

## FUTURE INSTITUTE OF PSYCHOSEXUAL MEDICINE EVENTS

### March 21st 1986 ANNUAL GENERAL MEETING

at 3.30 No. 11 Chandos Street at 8 p.m. Dr. Tom Main will present a  
Cavendish Square paper "How can we sing the  
London W1M 9DE Lord's Song in a strange  
Tel: 01580 1043 land."

### April 1st 1986

Deadline for contributions to the newsletter.

### May 16th 1986

at 2.00 p.m. No. 11 Chandos Street

A workshop led by Dr. Marshal Marinker on the subject 'Research and Communication in the Practice of Psychosexual Medicine'.

### September 19th - 21st 1986

Residential meeting at Bath University

### October 1st 1986

Deadline for contributions to the newsletter

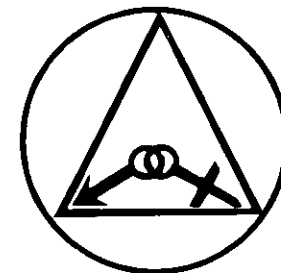
### September 25th - 27th 1987

Residential meeting at Selwyn College, Cambridge University

# Institute of Psychosexual Medicine

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## COUNCIL

Consists of the President and 12 Members, viz: Dr. Roland Freedman, Dr. Prudence Tunnadine, Dr. Judy Gilley, Dr. Jessie Yorston, Dr. Joan Coombs, Dr. Sheila Filshie, Dr. Margaret Gill, Dr. Jenny Lisle, Lady Morag Bramley, Dr. Heather Montford, Dr. Ruth Skrine, Dr. Ann Smith.  
Mrs. Nancy Raphael is an Honorary Permanent Co-option to Council.  
Dr. Jane Kilvington is and Ex-officio Member of Council in her capacity as Programmes Secretary.

Mrs. Judith Green will be at 11 Chandos Street on Thursdays.  
From 10.00 am until 2.00 pm — Telephone 01 580 0631.

## INSTITUTE OF PSYCHOSEXUAL MEDICINE

Newsletter No. 28  
November 1985

## EDITORIAL

The second edition of the newsletter for 1985 should arrive in the letterboxes of the members during November. The deadline for the autumn edition was September 1st but this date made little allowance for members to recover from their summer holidays and prepare items for publication. In future a deadline of October 1st seems more appropriate.

This summer there was little sunshine to distract members from the task of writing up clinical encounters for inclusion in the newsletter. I had hoped for more contributions but it was explained to me that as the weather was cold and wet members had to keep moving to keep warm, and writing was impossible.

It has been suggested that besides longer case studies many member doctors might wish to submit descriptions of brief encounters which have been illuminating and are worth sharing with doctor colleagues. The sole reason for sharing insights with colleagues is to enhance the doctors understanding of patients and how to help them. Patients and settings are disguised to preserve anonymity hopefully not detracting from the clinical material.

It is often hard to describe the work we do. It is even harder to conceptualise it and commit it to paper. However, a glance at the back cover will give an indication of the number of doctors working in seminars. If every seminar resolved to submit just one article a year there would be no shortage of copy for the newsletter. I believe that this would be a useful exercise for groups and would be enriching for the readership.

The 'guidelines' item could help with reporting case studies. As well as case reports and descriptions of brief encounters, could we have accounts of helpful moments in seminars?

Members must have ideas for research projects and it is clear that we ought to be more active in this. An obvious subject to research is Dr. Rogers denial that there is a deep well of sexual misery.

The newsletter is enriched by the contributions from the membership. Please may I repeat my request for more articles from more doctors. Thank you to those who submitted items for this newsletter, particularly Dr Robina Thexton who reported the Newcastle meeting.

Joan Coombs

## AN UNUSUAL MOTHER-DAUGHTER RELATIONSHIP

Independence from our parents is something we all have to learn in life. Some people are still being influenced by their mothers at 22 years — and some are still dependent at 72, as in the case of Mrs. T.

I was introduced to Mrs. T. by the District Nurse, (who gives Mr. T. his daily insulin) requesting an appointment for Mrs. T.'s 'cystitis' but alerting me to the situation by adding that there was 'something far wrong in that house'.

Mrs. T. kept the appointment. Summoned by the buzzer, she still knocked before creeping in hunched into the smallest possible space — a real little Mrs. Uriah Heap. She perched on the edge of the chair, having parked her bag in a corner — apologised for wasting my time — a tiny, spry little lady of seventy-two whose round doll-like face had a curiously youthful look. Little history was offered except a vague 'burning down below' and as she retired to prepare for examination, I wondered why she had come. However, a great deal was revealed during the examination. Putting my hand on her abdomen opened the flood gates, and her life history tumbled out.

She had a happy childhood as one of two sisters. She was devoted to her mother who had died aged ninety seven two years previously. She had a disastrous first marriage to a soldier who eventually went off with one of his lady friends, leaving her with her only child — a boy delivered by Caesarian Section 'because she was so small'. She and her son both remember the day they went to the cinema twice to help them through the day he left.

With her mother's support she found strength to refuse to let him come back when he gave up his girl friends. Her present husband is seven years her junior, also an ex-soldier. They are childless as she was sterilized after delivery. This marriage has been unhappy almost since its start. Mr. T. is very jealous, resenting any of her friendships, particularly those with men. She left her job because of this and now doesn't visit or entertain friends or family because of him. He has quarrelled with her son and forbidden him to come to their house. The only person she could visit freely was her mother — now dead. They quarrel often — and she 'flies at him'. She claims their sex life was full and active initially — although lacking in affection or tenderness. Now, because of her discomfort, Mr. T. uses 'the back way'. Apparently she lets him believe he is having anal intercourse, but there is no penetration. This, or any other intercourse, is repugnant to her — her life has little comfort. With the death of her mother she lost her only confidante and support, and now she is quite bereft and has had suicidal thoughts.

