IPM DIARY OF EVENTS

June 5 1987 at 2 p.m.
A workshop has been arranged and will be held at 11 Chandos Street. **Dr. Brendan MacCarthy** has agreed to lead it. He is a consultant to the Child Guidance Training Centre, London and a member of the Psychoanalytic Society. All members and associate members are welcome. The theme of the workshop is — **Incest: The Aftermath.**

September 1 1987
Last copy date for the November Newsletter.

September 25/26/27 1987
The Annual Scientific Weekend, Selwyn College, Cambridge.

September 23/24/25 1988
Annual Scientific Weekend, Leicester University.

September 22/23/24 1989
Annual Scientific Weekend, University College, Cardiff

Institute of Psychosexual Medicine

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Council consists of the President and 11 members (E), plus five co-opted members (C-O), one honorary permanent co-option, three ex-officio members (E-O) and one observer.

(C-O) Dr. Jenny Lisle, observer to NAFPD Council; (E) Dr. Anne Smith; (E) Dr. Susan Horsewood-Lee; (E) Dr. Gill Wakely; (E) Dr. Rosemarie Lincoln; (E) Dr. Merryl Roberts; (E) Dr. Ann Parker; Honorary permanent co-option, Mrs. Nancy Raphael; NAFPD observer on Council, Dr. Ann Morgan.

Mrs. Judith Green will be at 11 Chandos Street on Thursdays from 10.00 a.m. until 2.00 p.m.: Telephone 01-580 0631.

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 31, MAY 1987

EDITORIAL

It was in April 1984 that I prepared my first Newsletter for the Institute of Psychosexual Medicine. The task of editor has been greatly helped since then by the increasing flow of articles sent to me by members for possible inclusion in each edition. I hope that this supply of material will continue when Dr. Bramley takes over and prepares the next Newsletter.

Both accredited members and trainee doctors have written of clinical encounters and share them with the readership. There is much to comment on and members are invited to discuss clinical anecdotes as they would in a seminar when clinical facts are reported and digested, conclusions are drawn and lessons are learned.

Dr. Katharine Draper and the Research Advisory Committee are able to help any member to organise and develop research projects. Up to now there have been few calls for their recommendations. Even if each unique consultation is a "research project", there must be much to be learned from the study of themes and settings. My suggestion in the Newsletter of a study of the identity struggles and sexuality of twins produced no response! What about the value of glass dilators in cases of non-consummation? What about the effect of perineal inadequacy on sexual function and the response to pelvic floor repair? What about the effects of redundancy at work, or retirement, or of the challenge of a second marriage?

It is a fascinating area of human behaviour that we doctors are privy to. How wasteful that we each "discover the wheel" and share our discoveries and insights only occasionally and informally. The habits of narrative research and ventilation of insight must continue to develop if the work of the I.P.M. is to become significant.

The truth that sexual abuse in childhood does occur has dawned at last. Society previously denied these possibilities, ascribing such accusations to the wild imaginings of wicked children. In many areas of the country facilities are being developed to help children in trouble. Children grow up. Those whose sexual lives have been damaged by their experiences have often sought help from their doctors. Many did not and they kept their secrets. It seems that more of these will come forward asking for help now that secrecy is broken and sufferers believe that help is at hand.

Fear of AIDS is another new development. If fidelity is the only safeguard other than chastity, then more and more individuals will be trying to make relationships work rather than discarding ones that have become difficult. Human beings have often had the fear that sex is a punishable offence. How many will need help with feelings of guilt and fear of retribution?

These troubles require new skills from doctors. Such ills are not amenable to surgical techniques or medicaments and traditional medical

omnipotence. New concepts of doctoring are required, a revolution perhaps?

Some time ago Council agreed that patients in case studies should be described as Mr. A., Miss B. or Mrs. C. I remind subscribers of this elsewhere in the Newsletter. It seems to me that this formality can often alter the nature of the doctor/patient encounters which we seek to describe. This rule was made when matters of confidentiality were under discussion. However, all case studies are disguised to preserve anonymity. Not all doctors address their patients in one way throughout the consultation. We all have different styles. For some doctors the switch from the formality of 'Mrs. C.' to first name is of considerable significance and consciously done.

When editing I find that changing fictitious first names to Mr. A. and Mrs. C. distorts the account and changes the quality of the consultation that the author is reporting. In this edition of the Newletter the patients are described as the writers intended.

I have broken the rules; perhaps your new editor will not. Support her and keep sending her articles unsolicited. She deserves your support. She cannot write the Newsletter herself.

The vitality and success of this publication depends entirely on the membership. With your contributions and in Dr. Bramley's hands it could become an important and valuable journal. I hope it does.

It is with great sincerity that I wish Dr. Bramley every success in this aspect of the work of the Institute.

Joan Coombs

THE TWELFTH ANNUAL GENERAL MEETING

The twelfth Annual General Meeting was held at 11 Chandos Street on 20th March 1987. The business meeting started at 4.30 p.m. and was attended by almost 40 members.

The Minutes of the 1986 AGM had been sent to all members. The officers had little to add to the reports that had been circulated with the Minutes. Dr. Sheila Filshie drew attention to the fact that there has been a six-fold increase in referrals.

Dr. Katharine Draper reminded those present that the Research Advisory Committee could help members with research projects although few doctors have proposed schemes yet. There has been a pilot study evaluating the criteria for measuring changes in doctors and doctoring during IPM training. Drs. Sneyd and Tobert have been correlating results and there is a second study to be initiated on the same theme.

Dr. Ruth Skrine during her Chairman's address thanked the officers for the reports of their work. She repeated her welcome to Dr. Morgan as NAFPD observer on Council and thanked Dr. Lisle for her observations on NAFPD Council. Dr. Jones was thanked for taking over the administrative duties of the Director of Training at a moment's notice during Dr. Tunnadine's illness. Happily Dr. Tunnadine in improved health was in

attendance at the meeting and Dr. Skrine thanked her for all that she does for the Institute.

