DIARY OF EVENTS

Clinical Case Discussion Meetings: 7–9 p.m. 8th December 1983 at Royal College of Nursing, 20 Cavendish Square
12th January 1984
9th February 1984 } at Letsom House
8th March 1984.
Please notify Mrs Mary Walford on 01:580 1043 (12–2 on Thursdays) or by letter if you will require refreshments at 6 p.m.

Annual General Meeting

Friday, 23rd March 1984 at Letsom House, 11 Chandos Street, Cavendish Square, London W1M 9DE.

3.00 Council Meeting
6.30 Buffet
8.00 A.G.M.

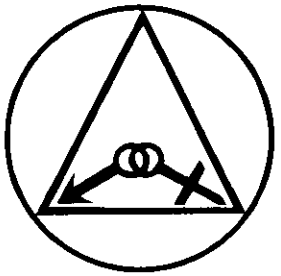
Residential Meeting

28th–30th September 1984 at Hugh Stewart Hall, Nottingham University

BROADGATE PRINTERS, ALDBOROUGH

Institute of Psychosexual Medicine

CONTENTS



NEWSLETTER No. 24 NOVEMBER 1983

LIST OF OFFICERS

President	:	Dr Tom Main
Vice-presidents	:	Professor Norman Morris Dr James Carne Dr Robert Gosling
Chairman	:	Dr Roland Freedman
Secretary	:	Dr Katharine Draper
Treasurer	:	Dr Jessie Yorston
Director of Training	:	Dr Prudence Tunnadine
Newsletter Editor	:	Dr Rosemarie Lincoln Idle Hour, 67 Yarmouth Road, Norwich NR7 0EW
Newsletter Secretary	:	Fiona Beresford-Frye
Programme Secretary	:	Dr Fay Hutchinson
Panel Secretary	:	Dr Judy Gilley
Referral Secretary	:	Dr Margaret Gill
Administrative Assistant to the Secretary	:	Mrs Mary Walford
Administrative Assistant to the Hon. Treasurer (also Membership & Subscription Secretary)	:	Mr Ronald Trowbridge 6 Dunsells Close, Ropley, Alresford, Hampshire SO24 0DN Tel: Ropley (096277) 2439

Members of the Council:

Dr J. Dewsbury
Dr Katharine Draper
Dr Sheila Filshie
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

Co-opted Members:

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

All correspondence to Letsom House, 11 Chandos Street,
Cavendish Square, London W1M 9DE

INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 24
November 1983

Dear Colleagues,

Often during the past five years my editorials have been written from exotic places and my final one is no exception. Turkey's national day found me watching the parade in a small fishing port and resort named Kadusi. The quiet and gentle demeanour of the Turks surprised me, remembering their rather violent history as warrior horsemen. The carpets for sale were a great temptation.

These five years have seen many changes and developments for the Institute, including the establishment of our London Headquarters at Letsom House and the monthly evening meetings starting in November. The residential meeting at Nottingham was thought by many people to be the best meeting which we have held so far. Dr Fay Hutchinson who arranged the programme and the speakers earned our appreciation. Over 100 members attended and it was fully booked, necessitating a waiting list!

It is the 10th anniversary of the Institute in 1984 and some newer members may not know much about the early days. Would anyone consider writing a history of the first 10 years? Are there ideas for a celebrating event for this year?

I have very much enjoyed being your Editor, except for the deadlines and I shall be sorry to put away my Editorial pen – but will sleep easier in my bed!

Yours sincerely,

Rosemarie D. Lincoln
Hon. Editor

NOTICES FROM OFFICERS

A. NOTICES FROM THE TREASURER: Dr Jessie Yorston

At the Nottingham weekend meeting of the Institute at the end of September, I learnt that a lot of people had uncertainties about their subscriptions: a) how much they should or did pay; b) when their subscriptions were due; and c) if they had covenanted their subscription how should they update them to meet the increased annual rate. Perhaps I could take this opportunity of reminding members about these points.

a) Associate members sub. is £15 p.a. by cheque or standing order (and this is allowable under Schedule E for Income Tax relief), or £12 p.a. by covenant.

Full members sub. (i.e. those who have been accredited by the Panel) is £25 p.a. by cheque or standing order, or £20 p.a. by covenant.

Retired members sub. is 50% of the existing sub.

A number of members have not yet updated their standing orders to meet the increased subscription and we should be grateful if they could advise their banks to do this.

b) The majority of subscriptions are paid in September but some members have opted to pay at other times and this is quite acceptable. If no subscription has been received by the end of the year, members should receive a reminder. It would obviously assist Mr Trowbridge and myself enormously if all members paid by standing order or covenant, thus decreasing not only our administrative costs but also bank charges on manual transactions. It is your money and I am trying to avoid wasting it on unnecessary expenditure.

c) There is no liability on covenanted members to update their subscriptions during the period of their covenant (now 4 years), but we should of course be very grateful if members would like to do this to bring them into line with the higher subscription. This can be done either by simply paying the difference by cheque annually until the covenant is due for renewal or by taking out an additional covenant and forms (C/I) can be obtained from Mr Trowbridge.

If you have queries about these or any other matters please do not hesitate to contact me, Dr Jessie Yorston or Mr Ron Trowbridge by writing to 11 Chandos St., Cavendish Square, London, W1M 9DE.

B. NOTICE FROM DIRECTOR OF TRAINING: Dr Prudence Tunnadine

In the earliest days of the Steering Committee, Dr Tunnadine was asked to be Secretary to a training Committee which consisted of herself, Dr Tom Main and Drs Jean Passmore and Margaret Blair. Their recommendations formed the basis of the scheme we have today, adapted from the scheme we had used under the F.P.A. umbrella, and modified in the light of our experience of those days.

Later when the Institute's Constitution was established, and later still after Dr Blair's death and Dr Passmore's retirement, Dr Tunnadine's role was defined as Director of Training, and that appointment was deemed an Officer of the Institute. Furthermore, when Dr Main resigned his Chairmanship of the Council and was succeeded in that role by Dr Blair and later Dr Freedman, he became President of the Institute – i.e. its Scientific rather than Administrative head – and agreed to continue as Consultant in Training.

There followed some years during which the Director of Training, despite the benefit of being able to turn to the Consultant for his vast training expertise, recognised that *administration* of training in areas far from London was unrealistic without Regional Co-ordinators, and asked the Council for permission to appoint such administrators in the provinces. This was agreed as was her proposal that the future Training Committee (appointed by the Director of Training) should consist of the Consultant in Training, the Director of Training, the said Regional Co-ordinators and those Advanced Seminar Leaders currently leading groups. Thus it is hoped for the future to combine available expertise both in local administrative conditions and in the maintenance of training standards.

This new Training Committee met briefly for the first time at the Nottingham weekend, and the Director of Training took the opportunity to draw the members attention to the above, and to warn them that we have some difficult tasks ahead.

On the administrative side, attention was drawn to the vital task of keeping formal records of doctors in training – not in terms of ability but to keep track of those applicants who do or do not actually join the groups they are offered; of whether those who do not, wish to remain on waiting lists; and of those who complete groups and are, or are not, recommended for advanced training. If recommended, do they find their way to such advanced groups?

Dr Williamson agreed to explore simple ways for leaders to obtain such records, with the assistance of Dr Anne Smith who has already attempted such records for her own seminar members.

On the question of training standards, it was pointed out that Basic Seminar Leaders may gain the Institute's accreditation by one of two methods; by showing evidence of their leadership skills at one of the two Leaders' Workshops which meet in London and Newcastle, or on the recommendation of a senior accredited leader with whom they have acted as trainee leader. In neither case is accreditation automatic, but may be proposed to Council by the Director of Training after consultation with the Training Committee and the recommending trainer or workshop leader. Such accreditation is reviewable every five years.

Advanced leaders are, similarly, not automatically accredited, and their accreditation is also reviewable every five years. The qualities upon which accreditation is based are listed in the training regulations. In addition to these an advanced leader must have led at least two successful groups over not less than five years. Another task of the new training committee will be to review these regulations with care, in the light of our increased experience since they were devised.

Finally it must be made clear that the Institute claims no authority to prevent anyone from leading groups, and indeed the Director of Training and

her Regional Co-ordinators may themselves invite individuals to begin leading in response to local demand before such leaders have the opportunity to test their skills or learn their trade. Almost all such invited leaders have been able to attend workshops. It is hoped that both they and the rest of the membership of the Institute will understand that there is no personal criticism implied in our insistence that such apprenticeship cannot be guaranteed to lead to full accreditation. In the same way as our criteria for full membership is an independent panel examination, it is vital that standards for leaders are not only high, but are seen to be stringent, if our increasing recognition by the outside world as the largest training organisation of its kind in the world is also to extend to our recognition as being the best!

The present Training Committee

Director of Training:	Dr Prue Tunnadine.
Consultant in Training:	Dr Tom Main.
Current Advanced Leaders:	Drs Hana Backer, Roland Freedman, Rosemarie Lincoln, Alexandra Tobert.
Regional Co-ordinators:	Drs Joan Coombs (North), Dorothy Morgan (Wales), John Rogers (Thames Valley), Ruth Skrine (South West), Anne Smith (deputy North East since Dr Freedman's assumption of National Chairmanship), Jennifer Tisdall (Devon and Cornwall), Elspeth Williamson (Wessex). Dr Rosemarie Lincoln (East Anglia) and Dr Alexandra Tobert (East Midlands) act as Regional Co-ordinators as well as being advanced leaders. All regional co-ordinators have been asked to train deputies.

C. COMMITTEES: – R. D. Lincoln

Scientific Committee: This Committee is composed of The President – Dr Tom Main; Director of Training – Dr Prudence Tunnadine; Treasurer – Dr Jessie Yorston; Secretary – Dr Katharine Draper; The Chairman – Dr Roland Freedman; Editor – Dr Rosemarie Lincoln, as Officers of the Institute.

Other members are invited to join by the President and those serving at present are Dr Margaret Gill, Dr Anne Smith, Dr Judy Gilley and Dr Alexandra Tobert.

Resignation of Dr Jean Pasmore from the Scientific Committee: The Committee accepted her retirement with regret and wish to express much appreciation for all her contributions as a member of the Steering Committee, a Leader Doctor and Founder Member of the Panel.