Throughout the interview Mrs. T. kept turning to me for advice and support and, without realising it, I slipped into the rôle of her mother, although giving her opposite advice. Where her mother had told her she must lie on the bed she had made, I found myself telling her to stand up for herself — to go out, see her son or leave her husband if that was what she wanted — and when she protested at this last course of action, I pointed out that suicide was another way of leaving him. This I could see was a very significant remark to her.

After this storm, vaginal examination was surprisingly easy and normal. She accepted the reassurance that all was normal physically without surprise, admitting that her pain was her body rejecting the husband she did not want. She refused to examine herself, saying that she was not ready for it. She left, thrusting into my hand a box of chocolates.

I saw her again two weeks later. With no timid knock on the door, she came in briskly, sat down confidently, bag on lap — she felt much better about everything, her discomfort had gone. She had seen a solicitor about a separation. Her husband had overheard her telephone her solicitor and they had had a long discussion, without violence, during which she had told him she intended seeing her sister regularly, and did not need his company on shopping expeditions. She had refused to have intercourse with him 'either way'. The timid little woman had discovered she was a person in her own right, with her own needs, and surprising reserves of strength. "I knew I could leave him when you told me I would if I killed myself. You see, my mother always told me to stay with him to look after him". To her, I had become a different, but substitute mother.

As things were so much better she had decided to stay with him. She agreed refusing intercourse would make matters worse, and promised to try again, but I did not feel optimistic (was this really her feeling?) as she had not yet examined herself. This situation persisted for several interviews — but when I saw her at Easter, after a month's interval, I knew immediately that her problems had returned and she crept in with the inevitable shopping bag — her 'burning down below' was back. Mr. T. was as difficult as ever and they had not resumed their relations. Her feelings of depression were beginning to overwhelm her again. She thought this was because she had missed her mother more at Bank Holiday time, but I knew I had left her too long between appointments. This was confirmed by her once again leaving me a small gift — buying my time and making sure she would see me again. Was she ensuring that I would not 'die' too and leave her unsupported in her difficult relationship with her husband?

We tackled the problem of her vulval discomfort anew and why she felt unable to examine herself. She volunteered that this part of her was no good to her and she would rather forget about it. She agreed that her body would not let her do this, and by her next attendance she had examined and was anxious to show me something she had discovered, actually her labia minora. During this examination she explored the normal anatomy with interest and no distaste or surprise. She agreed there was no physical reason to abstain from intercourse and that it would improve relations between her and her husband if she resumed intercourse 'the normal way'.

By her next visit she had resumed relations. Mr. T. was wanting to remove to a seaside town and she thought she would not go with him. Two week later she had seen her son and was going to a family wedding — against Mr. T.'s wishes. He had had 'flu and had needed to be cared for. By now, she had stopped bringing me presents and actually asked if she could leave her appointment for a month.

When I saw her again my first flush of triumph had faded, but I felt cautiously optimistic. She had developed considerable insight into her complaint and relationships with her husband — and with me — she volunteered that I had taken the place of her mother. I could see her need for a mother had lessened as she took a more positive attitude to her rôle as a wife and she would now accept Mr. T. as her husband, on her own terms, and had found the resources of strength in herself to maintain this relationship with only occasional support from her surrogate mother.

On reporting this case at this stage to a seminar, I had to admit that even despite Mrs. T. volunteering that she no longer needed my help, I had felt unwilling and unable to discharge her from my care. Somehow, I had to keep my 'daughter' coming to visit me regularly. She had managed to make me feel her dependence was necessary. Examining this relationship in public made me realise I had to allow Mrs. T. to drop her rôle as a daughter to progress in her rôle as a wife, and accordingly at her last visit I agreed with Mrs. T. she could now cope unsupported. She was working hard at her relationship with Mr. T. They were having intercourse 'normally' and she was coping with feelings of nausea she had had initially, realising it was 'psychological'. They were looking at properties locally. The family wedding had been a great success and she had gone with her son. Mr. T. was being much less aggressive. As she left she gave me a last gift — but not for myself — some handkerchiefs for my daughter. Was she reminding me of my real rôle as a mother? I have learned a lot from Mrs. T.

**AGNES C. STEWART**

## VICISSITUDES

The men fill me with deepest gloom  
I rarely seem able to help them.  
I try, and they are kind and say they feel better,  
But they don't  
And they won't.  
Well there's Bill, who's been married for seven years  
And can make love for hours and hours  
But never  
Has ever  
Ejaculated in his wife,  
And is sad; and would love to do it.  
He doesn't fit  
Into any category  
He would dearly love a baby, doesn't fear to hurt  
Or to damage; nor need to punish or deny  
We are stuck, we three  
And I  
As barren as them.

Then there's Joe who is thirty and large  
And diffident  
And never has managed it quite.  
But now it is worse  
Because his girlfriend has gone  
And he's not one to practice it on.

Or there's Fred  
Who came in  
All worried and broken  
No love for six months  
Unable  
And angry therefore.  
We talked, for an hour or possibly more  
And the queue grew anxious and fretted.

Two weeks later he walked in quite blasé  
And complained of a dose of the flu'.  
Slightly surprised  
And is some trepidation  
I asked how the love life was going.  
Oh fine, he said, I soon mastered that  
(In spite of the chat?)  
Well what would you rhyme with blasé?