She also thanked Dr. Jessie Yorston for her scrupulous accounting as Treasurer. IPM funds do not allow for further development of the work without increasing capital. Council are always looking at ways of increasing capital and suggestions from the membership are always welcome. Many officers do not claim expenses as they should. They give their time and pay their own costs and so the true expenses of running the IPM are not known.

Dr. Skrine thanked Dr. Coombs for work done on the Newsletter and commented on the increased copy and the habit of narrative research that seems to be developing.

In particular Dr. Skrine thanked Dr. Judy Gilley for her efficiency and hard work, deep understanding and tact as Secretary.

The election of Council followed. Six members were due to retire and all the other members were willing to stand again. There were six nominations which filled the vacancies and these were: Dr. Van Hegan; Dr. R. Lincoln; Dr. G. Wakeley; Dr. M. Roberts; Dr. A. Parker; and Dr. S. Horsewood-Lee.

Next the draft constitution was discussed. This was to replace the existing trust deed and was presented by Council with its unanimous agreement. It is vital that the constitution be accepted by the Charity Commissioners.

There was lively discussion about the voting rights of members co-opted to Council and a show of hands indicated that the majority felt they should have the right to vote. Dr. Freedman proposed that the draft should be accepted by the meeting. This was seconded by Dr. Main. There was a proviso that the draft be made acceptable with minor alterations by Council to meet the Charity Commissioners' requirements. Members present voted unaninmously on these lines and there were no abstentions.

The meeting then formally approved the auditors. Thanks were expressed to Mr. Ron Trowbridge whose efforts and work had reduced the auditors' fees.

Under Any Other Business, Dr. Draper drew attention to a job opportunity at the Elizabeth Garret Anderson Hospital. One psychosexual session could be expanded to two or three. Interested doctors should telephone Dr. Elisabeth Mackie on 0698 26291.

Dr. Main thanked the hard-working Council for effort and devotion. This vote of thanks met with general applause. The general meeting was followed by a brief Council meeting and co-options were made.

A most enjoyable buffet meal followed with wine and rich conversation amongst friends and then — what a joy! - strawberries and cream out of season!

At 8 p.m. there followed the clinical meeting. Dr. Judy Gilley spoke on, "Sexuality and Terminal Care". It is hoped that the membership will have the opportunity of reading this most moving paper later.

Dr. Gilley spoke of her experience as a general practitioner caring for and understanding couples when one partner is dying. For one couple, the frigidity of their relationship led to a request for the dying husband to be removed to the emotional austerity of a hospital bed. For another couple the vitality of their shared sexuality continued right up to the end. For others

still, the spark of vitality had become a memory though tenderness and loving touch remained.

It is not the IPM that can claim the compassion and intelligent depth of understanding that Dr. Gilley shared with us. Her humanity and her insights are her own and it was with humility that we listened to her skills and her care.

Dr. Gilley has offered her list of references in advance of the paper. In particular, she recommends Patrick Casemont's book *Learning from the Patient.* The discussion which followed was sad and lively in the face of death. Dr. Gilley's talk provoked much thought and we thanked her for it.

J. Coombs

SEXUALITY & TERMINAL CARE — References

1. Care of the dying in General Practice
   RCGP's outline search with 46 reference available from Dr. Gilley on request.
   Most recommended articles and books include:
   ROSIN (A.J.) & Co-workers (Israel). Understanding the dying patient. *The Practitioner*, Feb 1981. Vol. 225 (1352). pp 196-201.
   REILLY & PATEN. Terminal care in the home. *RCGP's Journal*, Sep 1981. Vol. 31 (230). pp 531-537.
   KUBLER-ROSS, Elizabeth. On death and dying. Macmillan paperback, 1969.
   KUBLER-ROSS, Elizabeth. Psychotherapy with the least expected. *Rehabilitation literature*, Mar 1968. Vol 29, No. 3, pp 73-76.
   PARKES, Colin Murray. Bereavement. Tavistock Publications, 1972.

2. CATH, Dr. Stanley H. and CATH, Dr. Clare. When a wife dies. *Reprint.*
   NORMAN (Malkath T.). When a husband dies. *Reprint.*

3. CASEMONT, Patrick. Learning from the patient. Tavistock Publications, 1985.

HONG KONG: AN EXPERIMENT — Teaching or Learning?

What can one do in two weeks and will it be worth while, were the questions I asked myself as I stood wilting at midnight in a long queue in the Hong Kong Customs Hall? Everyone's luggage was being stirred up or emptied out on to the counter in a search for drugs from Bangkok. The welcome received when I finally emerged soon made the irritating six hours late arrival fade from the memory. Great kindness and generosity characterised the whole visit.

My base was Robert Black Postgraduate College, built in Chinese style with a bright blue tiled roof tilting up at the corners. It had a magnificent view of the mainland and surrounding islands, and of the harbour below. Hundreds of boats were moving in or out, or were at anchor in the sheltered water at every hour of the day and night.

My programme included a public lecture, the Aw Boon Haw Lecture. It is named after the family who donated the funds for visiting professors. I took as my subject, "Another sort of medicine" and traced the history and development of the Institute of Psychosexual Medicine and the sort of training it currently undertakes.

Later, in a question and answer interview with Radio Hong Kong, I indicated the need for and the scope of psychosexual medicine. This was broadcast twice. I visited the Family Planning Association of Hong Kong and was amazed at their progress and achievement over the last fifty years and the variety of services provided, and I was pleased to see that they had started a very good youth advisory centre which was quite separate from the Family Planning clinics.