D. PUBLICATIONS

Miss Valerie Thompson has asked members who have anything published to contact her and let her have a reprint or reference number to the publication. This is to enable her to keep the bibliography up to date. The address is 81 Harley Street, London W1N 1DE.

E. ADHESIVE LABELS

Dr Katharine Draper suggests that it may be helpful to members to have labels prepared as shown in this example for use when writing letters and for other purposes.

KATHARINE C. DRAPER
M.A., M.B., B.CHIR.
Member of Institute of
Psychosexual Medicine.

F. TAPES

A Sub-committee is studying the best methods of demonstrating our work to the medical profession. The use of tapes will be considered.

G. PANEL PASSES: from Dr Judy Gilley

The Accreditation Panel met at Letsom House on 14th October 1983 and is happy to recommend that the following be admitted to full membership of the Institute:

Dr Carolyn Wilkins
The Coach House
71 West Drive
Harrow Weald
Middlesex HA5 6TX

Dr Susan Horsewood-Lee
3, Child's Place
London SW5 9RX

Members of the Panel are Dr Judy Gilley (Secretary), Dr Gill Hinshalwood, Dr Sheila Lucas, Dr Robina Thexton and Dr Alexandra Tobert.

Advance Notice
The Accreditation Panel plans to meet again in the Spring at Letsom House on Friday 11th May 1984.

H. ADVERTISEMENTS

EASTBOURNE HEALTH AUTHORITY
Psychosexual Clinic – Family Planning Clinic, Eastbourne.
Two additional sessions per month are required (preferably Thursday afternoon), commencing December 1983.
Applicants must be members of the Institute of Psychosexual Medicine. Application forms and further details available from the Unit Administrator, Community Unit, Avenue House, The Avenue, Eastbourne BN21 3XY.

TOWER HAMLETS HEALTH AUTHORITY
Director – Community Services for Women Senior Clinical Medical Officer

Application forms and further details from Personnel Dept. on 01-981-0041. Community and Psychiatric Services, Tredegar House, 97–99 Bow Road, E3 2AN or Dr M. Heath, MRCOG, Consultant Community Physician on 01-247-2803.

DR JOYCE JENKINS

My friend from student days died in August. We shared "digs" at Exeter when the London School of Medicine for women was evacuated there to avoid the bombing. We worked for 2nd MB together eating apples and drinking evening cocoa and swearing that we should "never" get through. Joyce in her modest way always underestimated her talents and in her characteristic quiet way she qualified successfully in 1946.

It was during our Casualty post at the R.F. Hospital in the doodle-bug days, I remember late night soul-searching as to whether she should marry the determined Norwegian Berger Jenkins. She did so soon after qualifying and the next 15 years were happily devoted to her husband and three children until Berger encouraged her to return to her profession.

Her medical career only truly blossomed when she worked in the field of Family Planning in Oxford from 1960 and it was then that she became interested in Psychosexual medicine and joined the Institute. She was greatly valued by her colleagues, both in Oxford and in Devon where she later moved. Her reputation was for steady good sense, loyalty and commitment to her patients' needs.

She practised navigation and took her yacht masters certificate and I am sure that she navigated her boat as she did her life, with care and modest skill. She maintained her serenity even through the last distressing months.

Rosemarie D. Lincoln

REPORTS OF MEETINGS I

Institute of Psychosexual Medicine – Residential Weekend, Nottingham University, Hugh Stewart Hall, Nottingham, 30th September–2nd October 1983

PROGRAMME

1. TRAINING FOR WHAT – **Dr Judy Gilly**
2. EMOTIONAL ABUSE IN CHILDHOOD – Seen in Youth Advisory Work with effects on Adult Sexuality – **Dr Jill Tattersall**
   SEXUAL ABUSE IN CHILDHOOD – As it affects Adult Sexuality – **Dr Sandra Buck**
3. PSYCHOSEXUAL PROBLEMS FOLLOWING CHILDBIRTH – Cases discussed at Bromley Study Group – **Dr Audrey Jones**
4. STUDY OF DOCTOR/PATIENT RELATIONSHIP – When the Doctor is female and the patient is male
   The North London Study Group – **Dr Rena Sampson, Dr Margaret Gill, Dr Jane Kilvington, Dr Jean Lee-Woolf**
   Chairman: Dr Tom Main
5. A CHANGE IN DOCTORING WHILE WORKING IN STUDENT HEALTH – **Dr John Munro**
6. THE CASE OF THE PAINFUL WOMAN – **Dr Heather Montford**
7. CELEBRATION OF CASES – **Dr Claire Smith, Dr Clare Roberts, Dr Susan Horsewood-Lee, Dr Brian Cogan** and **Dr John Kimmitt**
   President's Summing Up

1. TRAINING FOR WHAT?

Dr Judy Gilley

Dr Gilley opened the meeting giving the first paper. The questionnaire which had been circulated by Dr Friedman to Institute Members earlier in the year showed that of the 150 currently in training the first 50 analysed – 32 SCMOs, 3 GPs, 10 hospital doctors, 2 associate specialists, 1 senior lecturer in Obstetrics & Gynaecology and 1 senior lecturer in Sexually Transmitted Diseases Department.

Sessional Work in Psychosexual Medicine
The number of sessions which these doctors worked was between 2–5 a week which were – 55% in community clinics, 5% in family planning clinics, 16% in private clinics, 17% in hospitals and 3% in general practice.

Difficulties
These were – long waiting lists (sometimes 10 months); lack of secretarial help and problems with the making of appointments.

Role of the Institute
Should it have a trade union function – taking an interest in pay, conditions and job appointments? Has it an organisational role?

The way forward in Psychosexual Medicine
Should there be more attachment of this field of Medicine to Hospital departments for instance – Psychiatric or Gynaecological?

Perhaps there should be a few special centres which would be centres of clinical excellence having a research function as well as a training and therapeutic function.

Further development of a referral service may be desirable and we need to share information about any possible development.

Discussion followed when members expressed differing views as to whether the cutting of Family Planning sessions would affect Psychosexual sessions and whether the transfer of contraceptive work to General Practice would mean that in the future General Practice would be the setting in which patients sought help for psychosexual problems.

The attachment of Psychosexual sessions to the Psychiatric ones in hospital was not necessarily a good idea. Other members felt that with the National Health Service cuts their jobs might be in jeopardy.

It was acknowledged by the Meeting that the Institute Training Programme has the greatest number of trainees in Psychosexual Medicine in the world.

It was proposed that a working party should be set up to study the present situation and likely future difficulties. This working party is to be led by Dr Jenny Lisle.

She would like to hear from any members who have information to contribute along these lines.

2. EMOTIONAL AND SEXUAL ABUSE IN CHILDHOOD

reported by Dr R. D. Lincoln

Dr Jill Tattersall described case histories showing examples of how emotional abuse might affect adult sexuality.

The first was an exquisite young man who was the total opposite of his policeman father's ideal son. He enjoyed art and drama and hated football and mud. He was branded as a queer at school where he was teased and bullied. He opposed his father's wish that he should join the army when he left school and became a rent collector. He failed sexually with an older, divorced woman. His sex fantasies were about men.

Then Tina, aged 14, was the child of divorced parents and she lived firstly with her mother, who was now pregnant again. Tina would not go to school and had a series of unsuitable boyfriends, one of whom moved in with them. Later she lived with her father and his new wife and had an unplanned pregnancy which was terminated. She contracted serum hepatitis from a boyfriend. She is now married but whether her sexuality is affected is unknown.

Anne, who seemed to have marital problems based on childhood deprivation, was aged 37, married 13 years and had 3 children. She described her sexual relationship as "kidology" – she had no trust in her husband. She was brought up in a family in which her mother was the breadwinner and she remembered standing outside her mother's bedroom to beat her father off with a slipper. She said "I have never felt loved." She was the offspring of a brief visit of her mother's lover and she felt that the rest of the family shunned her. She was not visited in hospital when she was in for some length of time with cardiac problems, and she remembered being sent out for the bread on a cold night.

Jean, a single woman of 45 never enjoyed sex except with married men. Her mother behaved in a most bizarre way, having become schizophrenic after a hysterectomy. The patient herself had hospital admission for depression and eventually for a hysterectomy.

Dr Tattersall commented that perhaps these cases showed emotional starvation rather than abuse.

Dr Sandra Buck continues the theme in speaking particularly about sexual abuse in childhood and its effects.

Her first example was a woman of 28 complaining of dyspareunia. She sat with her head down and her face covered with hair and makeup and her fiancé spoke for her, saying that her father had told her that he was in love with her (an only child) and between the ages of 8 and 28 had sexual pleasure with her and she reached orgasm, although penetration had been impossible. The patient then feared that she must be abnormal because of the difficulties of penetration. The vaginal examination enabled this girl to examine herself and the doctor commented that it would be nice for her to have a sexual life of her own.

Another case study was of a child of five whose father started a sexual game with her and called it "our little secret". The child wanted her mother to know and for her father to be like a normal father to her, but secrecy seemed a promise of safety.

With these incestuous situations secrecy may be maintained by bribes or threats. One child described how her father used to put his finger up her whilst giving her a piggyback and it hurt, but she knew her father would be angry if she didn't agree and so it was easier to give in. The father may become very jealous and violent if the daughter protests and if the child discloses what is going on, everyone panics. Children fear that they will not be believed and be accused of "asking for it". A girl may enjoy the lodger visiting her in her bedroom and stroking her and then later when he ejaculates or penetrates, he may say "You asked for it." Mothers are often too busy, ill or suffering from emotional problems themselves and do not protect the child.

One patient had a horror of seminal fluid going up inside her and pushing her eyes out and was afraid that everyone would know. When the teacher

seeing her distressed, asked her about it, he could only comfort her by offering her an ice-cream.

The child has to cope with feelings of guilt and many do so by becoming withdrawn and depressed, promiscuous and sexualising all relationships. They may run away from home and get pregnant.

