INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 25
April 1984

EDITORIAL

Many members and associate members of the I.P.M. will have been aware of the development of this training organisation since its early beginnings well before 1974. Many members of the medical profession who are gradually becoming aware of the national network of training seminars and the standard of skill of accredited Institute doctors may be surprised to hear that the training established has been in existence for ten years. The Institute has not been evangelical and has only been involved in development of the skills of those doctors who sought it for themselves and their patients. There have not been formal career advantages for doctors who improve their clinical dealings with patients through training. Often there is no financial recompense for doctors who work to help those patients who have sexual difficulties as many doctors organise these special consultations at the end of long general practice surgeries or family planning clinics.

There has not been in the last ten years an overwhelming demand for training. Who wants to look for more work and devote pain, time and energy in developing a capacity to respond usefully to patients who present their sexual problems to the doctor? Nevertheless, the demand for training has grown and also the understanding that these skills in doctoring are not speedily acquired by attending conventional courses and emerging as an expert overnight.

Voltaire said "Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing". I am glad that times have changed since the eighteenth century and that more is known about medicines and disease, but how true even now is his observation about the dearth of insight into human beings. Perhaps in Voltaire's time complaints were never made about sexual difficulties, but these days patients are very likely to ask their doctors for help with their problems. The public are beginning to wish for "whole-person" doctoring.

The demand for psychosexual training will continue to increase. The I.P.M. and its study of Doctor/Patient transactions and research of each client's unique problems, provides the doctor who seeks it the opportunity not necessarily to become an expert in sexual medicine but more importantly, the opportunity to enhance his or her clinical sensitivity and skills whatever the setting.

This 10th anniversary is not a time for complacency or self-congratulation — it is only a milestone marking a progression. Nevertheless, it is a time to acknowledge ten years and more of hard work and dedication by those people who have done so much to develop the organisation this far. Without their foresight and diligence there would not have been this undeniable achievement to date.

The Institute is sometimes accused of being "elitist". Perhaps one of the reasons for this is its adherence to the standards it sets itself and its focus on the Doctor/Patient dealings. But perhaps this criticism is made because we have not until recently noised it abroad what we are about. It is the Institute's fault as we are reluctant to conceptualise our work and put our findings across. For all the work that is done by Institute doctors very little is written up in any section of the medical press including our own organ of communication. Other professionals are only just beginning to discover the value of this kind of training and its relevance to doctors and patients.

Members will be interested in the work of Ms Bebe Speed and Dr Hildebrand, both the similarities and also the differences of approach. The fact that both these accounts of clinical dealings with patients are not by Institute doctors and that there is not one spontaneous offer of work done by Institute members in our own newsletter seems to illustrate the reluctance of I.P.M. members to commit themselves to paper. Nevertheless, we appreciate the opportunity to gain some understanding of the work of Ms Speed and Dr Hildebrand and thank them for their contributions.

This is the first time I have compiled a publication of this kind and there will be shortcomings and imperfections I am sure. My aim is to emulate the work done by Dr Draper and Dr Lincoln as previous editors and to produce a newsletter of interest and value to the membership. I hope that it will develop as the work of the I.P.M. continues to develop and that the next ten years will ensure that the standards of training and the skill of doctors so trained will get the recognition that it so richly deserved.

Yours sincerely,

JOAN COOMBS
Editor

THE SCIENTIFIC COMMITTEE

This is the President, Dr Tom Main's committee. It is concerned with the professional standards of the Institute of Psychosexual medicine.

Dr Tom Main
Dr Katharine Draper (Secretary)
Dr Prudence Tunnadine
Dr Jessie Yorston
Dr Alexandra Tobert
Dr Roland Freedman
Dr Margaret Gill
Dr Rosemarie Lincoln
Dr Anne Smith
Dr Joan Coombs
Dr Judy Gilley

THE TRAINING COMMITTEE

This committee is assembled by the Director of Training to assist her in the work of administering training throughout the country. It includes Regional Training Co-ordinators.

Dr Prudence Tunnadine
Dr Anne Smith (Secretary)
Dr Rosemarie Lincoln
Dr Dorothy Morgan
Dr Jennifer Tisdall
Dr Elspeth Williamson
Dr Joan Coombs
Dr Tom Main
Dr Roland Freedman
Dr Alexandra Tobert
Dr Ruth Skrine
Dr Hana Backer
Dr John Rogers
Dr Shirley Snead

THE COMMUNICATIONS COMMITTEE

This is a small sub-committee which has been set up to examine channels of communication. At a meeting held on 8th March, 1984, the following were present:

Dr Katharine Draper
Dr Judy Gilley
Dr Jennifer Peebles
Dr Prudence Tunnadine
Mrs Nancy Raphael
Dr Margaret Gill
Dr Jane Kilvington
Dr Robina Thexton
Dr Jessie Yorston

The observations of this committee will be reported later.

THE ACCREDITATION PANEL

The Panel meets at regular intervals (May and October) so that associate members of the I.P.M. may present their work for assessment. The purpose of this assessment is to determine the candidates competence to work in the field of psychosexual medicine. This can be a demanding and occasionally painful task for both the candidates and the Panel. The Panel are assessing their co-professionals—mature men and women often highly respected in their chosen fields of medicine. An atmosphere of mutual respect, of shared craftsmanship and of joint concern for achieving high standards in psychosexual medicine must prevail.

Candidates wishing for assessment by the Panel should be doctors who have completed two years in a basic training seminar followed by at least one year in an advanced training seminar.

The day of examination begins with introductions followed by a seminar. Here, candidates have the opportunity to present examples of their ongoing work and all can contribute to the discussion.

After lunch there is individual presentation of work. It is suggested that candidates bring two cases for discussion, one in which they feel fairly satisfied with their understanding and one with which they were less satisfied.

When candidates are informed of the Panel's decision they may be given recommendations as to which areas of their work merit attention.

If the panel is satisfied with the level of skills displayed by the doctor, a recommendation is made to Council that the doctor should be accredited as a full **Member of the Institute of Psychosexual Medicine.** As a result of this the candidate is awarded the Institute's Certificate of Competence in Psychosexual Medicine. A doctor so qualified would be competent to accept referrals from other practitioners and agencies.

Currently the Panel consists of:

Dr Margaret Gill (Secretary)
Dr Alexandra Tobert
Dr Robina Thexton
Dr Gill Hinshelwood
Dr Shelagh Lucas (Reserve)

Details of the regulations for training and qualifications can be obtained from the Director of Training. Doctors wishing to present their work for assessment are requested to write to:

The Panel Secretary
The Institute of Psychosexual Medicine
11 Chandos Street
Cavendish Square
London, W1M 9DE

The next two meetings of the Panel for 1984 will be in May and October.

