DIARY OF EVENTS

Institute Meetings

Annual General Meeting Friday, 18th March, 1983 at the R.S.M.

5 – 6.30 A.G.M. in the Marcus Beck Library
6.30 – 6.45 Sherry Reception, Florence Room
6.45 – 8.00 Buffet Supper
8.00 – 10.00 Clinical Meeting

This meeting, the reception and Buffet have been generously sponsored by the Postgraduate Education Department of Ortho Pharmaceuticals.

Residential Weekend Meeting
Friday, 30th September – Sunday 2nd October, 1983
Hugh Stewart Hall, Nottingham University
Details of the programme will be given later.

Other Meetings

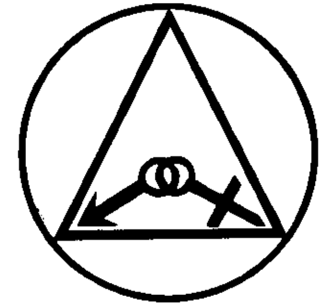
S. P. O. D. 2nd International Conference
19th – 22nd July, 1983 Owens Park, Manchester University
'Learning, Loving and Living'

Further details: S.P.O.D. Conference Organiser,
33 Grantham Road, Chiswick, London

7th International Congress on Psychosomatic Obstetrics and Gynaecology
11th – 15th September, 1983 Dublin, Ireland

BROADGATE PRINTERS, ALDBOROUGH

Institute of Psychosexual Medicine



Newsletter No. 22
November 1982

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FIRST INTERNATIONAL CONFERENCE
BRIGHTON – July 1982 p. 9

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LIST OF OFFICERS

President	Dr Tom Main
Vice-presidents	Professor Norman Morris Dr James Carne Dr. Robert Gosling
Chairman	Dr Roland Freedman 1 The Grove, Gosforth, Newcastle Upon Tyne NE3 1NU 0632-856156
Secretary	Dr Katharine Draper 29 High Street, Chipstead, Sevenoaks, Kent TN13 2RW 0732-452507
Treasurer	Dr Jessie Yorston "Luibeg", Gardiners Lane, Romsey, Hampshire 0794-512054
Director of Training	Dr Prudence Tunnadine 111 Harley Street, London W1N 1DG 01-935 5680
Newsletter Editor	Dr Rosemarie Lincoln Idlehour, 67 Yarmouth Road, Norwich NR7 0EW 0603-33771
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Panel Secretary	Dr Judy Gilley 42 Avondale Avenue, London N12 01-445 1654
Referral Secretary	Dr Margaret Gill 10 Peterswood Hill, Ware, Herts.0920 2676
Administrative Assistant to the Hon. Treasurer	Mr. Ronald Trowbridge 6 Dunsells Close, Ropley, Alresford, Hants. SO24 0DN 096-277 2439

Members of the Council:

Dr J. Dewsbury*
Dr Katharine Draper
Dr Ronald Freedman
Dr Judy Gilley
Dr Jane Kilvington*
Dr Jessie Yorston
Dr Rosemarie Lincoln
Dr Mary Rees
Dr John Rogers
Dr Rena Sampson*
Dr Robina Thexton
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. 22
November 1982

Dear Colleagues,

Having just returned from a happy experience of "Granny bonding" in Paraguay during which the acquisition of grandmotherly skills kept me so busy that I did not have the libido to write the newsletter, I have reflected on the last six months which have contained life's usual mixture of sadness and joy.

The death of our Chairman Margaret Blair a week before our first International Conference left us sad, but also very happy to have been associated with her, and the event for which she had worked so hard. Her last working day was spent in Norwich speaking about the "Requests for Abortion" when as always she was wise and tranquil. She enjoyed revisiting the beauty spots of Norwich after 25 years. She was a founder member of the Institute and with Margaret it is certainly built on a rock, and will endure.

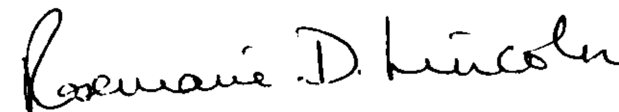
Dr, Roland Freedman takes on the Chairmanship and will add his particular "touch of class".

The Conference conceived on a beach in Hawaii succeeded beyond our expectations and remembered impressions are contributed to in this Newsletter by members. Special appreciation was publicly expressed to all the Conference Committee and especially to Fay Hutchinson who planned the programme. If there are laurels, we shall rest on them for three years!

The Council are considering an offer from John Libbey to publish a Journal for the Institute which would have a larger circulation than the existing Newsletter which is only available to members, and which would have the benefit of professional expertise in its Publication, but the Editor would remain a member of the Institute.

Are we ready for this step?
Would the benefits outweigh the risks?
Is there a need for a Newsletter as well?
Could we provide enough material?

The Leader Doctors weekend took place at Nottingham University in September. We were entertained on the Saturday evening at the home of Alexandra Tobert which was certainly a bonus to a hard working and enjoyable weekend. These meetings are particularly appreciated by Leaders who are not currently able to be involved in Workshops and it gives them an opportunity to increase teaching skills.



Rosemarie D. Lincoln
Hon. Editor

MARGARET J. BLAIR MB, BS

Dr Margaret J Blair (Mrs Michael Arnold), who worked at the West London Hospital, died at home peacefully on 25 June after a long and courageous struggle with cancer during which she continued to work, finishing her last paper while terminally ill in hospital.

Margaret Jean Blair graduated in medicine from the West London Hospital in 1946 and joined her husband Michael Arnold in general practice in Wembley. Her interest in the emotional aspects of her patients' problems, especially in relation to contraception, led her to join one of Dr Michael Balint's general practitioner seminars at the Tavistock Clinic and then to work in a group of Family Planning Association doctors, which was led by Dr Balint for five years and then by Dr Tom Main. She published several papers about the work of this seminar, notably one on frigid wives. She was chosen by Dr Balint to be one of the first leaders of groups to train FPA doctors in the treatment of psychosexual problems and, undaunted by a not very satisfactory first group, went on to lead groups all over southern England for the next 20 years with outstanding success. Latterly she ran the workshop for leader doctors from all over the country that was held at the West London Hospital. This was in addition to her post there, where her work was mainly concerned with helping young women towards a more mature attitude to sexuality.

Margaret was a founder member, secretary, and finally chairman of the council of the Institute of Psychosexual Medicine, which owes an incalculable debt to her wise guidance through its early difficult years. Her quiet, tolerant manner covered a firm resolve to stand by her principles and to seek understanding in depth before taking action; this understanding was facilitated by her ability to listen.

Margaret enjoyed being the centre of her family. She loved home making, crafts, gardening, cooking, clothes, and also travel. Her sense of fun was a delight to all. These qualities made her a much valued friend and colleague and a beloved physician to her patients. She is survived by her husband and by their son and daughter, who are both doctors.

Jean Pasmore

Geraldine Howard writes: Margaret Blair held the position of Associate Specialist in the obstetric department of Charing Cross Hospital, and her influence was profound. She came as a Family Doctor who was also in general practice, and she brought with her the additional skills of the Balint-Main approach to psychosexual medicine. Fifteen years later she had infiltrated her views into most areas of the department and had achieved wide academic recognition. She had shown that the move from general practice and family planning to the position of a medical gynaecologist was possible, and she hoped many others would follow. She showed us the value of non-directive counselling, of listening, and of caring. She had an infinite capacity to deal with emotional pain. She took over abortion counselling and aftercare, and her tolerance and understanding and support guided many hundreds through the turmoils of adolescence.

Through her enthusiasm the awareness of psychosexual problems in gynaecological practice became increasingly recognised within the department, and she encouraged discussion on every possible occasion. Although her illness was no secret, she never appeared to change. She believed that secondaries could be controlled by chemotherapy, just as diabetes was by insulin, and she dispelled our fears by her belief and immense courage. She was a devoted wife and mother and a great homemaker. Plants filled her home and every wall of her hospital office. She achieved the delicate balance between a wife and a doctor, and she managed to practise the science of medicine with the sensitivity and caring she showed in her home.

Although the death of Margaret Blair was a sad loss to the Institute, her memory lives on and deserves some tangible tribute.

Since it is the intention of Council to find a permanent home for the Institute it seems appropriate to associate Margaret's name with this project. Accordingly the Margaret Blair Fund is now open, and contributions are invited.

Cheques, in favour of the Margaret Blair Fund, should be sent to:-

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

Roland Freedman
Hon. Treasurer

NOTICES FROM OFFICERS

Notice from the Secretary

Practice of Psychosexual Medicine

Selected papers from the 1st International Conference and other meetings of the Institute of Psychosexual Medicine.

Members who were not at the Conference at Brighton may have been surprised to receive order forms for this book from the publishers, John Libbey & Co. Ltd when they had previously received free transcripts of the Weekend Meetings (thanks to Wyeth Post Graduate Education Dept.) and I would like to explain the background.

