that the Institute could help with training of Gynaecologists to be aware of these difficult conflicts.

A short discussion of these two papers followed.

Psychosexual Problems in the Post Natal Clinic

Dr Elizabeth Deman

At the post natal visit which is the final episode in the saga of pregnancy everything should have returned to normal. This visit is used as an opportunity to obtain information about bleeding, micturition, contraceptive method. Examination of breasts, abdomen, pelvis and blood pressure. Contraception is

discussed and future care arranged. Sexual problems may be overlooked if physical complaints are taken at face value. The doctor must notice the womans appearance and attitudes and relationship to the baby and other siblings. Complaints may be of sleepless nights, bleeding, discharge, backache, painful perineum and other physical symptoms but the moment of truth may often occur before the examination "Do you have to examine me?" or "I think I have been stitched up too tightly."

Clinical Encounters

1. A woman in her early 30's shouted at the sister in the post natal clinic who picked up the baby's carrycot for her – "Put that down!" This woman accepted the fitting of an I U D with resignation and nothing further was said but on her check visit six weeks later she talked about the many reasons for her tension at the first visit.

2. A woman of 36, a theatrical costume designer, well groomed and talkative was tearful at her post natal examination. She had a very bad squint which the doctor found hard to look at. The patient complained about constipation and difficulty about contraceptive method and then said 'my marriage is a failure – I am tired out with the baby, we did not have sex during my pregnancy. I hated my pregnancy – the honeymoon was a disaster!
She had damaged her eye in a road traffic accident and had to have plastic surgery. Her mother died suddenly and she could not cope and had analysis until she was married when her husband stopped it. The patient showed no emotion but the doctor and nurses were very concerned for her and she projected an idea of having a damaged body. The difficulty of enjoying sex in a mother's role was discussed and the doctor realised that she felt motherly to this woman.
At the next check visit she expressed fears of losing her husband saying "he must be fed up with me – I have to have 2 – 3 large whiskies before he comes home." and "I must find a baby-sitter." She mentioned that her father had left home when she was 15.
She talked about "the dramas of the labour ward" but did not detail them.

3. Mrs A requested to restart the pill after breast feeding. Just before examination she said "You can't examine me down there" "It is normal isn't it, to delay intercourse for several months? It all feels different since the birth. We had a marvellous sex life before". She felt she had closed up. Flushed and trembling she said "I wake up screaming in the night imagining a black doctor putting his arm right up inside me saying, "It shouldn't be long now – you are almost fully dilated!" The first stitching of the perineum had to be redone after an argument between the midwife and the houseman and it was hours later that she was returned to the ward. This patient was encouraged by the doctor to feel her vagina with her own fingers – the doctor guided her hand to the vulva and she was able to calm her fears by accepting the reality that her genital area was not too damaged.

The post-natal visit is used to:

a) Detect and refer overt puerperal depression.

b) Detect long standing sexual problems and refer for help if possible.

c) Understand anxieties and fears which may have resulted from events during pregnancy or labour. Patients with high expectations who have trained with the Natural Childbirth Trust may feel disappointed and let down.

The post-natal physical examination provides a valuable opportunity to understand the feelings of anger and disappointment and to be aware of the fantasies which may have arisen and also to understand the feelings about the fact that the vagina may actually be damaged by an episiotomy.

Discussion

There followed discussion about these three papers concerning antepartum and postpartum care. Points were made about helping staff to be aware of the psychosomatic events which occur, such as the repair of an episiotomy. There was a need for 'de-briefing' of the couple following delivery. The understanding of the choice of whether the husband should be present during labour was important because some men had such fears about it that they could not face it, and might be damaged emotionally by the experience.

Dr Main commented on the discussion by pointing out that Members were noticing the problem of the Rivalry of Women to their own mothers and the feeling of tresspassing in the field of motherhood. The women say the nurses are wonderful except for one who represents 'the Witch'. The Madonna is often the black nurse. These are the primitive images of motherhood and love is always ambivalent and the emotional problems of childbirth bring out the ambivalence.

The attendants may be seen as antagonistic and childbirth is such a compelling event that we may want to get in on the act out of envy!
None of us have many babies of our own.

Afternoon Session – Chairman – Dr K. Draper

Winchester Seminar

Drs Jane Berry and Jessie Yorsten presented a paper on Women Doctors studying men presenting with the symptom of impotence.

Fifty men with the presenting symptom of impotence had been referred to women doctors in N H S clinics. Thirty eight men were referred by G Ps and the other 12 from Consultants, SPOD and Family Planning Doctors. These doctors who referred the patients expected that the Institute doctors would be experts in the field, not only diagnosing syndromes, but could estimate physiological measurements of erection and to be able to refer for a penile implant.

The seminar doctors selected the patients which they thought they would be able to help and referred the others to appropriate consultants such as psychiatrists.

The Understanding of the Doctor/Patient Relationship

The doctors felt placed in the position of the expert and that they must do

something for the patients. Sometimes there was a feeling that they could do better than the man's wife.

It was noticed that those who presented with the greatest anxiety had the best prognosis for change. The doctors were aware that in situations of desperation they resorted to instruction "I wish you could see my wife" was often an escape from discomfort in the Doctor/Patient relationship.
Genital Examination was sometimes used to reveal a moment of truth.

Dr Yorsten gave examples of men who had not been able to use the doctor/patient relationship which was offered, and who had feelings of disgust about sex. She summarised the anxieties which they had met in other men in the series – alchohol, skin problems, phimosis, damage from masturbating, ageing changes, testicular atrophy, vasectomy, contraception.
The doctors noticed that some men feared women who "prepared themselves" and therefore seemed to be demanding, and others remarked that women "saved themselves."

Dr Yorsten gave an example of a divorced man who now had a younger girlfriend. During his 17 year unhappy marriage his wife had made him withdraw saying "You want it, you control yourself". He had put his feelings away. With the doctor he discussed his expectations of a lover who would be contraceptively prepared – and he got better. He later asked whether the doctor had hypnotised him!

Other clinical findings were about **performance worries** and **fear of failure.**

a) Problems in new relationships, widowers, divorcees, and beginners.
b) Guilt about pleasure for themselves (Public school syndrome)
c) Readjustment after illness or disability.