*by EILEEN BEDFORD*

## SOME ASPECTS OF BIRTH TRAUMA

THERE WAS A YOUNG LADY OF HEANOR  
WHO UNEXPECTEDLY WENT IN FOR CAESAR  
WHEN THEY OPENED HER UP  
SHE COULD SEE ALL HER GUT  
WHICH CAUSED HER TO LOSE HER LIBIDO

This cautionary tale is true; and when the patient drew the surgeons attention to what she could see in the highly reflective back of the operating-light, he said, "Oh dear yes, that has happened before"

Now that more surgery is done under epidural anaesthesia could the backs of these lamps be made non-reflecting?

The young woman said "It looked like a butchers slab", she was frightened and shocked.

The operation turned out to be more complicated than expected, and she needed transfusions and suffered from some pain. Her young husband also present had suffered fear and shock as well, but had stayed by her side. When she came to see me, she had been delivered for six months, but had been unable to permit intercourse. A straight forward listening to and understanding of her revulsion and fear seemed to help immensely and after only two visits she began to feel better and was making love again. She bore the hospital no malice and understood what had happened and said they 'meant to be kind to her'.

Prevention of emotional and psychological trauma of this kind would obviously be more humane, time-saving and economic; than allowing it to occur. But where the damage is unavoidable a little thought, care and time afterwards, can save much anguish.

Another young lady going into hospital for her first baby was looked after during labour over seven hours by two devoted midwives to whom she became very attached. They stayed on after time in order to deliver her. Unfortunately in the end she had to be delivered by 'Two strange doctors'.

It was a forceps delivery and she didn't see the midwives again. She felt very distressed that she was not able to push the baby out. She felt this as a great inadequacy in herself. She said she felt 'taken over' and was 'cut and delivered very quickly', 'in a few seconds'. She 'felt like a spectator' at the birth of the child 'outside herself watching what was happening'.

I explained to her the doctors dilemma. From her description, the urgency had been obvious, but no one had had the time or insight to make her aware. She responded immediately when I said that not only could the baby's life have been in danger but also her own, and that the doctors would have to act quickly.

We went through the whole birth together again and she was able to accept that perhaps she was not so terribly inadequate for not being able to make that final push. That baby's head was in the wrong position, was no fault of hers, or indeed of any ones. Yet this worry had prevented her too from making love and frightened to have another baby.

Whether she could have expressed her feelings of grief and disappointment if she had had the chance soon after birth, or whether she needed longer to come to terms with it; it is difficult to be sure; but although in many respects this case may seem trivial; it seems to me to illustrate the importance of there being some one available who has a listening ear, in the delivery and the post delivery days.

Recently I have done a lot of discussions and lectures with midwives and health visitors about this sort of psychosexual care and counselling.

They are on the spot, and the domiciliary midwife especially spends some time with the new mother while she tends her and helps her to bath the baby. The atmosphere is usually relaxed and communication easy.

I feel that we should not neglect the midwives availability and capabilities in this. We should do all we can to help them be aware of the ways in which they can both help mother and enrich their own work at the same time. Many of them are already doing this and are keen to learn more.

**DR. EILEEN BEDFORD**

## BRIEF CLINICAL ENCOUNTERS

### THREE MEN AND THEIR PAIN

I have recently met three men who have taught me a lot. I met them in three different settings, and the encounters were comparatively brief. On each occasion they were able to put into words, to their female doctor, a deep and previously unexpressed feeling. In two cases this only happened when their partner was excluded, and in the third she was partially excluded by the examination screen.

**MR. A.** was brought to a family planning clinic by his girl friend because they could not make love. She was sexually experienced, relaxed and easy during vaginal examination, her only emotion being frustration that they could not do it, and that it was so painful for him. What was wrong with her that she made it so painful for him? I was equally baffled as she admitted three fingers with the greatest of ease, could control her pelvic floor muscles, could examine herself, and had experienced no previous difficulty.

I saw him alone on three occasions before the clinic. He was a big country man of 21 years, who had not tried to make love before. The interviews were made uncomfortable by his fury at himself for not being able to do it. Every time he tried to enter her he experienced excruciating pain and bled heavily. When I examined him I found an infected ulcer at the base of his frenulum, which was duly treated. This appeared to be a traumatic ulcer, although his foreskin retracted easily. At the second interview I was convinced that he must have great fantasies about the vagina but could only elicit the idea that it was warm, moist, exciting and welcoming. I missed his first important offering that 'of course it was bound to hurt him', and it was not until he said that 'men have to be broken in, just as women do', that this slow witted doctor began to appreciate that he had fantasies about his own body. At the third interview he was able to tell me that it was bound to be painful when the foreskin was 'torn back to the base of the penis'. Light dawned, and we shared the relief and mutual embarrassment at his misunderstanding which had been gained from watching horses. He has not been back to see me; he hated the embarrassment of the female clinic, of his naivety, of having to come for help; but I have high hopes that his problem is solved.

**MR. B** came with his wife to a psychosexual clinic. They had been trying for a baby for seven years and had been through the obstacle course of infertility investigations. No absolute cause had been found, both being 'slightly subfertile'. They had had their name on the list for adoption, but had recently asked for it to be removed because the marriage was very shaky. The symptom presented to me was that the wife had lost all interest in sex, and could not bear him to come near her.

They are a lovely couple; good looking, intelligent — and despairing. When I saw her alone she told me of her fury that he did not appreciate how awful it was for her not to be able to have a baby. For the eight years of their marriage she had always felt that they had a deep and perfect understanding, and the sense that he did not share her despair made her feel very isolated and angry. She felt that marriage should be a total, complete sharing and understanding. When seen alone he told me that he was not someone to cry over spilt milk.

