

## DIARY OF EVENTS 1982

### Institute Meetings

- International Conference** 7th – 10th July, 1982  
Hotel Metropole, Brighton.
- Leader Doctors Workshop** 24th – 26th September, 1982  
Nottingham University.
- Autumn Clinical Meeting** Friday, 26th November, 1982  
7.30 p.m. Royal Society of  
Medicine.

### Other Meetings

**7th International Congress on Psychosomatic Obstetrics  
and Gynaecology.**  
**Theme : The Young Woman**  
11th – 15th September, 1983 , in Dublin, Ireland.

The National Marriage Guidance Council are presenting a series  
of exploratory study days with a Common Theme:  
**Change in Marriage**

30th June, 1982

**'Changing patterns of Marriage and Re-marriage.'**  
Newcastle upon Tyne, The Old Assembly Rooms.

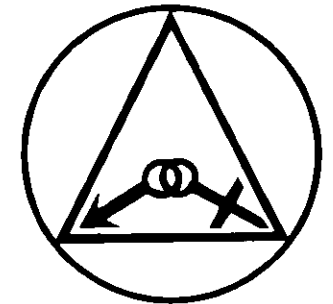
8th July, 1982

**'Changing Roles of Men and Women and the Effects on  
the Family.'**  
Cavendish Conference Centre, London.

**S.P.O.D. 2nd International Conference**  
19 – 22nd July, 1983  
Owens Park, University of Manchester.  
**'Learning , Loving and Living'**

Papers of not more than 10 minutes on Sex Education,  
Counselling or Practical Help and information should be  
submitted by 1st October, 1982 to:  
Christine Taylor, S.P.O.D. Conference Organiser,  
33 Grantham Road, Chiswick, London.

# Institute of Psychosexual Medicine



Newsletter No. 21  
May 1982

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### Members of the Council:

- |                     |                       |
|---------------------|-----------------------|
| Dr Margaret Blair   | Dr Rosemarie Lincoln  |
| Dr J. Dewsbury*     | Dr Mary Rees          |
| Dr Katharine Draper | Dr John Rogers        |
| Dr Ronald Freedman  | Dr Rena Sampson*      |
| Dr Judy Gilley      | Dr Robina Thexton     |
| Dr Jane Kilvington* | Dr Prudence Tunnadine |

\* New Members elected 1982.

### Co-opted Members :

Dr Joan Coombs, Dr Margaret Gill, Dr Fay Hutchinson, Mrs Nancy Raphael.

## INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 21  
May 1982

Chengdu  
Central China

Dear Colleagues,

This newsletter is being written in conditions of complete contrast to "laid back in California". I am perched on a bamboo chair in a small tea house which was being repaired 6,000 feet up a Chinese Mountain by the Provincial Parks Department whose workers shared their delicious china tea with us. This mountain is in the Yunnan Province of which the capital city is Kunming and it was here that the Burma Road ended. Decrepitude precludes me from climbing further up the mountain and so I am able to write this watched by friendly curious Chinese eyes. Tourists are still sufficiently unusual in China to excite friendly curiosity and not animosity.

Arrival in the Peoples Republic of China is indeed a culture shock and there is a flood of immediate impressions. Those which strikingly come to mind are the courteous formality and the no tipping and shaking hands and thanking the engine driver for a safe journey. Visually there is an impact of the intensive agricultural cultivation with no tractors or mechanisation. Wide streets with no cars, but millions of bicycles, many heavily laden with goods, remind one of the Champs Elysees with bizarre traffic. Other impressions are of ceramic dustbins, chimneys belching with black smoke, monster thermos jars, street-side decorated spittoons, delicious and over abundant food but alcoholic beverages which are either fire water or syrup. The meal ceremonial includes hot wet perfumed flannels for the face and hands which contrast to the other facilities which are still designated as places where one washes ones hands, but are very little removed from a hole in the ground!

The talk in China is of the one child family and a certificated pledge by a couple to have only one child brings an immediate cash bonus and preferential housing where possible. Priority for better schooling and child care is given for the only child, whereas if there is a second child 10% of the income of both the husband and the wife is deducted and the benefits of the 'one child family' are forfeited and should be repaid. On the farms the first child is allocated land and grain equal to an adult, whereas the second is not. In areas of high density population the penalties are said to be more rigidly imposed, whereas with smaller minority populations there is more flexibility and a second child may be allowed.