Impotence Associated with Long Term Relationship Problems

a) Dominant wife who is a passively aggressive sexual partner.
b) "A Pedestal Wife" (Men who put their wives on a pedestal rarely knock them off!)

Men with impotence from psychosis or organic causes were referred to other doctors for help.

Members discussed this paper, several mentioning the importance of discovering fantasies about penile size and other ideas about physique such as skin rashes and contamination.

The significance of the sex of the doctor who was the therapist was also discussed.

Hyperprolactinanemia and Impotence

Dr Joan Coombs

High Prolactin levels in the blood produce Galactorrhoea, amenorrhoea and infertility in women and in men it produces hypogonadism and impotence.
Hyperprolactinanemia is more common in women.

In Bradford Dr Coombs in collaboration with a male consultant psychiatrist, a male GP and a female F. P. doctor (who used behavioural techniques) studied a series of patients who presented with impotence. Each man was screened for physiological changes;

Testosterone
LH and LSH
Thyroid
Prolactin

A skull x-ray was arranged if Prolactin was raised and then tomography and mapping of the visual fields. If microdenanata of the pituitary were discovered treatment with bromocriptine was instituted.

Dr Coombs studied the emotional problems of the patients and she did all the venupunctures. Often this could be used as a moment of truth.

Of these men with loss of libido, 17 had normal assays. It was found that very few do have high prolactin levels but perhaps all should be screened to detect the few who have microadenanata.

Problems of the Referral Secretary – Dr M. Gill

There are 6 or 7 requests a month for referral and Dr Gill endeavours to put the patients in touch with members. It is important for members to keep her informed of their work addresses and phone numbers.

The original letter is usually destroyed. Some of the letters are very poignant and she replies using the understanding of the pain and anger expressed.

She quoted a favourite poets words: "Your pain is the breaking of the shell which encloses your understanding."

Dr Blair took the Chair for the Sunday Morning Session.

Following up defaulters – Dr Snead

A follow up by post for these patients who failed to keep their appointments at three separate clinics, had shown that in fact some patients were, for practical reasons, unable to attend and also for others, it provided a therapeutic tool. The patients could complete the form anonynously, but the clinic was able to identify the responses by coding. It was a way of accounting for NHS money spent on the work of psychosexual clinics and GPs who had referred patients were notified if patients failed to continue in therapy.

Dr Snead stressed the crucial role of the personality of the Secretary in continuance and response of patients.

The Sharpthorne Seminar — **Dr N. M. Campbell**

Dr Campbell gave clinical examples of the work he was doing in his Psychosexual Clinic Sessions. Later he talked about his work in the Seminar he attended and gave thumb nail sketches of some of his colleagues, using these to formulate his ideas about doctors. He felt that thay had three parts; one part scientifically trained, one the emotional and artistic and vulnerable, and a professional skill which can use the scientific and/or the emotional, in encounters with patients.

Celebration of Cases

Dr Barbara Devereux
Dr Elaine Cooper
Dr Audrey Jones prescribed cases with a successful outcome showing the use of the Institute seminar training in developing techniques by individual doctors to help their patients.

(Two of the case studies are included as clinical articles later in the Newsletter.)

Dr Tom Main's Summing Up

At the end of the Conference Dr Main commented how much we had enjoyed the 'celebration of cases' suggested by Dr Elder last year. He wished her well for her return to New Zealand. He said that the quality of thinking in the presentations improved with each annual Residential meeting and there is a corporate feeling in the Institute.

We are not alone — except with our patients! Our way of looking at human encounters can be applied in many situations which had been demonstrated by the papers which had been given during the weekend.

Leader Doctors Residential Workshop

Cheltenham **23rd and 24th October, 1981**

R. D. Lincoln

Many Leader Doctors are unable to attend the regular workshops in London or Leeds and so this residential meeting provides a valuable opportunity for sharing mutual difficulties and successes in leadership techniques.

Several doctors noticed that at times of evaluation or assessment the Group and its Leader may suffer vulnerability and anxiety. Dr Tom Main thought that the Leader had the role of a cricket coach rather than of a teacher and the Leader has to be able to understand the amount of anxiety which the group members can individually tolerate. Doctors always have a powerful internal conscience and so doctors difficulties with patients should be seen in terms of common sense rather than in such a way as to promote feelings of guilt in the doctor.

A change of the leader in an existing group also produced reactions and stress for the new leader and for the members of the group.

Losing members from the group, and also the advantages and disadvantages of having co-leadership were discussed.

Hospitality was provided by Wyeth and we spent a very comfortable and interesting twenty-four hours at the Golden Valley Hotel.

International Conference on Sexology

Jerusalem June 1981

Dr H. Backer

There was a very full programme at this conference at which there were numerous papers predominantly on the Behavioural approach to Sex Therapy. Other papers were read dealing with biochemistry and sex education and many related topics.

A film on sex education made in Holland showed the effect of sexual dysharmony on a young couples relationship, illustrating the breakdown which resulted. The treatment suggested was rather over simplified and used behavioural techniques.

One session was devoted to papers on rape and speakers from various "rape centres" spoke about the effects of rape. Xaviera Hollander spoke on Prostitution and this paper achieved headlines in the Israeli press.

At another session a debate arose when one speaker made a claim that since the advent of sex therapy the divorce rate had risen and that therapy may be a deterrent to sexual fulfillment.

Lunchtime Conference

Each day we lunched in groups of ten or twelve with one of the better known delegates as a leader and particular topics were discussed. These groups were sometimes interesting but some leaders had very little clinical experience in the field and could only quote from questionaires. Dr Money led a discussion on sexual offenders which I attended which was very interesting.

My regret throughout the conference was that the Institute was not more fully represented. Dr Dewsbury and I were the only members there. Many of the speakers had very limited experience compared with our own and we should be prepared to be more involved and to present papers at such meetings.

During the discussion if I contributed our ideas about such matters as physical examination the other participants were amazed and sometimes silenced! They were especially surprised by the idea that women doctors examined men patients as a routine practice. It was also noticeable that our techniques of thinking 'the patient is the one who comes' as a way of solving the problem of the non attending partner interested them.