When the 1st International Conference was planned it was hoped that the publication of the proceedings would also help to make the work of the Institute more widely understood. Various methods of publication were explored, including publishing through the R.S.M. Proceedings of Meetings series, which would have cost the Institute £5,000, a sum that was considered too costly.

The Conference Committee were approached by John Libbey & Co. Ltd., and after negotiations, they agreed to publish the proceedings as a hard back book, at their expense, if the Institute provided the copy, and the list of Members and those who had replied to the first application for the Conference. If the sales exceed 1,500 copies the Institute will receive 12½% royalties. It was decided to accept this offer.

At the same time, it was realised that the design of the Conference, restricting the length of papers to allow time to be spent in group discussions, meant that there was insufficient material for a book. The transcripts of previous weekend meetings contain many valuable papers which have only received limited circulation within the Institute, and therefore it was decided to include a selection of these to expand and reinforce the work that was presented at Brighton. We hope to produce a book that will make a statement about the work of the Institute. As Secretary, I receive many enquiries from those who have heard of the Institute but are unsure of what it represents; this book should help to remove 'the bushel from our light'.

Wyeth Pharmaceuticals Ltd., gave generous support to the dinner at the Conference and there will be no transcripts circulated this year. The Newsletter contains a summary of the proceedings but a full account of papers will only be available in the book.

The publishers have agreed to continue the pre-publication offer to Members of the Institute until the end of the year. An order form is enclosed.

Notice from the Treasurer

The finances of the Institute are satisfactory. The Brighton Conference made a profit. Mr. Ron Trowbridge continues to look after the finances on a day to day basis. He has prepared a register of members which he updates each month. Covenanted subscriptions are of benefit to the Institute and therefore we would encourage members to covenant their subscriptions.

There are several members who pay their subscriptions under their maiden names and who, as a result, can not be identified. Would any member who considers that they may be in this category please inform Ron Trowbridge.

Tax: The Institute has been approved under the appropriate Act by Inland Revenue in that the annual subscription paid by a member who qualifies for relief will be allowable against Income Tax under Schedule 'E'. Members will need to be provided with suitable receipts. This will not apply to covenanted subscriptions.

The Jane Berry Memorial Fund now stands at over £500.

Claims for Expenses: A form is now available on which members may detail any expenses incurred. These may then be claimed on the form. Copies may be obtained from Mr Ron Trowbridge. In the past, a number of claims have gone by default. It is now hoped that all expenses incurred on behalf of the Institute will be refunded.

Payments to the Institute: Would members please note that all subscriptions should be made payable to the Trust for Psychosexual Medicine and that all other monies should be made payable to the Institute.

Notice from the Director of Training

SEMINARS

New groups with vacancies:

- **Farnborough** Hospital Postgraduate Centre — Dr Audrey Jones — Tuesdays
- **Ipswich** Postgraduate Centre — Dr Rosemarie Lincoln — Wednesdays
- **Basingstoke** — Dr John Rogers — Thursday afternoons

New Groups will begin when there are sufficient applications as follows:

1. **Plymouth / Exeter** — Dr Jennifer Tisdall
2. **West London Hospital** — Dr Tom Main — Tuesday afternoons
   This will be open to new applicants or those requiring further on-going basic training.
3. **South East Yorkshire Area** by arrangement

Applications for on-going groups or for advanced group vacancies can be considered at any time, as can applications from experienced and qualified doctors who wish to return for refresher experience. Suitable vacancies cannot be guaranteed, but unless the Director of Training is informed of the demand she cannot, of course, even begin to arrange such groups or vacancies.

Director of Training — Dr Prudence Tunnadine,
111 Harley Street, London W1N 1 DG

Leader Doctor Workshop in London — Dr Tom Main

Leader Doctor Workshop in Newcastle — Dr R. Freedman

Newsletter 22 November 1982

Notice from the Editor

Proposals put forward by John Libbey & Co. Ltd., that he should undertake the publication of a Journal for the Institute are being discussed. The Journal would continue to be edited by a member of the Institute but the publisher would expect that members would subscribe to the Journal. An advantage to the Insititute Members would be the ability to publish articles which are sometimes not acceptable to the more conventional journals because they are not in the form of controlled studies. The question of whether there would be a necessity for a Newsletter as well as the Journal, is a matter for discussion.

Notice from the Panel Secretary

"Coming before the Panel"

Recently there has been a weekend meeting of the Accreditation Panel, Advanced leaders, the Consultant in training Dr Main and the Director of Training Dr Tunnadine, to discuss the process of accreditation. As a result of these explorations, the Panel will be experimenting with a somewhat revised format when it next meets candidates this Autumn. At the risk of destroying cherished fantasies about the Panel, we felt that some explanations might by helpful to potential candidates.

The aim of the Panel continues to be to assess candidates for their competence to work in the field of Psychosexual Medicine. This can be a demanding and occasionally painful task for both the Panel and candidates. The Panel are assessing their co-professionals, mature women and men often highly respected in their chosen fields of medicine. A successful meeting of the Panel with candidates must, therefore, depend on the creation of an atmosphere of mutual respect, of shared craftsmanship and of joint concern for achieving high standards in psychosexual medicine.

The day's Examination process must be structured so that there is a fruitful gathering of information about the candidate's work. The Panel will have in mind those questions which arise again and again in our seminars as we attempt to understand our techniques with patients, and how we are successful and less successful therapeutically. For example, the doctor's ability to study, think about and understand the referral of the patient, the presentation (single, pairs), the patient's appearance and manner (evasions, confusions etc.) and "why now?". What is to be learned from the doctor's relationship to the patient — does he/she see the patient as a partner in therapy, or as a boss, or an inferior etc? Is the patient seen as in charge of him/herself? The ability to listen and feel and listen again and think whilst listening; to choose interventions thoughtfully rather than to respond impulsively, and to observe the effects of interventions. Does the doctor ask of each phenomenon "What does this teach me about this patient?". What sense does the doctor make of the feelings which the patient arouses in him/her?

These and other observations made by each member of the Panel on the candidates presented work must be brought together at the end of the day for a decision to be made. At this point reports from the candidates seminar leaders about the candidates work in seminars will also be read as one of the factors to be taken into account.

What then of the practicalities? The day will start with a shared time for coffee and introductions of the Panel and candidates. The morning will be spent in a seminar. Formerly the entire Panel observed the seminar but we felt that the presence of three to four Panel members in a largely observing capacity was artificial and unhelpful. Hence only one Panel member will participate in the seminar which will be the opportunity for some candidates to present examples of their ongoing work and for all to contribute to the discussion.

After lunch there will be individual presentations of work; two periods of didcussion with one Panel member for each candidate. It is suggested that canditates bring for the afternoon two case transactions, one in which they feel fairly satisfied with their understanding and one in which they are less satisfied.

Future candidates will be informed of the panel's decision by letter, and will be given recommendations as to areas of their work which merit attention. The candidate will be invited to share this information with his/her seminar leader if this seems helpful.

Finally, when is a candidate ready to come before the Panel? This was discussed extensively. Some participants felt that the decision must be that of the candidate alone (obviously once the normal criteria for training have been fulfilled). Others felt that it was not the place of an Advanced leader to recommend a member (the implicit judgement of abilities might damage the trainer-trainee working relationship). One suggestion which may be explored by seminar leaders is that members of a seminar are uniquely placed in knowing each others work, and could be encouraged in open discussion to allow individuals to understand whether they are ready to present themselves. Perhaps this already happens informally.

Those colleagues wishing to present their work to the Panel are invited to write to me as Panel Secretary:-

Dr Judy Gilley, 42 Avondale Avenue, London N12

Nov. 1982

Panel Passes

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

Dr Sheila Filshie 2 Pembroke Drive, Mapperley Park, Nottingham.
Dr P. H. McScales Ballater, 108 Chistlehurst Road, Orpington, Kent.
Dr. Shelagh Wimhurst Anglers Reach, 42 Hampton Park Road, Hereford.

Notice from Miss Valerie Thompson

Those of you who attended the Brighton Congress will know that a Bibliography of papers published by our members and accociates has been printed and is available for the sum of 20p if a S.A.E. is forwarded to:

Dr Katherine Draper, 29 High Street, Chipstead, Sevenoaks, Kent TN13 2RW

I intend to revise this Bibliography. I shall therefore be grateful if you will keep me informed of any of your publications, preferably by forwarding a copy or reprint of the paper to me at 81 Harley Street, London W1. I would also be grateful for corrections of any misrepresentations that authors may recognise in the Bibliography and submission of any omissions of papers given prior to the Congress.

Sufficient copies of the Bibliography are available for circulation to any colleagues seeking information about our work.