REPORT OF A TALK GIVEN TO THE BALINT SOCIETY BY DR. TOM MAIN IN MARCH 1984.

Dr Main traced the evolution of the Institute of Psychosexual Medicine from its inception and especially its links with and debt to the work of Dr Michael Balint. The majority of the evening was then spent in descriptive analysis of the I.P.M. as a training organisation. Dr Main illustrated our method of training by using the work of the Leader Doctor Seminars.

The Leader Doctor Seminar aims to develop skills in training groups, that is, its concern is to enable Leader Doctors to get their own training groups to study the Doctor/Patient relationships in the cases presented.

The Leaders are not "problem solvers"—they meet together partly to resist concern with patients and to reinforce concern for doctors in training—for their habits, methods, moods, attributes and blind spots.

The leaders role is to listen to the doctoring of the case of the group and to be concerned with the work problems, how the group handles clinical problems, how the group handles the presenting doctor, how the doctor treats the group, whether the group thinks for itself, whether the group breaks up into smaller groups. The Leader must observe these aspects of the group's work and do something about it.

Simultaneously, the Leader is the model for the seminar, i.e. must be prepared to listen and think, to be ignorant and thoughtful, must address remarks to the professional group—to the professional ego. The Leader is not therefore "matey" as this is a defence against professional relationships and may be an excuse for deficiencies.

Dr Main then described the recognised basic assumptions concerning the work of the training group. These include that the cases presented should be accurate; that "wise remarks" and discussion of general topics are a defence against the work. Similarly, being clever, "jigsaw puzzling" i.e. trying to get the pieces of a case to fit neatly together without good evidence is not highly regarded. Flight into secondary events, turning to authority figures and books—"the department of good ideas"—is also a relapse from thought as is questioning the Leader.

All these are defences against the work which must be recognised as such by the Leader as must the anxiety which has generated them. The Leader must respect this anxiety but encourage the group to stick to the work. Fortunately the Leader can usually trust the group to spot such defences and can hope that attention will be drawn to them. He or she should intervene only if the group is seriously "off the rails". The asking of questions was also touched upon—most questions conceal the asker's point of view only and this needs to be demonstrated.

Dr Main then dwelt on the Doctor/Patient relationship as presented by trainees in their groups. He described cases where the relationship of the patient with the doctor is a clear reflection of the patient's relationship to the spouse. He traced the identification which occurs in a group with the doctor—e.g. a doctor who finds a patient boring (i.e.

'hates' the patient, does not want to work with the patient and gets 'tired') in turn bores the group. The group then hates the doctor and "beats him up"—the Leader in turn hates the group and needs from this to recognise the emotions transferred from the patient's hate of spouse. Such transmissions of events from patient—doctor—group—Leader show us how easily fantasies are transferred. The Leader may need to draw attention to this—"what are we doing, we never met this man?".

Dr Main also used the analogy of the Leader as Coach, i.e. one who has respect for the players, is keen to develop their skills, is merciless with regard to their bad points. The coach recognises that styles vary and is not concerned with the personal life of the player, only with the development of skills.

Our attention was then drawn to the wide variety of settings in which Institute trained doctors work—from V.D. basements to professional units. The most difficult setting, he suggested, was that of the hospital, because hospital procedures inevitably diminish the patient.

Dr Main next highlighted some of the Institute's research. The usually successful outcome of work with patients presenting with non-consummation was touched upon. In this context he described how working with the patient's fantasies and the contrasting of these fantasies with reality may be of significant therapeutic value. He stressed however, that fantasies need to be respected, e.g. the fantasy of "being too small" may mean that the women feels herself not to be fitted, not ready, not grown up enough for a sexual relationship, and there may be a reality to this which needs discussion and growing through. The common fantasy of a "barrier" has its counterpart in the huge jump from childhood to adulthood which is indeed a huge developmental barrier to be torn down.

Dr Main reviewed too the work of the research seminar which examined requests for abortion. It learned that a girl requesting abortion might feel that she was "trespassing" on her mother's territory by producing a baby; she might feel that she is not old enough, i.e. "not big enough" for a baby; the frequent statement "my mother never told me anything" may derive from a mother perceived as "hogging it all for herself". The girl may also be struggling to be "a good hard adult" and may reject her own babyhood and soppiness and therefore cannot cope with anything to do with the baby inside herself.

Some aspects of the work of the research seminars on vasectomy and non-ejaculation were also described. The initially high expectations of the women doctors treating men with non-ejaculation were described (another parallel with the initial high expectation of the wives) and their subsequent disappointments. Many men with non-ejaculation appeared to have experienced intense rivalry problems in childhood (a significant number were twins). They tended to be sweet, good sons who gave their mothers nothing in revenge. Many had intense feelings of rivalry for potential offspring. Those "brought" by their wives for help in producing a baby did understandably badly, but those who came for themselves did better.

Dr Main ended an intense evening's exposition with a warning about the uselessness and difficulty of generalisations. Unfortunately this was not heeded during the ensuing discussion which displayed a remarkable lack of creative listening ability and much dogma not fitting to a Balint-trained group of doctors.

JUDY GILLEY

Report of the 9th Annual General Meeting

The A.G.M. was held at the headquarters of the Institute of Psychosexual Medicine on Friday 23rd March, 1984. The Chairman, Dr. Roland Freedman opened the business meeting. After the minutes of the previous A.G.M. had been discussed, Dr Freedman pointed out to members that this year's A.G.M. signifies considerable change within the I.P.M. as several trojan officers were resigning from the council, their time of office having expired. He paid tribute during the course of the meeting to the work that they have given to the Institute.

Dr. Katherine Draper has worked for many years unstintingly both as secretary and as editor of the newsletter. Dr Fay Hutchinson, in the years she has worked as programme secretary, has also contributed much to the development of the Institute. Dr Rosemarie Lincoln, as newsletter editor for the last five years, has expressed that development on paper. In the early days it began as a duplicated news-sheet circulated to all members. Since that time the membership has grown and the newsletter has developed into a collectable journal containing useful articles and news of the association.

Thanks were also conveyed to Mrs Mary Walford who has provided secretarial support for the work of the I.P.M. and seen its installation into the headquarters at 11 Chandos Street. The I.P.M. is now a concept and a place. Mrs Walford's role is to be taken over by Mrs. Judith Green.

Dr Freedman thanked Dr Margaret Gill for her work as referrals secretary which she has conducted gently, persuasively and efficiently. Dr Sheila Filshie will be taking over this job having been voted onto the council during the meeting.

There followed reports from the officers and reports from the secretaries.

For the first time nominations for council exceeded the number of places and so there was a ballot. The membership of the council is listed at the front of the newsletter.