There was a session on the effect of religion on sex – various extreme denominations produced speakers – these were rather inconclusive as most of the speakers were members of these sects and those non members who did research came under attack from members of these groups.

Dr Judy Dewsbury gave a paper on impotence.

Congress members were entertained by the Mayor of Jerusalem at the Jerusalem Museum where a special exhibition of erotic art was shown. It would seem that sex and sexual fantasies were subjects for objets d'art throughout the ages.

The reception and buffet took place in the forecourt of the Museum with a magical view of the city.

ARTICLES

BRIEF PSYCHOSOMATIC THERAPY FOR CONSUMMATION OF MARRIAGE

H. Morag Bramley
Joe Brown
Katherine C. Draper
and
Jane M. Kilvington

Summary

We describe the treatment of sexual problems by Members of the Institute of Psychosexual Medicine who are trained to recognise and use therapeutically the doctor-patient interaction. A prospective study of long-standing cases of non-consummation was chosen for evaluation of therapy as there was a definite outcome. Of 50 couples, most of whom had previously had many unsuccessful consultations, 64% consummated within six months and 72% in 14 months. Among those who had failed actually to consummate at six months, one third had increased their ability to enjoy sexual activity. The average number of attendancies was six, involving altogether about four hours' work. These findings compare well with those reported in other studies and suggest that referral of such cases to a doctor specially trained in brief psychosomatic therapy tends to bring the best results.

The frequency of marital conflict and breakdown with its huge cost of broken homes and damaged children (Home Office, 1979; Lancet, 1979) is increasingly recognised. Examination of current therapeutic methods should contribute to better provision of treatment of relevant sexual problems. The dearth of research studies of brief psychosomatic therapy in contrast to directive or behavioural treatment methods has recently been emphasised and is due to reluctance to use questionnaire assessment for evaluation (Editorial, 1978). Completion of forms, before or during a consultation, interferes with the relationship which is the basis of such therapy.

This form of therapy was evolved by a study group of doctors, started in 1958, under the Family Planning Association (Friedman,1962; Courtenay, 1968; Tunnadine, 1970). The Institute of Psychosexual Medicine was formed in 1975 to continue the scheme of training in fortnightly seminars. Doctors discuss their work dealing with patients complaining of all types of sexual problems, with a qualified leader. They learn the technique of listening; of observing in the doctor-patient relationship the patient's individual ways of thinking, feeling and behaving in intimate matters, and of using the genital examination as both a

psychic and somatic event. After a minimum of three years training, a doctor is assessed by a panel and if passed may then become a Member of the Institute.

This pilot study of 50 cases was undertaken to assess the work of Institute Members and to prepare for further research. The subject of non-consummation which forms about 6% of their work was chosen because success or failure is clear cut, and elaborate questionnaires are not needed.

SUBJECTS AND METHODS

Non-consummation is defined here as 'failure of any penetration of the vagina by the penis in the present relationship'. Long-standing or difficult cases were chosen in order to omit those who might succeed spontaneously. The criterion for entry was non-consummation of more than three years' standing, and cases of shorter duration were included only if treatment from a N H S consultant or sex therapy clinic had already failed. After two days of training in the reporting method required, 20 Members of the Institute of Psychosexual Medicine, working in various settings, contributed to this study. They registered consecutive cases over an eight-month period. A control group of patients was not used as other treatments, even when described as behavioural or supportive, also involve complex interactions between the therapist and the patient, and isolation of the various factors would be impossible (Balint, 1961). Nor was it considered ethical to leave a randomly selected group of parients untreated, as non-consummation is of major significance and often decisive for the results of treatment.

An interview technique was employed in which the doctor looked for and drew attention to the feelings arising from interaction between himself and the patient, and he tried to be sensitive to the patient's unconscious communications. Genital examination was used, not only to check pelvic normality, but also to create a situation in which the patient's reaction could be observed and her feelings of fear, guilt, shame or shyness discussed; at the same time the patient was encouraged to express her fantasies. Some couples were treated seperately and some together but there was no pressure for the partner to be present.

Details of the initial social, economic, medical and sexual situation were recorded by the doctor after the first interview and further data added subsequently. The results of genital examination and the history of sexual responses to partners were recorded at initial and final visits; the number, and frequency and duration of visits were noted. The outcome after six months of therapy was reported by each doctor for all couples enrolled. Consummation without pleasure to one partner or with only partial penetration was noted as 'technical consummation only'. Results of therapy lasting more than six months were analysed seperately.

CASE REPORTS

Couple 1

A professional couple, married for 12 years, were referred for impotence and infertility. Treated previously by a 'sex therapist' and by a gynaecologist, no intercourse or pregnancy had occurred. The husband who was 36-years-old told the doctor of his fear of pain. The wife, aged 35, dwelt at length on her husband's difficulty and seemed to be 'managing' the interview. It became clear that the wife needed to protect herself by distracting the doctor's attention from her anxieties. While undressing she ordered her husband to turn his back, and now the doctor, who had felt irritated, realised that the wife felt exposed, vulnerable and shy. Vaginal examination was technically easy, and the doctor asked the wife what she thought it might feel like to have a penis inside. The wife said that the penis would have to 'get past sharp corners to get into the unknown'. The doctor did not comment on this fantasy, but simply listened and then suggested that the patient feel inside herself. Hesitantly, the wife managed to examine her vagina, and was amazed to find it smooth and relaxed. She was now able truly to discuss the imagined vagina, the reality and associated anxiety. At this moment the doctor was aware of the husband trying to see what was taking place. Conscious of the patient's pleasure in the discovery of the real vagina as distinct from the fantasy, the doctor invited the husband to feel inside his wife, and withdrew, leaving them together. Within one week the 12-year-old marriage was at last consummated.

A further history illustrates the much longer time taken to resolve some problems.

Couple 2

A 23-year-old social worker complained while renewing a prescription for oral contraceptives that she could not let her 28-year-old fiance penetrate the vagina. Frequent attempts over the last two months had made her increasingly tense and unhappy. She had been told that her vagina was very tight and needed a good stretch.