If something had to be accepted, then he accepted it, and he probably did not feel so bad about it as his wife did. I found it difficult to get to any strong feelings, until he began to talk about the infertility investigations and how he had hated having to produce specimens of semen, usually in the hospital lavatory. He always felt that the specimens were inferior, not as good as he could have produced under better conditions. In his very next sentence he said "I've never really thought of myself as very 'macho'." Some sense of the misery of being exposed as less of a man than he could be was palpable in the room.

I saw his wife next, and it was clear that he had been able to make some use with her of this 'moment of truth' with me. He had shared something about the difficulty of producing specimens, whilst she appeared to have grown up, and to accept that he also felt strongly about some things, and that absolute, complete sharing of every possible emotion was perhaps something of a fantasy.

They are back on the adoption list. She is beginning to be slightly more interested in sex. They have a long way to go but they are moving, and perhaps the doctor, by sharing limited but very real feelings of pain with these two individuals was able to act as a catalyst in the marriage.

**MR. C** reinforced my sense of the importance of semen as a symbol of manliness. He came with his wife to an apparently straightforward vasectomy counselling appointment. They were an eminently suitable, late thirties, three children, happily married, well motivated and well informed couple. They had an easy, loving relationship with a satisfactory sexual life. Physical examination on a couch behind a screen, with his wife remaining in the room, appeared to go smoothly. He dropped his trousers and lay down for me to examine him with no more embarrassment than usual. All was normal; and I made my customary rather vague remarks about it all being splendid, but his look of anxiety deepened. Was he worried about the operation I asked? Oh no, not at all. His anxiety remained and I commented on it. He burst out that he was worried about the specimens, he was sure they would not be up to scratch or compare adequately with other men's. The thought of it made him feel exposed and vulnerable; His sense of relief at having shared this fear was almost as great as the surprise on the face of his wife. I wonder if her tender reassuring response, and my offer of a further appointment to talk about it should he want to will make it possible for him to produce his specimens, or whether he will be another of those in the group 'results unknown: specimens not received'.

These short encounters remain in my mind as illustrating several aspects of psycho-sexual medicine. The fact that useful work can be done in different clinical settings, the need to see patients individually if they are to be able to share their sexual anxieties and fantasies, and the often incomplete knowledge about the outcome which makes the importance of the work hard to justify to those who do not understand it, and yet does not invalidate it.

Many years ago I was privileged to spend a year in a seminar with Michael Balint. My outstanding memory of that time is of Dr. Balint saying "why don't you listen to your patient"; "you don't seem to be listening to what your patient is saying"; "why don't you listen *some more* to what your patient is saying". These three men remind me that when one listens there are things to hear.

**RUTH SKRINE, M.B., Ch.B., M.R.C.G.P.**

## ANNUAL RESIDENTIAL MEETING 1985 – NEWCASTLE UPON TYNE

The annual residential weekend of the I.P.M. was held this September in Newcastle-upon-Tyne. The meeting was well attended in spite of the long journeys involved for many members. The accommodation was comfortable in Henderson Hall, a university hall of residence. Thanks must go once again to Dr. Jane Kilvington and also to Mr. George Rivas and his Wyeth team for all the hard work that went into making the weekend so successful.

There was a full programme with fourteen speakers contributing.

On the first evening Dr. John Rogers was invited to speak on 'The importance of the institute'. An elegant speaker, he delivered a provocative and possibly "tongue in cheek" and teasing address.

Dr. Rogers discussed the importance of the I.P.M. to the patients, the general public. The association keeps a low public profile, and patients have never heard of it. He said "Does this matter?" "Can they find us when they need us?" He also questioned the assumption that there is a deep well of sexual misery. In Dr. Rogers' experience there are not a lot of people with sexual problems. This provoked reports of the opposite experience from other members during the ensuing discussion.

The medical profession also are generally unaware of the existence of the Institute of Psychosexual Medicine. There is not a great demand for training, he said, and few requests for speakers. Dr. Rogers observed that the Marriage Guidance Council are in receipt of a government grant to support the work they do, but the I.P.M. has no assistance of this kind. Recently a Diploma in Psychosexual Medicine has been set up by another training body in an attempt to establish credible standards in this field of medicine. Our own certificate of accreditation has been in existence for some time, and to date there have been sixty nine panel passes, but the medical profession has little understanding of the meaning of this process of assessment and accreditation.

Dr. Rogers then went on to discuss the importance of the I.P.M. to the membership. He proposed that the Institute should be more involved in scientifically conducted research projects. He also observed how necessary it is that younger members 'take up the tools and build on the foundations already laid'. He said that the Institute is well worth preserving.

The discussion which followed was lively and ranging, and concluded the morbid questioning of the validity of the work of the Institute. The rest of the weekend was devoted to work.

### Saturday, September 21st 1985

Dr. Main was in the Chair for the morning papers which started with Dr. Heather Montford speaking on 'The Source of the Referral as a Factor in the Doctor/Patient Relationship'. Having studied the effect of various different settings on courses of therapy at last year's conference, Dr. Montford reviewed her recent caseload to note how patients got to her. She wanted to find out if the referral affected the doctor/patient interaction and in what way. Working in a referral session means that the doctor is viewed as some sort of 'expert'. We have to try hard to remain 'vulnerable' with the patient, to maintain the humility to 'muddle through' with the patient and also use discipline and understanding. All this comes with confidence in this method of treatment.

Dr. Montford tabulated the source of 100 first interviews over 6 months. She left aside the varied circumstances leading to the referral.