Effects on Adult Sexuality

A 26-year-old woman was referred because of emotional upset since the birth of her baby boy 18 months before. The husband could not cope with her distress. When she was 10, she had been bribed with a shilling to allow her twenty-year-old uncle to penetrate her vagina and she remembered bleeding. She did not receive the shilling! She told her mother who said "You want to keep away from him then." The patient said "Why didn't I scream?" and "Why didn't mother comfort me?" She had made a violent marriage, then lived with a man with whom there had been emotional violence. Now there was a new marriage. She was very angry with her mother for being so casual and eventually told her, but her comment was "It happens to us all but we just forget it."

The birth of the baby had produced the echoes of being left vulnerable and unprotected.

The Doctor's Role

The doctor has to suspend disbelief of the woman (although much may be fantasy) and help her to own the guilt of enjoying some of what went on. The hatred of the mother's neglect may enter into the doctor/patient relationship.

The doctor must share the emotional pain and help the patient to come to terms with it. Discussion followed and Dr Main commented that we all have incestuous wishes towards our own parents which are not acted out. The child is ready for tenderness, but *not* passion. The *man* is guilty and projects that guilt onto the child.

3. PSYCHOSEXUAL PROBLEMS FOLLOWING CHILDBIRTH

Reported by Dr R. Thexton

Dr Audrey Jones and the Bromley Group: Dr Bunty Barne, Dr Alison Edwards, Dr Hilary Graver, Dr Katherine Draper, Dr Elizabeth Deman, Dr Mary Morley.

The aims of the group:
1. To see if it is possible to identify a vulnerable patient in antenatal period.
2. Identify the factors related to childbirth.
3. Identify patients with long standing problems which become overt because of pregnancy.

Sources of referral of patients:

Post Natal	6
Subfertility	1
Family Planning	9
GP Surgery	6
Special category	17
Total number:	39

Overt symptoms: Difficulty with 1. Desire
2. Response
3. Satisfaction

Covert symptoms: Pain and soreness
Contraceptive problems
Subfertility problems
Ill health
Gynaecological conditions
Other

Twice as many patients had covert symptoms, but contrary to expectation episiotomy, as a source of trouble was not mentioned in 18 cases.

The factors considered:

A. Development of sexual maturity as shown by

1. Childhood
2. Adolescence
3. Relationships
4. Marriage, ability to share oneself with another
5. Parenthood – being one of a threesome

B. Physical and Emotional Effects of Childbirth

Some patients felt devalued as a woman or damaged and other feelings expressed were "feeling like a piece of meat". One husband likened the episiotomy scar to a slash across the face of a beautiful woman. Another result of an episiotomy was a patient who felt disappointed about her delivery and described how there was a fleshy bit in the way during intercourse.

Mothering excluding sexuality was a feeling expressed by one woman who said of her baby "She is all I needed and I must keep myself clean for her." There had been no sexual intercourse for one year.

C. The Doctors Listening Skills

The ability of the doctor to elicit the fantasies and share the feelings about the experience of childbirth were very important. The following categories of problem were noted:

1. Altered Body Image
2. Fear about the loss of control
3. Disturbed identity
4. Post Natal blues

4. STUDY OF THE DOCTOR/PATIENT RELATIONSHIP – when the doctor is female and the patient is male. The North London Study Group.

Reported by Dr. R. Thexton

Dr Jane Kilvington: The doctors were aware of the patients anger, pain and sense of inadequacy. They looked for fantasies, hidden fears and conflicts, and where the male patient sexualised the interview.

Case 1. A man of 50 years who said that his wife had a lover, but because they had an ESN son of 16 years, the home must not break up. He wept and the doctor was moved. He came again and said that sex had dropped off, except for hugs. He had tried the Masters and Johnson techniques to help his premature ejaculation (?) Impotence – but that was no good. He never showed anger to his wife in case she left. She was a huge person, didn't need him and she *knew* she was being unkind to him. He told the doctor that he had looked up her credentials in the library! Then he told her his father had died. The doctor/patient relationship was warm and friendly. He said "You see I feel like a schoolboy who never does his prep when I'm with my wife."

Case 2. Dr Rena Sampson. A 36-year-old company director told an unemotional story – with his present girlfriend he suffered premature ejaculation and so she went off with other partners. He had satisfied his previous girlfriend in other ways than intercourse. He complained he hadn't a willing partner to do the squeeze technique. The doctor suggested examining him – he was surprised – but it was normal. Then he said, "Women are difficult to please." Then he talked of how he loved his mother, and his father was an ill person and shadowy. The doctor's feelings towards him changed from pity to admiration. He realised this – in six weeks, he came again and reported having made love successfully. It was as though he had extricated himself from the two older women – one of them being the doctor!

Case 3. Dr Jean Lee-Woolf. A couple who were self-referred had not consummated their marriage in two years because it was so painful for *him.* The doctor examined him and his penis was normal, and the prepuce went back easily, but he fainted and had to lie on the couch to recover. Then he told the doctor that his parents had "warned" him about sex – then he learned, with the doctor, that he could push the prepuce back. He talked about his job, with bitterness, and the doctor felt that she had given him permission to fail. At the third interview, he was cheerful and confident, but he hadn't penetrated his wife – he had come to tell the doctor that he had been elected to the local council, and sex became less important.

Case 4. Dr Margaret Gill. A thirty-year-old man complaining of impotence for the last three years. His manner was defiant and sarcastic – he had three girlfriends: one in Holland, one in America, and one in Iceland. He had enrolled for an assertiveness course. The doctor interpreted his discomfort with her and his feelings of foolishness. He took this to mean that she was *angry.* The doctor felt motherly and dominant. He told the doctor with tears how he failed sexually. The doctor then asked, "Did he really want mothering?" Then he talked about his mother's death. The doctor began to feel vulnerable, and had an anxiety about being a sexy sort of doctor.

He put the doctor in her place and said he used her as a sexual fantasy figure. She said, "That's good!" and he cheekily said, "Perhaps I'll even tip you off your chair next time!"

Somehow, he allowed the Dutch girlfriend to stop treating him as a child. He had got cross with her, and now he could relate to her as an equal. The doctor wondered how far the boundary of professional conduct could be pushed. That was her anxiety.

These four doctors were willing to be used as women by the male patients, but they had the anxiety of skating on thin ice and were brave, using the motto of the S.A.S., "Who dares, wins!"

5. A Change in Doctoring working in a Student Health Service

Dr John Munro

Report by Dr R. D. Lincoln

Dr Munro said that he was a G.P. by training but developed a special interest in young people and later became a university Doctor. He found that he worked differently before, during and after Institute Training taken in Newcastle in 1975. "Before this time I remember an 18-year-old scrawny student with pigtails demanding the pill and the tone of her voice aroused in me antagonistic feelings. We talked about the boyfriend and then the attitude of parents and then one hour later I found that I was describing the anatomy of male and female with drawings and discussing the physiology of menstruation. I then said 'and what about the pill' – and she said that she didn't need it now and went.

"After training my approach was somewhat more skilled."

1. *Mary* a 22-year-old Theology student coming from a Methodist background, attractive and neatly dressed, said that she had taken a long time to make up her mind to come. She had been complaining of dizziness, abdominal pain and micturition symptoms and had attended her G.P. Her story given quite spontaneously was that she had started a relationship with a boy the previous April and in June had started the pill which she had stopped three months later saying she felt depressed. Then she restarted and had feelings of tiredness and faintness. Sexual intercourse had been enjoyable but she realised that she was having to sort out her conflict between her Methodist commitment and her sexuality.

Sometimes she experien feeling during intercourse of something loose inside having to be pushe side by the penis. She had not examined her own vagina and was unable to use tampons. On examination she was calm but detaching her intellect from her genitals. I could examine her with two fingers, but when I suggested that she should examine herself she said that she would be too dry. "You had plastic gloves on – and something seems to get in the way." She showed me what, and this was the labia and then she said that she couldn't find her clitoris. I showed her and suggested that she might touch it which after a pause she reluctantly did. We then talked about the difficulty in abandonment to strong feelings. She then said "I thought you were going to tell me to stop having intercourse. I thought that my boyfriend and I had worked out together our conflicts about religion and sex." The doctor commented that she was finding it difficult to give herself permission to live with her vagina. She did not come again but referred a friend to Dr Munro three weeks later.

2. A 19-year-old boy with spectacles and neat grey flannels said that he felt like a homosexual. He did not date girls because he felt that his work might suffer, and he said "I have started smoking" (feeling very wicked). He was one of two brothers and he was the "good" brother. His mother had said to him "If it hadn't been for you, I would have gone long ago" – he was often this angry with her. He had now grown a beard and wore jeans. He joined the Gay society and told his parents about it, who had suspected anyway.

3. Another girl who was a new student sought help because at 11.30 at night a boy had come into her bedroom and wanted intercourse. She had tried to struggle but it had taken place. She thought the sheath had burst. She was upset about losing her virginity but felt that what was not freely given could not be given away. She had lost respect for herself and felt unclean. She was in fear of being in her room on her own. The doctor felt confused and shocked. When told, the girl's mother said "I have heard this one before", but eventually believed her. Her father wanted to phone the police, but eventually phoned the Principal.

Dr Munro said that undergoing Institute Training had changed him because he wanted to be changed. He had gone on learning, feeling and experiencing and developing his own feelings. It had widened the scope of problems which he could understand.

6. THE CASE OF THE PAINFUL WOMAN

Dr Heather Montford
Report by R. D. Lincoln

Dr Montford described three cases in which pain was the presenting symptom. When the pain is genital it often concerns the patients sexual life and can represent feelings of anger, shame or distress.

a. A lively woman of 25 was referred from the gynaecologist because of painful intercourse and an awareness of the vagina following thrush infection. She said that she was very fond of the boyfriend with whom she lived but was not wholly committed to the relationship. Two previous boyfriends had left her and this boyfriend had comforted her. She was the middle child of three in her family and the others were clever!