Later this pretty girl admitted to the Institute doctor to whom she had been referred that she felt ambivalent about what she was doing. Her mother had told her that men, given a chance, exploited women and extra-marital sex was wrong. Her boyfriend could not promise an early marriage but said that it was normal and right for them to have full intercourse. The doctor was aware that this patient could not reconcile the two points of view and shared her dilemma. The patient also said that she had fainted recently while witnessing the use of a vaginal speculum. The doctor recognised that her moral problem was increasing the anxiety she had about her sexuality.

At examination she was anxious and showed marked vaginismus, allowing only one finger inside. She also rejected the doctor's suggestion that she should feel inside the vagina.

The doctor tried to interpret the patient's fear of sexuality but she preferred the former diagnosis of abnormally small vagina, thus rejecting the doctor's attempt to penetrate her ideas about sexuality as well as physical penetration.

During several half-hour interviews in the next few weeks, however, she gradually gained confidence and the vaginal examination became easier. Ultimately, examinations with three fingers was possible, the patient learnt to insert tampons and became familiar with her body, but the difficulty of intercourse with her boyfriend remained.

The doctor did not try to influence her decisions but let the girl talk at length about what she really wanted. One day she came saying her boyfriend, who was a physiotherapist, requested dilators. The doctor again suggested that the vaginismus during love-making was due to a conflict in the girl's mind; she gave the dilators, however, but was not surprised to hear about the boyfriend's amazement when he saw them used with ease. Now both partners recognised that the apparent tightness was due to anxiety created by her moral conflict. The patient left the area to start a further training, but her boyfriend remained constant in spite of their difficulties.

One year later there was a request for an interview. The patient looked radiant and reported that consummation had taken place.

In this case the patient had used the doctor's insight to come to terms with her normal sexuality but had needed time to resolve the moral conflict by herself.

RESULTS

Consummation rate, length of treatment and previous therapy

The rates of consummation are shown in Table I. There was no disagreement between members of couples or with the doctor as to outcome. Among the 18 women who failed to consummate after six months, one third had improved in response to her partner's caresses.

Attendance for therapy is given in Table II.

The mean number of contacts with the doctor was six, including defaulted appointments, letters and telephone calls. The mean time spent by the doctor with each couple was four hours and the median 2.6 hours. The consummation rate did not vary with time spent except in five couples, treated for over six hours, where it was only 40 per cent.

Only six couples were first presentations, the other 44 couples had previously consulted 98 agents including 23 NHS consultants (16 gynaecologists and 7 psychiatrists) and 7 non-medical therapists.

Some patient characteristics and their relation to outcome of treatment

The patients' ages ranged from 16 to 65 years, the majority were between 25 and 34 years old and only 7 patients were more than 45-years-old. It was the

first marriage for 38 couples; the second or further marriage for 5 couples and 7 were unmarried. Forty-three women were nulliparous; five women had become pregnant without penetration resulting in two miscarriages and four live births, and two women had borne six children to previous husbands. The most frequent social classes were 3 and 4.

The length of complaint varied from 3 – 37 years in the long-standing cases, with a mean of 6½ years. It was over 8 years in 13 couples, of whom 10 consummated, all desiring a pregnancy. The eight couples with a complaint of less than three years had already consulted seven National Health Service consultants and three sex therapists, and five couples achieved consummation.

Various degrees of impotence were present in 10 men and we are aware of this both as a factor in, and as a consequence of, non-consummation but do not discuss it here. In 23 couples the male partner was not seen. Nine men who were examined genitally showed no physical abnormality. The outcome among couples where men complained of sexual difficulty was no different from the average.

Table III shows the initial response to vaginal examination and previous relevant traumatic experience in relation to outcome. The other characteristics will be reported in conjunction with a larger study that is still taking place.

Table I

Rate of consummation in 50 couples

	Consummation achieved			Non-consummation		
	With pleasure	Technical	Total	Still in treatment	Presumed defaulted	Total
At 6/12	21	11	32 (64%)	8	10	18 (36%)
At 14/12			36 (72%)			14 (28%)

DISCUSSION

The literature reveals no reports of a prospective study with which our results can be directly compared, nor can we find any study restricted to difficult and long-standing cases which reduced the possibility of natural remission.

The retrospective studies fall into two groups, single therapists and the team approach.

In the former group Friedman's (1962) study of 100 selected cases (63 per cent first presentations) reported 71 per cent consummation. Duddle (1977)

reported that of 32 couples treated with combined behavioural and psychosomatic techniques of unrecorded duration, 72 per cent were able to consummate. The average duration of the complaint was small and only four couples had been previously treated. Ellison (1968) quoted 87 per cent consummation in 100 retrospective cases treated by deconditioning and psychotherapy but excluded all cases with insufficient information. These, in our experience, would be those who failed to develop a therapeutic relationship.

Table II

Attendance for therapy 50 couples assessed at 6 months

	Consummation acheived	Failed	Total number
Woman alone	14 (61%)	9	23
Man alone	0	2	2
Both	18 (72%)	7	25
Total	32	18	50

Table III

Details of patient characteristics and outcome

	Total number	% Consummating at six months
A. *Initial response to vaginal examination* (48 women)*		
Relaxed	12	67%
Vaginismus	26	76%
Rigid hymen	2	(50%)
Refusal	8	(50%)
B. *Previous relevant trauma* (48 women)*		
Traumatic medical encounter	13	61%
Other traumatic sex experience	11	55%
None	24	75%

( ) percentage of less than 10

* information not known for balance of 50

Although there are many descriptions of a team approach to therapy, only Milne (1974) gave results. A 33 per cent consummation rate was achieved in a group of 15 patients treated by a team including a psychiatrist, a psychologist, a social worker, outpatient sister and co-therapists, all concerned with different aspects of the treatment, which must prolong therapy. The doctor-patient relationship is fragmented in this situation.

Very few workers report time spent in therapy, though Ellison (1968) quoted a time of 4.5 hours for her selected cases. Bancroft's (1976) successful treatment of 6 cases of vaginismus required a mean of 17 sessions. The mean duration of four hours, for the treatment of difficult cases in this study, is shorter than available comparisons.

Many women attained consummation after attending alone; this does not support the contention of many sex therapists that couples must always be treated together (Bancroft and Coles, 1976).