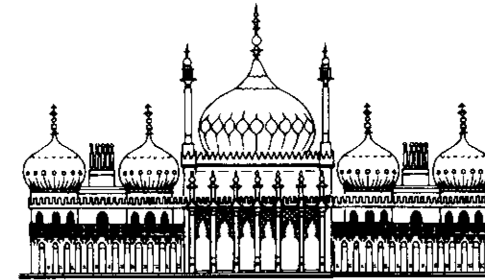
Vacancy

Psychosexual Problems Clinic

Qualified doctor required to do a session in City / Hackney District. The time could be arranged for the suitable candidate.

For further details, contact:

Dr Jane Leaver, Specialist in Community Medicine,
205 Morning Lane, London E9
Telephone: 01 986 3266 (ext. 383)



INSTITUTE OF PSYCHOSEXUAL MEDICINE
1ST INTERNATIONAL CONFERENCE

SCIENTIFIC PROGRAMME

WEDNESDAY 7 JULY SESSION 1

The Design of the Conference	**Dr. P. Tunnadine,** Director of Training
Training-for acquisition of knowledge or development of skill?	**Dr. T. F. Main,** President
Demonstration Seminar	**Dr. T. F. Main**

THURSDAY 8 JULY SESSION2, Chairman: **Dr. Barbara Law**

"While I'm here doctor, I don't suppose it matters, but . . ." Covert presentation of psychosexual problems	**Dr. R. Freedman**
"What can you say to young people today?" Youth advisory work	**Dr. F Hutchinson**
Seminar Group Discussions	

SESSION 3, Chairman: **Miss Valerie Thompson**

"We've never managed intercourse" Non consummation	**Dr. M. Bramley**
"I need help, I can't ejaculate – I'm surprised, I've always been good at everything else". Retarded ejaculation	**Dr. R. Lincoln & Dr. R. Thexton**
Seminar Group Discussions	

Free Communication Session, Chairman: Dr. T. F. Main

Doctors' difficulties in treating handicapped patients.	**Dr. Wendy Greengross**
Analysis of referrals to a psychosexual clinic in a psychiatric setting and an attempt to conduct a follow-up study	**Dr. S. E. Proctor**
Counselling in H M Prisons	**Dr. C. E. P. Roberts**
Genital pain in men	**Dr. D. C. MacDonald Burns**
Sexuality and body image	**Dr. Elsie Koadlow**
Extract from the film: 'Breaking the Ice'. This film was made to introduce the subject of psychosexual counselling	**Dr. Agnes Begg**

FRIDAY 9 JULY SESSION 4, Chairman: **Dr. Joan Marshall**

"It was such fun until our Johnny came along". Secondary frigidity	**Dr. A. Tobert**
"I'm impotent . . . Can you give me some pills?" Impotence	**Dr. J. Yorsten**
Seminar Group Discussions	

SESSION 5, Chairman: **Mrs. Nancy Raphael**

"Shall I bring him with me next time doctor?" Exploration of the dynamics of seeing couples	**Dr. K. Draper**
"Nothing seems to suit". Problems presenting in contraceptive work	**Dr. E. Christopher**
Seminar Group Discussions	

Free Communications Session, Chairman: Dr. T. F. Main

Emotional problems associated with infertile patients	**Mr. Frank Johnson**
Climacterium: A psychological perpective	**Dr. K. B. Chinoy**
Dependence and Independence	**Dr. Jane Kilvington**
The follow-up research in vaginismus after Masters & Johnson therapy	**Professor H. Musaph**
The risks of oral and anal intercourse	**Dr. Jules Black**

SATURDAY 10 JULY SESSION 6, Chairman: **Dr. Elsie Koadlow**

"I want an abortion, doctor". Requests for termination of pregnancy	**Dr. M. Blair**
"Our family is complete, will sterilisation mean the end of everything, doctor?" Sterilisation	**Dr. P. Tunnadine**
Seminar Group Discussions	

SESSION 7

Plenary Session. Report back from Seminar Groups and general discussion	
Closing Address	**Dr. T. F. Main**, President

THE DESIGN OF THE CONFERENCE

Report by Dr Anne Smith

The Institute of Psychosexual Medicine's Director of Training, Dr Prudence Tunnadine, opened the First International Conference of Psychosexual Medicine with a short paper outlining the current state of the Training Organisation and some of its development.

Participants were surprised to learn that 1300 doctors had now been trained, 400 of these had persisted with training to specialist level and 50 of these were now trained or training to lead newly formed groups.

Dr Tunnadine observed that in this Conference of three days doctors would experience some of the training technique that was used either once per week or fortnight but that the differences here, with concentrated work without 'thinking time', would be significant.

Outlining the progress of the Institute from its small beginnings in the 1950's with Dr Balint, Dr Main and a few Family Planning doctors, Dr Tunnadine referred to the keen clinical interest aroused in the 1970's by Masters and Johnson's and Helen Kaplin's work. The former measured love-making physiology rather than emotional transactions. Widespread amusement was caused by her description of Masters and Johnson studying couples making love whilst wired to apparatus in a laboratory "And this" she said, "was a study of 'normal' people!".

Institute doctors did not thus greet these behavioural techniques as manna from heaven but merely an an exciting re-opening of communication about psychosexual problems. We had already a fund of knowledge and experience of something quite different.

Dr Tunnadine introduced the next speaker as sometime Psychiatrist to Montgomery's Armies, Director of the Cassel Hospital in London, Vice President of R. C. Psychiatry, and now President and Consultant in Training of the Institute of Psychosexual Medicine — "The" Dr Tom Main.

Dr Main opened his paper stating that he was flattered and embarrassed by the introduction but would like to correct it by saying that he was "only" Tom Main.

Dr Tom Main illustrated, as only he can, the development of the Institute; like Topsy it just grew; the study of the doctor/patient relationship was a deep penetration on a narrow front (causing amusement when he added "I'm not sure if I am speaking militarily or sexually"). The Trainers technique was likened to that of a football coach who observed his players skill assessed their strengths and weaknesses, offered comments, but then left his players to think about the comments, and use or discard them.

He was proud that some members of his first seminar of 1960 were taking a leading part in the Conference but he shared their tragedy and immense sadness at the death of a beloved colleague, the Institute's Chairman Dr Margaret Blair, who had died the previous week.

Regaining his composure, Dr Main outlined the format of seminars, stressing that the doctors involved had to be actively working with patients; that the leader was concerned with the doctor's professional ego and not the personal ego; that the here and now be studied; and that the presentation of one person or two persons be accepted and worked with. Group dynamics were not remarked upon, unless they particularly illustrated the emotion evoked by the patient, or held up the work.

In selecting patients for this type of therapy one question was useful; if the psychosexual problem of the patient were removed, what would be left, a gross disturbance of mind? If gross, then this patient is not suitable for this therapy.

Dr Main finally observed that individual Leaders skills are not the same, and that leadership skills are very different from doctoring skills; the work must always be accompanied by a common feeling that what we can do, can never be good enough.

Dr Main's introduction illustrated vividly his understanding, caring, training skills, dedication, and humour, and the delegates of the Conference received it with enthusiasm.

THURSDAY 8th JULY — SESSION 2

Report by Dr Jenny Tisdall

Dr Barbara Law chairing the morning session, opened by commenting on the hotel's reluctance to publicly label the Institute, how this observation reminded her of attitudes met in her early career, and how different it was today when not only could sexual matters be discussed but it was almost fashionable to have a problem.

"While I'm here doctor, I don't suppose it matters, but . . ."
Dr Roland Freedman's paper discussed the covert presentation of such problems comparing and contrasting this in the two different settings in which he worked — general practice and a psychosexual clinic.

He stressed the importance of the first contact situation where a patient could meet a sensitive doctor who would "lift the cloak" to reveal the real fears and anxieties that were so often hidden behind a request for help with a physical symptom or alteration of mood. He spoke feelingly of the factors affecting the doctor's response — tiredness, lack of time, antipathy to this particular patient, that could reduce the sensitivity of the doctor in this important first contact. These presentations were contrasted with referred patients met in the psychosexual clinic where neglected and unfortunate first contacts had led to negative situations that had become hardened to a way of life that was more difficult for the doctor/patient team to change.

Dr Freedman gave illustrations of patients with covert symptoms meeting a sensitive doctor — but closed by sharing with us a patient who presented with impotence which could well have been associated with a psychogenic cause. He had a pituitary tumour — a salutary reminder to be aware of the possibility of the presence of physical cause for a sexual problem.

"What can you say to young people today?"
Dr Fay Hutchinson continuing the theme of awareness of real needs spoke about the work in Youth Advisory Clinics demonstrating this with examples that showed the anxieties, guilt and shame that so often lie behind the facade of a bizarre appearance and aggresive behaviour that was so threatening to many adults. She shared the observation that many extreme fashions seemed to run in three yearly cycles, thus effectively separating, protecting and unifying a peer group with a limited age range.

Dr Hutchinson chose cases that must have touched the parental feelings of most of her audience, but reminded us that this was not the only doctor/patient relationship such clients used and that many of the patients had a tolerant relationship with their parents that led to them being happy and confident in new sexual relationships.