On vaginal examination the patient showed distress and at the next visit she told the doctor that the vagina had been permanently damaged. Intercourse had now been successful. At the third visit all was well and the patient felt that she did not need to come again. In this case the symptoms had persisted after the physical cause had been treated.

b. Another patient who presented with pelvic pain was a fragile ethnic lady who lived in West London. Since her periods stopped at the age of 42, she had complained of lower abdominal pain which came on in the evening. She had been treated with many diets including one consisting of smoked foods for one year! She and her "husband" worked together but were not married. Sexual intercourse made the pain worse. During the vaginal examination the patient said that her husband had a strong personality and wanted to make love every night. The doctor commented that it seemed as though she felt that she was caught in a trap. "My husband may leave me if I do not please him. Perhaps I should be able to think for myself and refuse him." She expressed fears of growing old. The doctor explained the relationship of gut mobility, spasm and pain and over the year this woman had developed insight into her problem.

c. Sharon attended the doctor because at her post natal examination the doctor could not pass a speculum in order to take a smear. She had a baby of eight months and had only had intercourse once. She was a drab, depressed girl. She had had a planned pregnancy and a normal delivery but said that her mother had moved away from the district. During the examination she had her eyes tightly shut and told of how the experience of childbirth had made her lose all her dignity. At the next visit intercourse was getting better and she had talked to her mother about her sadness.

Dr Montford summed up by saying that patients who complain of pain are asking us to be doctors and we share their distress like mothers. The pain of anger is more difficult to cope with. The women described were afterwards able to let the doctor go.

7. CELEBRATION OF CASES

Report by Drs R. Thexton & R. Lincoln

Dr Brian Cogan: He sees his general practice patients with no-appointment system. The last patient on a Friday afternoon was a middle aged man complaining of abdominal pain for the past two weeks. He had been given a prescription by the partner, but he had come back. He refused to sit down and the doctor said "You'd better tell me what's the matter." He said "It happened

six weeks ago – I've had sexual intercourse with a dog. I was coming out of a pub – 3 men accosted me – there was a scuffle – two men held me down, pulled my pants down and I felt something rectally." The doctor was aware of feeling great terror, and also anger – he wanted to retaliate and do something to those brutal characters. He tried to get the man to go to the police, but he refused. He examined the man and there were no abnormal signs. The man asked if his stomach pains were coming from disease caught from the dog. The doctor asked him to come back in two days and have some tablets. He didn't return, except to the secretary for a repeat prescription in three weeks. Two weeks after that the doctor asked to see him – he looked better and denied any trouble.

The striking doctor/patient relationship here was the sheer terror felt by the doctor coming from the patient – but the doctor managed to keep thinking.

R.T.

Dr Claire Smith: Teresa, aged 20, was a tall, slender, striking girl in a grey coat and she came to the F.P. Clinic complaining of having no interest in sex. In her presence the doctor felt middle aged, but they got on well together. She was living with an older American Air Force Officer and had been since she was 16 and it was idyllic except for her sex life and she had never had an orgasm. She said that her father is twenty-five years older than her mother and her parents had divorced when she was 11 years old. She had had a happy childhood. She couldn't commit herself to marriage or sex. A pelvic examination showed no feelings and was normal. She didn't know what was stopping her making a final commitment. She showed no distress.

At the *second* visit she talked about her parents. Her mother had re-married and moved far away. She cried now as she talked about her father in his 70s. She visits him three times a week and she and her boyfriend cook his Sunday lunch. She thinks about him all day and can't enjoy herself as she feels guilty. She hadn't shared these feelings with anyone before. The doctor made some interpretations about her need to look after her father.

At the *third* visit she hadn't advanced emotionally at all. She said her father kept all her toys and clothes and her bedroom just as it had been when she was little. She planned now to redecorate her father's house. Perhaps it was a ritual cleansing, and she put away her toys. At the *fourth* visit she said her boyfriend had been away and she was looking forward to his return – the purge from her father's house was progressing. At the *fifth* visit she said she was free and happy and she didn't come again, but the doctor has heard from the G.P. that she is happily married.

The doctor shared her pain and guilt of separating from her father in the second visit and supported her as she symbolically moved from his house into her own home.

R.T.

Dr Horsewood-Lee: A patient presented in the doctor's private practice with no letter, looking younger than her age and wanting the doctor to cure her deep

pelvic pain. Her husband was a lighting engineer. She had a lot of complaints about doctors and wanted this doctor to be better. Her father-figure G.P. had given her the pill for dysmenorrhoea, but she left that G.P. six months before her marriage to go to the F.P. Clinic. They told her that she had an erosion which might be the cause of pain and she had a D&C, but there was no improvement and she demanded a private interview. She said that she came from a Roman Catholic family and she had found her honeymoon a great disappointment. She hated herself from the waist to the knees, hated the penis and said that sex smelt awful. "He wants to come in from behind – it's like animals do it and I find it disgusting – I want to educate myself and enjoy sex – our holiday abroad away from the families was happy." A vaginal examination was done and she examined herself and said it was dirty inside, but she smiled. The doctor/patient relationship showing that the patient had relinquished control at that moment. At the *second* visit the patient said intercourse was fine – but her husband had slipped a disc – "I didn't ask *how*!" The doctor discussed that she was a controlling woman and a bit bossy. At the *third* visit she said that they had had sexual intercourse and it was not painful. "Now I look forward to Saturday and Sunday mornings in bed." But she was disappointed still and commented "Weekends and mid-week suits *me.*" She said her husband was pleased – but the doctor noticed that she couldn't say it for herself. At the *fourth* visit she seemed to be titillating her husband and the doctor felt that she found that sex was fun now – "like a cat and mouse game, and I'm in control of myself".

Fifth visit. She was like a confident wife – "My husband has given me permission to have a baby." She didn't need to come for another three months and she made an appointment but didn't come.

The doctor felt she came into Category 1 of Pasmore & Blair's Classification of Frigid Women: a newly married couple in difficulties – confident they *would* get help. The vaginal examination helped her to accept her femininity. Dr Pasmore, in the audience, felt that this strong controlling woman was a bit too disturbed to fit into Category 1.

R.T.

Dr John Kimmitt: A dumpy drab woman with a 15-month-old daughter came to his general practice and said "I feel like a grandmother – tired all the time" and she burst into tears. The Kleenex box was at hand and the doctor gave her a tissue and said "You are upset – and also depressed?" – "yes". He asked her about her appetite and sleep pattern and libido. The latter wasn't affected. The doctor said "Depression often *does* lead to a loss of libido." The patient replied "then it is my husband who is depressed. He says I don't turn him on any more because I'm fat – we haven't had sex for six months – he hasn't anyone else – he's a keep fit fanatic, always jogging and has no time for someone who can't lose weight." She had tried to lose weight and had tried to dress provocatively. The doctor found himself reassuring her, saying "It's not too bad to be overweight!" He was doing all the talking and hurling abuse at this hurtful husband. He suggested it was *her* anger coming out in him – but the patient just said "My husband is right – I am unattractive." The doctor found himself

suggesting that she should stand up for herself and tell him where to get off! In two weeks she failed to keep her appointment. In three weeks the doctor called her back, she *had* lost weight, was made up and had a nice hair-do and dress. The doctor said "What has happened?" She went home and had a big row and told her husband her angry feelings and said "It's all thanks to you, doctor."

Discussion: Dr Main commented that it was the right moment for this woman to complain to her doctor and he listened and went on thinking "the iron was hot" at that moment – she owned her own feelings of lack of sexiness and changed. In G.P. work, the doctor feels required to give advice and it is hard to resist this.

R.T.

Dr Clare Roberts *"I'm Mandy, Fly Me"* or *"No I Won't."*

Mandy came to see me as her G.P. for her sexual problem. She is 28, slim, attractive and with a bright open face. She wore no make-up and her face had a well scrubbed appearance. She had travelled by motorbike and wore a drab all-in-one motorbike suit and carried a helmet, seeming slightly mannish. She radiated energy and liveliness and had a clear voice with a slight Scottish accent, at times pausing to think and she did not appear to be embarrassed or upset. She spoke freely, describing the problem as a sudden loss of sexual desire six months before. She used to be an air hostess and then life was exciting and dramatic. She would be away for a few days and then flying back to her lover with whom she had lived for three years. There would be a passionate few days and sex was delightful and then she would be off again to some faraway place. She did not now have the look of an air hostess.

She had then changed her employment and took a responsible job with a film animation company. She worked long and irregular hours and she was tired and absorbed, but loving it. She gave no reason for her change of job, but with the change she lost her desire to make love and "it only happens two or three times a month and only for his sake". At the same time she rebelled against doing the housework and demanded more simple affection which she had previously not been aware of needing.

She had only once before lost her sexual interest and that was when a relationship was breaking up, but she said that she and Jack were happy and committed. I did notice that she did not mention marriage.

Mandy told me that her childhood was not entirely happy and she described her father as "closed" and often failing in business. She remembered her parents moving into separate bedrooms when she was 7. She had always been a rebel and went off travelling around the world instead of pursuing an academic career as her parents wished. She took makeshift jobs to keep herself going, flitting about rather like a butterfly. She had been deeply hurt when her first love left and she became guarded in relationships, not seeing them as permanent.

The doctor's first interpretation was that she had suddenly changed her job from one which was feminine and caring to one which held more responsibility and involved directing other people. In other words a more masculine role. At the same time, she had withdrawn her sexual femininity and at this point the doctor commented on her appearance.

Secondly, the doctor observed that she was rebelling in a different way now that her lifestyle was changed. The doctor could imagine her defiantly saying "No, I won't."

Lastly the doctor said she needed affection and saw that as a child's prerogative which suppressed her adult sexuality.

She said that the doctor had given her food for thought. She said "What shall I do?" The doctor said that she was capable of being a sexual woman as well as doing her job, but the change had to come from her.

Doctor/Patient Relationship. This was an equalitarian exchange of communication and the doctor realised that she felt a sense of friendship for her and in fact felt hesitant about "exposing" her by presenting her case. When she returned for her second visit she surprised the doctor by walking in wearing bright clothes, make-up and a smile. She thanked the doctor for her help saying that sex was great and everything was fine. She went on to describe more fully her relationship with Jack who was large and stable, and she sometimes thought that she mothered him and she was rebelling against housework to test him and avoid the semblance of a mother. The doctor discussed with her the different needs for dependency in relationships.

The follow-up is that she remains happy and does not need to visit the surgery.

R.L.

Summing-up of the Conference

Dr R. Thexton

Some of the discussion groups wanted a leader to have been appointed, without a leader the discussion was too general. Groups need a leader who makes them concentrate on the work task – the single theme of the first morning – sexual abuse – was appreciated.