One evening was spent lecturing on psychosexual problems in Family Planning clinics and another one sitting down with the Family Planning doctors and hearing from them the kind of problems they encountered. In essence these problems seemed not at all different from the type encountered in Family Planning clinics in the United Kingdom. Unfortunately there is no seminar at the moment to discuss such problems. One night I spent two hours with the College of General Practitioners where I gave a lecture, and questions were asked. My main task, however, was to conduct six seminars with a group of doctors who were interested in working with psychosexual problems in their various settings. The group had been selected by Dr. Grace Tang (an Institute of Psychosexual Medicine subscriber). It consisted of eleven doctors: one senior lecturer, two consultants and four registrars, all in Obstetrics and Gynaecology, two general practitioners and one youth health care officer.

I was keen not to waste time but to get straight on with the usual work of I.P.M. seminars, but it seemed that giving a few guidelines at the start of each seminar might be helpful in spite of Hippocrates' adage, "Experience is useful, learning of other people's opinions far less so!" The problem was that I didn't want them to feel that being taught was the way to learn to practise psychosexual medicine. I wanted to set the scene for their work to be reported in a useful way and their participation in the discussion encouraged. I wondered whether giving talks of ten minutes would further my aims or impede them. Each seminar was allotted three hours and all

eleven doctors attended each of the six seminars.

At the first seminar, after introductions, I gave the following short talk:

"1. *Acquisition of skills*

In this series I will not be teaching you any facts as the learning is to do with acquiring skills. Anyone can learn facts from books. To gain skill in cooking, golf or sailing requires more than learning facts. It requires practice and coaching.

2. *Reporting*

Please report to us your on-going work. We would like to hear a description of encounters between yourself and a patient, from the moment you came into contact with that patient by letter, 'phone call or from their simply appearing in your clinic.

Please then give an account of the patient's appearance — dress, manner and behaviour — what she made you feel and how she behaved to you. Describe how the consultation developed — what she did and how you responded. Please do this from memory as the matters you remember and report are of significance and of more importance than medical details read from notes.

Please tell us how the consultation ended and why it ended when it did, and what was done about another appointment. Please then describe how you felt when the patient had left.

3. *Discussion*

What we are trying to do is to study the doctor/patient relationship and the only way we can do that is for you to take us into the consulting room with your description so that we can see and feel what is going on. We are here not to criticize your work as to whether it is good or bad, but to try to understand what is going on and to be interested rather than critical. We can then make comments and give our thoughts about what is going on between you and the patient and thus be able to understand how the patient behaves in her life — and in what way this is proving unsatisfactory or painful to her.

We will study every case described to us and concentrate on each by turn. We will not discuss generalisations or the fact that this case reminds us of one of ours. The latter is not helpful, as all doctor/patient relationships are different. If you are reminded of one of your own cases it may be appropriate to report that case after the first has been fully discussed.

(I will refer to the patient as 'she' although the same principles apply with male patients).

4. *An unstructured interview is useful*

After the patient has indicated that she has a psychosexual problem, then a relaxed sitting back and saying, 'Tell me about your problems' may help. Let the patient develop her story with as little comment as you can manage until you have begun to understand what the real problem is about, i.e. the needs behind her complaint.

It is difficult to break away from the medical model of question and answer and of the doctor taking charge. The patient has to be allowed to, in a sense, take charge of the interview and give you what

information she wants. The situation of sitting and waiting for the patient to speak may be a new one for you. You are giving your whole attention to this story and feeling it with the patient. You then withdraw yourself and try to understand what the patient is doing with you. Then an appropriate comment can be made — 'It seems to be very difficult for you to talk about sex', etc. — and note how the patient responds to your comment.

Question-asking on the whole is unhelpful and leads to what you would like to know and not what the patient wants to tell you. The patient in front of you has the answers to her problem in her unconscious mind. It is up to you to notice and pick up the clues she is giving by her dress, manner and behaviour with you.

Not knowing, being ignorant, is a very difficult position for a doctor to take, but this is one way to tackle emotional problems. You don't have the answers till the patient communicates them to you in some form or another.

A woman tells me that sex is painful and she avoids it because she has been torn during the birth of her baby. When I examine her I find she has had a Caesar. What is she telling me? That her idea of herself as a perfect mother having a lovely delivery is torn up and has caused her great disappointment and pain which she has never been able to share with anybody?

This group does not know the answers — nor do I — but together we must puzzle about and try to understand your reports of what is going on between you and the patient and make some sense of it".

This introduction was followed by a report of a dominating and managing husband who annoyed the doctor. He had brought his wife because she would not allow him to have intercourse. He thought she had some medical condition which prevented her from opening her legs. The woman was quiet but quite willing to open her legs for the easy vaginal examination by the doctor.

The second was an account of a well-dressed well-controlled married teacher. She gave her story of eight years pelvic pain and endless investigations with a smiling face. She hated sexual intercourse and just could not manage it. Her husband had found another sexual partner but this was related with no distress. She left the doctor feeling really puzzled and frustrated.

I felt that these were pretty typical first cases for a seminar. There was a very lively discussion, most of it on solving the cases by behavioural and other methods and not on observing and studying what was going on between patient and doctor. I wondered how much my directive start had led to the reporting of these two cases.

Before the second seminar I talked briefly about the usefulness of the genital examination:

"A great deal can be learnt about the patient's sexual difficulty in the performing of a genital examination where this is appropriate.

We can learn from the patient's non-verbal behaviour. How does the

patient approach the couch, how does she undress, what is her facial expression during examination, her comments, or her tears, or other bodily behaviour?

For example, one rather bossy, very made-up woman got on to the couch for examination — she had rather intimidated the doctor. When the doctor put one hand on her abdomen she noticed the tears welling up in the patient's eyes. The doctor was able then to get in touch with the patient's distress, which was her inability to enjoy sex with a new husband after the death of her first husband some two years before.

The examination is an intimate moment between the patient and the doctor. What she cannot reveal when sitting in the chair she may often reveal when on the couch.