Under the item "Any other business" there were suggestions and comments from the floor. It was asked if for subsequent elections of council there could be a postal ballot. Dr Elphis Christopher asked why were there not more doctors who belong to the I.P.M. Dr. Prudence Tunnadine replied that at present there are 1,500 part-trained doctors but not all doctors who are in training seminars apply for associate membership of the I.P.M.

The business meeting was followed by an enjoyable buffet reception by courtesy of Ortho-Cilag Pharmaceuticals Limited. As always this was a welcome opportunity to greet and talk with colleagues in other areas; something which is especially valuable for those of us who are usually working in relative isolation in our areas.

"Sexuality and Ageing" was the subject of the paper which was then presented to the meeting by Dr P. Hildebrand. Dr Tom Main introduced Dr Hildebrand, a distinguished psychoanalyst and psychologist, researcher and author as well.

SEXUALITY AND AGEING

Dr. P. Hildebrand,
Chief Psychologist,
Tavistock Clinic,
120 Belsize Lane,
London NW3

Dr Hildebrand's early association with the work of the I.P.M. began before it was in fact formed ten years ago. When the original F.P.A. seminar for doctors was convened to examine the ways of helping patients who presented psychosexual difficulties in family planning clinics, he acted as an observer in the group.

His own clinical work with patients though, differs from that of many I.P.M. doctors. He has been involved, in recent years, studying the sexual difficulties of patients in later life, forty years and over. His involvement with them lasts for some considerable time, as many as fifteen sessions which may extend over a period of two years. This has allowed him to study the life histories of many people as life has changed for them. As he observed, little is known about sexuality in later years and very little understanding of the sexual wishes, fears and behaviour of older people is found in clinical literature. All interest is focussed on sexuality of the young adult.

However, we belong to an ageing population. The public health revolution has led to a great increase in life expectancy and the life style of those living longer has changed.

Sexual anxiety is a problem the ageing patient has to contend with. As Dr Hildebrand observed, fear of impotence once the fortieth birthday has been reached seems to be entrenched in our culture. However, secondary impotence is reversible if it is not due to physical injury or trauma. The sixtieth birthday can be another landmark with waning sexual prowess, increasing fatigue, excess alcohol, stress or fear of impotence. The climate of the marriage is important and helps to insulate the couple from the sadness of retirement from career, or the sadness of the "empty nest" when parenting is over.

Within happy marriages there may be up to 46% which are not sexual. There are other forms of sexual expression. Happiness is not dependant on sex and intimacy replaces passion. Diffuse forms of sexuality may develop and some find a more fulfilling response. Men become more able to understand women. Women become more active and able to take initiative.

Dr Hildebrand told us that monogamy becomes less important and there may be a stable extra-marital relationship.

There followed two painful case studies. The first told of a woman of 68 who had been plagued by feelings of insecurity and inferiority all her life. Promiscuity sweetened her life. Through many vicissitudes and tragedy she was able to survive because of tender acceptance by her elderly lover. The second case history illustrated the continuing struggles of a 60 year old man with a long history of impotence, difficulty with relationships and unresolved self doubt.

Dr Hildebrand told us of the camaraderie amongst the ageing, when the condition is not denied; of an acceptance and understanding of dewlaps and bunions. He reminded us of continuing personal development in old age but that the boy could still be visible in the old man.

He suggested that intimacy should be just as valuable as the modern search for the **big orgasm.**

JOAN COOMBS

THE INSTITUTE OF PSYCHOSEXUAL MEDICINE 1974 - 1984
The First Decade
Act 1. Scene 1.
18th June, 1974.

The North Hall at the Royal Society of Medicine.
Dr Tom Main sits in the chair; with him on the platform are Drs Margaret Blair, Jean Pasmore, Fay Hutchinson, Sylvia Dawkins and Pru Tunnadine.

As they wait the hall gradually fills; some of the doctors are holding a hand-addressed letter from Dr Margaret Blair, Secretary of the Steering Committee that has called the meeting. There is a buzz of expectant chatter as the 72 doctors who have accepted this invitation assemble. Dr Main stands to address a full hall.....

At this meeting the decision was taken to form "a learned society for the promotion of psychosexual medicine through seminar training". Ten years later we are planning a "Celebration" of the Institute of Psychosexual Medicine (I.P.M. as it was finally called) in Lettsom House where we have a permanent office in central London. In this paper I will describe the events that led to the inaugural meeting, some of the intervening steps, and then give an account of the I.P.M. as it functions now.

Founding the Institute.

The inaugural meeting on 18th June 1974, was concerned to establish an organisation which would assume responsibility for the training and accreditation of doctors in psychosexual medicine. The scheme of basic and advanced seminars had evolved under the aegis of the Family Planning Association (F.P.A.) over the previous 16 years and this work is described by Friedman[1], Courtney[2], and Tunnadine[3]. In April 1974, the F.P.A. was due to hand over to the N.H.S. the training of doctors in family planning. The future was uncertain and Dr Main, who had been consultant to the F.P.A. for training in psychosexual medicine, had a meeting with the doctors who were then leading seminars for the F.P.A., Drs Pasmore, Dawkins, Tunnadine, Hutchinson and Blair. At this meeting on 23rd January 1974, they decided to form a Steering Committee to which Dr Blair was appointed Secretary, to set up a separate organisation which would be a medical body that would "arrange and supervise training, set and keep up standards and provide some support for doctors already trained" in the field of psychosexual medicine.

This Steering Committee arranged and paid for the Inaugural meeting on 18th June 1974 and worked out provisional suggestions for the Constitution and membership. Mrs. Nancy Raphael, who had always supported the development of psychosexual medicine on the

Committees of the F.P.A., was asked to join them. All past and present members of the F.P.A. seminars received a letter from Dr Blair, as Secretary of the Steering Committee, inviting them to the meeting on 18th June 1974. 160 wrote supporting the new society and 72 attended the meeting. After Dr Main's address, Dr Blair's exposition of the proposed constitution and a general discussion, the meeting agreed that they should found a "Learned Society for the promotion of psychosexual medicine through seminar training". The Steering Committee, joined by representatives from outside London, (Drs Gregson, Marshall, Tisdall and Naismith) were asked to prepare the Constitution, arrange a clinical meeting in the autumn and reconsider the name. Dr. Hutchinson was appointed Treasurer and 43 members joined the new Society.

Steering Committee

The Steering Committee continued to manage the new Society until the first Annual General Meeting on 19th March 1976, when the affairs of the Institute were handed over to the first Council.

