

### FUTURE I.P.M. EVENTS

1. A scientific weekend is to be held from September 20th to 22nd, 1985, at Henderson Hall, University of Newcastle. The programme for the meeting will be circulated to the membership as early as possible in July.

2. September 19th to 21st, 1985, a scientific weekend is to be held at the University of Bath.

Winter clinical meetings yet to be arranged.

# Institute of Psychosexual Medicine

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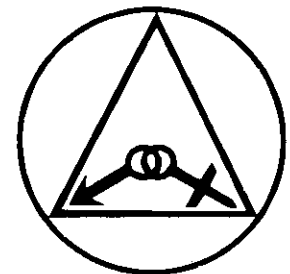
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## ANYONE CAN MAKE MISTAKES

Clive had found the clinic himself and had made the appointment himself, having never consulted his GP about his problem, which he described as reaching a climax too quickly after entering the vagina, not having a full erection and ejaculation being almost a dribble.

His tall dark-suited slim figure and dark melancholic moustache had an elegant Edwardian air and I found him courteous and direct but with a slight self-deprecating manner. He was an estate agent, aged 34, an only child whose father had died when he was 15 years old. In his early twenties, to invest in property, he had bought his own house. His mother had approved of this and he laughed as he described her as pushing him out of the nest. She re-married a few years later and Clive liked his stepfather.

He thought the cause of his problem was perhaps in the mind as he could not relax and got very wound-up. A physical examination was easy and normal as I expected and he returned to his story which he had clearly thought long about and told sadly of his disappointment with his performance and his disappointment for his partner as she was not getting full enjoyment. Sharply, I asked how did he know she wasn't. Well, she had told him, she feels sex has got to be right for her. Then chivalrously, he defended her: 'She worries for me that perhaps I may not have enjoyed it to the full.' But then he went on to say that she thought he should control himself more and let it build up.

My irritation with this unknown woman was rising and I pressed him again, 'What do you think of that remark?' Again defending, he told me he felt he was letting her down and felt degraded himself by not being more in control of his body. I looked at the neat suit, the bland face and anxious eyes and asked if his office desk was always tidy and at the same time I did a little mock act of tidying up the scattered notes on the desk before me. He laughed but took the point, admitting he was a worrier, always aiming high, for the best.

Suddenly, he came out with the remark that when not planned, sex was almost right. Then he retreated again and talked of how both should arrive at the same time and that when he lost his erection after ejaculation, there was nothing for her. He'd known Linda for a year; he spoke warmly and almost with surprised delight that they felt very compatible except that he had had less previous sexual experience that she had had. Briefly, she was 35 years old, a year older than he, divorced, with children of 14 and 10 years. Her husband had left her and she had had a hysterectomy. Again he told me she feels sex has got to be right for her and I asked if he was hurt at her criticism of his performance. Yes, he admitted but did not go on to express the anger that I felt was there. Indeed, I did not try to get it out in the open before us as I felt I should be careful — this relationship is very precious and special for him and for him to have openly expressed anger with her would have been disloyal according to his code and something fragile would have been cracked.

So warned off, I changed tack and suggested that perhaps with the pain of her failed marriage behind her, she was anxious, perhaps over-anxious, to have the reassurance of a really successful sex-life with her new partner. He agreed and added that Linda had been very hurt in the past and though her comments had hurt and upset him, he understood her attitude.

The next appointment was made for three weeks' time but unfortunately he arrived ten days too early at the Community Health Clinic where I hold my clinic on Thursday afternoons when I have no clerical staff with me. New bookings are made at the Family Planning Clinic, held in the evenings and I liaise by telephone with the booking clerk who, in Clive's case had, without consulting me, moved his appointment forward by one hour but gave him the wrong date. He was reported to have been very cross and said he couldn't run his business this way. So, I awaited his arrival with considerable concern and annoyance and was very relieved when he arrived breathless, having had parking difficulties, about five minutes late. At once I apologised and explained the booking arrangements. I was almost abject, awaited his anger, indeed I invited it but he brushed aside my comments and looking very pleased with himself, proudly told me things were much better and he lasted longer. Sex was much better when 'on the spur of the moment' and when more regularly which it had been and telling me that it was very important for sex to be right as after her divorce, she was very vulnerable. He told me they seemed compatible from the start, with the same interests and both had got on well with families and friends.

I wondered aloud why after mother had thrown him out, he had been reluctant to get involved and was told he had seen other people's mistakes. Perhaps mistakes could lead to pregnancies and the responsibilities of parenthood, while with Linda and her children, he had a ready-made family and perhaps with her hysterectomy, no risk of children of his own. He was however uncertain about marriage and though enjoying the relationship now, could not risk it. I felt there was a great fear of these powerful women that one has to please and consider. He told me the important thing that had happened in our first interview was that I pointed out to him that his performance was better when not planned and I remembered that we had laughed when I remarked that being told to start, stop, to build up and then start again, could only have been made by a woman who really has no understanding of a man's arousal and feeling during intercourse. How hostile to Linda, I must have felt, picking up the feelings that such a nice, pleasant, pleasing man could not express.

Some discussion about further interviews followed and no further appointment was made, leaving it open for him to return if he wished. As he got up to leave he remarked: 'I still think I should last longer.' I chided: 'Should implied ought. Why not 'I'd like to last longer?' He smiled. As we said goodbye, once again I apologised for the mix-up in the appointment dates. 'Anyone can make mistakes,' he told me.

**SHELAGH LUCAS M.B., Ch.B.**  
*Member of the Institute of  
Psychosexual Medicine*

## PROLONGED PSYCHOSEXUAL COUNSELLING - TWO CASE HISTORIES

I often get the impression when reading case histories of patients counselled by members of the Institute, that the problems are resolved in a few brief encounters with the doctor on perhaps three to six occasions.

I thought it might be interesting to report on two women patients where regular counselling sessions took place over two years: Case 1, 12 hours; Case 2, 13 hours, total time spent.

At follow-up, a year after their last visit, they were happy with their lives.

Both had had very traumatic events at the beginning of their sexual lives which later contributed to their psychosexual problems. At the time of referral neither had a sexual partner and their psychosexual problems left them lonely and depressed and unable to contemplate a sexual relationship with a man.

Both made a good relationship with the doctor, had good motivation and insight. As their confidence in themselves built up, they were able to develop a good emotional relationship with a male partner and eventually a good sexual relationship.

They each recognized when counselling was no longer needed. Without the sexual problems both had normal personalities without psychiatric problems.

### CASE 1

Caroline was 27, a small, slim, fair, attractive secretary who was referred by a Consultant Gynaecologist, with the following story:

For six years she had repeatedly attended the Gynaecology department for heavy, irregular periods which neither medication nor several D & C's controlled.

She had eventually asked for a hysterectomy, and it was at this point that her total lack of libido and distrust of men was discovered and she was referred to me.

### FIRST VISIT TO THE PSYCHOSEXUAL CLINIC

This lasted an hour during which she poured out distress but never mentioned her period problems then or at any subsequent visits.

Her main problem was that she was unable to be alone with a man and however much she might like his appearance or manner, feelings of panic at possible sexual advances stopped any friendship developing with a man.

She would like to marry for companionship and security but felt that her aversion to any sexual contact made this impossible.

### HISTORY

She had had a normal happy childhood and a good relationship with her parents and brother who was six years older than herself.

She was popular with boys at school and started her first sexual relationship with an eighteen year old motor mechanic, when she was 15.

She was easily roused, orgasmic, they used no contraception and she became pregnant and had a son when she was sixteen and a half. The baby was adopted.

Her boy friend had left her before the baby was born.

Six months later Caroline was 'raped' by a young man she hardly knew who called at her home when she was in, alone. She became pregnant again and managed to conceal the pregnancy until a few days before the birth.

With the first pregnancy she had felt great embarrassment and felt used by the boy who left her before the baby was born; with the second pregnancy she felt hatred for the man and shame about her situation. This time she had a daughter.

Caroline's parents were very supportive, the mother wanted to help her daughter. It was decided that she would continue to live at home and her mother would help her to look after Ruth. Caroline was able to find a secretarial job working for a large company in the country town where she lives.

Evenings and weekends were spent looking after Ruth.

Over the past six years she had met a number of young men who had shown an interest in her but her hatred of men had grown, she saw them as spoiling her chance of a happy life. She could not contemplate a sexual relationship and the men's interest in her waned. She felt she had never had a really loving relationship with a man; her fantasies were not of sex but of companionship, fun and a nice home with a man who wanted her for herself and would accept her daughter.

### COUNSELLING

She was seen at fourteen day intervals for thirty minutes for four months, then monthly for six months and later at two—three monthly intervals; the timing was at her request.

Counselling sessions were unstructured, sometimes she talked about men at work with great hope and excitement when they asked her out. The outings nearly always fell through and I began to wonder if they were fantasies. I did not face her with this as I felt she was very depressed and I did not feel that she was strong enough to stand mistrust from me. Gradually she was able to go out with a young bachelor farmer she met through work: she said he made her feel like a queen.

He made no sexual advances, he just liked her company and she felt comfortable with him but felt he was a confirmed bachelor.

During this time she became less tense, her clothes were more colourful and highlights appeared in her hair.

Ten months passed since her first visit and her next appointment was after a Christmas party at work. She said she was so happy she could hardly believe it, but she looked very tense and when faced with this she felt she did not deserve to be so happy, she had made such a mess of her life.

She had met James, a fellow employee in her company. She had noticed him in the past and liked him, but was afraid then to get involved. They talked all evening and they seemed to have so many ideas and interests in common that she felt she had found a real friend.

She asked for a two months interval and then brought James with her to the next appointment. It was obvious she had no secrets from him and he seemed to be a sensitive young man who appreciated and needed her as much as she did him. He had married at twenty two and his wife refused to consummate the marriage and left him to return to her parents. He was twenty eight and had been divorced for two years.

Over the next few months they started a successful sexual relationship. She came back one day and said that they had fixed their wedding date and had both decided not to have intercourse until they were married.

At the last visit Caroline came with her mother who had asked to meet me.

James and Caroline have now been married nearly two years, they have a six month old son and James has adopted Ruth. At Christmas she sends cards to me from them all.

## CASE 2

Julie was referred by her General Practitioner, having recently joined his list in a small country town: all new patients are given a chance to meet their doctor when they register. In his referral letter he said, 'At first she reported herself as a fit and healthy woman, but as she was leaving said she had a problem, 'she could not let a man touch her', and would like to talk to a woman doctor if possible.'

He referred her to me at the psychosexual problem clinic where I saw her two and a half months after her first request.

Julie was tall, slim, had a pretty childlike face and looked more like a tidy teenager in neat school uniform than the young woman of thirty she actually was.