In contrast she described the helplessness she felt in the face of the horror and violence that some of them had experienced, and reminded us of the humiliation girls could feel if a doctor insisted on a vaginal examination before an individual was ready for it. This was followed by a description of the similar humiliation exposed by girls who boasted sexual exploits amongst friends but, who, if given an opportunity confessed to inexperience and lack of pleasure.

Dr Hutchinson also commented on the neglect of help for young boys, who still tended to attend the clinics in the guise of partner, or with the protection of a group, and, who, when given the opportunity were beginning to express fears that they weren't "big enough", and who described the pressures of what they felt at the girls demands to produce 'instant sex'.

Dr Hutchinson closed by saying that her answer to the question posed by the title of her paper "what can one say to young people today?" was that she had no magic answer, that each clinical encounter was a unique experience.

SESSION THREE

"WE'VE NEVER MANAGED INTERCOURSE"

Report by Dr Morag Bramley

Dr Morag Bramley presented a paper on the Nuffield Non-consummation Study. 159 couples had been enrolled prospectively by 16 seminar trained doctors in their own clinics over 27 months. 60% had consummated at 6 months and 72% at 24 months from start of treatment.

Impotence was a factor in 30 couples, but these did not have a worse result than others. The average duration of symptoms was 4 years. Only 12 couples were first presentations and all the others had sought help from Health Service consultants and other agencies.

An average time of 3 hours was spent by the doctor on the 95 couples who consummated by 6 months.

It is not always necessary to treat the partner as those women who presented and attended for treatment on their own did better than the rest.

Body fantasies were expressed by many patients and the understanding and resolution of these was important for recovery. 23 women complained of traumatic experiences which contributed to their consummation difficulties and they attributed these to medical encounters.(No questionnaires of the patient were used as they would have interfered with the delicate doctor/patient relationship the understanding of which is the basis of this treatment.)

5 couples with non-consummation were described, 4 of whom were able to consummate successfully and one who consummated with poor results. One couple of 13 years non-consummation presented, because they were both keen to have children and other efforts to get help with their sex relationship, had been unsuccessful. Intercourse had initially been painful and produced vaginismus which increased, the more efforts were made to overcome it. Fantasies of

bleeding, ripping and pain were expressed during the vaginal examination and the woman was able to use the relationship with the doctor to do her last bit of growing up and feel that her genitals really belonged to her.

Another woman had a fantasy of unworthiness and abnormality because she had been illegitimate and when the doctor pointed out that she was keeping people at arms length she was able to look at this and understand why she had had to keep her husband out.

An older man had a fantasy that sex, in advancing years, was improper particularly as his first wife was dead. He used his relation with the doctor to come to terms with his adventurous new wife and his teenage daughters' emerging sexuality, and overcame his impotence.

'I NEED HELP, I CAN'T EJACULATE, I'M SURPRISED BECAUSE I AM SO GOOD AT EVERYTHING ELSE!"

Report by Dr R. D. Lincoln

Dr Rosemarie Lincoln and Dr Robina Thexton presented a study on the Problem of Men Presenting with Non- Ejaculation.

22 men sought help from a group of female doctors with the symptom of inability to ejaculate within the vagina. The problem was studied by case presentation in the Group which was led by Dr Tom Main over a 2 year period.

It was found that the prognosis was strongly influenced by their motivation. 12 patients actively sought help for themselves, for their own sexual pleasure. After treatment they were able to change and achieved ejaculation.

The other 10 patients were brought or sent to the doctor by wives or General Practitioners and usually in order that the wife might become pregnant. They wished to placate their wives rather than achieve pleasure for themselves. Many said "I can't satisfy my wife". During the study the ejaculatory pattern did not change.

The men exhibited a characteristic doctor/patient relationship in which there was initial excitement and hope that the Doctor could help, but the outcome was frequently disappointing and frustrating for the Doctor.

There was frequently an ambivalence to fatherhood and this was often associated with their experience of their own fathers being shadowy, or absent, and unable to support them against their powerful mothers, who they commonly saw as wanting them to submit to their wishes and being unappreciative of them. They placated their mothers but with underlying hostility.

It was interesting that 7 of the 22 men were twins which is an unusually high proportion. Sibling rivalry was particularly powerful, fear of fatherhood, and rivalry with the baby, and the need to be the woman's one and only was often very clear.

Genital examination revealed a derogatory attitude to their genitals.

Clinical examples of men who presented in each of the 2 groups were described. In spite of experience of the doctor/patient relationship with the men presenting with this symptom, during 2 years, the doctors in this group continued to feel initially that they could help this "poor man" and worked hard to make him ejaculate, but eventually with frustration had to humbly accept the poor prognosis.

THURSDAY AFTERNOON – FREE COMMUNICATION SESSION

Report by Dr Bunty Barnes

Dr S. E. Proctor – Newcastle upon Tyne

Analysis of referrals to a psychosexual clinic in a psychiatric setting and an attempt to conduct a follow-up study.

A service was set up in the psychiatric department since 1975. A total of 164 cases referred, 98 men and 66 women. 68% were sexual dysfunction and 13% gender problems. Patients were requested to attend for assessment by letter and if no reply a second letter was sent. 26% attended for an assessment interview and 8% replied by letter. The poor response reflected a high degree of ambivalence and the sensitivity of patients in this area of work.

Dr MacDonald Burns – London

Genital Pain in Men

This paper quoted three cases of genital pain in men with no obvious infection or abnormality. The first was quoted from the question and answer section of the BMJ where the condition was ascribed to prostatic symptoms. The other two cases were seen by the speaker who treated them for prostatic infection, subsequent tests were entirely normal but the symptoms were not cured. Has the doctor made matters worse by strengthening the anxiety of venereal disease?

Dr Elsie Koadlow – Australia

Sexuality and Body Image

Sexual response may be dependent on a satisfactory body and genital image. This was illustrated by four cases.

Dr Agnes Begg – Scotland

Breaking the Ice

This film was made to introduce both medical and paramedical staff to the presentation and possible treatment of psychosexual problems. Its use as a trigger film to stimulate discussion would be very useful.

Professor Musaph presented **Follow-up Research in Vaginismus after Masters and Johnson therapy**. He concluded that to obtain good results it is important to see patients without delay and to establish a good doctor patient relationship as well as to use dilatation techniques.

Dr Black spoke of **The Risks of Oral and Anal Intercourse**. He described the infections and traumas which may result and suggested treatment and advice which may be given.

SATURDAY MORNING – SESSION 6

Report by Dr Elizabeth Forsythe

In spite of a late night after the conference dinner and the lure of a fine morning in Brighton, there were remarkably few empty seats at the morning session. Dr Elsie Koadlow from Melbourne, Australia, was in the chair and opened the meeting by paying tribute to the work of the Institute and recalled with evident pleasure her participation in the first seminar – and her 'siblings' from that seminar. She introduced Dr Jean Passmore who was reading Dr Margaret Blair's paper entitled **'I want an abortion, doctor.'** Tragically Dr Blair had died shortly before the conference.

This paper with its wisdom and gentle, sensitive approach to the problem of counselling for termination was a moving tribute to the doctor who had written it. She pointed out that we must never consider the problem of the termination of that pregnancy alone; but also the failure in contraception and why the failure had occurred at this particular time. She wrote of individual problems which gave insights into the particular problems of this counselling.

One unmarried woman of 37 who lived with her elderly mother had an affair with a married man and became pregnant. She saw Dr Blair and demanded a termination. The partner was a business man and was away at the time. The woman decided that before she had the termination she must discuss it with her partner. Unfortunately she was not able to contact him and decided to wait. The outcome was not related; but had she become pregnant to prove her femininity?

An Asian girl who was being rebellious at home became pregnant with a West Indian boy friend. Dr Blair believed that the pregnancy was another manifestation of her rebellion. Her parents refused to let her contact the boy friend. The girl was admitted to hospital and was allowed to telephone her boy friend. Nobody knew what transpired but she left the hospital and was never seen again there. Dr Blair also stressed the importance of post-termination counselling.

Dr Prudence Tunnadine gave the second paper entitled **'Our family is complete, will sterilisation mean the end of everything doctor?"** Perhaps this paper was the most important part of the whole conference and I feel sure that this was so for many of those present. She revealed her feelings in speaking about the death of Margaret Blair and Jane Berry, to those expressed by Pagliacci in "On with the Motley". She said that, it seemed so unfair that they

had died, but we had attempted to separate private grief from the work of the Conference.

This public expression of a deeply felt personal sadness gave meaning to the idea which had been shown in the papers and in the seminars that it is essential to distinguish between private feelings and our professional feelings as doctors.