If she has her pants on when you come to do the examination — it may indicate her ambivalence about her right to enjoy her sexuality. She may have vaginismus and not allow a finger or a speculum to be inserted. You have then to try and understand what she is trying to tell you by her actions, as words were too difficult. Her vaginismus may be an angry keeping out of her husband or it may be fear of terrible damage or it may be, 'I'm too small yet to be a wife and mother'. You do not know what it means till you acknowledge what the patient is doing and encourage her to talk about the meaning of it.

One patient who had vaginismus told me that she feared damage. I asked her what she felt about the inside of her vagina and she said it was like raw liver without skin. This was a symbolic statement about the fact that she was thin-skinned and easily hurt. She then told me about all the hurts she had had, and how she could not commit herself to her present husband for fear of being let down and hurt yet again.

The patient may manage to make you feel very embarrassed — in which case you must realise the embarrassment is coming from her, as other patients do not make you feel this way. What is it, then, about this woman, that engenders such a feeling in you?

To notice how the patient is feeling and how it makes *you* feel is a valuable instrument for understanding the patient's problem. When you report physical examinations please notice all the feelings and actions present so that we can feel as if we were also taking part in this encounter. We can then discuss the meaning of it for the patient.

A person's anxiety about their sexual performance or their sexual parts is often their anxiety about themselves as a total sexual man or woman.

A description of a block in the vagina — which is absent on physical examination — may be a statement about a block in their ability to accept themselves as a sexual person with needs and desires which are not wicked, but good and right in the appropriate setting.

Reassurance of patients after a physical examination is often useless in psychosexual problems. It only reassures the doctor. Tha patient goes out knowing she has still got a block in the vagina unless it has been acknowledged and discussed and understood. Reassurance is unhelpful till you understand what the patient's anxiety is really about".

Four interviews were then reported and discussed. One was of a young woman complaining of pain on sexual intercourse since the birth of her baby two years ago. Vaginal examination was quite normal but the woman said she had real fear of another pregnancy because she couldn't manage the lively two-year-old she already had. She made the doctor feel that she was a young vulnerable girl who needed protecting and so the doctor called the husband and told him he must be more gentle with and more understanding of his wife. I felt that in the discussion of this interaction the group began to look at what was going on between the doctor and the patient. They explored what made the doctor call for the husband, rather than a discussion on how to help the patient.

Another woman complaining of non-consummation was described. I have heard many reasons for the refusal of sexual intercourse but this was a new one to me. The patient had a headache and so visited a herbalist. The herbalist had given her some medicine but had told her that a headache like this could prove fatal, particularly if she had sexual intercourse with a man. She said she feared having sex in case she would transmit this headache to her husband or to a child, as well as the threat of death for herself. In spite of this she had got married four months previously but explained the situation to her husband. However, she had kept coming to the hospital and asking for help, but not accepting it in an ambivalent manner, and it was recognised that this girl had fears about her sexuality although they were clothed in an unusual way.

There was an emphasis on non-consummation in the first and second seminars ending with this positive danger of consummation. Was this what the group were feeling about the work?

Before the third seminar I discussed the doctor/patient interaction in this way:

> "In a scientific inquiry you examine the part you wish to understand with instruments devised for the purpose. If you want to see if there are parasites in the blood you use a microscope. In psychosexual medicine the instrument you are using is the doctor/patient relationship which you just enter into — then draw back and look at it in a dispassionate and scientific way and say to yourself, 'What is happening here? What is the patient doing to me and how have I responded and what does that then teach me about the patient and her problem?'
>
> A woman with hair flying all over the place flung open the door of the doctor's surgery and rushed in and without even sitting down said, 'Doctor, doctor, you've got to help me! My husband is being physically violent to me and I've had to sleep on the couch downstairs. I'm feeling terrible and I'm losing weight' — and with this she plucked at her arms to show how skinny and stick-like they had become. It transpired that she hated sexual intercourse and continually refused it and had got her mother and her sisters on her side, agreeing that she had an awful husband. She was also trying to enlist the doctor's support.
>
> What was this woman doing with the doctor?
>
> *(a)* She was demanding the doctor did something for her, devolving all responsibility on to the doctor.

(b) She was trying to get the doctor ranged on her side along with her mother and friends and her sisters against the wicked husband.

(c) She appeared to be an outraged wife to whom terrible things were being done and she had no responsibility for any of them.

(d) She expected the doctor to be sorry and sympathetic with her and put everything right as parents do for children.

The doctor had to show her what she was doing. Being sympathetic with this woman might be comforting but it will not be a bit of use in helping her to solve her problems. Already mothers and sisters were sympathetic and that had only made the situation between her and her husband worse. The doctor had to withdraw from this interaction in which she realised that she was becoming motherly and sympathetic and see what the patient was doing to her.

She had then to ask the patient if she always expected other people to solve her problems as her parents had done. Had she ever looked at the part she might have played in making her husband dissatisfied?

Here is another example:

A man came into the consulting room, took one look at me and said — 'Oh, you're a woman. I expected a man. What do women know about men's problems?'

What was he doing to me — putting me down, trying to make me feel incompetent and useless?

I responded by saying, 'I wonder how often people have criticised you and put you down and regarded you as inferior?' This enabled the man to tell me how he had always been treated as second best compared with his younger brother — who had, in his eyes, had all the advantages: done well, was always being praised by his parents and he felt had supplanted him in their affections. That small encounter showed me the root of his problem.

His complaint was that he just could not bring himself to have intercourse with his wife. He could not get erections, but could manage it quite well with other casual contacts. His wife was longing for a baby and was very upset that he seemed unable to have intercourse with her.

He deep down did not want a child as he could see the child as a potential rival for his wife's affections. When I suggested to him that he did not really want his wife to become pregnant, he eventually agreed that this was so, although he wanted to please her and give her a pregnancy — he was really very ambivalent about it.

He had then to decide for himself whether he would use sheaths and once more enjoy sex with his wife — or put up with the anxiety of their child appearing as a rival and discuss this possibility with his wife.