In a group of 50 couples, the analysis of patient characteristics is limited. Nonetheless, some observations are note-worthy. The occurrence of six conceptions without penetration in 50 couples is interesting but not unexpected: Lamont (1978) reported 5 'virgin conceptions' in 27 couples. Pregnancy does not prove that sexual intercourse has taken place and physical stretching of the vagina does not deal with anxieties which have prevented penetration.

Vaginismus is often equated with non-consummation (Duddle, 1977) but 25 per cent of women in this study were relaxed on examination and these, contrary to expectation, did not have a better result. Previous treatments had helped to overcome the spasm but had not explored the patient's unconscious fears and fantasies; simple reassurance about anatomical normality had not been enough to help the women to consummate. Our study confirmed the usefulness of regarding the vagina as both a physical and an emotional organ and that vaginal examination can be used therapeutically for exploring both.

Surprisingly 26 per cent of women complained of a traumatic penetrating experience during medical treatment or examination – varying from hurried vaginal examination in front of students to insertion of rectal suppositories. Fact and fantasy may be mixed in such reports; neverthless a nervous patient may use a simple remark such as 'she is a bit tight' to reinforce existing anxiety-driven beliefs that she is too small for intercourse. A well-intentioned doctor may thus lend himself to confirm the patient's anxiety instead of helping her to understand it.

Despite the fact that the first report of satisfactory treatment using a psychosomatic approach was by Friedman (1962), our series showed that many non consummated patients suffer for many years and a diversity of referrals. This study suggests that these patients would be better served by referral to doctors qualified in psychosomatic treatment and able to offer complete privacy. It is no accident that 'private parts' are so called as dealing with intimate matters requires a privacy which the presence of students or a therapeutic team fails to provide. The method of treatment described in this paper can be applied to any sexual problem; but the outcome with other complaints is more difficult to assess statistically.

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TOO MANY HATS

Dr Joyce Blair

At age 33, I attended a few Psychosexual Seminars at the Margaret Pyke Clinic led by Dr. Rees. He helped me slowly to understand hysteria but, because I am an impatient person, I soon moved on – thinking that I had no more to learn from seminars. I continued to treat psychosexual problems in clinics and privately, gaining experience from the patients, from my own marriage and from observation of my friends' marriages, and (while I was ill with Brucellosis) from literature – the English novel!

At about the age 48, I again attended three Psychosexual Seminars with Jean Pasmore and two demonstration seminars with Tom Main. My family were now in their early teens; I had read Kaplan's New Sex Therapy and I intensified my work with Family Planning Clinics and also with couples privately. The great polemic now in Psychotherapy, was between the relative merits of Psycho dynamics and Behavioural Techniques.

It became clear to me that, in fact, Masters & Johnson were really human psycho-biologists; that is, they observed human sexual behaviour and physiology in vivo and in vitro – and used the practical knowledge gained to help patients who had poor techniques of sexual functioning, Kaplan observed that this, 'though not true Behavioural Therapy was successful as a programme of instruction – but that progress was held up sometimes by psychological blocks of varying degree and severity'. She used the clues gained from blocks in the practical work to explore unconscious areas, and to work with the psychodynamics. Thus there was a blend of observational biology and psychodynamics with no real conflict in the treatment.

At that time, true Behavioural Therapy was rarely used by doctors who are Members of the Institute of Psychosexual Medicine, and so there was no conflict. Clinical psychologists do use behavioural techniques and Derek Jehu's recent book gives a full account of several properly conducted statistical comparisons between currently used methods.

The main therapies are:-

1. Masters & Johnson
2. Modified Masters & Johnson
3. Behavioural Techniques
4. Use of Drugs
5. Psychodynamic Methods

Some doctors combine all these methods of treatment and some add cognitive therapy as well, ('use your loaf').

Reading the transcript of the latest Conference of the Institute of Psychosexual Medicine at York University and looking back over my own rather patchy association with the Institute I felt that and the Institute had both made a little progress.

The present schism seems to be one not of which treatment we should use, but of whether the Institute method of training is best for us as doctors. Does the answer lie in the ideas of Dr. Tom Main and others who think that students would only understand and remember facts which they personally had elicited by their own efforts and experience and that knowledge passed on in a directive manner from master to pupil would never be properly digested and retained. Freud ostensibly believed this and he is always described as allowing the patient to come to self-knowledge alone against the blank, non-directive wall of the analyst's presence. But most lecturers today add a footnote to this idealised portrayal of Freud to the effect that in his later years he was, in fact, more directive.

Pulling these threads together, I weave a new fabric for 1981. All methods of treatment are permissable! Accurate diagnosis will only come from a slow, constantly changing examination of didactic interplay between first patient and partner, and next the patient and the doctor. Moreover, since the so-called diagnosis will change with each sexual encounter of the couple under treatment, we are right to play the waiting game and to re-examine at each consultation – not to reject, but to nurse along the chronic case and treat each episode as it arises. We are not, I think, justified in employing an exclusively 'object relations' view of couples – although this is the only possible underlying creed and strategy for experienced medical practitioners. We should also volunteer help and direction to aid the couples functioning.

At 52, I now think that the Institute should remember that it is a body of doctors and, as such, it is unique in the field of psychosexual medicine and thus, very valuable to its Members. A multiplicity of organisations and professions exist to help the sexually dysfunctional. It is dangerous to treat without full medical training and a sound knowledge of psychodynamics. I echo Dr. Main's dictum that statistics of large numbers of cases are rarely as instructive as a few carefully observed couples; for me 'anecdotal' is not a dirty word. We should try to emulate Freud in keeping notes on every case and we can then look back and discover years later the progress of our patients.

The following cases treated over past years spring to mind as illustrating the stony path which we tread amongst the five methods of treatment listed above. These cases are neither statistically significant or particularly successful.

1. Masters & Johnson

A 34-year-old 'sensible', religious spinster came for breast examination. She told me she loved a shy man who was trying to persuade her to take the pill so that he could try coitus without worry before the couple committed themselves to a firm engagement. I asked them to attend together in two weeks, having instructed her about hymen stretching techniques. At that time I was in an enthusiastic psycho-dynamic phase, and so I was considering this man's Oedipus – but when I saw the couple together, my instincts took over. I asked the woman to get on the couch and I examined her again vaginally, whilst they held hands, chuckled and looked into each others eyes – almost oblivious of me. It seemed to me that they had everything going for them. I then told them that to make penetration possible she would have to raise her legs from the bed at the appropriate moment, so that the introitus would be at the correct angle. Light seemed to dawn on the pair of them and they went off with a packet of condoms and the lady returned two weeks later to report that 'all was well'. Observation and Instruction!