Our work is *case studies*, because people *differ. We* have to recognise the *individual* nature of the individual pain. Particular painful experiences get dodged and we must identify them.

A thought to remember: Children require tenderness, and cannot cope with passion which is a requirement of an adult.

Dr Main told a story and the *moral* of it was:
If you find yourself in the dirt, the person who put you there didn't necessarily have evil intentions – and if someone pulls you out, their intentions are not always good. Stay in the dirt and keep quiet!!

Psychosexual Problems Encountered in Genito-Urinary Medicine

Joan Marshall

Paper given at the meeting of the Institute of Psychosexual Medicine held at the Royal Society of Medicine, November 26th 1982.

My own personal background is that of a gynaecologist by training who came into Venereology by way of Family Planning and now find myself working in all three specialties. Training in psychosexual medicine has helped me to deal with problems which are liable to present in any of these venues. I have found it increasingly difficult to practice any of these specialties in isolation since they all seem to have some relevance to a greater or lesser degree wherever the cases present. This point of view is not always appreciated, as for example when Sister in the Special Clinic overhearing me giving some advice on contraception, asked "Are you quite sure Dr Marshall which clinic you are in this evening?"

Genito-Urinary Medicine embraces venereology and conditions affecting the genital tract which arise from sexual activity. This has led to a broadening of the scope of the work which makes the inclusion of psychosexual problems logical. It is increasingly being recognised that many patients attend the clinics with symptoms which may be an expression of underlying dysfunction. In the male, erectile failure or premature ejaculation may be the reason for symptoms which have no organic basis, similarly, as we all know, vaginismus and orgasmic dysfunction in the female.

Along with the development of the permissive society have come changed attitudes to sexuality and it is now acknowledged as normal that sexual activity should be enjoyable to both male and female. In any individual the precise pattern of sexuality is unique and no one sexual orientation can be thought to be more normal than any other. The most common form of interpersonal expression is a hetero-sexual relationship and at the other end of the scale is the exclusively homosexual relationship, male or female. There is an ill-defined group between these two who may presently enjoy or at some time may have enjoyed relationships both with their own and the opposite sex. There is also a group, small but perhaps increasingly seen of transexuals, physically of one sex but feeling psychologically that they are the other.

Psychosexual problems present either directly or indirectly and members of the Institute do not need me to tell them that. Where they present directly, patients can often talk about their anxieties and do so at a time that is right for them, often highly inconvenient for the doctor and may lead to difficulty for that individual if they are caught unprepared. Relating to one's own sexuality is never entirely easy and may lead to doubts and conflicts. Doctors working in the area of genito-urinary medicine are not immune from their own emotional reactions and have to learn to accept the reality of their feelings, to allow for their presence and control them so that they can be used to help the patient. The advantages of a training in psychosexual counselling are obvious.

My original paper on this subject of which this is an adaptation more suited to the present audience, was given at a Symposium on Sexually-Transmitted Diseases at the Royal Free Hospital in September this year to an audience of specialists in that field, and I outlined to them the training of the Institute of Psychosexual Medicine and its application to cases of this kind, having learnt to recognise the non-verbal communication, the relevance of presenting symptoms, the last-minute communication, the "Cry for help", the difficult patient, all of which constitute the indirect presentation of problems. The doctor with this training has learnt to listen, allowing the patients to express fears, anxieties or guilts, to observe and interpret presenting symptoms and in the case of female patients, to use the vaginal examination as a way of helping them to learn more about themselves and their feelings. The attitude of the doctor is all-important and also the willingness to use an unstructured interview, itself often an impractical proposition in a busy clinic where one is working under pressure.

My own personal experience in the Special Clinic is with women patients, but I see men if a couple are referred to me for advice. Case histories are seldom textbook cases and make for difficulties in trying to present examples of any particular problem, but I have selected a few which I have encountered at Praed Street Clinic and also in my gynaecology clinic which illustrate the multidisciplinary aspects of the work and which I hope will be of interest to you.

Impotence One couple was referred to me with this problem. The man was in his early forties, attending the clinic with recurrent non-specific urethritis. He was divorced, and apparently had a similar problem in his marriage for which he blamed his wife, and expected all would be well with his new relationship. He was by nature an anxious man and his fears that intercourse might lead to a recurrence of urethritis did not increase his confidence. When he did get an erection he blamed his failure to maintain it on difficulty in penetration due to his partner's complaints of dyspareunia. She was a nurse, strictly brought up in the Asian tradition in East Africa, and confessed to some guilt about a relationship with an exciting young man before coming to this country. The dyspareunia was originally due to a thrush infection. At the time I saw the couple, she was living with her mother and two sisters and was the principal bread-winner for the family. The situation between the couple was not helped by the fact that love-making nearly always took place in the living-room of her home, after her mother and sisters had gone to bed. There was a good deal of dissatisfaction on both sides and I felt it would be better to refer them for long-term counselling, but they failed to keep appointments and eventually the relationship broke up. I saw her again a few years later, now happily married to a man of her own background and with two small children. She attended the clinic again with vulval irritation which was diagnosed as lichen sclerosis et atrophicus, but there did not seem to be any associated psychosexual problem at that time.

Lack of Orgasm A girl of twenty was referred to me by a colleague to whom she had complained about her failure to achieve orgasm. She had attended the Special Clinic on a number of occasions for checks and looking back over her record I realised that I had seen her at her first visit. At that time she gave a history of having been raped by two friends of her then current partner. She was distressed and I noted her comment "My boyfriend will kill me if he finds out!" I tried to talk to her about her present relationship and her feelings about sex in general, but when I recalled the circumstances of her first visit to the clinic two years previously, she vehemently denied the episode and terminated the interview by walking out, saying "I don't see what that has got to do with it." I invited her to come back but needless to say she has not done so, the subject being obviously too painful to discuss.

Another girl in her twenties complaining of lack of orgasm had a long-standing relationship with a boyfriend whom she knew to be bisexual. This relationship was evidently very important to her and she did not wish to end it, but she had great difficulty in coming to terms with his bisexuality as well as the anxiety about the risks to her of a sexually-transmitted infection.

Loss of Libido A woman in her early fifties was referred to the gynaecology clinic with loss of libido. This was coincidental with the onset of diabetes at the time of her menopause. She also complained of dyspareunia which was found to be due to thrush and treated, but the initial problem remained. Looking back over her marriage, we discussed her feelings about giving up her career as a Ward Sister when her husband did not want her to work, her failure to become pregnant until after they had adopted a child, the need for her to have a Caesarian Section rather than a normal vaginal delivery, her struggles with breast-feeding and how at the menopause new difficulties had arisen. All of these you might think would lead her to feel she was not a very successful woman, and might be contributing factors to her problem. However a chance remark about her anxiety that her husband, in a stressful sedentary job, who also smoked and was overweight, might have a heart attack during intercourse revealed the true underlying reason for her loss of libido. Reassurance on this score led to a dramatic improvement.

Venereophobia We see a number of patients in the Special Clinic repeatedly with this anxiety, but I had a nurse referred to me with this problem in the gynaecology clinic. She was terrified that she had venereal disease. Swabs had originally shown thrush for which she had been treated, but she continued to be anxious when culture results were negative as she remembered from her lectures that you could still have gonorrhoea which might not show up on culture. I discovered that she had only had vaginal swabs examined and these she had taken herself! I assured her that I could take all the necessary tests as if she were in a special clinic, but that she must accept that having been taken properly, results if negative were valid. She agreed to this and it was interesting to see the change in her as she put that worry out of her mind and we were able to discuss the precipitating cause of her anxiety, namely her relationship

now ended with a boyfriend unacceptable to her father. The opportunity to discuss her relationship, her feelings and her father's reactions helped to restore her self-confidence as shown by a marked change in her appearance and demeanour when she returned the following week for the results of her tests, which were all negative and she able to put this anxiety behind her.

Non-consummation I have seen and treated successfully two cases of non-consummation in the Special Clinic. The first was that of a young married couple, both students from Iran. The wife first presented in the clinic with dyspareunia and was found to have thrush. At her second visit she asked if she might bring her husband, since they had not had intercourse since they were married and even after treatment for the thrush it was still not possible. The husband turned out to speak very little English so we had to communicate through his wife as interpreter. I established that neither had any previous sexual experience. The husband agreed that I might teach his wife to examine herself and stretch the vaginal introitus, but the discussion was fairly basic due to the language difficulties. It was obvious that they had a good relationship and the consultation had the desired effect, since they returned to report success at the next visit.

The second case was that of an Egyptian couple referred by a colleague after the wife had been treated for thrush. It appeared that they had only been married for a short time and intercourse has been impossible from the first. The initial difficulty was due to the fact that the wife had been circumcised. Hymenectomy had been performed in Egypt but penetration had still not been achieved. I saw the couple together since the wife's English was not very good and the husband was present during the examination. He admitted to previous experience, but she said she knew nothing about men until she married. I was able to examine her in the clinic without discomfort and succeeded in teaching her to examine herself. She had no qualms about letting me examine her and demonstrate to her husband the best position for penetration, but the suggestion that he might also put his finger in her vagina, for mutual reassurance, produced an unexpectedly violent rejection. "NO! No! I am fasting!" I discovered that it was during Ramadan and that a man may not touch his wife at certain times, and this was one of them. After a little discussion it was decided that it might be permitted in the circumstances, for good medical reasons! The outcome was very successful. She returned to report in her own words that – "We were making love when suddenly he said 'Congratulations' and we *were* making love!" She is delighted that she is now pregnant.

Last-minute Communication A lady in her sixties was referred to the Special Clinic from another department of the Hospital for a routine cervical smear. She was a little surprised to find herself in the Special Clinic but happy to receive such prompt attention. I wonder if it was finding herself in that clinic which prompted her classical last-minute communication. "Can I ask you Doctor, my husband is in his seventies and still wants intercourse three or four times a week, is it alright?" My immediate response was "You should be so

lucky!" coupled with the assurance that there was no reason why they should not do so. Her query may have been simply asking for reassurance but also at their age "Permission to enjoy." Either way she seemed happy with my reply.