His anxieties had made him impotent with his wife and these anxieties were apparent in his very first words to me and the relationship he made with me in putting me down and make me feel as he had felt for years with his parents.

I could have responded to the feelings of anger I felt at being put down and said, 'If you want a man doctor, go and find one — I have

plenty of other patients to attend to', but this would not have helped him to understand his conflict at all.

After each interview with a patient ask yourself: 'What went on between us — what did I feel and what did that teach me about the patient and his ways of relating to his partner?'"

After this talk we had three depressing, sad and difficult cases. One was of a woman referred to the sexual difficulty clinic who had been married twice and both marriages were unconsummated. She felt she had been rejected by her mother who sent her to boarding school. Her father had died when she was very young, and mother had many boy friends. In the first marriage her husband had tried to help her. They had been to a Marriage Guidance Clinic but without success — he eventually divorced her.

After ten years she married again and was now separated from an angry husband. Examination showed vaginismus and adductor spasm. In the end the doctor had also rejected her and passed her on to a psychiatrist.

We finally got round to discussing the fact that this was a woman who made everyone reject her, but she had never been helped to look at this.

The second was a 32-year-old depressed woman who had not had sex for four years. She had had pelvic pain for years and sat with her head hanging down. Her husband tried weekly to have sex and she always refused because it was so painful. The doctor did a P.V. which was painless and normal, but the patient's story of one child being sold by her husband because they were so poor, one child dying, her first husband being murdered and the child of her second husband being handicapped, indicated plenty of reason for pain. The doctor colluded with her desire for magic help and prescribed hormones and analgesics which made no difference. A laparoscopy was then suggested and the patient seized on this. After this operation the patient seemed sadder than ever that all had been found to be normal. This case gave us a good picture of evasion of pain by doctor and patient and the result being untherapeutic.

The third was a non-consummation of ten years standing. The wife had felt insulted on the wedding night because her husband had put on the light and looked to see if there was blood on the bed. Thereafter she had had vaginismus and the husband could not penetrate. The mother-in-law and husband had taken the girl to the Philippines to have an operation to make her bigger. This had made no difference to her ability to have sex. The woman's anger was not explored and the doctor felt that the problem had gone on so long that she should send her to the psychiatrist. The woman must have had such an overwhelming anger that the doctor could not tolerate or investigate it and so felt the only course was to pass her on.

I felt disappointed that this case had not really been treated at all. I think the whole group felt depressed by these cases reflecting the feelings of sad and angry patients. However, it did indicate that this work is not easy but often painful if it is really pursued.

Before the fourth seminar I talked about what sort of doctor the patient meets and the importance of the referral:

"A doctor who worked in a family planning clinic but who was interested in psychosexual problems, received a letter from a psychiatrist asking her if she would see a woman who had lost all interest in sex since she had reached the menopause. The doctor then became anxious — 'How does the psychiatrist expect me to do better than him? I will have to do very well with this patient to show him my work is worth while'. When the patient comes in, who does she meet — a quiet calm relaxed doctor, or a doctor who has been put on her mettle or made anxious by a psychiatrist's letter? The patient meets an anxious doctor. This must be taken into account when we study the doctor/patient interaction — because something has altered the doctor even before she met the patient.

One young doctor was reporting to a group and she said, 'A general practitioner wrote to me asking me to see a middle-aged man with impotence'. She said, 'I've never dealt with a case of impotence before'. Instead of calming down and following her usual procedure of listening to the patient's story and trying to understand the doctor/patient relation, all her wits departed and she acted in an uncharacteristic way which did not really help her to understand the patient's problem. This patient therefore met a doctor who had lost some of her efficiency because of the effect of the referral letter.

If patients are referred to you, it is usually because you are thought of as the expert — and we feel anything but expert when we meet psychosexual problems — we know we have to be ignorant until the patient somehow gives us the clues to the answer. We have to remind ourselves that our function is to listen and to think, whether people think we are expert or not — but even the listening and thinking disappear when we feel that the referring doctor is expecting a lot of us. We start trying to think of clever solutions to the patient's problems — instead of letting her tell us the answer.

A patient, Mrs. A., requested a visit to my psychosexual clinic and so her doctor wrote asking for an appointment. She was given a date and time and she sent a note saying she was sorry she could not keep that appointment. She was sent another appointment — she wrote back saying that appointment was also inconvenient and she gave a list of dates when she might be free. This went on over about six months and I began to think — if this woman really wants to come she will make an effort to attend one of the appointments given to her; but then I thought — this really tells me something about the patient. She made the effort to go to the general practitioner — she wrote to us several times and yet she had not appeared. She was really ambivalent about discussing her difficult sex life with me — which was a picture of her ambivalence about having a sex life at all with her husband. She could not commit herself either to me or to her husband and when she finally appeared I was able to show her this and explore the reasons for her ambivalence. What happens before the patient actually appears can be quite important both for our part in the interaction and for the understanding of the patient's attitudes.

Being aware of what sort of doctor we are when the patient enters the

room is very useful if we are really going to study the doctor/patient interaction. A general practitioner was sitting in her evening surgery late on Friday at the end of the week. She was tired and looking forward to her supper and to relaxing with her feet up. While she had this peaceful picture in her mind the last patient came in. He was a young newly married man and he said he had got a cold and a chest infection. She groaned inwardly as she had had to explain to about six other people with colds that night, that antibiotics were no use for colds — but then the boy coughed and she thought, 'I had better listen to his chest'. As she put her hand on his shoulder and her stethoscope on his chest he then said, 'I've got another problem — my sex life is terrible'. At this point the doctor's heart went to her boots as she realised her supper was receding. What sort of doctor was she now? She felt guilty because the boy actually had bronchitis and needed antibiotics and she had misjudged him — so she settled down to listen to his problems. She could have said, 'Come next week and we'll discuss these things' — but she felt he had plucked up a lot of courage to come and might not come again.