At the meeting on 24th October 1974, Dr Tunnadine was appointed Training Secretary and asked to organise seminars and respond to all enquiries for training. At the same meeting it was decided to ask Dr Draper to edit a newsletter. I accepted this invitation and joined the Steering Committee. It was eventually decided that there should be three newsletters a year, that circulation should be restricted to members (because of the confidentiality of case reports) and that a summary of the contents would be available to the National Association of Family Planning doctors' journal.

The Steering Committee applied to the Charity Commissioners for charitable status, the proposed constitution was approved, and the Founders (i.e. the Steering Committee and two trustees, Mrs Nancy Raphael and Dr Stephen Pasmore) set up the Trust for Psychosexual Medicine which is a registered charity into which all membership fees are paid. At the second meeting of the new "Medical Psychosexual Society" on 15th November 1974, it was formally decided that the title "The INSTITUTE OF PSYCHOSEXUAL MEDICINE" should be adopted. While the administration of the I.P.M. was in its infancy (differentiating the constitution, the functions of its officers, its name and charitable status) the prime function, i.e. **training**, was already in a sophisticated state of development and expanding fast. At the first A.G.M. on 19th March 1976, there was already a Leaders Workshop, a specialist research seminar, 4 advanced seminars, 12 basic seminars and 4 informal study groups, which represented nearly 200 doctors in training. The training of leaders and accreditation by the panel were the subject of continuous review and development. The F.P.A. officially recognised the I.P.M. as the organisation responsible for seminar training at the end of 1975 and the Monkton Fund, set up by Mrs Raphael to support doctors attending advanced seminars, was transferred to the I.P.M.

In the first year and a half, while the I.P.M. was evolving so rapidly, a brief business meeting was held before each clinical meeting. At the meeting on 4th July 1975, it was decided to set up a Research subcommittee "to look into the question of evaluation of our work" (Doctors Bramley, Brown, Draper, Kilvington and Shirley-Quirk). This committee, after much deliberation, decided to carry out a prospective study of non-consummation as there was a definite outcome. 16 Members took part and the results were published in The British Journal of Obstetrics and Gynaecology [4,5]. A subscription by members supported the pilot study and a Nuffield Grant was finally obtained for the full project.

1st A.G.M.—19th March 1976.

At this meeting the elected Council took over responsibility as decreed by the Constitution. The original Steering Committee was joined by Drs Barne and Shirley-Quirk to form the new Council. This Constitution, with only minor modifications to meet the developing needs of the Institute, still governs the I.P.M.

The first weekend clinical meeting was held in Bournemouth in 1976 and this has since become an annual event. Clinical meetings are normally restricted to members but an exception was made at the 1st International Conference held at Brighton in July 1982 [6]—nearly 200 doctors attended. The initial expenses were borne by loans from members but the final surplus has been invested in a special account so that it is ready for the next Conference.

In 1978 it was decided that it was necessary to pass the Panel to become a full Member. The Council was expanded by co-option and some of the duties of the Secretary were devolved to the Programme Secretary (Dr Barne), the Referral Secretary (Dr Backer) and the Publications Secretary (Dr Thompson).

Rather than give a diachronic account of all the continuing changes to meet the expanding functions I will describe the present organisation of the I.P.M.

The Present Organisation of the I.P.M.

Certain functions of the I.P.M. are governed by the Constitution. These can only be modified at the A.G.M. and any significant change would entail resubmission of the Constitution to the Charity Commissioners; these functions will be given in bold type. Other regulations derive from, and can therefore be altered by, a decision of Council.

AIM OF THE INSTITUTE

To be a learned body for the promotion of Psychosexual Medicine Through Seminar Training.

OBJECTS OF THE INSTITUTE

1. **To run training schemes**
2. **To ensure the maintenance of standards**
3. **To appoint trainers**
4. **To gain recognition of certificate from the Royal Colleges of Obstetrics and Gynaecologists and General Practitioners.**
5. **To hold meetings**
6. **To organise research**
7. **To publish news-sheet or journal**

MEMBERSHIP

Membership shall be limited to Medical Practitioners. There are four categories of membership.

1. **MEMBERS**
   Doctors who have been passed by the panel, approved by council, paid the membership fee and thereafter an annual membership fee.

2. **ASSOCIATES**
   Doctors who have been in training in an accredited seminar for at least two terms but who have not yet been passed by the panel. Associate members can attend business meetings but must not be allowed to vote.

3. **SUBSCRIBERS**
   Doctors working in the field of psychosexual medicine who apply to the institute and are accepted by the council although they have not had the formal institute training. Subscribers can attend meetings but must not be allowed to vote.

4. **HONORARY MEMBERS**
   Those distinguished for their work in the field of psychosexual medicine who have been invited by the council to become honorary members. Honorary members can attend business meetings but must not be allowed to vote.

At present the total membership is 333.

Full Members	151
Associates	164
Subscribers	8
Honorary	2

There are also 8 retired members, a new category for those who have ceased clinical practice and pay a reduced subscription.

MANAGEMENT

The affairs of the Institute shall be managed by a council consisting of 12 members elected by members of the Institute. They shall have powers to co-opt and a duty to appoint a chairman, secretary, director of training, treasurer and editor. Elected members will not normally serve for more than 3 years and will stand for election annually.

There shall be a president who will represent the Institute in scientific matters with no fixed term.

Representatives of the Royal Colleges of Psychiatry, Obstetrics and Gynaecology and General Practitioners shall be invited to be vice-presidents.

The chairman of the council will be elected by the council with a term of office not normally more than three years.

The secretary and treasurer shall not normally serve for more than 5 years consecutively. The editor will not normally serve for more than 3 years consecutively.

OFFICERS OF THE COUNCIL

President:	Dr Main, who is also Consultant on Training.
Chairman of Council:	Dr Roland Freedman. Appointed 1982.
Director of Training:	Dr P. Tunnandine. Founder Member.
Secretary:	Dr J. Gilley. Appointed 1984.
Treasurer:	Dr J. Yorston. Appointed 1983.
Editor:	Dr J. Coombs. Appointed 1984.

In order to share the increasing workload the Council devolved certain tasks to Secretaries who have played a valuable part in the expansion of the I.P.M.

Panel Secretary
The Panel Secretary makes all necessary arrangements for the meeting of a Panel. Dr M. Gill was appointed in 1984.

Programme Secretary
The Programme Secretary arranges the scientific meetings of the Institute. Dr J. Kilvington was appointed in 1984.

Publications Editor
The Publications Editor is responsible for the transcripts of the weekend meetings. Dr R. Sampson was appointed in 1982.

Referral Secretary
The Referral Secretary deals with correspondence from patients asking for help with psychosexual difficulties. Dr S. Filshie was appointed in 1984.

Secretary of the Scientific Committee
Responsible for arranging meetings under the President's instructions. Dr. K. Draper was appointed in 1983.