Our interpreters had very little knowledge of contraception or its terminology and so my first week was spent in tutorials with them. Long engagements and premarital chastity is expected and strong social pressure is brought to bear to maintain it. The acceptable age for marriage is about twenty-four. No woman becomes pregnant before she is married and so contraceptive advice is only given just before marriage. There is no sex education in schools and even instruction about menstruation at school is not related to the reproductive process. However our guides who were highly intelligent civil servants (cadres) told us that they were thinking about beginning to teach physiology of reproduction in school. Now that the Chinese have contact with Western visitors and films one hopes that constraints will not be re-imposed. There is intensive and widespread publicity for Family Planning and so I wonder what the children think that means.

Enough of travelogue. We now look forward to Brighton and I hope that members have already submitted papers for consideration for the free presentations.

There has been a good response of registrations which continue to arrive from both members and non members.

We continue to miss Jane Berry very much and have been grateful to Mrs Nancy Raphael and Ron Trowbridge who have managed the financial administration so well in the interval until the appointment of Roland Freedman as Treasurer. The fund set up by the Institute in memory of Jane is growing and the Executive will discuss in what way it should be used. Members may like to let them have ideas.

Dr Judy Gilley would still like to know of the professional addresses of Institute doctors and also many seminar members have not filled in Registration cards. Leader doctors please note!

It would be nice if all eligible seminar members would also join the Institute and therefore receive news and views through the newsletter.

Now for a visit to the Acrobats!

Yours sincerely,

林月博士

Rosemarie D. Lincoln

Rosemarie D. Lincoln  
Hon. Editor

## NOTICES FROM OFFICERS

### Jane Berry Fund

Contributions have now reached almost £400 and discussions are continuing as to the best way to use this money. There have been suggestions of a Prize Essay or a continuing Memorial Fund. Members who have not yet contributed and would like to do so should send their donations to:

Ronald Trowbridge, 6 Dunsells Close, Ropley, Alresford, Hampshire SO24 0DN

### International Conference

Registrations are coming in satisfactorily and members are reminded that the course fee is cheaper for early applicants. We hope that some members will submit papers for the free communication session.

### Nuffield Research

Requests for reprints of the article 'Brief Psychosomatic Therapy for Consummation of Marriage' have been received from Canada, U.S.A. and many countries in Europe.

Non-consummation Study:- 159 Couples. 72% of couples have now consummated by 24/12. The average number of visits was 6, consisting of 3 hours of therapy in total. Those couples not consummated have so far received 3½ hours therapy in 6 or 7 visits.

An edited article on Non-consummation is to be incorporated into a book edited by Roland Freedman.

### Report from the Panel

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

Dr N. M. Campbell — 79 Manor Road, Worthing, Sussex.

Dr Jennifer Peebles — Park House, Hampton Court, Surrey.

Dr Barbara Robson — 40 Thornton Road, London SW19 4NQ.

At present the panel's method of approaching the accreditation of candidates is being reviewed and so there may be a larger interval than usual before the panel meets. Members wishing to submit their names to the panel should however still apply to the Panel Secretary — Dr Judy Gilley, 57 Leopold Road, London N2.

As many members have long distances to travel when they come before the panel it was felt that a central position would be more convenient.

The Wates Suite, Margaret Pyke Centre, Soho Hospital for Women is to be used for the Panel meetings.

#### **Treasurer**

Members are encouraged to pay their subscription by four year covenant to save the Institute Tax.

#### **Referral**

Dr Margaret Gill reports that there is now a doctor who will accept patients who speak German, Spanish or Russian.

#### **Secretary's Report**

Dr Margaret Blair was unanimously re-elected Chairman of the Council.

Dr Roland Freedman has accepted the position of Treasurer owing to the tragic death of Dr Jane Berry.

New Members of the Council are Drs Jane Kilvington, Rena Sampson and Judy Dewsbury.

#### **Publications**

Miss Valerie Thompson reported that the Bibliography is now prepared and would soon be printed and available.

She has retired from the office of Publications Secretary and at present there has not yet been a new appointment. The Institute expresses much appreciation of Miss Thompson's work in collecting the bibliography which has been a difficult task and in editing the reports of the Residential Weekends for many years.

The proceedings of the meeting at Cheltenham 1981 will be edited and circulated in due course.

## **REPORTS OF MEETINGS**

### **International Conference on Sexology**

**Jerusalem June 1981**

**Dr Raymond E. Goodman**

It was really something to hear W. H. Masters (of Masters & Johnson fame) lecture, and say unequivocally that some of their early ideas were wrong, and that he believed that at least 20% of patients with sexual disorders had an underlying physical cause. Some of Masters patients with impotence, who had not responded to his various therapies were found to have prolactin-secreting tumours of the pituitary: the laboratory had kept the original blood samples. Dr Masters told of a man who had had a penile prosthesis fitted because of his intractable impotence, no doubt at great cost. The patient's complaint was that his wife would use the device by erecting it while he was still asleep — he seemed to have lost all involvement in the act. Perhaps this is a salutary lesson in treating parts rather than patients!