When the patient produces the problem — this is the time to listen to it and this also is the time when the patient is ready to work with you and he will try to gain what insight you can give him.

A general practitioner was sitting in her surgery one sunny morning when she looked out of the window and saw one of her patients getting out of her car and her heart sank as this patient always made her feel depressed and sad. Instead of realising that she must make the patient tackle her own problems, she just felt the awful feelings that came upon her each time she sighted this patient. The patient usually dumped all her miseries on to the doctor's plate, expecting her to deal with them all, and left the surgery much happier, but leaving a burdened doctor and her own long-term problems unsolved. If the doctor had never met this patient before she would have listened to the interview with a much more open mind and perhaps realised what the patient was doing to her.

A psychiatrist sent a man with impotence to me and in his letter said that he was not very promising material and he did not think the man could improve much. This inevitably set my mind in an attitude before the patient entered the room, but by the end of the interview I was surprised to find that I had a great deal of respect for the patient. It is so easy to collude with what you are told about a person instead of being absolutely fresh and with a clear unprejudiced mind when you are faced with a new patient".

The three interviews which were described at this seminar all seemed to indicate that the doctors were ambivalent about what they were doing. The first was an encounter with a young woman who had been unable to have sexual intercourse and complained of pain when the husband attempted it. When a vaginal examination was done the doctor thought she had a thick hymen that needed surgical intervention, but he first tried behavioural therapy which did not work. He then suggested operation but said she must make the choice. He finally did an operation, but was not sure whether the

woman finally enjoyed sex thereafter. There was a lot of critical discussion rather than discussion of how this patient had made him so ambivalent about whether the cause of her trouble was physical or emotional.

The second case was presented by a doctor who wondered whether this was a case or not and should she just leave the patient with her own solutions?

The patient came with a discharge which the doctor suspected might be some sexually transmitted disease. When it was discussed the patient told her that her husband was possibly having an affaire because their sex life was so unsatisfactory. They lived in a small room with two double beds in it for themselves and their two daughters. Over a low partition slept mother-in-law. In the middle of the night the husband would start to have sex with her and it would be over in a minute. The woman spent a great deal of time playing Mahjong with her neighbours and mother-in-law did the cooking. She said she was quite happy because her husband had a good job and brought home the money. So the doctor wondered whether she should disturb this situation. The patient had said she did not want to upset her husband by talking about their unsatisfactory sex life and it was obvious that she did not want to disturb the doctor either because she ended up by comforting the doctor and telling her not to worry and treating her like a child. These observations were not used by the doctor with the patient but were discussed by the group.

The third was about a patient who wanted an abortion at twenty weeks after deliberately getting pregnant hoping to keep a failing marriage together. Her husband was having sexual intercourse with another woman. The doctor tried to persuade the patient not to have an abortion because it was dangerous, but the patient then threatened to commit suicide because her husband said he would divorce her and give her no support if she had the baby. After a lot of discussion, the visit of an angry husband, and a discussion with her closest girl friend, the patient finally decided to continue with the pregnancy and have the baby adopted. The doctor then wondered if she had been too persuasive and the patient was not really making up her own mind. There was a good attempt at discussing what was actually going on between the girl and the doctor, but the material of the case seemed to indicate some ambivalence about the work.

Before the fifth seminar, I discussed how the consultation ends:

> "Sometimes the patient keeps the most vital bit of information to the end, such as the family planning patient who says as she has her hand on the door, 'By the way, I don't know why I bother about the pill because we hardly ever have sex and I don't enjoy it'. This may tell you that she is wondering whether she has a right to enjoy it or if it is legitimate to talk about such things to the doctor. It is a signal for us to ask the patient to come back and encourage her to talk about the problems with sex. Although time may be short, a willingness to start will help the patient to see that she has permission to discuss such a subject another time.
>
> A young woman who had been referred to me with sex problems, spent an intensive half-hour pouring out her problems and then rose up without a smile or a word of thanks and with hardly a goodbye, left the room. After she had gone I suddenly realised that she was enacting what was her basic problem — she loved her husband and her children but had extreme difficulty in voicing or showing them by touch or words that she cared for them. She had all the feelings inside but could not let them out. I failed to catch her and say, 'I see you can't even smile at me as you leave. Your feelings are still bottled up!' She gave *me* the same feelings that her children must have had, as I felt when she left that she had not appreciated the time I had spent with her.
>
> At the end of the interview a patient may say, 'I'm afraid I'm wasting your time, doctor'. They may be dubious about their intrinsic value as persons or may feel they do not deserve sexual happiness. This may be commented upon to help the patient to understand her attitude.
>
> If a patient is excessively grateful to you as they leave — there is some message in that for you to understand. A widower who was impotent with his second wife gave me the clue to his problem in his parting behaviour of excessive gratitude. He needed to keep women happy and he could not see how to keep his wife happy and his daughter happy, as he felt his daughter would be upset at his enjoying sex when her mother was dead. He found the solution of impotence.
>
> You might ask in the same way, 'What sort of doctor did the patient meet? What sort of doctor did the patient leave behind?' — A happy satisfied doctor that the patient had been helped? A depressed doctor who felt it was all hopeless? — These feelings are reflections of the patient's feelings and should be studied".

Among the cases presented was a girl who had had a miscarriage and was still bleeding at the time of her postnatal examination. She refused vaginal examination and said she would come later for it. She told the doctor rather angrily that her mother had abandoned her as a baby and that a Buddhist nun had brought her up and now the nun had died. She kept coming to see the doctor and refusing examination and the group pointed out that this girl had found a substitute mother and had devised a means of not letting her go by continuing to evade the postnatal examination and insisting on another appointment. The girl was also ambivalent about whether she could be a mother or not. This case made me feel that perhaps there was some anger or sadness at the prospect of the seminar ending and it was actually voiced by one of the doctors after we had finished discussing this case. We then went on to the roof as it was a beautiful day and photographs were taken to remind us of each other: perhaps an unconscious symbolic act!