2. Modified Masters & Johnson

During a time of enthusiasm for Dr. Kaplan's 'New Sex Therapy', I started to see a couple weekly at home. The main complaint was the wife's total loss of libido; she was older than the husband and she told me that the loss of libido was because a previous boyfriend had once entered her rectum 'by mistake and it hurt'. I then gave her Sensate Focus exercises, and I was surprised by the wife reporting at the next consultation that she had 'felt randy for the first time for months' and they had had intercourse. I then tried deeper exploration of the wife's problem and after three months of seeing them I knew every detail of the wife and husband's past lives – but I was continually being dragged into wrangles about details of their domestic life and finances. The wife persisted 'Who should clear up the dog's mess? Who should wash up? How much do-it-yourself chores the husband owed (the wife having bought the house). Whether he should clear up after each job. Whether she should have supper ready upon his return from work' etc., etc. At that time, I had not read books on behavioural therapy and I did not realise that a series of contracts which I had devised for them to keep the peace was, in fact, this. However, there was no sex at all by now and a repetition of the wife's fears that the penis might enter her rectum.

This woman's father was a playboy and always spent much time on his yacht with various partners. She as a child had not learned to trust or to depend on a man.

3. Behavioural Techniques

I have seen several honeymoon couples who have profited instantly from the 'squeeze technique'. A wife who fails to be able to help her husband to improve premature ejaculation in this way may need help along more psychodynamic lines.

Another case I tentatively decided to treat by the technique of Thought Stopping (in this case combined with aversive stimulus.) This pretty girl had had two divorces and had recently married again and she told me that her father had 'forced' her to stimulate his penis when she was a child – so that she now always remembered this and felt 'let down' at a certaing stage of coitus. She had seen psychiatrists during her previous marriages and so I told her to try a simple manoeuvre. As soon as she felt the impetus of coitus to be flagging I suggested that she pinched herself and firmly switched her thoughts to fantasies of happy holidays, pleasant scenes, erotic pictures, erotic pictures, etc. She returned to the clinic a month later, telling me that all was going marvellously. Pragmatic treatment without reference to cause of symptoms!

4. Drugs

A graduate who presented with the complaint that the wife 'kept having affairs'. On their arrival, I noticed that the charming husband had a slight lisp and was very gentle and he aroused my maternal instincts. The wife was striking, pretty, but red-faced and hoarse; during the consultation she taunted her husband with plans for outings with her men-friends. It seemed to me that the wife was presenting in typical hypomania; she was having psychotropic drugs from her General Practitioner. I referred her back to the GP as I felt she needed the dose adjusted; unfortunately, the GP suggested that this couple should live apart for a year. Looking back, I felt that I did not know enough to help this husband become a complete functioning male. It was not until later, when I attended further psychosexual seminars, that I really understood the Oedipus Complex. I investigated his relations with a dominant, bossy mother, but should have known more about a son's relations with his father. Or perhaps I should have copied the method of Minuchin – an American Psychotherapist – and said 'Do it to her, man'. This case from long ago illustrates for me the dangers of our long drawn out method of training; surely an intelligent doctor could be helped earlier with such basic facts? Could I have helped this couple to stay together if I had had a little more information about the workings of the male psyche?

5. Psycho-Dynamic

A pretty lady wearing a beautiful blue dress, with long blonde hair and fingering constantly the crucifix on a chain round her neck – complaining of soreness on intercourse. Having delivered a little talk on Monilia, I examined her. She was not sore, but was in the pre-orgasmic plateau stage and, judging from her busy life, she'd been in the same state on and off for months. Whereas I had been thinking that her goodness and religiosity were inhibiting her, I found that she was a straight Masters & Johnson case. No psychotherapy needed, just information, and the couple could find time to finish off coitus themselves. I think this case also emphasises that many doctors are mistaken in thinking that a strict religious upbringing, of itself, is a bar to happy sexual funstioning. This was demonstrated by Dr. May Duddles' series of cases in which she found that, vaginismus, is experienced as often after marriage whether or not the patient was sexually active before marriage.

I hope that these illustrative cases, although somewhat paradoxical in outcome show that we need to re-examine the present state' at each consultation. If we have knowledge, but no preconceived notions about the patient the treatment will suggest itself; almost a conditioned reflex.

In conclusion, having written this light hearted commentary, I realise that a few concrete suggestions for amending the present training programme should be made. Some years ago Dr. Margaret Blair suggested that I should write to the Newsletter along these lines; I would have profited most at the very beginning of the training from a brisk, 6-month course, covering all human sexuality in a factual, directive way, perhaps leading to a certificate in 'Human Sexuality'. Thereafter perhaps there should be 18 months of Psychosexual Seminars, leading to Membership, which would then qualify doctors to work in Psychosexual Clinics. A final one-year course leading to Fellowship, I feel, should combine the seminars, as we know them, with lectures on the whole field of psychiatry in order that doctors could put their own work into the perspective of other psychotherapeutic ideas. With this Fellowship, the doctor could teach, lead seminars and act as a Consultant for Members: such a course would, I hope, improve our standing and that of the Institute in the academic, psychiatric field of medicine.

CELEBRATORY CASE HISTORIES

A. "The husband who took his mother breakfast."

Dr Barbara Devereux

This patient who was a 61-year-old diabetic had made several attempts to get treatment for his impotence and he reported that he had been told he should be "grateful for what he had got!" He had been impotent for ten years. Finally he was referred to the psychosexual clinic by the PAS due to his persistent efforts to get help. He questioned whether the trouble was due to diabetes. He had morning erections and could masturbate. He was a tall white haired man with a slight speech impediment and gave the impression that he might be a non-conformist preacher.