I was privileged to be invited to read Tuppy Owen's paper on a rescue service for very badly handicapped people in London. By chance the paper was left to the end of the morning, and most of the audience rose to leave. I especially asked them not to, for I explained that most of the people I was to describe were those usually omitted or overlooked as 'hopeless cases'. Nobody left the hall until I had finished, and then there was much feedback.

There were papers on many aspects of sexual medicine viewed from different standpoints. My own paper on current research interest on transsexuals was well represented, and many studies on the intra-uterine hormonal background were cited. It was of interest to hear one author (1) suggest that endogenous peptides and opiates might play a part in control of ejaculation, because opiate receptors have been found in the vas deferens of men. The euphoric feelings after orgasm may also involve the effect of encephalins and endorphins on the neuroendocrine system.

Many old colleagues met and discussed and argued about ideas and there was a delightful trip to Masadas as well, with breathtaking tours of Jerusalem and its environs.

Altogether a Big Plus for Sexual Medicine!

(1) Murphy, M. R. Endogenous Opiates and the Mechanisms of Sexual Behaviour. 5th World Congress of Sexology. Jerusalem, 1981.

## “TO CUT OFF YOUR NOSE TO SPITE YOUR SEX”

Presented at the AGM on 19th March, 1982, by Dr Helen Manning

Thank you for asking me here tonight, although I must admit I would prefer to be doing almost anything else. May I explain? I made a chance remark at a dinner, one of those remarks that was meant to disappear unnoticed and to have no consequences. That was my mistake because Tom Main was sitting on my left, and the result is that I am here with the task of upholding it. The title was another mistake. It sounded explicit when first said, but in one notice I saw that I was described as a surgeon! And that made me think. It produced a different meaning!

What was this mistaken remark of mine? That nasal turbinates are erectile tissue and chronic congestions can result from emotional problems almost as a cut off, a rejection of involvement, a refusal to be stimulated.

I would like to go into the background of this thought.

(i) I see sexual emotion and communication as part, albeit a special part, of emotional communication, but find that rarely, if ever, in problems is it the only area of failure. I say this because, in some cases I'll mention, the “last straw” trigger was in non sexual situations.

(ii) As an ENT and Allergy Specialist, I look in about 5,000 noses a year — for many years. When I started, life was simple. — Nasal obstruction? Was it infection? — Antibiotics. Mechanical? — Operate. Vaso motor? — whatever that means? Ignore or perhaps chop off part. These last are the cases that I now feel are often emotional and mutilation is not the answer. Anosmia — bad luck. We didn't and don't understand it!

The Nose, this will be like coals to Newcastle perhaps, but first let's remember the structure of the nose. A lining increased by three folds on the lateral walls, superior, middle and inferior turbinates arranged as a ducting system for air entry. Normal nasal breathing one third air intake upwards over the superior turbinate to the olfactory septum; two thirds straight back above and below the inferior turbinate. Sniff, a flower, a person, food, the ratio is reversed. The space between the inferior turbinate and septum through which the air passes to be moistened, warmed and filtered is small, optimum 2mm, therefore not much swelling is necessary to block this space. Swelling of the inferior turbinate reduces total air entry and therefore a reduced one third going to the olfactory area. But if there is swelling of the superior turbinate or polyps in that area the one third cannot even get there.

(iii) The type of blood vessels in the nasal mucosa are unique and contain sinusoids, the walls of which are constructed to allow rapid passage of fluid into the tissue causing swelling. The parasympathetic system is responsible for this congestion, just as for penis erection. Constriction of the sinusoids is controlled by the sympathetic system like ejaculation — very similar.

(iv) Neurophysiology. McLean says that in the limbic ring in ancient species behaviour and species preservation, integrated with olfaction. The upper part of this limbic ring serves as the highest integration system of sexual behaviour, the

bottom of the ring for self preservation and olfaction influences both. Further studies in this field demonstrate the power of olfactory cues for sexual arousal in ‘lower animals’ both recognisable odours and pheromones. Some even say our choice of partners depends on pheromones. As so well described by Alex Comfort. How confusing we now make this from the unwashed to Brut. Maybe we wine and dine to start the olfactory process! So it would be logical to postulate that a refusal to relate, to be aroused, could be the cutting off, so to speak, of ones olfactory area by nasal congestion and maybe that in turn is not attractive to the stimulator.

I have a picture in my mind of a man who wishes to demonstrate well being and success standing, chest puffed out, inhaling deeply through his nose — the effect if done through the mouth is not the same!