She linked mourning with the possibility of grief following loss of fertility and the necessity for this to be thought about after sterilisation. Dr Tunnadine said that her approach to the man who requested vasectomy was: 'O. K. you can have a vasectomy, but now let's sit down and talk about it'. She believed that it always had to be brought back to the is this the right thing for you?' She stressed that such a decision must never be made during a crisis.

Dr Tunnadine described the sense of loss which often followed a hysterectomy. She said that it had often been assumed that all orgasm was clitoral but this is not so. After a hysterectomy and particularly a vaginal one, the sense of pressure in the vagina on the cervix could be lost and orgasm would not occur. Relearning could be achieved with understanding of the problem. This paper concluded the Conference apart from the final seminars and discussions. In it important concepts were reiterated which had emerged from all the preceeding papers. These concepts included the importance of the Doctor/Patient Relationship, the therapeutic use of the doctors professional feelings; the value of the Physical Examination if used as a psychotherapeutic event, and also that the 'here and now' atmosphere in the consultation could be more useful to the doctor than the patient's past history.

Dr Tunnadine ended by comparing the training process of the doctor to the achievement of a beautiful lawn. A Texan oil-magnate once asked a college gardener in Cambridge the secret of how it was done, and he replied "You plant the seed and let it grow and then you mow it and water it for 500 years!'

REPORT BY DR JOAN COOMBS

In spite of the train strike, doctors arrived in Brighton for the 1st International Conference of the Institute of Psychosexual Mecicine. There were 117 Institute members and trainees, and 72 non-members. There were 14 overseas delegates who had travelled from Australia, U.S.A., Canada, Norway, Malaya, Ireland, and Holland. Brighton was busy and the weather was delightful, but because of the intensity of the programme few of us were able to appreciate the setting or the weather. They were irrelevant. In fact the programme was exhausting, and there was little time for mingling informally, and for me this was a disappointment. Most of us work in isolation, and the opportunity to talk with others about their work in their settings is one I appreciate.

The papers which I heard from Institute members, were satisfactory to me, but I knew what to expect. I did find the papers by non-Institute members interesting, and welcomed their inclusion.

I felt that the strength of the programme was in providing frequent opportunities for group discussions. It was an opportunity for members and non-members to meet and to discuss the tasks which we share in our work. However, I was surprised and dismayed to find that some group members saw the Institute of Psychosexual Medicine as dogmatic and intolerant, but as the groups met more, understanding developed and I felt that these misunderstandings abated. Perhaps this is because I do see couples if they present, and I do use behavioural methods if it is the only therapeutic tool which the patient can use. The criticism of the Institute is that they never see couples, and reject behavioural methods at all times, but during my years of training I have never found this to be the case, however, but it does seem the myth persists.

The programme required group leaders to meet frequently and to report back on their groups. I found no value in this and felt that it set the leaders apart from the rest. I was at another Conference recently when the group leaders disappeared, and I felt that the rest of us were being discussed. It certainly provoked anxiety in me.

I felt the greatest disquiet about the demonstration seminar held at the beginning of the Conference. It seemed unnatural and contrived to me, and gave no real flavour of a true group. If I had never been in a group before it would not have encouraged me to join one, and the one thing that emerged as far as I was concerned was an unnatural focus on the leader. Eye-lines and communications were largely directed at him and co-equality was not demonstrated. When I left, my over-all feeling was of satisfaction with the Conference and I felt that the Institute's work had been displayed as well as it could be in this setting. For many people I know it became apparent that Institute training can distill something that is honest and pure and precious and of value to patients. I remain worried that for some the Institute is still seen as dogmatic and intolerant of other therapeutic tools.

On the whole, I felt that the format allowed the aims of the Conference to be met. Many people had worked very hard with this venture and they should feel reasonably satisfied that it was a worth-while project.

REPORT BY DR HEATHER MONTFORD

This is not a factual report but some retrospective impressions; some personal, and some shared when the Institute held its first International Conference during a generally happy and stimulating weekend.

The place — Brighton, playground of the Prince Regent and his ladies — and the Metropole Hotel, haunt of would be divorcees. What more appropriate setting for a conference about sex? It was well supported by members, less well by others and there were sadly few from abroad. At once the atmosphere is different and not like our usual relaxed friendly, informal meetings, but tense, expectant, politely formal, and we were aware of strangers in our midst!

There is a formal welcome and our President Tom Main expertly describes the history and work of the Institute, then on to a Civic Reception at the

Pavilion, for Brighton is on show today too, with a dashing young Mayor and his dolly bird wife. A hurried supper was followed by the evening's entertainment — Dolphins? Maestro Main, with wit and sparkle, skilfully leads his performing troupe. It's called a demonstration seminar. Curious, absorbing, interesting to watch but not much like the real thing.

Day 2 — Early morning mist heralds a blazing day and the real work begins. The very best of the Institute's work is on show. We've heard much of it before but now it has been shaped, polished, groomed to perfection.

We begin at the beginning — covert presentation of psychosexual problems, and youth advisory work. There is no opportunity to question or challenge the speakers (perhaps this was bad) but we are immediately whisked away into smaller groups each with a leader (this was good). Discussion is vague, amorphous at first, gradually warming to understanding and it consolidates, and begins to work. Lunch was good. (The food and service were excellent and the accommodation marvellous for anyone lucky enough to have a "room with a view".) Back to more papers — research on non-consummation and non-ejaculation. Back into groups again. A relentless pace. Outside the sun blazed, the sea sparkled and the beach tempted, while several feet below the ground in artificial light and sweltering heat we listened and talked and listened and talked. Free communication session and some interesting short papers mainly from non-members, a film eventually ended the day. Some of us visit the theatre — Shaw's "Getting Married". Surely not by chance. The hotel brochure advertises other delights and certainly the Prince Regent would have approved!

Day 3 — Papers were presented on Secondary frigidity; Impotence; and Katharine Draper's original wheels-within-wheels, showing the dynamics of seeing couples; Contraceptive difficulties by Elphis Christopher, full of warmth and caring; and then more discussion in groups. From some of the participants there are rumblings of discontent — in the groups, in the corridors and over lunch. "You are so limited, so rigid." "What about sexual deviations, perversions, homosexuals, cultural differences?" "It is all about married people and family planning." There is talk of magic, a new religion (is it by chance that we are sharing the Metropole with black Evangelists?), and of undue deference to Tom Main. We are given the afternoon off but the sun has gone in and it starts to rain. We have another free communication session and we have a splendid formal dinner, sponsored by Wyeth, returning Mayoral hospitality.

Day 4 — Two final papers, group discussion again and a final plenary session. There are polite, friendly comments. Had the dissentients all gone home or did Prue Tunnadine, at her inimitable best, ostensibly talking about sterilisation somehow manage to show our vulnerability and to heal bruised feelings and put us all together again?

What was the discontent all about? Did some have false expectations, and hoped to learn about sex therapy and heard instead about doctoring? Or was it the Institute's woolly thinking — a failure to conceptualise its ideas properly and put them across? Could it have been the Institute's defensiveness? There was the anxiety of putting our work on show for the first time. There was the pain

and anger of private and collective grief over the recent death of two of its most valued members expressed in Jean Pasmore's stoical and moving reading of Margaret Blair's contribution and Prue Tunnadine's impassioned outburst "It's not bloody fair!" There were private doubts about skills as learners and as leaders. Might I even have imagined it all and be expressing my own internal doubts; my own devil's advocate?

Did the criticism really matter anyway? We should have been sorry not to have raised a bit of dust. and there were many who liked what they found. Somebody said on the last day "You have something very special here".

At the end of the Conference as we emerged like moles blinking in the daylight we said "We're glad it happened, we're glad we were there. Now lets get back to the real world and learn some more from our patients".

REPORT BY DR R. D. LINCOLN

Reprinted from the British Journal of Family Planning

The sun shone on Brighton; over 200 participants gathered for an intense three days of work. The aim of the Conference was to demonstrate the Institute's training methods, and to show something of the work which has been done by doctors using skills developed by these methods during the last thirty years. Dr Tunnadine, Director of Training, pointed out in the opening address that 1300 doctors had taken part for varying lengths of time in Institute Seminars. There were now 50 doctors available to lead training groups. Dr Tom Main, President, who spoke in more detail of the training methods, described the task of leaders as being like a coach rather than a teacher, because the aim was the acquisition of skills rather than of knowledge.

The doctors attending the Conference included many who were non-members of the Institute, who visited not only from the United Kingdom, but Holland, Australia and the United States. The fields of medicine which they represented were psychiatry, gynaecology, genito-urinary medicine, general practice, as well as family planning sexual problems. The design of the Conference was to encourage maximum participation, and this was achieved by a series of papers being given by members of the Institute, followed by a small group discussion led by an Insititute Group Leader. It was interesting and rewarding that there were many comments that doctors who had not experienced exposure to this method previously, found it a 'mind-blowing' experience.