From G.P.	37
Self referrals	31
From Family Planning Doctors	20
From Health Visitors	5
From Hospital Consultants	5
From Dr. Montford's own Family Planning Clinics	2

### FROM GENERAL PRACTITIONERS

The majority came from the family doctors. These patients already expected doctoring and physical examination. The doctor tries to be sensitive to her patient's feelings without becoming over-involved. She tries not to be influenced by the tone of the referring letter but values the discipline of replying and passing back insight achieved to the referrer.

### SELF REFERRALS fall into two groups:-

- (1) Those seeking **anonymity**. They are ashamed, embarrassed or fearful. They are clients of phone-in programmes, writers to Agony Columns, sometimes giving false names and false addresses. Sometimes they fail their first appointments. Getting the right pace for interpretations in the first interview is difficult. The story of Doreen followed. She was an angry, frigid woman who expected the doctor to help her to enjoy sex without doing anything about it herself. She was even unable to talk about what happened between herself and her husband.
- (2) Those who seek the best. A group who may have tried Masters and Johnson type therapy, also want to be anonymous, now try the Institute doctor. An example was given of a widower, impotent in the affairs he had had after his wife's death. He had a need to cover this with boasting and with attitudes of superiority over women. He did work with the doctor, and got better.

### REFERRALS FROM FAMILY PLANNING DOCTORS AND NURSES

Sometimes a confused patient provokes the nurse to feel she needs psychosexual help. She may not be ready to explore her sexuality in depth but benefits from the chance to talk things over.

Annabel was a girl who went to University, not ready for the lovemaking she felt was expected of her. After two appointments with the doctor she was confident to postpone this stage of her life.

### FROM HOSPITAL CONSULTANTS

These are from physicians who often refer male patients who have become impotent on hypotensive therapy. Patients are also referred by gynaecologists. These are often women with physical symptoms who are amenable to treatment if they have been gently led to consider that pain can be psychosomatic when organic pathology has been excluded. The sensitive vaginal examination can be very rewarding as a therapeutic tool in these cases.

Colette, whose pelvic pain had been investigated by gastroenterologists and gynaecologists was able to communicate the pain of her life with her punitive husband whilst lying on the examination couch. The doctor shared it with her, and after this she came to terms with it and was happier.

## FROM HEALTH VISITORS

Often these patients have social, environmental, and personality problems compounding the psychosexual one. They are not suitable for brief interpretive psychosexual therapy. Their motivation to work does not match the motivation of the Health Visitor to send them. It is often more appropriate to support the Health Visitor, but if the doctor doesn't set her sights too high, small improvements are worth while.

An example was given of an obese, angry mother, who had difficulties in all areas of her life and who had banished her husband to another room. The doctor showed she valued this woman, and hoped she could get back the pleasure she had 'when we was first married'. There was an improvement.

## SELF TO SELF REFERRALS

The success rate with these cases is higher because the doctor hears the patients complaint herself when it is first made. The doctor/patient relationship has already started, and in a sense the doctor has selected the sort of patient she knows is amenable to help.

Dr. Montford concluded that, as ever, the relationship between one doctor and one patient is unique. It is worthy of study, as also is the course of referral which inevitably affects it.

**DR. MERRYL ROBERTS** works in an IUD clinic training doctors in the technique of IUD insertion. She also manages to teach doctors the relevance of unconscious communication from patients in this work.

As an example she described a hospital doctor good at statistics but a novice where patients feelings were concerned. At his last session he was conducting the clinic. A young woman came to have her coil out. The trainee doctor was about to remove it. Dr. Roberts sensed that there were sad feelings behind the patient's brisk exterior and she intervened. The story came pouring out. She was having the coil out because her husband had left her. She was grief stricken, upset, angry and betrayed. She shared her distress with Dr. Roberts, she had her coil out, she felt better and she left. The trainee doctor was surprised at the amount of distress that had been shared during an ostensibly routine consultation.

During another routine IUD training session a patient was complaining of a variety of vaginal symptoms. She let it drop that 'I never think of that termination'. Dr. Roberts helped her to go on a bit more. 'I was crying when I came round from the anaesthetic'. She wept copiously during the interview as she told how her boyfriend had not supported her. She said she bitterly regretted the termination and felt betrayed and bereaved.

She believed that she might never be able to have another pregnancy.

The trainee doctor was changed by that which he had witnessed in Dr. Robert's clinic. He valued what he had learned of the sensitive sharing and handling of patients feelings and Dr. Roberts felt that this was more important than straightforward IUD technique.

**DR. JOHN PENIKET** is a male general practitioner. He has a personal list. That means that each G.P. partner in a practice of five keeps his or own patients. If patients are seen by other doctors they are always referred back to the personal doctor. Dr. Peniket finds a great volume of distress in his patients due to psychosexual DIS-EASE.

Dr. Peniket described the case of a wealthy fifty-three year old woman. She had a thick folder of notes which contained 81 letters from various consultants. She had had fifteen operations. In 1974 when Dr. Peniket first joined a training seminar he began to help this patient. He encouraged her to talk about her inhibited Roman Catholic upbringing and her unhappiness that she had never had an orgasm. He has spent many hours helping her and she has not sought any more operations.

Out of 64 patients 47 were women. Most of the male patients complained of impotence, four of premature ejaculation and one of delayed ejaculation. Most of the female patients did not complain of a sexual problem but presented with depression, anxiety etc.

Dr. Peniket finds his work with the psychosexual problems of his patients is an important part of his work as a general practitioner. He hopes that psychosexual doctors will always write to the general practitioners to inform them of therapy going on with their patients.

**DR. MARGARET GILL** began by remembering how she previously would fly from uncomfortable moments in doctor-patient transactions; ordering tests, questioning, resorting to physical examination.