Perhaps this is why nasal obstruction in children and partners is so threatening. Obstructed noses always seem to be brought to clinics by the ‘loving’ mothers, fathers, husbands and wives. Snoring — the snorer doesn't mind but how angry is the listener. How threatened teachers with the child who won't shut its mouth. All are told ‘blow your nose’. How satisfactory that even if they do, the nose is still blocked. We say, perhaps not here, “don't look so gormless, shut your mouth”.

(v) Hormones affect sexuality and also influence nasal congestion. Chronic stress and depression produces reduction in circulating androgens via hypothalamic pituitary axis but successful sexual responses depend on circulating androgens. So often in these patients we find sexual depression. Some of the easiest nasal congestions to solve are those caused by oral contraception — just a change of pill or method. Anger and aggression produces clear airways — provided frustration does not follow.

I had a patient who summed it up. He was a manager of an electrical products shop — one of a well known chain. If his area manager arrived unexpectedly his nose immediately cleared and, provided all went well, stayed clear; but if he had a few days notice, by the time the area manager arrived, his nose was blocked and usually stayed blocked. This insight was only gained with prompting as this wasn't how he had seen himself.

I had three managers of supermarkets in one year, following instructions from above, a few years ago, that they must all up their sales. But as they basically served the same community, there was no chance, hence the frustration. I felt it would have been a good idea if they had got together for lunch.

We have learnt to use vaginal examinations as our entre to emotional reactions. Some nasal examinations can be used the same way. The nasal speculum — the cusco of the E.N.T. Department. One is certainly in eye to eye contact!

A few years ago, Mrs A was referred, in addition to the usual referral letter, by an urgent phone call from her G.P., ‘Please could I see this nice girl quickly, who had complete nasal obstruction which was making her life very difficult.’ He couldn't understand the cause, as until a few months before, she had never

had any nasal problems. She arrived, an attractive girl of twenty-three, who after the last three or four months had developed severe nasal obstruction, severe enough to make eating and speech difficult, her sense of smell had gone. She added that she suffocated if she tried to kiss her husband — “and this is awful as I have only been married for three months”. She was not on oral contraceptives, her husband preferred to use the sheath. After examination which confirmed almost complete occlusion of her nasal airways, I started doing skin tests, she laughingly suggested, “perhaps I am allergic to my husband”. I think to her surprise and relief I picked up this statement and out poured the story. She had discovered a few months before her marriage that she was not in love with her future husband and had met someone else. But being a nice girl she couldn't face the distress she felt that would be caused to her fiancée's parents and friends if she called off the marriage. So she went through with it and as she said, found, “my husband really gets up my nose”. Complete vaginismus of the nose?.

We discussed her feelings and her attitude to others — she left. Three years later I met a small baby, with an attractive vivacious mother — my original Mrs A, now Mrs X.

Mr. B was also referred for nasal obstruction of about six months duration. He had had a similar episode three years previously. He seemed a well adjusted married man. No cause was found for his problem. ‘Suitable’ medication was given with the suggestion that if it didn't settle we would see him again in three months. Four years later he was re-referred with exactly the same problem. He told me that his nose had cleared shortly after his last visit and had remained clear until about two months ago. This recurrent problem — why? There seemed no rational explanation, until a chance remark revealed the answer, his wife was pregnant. And how old were his other children? Four and seven! He felt ‘cut off’ from his wife during pregnancy. This time the answer was easy. They had already decided that after the birth of their third child, they would have the ‘marriage’ sterilized. I have not seen him since.

Mrs C was a divorcee who had recently moved to my area. She was in her early thirties. She had suffered from nasal obstruction and sneezing for a few years, but had also had similar symptoms as a teenager. No obvious cause for her symptoms was found. She remarked “one does feel so unfeminine with a bunged up nose”. Given slight encouragement she revealed that she had felt unattractive and rejected since her marriage broke up — her husband having left her for a “beautiful blonde”, and although she would like to be in another relationship, she couldn't face the chance of being hurt again. She had had insecure feelings about her ability to attract boys as a teenager. We discussed whether she used her nose to mirror her feelings.

Things have markedly improved both in her nasal airways and her social life.

Mr. D . A good relator, maybe . . . He sneezed every time a sexually attractive girl came too near. Was this a rejection or a positive come on or perhaps an orgasm.

One advantage of the nose as a sexual indicator is that it is common to man and woman, unlike the vagina or penis. It is more accessible. I suggest that nasal obstruction with no pathological cause should ring a bell in our heads, otherwise we may confirm the hopelessness of trying to relate.

#### Discussion Points

Discussion followed about aspects of Dr Manning's talk such as snorers, blocked ears and no sense of smell in pregnancy. It was pointed out by one speaker that orgasm could be likened to a vaginal sneeze. The pleasure of nose picking has the quality of masturbation. Dr Main pointed out that the Rhinocephalon is the oldest part of the brain and the olfactory sense very involved in pregenital sex which is emphasised and is less frightening than genital sex. He also mentioned that the child's nose is level with the parents genitals. Nowadays “Brut” disguises this!