Doctor-induced problems I have seen in the gynaecology clinic a lady in her early fifties who complains of a constant feeling of burning in her vagina and dryness making intercourse and sometimes even walking uncomfortable. Before being referred to me her GP had sent her to the Special Clinic for investigation and she spoke very bitterly about her experience there, and the feelings of dirtiness and degradation with which it had left her. She had had a repair operation at the age of 36 and intercourse had been a problem ever since. After the operation which had been to her an assault on her person, she had never been able to associate her vagina with feelings of pleasure. She was able recently to discuss for the first time her feelings of anger and resentment for the medical profession at their failure to appreciate the effect of their actions on herself and her sexuality. There has been some improvement, but I feel there is a lesson to be learned because we do not always consider the effect of our well-meant advice on our patients.

Another example of a problem induced by a doctor, nothing to do with genito-urinary medicine, was the case of a patient who came for a routine post-natal check-up and refused vaginal examination announcing that intercourse was also going to be an impossibility because she had so many stitches at the time of delivery. It transpired she asked the doctor who sutured her episiotomy about the number of stitches he had used and his joking reply "One hundred and one" had been taken seriously! Leaving us to, metaphorically, unpick every single stitch. Another lesson in stopping to think what you say to patients if it is liable to misinterpretation.

The Doctor-patient relationship This has taken on a slightly different meaning in the context of the types of patients seen in the Special Clinic. Leaving aside embarrassment which may be felt at being examined by a member of the opposite sex, which mostly now seems a thing of the past, there are some male homosexuals who prefer to see a female doctor, since they feel less threatened in this situation than they would with a male. We have sometimes wondered if the frequency with which some patients present for examination means that they have developed some particular attachment or even that they are "Turned on" by the examination itself. I found myself in an unexpected situation when a rather "Butch-type" lesbian brought her girlfriend for tests after she had obviously strayed with a male partner, and insisted on being present, telling her during my examination, "Now don't get randy will you." It looks as if the conventions for chaperonage of doctors may need to be reviewed, in the light of this sort of experience.

Transexuals We see transexuals who have had sex-change operations from time to time in the clinic. They see themselves as women and we must accept them as such. I was recently asked if there was help available for a patient who

has had such an operation. She has no difficulty in accepting the female role for herself, but is finding it difficult to make the sort of relationship which she had envisaged since the men she meets do not seem to be able to regard her in that role. I was able to suggest an expert counsellor, but could not help wondering how successful the application of our counselling might be in this situation.

I have no need to try to convince fellow members of the Institute of the advantages of a training in psychosexual medicine since I am already preaching to the converted, but I hope you may think that I have been successful in demonstrating to my colleagues in genito-urinary medicine that the incidence of these problems may be increasing in their departments and that doctors in this field should at least be prepared and able to assess which patients need simple counselling and reassurance, which need advice from an expert in psychosexual counselling and of course those who need psychiatric help. From my own experience I feel that those who wish to acquire these counselling skills would find it as I do, a rewarding part of the work.

Incidentally, whatever our image of ourselves and the work we do, it is interesting to find out that some of our patients cannot believe that there could possibly be any rewards in it for us. I quote the one who asked me "Do you choose to do this work – or is it a punishment posting!"

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ARTICLE

Non-consummation of marriage treated by members of the Institute of Psychosexual Medicine: a prospective study

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Summary. A prospective study of the treatment of unconsummated marriage was carried out by 16 doctors trained by the Institute of Psychosexual Medicine. This training stresses the development of skills in using the doctor/patient interaction therapeutically, rather than in the acquisition of knowledge. The 159 couples admitted to the study had a mean duration of symptoms of 4·2 years; 60% of them had consummated by 6 months and 72% by 24 months. Other improvements in sexual function occurred even among those failing to consummate; 135 couples had previously consulted 253 other agents. The average cumulative length of treatment at the 6-month review was 3 h. Partners attending alone did as well as couples who attended together.

There is an increasing rate of marital disharmony and divorce (Home Office 1979; National Marriage Guidance Council 1981), with an estimated cost to Britain of £1000 m yearly (London Family Planning Information Service 1981*a*, *b*). General practitioners, usually the first to encounter any resulting health breakdown, have little training in the management of the psychosexual problems (Courtenay 1982) which often underlie marital strife. We have completed a prospective study in an attempt to assess the work of doctors trained by the Institute of Psychosexual Medicine (IPM). Tunnadine described the aims and methods of this training (Tunnadine 1970; Tunnadine *et al.* 1982), which is available to all medical practitioners who work with patients presenting with hidden or overt sexual difficulties.

Non-consummation of marriage was chosen for the study because assessment of the results could be more definite than with the other sexual problems. In addition, questionnaires for patients to complete, which tend to interfere with the doctor/patient relationship, could be avoided. The difficulties and morality of a controlled trial with such distressed patients were discussed in a preliminary paper by Bramley *et al.* (1981).

An independent assessment of couples was carried out before and after 6 months' treatment. An attempt was made to assess medical time spent on treatment and the nature and amount of previous unsuccessful therapy.

Doctors, patients and methods

Sixteen members of the IPM volunteered to take part in the study. Their work setting varied and included general practice, family planning, hospital outpatient and private practice, in different areas of England and Wales. Half the doctors worked in more than one setting.

Before qualifying for membership of the IPM, the doctors had received a minimum of 4 years' seminar training and been examined by a panel and passed as competent in psychosexual treatment.

In order to achieve conformity of recording of results in the study, they attended 2-day workshops at which scripts of the dialogue of eight case studies from treated patients were role-played in front of them. Previously tested forms were filled by the doctors and by the eighth case presentation satisfactory uniformity of form filling was reached.

The doctors entered into the study all couples <50 years of age who stated that there had been no penetration of the vagina by the penis with the present partner. Only couples whose relationship was between 1 month and 16 years were enrolled. A total of 159 couples was admitted to the study. The forms were filled *after* the consultations. Direct questioning was avoided as it might have altered the usual unstructured interview and interfered with the use of the doctor/patient relationship which is the basis of this therapy.

Details of the initial social, economic, medical and sexual situation were recorded by the doctor after the first interview and further data added subsequently. All forms were assessed after 6 months' therapy and simpler forms issued to record the effects of further treatment.

Half the patients were asked if they would accept two visits from an experienced psychological social worker (PSW) at the beginning and end of treatment (the PSW was unknown to patients or doctors). The PSW then travelled to, and interviewed, those couples who accepted. She assessed initial non-consummation and results 6 months after enrolment.

The clinical encounter with the doctor and the genital examination were used to help patients (male or female) to gain insight into the particular fears or fantasies which were preventing penetration and the enjoyment of normal loving sexual intercourse. Couples were treated together or separately as they presented.

Case reports

Couple no. 1

A healthy middle-aged man complained that in spite of treatment with Potensan Forte, he could not have intercourse with his new wife. He had married her after 4 years as a widower subsequent to 24 years of happy marriage. His refusal of examination by the woman doctor and apparent shyness at discussing sex indicated that he was relating to her as a woman rather than as a doctor. As he relaxed, he spoke of the ignorance he felt beside his wife who wanted sex in all sorts of novel and exciting ways which to him were improper. It became apparent that his ignorance was a defence against fear of not being able to satisfy his new wife, and of offending his teenage daughter by showing sexual interest at his age and when her mother was dead. He thanked the doctor effusively as he left, thus making her aware that he was a man who needed to please women. His efforts to please his sexually adventurous wife and also to be a proper father to his daughter had produced a conflict which contributed to his impotence.

The patient was able to use the relationship with the doctor to free himself from his negative feelings about his sexuality, his age and his status as a widower and was able to enjoy happy intercourse with his wife whom he brought to the fourth and final visit.

Couple no. 2

A secretary of 36, married for 13 years to a fitter of 35, presented to the doctor looking depressed. They wanted children and had been unable to have intercourse. The woman, who had received no information about sex from her mother, had found the first attempts at intercourse hurtful. Subsequent efforts were increasingly painful, so they had resorted to mutual masturbation. The man's parents had recently been berating him because as an only son he had produced no grandchildren for them. His despair over this had instigated a further search for help. Previously they had been offered tranquillisers and artificial insemination.

When invited to the couch the woman said firmly that the general practitioner could not examine her. She made the doctor feel that she had great fear of penetration and indeed she had extreme vaginismus. As a finger was laid on her vulva she was asked how it felt and she described the bleeding, ripping and pain which would occur when penetration succeeded. She felt she must be abnormal "down below" and also in the head to have put off intercourse for so long. After a discussion concerning her feelings of abnormality both physically and mentally and fears of pain, she ventured to put her own finger into her vagina.

On the following visit she looked much happier, said she had relaxed and accepted her stretchy vagina and examination confirmed this, but her husband who had partially penetrated was nervous and afraid of hurting her again. She invited him to push in spite of her previous protests and on their fifth visit they reported regular and full intercourse.

The woman used the doctor/patient relationship for further sexual maturing which lack of parental encouragement and fantasies of pain and tearing had prevented her from accomplishing.

Couple no. 3

A woman of 30 whose 2-year marriage was unconsummated was referred by her general practitioner who said that neither he nor a gynaecologist had been able to do a vaginal examination. He felt that this was connected with a reported painful examination at the age of 24. The pleasant young woman soon became distressed when she talked of her husband's infidelity and her own failure to relax. She said she expected pain.

One finger was inserted at vaginal examination but the doctor noticed that the patient seemed uninvolved with this transaction. When invited to feel inside herself she said it was impossible as there was no opening there. It seemed that the fear of accepting the reality of her vagina was so great that she preferred the fantasy of denial. She had always hated the idea of things going inside but was encouraged by the doctor to discuss feelings connected with

penetration. Scenes from childhood then emerged when soap suppositories had been inserted into her rectum. The overwhelming feelings of panic and humiliation were still within her and caused disturbance each time her vulva was touched. After this memory had been shared, the woman was successful in her attempt to put a finger into her vagina. At the fourth session the patient happily reported consummation of the marriage.

Couple no. 4

A girl of 27 married for 6 months said she felt that she could not please her husband. She looked with innocent eyes at the doctor and said that her mother had told her to do everything her husband wished. The doctor felt that the patient wanted another authority figure and said that it seemed that the girl wanted more instructions. This statement encouraged the girl to talk about her childhood, her religious mother and her priest.