I said, 'come and sit down,' and that was all I got in during the hour of her first visit.

With a slightly embarrassed smile on her face and in a low monotonous voice, she said she wanted to tell me her story from the beginning; she desperately needed to confide in someone outside her family.

Eventually it took two further visits each lasting an hour, until she reached the problem for which she had been referred.

There was no need for any intervention from me as the story came out painfully but without interruption; I was very conscious that she did not want me to talk or her courage might fail her.

### HERE IS A SUMMARY OF HER STORY

She is the middle child and only daughter in a family of five. From the age of six to about fourteen her father had regular intercourse with her. During the early years she did not realise incest was not a normal part of life and enjoyed it and sexplay with her father, and found it exciting. She had a rather isolated upbringing, living well away from neighbours and going to school intermittently only, not going frequently enough to learn to read and write.

Her father who ran a successful scrap metal business in the nearby town, was very promiscuous. He found pleasure in distressing her with tales of his sexual exploits with other women, while continuing sexual relations with her.

Her mother seems to have closed her eyes to the situation, entertaining her own partners in a caravan in the garden.

She feels she led her father on and felt increasingly guilty as the abnormality of the situation dawned on her: however the pleasure she derived from love-making with her father and threats of violence if she stopped, held her back from seeking help outside the family.

By the age of fourteen she told her older brothers and asked them to help her stop her father. They did this, but started having intercourse with her, which she said she enjoyed for a while, but felt guilty all the time.

All this came to an end when at sixteen she met Tom, a young electrician, two years older than herself and they fell deeply in love. She was able to confide in him and he threatened her father and brothers with disclosure to the authorities: all incest stopped. Tom took charge, found her a job as a nanny and when she was eighteen they married.

Their marriage was very happy, emotionally and sexually, and she was devastated when he died of acute leukaemia after six years of marriage.

For three years she needed tremendous emotional support which she got from her eldest brother and his wife with whom she lived and who found her work in his business.

Gradually as she recovered, she felt very used and claustrophobic with them. She was used as a constant baby-sitter, money from her husband's life insurance was required to expand the brother's business and she had no time to build up a social life. At this point she moved to the small country town to become manageress of a second shop her brother had bought.

To rebuild a social life she joined a mixed darts club and found that she had unbearable feelings of panic when a male partner touched her, even in a friendly way. Feelings of revulsion started at the thought of a sexual relationship and at this point she had asked for help.

## COUNSELLING

Over the next twenty months she came at four and then six weekly intervals for totally unstructured sessions lasting about forty five minutes each. We talked about whatever she wanted to say, she still wanted me mainly to listen.

Over the months it emerged how guilty she felt about her part in the incestuous relationships and that somehow she felt responsible for Tom's death because of this. She felt that she needed to atone for her guilt by helping her brother and his wife, however manipulated she felt. She was not religious and gradually accepted that as a young child or even an adolescent girl, she cannot in any way be blamed or held responsible for her enjoyment or participation in incest. Her panic feelings about a sexual relationship with a man subsided when she no longer blamed herself for Tom's death and the fact she had not been able to face a pregnancy during their marriage in case it was a daughter who might be subjected to incest.

After about a year of counselling she met John, a twenty eight year old estate agent with whom she developed a very good emotional relationship.

She brought him to one session after she had been able to confide her past history to him and it had been accepted without blame or disgust.

They began a very satisfactory sexual relationship. During the next six months she was able to get her money back from her brother and buy a small house jointly with John.

Her clothes had become feminine, she started to wear make-up and her voice lost its monotony.

At the end of the second year of counselling she said she could cope alone.

## THOUGHTS ABOUT THESE TWO CASES

I see about eighty-nine new patients a year, only one or two of whom have chosen such prolonged counselling for themselves.

I was very aware in each case that they needed to build up a good relationship with me to give themselves confidence to build up an equally good relationship with a new partner. Once the emotional relationship was good, the sexual problems totally subsided.

**SYBILLE STOVIN M.B., B.S.,**  
**Member of the Institute of**  
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## SPACE AND MOOD

### Two non-patient dimensions of the doctor-patient relationship.

Doctor Robert's delightful account of disturbed priests revived for me a question that I often ruminate about on the journey back home from Torquay, namely, why are people from the Torbay area able to make so much better use of their appointment time than their cousins further West? We Plymouthians have a saying that civilisation stops at Exeter, but there must be a little more to it than that! Do the different settings make for a more comfortable patient, or a more relaxed doctor, or both? Or could it perhaps, be something to do with the better provisions of personal 'space' — a concept used often by my child guidance colleagues for that particular dimension of time and attention that we all need as individuals from time to time outside our family systems.

Up until about eighteen months ago I was working in three different settings, two in my home town, Plymouth, and a third thirty miles away in Torbay Hospital. The regular, weekly Plymouth session was held in the hospital's ante-natal department, a bleak, featureless place which has a small reception desk and waiting area at one end and three cramped consulting rooms with thin partitions at the other. Between the two is a vast waiting space surrounded by cubicles whose drawn back curtains expose a towelling-gown apiece. The effect is to heighten ones feelings of being tolerated, rather than welcomed, by a building so obviously waiting to get on with it's normal function. My room held a small desk, couch and two chairs. The door opened in a rather threateningly exposing fashion onto the foot of the couch. Behind the chair used by the patient was a door designated as an emergency exit, and through it's frosted glass panel I could occasionally see heads of people seeking shelter from the rain as they waited for their bus. Immediately inside the door patients would continue to weep, or pour out intimate details quite oblivious of the bus queue, whilst I tried hard to ignore the problem and tell myself for the umpteenth time that I really must enlist a colleague to test the soundproofing. Above our suite was the renal unit and directly above my room lay the utility room which housed the clinical machinery. I guess Monday mornings were reserved for cleaning under these heavy gadgets, because occasionally noisy diversions would startle us from time to time.

By contrast, when the waiting lists threatened to overwhelm us, we could persuade the authorities to allow us to hold a few extra sessions on occasional Friday mornings in a local authority Maternity and Child Welfare Clinic. The consulting rooms here are light and spacious and open directly off the waiting room. The examination couch is in one corner and can be screened by curtains. My desk faces into the open area whilst the patient has her back to the emptiness and looks out of large windows onto grass and trees, where the only distractions are the squirrels. There is no clock, no telephone and a helpful receptionist right next door keeping us free from interruptions. I could deliberately switch a particularly anxious or well defended person to a Friday session if at all possible. This often had rewarding results and I found I began to look forward to Fridays. Mrs. F., was one such — she was herself a needy child, and had a toddler who constantly disrupted our sessions on a Monday morning. A change of venue, an illusion of time and an awareness that we had made a special arrangement helped us both to relax. Soon the toddler was happily settled with a box of toys in one corner and Mrs. F. began to use the session to build up a very dependant

relationship which, she was able to use to work through much unfinished business from her own childhood and so allow herself to begin to tolerate dependance within her marital relationship.

Once a fortnight work is preceded by a comfortable 40 minute drive to Torbay where the session is held in a small room tucked away in the corner of a huge, new and very modern out-patient department. There is a rather forbiddingly clinical examination room adjoining mine, but a small secluded waiting area just around the corner. No squirrels here, but again a feeling of quiet and plenty of time. More importantly there is Sister A., a warm round maternal figure who keeps the whole department running smoothly with the help of a small cluster of less ample, but equally welcoming assistants who provide coffee on a tray and 'are you sure you have everything you need, doctor.' This doctor laps up every minute of it and as a result feels more able to feed the patient she is going to see. True the waiting lists are shorter here than in Plymouth, but the feeling of more time for each individual patient is completely illusionary. Is it, perhaps, something to do with being some way from home and an awareness on the doctor's part that this bit of 'space' will be purely for psychosexual work and there will be no interruptions about other work?

Just over a year ago the Plymouth Hospital appointed an extra obstetrician and so we were asked to surrender our Monday morning venue. At last we were free to press for the base we preferred and a permanent receptionist cum secretary. The authorities obliged and now all our sessions are held in the original Friday setting. No, we have not suddenly acquired the right magic for all our patients, but we are sure the overall standards of service are better and my colleague, confirms this saying how much more she enjoys her work since we have moved.

I am convinced that the setting can be a valuable tool which may enhance the doctor/patient relationship and help us to achieve an atmosphere that fosters a sense of temporary withdrawal from the outside world giving 'space' where it is safer and easier to puzzle together about whatever it is that has brought the patient forward to make that courageous step of asking for help in such a private area of their life.

An alternative travelling pre-occupation of mine is the way the doctor's mood can affect the doctor/patient relationship. Have any other members of the Institute noticed that the effectiveness of their doctor/patient contact seems to bear an inverse relationship to their own mood? Why? Is it something to do with permission to be vulnerable? Is it an increased awareness and empathy with the other person's pain?

About this time last year my own distress was obvious to anyone who read a newspaper. In early February I was asked to see a young couple whose GP was feeling impotent in the face of the emotional distress, that, as she saw it, was secondary to a physical problem. The young wife had experienced crippling back pain and dyspareunia ever since an accident some five years previously. So I met James and Philippa. Philippa was a sad, angry young woman with a long black coat, spectacles and fair hair swept back into a tidy bun. James was a big, handsome lad with a soft Scottish accent and huge brown eyes that were near to tears at times. He sat in guilty silent misery whilst Philippa gave me the story. They had met in the Air Force about four years ago and shortly after she had had her accident in the course of her work. Ever since that time she had had severe back pain. They married two years later, but within a month she had to have a

## AN INVITATION FROM ITALY

laminectomy because of the continuing pain, and numbness in one leg. Intercourse had always been painful, especially when she was excited and gradually any enjoyment had faded away. She wanted him to continue regardless, but he refused because of her pain. She had sought the help of the pain clinic about a year previously and had some temporary relief from an epidural injection. She didn't know whether she would be allowed to have more. I was given a vivid account of the various positions used to try and avoid the pain and of their increasing emotional withdrawal from one another. She was furious because she did not like being made to feel that she was depriving him.

She agreed to show me the pain. She prepared readily for the examination but said, 'Gosh, isn't this embarrassing' in a completely flat voice as she demonstrated the various coital positions. The tenderness was minimal. I tried rather clumsily to convey to them both what rotten luck it had been for a lively young couple to have to ask for help at this stage of their life. He said, despairingly, that he thought his appetite must be excessive and I replied that the pain must have made it seem that way to him. I was aware of her anger about people underestimating her discomfort but somehow it did not seem the right moment to comment. I agreed to contact the pain clinic for her and ask about the possibility of further injections. We all three knew that we had not heard the whole story.