### 2nd International Conference on Sexuality and Disability

Paris 30th October, 1981

Dr Robina Thexton

Speakers from Britain, Italy, USA, Switzerland and Holland gave papers at this conference, as well as those French doctors and health care workers, who were in the majority.

The first morning was taken up with spinal cord injuries, and the first speaker, Dr Premmisra from Glasgow, showed slides which he uses with patients, demonstrating possibilities for sexual expression by paraplegics.

The next speaker from USA, had researched with paraplegics on the importance to them of sexual rehabilitation:-

58%	Very Important
16%	Important
23%	Somewhat Important
3%	Unimportant

As a physiotherapist working with paraplegics, she aims at some sort of sexual rehabilitation.

The afternoon started with papers about mental handicap, and conflicts between parents and educators were discussed. It was stated that 50% of mentally handicapped people marry, and discussion on whether the right to procreate is an absolute right followed.

My turn then came to speak in English, but I had provided a French version for the translators to read, so that the finer points of my subject ‘The Balint Analytical Method of Treating Sexual Problems of the Physically Handicapped’

would not be lost. Some of the audience were members of Continental Balint Seminars and nodded as I described the beginnings of the seminars in London and how a technique evolved of interpreting the doctor/patient relationship to understand a patient better, and thereby help him understand himself, and see how to make a change in his attitudes and goals where necessary. I added that feelings picked up during examination of the genitals were used, and that selection of suitable cases with which to use this technique is vital. My aim was to show, with case histories, that this technique can be used successfully with selected physically handicapped people, as with others. The doctor becomes a humble co-worker with the patient, prepared to listen while the patient tells about his troubles and his feelings, and by understanding him, help him to gain insight.

Where there is physical handicap, the change needed may be in the area of self work, self image, acceptance of changed circumstances, anger and grief. I described the last three handicapped people I had seen in a psychosexual counselling session.

1. A 33 year-old Irish labourer, who had an ileostomy from 17 years. This inadequate appliance in a village in Ireland had left him feeling out of control of his bowel movements, and also in fear of letting go in other areas, like relationships.

2. A 47 year-old married woman with a paralysed right leg, after a laminectomy which went wrong. She had found out about her husband's extra marital relationships. The strain in the marriage was nothing to do with the handicap but she had approached the session via SPOD. Her distaste for the "mess" of intercourse in the first years of her marriage had to be interpreted. She changed and stopped rejecting her husband, and he gladly gave up his other partner and enjoyed caring for his invalid wife again. They now manage love-making frequently.

3. A sad case of a 50 year-old man, who had had three cerebral haemorrhages. He now wants his wife to make love to him, and she finds it hard to become the active partner, when she had always been the responding one in their previous sexual relationship. The counselling aimed at helping them both express their anger about the illness. She is worn out with the extra work about the house, and the child-like demands of her crippled husband. She could not give him the support he needed, and could not find the reserves within herself to accept the change in their circumstances.

Dr Wendy Greengross followed my paper with hers about the problems that parents have in coping with the sexuality of disabled children. Counselling should be offered by professionals, to all these parents.

On the second day, papers were given about sexuality and blindness and deafness. Duncan Guthrie, Director of the Disabilities Study Unit at Arundel described a survey of Sex Education, which is claimed to be provided for

260 disabled children in special schools. He showed that these children only have half as much knowledge as their able bodied peers.

More papers of cardiac rehabilitation, diabetes, acromegaly and cancer followed. There was a great deal to be learned. My regret was that my understanding of French was limited. Listening to the simultaneous translation into English, by a Frenchman with a guttural French accent and a cough was not easy.

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## ARTICLES

### HORMONAL AND PSYCHOLOGICAL STUDIES OF MEN PRESENTING WITH SEXUAL DIFFICULTIES

Joan Coombs

In 1970 Prolactin was identified as a hormone secreted by the anterior pituitary, and specific radio immune techniques were developed to measure it.

Bromocriptine (Parlodel) a dopamine agonist lowers prolactin levels in the serum. Hyperprolactinaemia causes anovulation with amenorrhoea and galactorrhoea in women. It is less common in men, but it can be linked with hypogonadism.

Prolactin secretion is increased under conditions of stress, and so venepuncture itself can give a transient high level, therefore the test should always be repeated under tranquil conditions.