When asked what sort of woman she wished to be, the patient answered by saying that the Virgin Mary was a perfect example. The doctor then knew that here was a conflict between goodness and sexuality and therefore mentioned that Jesus Christ had brothers and sisters. The girl would not accept this but at a further visit was able to acknowledge sexual wishes and even admit that she had masturbated. She feared that this had damaged her as her labia seemed too long.

After genital examination the patient was encouraged to feel for herself that vulva and vagina were normal. Ideas of sexual guilt were then discussed. The woman was now more able to make her own decisions and consummation took place after the second consultation.

Results

Consummation rate and PSW results

The cumulative consummation rate was 60%, 68% and 72% at 6, 12 and 24 months. The true rate could have been higher as some defaulted who may have consummated and 12 couples were not followed beyond 18 months. At 6 months 20% were still continuing in treatment and at least 60% had already consummated (Table 1).

Table 1. Summary of outcome at 6 months

	All couples	Those with two or more attendances
Consummating		
With pleasure	65 (41)	62 (42)
Technical only[a]	30 (19)	29 (20)
Not consummating		
Still in treatment	35 (22)	35 (24)
Defaulted	29 (18)	21 (14)
Total	159 (100)	147 (100)

[a] Penetration without real pleasure for woman.
Numbers in parentheses are percentages.

Seventy-eight couples were allocated to a doctor and the PSW but, of these, 26 refused to see the PSW. Eighty-one couples saw a doctor but were not asked to accept two assessment visits from the PSW. Only 29% of the 26 couples who refused to see the PSW had consummated by 6 months but 62% of those who saw only the doctor, and 58% of those who agreed to see the PSW as well, had achieved penetration by 6 months. The PSW differed once from the doctor in her 52 initial visits. A couple told her that they had consummated when intercrural activity only was taking place. The doctor found the hyman intact.

The PSW disagreed twice with the doctor on her 52 final visits. One couple achieved penetration *a tergo* but reported failure to the PSW. The other couple inferred success to the PSW but the doctor reported non-consummation as they defaulted after adopting a sister's illegitimate baby.

Other improvements, previous therapies, length of complaint and present treatment

The 147 couples referred to in the subsequent text and tables are those remaining after the exclusion of 12 couples who had incomplete data because they defaulted after one attendance. Fifty-six of the 147 did not consummate by 6 months, but 38 of them (68%) showed improvements in potency in men complaining of impotence, and in women increasing orgastic ability, enjoyment of sexual contact and relaxation at vaginal examination.

Of the 147 couples, 135 had previously consulted 253 other agents for their inability to consummate and of these 74% consummated by the end of the study. The agents included 35 gynaecologists, 17 psychiatrists and 2 physicians in the national health service, 12 non-medical therapists, with the balance comprising general practitioners and family planning doctors. Only 12 couples had not sought help before. The mean duration of complaint was 4·2 years.

Table 2 shows results by length of symptoms. Almost half the 95 couples consummating at 6 months did so within a maximum of 3 h treatment and six doctor visits (Table 3) and 90% had succeeded within 6 h treatment. The longest treatment was 11 h.

Consummation rates for couples in whom one or both partners presented or attended are shown in Table 4. Couples where the woman alone presented and attended did better than others.

Table 2. Percentage consummating at 6 months by length of symptoms in 159 couples

Duration of symptoms (years)	Total nos	% consummating after 6 months
0–1	57	58
2–4	58	60
5–16	44	61

Table 3. Amount of treatment given in the first 6 months to 159 couples

		Consummated (n=95)	Not consummated (n=64)
Number of h treatment given	Mean	3·0	3·5
	Median	2·8	3·7
	SD	2·3	2·5
Number of visits to doctor for treatment	Mean	5·5	6·2
	Median	5·6	6·0
	SD	3·0	3·8

Table 4. Percentage consummating at 6 months by whether one or both partners attended, in 146 couples

	Number of couples	% of couples consummating
Woman alone at presentation *and* alone subsequently for treatment	67	64
but man came as well subsequently	27	59
Man and woman at presentation *and* both subsequently for treatment	52	61
but woman *alone* subsequently	1	—

Patient characteristics of 147 couples

The age range was 16–50 years. Most of the women were between 15 and 25 years and most men between 25 and 35 years. It was the first marriage for 94 couples and 139 women were nulliparous. Eight women had conceived 10 times without penetration resulting in seven full-term deliveries and three abortions. Only three of these eight women overcame their problems. Analysis by social class (Table 5) shows that the best results were among unskilled workers. Of 45 females who reported traumatic sex or penetrating experiences, 23 attributed these to medical encounters (e.g. speculum inserted despite vaginismus) (Table 5). Those whose vaginal examination was easy did not do better than those with vaginismus (Table 5). Fantasies described by the women are listed in Table 5, only seven women revealed none.

Table 5. Initial characteristics of partners in 147 couples

Characteristic	Women		Men	
	No. of women	% consummating by 6 months	No. of men	% consummating by 6 months
Social class				
Professional and managerial	54	57	48	54
Skilled clerical and manual	76	64	88	64
Unskilled	14	79	10	80
Not known	(3)	—	(1)	—
Previous traumatic sex or penetrating experience				
None	95	65		
Yes, due to medical encounter	23	61		
Yes, other	22	54		
Not known	(7)	—		
First female genital examination				
Relaxed	29	62		
Vaginismus	88	65		
Other	13	53		
Refused	17	52		
Female fantasies stated by patient				
None	7	—		
Too small	40	65		
Pain/damage	59	58		
Dirty/barrier and other	41	54		

Discussion

The 72% consummation rate in the present study of 159 couples could not be compared as we could find no other similar prospective study. No control couples were included because there were too many variables for these to be useful (Balint 1961) and to leave a randomly selected group untreated for a period, as control subjects, seemed unethical in such distressed patients. Of 104 visits to 52 couples by the PSW there were only three differences with the opinion of the doctor. These in retrospect were entirely explicable. With such a high degree of correlation, it was thought unnecessary and uneconomic to extend PSW visits to the remaining couples. Previous unsuccessful treatment had been received by 135 couples, from 253 agents and 74% of these achieved full intercourse. Many couples who did not consummate had other improvements. This suggests that the IPM method can help couples who have not responded to other treatments.

Therapy was not lengthy compared with Marriage Guidance Council estimates of 12 sessions each lasting 1 h for selected patients (Myerscough & Blum 1982). Treatment was allowed to proceed at the patients' pace, using insights from the doctor/patient interaction and genital examination as a psychosomatic event during which fantasies were revealed. Interpretation of

fantasies or erroneous ideas mentioned by all but seven women patients was important in helping them to develop a more mature attitude to sexuality and enable intercourse to take place.

Patients were seen as they presented and then either separately or together according to individual need. Many insist on treating couples only (Bancroft & Coles 1976), and those who prefer to seek help alone are then excluded. In this study one partner attending did no worse than others.

The eight women who conceived 10 times without penetration should be of interest to lawyers. They gave birth before experiencing intercourse which was likely to reinforce fear of genital pain and indeed only three consummated.

It might be thought that interpretive therapy is only suitable for the intelligent and well educated, but this study shows a higher rate of consummation among the unskilled. If the doctor listens and adjusts vocabulary, feelings can be easier to reach in this group. Twenty-three women felt that previous medical encounters had increased their difficulties. Previous doctors could have inadvertently confirmed fears of painful penetration or a too small vagina. "Oh! you're a bit tight" was frequently reported. Twenty-nine women with relaxed vaginas had no better result than those with vaginismus. Previous therapy may have taught relaxation but not explored the patient's sexual fears and fantasies.

Treatment by members of the IPM helped 72% to consummate after an average of four years of misery. This length of time represents unnecessary suffering. The need for the availability of treatment for patients and training of doctors should be more widely recognised.

Acknowledgments

This study was financed by the Nuffield Foundation. We thank Members of the IPM who took part in the study. We are grateful to Mrs B. L. Harding for her persevering work as PSW and to Dr R. A. Dixon and Mrs J. Gyte for statistical advice and help.

CASE STUDY I

Secondary Sleeping Beauty Syndrome?

by Dr Margaret Gill

In the case I am about to describe a woman dealt with intensely painful feelings by focusing them onto her vagina. She denied both the pain and her sexuality and in a sense put her femininity into suspended animation for a while. The vaginal examination proved to be the key which unlocked the feelings so that they could be looked at and accepted. She then "woke up" to her sexuality again. In the Sleeping Beauty story, however, the prince who woke the princess could only get to her when she was ready to be woken, when the 100 yrs were over and when the thorn thicket of her defences gave way. In the case of this patient and possibly in many others the woman was *ready* to face her feelings when she came for help. A "moment of truth" may depend just as much on the patient's readiness to face the truth as on the doctor's ability to face her with it. After all, the "truth" comes from the patient, not the doctor.

I have called Mrs S a secondary "Sleeping Beauty" because before her problems began she had a good sex life. After four years of marriage her first pregnancy ended as a ruptured ectopic at four months. She was very ill and had both her affected tube and the opposite ovary removed – the latter because it was cystic. Later attempts to approximate the remaining tube and ovary did not result in the hoped for second pregnancy.

Mrs S was referred for psychosexual help about 18 months after her pregnancy. Her G.P. said that after losing the baby the family never discussed the matter of the operation with her. He felt that she had never had the opportunity to mourn her loss. She had never cried once. Since the loss of the baby, her sex life which had been "fantastic" had gradually deteriorated. It seemed to the G.P. that Mrs S was frightened that her husband would hurt or damage her in some way during penetration. Initially there had been loss of lubrication and apathy, but over the last 6 months she had developed vaginismus with spasm of the thigh muscles so that intercourse had become impossible.