The mix of Members and Associate Members and visitors provided a medium where strong criticism was heard and shared, and also some admiration, and always an eagerness to learn more about the availability of training. The seminars were hard work and there was great ambivalence shown by the Conference members, who complained both about the pressure of the programme and yet were reluctant actually to take the time off when offered!! In addition to the invited papers presented, there was also a time for any doctor to present his own papers, and the topics were widely varied.

The Conference provided an opportunity for Insititute trained doctors to crystallise their ideas about the strength and weakness of the Institute. In the face of questioning from doctors trained in other ways, we had to conceptualise what were the differences and the common tenets held.

During the 'mingling time', many interesting comments were voiced. For instance, one visitor remarked "These modest women are so confident", while a critic thought that there might be some arrogance behind the confidence!

The full text of the papers is being published by John Libbey in March 1983, and edited by Dr Cathaerine Draper. The title is "The Practice of Psychosexual Medicine".

The weather was right royal for social functions, including a visit to the Brighton Pavilion as guest of the very young and charming Lord Mayor of Brighton, and the Lady Mayoress. The programme was so full that the only time the participants had to swim was before breakfast, and we could say in more senses than one "Come on in, the water is nice and warm"!

The Institute of Psychosexual Medicine has come of age!!!

ARTICLES

COUNSELLING IN H. M. PRISONS

Dr Pat Roberts

Some years ago I was given the opportunity to work with psychosexual problems in our local men's prison. It was an experimental project and no-one was certain what the response or outcome would be and I was unsure, myself, what I could contribute.

It seemed likely that most sexual offenders would be labelled psychopathic and therefore outside the scope of our seminar training and it could be argued that in such an unreal situation as prison any heterosexual counselling must be largely hypothetical.

Even in a prison with a caring reputation such as this one, unless a man asked for, was recommended, or his behaviour justified therapy, none would be offered and many completed their sentence without ever discussing their offence or their feelings about it.

The project had been dreamed up by the administration without, it seems, much liaison with the medical department, who not unnaturally were a little alarmed at the prospect of a do-gooding woman doctor being foisted upon them.

There were already two medical officers with psychiatric qualifications, another male member of the Institute and a visiting consultant psychiatrist on the staff. The hospitals officers particularly feared that the men might think this a lark or a soft option and that the enterprise was doomed to failure. Intimidated by all this expertise and armed only with my seminar training, I agreed to a six months trial with patients referred by the SMO and I prepared to play it by ear.

I have always felt that my first patient was a test case – perhaps intended to discourage. He was a wiry, voluble little man with an incomprehensible Midland dialect, speech impediment and missing front teeth, demanding to see a sexologist. For twenty minutes he raged about the prison system before telling me with some diffidence (after enquiring first as to whether I was a married lady) that he had a "sma' penis". I thought we built up a reasonable rapport, but after the second visit he went back and bashed up his cell. This being one of the few means of venting frustration in prison no-one was too dismayed, but when after the third session he emptied his chamber pot over an officer's head, disciplinary action was swift. Everyone was politely reassuring; he would probably have done it anyway without my help, but I cannot say that I felt it an auspicious beginning.

The case was, in fact, quite harrowing. Serving a life-sentence for a murder that was almost accidental, he had been in prison just too long and was highly ambivalent over the prospects of release. Each time parole was pending, the anxiety became so unbearable that he reacted with violence. Unfortunately, he was moved to another prison almost immediately and I did not see him again.

Ensuing referrals seemed more realistic with an air of familiarity about them. Two men who had stabbed their wives, a rapist lorry-driver and an incestuous father; domestic situations in which it was possible to speculate whether or not an earlier visit to a marital problems session might have prevented tragedy.

Had the wife agreed to have her prolapse repaired and the husband's anxiety over damaging been ventilated, would he have been driven to stab her with his screwdriver? If the second wife had sought help for her frigidity, would this miserable little man now be serving 5 years for seeking comfort from his daughter? Had the lorry-driver not categorised his women so rigidly into Madonnas and whores, need he have tied his woman naked to a tree in the park with her clothes neatly folded just out of reach? These were obviously over simplifications but suggested that there might be scope for working along accustomed lines.

The most striking impression was that everything here seemed a little larger than life. These were men who had acted out their fantasies or whose fastasies had taken over.

Another finding was that although these men seeking help may not necessarily have been completely truthful concerning their offence, they were devastatingly honest regarding their feelings in the here and now. As in a crisis situation, very little intervention produced surprising results and precepts and truths sought diligently in the seminar became readily recognisable.

It was as though, in this state of isolation from the outside world, stripped of their outer clothing as it were, they were more ready to bear their souls also.

It is true that there were other defences to be breached. The sense of pain and loss was at times devastating and both patient and doctor developed their respective mechanisms for coping.

My first patient complained of a small penis and when the second and third also did, I took this to be interesting evidence of regression, until it occurred to me that his had something to do with the doctors difficulty in regarding these men as other than naughty little boys.

Apart from loss of freedom and loss of family life, perhaps with breakdown of marriage, there is loss of respect and of self-esteem which was probably never very high at the best of times. The nonce or sexual offender is at the bottom of the prison social scale. If the offence involved children, he is frequently persecuted and victimised and has to be segregated for his personal safety and the loss is further compounded.

It is a fact that punishment in this instance imprisonment, is important to most offenders who wish to pay back their debt to society. For a minority, it may be seen as a much-needed if adverse form of attention, but others have a great need to atone for an act of which they are ashamed and desperately wish they had not committed. The horror of what they have done, or at the strength of the emotions they have been unable to control, is often so great that they cannot bear to consider it and develop a partial or total amnesia for the sequence of events. Several of this early group of patients displayed hysterical reactions of this kind and it was exciting to find that by using our techniques to reach pain and fantasy, the amnesia might be lifted. This was desirable if we were to discuss the fear of repetition.

CLINICAL ENCOUNTERS

Denial and repression had been Tom's pattern of coping with pain and loss during his life. Socially deprived in childhood, he suffered a fortuitous calamity which left him unable to cope with normal patterns of attachment and loss, or to communicate sexually with his wife.

His offence followed repeated situations of loss and rejection, some of which were real and some imagined. He reacted in an explosive and bizarre way to a relatively minor frustration. He drank two bottles of wine in his mother's house, ran home, poured paraffin over the dog, set it alight and stabbed his wife in the stomach when she came to the rescue and then ran amok, holding off a posse of police.

He came to see me shaking from head to foot, mumbling incomprehensibly and occasionally managing a short phrase. His wife felt that she must leave him; unless she could be reassured that it would not happen again.

We talked at length about his pain and anger at the many rejections and when his wife was late for a joint consultation his anxiety was revealed. He and his wife were able to talk over their difficulties in communication and now keep in closer touch. He survived refusal of parole very well, thinking first of the disappointment for Rosa and he has matured in a remarkable way.

Nigel's pain was reached through the shame of a negative sperm count, (a fact he had never admitted), which had driven him within an ace of castrating a homosexual youth. The result had been sent through the post on Christmas Eve and led to the breakdown of his marriage.

John, who had rammed a piece of wood down a woman's throat, was suddenly able to recall the details on the eve of his own tonsillectomy. While discussing his apprehension over the operation, he talked of his mother's hysterectomy ("they left **bits** behind") revealing terrifying fantasies of damaging her during his birth. He had recurrent nightmares of being pushed violently through a long tunnel. This boy needed a lot of support, growing up rapidly in the first year he spent in an adult prison. Eagerly, he talked through his childhood sexual feelings towards his mother. He loved her so much he wanted "to get in bed with her".

However, not everyone presents with gloom and despondency. There are characters like Flash Harry to brighten the scene. Harry was referred with some apologies — "I wonder if you would see him — not a marital problem — but a compulsive gambler whose wife keeps writing to get help for him".

Harry is an engaging character — the only man in the prison to wear a tailored suit of faded denim dashingly patched in darker blue. His shirt is well laundered and starched (he knows how to arrange these things) and he wears tinted spectacles, legitimately as it happens, for recurrent iritis. Appearances are all important to Harry with his air of a man of the world. He knows, too, how to handle women, leaning nonchalantly across the desk to flick his ash into the waste-paper basket by my side, withdrawing his hand quickly I notice, like a

little boy expecting a smack on the wrist. His colourful language and vivid turn of phrase would provide years of after-dinner anecdotes for carefully selected audiences.

His notes showed that his first three marriages had ended in disaster and he was now living with the common-law wife who showed such concern. His comments on this were memorable.

"Me a marriage problem? Don't you get me wrong doctor. I'm a faithful man. While I'm married I keep my cock indoors".

Harry is remarkable, having lived on his wits all his life. At forty, he is still unable to read or write. Skilled at his job, he has depended on his good wives to balance his accounts and place his bets. Each in turn thought she would change him. His little boy charm and dependency were enjoyed by both until, as with his powerful mother, the restrictions began to irk and bore him and he developed a need to denigrate and humiliate his women. Craving also for a high level of excitement, he would gamble away the lot. He is anxious to change. ("You gotta help me Doc!") but he needs room to manoeuvre and has now gone off on a Painting and Decorating course. He says he needs to come back and I find I am anxious to see him. It is debatable how long I too will last.