#### Causes of Hyperprolactinaemia — John Marshall International Medicine 7

1. PHYSIOLOGICAL  
Pregnancy  
Postpartum
2. DRUGS  
Phenothiazines : Chlorpromazine  
Promazine  
Thioridazine  
Fluphenazine  
  
Methyldopa  
Rauwolfia Alkaloids  
Tricyclic Antidepressants  
Oral Contraceptives
3. PITUITARY TUMOURS  
Prolactin Secreting  
Growth Hormone Secreting  
Non Functioning Chromophore Adenoma
4. HYPOTHALAMIC AND STALK LESIONS  
Encephalitis                      Trauma  
Basal Meningitis                Histiocytosis  
Hypothalamic Tumours        Sarcoidosis
5. HYPOTHYROIDISM  
Severe Thyroxine Deficiency
6. CHEST WALL — Mediated via neural reflexes  
Nipple Stimulation  
Post Herpes Zoster

## 7. RENAL FAILURE

### THE MEDICAL TEAM

The team consisted of a male psychiatrist, a male GP, a woman doctor working in Family Planning and the author, who works in Family Planning, Psychosexual Medicine. Each doctor used their individual styles and techniques.

### THE PATIENTS

Many patients arrived at the clinic expecting traditional doctoring, with investigation, diagnosis and medication. The men exerted pressure for this, and produced a feeling in the doctor that not enough was being done for their distress. Very few believed that their impotence was psychogenic, and most were convinced that the problem was physical. This situation often being reinforced by the referring doctor, and the partners. An organic basis for the symptom was much more acceptable.

This study was not a 'retreat into tests', but enabled an assay service to be used in the study of a large number of men complaining of sexual inadequacy. All the staff agreed to the investigations.

### THE ASSAYS PERFORMED

The assays performed were as follows:-

1. Testosterone
2. Gonadotrophins: Luteinising Hormone (L.H.)  
Follicle Stimulating Hormone (F.S.H.)
3. Thyroid Function Tests
4. Prolactin

The incidence of hyperprolactinaemia was rare.

### INVESTIGATION AND TREATMENT OF HYPERPROLACTINAEMIA

If there is a persistent hyperprolactinaemia, skull X-ray, tomographic scans, and assessment of visual fields should be done to exclude the presence of a pituitary adenoma, and should there be a possibility of such a tumour, the patient should be kept under periodic surveillance in case of growth of the lesion. Bromocriptine is effective in lowering prolactin levels to normal in 95% of patients, irrespective of the cause of hyperprolactinaemia, and it allows the medical management of many patients with micro adenoma of the anterior pituitary. There seems to be no case for the use of bromocriptine in men who have a normal prolactin level. To avoid side-effects, the dose is gradually increased from 1.25 mg nocte with food, increasing by half a tablet a day until 2.5 mg tds is reached. Bromocriptine (Parlodel) may cause nausea or vomiting, and sometimes postural hypotension. One patient declined medication because of the intense nasal congestion. There is some evidence that bromocriptine can

reduce tumour size, but cessation of medication can lead to a return of the hyperprolactinaemia, and its symptoms.

#### ANALYSIS OF THE PRESENTATION OF SEXUAL INADEQUACY

- GROUP A 21 men with premature ejaculation and impotence.**  
10 of Asian origin (often with language difficulties)  
11 European  
Of the Asians, 8 were screened, and only 1 had a marginally raised prolactin, which improved dramatically after the discussion of his guilt about masturbation. One other of this group was found to have high gonadotrophins, low testosterone. He had suffered from a stroke, and was hypertensive, and he also had a history of marital strife. Language and cultural difficulties in the Asian group of patients prevented the effective use of the doctor/patient relationship in the diagnosis and treatment. Emotional factors found were guilt, marital strife and infidelity. The patients had inflexible expectations of the doctor who was forced into the role of initiator of tests and prescriber of medicine.  
Of the European men, 6 were assayed, and prolactin levels were all found to be within normal limits. The aetiological factors for sexual inadequacy in this group included difficulties with trust and communication, anxiety concerning a new partnership, when there had been failure of a previous one, and another who thought there was a lack of interest by his partner.  
Five men were not assayed, because they realised there was an emotional cause for their symptoms. One was a 49 year-old diabetic, who regained his potency when there was adequate contraception, and his wife's anger abated.
- GROUP B 19 men presented loss of libido.** All were European.  
14 men had normal assays.  
1 man had a raised thyroxine, and was lost to follow up.  
Another man who lost his libido when told of his azospermia, had an elevated prolactin and a raised F.S.H. An X-ray showed thinning of pituitary sella, but the patient refused follow-up, and defaulted despite many letters.  
3 other men had relationship difficulties. One was angry that sacrificial vasectomy did not revitalise sex — his wife had never enjoyed it anyway. The second man was overweight and depressed, with an angry wife, and their relationship improved. The third was locked in marital warfare, and the couple defaulted from the clinic.
- GROUP C Inability to Ejaculate With Wife.**  
6 — all of European origin. 2 — assays performed — no abnormality shown.