In the final seminar I talked about our desire for certainties and our need for defences:

> "You will feel dissatisfied with not receiving certainties from me: rules or lists or even a lot of knowledge about sexual behaviour.
>
> There is a need for certainty and knowing, both in ourselves and in our patients. 'Have you not got a pill or injection, doctor, that will cure my loss of interest in sex?' Working with uncertainty is threatening but is inescapable in this work. Training enables you to see that open-mindedness, and the ability to go on thinking about what is in front of

you and not to reach for certainties and answers, is a rich therapeutic skill — rather than being seen as frightening ignorance. Through it we can continue to apply our thought until the understanding of this particular patient's problem becomes clear. Both doctors and patients use defences to stop them looking at uncomfortable pain. Both also use defences against work — i.e. not going on thinking and working at anxiety-producing problems. Defences are also used against fear and against embarrassment.

One of the doctors in a group described a patient who telephoned the family planning clinic and asked if she could come for an examination because she had a cyst which was causing her pain.

When she arrived a nurse took her particulars and found that she was menstruating. The nurse came to the doctor and said, 'She's menstruating, perhaps you'd like her to come back for examination next week?' The doctor then went and asked the patient if she was actually bleeding and the patient said that she was not. Then when asked to get on the couch she said she had a Tampax in and finally when she went and took it out and came back she got on to the couch with her pants on. She was putting up one defence after another to avoid looking at her sexuality. Finally the vaginal examination took place and there was no sign of any bleeding or any cyst, but the patient said, 'What is the pain, then?' It turned out to be the pain of a very unhappy sex life which it was difficult to look at and explore with the doctor. She was in distress but still put up defences to looking at her real problems.

Another doctor in a group described a patient who wanted to come off the pill to start a baby and then said she had a bit of difficulty with sex. She wondered if her husband was going into the wrong hole — she did not know anything about her vulva or vagina and her ignorance was a defence against looking at her anxieties about sex.

When on the couch the doctor suggested that she explore with her finger to ascertain the vaginal opening; the patient said she was a Christian and that was masturbating and she would not dream of doing such a thing. She was putting up a religious defence against examining her sexual anxieties. The defences have got to be spotted and discussed with the patient. Perhaps with, 'It seems that sexuality is so frightening to you that taking an active part in sex life with your husband presents you with much anxiety — can you tell me about it?'

Mrs. C. came to the doctor to change her pill for some medically safer contraceptive. Near the end of the interview the patient said, 'My husband has a problem — he's not interested in sex. We practically never have it'. Was the change of contraceptive just a respectable visiting card to talk about a sex problem? The patient was immaculately dressed and very beautiful and the doctor somehow felt she could not explore with this beautiful woman a sexual problem, so instead of asking the woman to discuss the problems with sex, she said, 'Come back and bring your husband' — which was the doctor's defence against the awful feeling of 'What on earth do I do next with this stunning woman with her sexual complaint?' The patient who

comes is the one with the problem and this should be investigated and not avoided. It was perhaps this woman's very untouchableness that was making a problem for the husband. Sending for the partner is a good defence against looking at that which is in front of you.

When the man eventually came with his wife, the doctor again defended against work at the problem and, instead of exploring the reasons for the husband's inability to have sex, found herself discussing his lack of employment, difficulties with neighbours — instead of saying, 'What is your problem with sex?'

A doctor described a very overweight 21-year-old girl who came complaining of infertility. It transpired that they were not having intercourse because she disliked it. The whole interview was taken up with the patient's overweight problem and the sex problem was avoided by both doctor and patient. It was easier to talk about weight. The doctor only realised after the patient had left the room that the patient's defences had stopped her looking at the problem which she had originally presented.

Patients do peculiar things to us to make us put up defences against looking at the problem in hand; they can stop us from sticking with pain till we understand it, or enduring embarrassment till we can help the patient understand the anxieties that are making him embarrassed.

This kind of work is not easy, ever. It involves going through painful and difficult feelings with patients which we would much rather avoid — but if we can be interested in these awful inadequate or painful feelings the compensation in work satisfaction and helping of patients can be very rewarding".

Among the last cases to be presented was an angry woman who for years had complained of pelvic pain. No physical cause had been found and so she had been sent to the psychosomatic gynaecology clinic which has recently been started. She told a story which blamed everyone but herself for her various troubles. Her husband was a violent man who was always hitting her and finally had broken her ribs. She had gone to the herbalist who gave her some medicine. After taking the medicine for some time she discovered she was pregnant, so went to the hospital and asked for an abortion as she feared that the medicine could have damaged the foetus. She was refused an abortion as she had insufficient reason. Her sister suggested taking her to China to get it done. They went, paid the money and she was to come for operation the next day. The clinic had looked filthy and she wanted to go home, but the sister persuaded her to have it done. Since then she had had pelvic pain. She had been to numerous doctors and had lots of tests and antibiotics but no-one had really listened to all he complaints.

The doctor tried to resist giving further treatment but finally gave vitamin C. When the patient returned she was much better. She had take some responbility for herself and divorced her violent husband, and was going to start a new life. The pills she had felt were very good and strong because after three days she had come out in a rash and she felt the bad infection was coming out and that the pills had done their work, so she had

stopped taking them.

The group felt that the doctor had given this patient confidence to stand up for herself and take responsibility for ordering her own life.

Another case reported was of a woman who did not want sex but wanted her marriage to be good. She complained that the three teenage children who slept in their only room could see and hear them. She had asked her husband to move the bed round so that they were more private. He had refused saying that it would take up more space and there would not be enough room when their relatives came to visit. The busy doctor had allowed enough time for this woman to discuss all her problems although she could see the big pile of case sheets on the desk, of patients still to be seen. The doctor suggested that she had found a bad solution in sex refusal and this was making things worse not better, thus depriving herself as well as her husband. She felt that the woman had gone away and really worked at the problem for herself. She came back later looking very pleased and said things were much happier between them. They had started sex again and the husband said when he had time at New Year he would move the furniture round. She would not need to see the doctor again. She had been able to use the doctor's help and get on with things for herself.