Bibliography
While Miss V. Thompson was Publications Editor she made a Bibliography and continues to maintain this. Any member who has had a paper published is asked to send a copy or report to Miss V. Thompson.

The Council meets three times a year; at the Weekend Meeting in the Autumn and twice in London in Spring and Winter. To supervise the details of management the Executive Committee was formed in 1977, the Chairman, Director of Training, Treasurer and Secretary meet regularly to attend to the details of proposals and prepare reports for discussion and decision by Council.

TRAINING

The Council shall set up and organise seminar training.
The Council shall have power to appoint and dismiss trainers.

The Director of Training is responsible for the organisation of Basic and Advanced Seminars and the Leaders Workshop; she is assisted by Regional Co-ordinators. When necessary there is an Administrative Training Committee composed of the Director of Training, the Consultant on Training and the Regional Co-ordinators and Advanced Leaders who have groups.

When standards and policy of training are under discussion the Scientific Committee meet with the Advanced Leaders, the Director of Training and the Consultant on Training.

ACCREDITATION

The council shall have the power to set up a scheme for the accreditation of trainees on completion of training and to issue certificates of competence.

The Members of the Panel, at present Drs Tobert, Hinshelwood, Lucas and Thexton, are appointed by the Council on the recommendation of the Scientific Committee.

The Scientific Committee
This Committee was set up by the Council in December 1979 and is responsible to the Council for scientific standards in all aspects of the work of the I.P.M. Officers or individuals can approach the Committee for assistance with their duties, or the committee can instigate a review of aspects of the work. The Committee reports to the Council.

The Committee is chaired by the President and is composed of all the Officers plus 5 other members nominated by the President and ratified by the Council, at present Drs Draper (Secretary), Gill, Lincoln, Smith and Tobert.

Conclusion

Since January 1983, we have had a permanent office in the elegant premises of the Medical Society of London. All Council, Scientific and Panel meetings, and the Annual General Meetings have enjoyed the new premises and we have been able to hold a series of monthly clinical discussions through the winter of 1983 - 1984.

All the objects set out in the Constitution that were proposed at the historic meeting in June 1974 have been met, except the formal recognition of our accreditation for which negotiations are in progress. This paper has stressed the infra-structure of administration necessary for efficient functioning, but throughout this decade we have "steadfastly pursued our central task of maintaining our specific method of training by seminars, a method centred on the study of Doctor/Patient relationship and the elucidation of unconscious factors behind symptoms".

Katharine Draper

References

1. Friedman, L.T. (1962): Virgin Wives. London: Tavistock Publications.
2. Courtney, M. (1969): Sexual Discord in Marriage. London: Tavistock Publications.
3. Tunnadine, L.P.D. (1970): Contraception and Sexual Life. London: Tavistock Publications.
4. Bramley, M. et al. (1981): Brief psychosomatic therapy for consummation of marriage. Br. J. Obstet. Gynaec. 88 819-824.
5. Bramley, H.M., Brown, J., Draper, K.C. and Kilvington, J. (1983): Non-consummation of marriage treated by members of the Institute of Psychosexual Medicine: A prospective study. Br. J. Obstet. Gynaec. 90 908-13.
6. Draper, K.C. (1983): Practice of Psychosexual Medicine. London: John Libbey.
7. Main, T.F. (1977): Minutes of the 2nd A.G.M. of the Institute of Psychosexual Medicine.

SEXUAL DYSFUNCTION FROM A FAMILY THERAPY PERSPECTIVE

Bebe Speed
Roy Shuttleworth
The Family Institute, Cardiff

May 1983.

This article briefly describes work conducted at the Family Institute, Cardiff, with couples presenting sexual difficulties. The approach used draws on the ideas of family therapy as a source of conceptualising and treating sexual dysfunction.

The Family Institute, Cardiff, was established twelve years ago and is funded by Dr Barnado's. Currently, there are five full-time members of staff, one part-time member and three associates, all of whom are variously trained in psychology, psychiatry, social work and psychotherapy. Besides clinical work, the Institute has a heavy commitment to training programmes and courses, both within and outside the agency, as well as undertaking some research. Approximately half the referrals are self-referred whilst the rest are referred by other professionals in the Cardiff area and further afield. The range of problems for which help is sought is wide, including psychiatric symptoms, behaviour problems in children and adolescents, marital stress and sexual difficulties.

Two-and-a-half years ago, the authors began working together as a co-therapy pair seeing all couples and individuals who referred themselves or were referred specifically with sexual problems. In that time we have had forty-seven couple referrals: fourteen from general practitioners, twenty-five self-referrals (many at the recommendation of a general practitioner) and eight referrals from other professionals, including social workers, health visitors and a worker with S.P.O.D. Of the forty-seven, forty-two arrived for their first appointment, a "show" rate of 89%. Low sexual desire in the female partner was the problem specified in 55% of cases at referral or during the first interview, with impotence the next most frequent, 19%, followed by non-consummation, 9%. Women were twice as likely as men to be initially presented as the dysfunctional partner, thought it is common to find on closer questioning that the male partner has sexual difficulties too, such as premature ejaculation.

Conceptualising Sexual Dysfunction

There have basically been two ways of conceptualising sexual dysfunction: the psychoanalytic (see, for example, Malan[1] 1979) and the behavioural (see, for example, Masters and Johnson[2] 1970). Many workers in the field, for example, Kaplan (1974[3],1979[4]) found the behavioural approach to be inadequate in the light of some of the problems presented by clients and went on to develop a way of conceptualising sexual dysfunction which incorporated both behavioural and psychodynamic ideas. We too, found a Masters and Johnson

approach on its own to be inadequate. Unlike Kaplan, however, because of our different context, we have drawn on the ideas developed in the field of family therapy to extend our conceptualisation and treatment of sexual problems.

As I have said elsewhere (Speed[5]1984a), family therapy is not a unified theory and practice. One central tenet is, however, that the focus of interest be on what occurs **between** people rather than on what occurs inside people. Thus symptomatic behaviour, including sexual symptomatology, is not isolated and treated separately as the individual's problem but is seen as a form of communication and as part of a repetitive sequence of interaction between people in a relationship configuration. People interact in configurations or systems in patterned ways and symptoms are part of that pattern.

For example, a couple, Tom and Maria, were referred to us by their G.P. because of Maria's long standing loss of sexual desire. Apart from his wife's lack of sexual interest, Tom had no other complaints about their relationship. Meanwhile, Maria was full of complaints about her husband. He worked too hard and always fell asleep when he came home. He didn't do what she asked him to. He wouldn't talk to her, preferring to read the paper or endlessly watch television. The pattern between them seemed to be that the more Maria complained and criticised Tom, the more he withdrew and the more Tom withdrew, the more Maria complained. In our view, the sexual difficulty was part of this pattern. Maria's refusal to co-operate sexually could be seen as a source of power in a situation where she otherwise felt powerless. But, at the same time, the impact of Maria's sexual withdrawal on Tom made him feel rejected and, therefore, tended to make him withdraw from her even more.