Four of these six had bitter hostile relationships with their partners. One had retrograde ejaculation after a prostatectomy at the age of 70. The other improved after protracted clinic attendance and application of behavioural methods by one of the doctors favouring this approach. He was seen by the doctor a total of 22 times.

- GROUP D Miscellaneous (27 Cases)**  
**Loss Of Pleasure from Ejaculation**  
4 men. No abnormality was found on assay in 3 of these men. 2 blamed vasectomy.  
1 had the symptoms since his wife's infidelity.  
1 had always feared sexual intercourse, as had his wife.  
**Vague Sex Difficulties**  
6 men. 2 were assayed and showed no abnormality.  
Of those with the complaint of lack of penile size, no showed hormonal abnormality.  
**Feelings of Sexual Inadequacy**  
17 men. 9 men showed normal assays. One had slightly raised prolactin, probably due to anxiety about the venepuncture. One man had a raised thyroid function test, but defaulted. Of the 16 assayed, only 1 had a hormonal abnormality. 11 were not assayed, the total number being 27.
- GROUP E Complaining of Premature Ejaculation**  
57 men. 24 men were tested, and there were six abnormal assays (33 not tested). Several were found on repeat to be normal, and several patients improved without medication, but by contact with the doctor.
- GROUP F Patients Presenting with Impotence**  
156 men. 103 had normal assays, 36 did not have tests performed for various reasons.  
**Abnormal Tests**  
5 had low testosterone (2 with high F.S.H.) 3 of these men regained their potency before the test results became available. One man had diabetes and hypertension. He defaulted. One man had underactive thyroid function.  
**Patients showing Hyperprolactinaemia**  
10 showed initial hyperprolactinaemia, whereas in 6 it was persistent. 1 of these men had chronic renal failure, and regained his potency on Bromocriptine.  
3 showed no pituitary lesion on investigation, and in one the prolactin level returned to normal.

1 took Bromocriptine and his potency returned, but then he was lost to follow-up. He had lost weight and had digestive problems. 2 men were found to have eroded pituitary fossae.

1 patient, an Asian, defaulted, and the other, a young man of 19, started taking Bromocriptine, but had such extreme nasal congestion that he stopped therapy. He is still under care, and his prolactin has reverted to normal. His potency is variable, and he is in a new and happier relationship.

#### SUMMARY

Two out of the 121 tested did appear to have pituitary lesions, an incidence of 1.6%.

Three out of the total number of 290 men complaining of inadequacy, possibly had pituitary adenoma. A small proportion, 1.57% of the men screened for hormonal abnormalities were found to be suffering from hyperprolactinaemia. There were other hormonal abnormalities revealed occasionally.

There seemed to be a therapeutic effect for many men, in learning of the normal hormonal tests. It certainly allowed the patient to examine emotional factors contributing to the problem, which might otherwise have been given no credence.

## DR JANE BERRY

### An Appreciation by Prudence Tunnadine

We will each have our personal memories of Jane Berry. She is of course irreplaceable — not only as a vibrant person but as one of the leading key figures of that younger generation upon whom the future of our Institute will depend.

My own last talk with her at Cheltenham was of her abiding passion, cricket. We drank to the skills and the spirits — individual and complementary — of three of her heroes, and debated their individuality and their mutual enrichment and interdependence. Willis the dedicated grafter; Botham the brilliant swashbuckler; Brearley the enabler, not by accident, we felt, a psychotherapist. We compared this to the Institute's variety of individualism of style, and its parallel need for mutual interdependence. Fanciful it seemed then; less so now when we have to manage without her.

There might be no place for clinical debate in a memorial comment for another than Jane, but her own insistence on clarity of thought; her vigorous appetite for stimulating professional criticism, encourages me to offer an idea here. I felt a little sad that her B.M.J. obituary referred to us as the Institute of Psychosexual Counselling, for Jane was keen on defining the distinction between counselling and therapy, and it is a topic which continues to provoke and confuse us in our search for identity.

In her memory, then, I offer my own view of the distinction — one I have discussed with her more than once — as a possible topic for discussion by others in the journal.

For me the distinction is clear. In therapy I may make use of the 'transference/counter-transference' elements which we call the 'doctor-patient relation' ... In counselling I cannot. For the more I become, or choose to be, a befriender, a helper, and instructor, and advice giver, the more do I structure the doctor-patient relation so; the less can the transaction be diagnosed as at least half the function of the patient. . I wish I could also boast of being so skilful that I never stray from the one method to the other and back again — for I do both. . . As usual our Institute training demands, it seems to me, not that we be therapists (using the unconscious) or counsellors, (using common sense and knowledge only) . . but that we know the difference and are thoughtful about which — and why — we do one or other at any given consultation.