A month later they returned. Philippa looked dreadful. She struggled to her chair and sat down with great difficulty. She had had the injection four days ago but it had not made much difference. Yesterday she had had a physical examination as part of her outstanding claim for compensation for the injury, and this had left her in great pain. This was the first I had heard about the claim, 'What are you fighting for?' I asked — there was a pause and then the tears began to tumble and for some time James struggled to comfort her. 'The pain was terrible' she said. 'No-one understood how awful it was for her. It had spoiled everything. James never liked the Air Force. He wasn't the hard one — she was. She loved the work and all the opportunities she had had to prove her fitness through the club sporting activities and now the crowning insult was that she even had to ask him to do the housework.' Without prompting she went on to talk about her family. About how pleased father was that she had chosen that particular career and how he really wanted her to be a boy. How father beat her and her mother and sister. How, though, if she did not do exactly as she was told he would thrash her, then if she cried he would say she was a weakling. If she didn't cry then she was being insolent. 'I learnt not to cry.'

We all three together agreed they needed a pause from frantic efforts to be brave and agreed that they would avoid penetration for a while in the hope that they would feel safer to enjoy physical contact again in every other way. By the end of the session she was moving more freely and looking a good deal more relaxed.

A month later they strolled in looking cheerful and Philippa was walking quite freely. 'Quite a lot has happened, my back is so much better and it seemed such a shame not to take good advantage of it whilst we were on holiday that I am afraid we did not take too much notice of the ban and it was O.K. and it was O.K. eight times last week and three times yesterday and I am swimming again and walking without pain.' So what helped, a successful injection, a settled claim or a doctor who was there in her own distress but alongside them?

**DR. JENNY TISDALL**

Recently the Department of Teaching Media of Southampton University was invited by the 'Centro Sperimentale per l'Educazione Sanitaria' — part of the Medical Faculty of Perugia University in the Umbrian region of Italy — to contribute to a conference on the use of audio-visual aids in medical education at undergraduate and postgraduate level and in nurse training and health education. Perugia University is one of the oldest universities in Italy with a large Medical Faculty but it apparently makes little use of audio-visual aids and the Southampton Teaching Media Department was asked to demonstrate how films, videos, tape-slide programmes, medical photography, etc. could be used.

It was an interesting challenge, and the team who were persuaded to accept it consisted of teaching media personnel including the department's director, film producer, senior cameraman, two health educationalists, two senior nurse tutors, the professor of human reproduction and four other clinicians from Southampton. I was included in this group because the Italians had specifically asked for family planning and psychosexual medicine to be in the programme.

There were two main problems so far as I was concerned. Firstly, my almost total lack of knowledge of the Italian language, and secondly the selection of material to be shown. The first problem was overcome to some extent by simultaneous translation which was superbly conducted by two young women in the formal sessions of the three day conference, but of course it remained an inhibitory influence in informal conversations over coffee and tea breaks.

Selection of material was a difficult problem. I had been allocated one hour in which to demonstrate possible audio-visual media used in training in family planning and psychosexual medicine, so it was obviously going to be possible to show only a few minutes of a number of different items. Family Planning was not too difficult and included a selection of tape-slide programmes, videos and the use of OHP material. After looking at all the available material on hormonal contraception I was reminded how quickly these become outdated and on this subject I do prefer the OHP with updated charts and reviews of recent surveys etc.

Audio-visual material in psychosexual training is very limited indeed as most members of the Institute know. I eventually selected a cross-section of different types and showed brief extracts. Firstly some role-playing videos which we made in Southampton illustrating some sexual problems which can present at a family planning clinic. Secondly, I showed an extract from the film 'Breaking the Ice' which was made in Edinburgh which illustrates very well the problems a patient has in presenting her sexual difficulty to various health care professionals. Thirdly, I showed an extract from one of a series of videotapes made by the Department of Psychiatry at Birmingham University. Finally, I selected an excerpt from a videotape 'Why is it for them and not me?' This is a series of interviews with young physically handicapped adults. It became very apparent that there is a need for more audio-visual media.

As always with conferences one of the major benefits is the interesting people whom one meets. I particularly enjoyed meeting Professor Maria Modolo who was one of the instigators of the conference. She is an enthusiast with a pioneering spirit. In 1971, before contraception was legalised in Italy, she opened a family planning clinic in Perugia — after attending a two week training course

at Margaret Pike centre in London. In 1975 the Italians passed a law enabling family planning clinics to be held as part of the Italian Health Service and contraception is now readily available to all, I was told. The methods of contraception, types of intra-uterine devices and pills used are very similar to our own. In 1979 an Abortion Law was passed which apparently makes abortion fairly readily available up to 14 weeks gestation.

Nobody I met could tell me of any training in Italy in psychosexual medicine, and there is very little help available for patients in Perugia. I was told that if a patient presents with a sexual problem at a family planning clinic in Perugia, he or she would be told that the choice was either to go to the 'Mental Health' clinic or to a private specialist. Nobody knew what training the specialist might have had. There was an air of disbelief and some envy when I described the training available through the Institute.

I enjoyed the visit very much and learnt a lot about medical education in Italy and about the family planning service there. It did make me more appreciative of the training opportunities we have in the Institute seminars.

**DR. JESSIE YORSTON M.I.P.M.**

### SECRETS

Yesterday at the psychosexual clinic I saw a man who had been referred by my GP husband. There was a letter telling me that the patient had increasing erectile difficulties for the past six months. All examinations and investigations had been done. My husband had had several chats with him but there had been no improvement.

Mr. S. was a small neat man in charge of his own building business. He was a keen swimmer and squash player. He seemed competent in his life and at this interview he talked readily about his feeling of inadequacy and how he knew he must be disappointing his wife. He had a vasectomy five years ago with no ill effects. His erectile difficulties started about three years ago. Several times he said that his wife kept so quiet about it all. In the end I said 'that seems to bother you a lot.'

When I went home I told my husband 'I can't make anything of your patient, only that he seems upset about his wife's silence. He said 'Don't you remember. I told you I arranged a day abortion for her. She had become pregnant during an affair three years ago. I daren't write it down as her husband doesn't know.' I had quite forgotten.

**DR. DOREEN ANDERSON M.I.P.M.**

### THE WORK OF THE REFERRAL SECRETARY

At the A.G.M. in March 1985 I presented the report of my first year in office as Referral Secretary and amongst the information given I noted that the Institute had received 118 requests for referral. Most of these were by letter (111); 6 were taken over the telephone and the last was made in person by a gentleman who called into the office in Chandos Street. The standard 'information only' letters, some 67 in all, were dealt with promptly from the office by Mrs. Green, the remaining 44, somewhat more complex, were forwarded to me for personal replies.

The degree of general awareness of the Institute's work was evidenced by the twenty-one letters received from members of the public almost evenly split between the sexes (11 men and 10 women). The letters were often long and usually sad, identifying their sexual unhappiness and asking for some sort of help. The brief quotes from the opening lines of three of these letters are typical of the information sought:

'Dear Doctor,

Please can you send me some helpful literature to suggest something to help keep my marriage together...'

'Dear Doctor (Tunnadine)

Having read your excellent book and having trouble due to my impotence my wife and I wondered if you could tell us if there are practitioners of your method in our area...'

'Dear Doctor,

I saw your address in a woman's magazine and wondered if you could please give me some help. I had cancer of the cervix treated with radiotherapy in 1982 when I was 40. Since then intercourse has been so painful...'

Most of the writers of these letters asked for the names and addresses in their area of doctors who have been trained by the Institute to whom they could refer themselves for treatment. Some had approached their General Practitioners, while others, too embarrassed to approach their General Practitioners, had read about our work in 'Doctor Tunnadine's excellent book' or had read 'an article by Claire Raynor in the 'Observer' Newspaper, others 'in an article in Woman's Own' or 'a Channel 4 book, 'Coping With Sexual Relationships' by Judy Greenwood.' There are always significant peaks of interest by the general public following a mention of the Institute and our work in the popular press.

Articles in the medical press also play their part in engendering interest and the mailbag increased with letters from the medical profession in particular following the article in 'Mimms' by Dr. Tunnadine. A number of doctors wrote expressly to ask for help with patients, while others requested lists of counsellors practising in their vicinity. As Referral Secretary I have responded to eleven practitioners anxious to know where they could send patients for help and to two newly appointed Consultants in Obstetrics and Gynaecology, one based in Lanarkshire and the other in London — very encouraging signs indeed!

Another eight enquiries have been received from members of the Institute who wrote to me asking me to recommend suitably qualified doctors to continue treatment for patients who were moving to other areas.

Finally two requests come from midwifery students who were writing projects on sexual problems and who were interested in the bibliography compiled by the Institute. An interesting, varied and, above all, I believe a helpful year.

In the months preceding December, 1983 there had been a significant increase in the number of enquiries about the Institute and its work. In response to this and following a lengthy discussion by the council it was agreed to compile a list of full members who were willing to accept referrals.

Dr. Margaret Gill, who was then Referral Secretary, and Mrs. Walton set about the mammoth task of compiling lists in regional groupings and these now form the basis of the information sent to the medical profession and potential patients, along with an accompanying letter from me as required. The choice of regional

list is not as easy as one might at first believe, as my knowledge of the geography of England was never much good, but an awareness of the nearest accessible town to the enquirer is slowly building up. I hope one day to master the precise whereabouts of the London postal areas.

In a continuing attempt to update the referral list I write to each newly accredited member on 'passing the panel' to ask if he or she will accept referrals. Despite this Mrs. Green and I feel that the lists are out of date and need to be revised. I would be grateful, therefore, if all full members willing to accept referrals would write to me with the following data as soon as possible to ensure that the information I pass on is accurate.

Addresses — these should be business or consulting addresses where patients will be seen and a contact address and telephone number where patients and medical practitioners can arrange appointments, if different from the consulting address. Should the contact point be a home address it would be helpful to have times at which it would be convenient for telephone callers to ring.

Additionally I should like to know whether patients will be seen privately (including BUPA schemes) or via the National Health Service. I would be grateful for some indication of consultation fees as patients and General Practitioners invariably ask for this.

It is equally important to know when a member retires from Institute work as I have already tried to refer a patient to a doctor who retired some years previously!

This information will greatly assist Mrs. Green and me to deal more efficiently with the enquiries we receive.

**DR. SHEILA FILSHIE**

#### **THE IPM — A CONFIDENT FUTURE?**

One of the objectives of the IPM Working Party which was formed at the Nottingham Meeting in 1983 was to explore areas for future development.

The Survey was carried out to gather basic information about the IPM membership in order to build up a profile of our members and the work they were doing.

Although most of the questions on the questionnaire were structured the last two questions were deliberately open-ended so that members could comment about work opportunities and the way in which they felt the Institute should develop its activities.