HOMOSEXUALITY

The two questions I am most frequently asked about the work are, "Are you not nervous?" and "What about homosexuality?".

As yet, I have had no cause for alarm and, sadly, most of my patients are more fearful of me. I suppose I should admit to the merest frisson, when they told me that the charming young Blue Band who brought me endless cups of tea standing on each occasion spoon poised and asking "Sugar or no sugar Doctor? — I never **can** remember" — was serving a life sentence for poisoning his mother!

There is in my room what, in the early days, seemed to be an inordinately large desk, behind which men shrank submissively in a manner I found strangely disturbing. It is a measure of progress that they are now able to sprawl across the table. It no longer seems to symbolise a 'them and us' attitude, interfering with the easy establishment of an equal relationship.

There is of course much homosexuality in prison. The revelation for me has been the infinite range of reactions and attitudes towards it. Judging only from the comparatively few patients I have seen, although all have discussed it, it seems to me that, deprived of heterosexual outlet and faced with the pressure of a 'faute de mieux' situation, men are forced in a unique way to consider their total sexuality. As one young man put it: "I have come to the conclusion that I am 60% male and 30% female — do you think that a fair assessment?" We never quite decided about the other 10%.

It is particularly hard for the young and the long-term prisoners. One such lifer newly arriving in an adult prison after 5 years in juvenile establishments and not entirely a stranger to homosexual practices, exclaimed in anger and disgust at the "old men always after your back-side". By the next visit he had cut his curly hair and kept rippling his biceps. "I'm a man like they are and after the

same things. Why can't they realise it?" He had submitted, felt degraded and was obviously nervous as to whether he could avoid such a situation again in the future.

Another rather disturbed youth spent a tormented session after using a lavatory brush on himself. He tells me he has now applied for one of the few shared cells.

Some seem to have settled for masturbation with heterosexual fantasy. Those with doubts over their masculinity are more threatened and confused. From one of these I had a run down on the prison sexual hierarchy, ranging from heterosexual "wolves" who demand homosexual submission (one bank robber apparently fell into this category) to the "fagots" who offer themselves passively – all this while he tried to find his own level on the scale.

There are, of course, many whose homosexual orientation was established long before coming into prison and who are not of the promiscuous minority. The stress for them could be intolerable.

One confirmed homosexual I have as a patient, fell as a crumb from the psychiatrist's table. A charming, personable, slightly narcissistic young man who does not seek help for his homosexuality, but for his attraction to adolescent youths – one in particular. Newly arrived at the prison with only six months left to serve, it was considered too short a time to do anything worthwhile with him. With home-leave pending, his need to talk was desperate; his relationship, his future, his fear of the aspects of homosexuality which send cold shivers down his spine, of his brief heterosexual experiences, of his admired and respected mother. "A very aware woman" he calls her, aware of his seduction by the family friend but never speaking about it, nor of his later overtly homosexual behaviour. He talks of his father killed in North Africa before his birth, of his conviction that he is illegitimate having worked out the dates, of his belief that his father was homosexual too, (his mother does not talk of this either), of the golden years of his adolescence and his shame at being in prison. The flow is endless and I do not know where it will lead us. I suspect the psychiatrist is right in his assessment, but none of these anxieties have been shared before.

Were it not for the discipline of seminar training, I should have been wildly searching for clues as to the reason for his homosexuality. Instead, I find I can tolerate the anxieties – which he introduces each time as "amusing", but ending with the phrase, "I do find this disturbing".

SPECIAL DIFFICULTIES OF THE DOCTOR

The knowledge that the doctor may have to write a report for the Parole Board or prison of next referral can interfere with the doctor/patient relationship. On the whole, we are both aware this is happening and I did think I had developed a technique for dealing with this hazard. On at least two occasions, however, additional information (mainly factual) has been produced after the parole result was known – once in gratitude for a positive outcome and once in the pain and anger of a parole refusal, just to show me I wasn't as clever as I thought.

I personally find reports difficult. There are facts to bog you down. Who is going to read them? There is at least one psychiatrist on the Parole Board, but also departments where the mention of fantasy can render a man suspect. I never include anything confidential and, if possible, nothing adverse unless it can be affirmed that, with insight, the man may be or has already changed.

Freud, himself, has told us (or was it Dr Main?) that insight alone is not enough – I do believe him, but the word itself works magic in reports.

Frequently, I am right out of my depth and utterly dependent on what I have retained from seminar training. Without it, I would regularly be anxious as to what I should **do** and take flight into action, rather than sit it out and wait for what the patient will offer.

This is particularly true with the persistent sexual offender. What can one **do** with a man like Jim charged with buggery 72 times. Jim decided this for himself. He asked to discuss his sexual development.

A likeable little fellow, a youngest child, whose mother had instilled a fear of making girls pregnant, he was afraid even to walk with girls in case anyone thought he was up to something and he played with youngsters of ten to twelve years on their level. Sexual activity was minimal and just what boys of that age might do to one another. It seemed less bad than doing it to girls.

He developed a lasting relationship with one boy, Trevor, teaching him outdoor sports and crafts. He encouraged him to go out with girls and send Valentines, things that he wished he could do himself. Sex was again minimal but important. Court proceedings debased this relationship and fear of how it might have damaged Trevor helped him to mature. He can now talk about sex with a woman and with men in the unit. Seductive films which formerly disgusted him now give him an erection and he wonders if this is a hopeful sign. He is talking of a heterosexual future, but realistically. In his previous two sentences he never thought to discuss his offence; he would have risked persecution.

My two newest patients Bill and Ben are 31 and 28 respectively and look in their teens. Bill behaves like anyones favourite nephew of 10 years, and any moment I expect to hear him call me Auntie Pat, but he will touch boys. His I. Q. is 79.

Ben is an odd little chap, who used to steal racing pigeons and has sought masturbation by youngsters for 10p a time since he was 13 years old. Both have spent years in hospitals and open prisons.

Medication on release makes the community feel safer and relieves everyone's conscience, but there has to be motivation. Last time, Ben found a girlfriend who kept him out of trouble for a bit. Eventually she wanted sex. He stopped the pills and in a few days had offended again.

In general, the difficulty lies in forming any adult relationships at all. Few have the ability to chat up a girl and segregation, of course, does nothing to develop social skills. None of my present small group of child molesters have shown any violence, none have gained much pleasure from their action and none have sought adult homosexual relationships. Their sexual inferiority appears total.

I do try to keep a focus in mind, but it may have to be broadly based. In this situation one has to be prepared to play many different roles, without being too proud and purist about it; anything from witch to wet-nurse, social adviser, bereavement counsellor or safe confidante. Frequently, I hear of minor undetected crimes like readdressing parcels to yourself when working with British Rail.

Timing has to be geared to the needs of a man who may have no idea when he will be released.

EVALUATION OF THE PROJECT

Any exploration into new territories is exciting (and it has been an exciting learning experience) but it is salutory to attempt to evaluate the results. Perhaps they are not very startling:-

1. It is true to say that a small number, depressed and fearful over their sexuality, can now accept it and if they get out in time may even enjoy it.
2. A few have shown remarkable personal growth. The opportunity to share their load of guilt and anxiety in a safe setting, to be accepted warts and all has enabled them to regain some self-respect.
3. I believe a number are unlikely to offend again in the same way.
4. More men are asking for help and we sometimes have a waiting list.
5. All are not helped. A monosyllabic transvestite burglar gained little from our talks, but vividly conveyed to me what secrecy meant for him in both his spheres of activity.

Some wise person said that as long as we feel our participation is worthwhile, we shall find ourselves able to tolerate high levels of disturbance in others without disengaging.

I have no doubt that it is worthwhile. Between the frankly psychopathic and the border-line ESN, there is a grey area where vulnerable, inadequate and lonely men display behaviour differing only in degree from many who turn up in clinics and surgeries. Prison does not seem to be the place for them after the initial period of atonement.

It may be my fantasy that our sort of participation can do much to rehabilitate and return them usefully and with some hope of joy to the community. All too many have been shut out and conveniently forgotten.

One prison governor I knew likened his work with prisoners to giving a push to a needle stuck in a groove. I have also heard him reading to a prison assembly from "The Dry Salvages", a passage which is true for all our patients and also for ourselves, but particularly applicable to the sort of men I have just described, those who are shut out and in a state of transition.

> "Fare forward, you who think you are voyaging;
> You are not those who saw the harbour
> Receding, or those who will disembark.
> Here between the hither and the farther shore
> While time is withdrawn, consider the future
> and the past with an equal mind."

Hopefully, at what T. S. Eliot calls

> "the moment which is not of action or inaction"

the doctor/patient relationship will work its own strange alchemy.