Jane aimed high in professional discipline and wished always to conceptualise her thoughts — adventurous though they were. She also loved a debate. . Perhaps this one is not only of interest but long overdue in identifying what manner of Institute we are. . Who has not spluttered at a cocktail party when asked "what kind of doctor are you?" My one sadness is that I cannot remember Jane's riposte. . can anyone remind me? For, like her, it was clever. . and it was fun.

## LATENT SEXUAL PROBLEMS OCCURRING IN MENOPAUSAL WOMEN

**Raymond E. Goodman**

Psychosexual Clinic, Salford Area Health Authority  
Eccles Health Centre, Eccles, Manchester.

Many women experience sexual difficulties around the menopause associated with ovarian failure and the resulting hot sweats, vaginitis and backache due to osteoporosis. Insomnia, depression and changes in the family dynamics may add to the woman's distress. Simple counselling and hormone replacement therapy where necessary are usually enough to resolve these problems.

This study looks at a group of twenty such women in whom this therapy was inadequate, and who were referred to the above clinic. Further assessment revealed that three of the women had deep marital conflicts, two suffered from myxoedema, one had diabetes mellitus, one had endogenous depression, one was suffering from schizophrenia and one was a paraphiliac. One had been the victim of an incestuous relationship with her father, and five of the women were actually having an extra-marital affair, two of which were lesbian relationships. In the remaining five women no cause could be found that would account for their sexual lack of interest.

Treatment consisted of correcting the underlying pathology before attempting sexual counselling. In the group where no cause was found, androgens, in the form of 'Sustanon 250' intramuscularly monthly for three months trial were offered. The rationale behind the treatment and the possible side-effects were explained to the patients. One refused because she had an acne problem, and another because she was a professional singer and was worried about any possible voice changes. The other three women in this group responded well to the hormone.

This study highlights the fact that not all middle-aged women who experience sexual difficulties can be glibly passed off as 'menopausal'.

## CORRESPONDENCE

A letter has been received from Dr Anne Mathieson —  
Pipers Tye, 50 Rignal's Lane, Galleywood, Chelmsford. . .

Dear Rosemarie,

You asked for feedback re absence at annual conference. 1980 at York clashed with the last weekend of University vacation. My three children, who had been far afield all summer, converged that weekend and I could not bear to be away from home, and miss catching up on news and enjoying their company when it was so quickly time for them to start new terms again.

1981 at Cheltenham I had to miss owing to a prior engagement to spend the week 20th — 26th September lecturing in Southern Ireland, otherwise I should have been there.

July 7th — 10th is ideal for me and having missed two years I am really looking forward to it this year at Brighton.

With best wishes,

Anne.

## NEW MEMBERS

- |                        |   |
|------------------------|---|
| Dr Ann Parker (A)      | High Willow, Old School Lane, Gouillon, Abergavenny, Gwent. |
| Dr Gillian Jones (A)   | 18 Fordington Avenue, Winchester, Hants.                    |
| Dr Anne Pedrazzini (A) | 'Penrhos', 15 Sandy Lane, Newcastle under Lyme, Staffs.     |
| Dr Janet Perrin (A)    | 21 Alexandra Road, Gloucester.                              |
| Dr Anne Kirkbridge (A) | Fishers Brook House, Calne, Wiltshire.                      |

## CHANGES OF ADDRESS

- |                       |   |
|-----------------------|---|
| Dr Lesley Farebrother | 14 Ethelbert Road, Rochester, Kent.                   |
| Dr D. K. Suri         | c/o South West Hospital, London SW9.                  |
| Dr Sally Waters       | Swallowfield, Wheelers Lane, Linton, Maidstone, Kent. |

## SEMINARS

Any doctor interested in joining seminars should contact the Director of Training — Dr Prudence Tunnadine.

### Groups — Continuing

Leaders workshops in London and Newcastle.

Advanced groups in London, Leeds, Newcastle, Sharpthorne, Guildford.

Research groups in London, Bromley.

Basic training groups in London, Swansea, Sheffield, Wakefield, Leeds, Bradford, Norwich and Maidstone.

### Groups — Completed

Liverpool, Newcastle (2), Taunton, Southampton, all basic. Newcastle advanced and Bromley advanced.

### Groups — New

Basic, Newcastle (2), London (a second), Bath, Liverpool, Nottingham, Diss.

### Groups — In Planning

Advanced in Salisbury, Newcastle, Leeds, ? Exeter.

Gloucester continuation group has reconvened.

New basic groups convening for Plymouth, Wessex, Bromley, East Berkshire, West Midlands (probably two), perhaps Ashford, Kent.