She described a familiar discomfort when the patient says 'I don't feel anything'. The doctor faces a vacuum, 'nothingness', or is it a brick wall not to be jumped over or knocked down but to be studied brick by brick.

She then presented a very detailed case in which there were many such uncomfortable moments.

Instead of distracting or flying from them Dr. Gill nowadays studies them with the patient. In this way she becomes aware that at the centre of 'nothingness' there is something. Strong verbal connections about not wanting sex are often indicative of the opposite feeling. Dr. Gill said that she has learned to notice defences earlier. She has learned not to react to defensive behaviour but to recognise it and study it with the patient who then may be freed of it.

**DR. ELEANOR BARRON** then presented a detailed account of her work with a young girl who had been referred to her by a gynaecologist. The girl was twenty and complaining of dyspareunia. The gynaecologist had found she was tender when the vaginal wall behind the bladder was pressed. There was always pain inside and her husband was getting fed up. There had been bladder surgery when the patient was seven for diverticuli. The emotional history was complicated but eventually the patient was able to change and to enjoy intercourse.

Some discussion preceded the meeting breaking up into eight groups for further discussion.

**The afternoon session** was chaired by Dr. Tom Main, Dr. Ann Smith introduced three members of her basic Newcastle training seminar and they each contributed case studies.

**DR. JILL MILLAR** works as a general practitioner. She presented an account of one of her young women patients who presented with tiredness. The doctor suspected there was a psychological cause for the fatigue but not until after clinical tests and a change of pill did the patient reveal her feelings of unhappiness and wept. Over the months Dr. Millar has worked hard with this patient and feels that there is a lot more work to be done but also feels that in her general practice she can keep on with it.

**DR. TOBY LIPMAN** is also a family doctor who says that seminar training has changed his approach to emotional problems presented by his patients. He described two cases where thoughtful interpretation of the patients effect on the doctor allowed both patients the opportunity to express and work through their sadness. Neither case was of a sexual problem, more of a life problem but the doctors response proved to be helpful in both cases.

**DR. LYNNE BLOXHAM** also a general practitioner described two case studies. The first was of a young woman who complained of pain with intercourse and asked for cream for it. After reassurance by the doctor and later by a gynaecologist that her body was normal the patient stopped taking the pill and stopped having intercourse. She observed: 'I always wanted to run before I could walk'. The second woman presented as an acute emergency. Her severe headache started during intercourse. She was admitted to hospital to exclude the possibility of subarachnoid haemorrhage. Later her real problem emerged after a secondary presentation of vulval soreness. Her relationship with her husband had deteriorated to the extent that she only tolerated him because of the children. She had had an extramarital sexual relationship but was plagued by guilt.

Small group discussion followed these case studies.

A sherry reception was followed by dinner on Saturday night. George Rivas of Wyeth had arranged this. He had also arranged for a pipe band to play. This was highly entertaining and gave everyone the opportunity to relax and enjoy the music after the intensity of the work of the day.

On Sunday morning Dr. Roland Freedman chaired the meeting. He welcomed hospital consultants from Newcastle who were guests during the morning session.

Dr. Tom Main presented the first paper on 'The Importance of the setting'.

### THE SETTING

Dr. Main observed that people live their lives as a whole and that psychosexual problems are part of the general character. Psychosexual development is part of the whole personality development. The 'psyche' and the 'soma' go hand in hand.

Psychosexual development affects the quality of life. It affects parenting. It affects industry. An impotent man is impotent at work, bad at driving and so on. If he gets better everything improves, including his appearance. If it is the whole person who is impotent it is difficult to measure improvement. He may become more assertive with his mates, get a pay rise and intercourse will be better. How can you give any exact measurement?

A psychosexual problem is a disturbance in relation to:

1. The genitals – too small, dirty, dangerous, smelly etc.
2. Or the genitals of the opposite sex.
3. Or in relation to self eg. punitive – its **too** much fun so it causes headaches.
4. In relation to other people – need to dominated or submit or difficulty with parent of one or other sex.

It is important to diagnose at which level it is right to work. It is important to have methods of **investigation** rather than standard treatment.

We are doctors concerned with the whole person. The body is brought in from the first because we do a physical examination.

We also examine the mental attitude not by taking a history but by examining the 'here and now' in the interview, by examining the doctor/patient relationship in action every second. People differ and the level of disturbance differs. Other disciplines have fixed principles of technique. For example the hypnotist knows that he will hypnotise the patient even before he sees him. The psychiatrist knows he has seven minutes to give the patient. A G.P. can take five years. So we see that doctors act differently in different settings.

### PRINCIPLES OF THIS PSYCHOSEXUAL TECHNIQUE

1. To listen without interruption using our own thoughts. If we interrupt we influence the patients material.
2. Identify with the patients story and now and then pull out and think 'What is going on now between us two?'
3. Then you can offer a deduction to the patient tentatively 'It seems that ....' Offer it, do not **tell**. No moralities are offered by the doctor. The doctor should be interested in the moralities of the patient. He does not give advice, reproaches, consolation or even sympathy.

Unfortunately doctors are scarred by their previous training. A physically ill patient gives his body over passively to the expert body doctor who takes a history. History about personal development is more difficult. History tells you about the historian and the things he is interested in. We need to learn about the patient and wonder why he gives this or that version of history.

In general practice psychosexual problems are disguised under other symptoms such as headaches and sadness.

In family planning clinics the concern is with contraception and the complaints are veiled with this.

In psychosexual sessions it is a frank sex problem which is aired.

In gynaecological departments there are bodily upsets to be diagnosed along with the problems in the mind.