He talked freely and the doctor had to interrupt him at times to stop the flow of words, and, replying to the question "I wonder what happened ten years ago?" he said "My mother came to live opposite"! He was an only son, and married whilst in the Army in Germany. He doubted he would have even married if he had not been away from home. "When I took my German wife home my mother found if very difficult to accept her. I stuck up for my wife when we came back" he said. He continued that he and his father were both under mother's thumb although she was known as "poor little Mrs Parker". When his father had died, he and his wife felt responsible for mother and she came to live opposite.

At the end of the first consultation he said "you've given me something to think about – I did feel responsible for her."

He returned two weeks later saying that they had had intercourse every night for a week. His wife had initiated it the first time but it had been successful and enjoyable. "I was so relieved that it wasn't due to diabetes and I feel more of a man." He then related how he and his wife used to have intercourse on a Saturday and Sunday morning and he would feel anxious and afraid that he would be late taking breakfast to his mother. "I was still feeling like a small boy having to please my mother." In fact he still felt guilty every time he passed the nursing home where they had arranged for his mother to stay whilst he and his wife spent a holiday in Paris – although his mother had now been dead for several years. In Paris he had been potent!.

This man,in the presence of a doctor who accepted sexuality as normal in a man of 61, (even with diabetes), had developed his own insight about the domination of women and his need to please, and was able to use it to become more potent again – he said that he felt ten years younger and the doctor noticed that she felt very pleased – he had pleased her?

The question remains as to how much this man was freed, and how much he still needs to please his doctor, his wife and his internal mother.

B. A case of non-consummation presenting as impotence

Dr Elaine K. Cooper

The couple were referred by the sympathetic Sister of the ward, where Mrs B was a ward orderly, and she had noticed that Mrs B was very distressed. This couple were both 24 years old and had been married for five months.

The presentation was that it was a problem of impotence.

The problem was their inability to have intercourse due to the husband's poor erection and premature ejaculation. This had occurred before their marriage but they thought it would be all right when they were married. Mr B had been to his General Practitioner who reassured him saying "don't worry, it will be all right". But Mr B still worried. As always – reassurance was of no value.

Mr B, a Telecom engineer, was the youngest of five children, the youngest of these being six years older than he. He was, according to both of them, spoilt by his mother.

Mrs B was an only child. Her father died of emphysema when she was seven years old. Until her marriage she had lived with her mother in a one-bedroomed flat sharing a bed with her.

In the discussion Mr B felt uncomfortable and talking about sex was difficult for him. He could not say the word masturbate and I said it for him.

I examined Mrs B, she was quite relaxed and easy to examine but looked bothered. I commented on this. She said "I am bothered because I don't know what is going to happen". This feeling and fear of not knowing what was going on was reiterated when she said she wanted to attend the next appointment with her husband as she did not want him to feel anything was hidden from him. She seemed to feel that people hid things from her.

I suggested an active remedy for the premature ejaculation – the squeeze technique. The seminar said I had been "accepting and optimistic" – a different sort of mother – was also instructive and directive" and I was criticised for this

At the second interview the couple had achieved intercourse on some occasions. Mr B complained that he felt the need to perform when they entered the bedroom and therefore preferred to make love downstairs. I asked him how he would feel if he was told not to try again until after the next visit and he said he would feel relieved, It was agreed that no intercourse would take place.

Reporting this interview at the seminar, I was criticised for being directive. I saw how unhelpful it was to give this advice and that discussing why he feared performing would have been more constructive.

I recognised that this had been a bad session for me. I was feeling low before the interview as I had returned from my mother's funeral the day before. I was pleased to hear the good news that they had made progress but throughout the interview was aware of the need to keep concentrating hard to prevent personal thoughts intruding. I thought I had managed to keep my own feelings hidden. When they talked of their mother, I was aware of feeling that my mother was not there anymore. They too were having to break the emotional ties with their mothers. It was painful for them too. I had kept thinking of my loss because they were thinking of their's and I had needed to shield all of us from the pain by giving advice. The feeling of having mishandled the whole interview and the likely damage done caused me considerable discomfort.

At the third interview the couple said they were worse. Mr B said that theadvice not to have intercourse had not worked and that their general situation had deteriorated and that they had therefore decided to resume intercourse again and had mutual orgasm. It seemed to have been helpful to him to find that the advice of the 'doctor – mother' figure could be wrong and he had overruled it, as he was unable to do with his own smothering mother. He did not like his wife to show her bad feelings and cry – he needed her to be strong. She was afraid that by showing her feelings he would leave her as her father and previous boyfriends had and she would be hurt again. They were, in fact, better and Mrs B felt she would come alone for the next session. The uncovering of bad feelings had led to progress, as the Group's sharing of the doctor's pain and grief, when she reported, had brought relief.

At the next interview Mrs B forsook her smart white coat and came in casual clothes. She hung up her jacket as if setting to work. She said she was much better. She seemed to have appraised herself and she was taking responsibility for being the patient. She had set about putting her house in order. She had spoken with her father-in-law and shared with him her difficulty that she could not stand her mother-in-law babying her husband. Her father-in-law shared with her how he felt at always being put second to his son in his wife's eyes. Mrs B had also talked to her mother and discussed the marriage problem. Mrs B's mother said "some men are impotent and you have to put up with it". Mrs B felt strong enough to put her mother down saying "this was not so as they had proved it". She was angry with her mother and blamed her for their difficulties saying "it's because of you I am as I am". They had cried together and then felt better.

It seemed that Mrs B had something more to say. She was trying to say that she did not need to come any more but seemed afraid to hurt my feelings. I felt the need to help her out and ease her difficulty by asking "do you need to come any more?" and when the patient said "no" told her that I was very pleased that she could now cope without coming to see me, but I was aware that a small bit of her did want to return. I gave her my telephone number.

At the time I did not think to ask why Mrs B felt bothered about hurting my feelings. At the Group later, we discussed the value of verbalising the difficulty, interpretting it and sharing it.

I asked Mrs B how she would manage if more problems arose and she replied "We'll face them and talk about them. We've changed about how we feel about bad things haven't we? I'll come out with it and not stay silent".

I asked how it had been when her father died. She said "I was only seven and he died on Christmas Day. I knew he had been taken to hospital but no-one would tell me what was going on. My mother came home and cried and wouldn't tell me. I felt so confused".