Not only did this pattern operate between the couple, it was also part of a wider pattern within the family system. This was a second marriage for Maria who had an eighteen-year-old daughter from a first brief marriage. Maria and her daughter had always been close and it was the daughter to whom Maria turned for the affection and support that she felt lacking in her relationship with Tom. But is was possible to see the other side of the coin. The more Maria turned to her daughter, the more Tom felt left out and the more he withdrew. In this view, the distance existing between Tom and Maria, exemplified by the sexual difficulty, fitted with other patterns of closeness between mother and daughter and Tom's preoccupations with work. Thus, rather than seeing a sexual problem as an intrapersonal phenomenon, our approach views it as part of continuing interactional sequences between members of a relationship system.

The Approach in Practice.

Our aim initially is to assess the sexual problem itself, its place in the couple's relationship and the place of the couple's relationship in the wider context. Working as a co-therapy pair, the authors begin by seeing the couple together and asking, in some detail, about the

problem. What is the difficulty as the couple see it? Is there more than one problem or one underlying another? How long has it been a problem? Who is it most a problem for? We are also interested in the quality of the couple's relationship generally. Is the sexual difficulty just one aspect of a relationship which is more or less foundering, or is it a problem in an otherwise largely satisfactory relationship? Frequently, a couple state that they have other relationship difficulties but occasionally these are disguised by some couples who insist that their only problem is a sexual one. There are also often issues within the wider family related to the sexual and other marital difficulties. For example, it is sometimes the case that a couple will have accepted difficulties for many years and it is only now, with some change occurring in the wider family, that they define themselves as needing treatment. A common example is couples beginning to see their previously accepted level of sexuality functioning as a problem at the time when their children grow up and begin to leave home (see Haley[6]1980).

Unless it is clear at this initial stage that there seems little to be gained from detailed sexual information, for example because the couple are, in fact, on the point of splitting up or because there appear to be profound problems at a more systemic level, the next stage of the assessment procedure is taking a sexual history, the male therapist seeing the man and the female therapist the woman. Having gathered information on all the levels, the co-therapists then try and construct a hypothesis to account for the existence and maintenance of the sexual difficulty. Such hypotheses may focus primarily on the couple's interaction or be more wide ranging to include interactional patterns in the whole configuration. Sometimes we do not have sufficient information to make a formulation and we will then suggest a further appointment. Occasionally at this stage, we may ask a couple to do a task relevant to the problem, for example a non-genital sensate focus exercise or a monitoring task, for example, asking them to make a note concerning certain aspects of the relationship. Whilst such tasks may produce change and can be helpful in giving the couple the sense that therapy has begun, one of the aims of such a task at this stage is to seek information about a couple's responsiveness to requests from the therapists to do tasks and to do things differently. It is our experience that people differ widely in this respect and if people find it difficult to respond to such requests, we will subsequently tailor our approach accordingly.

Interventions.

People's beliefs about what they do and why they do it and about what others do and why, are in a mutually determining relationship with their actual behaviour. That is, beliefs shape behaviour and behaviour shapes beliefs. Therefore, change can be induced by altering either people's beliefs or their behaviour or both. In our work, we attempt to provoke change by using techniques which are aimed at change at either of these two levels.

1. **Changing Behaviour**
We ask couples to undertake a wide range of tasks and different behaviours, both within and outside a therapy session. The sexual tasks developed by Masters and Johnson and required of couples to do as "homework" are an obvious example. We also use a number of tasks aimed at other aspects of the couple's relationship or at the wider network of relationships. For example, a task we gave Tom and Maria, the couple mentioned earlier, was that they should organise a weekend away together, the first time they would have had alone since their marriage because of the continuing presence of Maria's daughter. Initially Maria was worried about leaving her daughter but following some reassurance began to enthusiastically plan a weekend in a caravan down to the meals they would eat, complete with candles on the table. Our main, though unstated, aim in using this task was to begin to restructure the family relationships, to put Tom and Maria together more and to remove Maria's daughter temporarily from the triangle. The couple reported an excellent weekend with the bonus of continuing and additional enjoyment of the sexual tasks we had also been requesting them to do.

2. **Changing Beliefs**
Along with therapists of different orientations, we use a number of interventions aimed at changing people's attitudes and beliefs. Where necessary, we will give factual information, use reassurance and try to enhance communication between the couple.

We also, however, use techniques aimed at changing beliefs which emanate more from the field of family therapy. One major strategy we use is reframing where a different meaning is attributed to events and behaviours by the therapists than that normally attributed to them by the couple. Reframings are sometimes simple aimed at one aspect of a couple's relationship or more complex involving an hypothesis concerning the whole relationship context. With some of the couples we have seen sexual difficulties can be viewed as a way of regulating distance between the two spouses (see Speed [7] 1984). A comfortable degree of closeness and distance is one of the crucial aspects of a relationship every couple somehow has to negotiate and lack of sexual closeness and success along with other devices such as marital rows, closeness with friends and involvement with work are ways that this can be dealt with. The degree of closeness between partners is also affected by and affects the degree of closeness between partners and other family members, for example children and parents. For example, a common pattern, mentioned earlier, is that of couples whose main focus over the years has been as parents rather than spouses. There may have been sexual difficulties symbolising marital distance for many years but this has not been defined as problematic as long

as, for example, the wife has been caught up with children and the husband with work. Stress and ultimately referral for help may result when the children begin to grow up and the wife begins to look more towards the marriage for satisfaction or begins to look outside the marriage and has an affair. In situations where we perceive such a balance of closeness within various relationships in the family, we may reframe sexual difficulties as admittedly painful and difficult (i.e. accepting the couple's definition of the situation) but nevertheless helpful and important in allowing the continuing existence of other closenesses which might otherwise be in jeopardy (a new definition of the situation). Thus a previously implicit pattern in the family is made explicit. This may produce change because the difficulty has been defined as helpful, thus potentially reducing anxiety or it may produce change by acting as a challenge to the balance of relationships previously existing. We may also sometimes point to the risks to other relationships in changing such a balance and advise that any change should only occur very slowly which can also provide reassurance but to some couples be a challenge.

As yet we have no formalised outcome data though we are informally aware of the progress of some couples who have continued to do well. We are currently devising a follow-up format which we will use with all couples and individuals seen by us at least twelve months after the last interview. During the course of therapy with each couple and individual, however, we have been continually aware of how much we have been helped by the extension of our conceptualisation afforded by an interactional, systemic view and by the repertoire of ideas for interventions upon which we have been able to draw. We hope in this article that we have given a brief idea of some of these approaches and their use in the therapy of people with sexual difficulties.