In this article we summarise firstly members' comments and secondly the Working Party's views regarding areas for future development as presented at the Nottingham Meeting in September 1984.

#### **Comments about work opportunities in 'psychosexual medicine':**

We did not specify whether this related to present or future opportunities so both were commented upon.

**1. Very few doctors are satisfied** — only 6 (2 from the private sector).

**2. Overall there is a strong feeling that psychosexual medicine is still largely unrecognised in the NHS.** It has a very low priority for funding, especially new sessions.

There are too few NHS sessions, and some have very long waiting lists (not actually what emerged from the survey figures).

The growing public need always exceeds clinic availability.

'There is plenty of work to do in my area, few trained doctors, and no money for sessions.'

'Potentially endless supplies of patients, and no designated sessions for them!'  
'The frustration of a 2 year waiting list means that couples are often divorced when sent for!'

'Patients can only officially be referred to a consultant psychiatrist - a one year wait!'

**3. In all settings psychosexual work is still largely done in 'unpaid overtime' and therefore goes unrecognised - in status and financially too.**

#### **Comments:**

'There is a need for separate psychosexual clinics; we should not manage in overloaded family planning clinics.'

'There are too many brief consultations in ordinary F.P. sessions.'

'Plenty of patients present problems, but doctors often work in their own time and their skills are not acknowledged - nor paid for!'

**4. Geographical difficulties** - too many to enumerate. As Judy Gilley raised last year - the need for planning exists.

'There is only a half designated psychosexual session in the whole of Bristol. A good deal is done unofficially, but therefore goes unrecognised.'

'There are no clinics in our area, trained doctors are available.' — 6 comments.

'There is a clinic vacancy, and no trained doctor to apply.' — 3 comments.

'A session will be cut on the retirement of the doctor - the clinic was on the individuals reputation.' — Several comments.

'Sessions recently have been reduced'

'Cut back dramatically in my area.'

**5. Work opportunities seem unrelated to a career structure in the Institute and to Panel accreditation.**

#### **Comments:**

'After passing the Panel I can still only do a little work fitted into family planning sessions. Where now?'

'I think more status should be attached to this work. I am in charge of the only psychosexual clinic at U.C.H. where I work as a consultant - diagnosing and treating patients with no superior. I feel this merits higher status than clinical assistant.'

**6. Opportunities to recognize the problems are huge in General Practice, but there is no time and little training to cope.**

#### **Comment:**

'As more family planning advice is given in General Practice, family planning clinic numbers may fall, and so psychosexual opportunities should increase to fill the space.'

**7. Opportunities in the private sector are few**

#### **Summary:**

1. Few of us are satisfied
2. There are too few psychosexual NHS sessions
3. Psychosexual work is often unrecognized and done in unpaid time
4. There is a lot of geographical variation, but no new sessions were reported - only cutbacks

5. There is no relation between work opportunities and Panel accreditation or indeed to any career or salary structure
6. In General Practice psychosexual opportunities are limited by time and lack of training - but are on the increase
7. Private sector opportunities are few

**Question 17 invited** 'Any other comments on the way in which the Institute should develop its activities?'

There were three areas of reply:

- I. Training — mainly positive comments
- II. Recognition and status — mainly critical comments
- III. Public Relations — mainly critical comments

**I. Training** - many positive and enthusiastic comments

**(a) Training of Members**

1. More basic seminars to include young GPs and clinic doctors
2. More advanced seminars
3. Could we introduce the use of video as a teaching method? and 'is the seminar training too long and inconclusive for many doctors who then resign?'

**(b) Training of other doctors**

The largest number of comments in the Survey was to include the Institute method into GP vocational schemes, MRCOG and Community Medicine training

**Comments:**

'We should encourage training especially in General Practice — in future this may be the setting for much psychosexual counselling'

**(c) Multidisciplinary Approach**

One day conferences in the regions for all interested doctors — extending the technique into use in prisons, bereavement counselling, work with maladjusted teenagers, etc.

**(d) More Research**

e.g. a pilot of the idea of a 'Crisis Panel' possibly in London

**II. Recognition and Status**

**Comments:**

'Have we been dragging our feet?' or 'are we an unusually self-effacing bunch?'

**Recognition:**

(a) The progress towards recognition of the Institute's certificate by the RCOG and RCGP is unsatisfactory. Should we apply more pressure on our Council Representatives - or are we too dependant on them? What action could we take ourselves?

(b) Where do we stand viz-a-viz the Diploma of Sexual Medicine? Why is it recognized and we are not?

**Status:**

Whilst we should remain a legitimate branch of the total patient care in the NHS we must strive harder for promotion. Institute doctors rarely have salary status above SCMO.

However, comments were wholly against the Institute being involved in Trade Union activity.

**III. Public Relations**

An area which was thought to be very inadequate.

**Comments:**

'Better value for £25/year? possibly through improved administration'

**(a) P.R. within the Institute**

1. Local members should be put in touch with each other
2. Can we improve our image of 'arrogant and insular?' There was a plea 'Don't let us be too inward-looking!' 'Some members are described as self-congratulatory, even complacent' Clearly not those commenting doctors!

**(b) P.R. with other Professions**

— or 'tell everyone about the Institute!'

1. Advertise for training services in the journals of RCGP, RCOG and others
2. More teaching on courses to nurses, social workers, CHCs, Probation services — or as one doctor put it 'to any virgin audiences!'
3. Approach post-graduate deans and DHOs especially in areas where there are no clinics
4. Liaise with hospital departments of Obstetrics & Gynaecology, or Psychiatry. 'We could lose our 'luxury medicine' image'
5. Liaise with GPs. 'We could start by writing back to them about referred patients'

**(c) P.R. with the Public**

**Comments:**

'More publications please'

'Should we dissociate from our mainly Family Planning image?'

**AREAS FOR FUTURE DEVELOPMENT**

**1. Training**

The Institute is a training organisation and its first objective as written in the Constitution is to run training schemes.

There has been a steady demand for training over the years and the demand for training is continuing to increase, particularly at the basic seminar level.

The training regulations state that by the end of the two year basic training most suitable doctors will have acquired enough skill to diagnose psychosexual problems and make some approach to dealing with them in the course of their normal work.

The Institute could explore the possibility of including basic seminar training in GP vocational training programmes, in Obstetric and Gynaecological training for medical students and MRCOG courses as well as inclusion in the family planning training programmes. But as Dr. Judy Gilley stated last year — if training of GPs for example is to be a growth point then there must be a very clear appreciation of what our training facilities are.

From the information provided by seminar leaders it appears that there are large numbers of doctors in training at the basic seminar stage. A large proportion proceed no further. Have they gained enough for their particular needs or gained nothing and opted out? It is vital there is continuous evaluation not only of trainees but of training at all levels. This is particularly important if the Institute's objective of ensuring the maintenance of standards is to be met.

Advanced seminars are aimed at those doctors who wish to do specialist work in psychosexual medicine and if accredited such doctors would then be considered competent to accept referrals from practitioners and other agencies. Despite this specialisation, for most of those accredited, psychosexual medicine is not a total speciality. Is this because of the demanding nature of the work, the lack of career prospects or for other reasons?

Future seminar leaders must be found from accredited members. The expected fall in membership with the retirement of the Founder members could produce a shortage of suitably trained leaders. We need to consider such implications if we are to plan for the future rather than continue to develop in an ad hoc way.

## 2. Research

Another of the Institute's objectives is to organise research. If we are to gain recognition for work done with patients it is essential we conduct studies to measure outcome of treatment. In other words we must make an evaluation of our work with patients and stand comparison with other techniques of treatment. Presenting the results of our work in an objective way will not undermine skills gained in training.

## 3. Administration

It is clear that an enormous burden of work in any training organisation falls on the Director of Training. From the job description provided for the Working Party by the various officers of the Institute it is clear that they, and particularly the Director of Training, carry a considerable workload, which is steadily increasing and for which they receive no remuneration.

The Institute has now reached a stage of development when it is almost too big to rely solely on the services of voluntary officers, yet is too small to finance paid officers and equip and run an office.

It seems unlikely we can move forward without a more systematic administrative organisation which could cope for example with a computer. We need to explore how professional institutions begin to set themselves up with paid executives as they grow.

An alternative to independent growth would be the formation of a liaison or affiliation with another professional body already having the framework necessary to run an efficient training organisation.

## 4. Recognition

However, central to all the areas discussed is recognition of the Institute's training both at basic seminar level as well as at accreditation level. Exploration of how recognition might be achieved is an urgent priority in terms of the Institute's future development.

## 5. Public Relations

The Institute needs to develop its public/professional image as a training organisation.

Information about the Institute's policies on training needs to be distributed in a more systematic way. This is important to aid recruitment and selection. Members and outsiders have criticised the Institute for being too insular. It is important to develop links with other organisations and improve our communications.

Problems re doctor's work situation are not the concern of a training organisation as pointed out by our President. However the fact that many members mentioned the need for opportunities to discuss more general problems concerning their work situation and the provision of services for patients is an area worth exploring possibly in terms of setting up a society for psychosexual medicine and perhaps with a wider membership.

It is ten years since the Institute was founded. Much progress has been made but there are now various problems outlined in this article, which need facing if the Institute is to develop confidently in the future.

Council and the Working Party are looking at ways in which these problems can be tackled but *your* ideas — visionary or practical — would be very welcome.

Please contact any member of the Working Party either directly or via: Lettsom House, 11 Chandos Street, London W1M 9DE.

**JENNY LISLE, MSc, MB, MFCM, D.Obst, RCOG**  
**ELSPETH WILLIAMSON, MBBS, DCH**  
**SUSAN HORSEWOOD-LEE, MBBS, MRCGP**

## BECOMING AN INSTITUTE LEADER

Individual conversations from time to time show clearly that, outside the leaders workshops, how our leaders are appointed is by no means clear to the membership. Do we achieve greatness, or do we have it thrust upon us? The answer to that question — and I hope to show why — is either or both. More importantly, is it the right question?

It is inevitable that in a training organisation the trainers appear — are, in some senses — at the top of the hierarchical heap, if hierarchy there be, whether in fact or in others' fantasy. Yet in truth the task of leadership is not about relative

'greatness'. Leadership skills are not better than, but different from, clinical skills, and have to be at least equally toughly and painfully acquired. The fundamental *sine qua non* of a trained leader is, as for a trained clinician, an ability to be confidently grounded in the nature of our work, with some ability to hear, think about, conceptualise, what goes on in the here and now — in group or consultation; and then to decide upon how to contribute or intervene so as to facilitate the enlightenment of the recipient — patient or trainee or group.