CORRESPONDENCE

A letter has been received from Mr. Elliot Philipp,
94 Harley Street, London W1N 1AF

Dear Dr. Lincoln,

It has been observed that some women react when a Papanicolaou smear is taken from the cervix, whereas others do not.

Questioning a fair number of these women sensitive in this way has revealed that many of them achieve at intercourse a "deep" orgasm that is different in kind from the orgasm they achieve from clitoral stimulation. Those who do not feel the spatula touching the cervix equally for the most part do not experience deep orgasm, and in fact do not usually appreciate what the question is about if asked.

It seems possible that the innervation of the cervix may be different in the two groups of women and also that there may be gradations of the ability to feel with the cervix, as there is between those people who have great musical appreciation and those who are tone deaf. Some of the gynaecologists and other experts with whom I have discussed this hypothesis have pointed out to me that some patients experience pain when the volsellum is applied to the cervix and even go into a mild state of shock, whereas others do not seem to feel it at all. Others find the whole process of having a smear taken distasteful, but that is mainly because of the passage of the speculum rather than the sensation in the cervix from the spatula.

Other experts have told me how some patients after hysterectomy, complain that they have lost a great deal of "feeling".

The first step obviously is to find out whether other observers have obtained the same varieties of reactions from women having smears as I and the people with whom I have spoken have.

The second step is, wherever possible before hysterectomy is carried out, to obtain a history along these lines from the patient, and to arrange for the Department of Anatomy, if possible, to search for sensory nerve-endings in the cervix. There would obviously have to be collaboration between the clinician, the pathologist and the anatomist.

Would anyone interested in carrying out a multi-centre research on this subject, which may result in some modification of Masters and Johnson's views on "deep orgasms", care to write to me stating whether they would cooperate and in which way they would be able to do so.

Would they also kindly indicate whether a questionaire should be circulated. My own feeling about questionaires is that as a whole I rather dislike them, but I would be willing to draw one up with some help if it was thought by the consensus of opinion of those writing to me that this would be advantageous.

Looking forward to hearing from as many experts as possible,

Yours sincerely,

Mr Elliot Philipp

"Left Sided Genital Pain in Men"

– from Dr Anne Smith, 6 The Crescent, Longbenton, Newcastle upon Tyne NE7 7ST

Mr. S. aged 24 years

Mr. S's mother asked me to see her son because of his depressed and strange behaviour at home. I said that I would see her son only if he requested it.

Two days later Mr. S. arrived in surgery; he was tall, handsome and had a warm personality. He said that he was depressed because he had been impotent for one year. When I asked him to tell me about it he produced a long list of girlfriends with whom he had had sex very successfully but suddenly 1 year ago he started to lose his erection when he was about to penetrate the vagina. Some girls laughed and ridiculed him, others tried to understand and help him but he did not improve. He asked me to examine him because he felt convinced that there was a physical reason for his problem.

He stripped completely and lay on the couch with his arms above his head (my seminar colleagues thought he was saying "look how good I am" but that was not my feeling at the time. I felt that he was saying "I've bared my soul to you so here is the rest of my useless body"). I examined him and as I was about to examine his scrotum he said "When I am about to have intercourse I get a searing pain in my left testicle as though someone was twisting it". I explained that I could not find a physical reason for his pain or impotence. I requested a sample of his urine, tested it and threw it away.

When he came back to the consulting room he was shaking with rage. He banged my desk and launched into details of a relationship which had ended 1 year ago. His girlfriend at that time had, unknown to him, stopped the pill, got pregnant, told him about the pregnancy and her appointment for an abortion all in the same few minutes. There was no discussion about what he might want.

It was during seminar work that I came to understand how I had managed to release the tirade within the patient; my rejection of his hopes of a physical reason, my rejection of his body (I was very much a professional Dr. during the examination!) and then the ultimate rejection of his emission, i.e. his urine, for him released the anger he felt at the rejection of his sperm and baby by his girlfriend.

During a follow up visit we talked about these feelings of rejection and anger and he came to realise that from that girlfriend onwards he was stopping himself from giving his sperm so as to avoid having it killed and himself hurt.

It is 2 years now since I worked with this fellow. Six months ago I met him in a cafe and he sought me out to introduce me to his fiancee almost with a wink! One month ago he sent me a short note saying that he was now married and was moving to his own home. There was a P.S. after his signature. All it said was "Thanks".

Mr. E. aged 34 years

I first met this man in his own home when he requested a home visit because of back pain.

Unusual things happened – he was watching me from his window (normally my patients with back pain are not strolling around the house!), and when I went in he said that he lived alone and that a friend would be there soon. This struck me as a strange thing to say and I found myself wondering if this fellow was homosexual. Again I was surprised because I do not normally walk into a patient's house and start wondering about their sexuality.

Mr. E. was a dustman and said that he had strained his back 4 days previously but, clinically, I felt that his back was of minimal importance to him and that there was another problem. However he very quickly brought the consultation to an end.

Several weeks went by before he came to see me – meanwhile having had his back x-rayed by my partner and several certificates. Now he complained that since his back 'injury' he was impotent. He told me that he had morning erections but when his friend (a married lady) tried to stimulate him he lost the erection. At present she no longer bothered to stimulate him because, he said, it only left her frustrated and so they lay together totally inactive. During his presentation I vividly remembered my feelings when in his house and asked him to tell me how he had been previous to the back problem. He gave me an aggresive account of his wife having an affair while he was in the South looking for work; of his next partner being put in the 'mad house' by him because she heard voices coming out of the taps; and now of the relationship with the 32 year-old married lady whose sex life was no good because her husband was too quick. At first Mr. E. said things were great because, compared to her husband, he was good and slow. I found myself smiling at this slow man who had stopped and realised how other females must feel when with him. He responded to me with such an outburst of abuse, questioning my medical qualifications etc. He let rip with his emotions.

After his outburst he said he was usually a meek little man to whom life and women in particular, had been lousy. This we discussed in an attempt to put him in touch with his anger at the female sex but the anger again became immense and he told me that talking like this was a waste of time when he had a physical problem. So I examined him! and, as I was about to examine his genitals (aware of his anger and desperately trying to control my own anger with him), he said "and that's where (pointing to his left testicle) it hurts a lot when I am going to

enter her". I tried to use this with him — that there was I demanding of him and producing the pain just as his sexual partner did but being able to release the angry feelings also. I thought he had some understanding of his own feelings and impotence at that moment and closed the consultation.

I felt sad to discover from my partner that the following day he had demanded a neurological assessment; the neurologist thought that his problem was psychological but put him through the investigative hoops which were all normal. To my knowledge he is still impotent, still angry, and still blaming a dustbin.

Mr. M. aged 54 years

This man has been known to me for two years. He first presented with a tennis elbow — this took a long time to resolve and was immediately replaced with neck pain, knee pain, hip pain etc. As one thing improved another became worse. All clinical examinations and investigations were normal — except for mild spondylitis.

Mr. M. is a small, thin, agitated sort of man — not pleasant to be with — I felt irritated by him and was sure that there were emotional problems. However, when I attempted to open up these feelings I was abruptly 'shut up'. Eventually his company with whom he had worked for 30 years paid him off. "Life was awful to him", he said.

About one month ago he returned complaining of a swelling in his left testicle. He told me this with a great deal of embarrassment. I asked him if anything caused pain or discomfort in the swelling — silly question because all I got was an answer no. Then I wondered if it caused difficulty during coitus. "Er well" he said embarrassed "we do not bother with that now. My wife's in the change of life, had a heart attack . . ." etc. etc. Previously he had told me that his sexual life was happy.

I expressed surprise that he wasn't having any sexual intercourse or even the desire for it. He responded to this with a long list of his wife's opinions and gave me no hint at all of him having thoughts or feelings of his own and so I remarked that I now had a picture of his wife as a very large dominating lady. And what did I do next but become a very large dominating lady doctor by sending him onto the couch to examine his swelling! He immediately said it was very painful (pointing to his left testicle) when he used to try to enter his wife's vagina. Physically he had a small epididymal cyst. We talked about his pain when in situations with women and how he saw his wife dominating him. From being very embarrassed, nervous and small he seemed to grow in front of my eyes and became more forceful, determined and self respecting.

A follow up consultation was cancelled by a phone call from him — all he said was "I shall not be coming on . . . to see you. It's easier to stay as I am".

Dr Anne Smith writes:

If anyone reading these Case Histories has had similar moments of truth at the point of male genital examination such as the severe pain described in the left testicles of these men, I would like them to write to me. My particular interest is "In these men, why should the psychological pain always be in the left testicle and not the right or even both".

Yours sincerely,
Anne Smith

NEW MEMBERS

Dr Ann Palmer	6 Fairmead Road, London N19
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Dr Judith Gray	19 Deramore Drive, Belfast
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