BEBE SPEED

References

1. Malan, D.H. (1979) Individual Psychotherapy and the Science of Psychodynamics. London, Butterworth & Co.
2. Masters, W.H. & Johnson, V.E. (1970) Human Sexual Inadequacy. Boston, Little, Brown & Co.
3. Kaplan, H. S. (1974) The New Sex Therapy: Active Treatment of Sexual Dysfunctions. New York, Brunner/Mazel.
4. Kaplan, H. S. (1979) Disorders of Sexual Desire. London, Balliere Tindall.
5. Speed, B. (1984a) Family Therapy: An update, Association for Child Psychology & Psychiatry Newsletter, 6, 2-14
6. Haley, J. (1980) Leaving Home: The Therapy of Disturbed Young People. New York, McGraw-Hill.
7. Speed, B. (1984b) The Use of the Milan Approach in Sex Therapy in Campbell, D. and Draper, R. (eds) Applications of Systemic Family Therapy, The Milan Method, to be published by Academic Press, London.

Training Ten Years On

Numerically, the continued success of our training is beyond question. Another twelve new groups last year; some twenty new leaders in training. No other "courses" for doctors have to my knowledge yet reached double figures, and it is interesting—sad perhaps—that the Balint Society, to whose founder we owe our origins, runs very few training groups. Concerned as they are with the broad spectrum of general practice, this needs understanding, when about half of our new trainees today are general practitioners, as are a number of our leaders. Yet since what we learn is a method of doctoring—a skill—rather than facts and theories, the case material studied is of course now far more wide ranging than the sexual difficulty of women family planning patients with whom the work began.

Self-congratulation is tempting, but it is more important to study the reasons for this, and for the less encouraging fact raised from the floor at the AGM, that relatively few of the nearly 1500 doctors touched by our training to date have elected to join the Institute.

It is increasingly clear to me, whilst acknowledging our debt to Michael Balint for the first study, that Tom Main's foresight in training trainers, and this alone, has made possible the nationwide organisation we have today. His insistence too on the disciplined confinement of the case study, and in parallel study of leadership technique, to a deep but narrow front, has resulted in a swift—for the apt trainee—acquisition of a limited but profound skill; that of an awareness of unconscious factors in here-and-now encounters. This, as we all know, colours and enriches all our doctoring, not merely with sexual problems.

Are there grounds then for anxiety that we depend too much on this one man? This is expressed most often, I find, by those who have not experienced his own groups, and he would certainly regard it as a training failure if we did. Administratively he handed over responsibility long ago to avoid just this. He would dread leaving an Institute which looked backward with "the Master would have said....." What this master, like Balint, truly says is "think for yourselves". I responded to his proposal to cut down his training sessions too with "Please don't. I don't actually **need** a Rolls Royce—but if I had one, I would not leave it in the garage".

What then of the numerical gap between those who train and those who join? Full membership will always be limited if we keep our standards of qualification high, but leaders must encourage their trainees to join as Associates after their second term if the Institute is to grow in its other functions. Whether a primarily training and qualification organisation **should** have other functions—social, political—remains a matter for the membership. Meanwhile, clearly many trainees have no taste for "joining"—but perhaps among those are some who have got from us all they need. If our chief task is to improve standards of independent everyday doctoring, then arguably such free spirits may themselves merit some pride!

PRUDENCE TUNNADINE

Letter from the Referral Secretary

Members may have noted from the AGM report that we have had a very large increase in requests for our help from the public after publicity such as Prudence Tunnadine's Article in the 'Observer' and Claire Rayner's letter page in the 'Sun'.

We can only put these people in touch with **fully accredited** members as Council cannot vouch for those not passed by the panel. In some areas, however, there are associates only. Some of these doctors are running special psychosexual clinics and would therefore be experienced. If you are in this category, may I urge you to consider coming before the panel for accreditation so that people who write in asking for help in your area can be put in touch with you.

MARGARET GILL

Note from the Treasurer.

COVENANTED SUBSCRIPTIONS. Owing to some confusion and delay on the part of our former accountants, and to difficulties caused by the four changes in treasurer over the past three years, there have been complications in processing the convenanted subscriptions and in recovering the income tax. I should like to apologise to those members who have had to sign additional forms in the past few months and I sincerely hope that we now have a straightforward procedure for dealing with future covenants.

JESSIE YORSTON.

Dr Frances M. Davies	The Old School House, Turville, Henley-on-Thames, Oxon.
Dr Rosemary A. Bradbury	Hartford Cottage, Off Moorend Lane, Silkstone Common, Barnsley, South Yorkshire, S75 4RL
Dr Christine T. Horrocks	24 Cliff Court Drive, Frenchay, Bristol BS16 1LP.

Books by Members of the Institute of Psychosexual Medicine.

The Practice of Psychosexual Medicine.
Edited by Katherine Draper. Published by John Libbey & Co.

Members are reminded that the 25% discount on a members signature is available for an indefinite number of copies. The leaflets will be sent from the office on request.

The Making of Love
By Prudence Tunnadine. Published by Jonathan Cape. 1983.

Sexual Medicine.
By G. R. Freedman. Published by Churchill Livingstone. 1983.

Themes in Psychosexual Medicine.
Edited by Rosmarie Lincoln, 1981. Published by Dr. Stuart Phillips, PhD, BSc. 16 Glena Mount, Benhill Wood Road, Sutton, Surrey, SM1 4HW.

Contraception and Sexual Life: A Therapeutic Approach
By Prudence Tunnadine.

The Following Changes of Address have been notified Since September 1983

Dr Gillian M. Wakley	'Aria', The Hayes, Cheddar, Somerset, BS27 3AN
Dr Elizabeth M. S. Wotherspoon	York House, Puddleton, Dorchester, Dorset. DT2 8RR.
Dr A. M. A. Lee	'Brondeg', Church Road, Gilwern, Abergavenny, Gwent.
Dr Susan M. Horsewood-Lee	59 Wimpole Street, London, W1
Dr Judy Lawrence	'Spindrift', Rue du Portelet, Torteval, Guernsey, Channel Islands.
Dr Elizabeth Stanley	82 Harley Street, London, W1N 1AE
Dr Prudence Tunnadine	Flat 7, Wimpole House, 29 Wimpole Street,

narrow front, has resulted in a swift—for the apprentice—acquisition of a limited but profound skill; that of an awareness of unconscious factors in here-and-now encounters. This, as we all know, colours and on enriches all our doctoring, not merely with sexual problems.