It seems that from this time onwards she had never been able to verbalise distress.

The turning point in this case seemed to be at the interview which I considered to be a bad session, when I was feeling sensitive to feelings about my mother and to loss. Mrs B was enabled to work through her bad feelings about the mothers in her life and loss of her father. She and her husband were then free and able to be adults responsible for, and able to enjoy, their own fulfilling relationship.

C. The "and what about me?" syndrome

Dr R. D. Lincoln

1. At the end of a morning clinic, arriving about twenty minutes later than her appointment, a trim, blonde woman in her 40's came in to see the doctor, requesting an IUD check and smear.

She was looking quietly angry whilst the examination was done and then, almost at the end of the visit, she made a rather acid answer to one question – whereupon I said "You seem rather angry with us to-day about something". She said "I'm not angry – but just can't spare the time", and then her eyes filled with tears and she wept, taking me rather by surprise.

She said "I'm just so tired". I asked her whether it was her job as P.A. to a Hotel Manager which was making too much demand on her, and she said "I like my job and can't manage it well, but everyone depends on me. I like this really and I used to be able to cope. Do you think that it is the change?"

With difficulty, I tried to get her to talk about her personal life and what problems there might be; reluctantly, she told me she had two teenage daughters with whom she got irritable and she felt that they did not do their part in the house, and she nagged and worried. She had been divorced ten or more years previously and had brought up these two girls on her own and had done her job

in the hotel. She had been a lover, she told me, of an ineffectual and rather neurotic man friend who visited her frequently, but who was also dependent on her.

As I watched the temporary unwinding of this capable woman I said "I'm sure you often feel "And what about me?"". With this, she relaxed, smiled and agreed, and we could then talk freely about her need for someone to care for her sometimes and her tiredness and loneliness.

This patient returned several weeks later much more composed and on an even keel and since this has sent her daughter's friend and one of her daughters to see me about contraception.

This woman made me very aware of the exacerbation of dependancy needs at the time of the menopause: a busy, powerful, capable woman finding that she does not feel her usual self.

2. Another woman illustrated the same ploblem. She attended the Clinic, asking for HRT, although she had minimal problems with flushes. She said that she was depressed, irritable and could not cope with her life anymore. She was a tall, well turned out blonde and quite an attractive woman for her years – although she was 48.

In discussion with the doctor, she was very reluctant to accept that emotional difficulties do occur in the 40's which are not necessarily related to hormone change, or improved by hormone replacement therapy. The story she told me was that her daughter had recently started to do her nursing training and her mother missed her because she did sometimes give her a hand in the home – although she emphasised, "Of course, I would never ask her"!!

There were two teenage sons and a husband who were pretty chauvinistic in attitude; no doubt, reinforced by this woman's independence and need to manage. The marriage relationship she described as "He doesn't say much" and clearly communication between them on an emotional level was now minimal. Her elderly mother lived in a Granny flat and the patient said that she was marvellous; she had always been able to manage for herself.

An interpretation to this patient of her inability to depend on anyone and yet her subconscious need for that, and her resentment about the family situation was not accepted, She returned for two visits, saying that she was "just the same!". She had made no changes in her behaviour or attitude.

Oestrogen therapy had relieved the flushes, but she neglected to say so until questioned by the doctor. She just could not appreciate being cared for.

On the third visit we had arranged that she should have a routine cervical smear

and whilst she was on the couch I began talking about her daughter and her nursing training. She said "I get on very well with my daughter and she has begun to tell the boys that they should do more for themselves. She says that I make a rod for my own back too!"
She laughed and I said "Yes" and that I thought I had been trying to point out that she was allowing herself to be a victim of her own attitude. She suddenly saw it, and accepted it during the vulnerability of the physical examination. She had never been able to accept the fact that she had needs and rights of her own until that moment!

She had learned from girlhood that independence was virtuous and could not allow herself to feel any dependency even at the vulnerable time of the menopause.

CORRESPONDENCE

A letter has been received from Dr J. Brown of the Elm Street Clinic, Ipswich :

> Dear Dr Lincoln,
> Thank you indeed for and congratulations on the new format of Newsletter No. 19.
> Further to paragraph two on page 4 surely we only change our name when (and hopefully this is not too far distant) we, like the anaesthetists and community physicians become a faculty of an appropriate Royal College.
> Then the title Faculty of Psycho-sexual Medicine will without spelling it out in detail embrace the facts that members treat patients, train colleagues and uphold standards in this important branch of medical practice.
>
> Yours sincerely,
> J. Brown

PUBLICATIONS

"Themes in Psychosexual Mecicine" edited by Rosemarie Lincoln has been published and is available at £2 from the F. P. A. bookshop. This booklet is a collection of articles published in response to requests from General Practitioners for help in understanding the psychosexual problems presented to them by their patients. In these chapters, guidance is given on the various therapeutic methods available, and suggestions are made, where appropriate, for the referral of patients.

Some themes will be found to recur, their repetition serving to emphasize their importance. These include: the role of body fantasies; presentation of relationship difficulties by several symptoms; interpretation of the doctor/patient relationship as a way of understanding and treating the problem.

Many of the authors are members of the Institute of Psychosexual Medicine to whom acknowledgement is made, who gained their expertise by its seminar training. Dr Michael Balint headed the first psychosexual seminar in 1958, in response to the needs of medical practitioners in family planning to gain insight into problems presented in the clinics. In 1959 Dr Tom Main led the second seminar and has advised on the setting up of succeeding seminars.

We are grateful to the Editors and Publishers of MIMS magazine, Novum (Schering Chemicals) and the British Journal of Family Planning (with assistance from Wyeth), for permission to republish articles originally commissioned by them; also to Dr Stuart Phillips who helped to prepare the articles for reprinting.

Rosemarie Lincoln in the Foreword

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Dr Jane Berry
Treasurer of the Institute 1981

It is with deep sadness that we record the death of Dr Jane Berry after a short illness. A trust is being set up in her memory to commemorate her interest in the Institute.

Members wishing to contribute can send donations to:-

Dr Jessie Yorsten
"Luibeg"
Gardiners Lane
Romsey
Hampshire

Dr K. Draper and Dr J Yorsten will be representing the Institute at the memorial service.