But, in leadership, understanding the case is not only the basic minimum requirement; too much emphasis on this — our comfortable well-established clinical model — is not our prime task. Indeed insofar as we are all tempted to be interested in case solving the best clinicians are *not* necessarily the best leaders. In leaders we look not so much for additional gifts but for different ones; the ability to think about what is going on in the reporting doctor's clinical transaction, and not only to 'help' — a word perilously close to 'supervise' — that individual to think for themselves about it, but further, to find a way of so doing which enables other members of the group to focus their interest on the doctor-patient interaction so that they — not we — come to offer their own perceptions.

Thus at the leaders workshops leaders present for discussion and criticism the events in their groups, and the focus is on understanding these group events and the leaders handling of them. As in clinical training, while our study is of leadership techniques and, in effect, group dynamics, we, alas, get no theory of these fed to us. Again the painstaking examination of what we actually do, our trials and errors, their effects on progress — of the group and its training rather than of the patient and their 'improvement' — is frustratingly difficult but in the long run self-evidently the way which 'grows' independent-thinking workers best.

So who are the 'chosen' and why? The Institute has no power and indeed no wish to discourage any of its members from leading any group they choose, with or without workshop aid, but such aid is on offer for any one who is actually leading, or proposing to lead, a group of workers in a **relevant field**. This is increasingly enlarging to include nurses in **comparable fields to psychosexual medicine**; but just as we can usefully contribute to the training of GPs their **psychosexual and related work**, but would not encourage the discussion of chronic, *sáy*, asthma as a symptom of lifelong family psychopathology, so would we have little to offer a leader whose trainees' concern was, say, long term psychiatric social work. Their settings and opportunities are too different; their needs too distant from the psychosomatic. Conversely, the Institute clearly cannot **recognise** as its accredited leader anyone of whose current training practice they have no knowledge; not to be exclusive, but simply because our trainees, like our patients, are entitled to know the strengths and limitations of what we have to offer, at the level, if you will, of a 'trades description act'. Any full member of the Institute who is leading or preparing to lead a relevant group and who wishes to share their work with like minded colleagues may write to me to apply for an invitation to join the workshop. Accreditation of **all** leaders — and that includes Drs. Main, Freedman and me! — is reviewed every three years on the only evidence the Council can get — that of their workshop colleagues.

From my administrative end, leaders emerge in two broad ways, and these are, as most things in life, based upon realities and necessities. There are areas of the country where we have half a dozen individuals who would — or at least with training might — make admirable leaders. But geography dictates the training

potential of that area has been satisfied — at least for a 'generation' of doctors; perhaps, by definition, this accounts for their talented presence! It may well be then that in starting a new group, I would be tempted for the future of the Institute to offer the leadership not on 'merit' or even experience, but to a promising new-comer on grounds of youth, and the likelihood of their working on longer into the future, alone. Rough, this, on an 'old hand' who feels passed over *if* — and I repeat *if*, we see this as 'promotion'.

Elsewhere we may have no-one who is either trained or potentially trainable or even wishing to be either of these, for leadership. Thus either a clinically able 'old hand' or a 'we hope trainable' new talent literally gets leadership 'thrust upon them' and the best we can do is to offer them what workshop help — and I mean help this time — we can, in undertaking what is a jolly tough and burdensome task on our behalf.

A word of warning however — it is our unchallenged experience over, now, some 20 years of leadership training, that eager leaders longing for groups don't get good ones! As with patients, leaders who respond to trainees clamouring for training are in a much better position to keep their numbers and get positive work done. It's a very hard fact to swallow — but less hard perhaps than coming to believe, as so many eager beavers do, that the failing numbers are all their fault.

The rest of the world believes — even Michael Balint believed — that only psychoanalysts could lead training seminars like ours. Though he encouraged a few of his early FPA doctors to give it a go, no training was provided, and even some other psychoanalysts with special interest in groups found it difficult and their projects in our field folded. We owe to Tom Main's daring imagination — born, as he would himself insist, out of the necessity to find enough trainers — a pyramidal training scheme which is unique in the world, not only in numbers but in content. Some 'ordinary' doctors *can* be trained to lead. Just as our psychosomatic work is a truly new, I believe, application of Psychoanalysis, of a different order from other analytically based psychotherapy, so perhaps is our leadership training a special application of psychoanalytic thinking, though applicable to the training of other trainers than ours. Inevitably in looking to the future of our training, 'talent spotting' must go on. In so doing, it is important to stress yet again that leadership is not offered, as it must seem, to 'teachers' pets' or even to those we might view as clinically outstanding. Rather we look for those who show interest in, and ability in, group matters; who so intervene in discussion not necessarily most pertinently to the case or even to the doctor patient relation, but in such style as encourages *their colleagues'* thoughts towards growths of insight.

The danger whenever Tunnadine puts pen to paper is that stuff gets fixed just there as the 'right thing'. For the dynamics of our work the waste bin would be a better place for it. How awful if, now, would-be leaders start trying to contribute that sort of clever remark to catch the leader's eye! It won't work mates! Any more than trying out suggestions from books works with patients. But it can be learned, by some of us, by hard workshop graft, and there is no reason why we should not keep trying. Why anyone should *want* to be a leader is another matter. They must be crazy for it *is* difficult, and for myself, without a workshop, it would even now be impossible.

**DR. PRUDENCE TUNNADINE**  
*Director of Training*

## THE LEADER-DOCTORS WEEKEND WORKSHOP

Perhaps members of our association sometimes wonder what is involved in leadership training. All doctors who are currently leading training groups are required to attend leaders workshops. Until recently there was a leader workshop in Newcastle conducted by Dr Tom Main but it came to an end because there were not sufficient trainers with groups in that area. At present the only workshop is in London under the guidance of Dr Prue Tunnadine.

However the leaders weekend workshop gave doctors a further opportunity to study leadership skills. It was held at the Institute's headquarters at 11 Chandos Street on 23 and 24 March and was attended by 30 doctors, most of whom are already leading or have led training groups. Also present were visitors invited by the Director of Training because of the probability of them leading groups in the future. Among the visitors was a nurse-seminar-leader nurse. The need to continue and develop training is obvious as the clinic case load increases. The leaders grow older and the younger doctors are needed to take on the work.

Discussion was vigorous throughout the programme and ranged over many topics. These included the various ways training groups are formed and the special difficulties of groups that are too big or too small and the differences between expanding groups and contracting groups.

Dr Main talked of the differences between the 'here and now' and the 'there and then.' When there are difficulties in the present, patients will direct the doctors attention to a neutral topic which is often the dead, remote past. This represents a flight from the intensity of the 'here and now' to the relative safe neutral discussion of the 'there and then.' Seminar trainers have the same problem and their task is to steer the work of the group to examination of present interactions. He reminded trainers that their job as group leaders is not to solve cases but to focus on the activities of the group and warned that the tendency to regress never ceases and always threatens study.

Dr Main also reminded us that history is sometimes a version of past events which may represent a received impression and a distortion of the truth. The view of history should be studied not at its face value but for its relevance to the present.

Most of the programme involved the large group splitting into two which gave doctors the opportunity to present leadership problems for discussion amongst colleagues. It seemed that clinical conversations never stopped and extended far beyond the programme into meal times and travelling time.

It was a rare opportunity for many doctors who wrestle with the problems of leadership in relative isolation to share and learn from the experience of others.

Although we all meet as doctors and our focus is on clinical work it is remarkable how warmth and friendship has grown from that contact. For me and for many others it is a great pleasure to find such friendships. For most doctors out of town, London based members gave hospitality in their homes which was an enjoyable bonus.

Another bonus was the delightful dinner provided at 11 Chandos Street through the generosity of Wyeth Laboratories. Dr Main expressed the thanks and appreciation of all present to Mr. George Rivas and Wyeth for their continuing support and encouragement for the work of the Institute of Psychosexual Medicine.

JOAN COOMBS

## THE ANNUAL GENERAL MEETING MARCH 1985

This was held at 11 Chandos Street on 22 March at 4.30pm and the chairman was Dr Roland Freedman. Members will have received the minutes of the 1984 AGM and also copies of the officers reports for the 1985 meeting.

There were three vacancies for council. Because nominations exceeded places, full I.P.M. members who were present at the meeting voted Dr Ruth Skrine, Dr Ann Smith and Dr Heather Montford onto the council.

The matter of the increase in membership fees was discussed. Administrative costs are rising all the time. It was agreed that fees should be raised to £35 for full members, £35 for subscribing members and £25 for associate members.

The one resolution on the agenda was carried. It stated that "Arising from the Council Meeting of 22 June 1984 concerning the status of Doctors who became members before 1978 but who have never been before the Panel. Constitutionally they are designated full members and pay full membership rates. Council proposes 'If such doctors allow their subscription to lapse for two years, they should have the option of either presenting themselves to the Panel of Accreditation or subscribing as Associate Members thereafter'."

There was one proviso that members should have plenty of notice that their membership had lapsed rather than lose their full membership status by default.

Under 'any other business' Dr Freedman informed the meeting that a meeting was to be arranged between three I.P.M. doctors and the Royal College of General Practitioners to discuss psychosexual training and general practitioners.

A brief meeting of the newly formed council was followed by a buffet supper.

Later Dr Roland Freedman delivered a paper entitled 'Freud - Balint - Main' illustrated by many photographs together with a rare recording of Sigmund Freud's voice. This was received by a larger audience than in the afternoon and prompted interesting discussion.

JOAN COOMBS

## A STUDY DAY IN YORKSHIRE

An Introduction to Psychosexual Medicine was held at Wakefield Postgraduate Medical Centre on 21st March 1985. Seventy interested doctors attended for the day. Dr. D.M.M. Anderson planned the programme and arranged for the circulation of the programme. After an introduction by Dr. Anderson there followed papers 'Emotional and Psychological Aspects of Contraception' by Dr. J. Coombs; 'An Assessment of the Behavioural Approach to Psychosexual Problems' by Dr. R. Freedman; 'Sexual Difficulties in Men' by Dr. Prue Tunnadine; 'Female Sexual Dysfunction', a seminar led by Dr. J. Coombs; 'Psychosexual Problems in General Practice' by Dr. J. E. Rogers; and 'Influence of Seminar on Management of Care' by Dr. L. Sykes.

They were a very responsive audience, and it was very gratifying to find that during the seminar session there was lively participation from the whole of the group. Whether there was enough enthusiasm to lead some of these doctors to seek seminar training in the area remains to be seen. The following account was written after the study day, and illustrates one doctor's wish for expertise that would insulate from feelings of inadequacy. How we wish we had not appeared to be experts privy to knowledge, and how much we understood her feelings of vulnerability!