The pressures on doctors in their different sessions is always great; to agree with the referring doctor; to see an unsuitable patient to please a colleague; to get a patient better to impress a consultant and there is always pressure of time making it hard to sit back and listen, understand and interpret.

This paper was the introduction to the four papers which follow, they describe the work of doctors in various settings.

**DR. FAITH HADDAD** described her work with psychosexual patients in a gynaecological out-patient department. She sees patients with infertility; those suffering from endocrinological problems and those with frank psychosexual difficulties. All patients come by referral, 50% from G.P.'s and 50% from colleagues within the hospital. Expectation of cure is high but they are not easy problems and require a lot of time. Some patients are not suitable for this method of brief interpretive psychotherapy like the woman complaining of anorgasmia who was totally unable to maintain a good relationship with anybody because of a wider personality disorder.

The hospital setting has various effects on patients. Some are intimidated by registering and sitting in queues. Some are disturbed by the noise coming from adjacent consulting rooms and the doctor is often faced by patients who are already angry and upset because of the setting before the consultation begins. Sometimes Dr. Haddad is able to use these strong feelings to 'get to' the other feelings upsetting sexuality.

A teaching hospital has a commitment to teach medical students. Dr. Haddad had tried including them in her consultations. She found that this interfered too much with the one-to-one interaction between doctor and patient like the impotent man who started to boast of his prowess in the presence of the young male medical student. Nowadays Dr. Haddad holds seminars for case discussions with her students where they learn about how patients present overtly or covertly and begin to understand the doctor/patient relationship.

Gynaecological colleagues often refer patients when they have too little time in their own clinics to deal with this kind of work. Some patients resented the assumption that their problem was 'all in the mind' as they had come to hospital believing the problem was physical. A woman with pelvic pain had both. She had already had two negative laparoscopic examinations to find the cause of her pain. Examination of her emotions revealed distress about being raped at the age of 16 and also that her mother was sexual prior to marriage. These feelings were relevant and over a year she managed to come to terms with them.

Dr. Haddad is able to see two new patients and four or five follow-up patients each week. She feels a pressure to do well both from the referring doctors and also from the patients.

When couples are referred she attempts to assess which is the partner she can most productively work with. Hospitals expect statistics from sessions. In this type of work it is not easy to give facts and figures. In later discussion Dr. Robertson said ideally there should be an Institute doctor working in this way in every gynaecological department.

**DR. PRUDENCE TUNNADINE** spoke of working in private practice. This was an analysis of the special relevance of the setting where money changes hands. Patients seek this setting for various reasons. They know there will be privacy and they want to be anonymous. Patients and referrals have chosen Dr. Tunnadine and know that she is the doctor who will be seen. Her work is medical gynaecology, with 'well women' checks, contraception as well as psychosexual problems. This often leads to a discussion of the clients need for a private life whilst having a public face and the difficulties they have with this. Other patients seem to seek the limelight, perhaps their personal uncertainty makes them boast. Very wealthy people have their share of distress.

Dr. Tunnadine finds herself reminding the patient who does not feel good enough to be treated in private practice 'you are the customer you know'. Some patients find it a relief to discover that this 'lady doctor' can after all talk in their language and that a stiff upper lip is not expected of them. Dr. Tunnadine feels discomfort if patients do not seem to be improving. Can she go on taking their money if they are not getting better? She resists the temptation to do psychotherapy and finds that some of the best work is in the quick 'one-off' interview.

She said that in private practice every thing depends on the doctor who cannot then make excuses for inefficiency or blame others. Dr. Tunnadine feels that this fact concentrates the mind wonderfully.

**DR. GILL HINSELWOOD** described her work in a student health setting. Young people attending college or university have a goal to obtain a degree or diploma and eventually to be financially independent. An equally important task is that of personal and sexual maturation which it is expected will take place at the same time. It is a time of excitement and sometimes of terror or at least discomfort. Dr. Hinshelwood then described three cases which illustrated the unrecognised need for progress in sexual development.

This was reflected in impaired performance and uncertainty about academic life.

The first six weeks of college life is an anxious and unnerving time. Some students carry it off with bravado, manic activity and alcohol. Some are desperately homesick especially those from overseas. Later there are failed hopes, changes of course or college. Only a few reach the college doctor.

At examination time though college doctors are very busy. Exam nerves seem to precipitate sore throats, migraines and gastro-intestinal upsets. When students come to the compassionate college exam crisis centre it is still necessary to understand the real reason behind the panic as in the third case where the 'examination' was evocative of a previous terrifying and humiliating medical examination in a girl student's formative years.

Students have not asked Dr. Hinshelwood directly for help with psychosexual problems. The difficulties have come to light during discussion of other matters eg. unwanted pregnancy, sexually transmitted disease, rape, contraception or an excessive preoccupation with sport or work.

Students attempt their own solutions first. They change their partners or their sexual orientation or their contraception. Later they may involve the doctor and then do have the chance to develop insight and adjustment.

**DR. GILL WAKLEY** works in a family planning clinic where the nurses are friendly and sympathetic and good at spotting distressed patients who need the doctor.

A woman was seeing her G.P. for cystitis and thrush but the soreness continued. She chose sensibly to stay on the pill although her husband had left her and was living with his mistress. The doctors examination and tests were all normal but she said 'feelings of being used or contaminated also cause pain', where upon the patient shared her anger about her husband. Next week the woman telephoned to say the soreness had gone.

Dr. Wakley then described another patient who hurried into the clinic to have her cap checked after having a baby. She complained bitterly that sex wasn't quite right and that she wasn't able to stop work and be with her baby as she would have liked because her husband was still having to support his first wife.