Are there grounds then for anxiety that we depend too much on this one man? This is expressed most often, I find, by those who have not experienced his own groups, and he would certainly regard it as a

Dr S. K. Mehra	20 Wentworth Court, Darras Hall, Ponteland, Newcastle upon Tyne

New Members whose Applications were accepted from 1 October 1983

Dr Susan M. Royce	Top Farm, Barking Tye, Ipswich, Suffolk
Dr David A. Gregory	13 Claremont Street, Spital Tongues, Newcastle upon Tyne, Tyne & Wear, NE2 4AH.
Dr G. Rhugani	27 Barley Lane, Goodmayes, Ilford, Essex.
Dr S. Sengupta	27 Stirling Drive, Chirton Park, North Shields, Tyne & Wear, NE29 8DJ.
Dr M. Veeravahu	19 Bedford Drive, Sutton Coldfield, West Midlands, B75 6AU
Dr Elizabeth S. Nyholm	435 Church Road, Yardley, Birmingham B33 8PA
Dr Margaret E. Macnair	29 Gilston Road, London, SW10

Dr Gita Chandra	Falkirk, Killingworth, Newcastle upon Tyne, Tyne & Wear, NE13 0QA.
Dr Eiry Jones	Lynway, Dilwyn Avenue, Hengoed, Mid-Glamorgan.
Dr Jane Price	9 Soberton Towers, Soberton, Hampshire.
Dr B. Z. Davies	412 Barrows Lane, Sheldon, Birmingham, B26 1QL
Dr Mahesh K. Arora	19 Barne Close, Nuneaton, Warwickshire, CV11 4TP
Dr Jean C. Marfleet	186 Maldon Road, Colchester, Essex.
Dr Daphne Mary Scott	'Fairbrook', Oxted, Surrey.
Dr Anne H. Hagyard	'Wiverton', Halifax Road, Heronsgate, Rickmansworth, Herts.
Dr Trevor Zutshi	Fir Tree Cottage, High Street, Otford, Kent.
Dr Frances M. Davies	The Old School House, Turville, Henley-on-Thames, Oxon.
Dr Rosemary A. Bradbury	Hartford Cottage, Off Moorend Lane, Silkstone Common, Barnsley, South Yorkshire, S75 4RL
Dr Christine T. Horrocks	24 Cliff Court Drive, Frenchay, Bristol BS16 1LP.
Dr Susan Norman	1 Leigh Road, Clifton, Bristol BS8 2DA.
Dr Brian Cogan	4 Eastcliffe Avenue, Kenton Park, Newcastle upon Tyne, NE3 4SN.
Dr Cleanth Jones	24 Jestyn Close, Dinas Powis, South Glamorgan
Dr Susan M Smith	'Oak Ridge', 8 Squire Way, Henfield, West Sussex.
Dr Pauline Allen	Brook Cottage, Churchend, Eastington, Stonehouse, Gloucester.
Dr Hilary Richards	18 St. John's Road, Clevedon, Avon, BS21 7TG.

STOP PRESS

Panel Passes

The Accreditation Panel met at Lettsom House in June and recommended the following members to the council for full membership of the Institute of Psychosexual Medicine.

They are:

Dr S. A. Bolt	The Medical Centre, Hythe, Southampton, Hampshire.
Dr Mollie E. Clay	1, Arbutus Close, Dorchester, Dorset.
Dr Judy de la Hoyde	146, Warsash Road, Warsash, Southampton, Hampshire.
Dr Valerie Hall	77, Moorside, North Fenham, Newcastle upon Tyne.
Dr Merial Roberts	16 Ethelbert Road, Canterbury, Kent.

Withdrawal Symptoms?

Who choose coitus interruptus as a long term method of contraception? What are the dynamics of the relationships in which this occurs?

Two case studies of men whose presenting symptom was impotence and who had previously led a vigorous and satisfying sexual life shew that their sexual difficulty was related to the need to please their wives and to the conflict about expressing openly their own needs and feelings. Both men were referred to the Psychosexual Clinic by their General Practitioners.

John Davies had been impotent for eight months and his doctor said that it had begun when his wife started a University Course. This was indeed the time but the symptom had another cause. This man was tall, good looking, confident and articulate; a graduate teacher. He presented his problem directly saying "I think that I have got a psychological block. My sex life has always been fine and I have got a wonderful wife, two lovely children and my wife is a super mother, and I have a very good job". Everything sounded a little too rosy. He went on to say that his wife had started a University Course which he thought was good for her because she did not feel needed enough now that the children were growing up. In fact she would like to have another baby.

In response to my question about contraception he said that they had always used withdrawal quite satisfactorily and he added that contraception was a topic which his wife just would not like to talk about. "Of course I always make sure that she has several orgasms before I withdraw".

I interpreted to him that it seemed very important for him to please his wife and he agreed, and I then commented that perhaps he did not really want another baby although his wife did. He said "Oh no, I do not want one but often my wife pleads with me during intercourse not to withdraw". This gave me the opportunity to point out to him that his impotence solved a dilema for him. He could not openly thwart his wife, but his 'psychological block' avoided the conflict about withdrawal.

He said "it does seem rather obvious" and that he would consider it, but he failed to keep his next appointment. I think that he was too amazed at himself for using this unconscious mechanism to share it further with the doctor. It is to be hoped that we can deal with the conflict in a more realistic way.

Joe Ginori was 63 and his wife 47. They had moved to England early in their marriage 20 years before and now kept a shop together. He was courteous and charming and said they had been very happy in England and he spoke fondly of his wife and four children. He had been treated with pills by a urologist for prostatic enlargement and he feared that his impotence might have resulted from the pills, shrivelling his genitals as well as his prostate. He had refused an operation on his prostate because he had been told that he would no longer be able to ejaculate if the prostate were removed. During the consultations it became clear that the problem might be related to the method of contraception and his need to satisfy his younger wife. They had always used coitus interruptus and intercourse had been prolonged and enjoyable. He always made sure that his wife reached orgasm before he withdrew and it was most important to him to control himself and to give her full enjoyment. With the years it took her a little longer to reach orgasm and his control was not quite so confident as it used to be. The anxiety of trying to hang on until his wife reached orgasm caused his erection to fail. He said that this was more than his 'Latin temperament' could bear!

When he had understood the problem, he agreed to discuss with his wife whether she might use a simple form of contraception such as spermicidal foam, so that he need not worry about withdrawal before ejaculation. On his third visit his wife was taking the responsibility for contraception and his problem was solved, much to Joe's delight. He had also decided to have the recommended prostate operation.

Rosemarie D. Lincoln.
Senior Medical Officer. Family Planning/Member of the Institute of Psychosexual Medicine.