## AN INTRODUCTION TO PSYCHOSEXUAL MEDICINE, 21.3.85. MY IMPRESSIONS OF THE CONFERENCE

I should perhaps explain at the beginning of this article that I am a G.P. Trainee nearing the end of my vocational training scheme.

My experience of psychosexual medicine is very limited. I was questioned about it in my gynaecology final examination, and I have seen a few patients in surgery — most of whom I referred to our local adviser, Dr. Anderson. My knowledge has increased little since finals.

I was impressed at the number of people who attended the meeting, many having travelled a fair distance. I got the impression that everyone was keen and well motivated, so hopefully we would hear some lively questions and discussions, and people would go away having gleaned useful information.

The speakers were all very articulate, surely because they were very confident in the knowledge of their subject. This made them a pleasure to listen to — I saw no-one sleeping.

Personally I was hoping for more basic instruction in the form of illustrated cases — however many people were more knowledgeable, and might well have been bored by this approach.

I must confess I was disappointed with the lecture on 'Behavioural Approach.' Dr. Freedman is obviously a very experienced practitioner, and I feel that asking him to talk about a subject in which he has little faith, and (from what he said) limited success, was unfair.

It would have been interesting to have heard another speaker 'pro-behaviour therapy' discussing the role of this method as well.

I enjoyed the seminar session very much. Dr. L. Sykes's patient, particularly, interested me. I felt that my feelings were at odds with everyone else! To me this poor wife was getting the blame and consequently the symptoms for what may have been primarily, or at the very least equally, her husband's problem.

In summary, therefore, I enjoyed the day immensely. The speakers were well prepared and easy to listen to. The questions and discussions were lively and instructive.

**DR. C. LAW M.B., CH.B.**

## A NEW COMMUNITY PSYCHOSEXUAL CLINIC

Family Planning Services in Gwent are organised within the Community Unit. If a patient presents with a psychosexual problem in a community family planning clinic they are given extra time (if the Doctor is trained) when they present, or are seen before or after normal clinic times.

For about three years I had also utilised some of the time in a clinic allocated for vasectomy counselling, to patients with psychosexual problems.

In January 1984, the number of referrals for patients with psychosexual problems was increasing and the patients for vasectomy counselling also. A separate clinic seemed the obvious solution, but I knew that I would have to back feelings with facts. In February, I therefore reviewed the number of psychosexual patients who had attended the 'Vasectomy Clinic' over the last three years. The review included source of referral, number of male, female or couples referred., the presenting complaint, the approximate number of sessions the patient had

attended, and the number of patients on the waiting list. This information together with a short account of the Institute's work and its aims and objectives, was forwarded to the Specialist in Community Medicine (Community Unit). The growing need for a recognised Psychosexual Clinic was stressed.

The Specialist in Community Medicine was supportive and acknowledged the need, but requested a break-down of requirements for a separate session, including staff time, number and grade of staff, clinic facilities etc. This was in order to decide whether the clinic could be developed within existing resources, or if a bid on development monies would be needed. I felt that the latter would be impossible, and thus the clinic, in the present financial climate.

A Family Planning Clinic was due to close (owing to falling numbers) and I therefore proposed that the money for that clinic could be utilised for the psychosexual clinic incurring no extra capital outlay or revenue costs. The location was not suitable however and other premises had to be found.

A reply in April 1984 from the Specialist in Community Medicine agreed that there should now be no problem in setting up the clinic, but she thought it needed the support of the Consultant Obstetricians and Psychiatrists if it were to succeed as a speciality in its own right.

A copy of the review of Psychosexual patients attending the 'Vasectomy Clinic' and information about the Institute was sent to each of the Divisions of Obstetrics and of Psychiatry. As many Consultants as possible were contacted personally.

In July the Divisions of Obstetric and Psychiatry gave their approval and support to the proposed clinic, each stating that they felt sure there would be no shortage of patients.

The Chief Administrative Medical Officer was informed and in August 1984 formal agreement of the Unit Managers was obtained and development of a psychosexual clinic was put forward in the Health Authority's Strategic Plan and Operational Programme.

The location of a psychosexual clinic is obviously important, and although hospital premises are not ideal, patients find that the hospital is more easily accessible than many other clinics in this area.

The Hospital Unit Administrator was then approached, and I was allocated accommodation for the Psychosexual Clinic in the Obstetric Department, 'providing there was no demand on the Hospital Budget for clinic resources and staffing.'

The first session of a Community Psychosexual Clinic began at the end of January 1985, nearly one year from its conception. The Obstetric Department seemed a very appropriate place for this 'new baby'.

The clinic had not been advertised, but when Psychosexual Medicine is discussed with Medical and Nursing staff, they are then informed that there is now a Community Psychosexual Clinic available. The number of referrals for patients with psychosexual problems has increased enormously in the first quarter of 1985.

As the work of Family Planning in the Community is changing and clinics may be closing, it would seem sound policy to consider the possibility of using such clinics for psychosexual work before the money utilised for staffing these clinics is 'lost' for ever.

I wish to thank the Specialist in Community Medicine and the Consultants of Obstetrics and Psychiatry without whose support the clinic may not have got off the ground.

**DR. ANN PARKER M.I.P.M.**

## CLINICAL MEETINGS

Last year a series of Winter clinical meetings was held monthly, usually at Chandos Street. Although this was in response to a request the purpose of the meetings, which were conducted on seminar lines, was not made plain. Perhaps this was because in the Institute's characteristic non-directive way it was thought better that participants might use the meetings to suit their own individual needs.

Some came in order to meet friends and colleagues over an excellent meal and a glass or two of wine in the delightful setting of 11 Chandos Street with something of professional interest to add focus to the evening; some welcomed a place where they hoped to find help with difficult cases; some hoped to hear cases presented with expertise; some felt they needed to 'come in from the cold', neither attending nor leading a group and feeling out of touch with their seminar training they looked for an opportunity to underline or refresh their skills.

Were the meetings successful? It seems not, as having begun with around 30 participants for the first meeting the numbers dropped to 8 or 10 by the sixth. This season the first meeting was cancelled because of lack of support. The second meeting only mustered 6 people, 3 of whom had been attending a council meeting and were already in the building. The rest were cancelled.

I appreciated the meetings. I had been out of a seminar for a few years — a time, I felt of personal re-assessment and development. I needed to see what others were doing and test my ideas alongside their's. Three meetings showed me that there was not enough. I decided to join an on-going group and my original need for the meetings no longer existed.

Nevertheless I enjoyed the evenings. The atmosphere was pleasant and relaxed, the food was excellent, it was good to meet friends. The cases presented were always interesting, if not suitable for treatment. It was disappointing we would never hear the follow-up. I think we worked but perhaps as individuals. To function properly as a group we knew each other not at all or too well, and would have needed more time together. We chose whoever was the most experienced leader doctor to lead. Once we did without. The fact that we did not work as a group perhaps made leading difficult — either too directive or too passive — but without a leader we were disorganised and did not stick to the presented case.

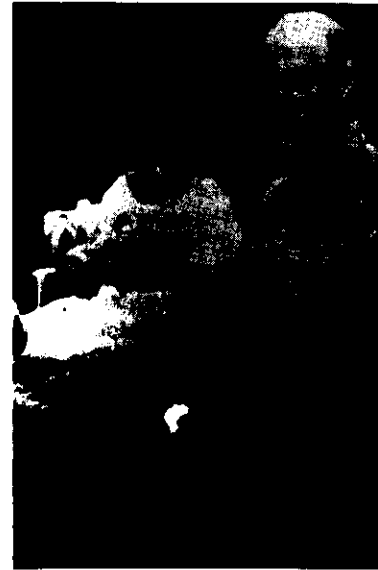
What suggestions for the future? Firstly, I would like the meetings to be a little more formal. Each meeting to be the responsibility of a different leader doctor who would choose a topic for discussion, possibly arrange one case presentation in advance but allow time for other cases on the chosen topic to be discussed. The name of the leader and the topic for discussion to be published beforehand. (At the AGM it was suggested that the meetings be elsewhere than London and be the responsibility of the regional training co-ordinators). Secondly, I would like the meetings to be open to non-members of the Institute, those not even in seminars, such as trainees in family planning or general practice or doctors who refer cases to us.

It is often said that our training is best for those who beat at the door for it. Could we not sometimes open our door just a little to show what we have to offer, show our own interest and enthusiasm (and our expertise) and thereby stimulate others' interest in our work? These clinical meetings might provide just this opportunity.

**DR. HEATHER MONTFORD MB., BS., DRCOG.**

## FREUD, BALINT, MAIN

Sigmund Freud was born in Freiberg in 1856. He came of a middle class Jewish family which moved to Vienna four years after Sigmund's birth. He was the oldest child of his father's second wife, which some would say was significant in the light of his later researches. He was a hardworking and exceptionally intelligent schoolboy, being regularly top of his class at the Gymnasium from almost the time he achieved entry at the early age of nine. It seems that he had no particular



*Sigmund Freud & Grandson*

yen to be a doctor, 'to help suffering humanity' as he put it. Rather did he have an insatiable need to understand and to investigate. Before practising as a doctor, which he did mainly for financial reasons so that he could afford to marry his fiancée, he worked for six years as a neuro- anatomist.

In 1885 Freud, by means of a travelling bursary, got himself to the Salpêtrière in Paris, so that he could study at the feet of Charcot the great neurologist. Charcot was of course highly involved with hypnotism and hysteria, which was regarded as a biological disturbance, probably inherited. Freud's interest in this technique was stirred as an instrument for investigating the mind. However, Freud's enquiring mind was not satisfied by Charcot's use of hypnosis to remove, or indeed induce hysterical symptoms by direct suggestion. He had to know how and why. From this time forward it would

not be enough for psychologists to observe and describe behaviour. As far as he was concerned, it had to be explained. I shall return to this theme later.

It has been remarked, perhaps ironically, that man's self-esteem has suffered three great blows. The first was when Galileo demonstrated that the earth was not the centre of the Universe. The second was when Darwin showed that man, traditionally made in the image of his creator, was a produce of evolution from primitive creatures. The third was when Freud indicated that man's infinitely adaptable and creative mind was nothing more than sublimation of his basic instincts. Far fetched though some of their theories may be, there can be no doubt that each of the three changed quite profoundly the way we view ourselves.