The patient asked the doctor if this was post-natal depression but the doctor replied "No, just ordinary understandable feelings".

At her next visit the woman was much better and felt that she had been able to share her negative feelings and they had been accepted as normal. Both she and the doctor felt that the family planning clinic was a natural place for this to happen and in the course of two routine family planning consultations this woman had been helped.

Dr. Wakley's paper concluded the programme which was followed by general discussion of many of the topics.

A full transcript of the proceedings will be circulated by Wyeth later but this shortened account of the meeting was prepared in the hope that it would be of interest to newsletter readers.

**DR. ROBINA THEXTON**

## NOTICES

### 'Comments to avoid' prompted by DR. GILL WAKLEY

Patients often misunderstand doctors remarks. They seldom question them or challenge them. Doctors are frequently unaware of the patients interpretation of chance remarks. Here are some reminders:

"Could I have a larger speculum please."

"You are too tight today."

"Your cervix looks a mess."

"Now you are this age you must come off the pill."

"I'm just going to take a bite out of your cervix."

There must be many more and perhaps members would like to submit reminders of words to avoid for inclusion in the next newsletter.

## PANEL OF ASSESSMENT

The I.P.M. panel of assessment will meet next on May 9th 1986. Candidates wishing to go before the panel for assessment should apply to the Panel Secretary:-

Dr. Margaret Gill  
10 Peters Wood Hill  
Ware  
Hertfordshire SG12 9NR

## LONDON SOCIETY OF FAMILY PLANNING DOCTORS

All doctors welcome to join.

Subscription £3 per annum.

Clinical meeting held twice yearly in March and October at The Royal Society of Medicine, and occasional social meetings.

**Next meeting** The increasing Problem of Genital Tract Precancer  
**March 14th 1986:** in Young Women.

Speaker Mr. Albert Singer

Application forms for membership from the Hon. Secretary:

Dr. A. Main  
4 Queen Anne Drive  
Claygate, Surrey  
Telephone: Esher 66380

### 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 author's name.

Recently I discovered the document 'Guidelines' which was compiled by Dr. Judy Gilley in 1982. I include it in this newsletter to help doctors analyse and describe their clinical work. Contributions for the May edition to be submitted by April 1st please.

ED

## GUIDELINES FOR DOCTORS WRITING UP CASE STUDIES

**Did he/she study, think about and understand:-**

1. The referral.
2. The presentation (single, pairs, "I always do...").
3. The patient's appearance, manner (evasions, confusions etc.), precipitancy.
4. Why now?
5. The patient as a partner or 'un malade', a boss or an inferior etc.
6. The patient as someone who is in charge of him/her self.

**Did he/she:-**

7. Listen and listen and listen and **think**.
8. Choose his/her interventions thoughtfully rather than respond impulsively.

9. Observe and report the effect of the intervention.
10. What interventions were used?
11. What interventions were thought about and not used?
12. What were this doctor's characteristic defences – Doctorhood, Authority, resort to seminar opinions, books, change of presentation (sending partner out), mollifying, physical examination etc.?
13. What insight into these defences does he/she have?
14. Did he let the patient use him; how did he use the patient?
15. Was the genital examination well timed or defensive or competitive or evaded; how conducted and how used.
16. Does he/she ask of each phenomenon 'What does this tell me about the patient?'

**DR. JUDY GILLEY**

**DR. ELIZABETH FORSYTHE** editor of the British Journal of Family Planning writes inviting members of the Institute of Psychosexual Medicine to submit articles on psychosexual problems for publication if of sufficiently high standard.

Contributors should provide copy to the Editor by not later than the fifth day of the month, two months prior to publication.  
27 Sussex Place, Regents Park, London NW1 4RG.

### **An introduction to Psychosexual Medicine**

**November 28**

A one day course 'An Introduction to Psychosexual Medicine' suitable for general practitioners and family planning doctors, and also a useful introduction for doctors planning to undertake seminar training with the Institute of Psychosexual Medicine. Chairman: Mr. John Guillebaud – Medical Director.

Programme will include videos, lectures and group discussion on: Type of problems encountered; their recognition; doctor/patient communication and methods of treatment.

If you are interested in attending, please send in cheque for £20 (made payable to Bloomesbury Health District). This fee includes coffee, lunch and tea. Enquiries to Heather Goodman, Margaret Pyke Centre, 15 Bateman's Buildings, Soho Square, London W1V 5TW (Tel 01-734 9351).

### **National Association of Family Planning Doctors A.G.M.**

The Twelfth Annual General Meeting of NAFPD will be held at Jesus College, Cambridge on Friday, April 4, 1986. This will be followed by a symposium which will extend to Saturday, April 5.

## **SITUATION VACANT**

### **BASILDON & THURROCK HEALTH AUTHORITY COMMUNITY SERVICES**

#### **PSYCHOSEXUAL COUNSELLOR**

This post is attached to the family planning clinic at the Billericay Health Centre and the session is held on the 1st Wednesday evening in the month from 6.30 p.m. to 9.30 p.m. It may be possible to alter this if absolutely necessary.

It is anticipated that counselling could be carried out by a medical practitioner who has had training in psychosexual counselling, a psychologist, a marriage guidance counsellor with experience in this field, or any appropriately experienced counsellor/therapist.

A sessional fee will be payable according to professional status.

For information and informal discussion regarding this post please contact:-

Dr. M. Heath  
District Medical Officer  
Basildon Hospital  
Tel: Basildon 287611 Ext. 247

Application forms and further information available from:-

Miss V. Harrison, C.A.A.  
Community Services  
Level 'F'  
Basildon Hospital  
Nether Mayne  
Basildon SS16 5NL