Mrs S presented with her husband. She was wrapped in a white fur coat, wore a maternity smock and in spite of being overweight and tall, gave the appearance of a doll wrapped in cotton wool. She could give no reason at all for her panic. I said to her that I was going to ask her to do the most difficult thing and let me examine her. I gave her the control, however, to stop me at any time she wanted to. Mr S left at his wife's request. She said "I feel sick at the thought." With encouragement she did climb onto the couch. I gently touched her vulva and asked her how it felt – she looked anguished and said "I want to crawl away up the couch." I commented that she seemed ashamed of her vagina, even disgusted by it – why was that? Crying, she talked of her anger that she had lost most of the parts that made her a woman, her resentment towards the baby for doing that to her and her fear that there may have been something wrong with her beforehand to make the baby grow in the tube. She said "Even the parts left don't match up." She felt a complete mess inside, totally unfeminine, and that was why she did not want any physical contact at all. It was so difficult for her to say that she resented the baby when everyone assumed that she should be feeling only pain at its loss.

At the next visit we discussed the unfeminine feelings in more detail. Mrs S had not tried to lose weight since her pregnancy, she had stayed in maternity smocks and not worn trousers. This was interpreted as an attempt to stay pregnant and to avoid the feelings that had followed her operation. She expressed anger at vaginal examinations done in hospital "as if you were not a part of it". She was angry with the doctors and with her family for not discussing anything with her, for treating her like a child. I pointed out to her her own part in all this, her unwillingness to face her unpleasant feelings and she agreed with me. Details of what happened in hospital were difficult for her to remember – especially the special name her grandfather had for her when she was pregnant. It had been a Welsh name and he had not used it since. I suggested she ask him about it.

When I next saw her Mrs S looked quite different. She had lost 5 lb in weight in two weeks and was wearing a straight black skirt and pretty white blouse. She had felt her vagina and been surprised how "roomy" it was. She was delighted that it felt so nice. There was no feeling of threat when her husband approached her now and she had talked a great deal to him and to the rest of her family. They were all relating very much better and I sensed relief on all sides. She felt ready to try Tampax again – it had been too painful after the operation. Her comment was "I feel as if I have taken back responsibility for myself, I feel like a woman again."

The next visit showed even more improvement. The couple had resumed intercourse and Mrs S had felt relaxed and happy. I examined her again, this time it was full and easy. She said "There isn't all that much missing after all, is there." She was not now nervous about her next hospital visit for infertility. Previously she had refused the suggestion of in vitro fertilisation because it would feel like just another thing being done to her. Now she thought that perhaps she and her husband could choose this method of having a baby if it became necessary.

I can claim no special credit for doing anything out of the ordinary with this patient, indeed it was very clear that *she* did the work and effected the change herself. Had that not been the case the change would have been suspect anyway. That does not detract, however, from the immense satisfaction of being around when the thorn thicket gave way and the Sleeping Beauty was ready to wake up to her sexuality and allow penetration again. I can't help feeling glad for all of us that it did not take 100 years.

CASE STUDY II

The vaginal examination as my therapeutic tool

by Dr Lorna M. Sykes

Anne was referred to me by the G.P. "because she is unable to have intercourse with her boyfriend as she cannot bear the thoughts of any penetration into the vagina".

She arrived in my clinic looking small and forlorn with hair drooping all over her face, a duffle coat drooping from her shoulders and various bags and packages drooping from her arms and hands. Having divested herself of all these appendages I discovered that underneath she was wearing a boiler suit.

She sat down and began to tell me about her problem. She enjoyed making love, was able to get an orgasm but could not allow her boyfriend to penetrate the vagina at all. She also volunteered the information that a colleague of mine had treated her for a considerable time with behaviour therapy with no improvement whatsoever. I felt very threatened.

I decided that I had better get on with it and so asked her to get on the couch so that I could examine her. She got up willingly enough but as soon as I got near her there were floods of tears and sobs and she would not let me approach the vagina. I asked her what she felt about having a family and this produced an explosion. Children were terrible and ruined your life by restricting all your activities. In fact her mother's life had been completely spoilt by having children. I found myself explaining that I also was a mother and that I had not felt my life to be ruined by my children, and in fact they had brought me much joy. She then allowed me to show her how to touch her introitus, but when asked what it felt like she said there was a door there that would not open. I explained that this part of her anatomy was a most feminine part and maybe she should try to explore it and open the door.

The following week again I asked her to get on the couch but she would not feel the vagina as she said it was too painful. In spite of trying to get in touch with all her pain she would not allow me near her either physically or emotionally. I fed this back to her and also pointed out that in the boiler suit it seemed to me she was trying to deny her femininity.

At the next consultation a rather nice fringed scarf had appeared over the boiler suit and I duly admired it. When we again came to the physical examination she could not insert a finger into the vagina and when I tried there were tears again with an outburst about her having a mental age of fifteen. We explored the feelings of being only fifteen and not quite grown up, but each time I got near her I was rebuffed and again I fed this back to her so she could understand that she was blocking any communication between us. This resulted in her confiding in me that her parents were unhappily married and she had a good deal of resentment against her father. In fact as a child after altercations with him she would go up to her bedroom and whip the bed. After having expressed some of these violent feelings, at the next interview she allowed me to put a finger into the vagina and I was able to share the pain so that we were able to talk about the nasty side of one's character needing to be

hidden. She complained however of the pain when I removed my finger and I tried to explain that possibly letting one's feelings out was painful in itself.

By the next visit she was beginning to look more like a woman. She had actually managed to wear a skirt and the scarf was draped most attractively round her shoulders. She had also managed to insert her own fingers into the vagina and had worn a tampon occasionally. I examined her with two fingers but again she showed distress on my removing them from the vagina and I observed again how painful it is to let your feelings out. This brought forth a confession of a tantrum in which she had thrown a plate at her father during the previous week but had also felt very ashamed. We were able to talk about growing up and living one's life apart from one's parents. She then got very cross with me because she said she was not getting on fast enough and her final exams were coming up after which she would have to leave the town. I said she could decide on the time for her next appointment and she chose one in two weeks time.

By that time she had managed to have intercourse but said that it was very painful. She had also used Lillets and got one stuck but was able to laugh about it. We talked about marriage but she said it was not for her. I found myself talking about the freedom which one could have within a permanent relationship if mutual trust was there. At this point and after all this time she told me her mother was Indian. I was stunned and at a loss for words!

At the subsequent interview she had had intercourse twice and had bled a little. Examination revealed no damage and she was reassured. I explored her feelings about her mother's nationality but she did not seem unduly concerned or worried about the cultural differences. She asked to delay the next appointment because of her final examinations.

At the next visit I was highly delighted to see her looking absolutely stunning with her hair beautifully arranged and even wearing some jewellery. She was having intercourse regularly but complained that during intercourse she felt that she might wet the bed. I said, "Would it be so very terrible if you did?" She replied that as it was Peter's bed and in a rented flat it would not be very nice. I asked if she felt she could cope with cleaning up the mess because after all sex can be messy. She blossomed forth and said that mess did not worry her at all because they often had oral sex and even if he ejaculated in her mouth she was quite prepared to swallow it as it was easier that way.

I then asked if she had ever felt that she was going to wet herself as a child and she explained that many years previously she had been at an orchestra practice and being unable to excuse herself she had made a pool on her chair and the floor around her. We shared the feelings of shame she had felt then in front of all her contemporaries. After this she sat fiddling with her belt and I asked what was troubling her. To my surprise she said she thought she ought to have a smear. I offered to do it there and then and promised I would stop if it became too painful for her. She insisted that I should first show her the speculum which I did, but when I mentioned the stick to take the cells off the cervix she panicked again, so I demonstrated with the spatula on the end of her nose. She got onto the couch very readily and I was able to do a smear very

easily. I praised her for co-operating so well and said, "This has been a good interview because you have not only allowed me into your vagina to examine your cervix, but you have allowed me to look inside you at your feelings." I asked if she would like to come again as it was by now the end of the academic year. She said that she would like to come one more time and would travel from home to see me.

On this occasion she arrived with Peter because she wanted us to meet each other. I asked if all was well sexually and she said "Yes it is", giving me a radiant smile. Rather for fun I turned to Peter and said "And is she proving to be sexually satisfactory to you." He took a long look straight into her eyes and said "Oh yes she is!"

CORRESPONDENCE

A letter has been received from Dr E. J. Blair, Sandbanks, South Bank, Hassocks, West Sussex BN6 8JP.

Dear Editor,

At the time of my resignation from clinical assistantships in Psychosexual Medicine at the Elizabeth Garrett Anderson Hospital, London, I would like to pay tribute to the experience that I had there. It was an opportunity to extend my skills in several methods of sex therapy, being given a quiet room, ample time with patients and excellent facilities for hormone assay and skull X-ray as well as access to microbiology department.

Dr Wendy Love taught me to view the sub-fertile couple from a psychological and physical standpoint. From Dr Spenser and Dr Margaret Jones I learned more about the sympathetic care of gynaecological and family planning crises. I was able to venture into psychiatry and psychotherapy with Dr Bruce and Dr Maclay and to all these people I feel very grateful.

The E.G.A. is a valiant hospital struggling to keep going and in the future they are proposing to employ three doctors to work in the field of psychosexual medicine.

Yours sincerely,
Joyce Blair

NEW MEMBERS

Dr Frances Davies	8 Gorst Road, London SW11.
Dr Jonna Lister	29 Wistaria Lane, Yateley, Camberley, Surrey GU17 7HY.
Dr Jean McLellan	208 Abbots Road, Abbots Langley, Herts. WD5 0BD.
Dr A. Gillian Ward	69 Moorside North, Newcastle upon Tyne NE4 9DU.
Dr Beatrice Campbell	Beacon House, Beacon Road, Ivybridge, Devon PL21 0AG.
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Dr Sheila Cohen	Church Lane House, Whitburn, Tyne & Wear SR6 7JL.

CHANGES OF ADDRESS

Dr Jean Lee-Wolf	25 Westland Drive, Brookmans Park, Hatfield, Herts.
Dr Maurice Hamilton	20 Scotts Lane, Shortlands, Bromley, Kent.
Dr Shirley Snead	30 Church Road, Lilleshall, Shropshire.
Dr Joyce Neil	42A Cadogan Park, Belfast, Northern Ireland.
Dr Anne Hagyard	"Wiverton", Halifax Road, Heronsgate, Herts.
Dr A. M. A. Lee	"Brondeg", Church Road, Gilwern, Abergavenny, Gwent.

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Basingstoke	–	Dr Rogers
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For further details contact
Director of Training:
Dr Prudence Tunnadine.