On his return to Vienna in 1886 Freud married Martha Bernays (Slide 4) and set up in private practice as a consultant in nervous diseases. After experimenting in vain with electro therapy, his interest turned back to hypnosis and his recollection of the case of Anna O, cured of hysteria some years before by his friend Joseph Breuer. The method had been to persuade her under hypnosis to recall forgotten traumata and to discuss emotional problems. Breuer, however, was prepared to accept that her symptoms, for example a paralysed arm in her case, were fortuitous — a mere coincidence, having no specific cause and effect

relationship. Freud felt the need to explain why a specific memory had been expressed, and how that could be explained in the light of the symptoms. Clearly there was a part of the mind below the level of consciousness which expressed itself in ways so far inexplicable. In our work we take for granted the need to interpret what is not comprehensible, spoken or unspoken. For a time, Freud experimented with hypnotic suggestion, but it soon turned out to be an imperfect technique, acting irregularly and uncertainly and sometimes not at all. Little by little accordingly Freud abandoned the use of suggestion and replaced it by an entirely fresh instrument which eventually became known as free association. He adopted the plan of simply asking the person whose mind he was investigating to say whatever came into his head. These were the early beginnings of psychoanalysis.

Those of us in the Institute who use hypnosis as a method of treatment are well aware that it is a poor tool when used merely as a form of direct suggestion. However, in an uncertain and indefinable minority of patients, important memories come into consciousness and can be of therapeutic benefit.

Freud's concept of the unconscious was now evolving. The mere recognition of unconscious mental processes was by no means original. As a schoolboy he was familiar with the terms 'unconscious mind' and the 'subconscious'. His picture of the unconscious differed considerably from that of his predecessors, in that he pictured it as a dynamic force rather than as a mere wastepaper basket of ideas and memories which had fallen below the threshold of awareness because they were relatively unimportant and lacked the mental energy to force their way into consciousness. He was able to show that precisely the opposite was the case, that the unconscious plays a predominant part in mental life since it takes energy for the instinctual drives and its contents being kept out of awareness, not because they lack significance but because they may be so significant as to constitute a threat, in other words a receptacle of the unacceptable. When this occurs, they are actively repressed and find expression only by devious methods. The process of repression is itself quite unconscious. During this period between 1887 and 1902 Freud was developing theories of unconscious motivation, repression, resistance and transference. This is well documented in Freud's voluminous correspondence with his friend, Wilhelm Fliess, a brilliant but somewhat unbalanced ENT surgeon. It is apparent that the seeds of psychoanalysis were beginning to germinate during these years. In retrospect it is clear that the research which underpinned these beginnings was Freud's own self-analysis. This has remained a unique enterprise. It was the only analysis that Freud was to have; so that it is also unique in the sense that in orthodox psychoanalysis the analyst must himself be analysed, but by another analyst. The concept of Id, Ego and Supra-ego, as sub-divisions of the mind, was an elaboration to come later.

In the years between 1900 and 1910, Freud had to change his mind concerning the causation of hysteria, which he had come to believe was the result of sexual seductions in childhood. However, he discovered that in many cases, no such seduction had occurred and that they were almost certainly figments of imagination. He had already noted that not only symptoms but also dreams and slips of the tongue are unconsciously motivated. As in the physical world, nothing happens without cause, and he felt entitled to assume that there must be some adequate reason why so many of his patients imagine themselves to have been the object of sexual seduction by a parent. From his observation that fears are

frequently the expression of unconscious desires, that a conscious fear is often the expression of an unconscious wish, Freud was led to formulate the hypotheses of infantile sexuality and the oedipus complex which are sometimes relevant to our work.

In Freudian psychoanalysis, the analyst adopts a strictly neutral position and on the whole avoids comments about progress. His aim is to be as unobtrusive as possible and to provide a screen for the projection of attitudes, undistorted by his own personality. However, Freud was unable to ignore the problem of transference. Although he studied it as a scientific phenomenon, he did not make therapeutic use of it. He concluded that the emotions of love or hate shown to him by patients were the revival by the analysis of emotions felt in early life towards significant persons.

We are still at some considerable distance from linking up with our focus on the doctor/patient relationship. The next link in the chain was a Hungarian psychiatrist, Sandor Ferenczi, a friend and disciple of Freud. He never really broke away from the master, but he was concerned about the impracticality of prolonged psychoanalysis for most people (five times a week for several years). He was, moreover, the first ever professor of psychoanalysis, and it was he who laid down that analysts must be analysed. He experimented with various innovations, such as encouraging the patient to dramatise his experiences as they were recollected, while the analyst entered into the spirit of the game (a kind of psychodrama). Most important, however, was his recognition that the patient/analyst relationship is a two-way one, i.e. a transference from analyst to patient as well as in the opposite direction. Ferenczi was the first to emphasise the importance of the counter-transference. He envisaged it as indicating changes in a relationship. The way the patient felt towards the analyst was not to be ignored.

The Nazi persecution started in the early 1930s and in 1933 they burnt Freud's books. Freud's comment was 'What progress we are making. In the Middle Ages they would have burnt me. Nowadays they are content with burning my books.' When one ponders on what was to follow, a somewhat unprophetic comment. By 1938 it was no longer safe for him to remain in Austria, and he came to England.

A pupil of Ferenczi's was a fellow Hungarian, Michael Balint. He was born in Budapest in 1896, the son of a G.P. and, like Freud, psychology was not his first love. He originally wanted to be an engineer but quickly became interested in medicine and psychoanalysis. His own analysis was conducted by Ferenczi, and he soon made important contributions to psycho-analytical theory and practice.

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The photographs illustrating Dr. Freedman's paper 'Freud, Balint, Main' have all been reproduced by Mr. David Barritt.

Because of limitation of space it has not been possible to print all 26 of them in the newsletter. If anyone would like to have a complete set, they are available at a cost of £5.50 including postage and packing. Orders should be sent to: D.G. Barritt, Esq., 'Almias', Crag Lane, Huby, North Yorkshire  
No later than 1st July, 1985.

He was drawn to the object relationship school of psychology, in short - instincts do not exist in a vacuum, there always has to be an attachment.

Ferenczi had established the importance of the transference and of the counter transference. Balint took it further. Later it was to become a cornerstone of his research and teaching seminars.

It was in 1950 Balint established seminars at the Tavistock Clinic to train general practitioners in psycho-dynamics and psychotherapy. He had always been



*Michael Balint*

interested in emotional and relationship problems and had started a similar project whilst still in Hungary before the war, with considerable success. However, the totalitarian regime would not, and could not tolerate this Jewish psychiatrist's enterprise and libertarian indoctrination, and he found himself under increasing pressure from the authorities. When finally he found members of the secret police sitting in on his seminars, he had had enough and he was off. As with Freud, it was Ernest Jones who played an important part in helping him to come to England. For a while he settled in Manchester before becoming established in London in 1949 and working with Enid Eicholz on a research project into methods of teaching social workers concerned with marital problems. She became his third wife. (Slide 18)

What sort of a man was he? He was an extraordinary combination of contrasting characteristics. In the cause of promoting what he believed in he was determined, to the extent of being almost unstoppable. He could be impatient, irascible and intolerant with those who tried to impede him. By his unceasing demands for more and more support, and more funding for his research, he infuriated Jock Sutherland, Senior Analyst at the Tavistock Clinic, who called him insatiable and greedy. Yet in his work as an analyst, both with patients and with pupils, he was an exemplar of a good listener - patient almost to exasperation. He was a man of towering intellect with a superb memory, who displayed great courtesy and charm - qualities which he disdained in himself.

Tom Main had been fascinated by psychology since his schooldays when he read the 'Interpretation of Dreams' and other works of Freud avidly, if with limited comprehension. He became an undergraduate at Newcastle University Medical School, where he was one of the outstanding students of the year. After qualifying, his interest in psychology and psychological medicine led him into psychiatry. At that time, which was a few years before the war, psychiatry concerned itself primarily with those severely disturbed members of society who, if the expression can be used without derogatory overtones, cluttered up the mental hospitals.

These had barely emerged from the status, and perhaps at that time more appropriate epithet of lunatic asylums. Tom was for a time Senior House Officer at Stannington Hospital, a few miles North of Newcastle, which was the catchment hospital for Gateshead on the South side of Newcastle. I gather that this was not a very fulfilling experience. Apart from the fact that doctoring, whether traditional or innovative, could make little impact, there was a disturbing element of corruption and bribery within the ranks of the nursing staff.



*Tom Main*

Tom Main had a good war, if that is not too glib a term. It was good in the sense of the considerable and increasing influence he was able to exert on the selection and training of soldiers and of leaders. It may not surprise you to learn that he was something of an enfant terrible and that his unconventional, or rather anti-conventional views regarding morale and discipline landed him in what could have been hot, or even boiling water. In essence, these were embodied in the concepts that good morale leads to good discipline, not the other way round. In other words, square bashing is an unproductive exercise but selecting leaders who can really lead is. Naturally this notion did not endear him to the officers of the Guards units amongst whom he had been spreading his revolutionary propaganda. He was sent to General Paget to be carpeted and kicked out. However, the General listened to Main's views, and so persuasive was he that he was invited to join General Paget's staff.

Various stratagems were developed to find leaders. For example, one of these was to set a group of men an impossible task and to observe how they coped with it. In the course of these, leaders would evolve as if by self-selection.

It was, however, also a good war for Tom in that he became still more certain that Freud's teachings and his own understanding of them could be, indeed needed to be, applied to army psychiatry. He was one of a small group of young army psychiatrists who bothered to try to understand the symbolism of the behaviour of people in the stress of battle. In a very vivid way he was able to observe the operation of castration complex, oedipus complex, etc. and became increasingly drawn towards psychoanalysis. At the time of the Salerno mutiny, he was on Monty's staff and was the psychiatrist responsible for interviewing the mutineers. Listening to them and understanding how they came to be in such a predicament, he was greatly upset by the way in which they were being treated. It was this experience and because of his distress at observing so many of his friends dying in the invasion of Europe, that Tom entered analysis, with Susan Isaacs. This first essay into analysis had to be curtailed by the passage of events.

By the time the war ended, Main had formed the basis for a career in psychiatry as a psychotherapist. In 1946 applications were invited for the post of Medical

## LETTERS

Dear Editor,

January 24th 1985

Director of the Cassell Hospital which specialised in psychotherapy. Against stiff opposition from a formidable shortlist of applicants, Tom triumphed. The Cassell was a private hospital in Stoke-on-Trent, founded by Sir Francis Cassell, uncle of Edwina Mountbatten, and it was extremely well endowed. With Mountbatten influence, it was not long before Tom managed to arrange the removal of the hospital to Ham Common, Richmond. He felt it important to be within easy reach of London in order that his staff should have ready access to psychoanalytical training. Main wished to continue his own analysis and had much heart searching before reaching a decision about whom to approach. His initial choice was Melanie Klein, but he had heard about and read some of the writings of Michael Balint. He was particularly impressed by his thoughts concerning counter-transference and all that derives from this.

The intertwining of Michael Balint's and Tom Main's professional lives are well known. In 1948 Tom entered analysis with Michael Balint and this continued for the next ten years. Apart from their professional association, they became very good friends, with an insatiable appetite for teasing and for arguing with each other.

Michael Balint instituted training seminars for general practitioners in 1950. During the 50s doctors, particularly those involved in family planning, were finding themselves more and more involved in having to deal with problems which they did not really understand. They felt themselves ill-equipped to respond to the growing demand for psychosexual medicine. In 1958 a group of these doctors sought Michael Balint's help in improving their insights and skills. Under the auspices of the Family Planning Association, the first research/training seminar was set up under Balint's leadership. He seemed an obvious choice. His elaboration of the importance of the counter-transference, his emphasis that the most important drug at a doctor's disposal was himself, his stress on the importance of understanding the unconscious elements in relationships, his declaration that reassurance without clear understanding of the exact nature of the problem was no reassurance at all, were just some of his extremely relevant thoughts and ideas. His insistence that doctors' reports to seminar groups should be verbal without written backup seems to be an application of free association to the training situation.

Main had been closely associated with him from the start in this enterprise. He acted as co-leader and deputy leader (Slide 24). When Balint's impatience with administrative bureaucracy caused him to resign from the leadership in 1960 Main took over. Balint's seminars had shown the importance of the vaginal examination as a psychosomatic event, both in non-consummation and in general female sexual dysfunction. Main's seminars, as well as continuing these researches, also studied vasectomy, pill contraception and impotence.

There was by now an increasing demand for more training seminars in all parts of the Kingdom. Balint had always maintained that these could only be led successfully by psychoanalysts. Main had other ideas which brings us to the present situation of doctors being appointed to be leaders, not because of what they are but because they have the right qualities as individuals.

In conclusion I would say that I was one of those doctors who found himself ill-equipped to respond adequately to the demands that psychosexual medicine was putting on him in the late sixties. I was allowed into Tom Main's seminar, at first on probation. To say that I have never looked back since is the wrong cliché, because I have often looked back at a memorable experience.

*Dr. ROLAND FREEDMAN*

I would find it very helpful if you would let me use the newsletter to discuss with the membership problems I have run into concerning the winter meetings. As you know, the Institute programme over many years has consisted of an A.G.M. in the spring and a residential weekend in late September plus some sort of meeting during the winter. For the last two years this winter event has taken the form of five evening meetings at Chandos Street, when a social hour, including supper, has been followed by an ad hoc seminar.

The evening meetings in 1983/1984 were enjoyed; those for 1984/1985 have been poorly attended and on some occasions had to be abandoned. Several reasons for the change have been suggested but it is not clear that any specific reason is the cause. Some people have said that after the first excitement of having our own H.Q. the attractiveness of turning out in the evening has waned, but it may be more complicated than that. There was a resolution passed by Council (which it later rescinded, but not in time to change notices) saying only accredited members were eligible. This may have had a dampening effect, particularly as one might argue that those who have not, for various reasons, ever sought accreditation are those who get most out of the meetings.

I should be grateful if members who particularly like the idea of winter seminars would let me know. In the absence of strongly voiced wishes I shall suggest to council that we revert to a single meeting in November.

Yours sincerely

DR. JANE KILVINGTON Programme Secretary

### NOTICES FROM THE TREASURER

At the A.G.M. on March 22nd, 1985 it was agreed that the subscription rate should be increased and the new rates are as follows:

Full members .....	£35.00
Subscribers .....	£35.00
Associate members .....	£25.00
Retired members 50% of the current rate.	

I regret having to make this increase but it is two years since the last increase and I am hopeful that we shall be able to hold this new rate for several years. We are increasing in numbers and it is time we extended our facilities, for instance we need our own telephone line at Chandos Street with an Ansafone. We also need more secretarial help for the Director of Training and perhaps some assistance with facilitating regional clinical meetings.

Over the next few weeks all members will receive letters explaining the new rates and how it affects their existing payments. Of course, those who have covenanted their subscription for four years are under no obligation to increase their subscription during the period of the covenant.

### NOTICE FROM THE SCIENTIFIC COMMITTEE

The Committee is considering the reinstatement of the Research Committee, and would be glad to hear from any doctors who are interested in undertaking research. Please write to me if you would like to participate.

*Dr. KATHARINE DRAPER*

## PANEL PASSES

The following doctors have passed the panel of assessment and are now full members of the Institute of Psychosexual Medicine.

May 1984	October 1984	February 1985
Dr. Shirley Bolt	Dr. John Lang	Dr. Ann Parker
Dr. Merryll Roberts	Dr. J. Sarah Gibb	Dr. Anne Shaw
Dr. Mollie Clay	Dr. K. Agrawal	Dr. Peter Barrett
Dr. Valerie Hall	Dr. Elaine Pemberton	Dr. Margaret McNair
Dr. Judy de la Hoyde	Dr. Mary Thomas	Dr. Sally Waters
		Dr. Gillian Van Hegan

## APPLICATIONS FOR ASSOCIATE MEMBERSHIP

All seminar leaders should have a supply of application forms (Form A) and also forms of approval by the seminar leader. Those who wish to become Associate Members should complete these forms after two terms.

After completion the forms should be sent either to Chandos Street or direct to Mr. Ron Trowbridge, 6 Dunsells Close, Ropley, Alresford, Hampshire with the appropriate payment. A receipt will be issued and their names will be added to the Membership List. The Editor will be informed and they will receive a copy of the last Newsletter and future editions.

If any leaders have no supplies of these forms let me know and I will forward them immediately.

**DR. JESSIE YORSTON**

### Notes for Contributors to the Newsletter

Articles on all aspects of work in psychosexual medicine are welcome for publication in the newsletter. Manuscripts should be typed on one side of A4 paper, double-spaced with wide margins. The first page should include the title and the name and qualifications of the authors and their appointments. Each page should be numbered and also bear the title and the authors name. Ed.

The deadline for articles to be included in the October issue is September 1st.

## SITUATION VACANT

### Psychosexual Problem Clinic — Hertfordshire N.W. District.

Fortnightly sessions on Wednesday (or other) evenings at both St. Albans and Hemel Hempstead will be advertised in the near future. Those interested could apply for information to Dr. Jane Kilvington who is retiring. Either one or two doctors are needed for a total of 4 sessions a month.

## New Members whose Applications were received after 16th September 1984

Dr. Rosalind M. Oliver	The Vicarage, Blackwell Road, Huthwaite, Sutton-in-Ashfield, Nottinghamshire NG17 2QT
Dr. S. A. Kulkarni	42 Robin Down Lane, Berry Hill, Mansfield, Nottinghamshire
Dr. Dennis M. Kochan	25 Beaufort Road, London W5 3EB

## New Members whose applications were received and/or accepted during the period 23 October and 1st December, 1984

Dr. William R. Gray	88 South Street, Mosborough, Sheffield S19 5DF
Dr. K. R. Manilal	1 Redgrove Way, Walton, Chesterfield, Derbyshire S40 3JN
Dr. Anne E. L. Basketts	38 Stone Road, Toftwood, Dereham, Norfolk NR19 1JS
Dr. Viopapa E. Annandale	62 Hill Road, Costessey, Norwich NR5 0LZ
Dr. Lynne Bloxham	Thorney Holme, Thorney Holme Terrace, Blaydon Bank, Blaydon, Tyne & Wear
Dr. Stephen C. Ilingworth	130 High Street, Hanham, Bristol, Avon
Dr. Sandra James	43 Oak Village, London NW5 4QL
Dr. Christine M. Jenkins	118B Dukes Avenue, Muswell Hill, London N10 2QB
Dr. Alison E. Mack	9 Merrylee Road, Glasgow G43 2SU
Dr. Alison Pinder	18 Hartley Avenue, Highfield, Southampton SO2 3QZ
Dr. Roseanna Pollen	62 Malvern Road, London E8 3LJ
Dr. Hilary Radcliffe	4 Corner Green, Blackheath, London SE3 9JJ
Dr. Agnes Stewart	Pine Lodge, Stainborough Lane, Hood Green, Barnsley, South Yorkshire S75 3EZ
Dr. Anita Taylor	2 Yew Tree Avenue, North Anston, Sheffield S31 7EW
Dr. Judy Thompson	St. Andrews, 2 Eastern Parade, Southsea, Hampshire PO4 9RL

## FULL MEMBERS

Name: .....

Consulting Address:

.....  
.....  
.....

Contact Address if different from address above and telephone number:

.....  
.....  
.....

Available for telephone calls between .....

## TYPE OF CONSULTATION

- |                                |        |
|--------------------------------|--------|
| 1. National Health Service     | Yes/No |
| 2. Private Patients            | Yes/No |
| 3. Medical Schemes (e.g. BUPA) | Yes/No |

Approximate cost of consultation:

Per session: .....

## ADDITIONAL INFORMATION

Please return this completed form to:

Dr. Sheila Filshie  
2 Pembroke Drive  
Mapperley Park  
NOTTINGHAM

## INSTITUTE OF PSYCHOSEXUAL MEDICINE TRAINING SEMINARS

Applications are invited for the following courses of basic training seminars in psychosexual medicine, from doctors who meet patients with these and related psychosomatic problems in the course of their clinical work, and who seek to improve their skills in dealing with them.

Applications for details should be made in writing please to the Director of Training, Institute of Psychosexual Medicine, 11 Chandos Street, Cavendish Square, London W1M 9DE.

**Existing seminars** with some additional vacancies:

Bromley, Kent; St. Albans; Birmingham; Leeds; Newcastle; Norwich; Ipswich; Cambridge; Bristol; Southampton; Sheffield; Nottingham; Barnsley; London North East

**New seminars** which may begin when there are sufficient suitable applicants.

London Lisson Grove; Basildon; East Kent; Southampton (second group) or elsewhere in Wessex; Bath/Bristol area; Wakefield; South Wales/Mid-Wales; Northern Ireland (Belfast/Derry); Reading/Oxford

## LEADERS WORKSHOPS

London (West London Hospital)

A second under consideration

## ADVANCED GROUPS

Two in London (Dr. Main, West London Hospital, Tuesdays or Thursdays)  
Plymouth  
Newcastle  
Sharpethorne, Sussex (Dr. Main, continuing seminar)

A new advanced group in Sheffield (or nearby) will begin shortly. Applications for this and for the following are invited from doctors who have either completed their basic training and are recommended by their previous leader to proceed to advanced training or have completed training but are interested in a refresher course of seminars.

New advanced groups which could begin when sufficient demand is established would meet at:

1. Bath/Bristol
2. London (Dr. Tunnadine, Monday or Wednesday)
3. Elsewhere in response to sufficient local demand.