The final case was of a young girl whose mother was in Australia and who complained of terrible itch down below which she said had been caused by a gynaecologist who had examined her without gloves on. She had consulted the gynaecologist, complaining about trouble with her periods. Somehow the examination had taken away her virginity or made her dirty. She now refused vaginal examination and introital swab tests all proved negative. On the third visit the itching had subsided and the doctor said all seemed better now, but the girl insisted that she needed another visit. She was given one for four weeks, but told that if she really felt she needed to come she could telephone for an earlier one. She telephoned and asked for one in two weeks and then never turned up.

The group decided that she could now do without her allowing mother-figure who had helped her to realise that a vaginal examination did not make her dirty or lose her virginity but was perhaps a part of her growing up process. It was now time for her to face adult life on her own.

This seemed to me to be a fitting case on which to end. The group were now going to make their own arrangements to have further seminars if they wanted.

A large and beautiful cake appeared at our last tea break. It had "Thank you" on it. It was a nice symbol of their appreciation of the work we had done together.

CONCLUSION

I had tried to think of some way of monitoring any progress made during the seminars. I decided to fill in a form for each doctor every time they presented a case. Thirteen different qualities in the case reports were graded and noted. I recorded these immediately after each seminar without reference to previous entries. At the completion of the course the scores were reviewed. I found that the three doctors who had each presented three cases had increasing scores with variations of different characteristics. The

four doctors who had each presented two cases all had improved scores in the second cases. Three doctors presented once only and one doctor presented no cases but played an active part in discussion.

What can one do in two weeks of seminars? Does it help to give guidelines before starting? I cannot answer the questions. I must be content that all the doctors attended all the seminars. There was very lively discussion. There were plenty of case presentations. Some of the doctors were really keen to continue studying the interactions with patients.

My final experience in Hong Kong was a very pleasant occasion when Professor Ma, the head of Obstetrics and Gynaecology at the University Hospital of Queen Mary, took me for a tour of the New Territories. We went to the border of China and to her lovely cottage and garden which has a magnificent view of Lantau and other islands. There she cooked me a beautiful and delicious dinner of fresh shellfish and I began to feel that living in Hong Kong could be a very happy and delightful experience.

As the Jumbo jet roared down the runway between the high buildings and towards the sea, I hoped I was more sure of the pilot's accomplishments than I had been of my own achievements during a very happy visit.

Dr. Morag Bramley
Member of the Institute of Psychosexual Medicine

Queen Mary Hospital IPM Seminar, Hong Kong. Back row, left to right: Grace Tang, F.W. Chang, Barbara Grazette, Wendy Mak, Katharine Siu, Paul Siu, Katharine O'Hoy, C.P. Lee. Front row, left to right: Nancy Fok, Amelia Wong, Angela Ng, Dr. Bramley

IMPEDIMENTS TO HAPPY SEX

"Doctor, we have not been able to make love for two years because I am so sore inside".

"Doctor, I have got this awful discharge. I cannot possibly let my husband near me".

A woman who brings such a complaint to a doctor in a psychosexual clinic, often as a last resort, almost always knows that she is capable of happy sex and has experienced it in the past. She has a physical symptom and is understandably convinced that it must have a physical cause. Indeed, such was commonly the beginning of the trouble. There has been a monilial or trichomonas infection which has been diagnosed and treated. Later repeated swabs have been reported to be clear. But the symptoms persist. Anxiety and resentment are added to the initial distress.

The G.P. is puzzled and helpless and refers his patient to a gynaecologist. She awaits a hospital appointment (usually on a non-urgent list), convinced that she has an illness which no-one is helping her to overcome. The daily effect on the relationship between husband and wife is not difficult to imagine.

The Girl in Mourning

Case 1. Mrs. A. is an intelligent, attractive young woman of 22, doing well at her job in an office. She had been married for two years and was much in love with her husband. Their sexual relationship had been very good premaritally and for the first six months of their marriage. Then she had developed a discharge and was found to have a thrush infection. This was treated and Mr. and Mrs. A. were confident that soon all would be well. Temporarily this was the case but soon the symptoms recurred and this time there were no other very positive physical findings. She was referred to a gynaecologist and finally reached me in a hospital psychosexual clinic. She tried hard to maintain her composure but was soon sobbing uncontrollably. Love and libido were strong and the pain which prevented the expression of both caused her the deepest distress — "I want to so much, but the pain won't let me".

"Tell me something about yourself", I suggested. The story unfolded. Her mother was found to have breast cancer when my patient was 15 and died when her daughter was 17. They had been a warm and loving family and now there was a sense of desperate loss. Getting married without her mother's help was very hard. My patient cried and cried. She had two brothers and after her mother's death she had tried hard with her father's help to look after them and to keep the home going. Often she had held back her own tears and got on with what had to be done. About a year ago her father had announced his engagement to a younger woman. "She is great", Mrs. A. said, and cried.

We met about five times and shared the grief. We both realised that the recurrence of symptoms after the initial improvement coincided with her father's engagement.

She came for her last appointment to tell me that she was well.

Intercourse had been resumed with full pleasure. Her father had married and she had found a friend in his wife. The four of them were playing tennis together.

The Girl in Conflict

Case 2. Mrs. B. was a successful 30-year-old business-woman, going steadily up the ladder of success. Her face had the beauty and composure of a Madonna. She came as a result of referral from a gynaecologist who could find no physical reason for her persistent vaginal soreness although initially there had been a trichomonas infection. Intercourse had been prevented by pain for about two years but had before been very good. She was sure that a physical malady had been missed.

She had been living with her partner for ten years. As she described him they appeared to be an oddly assorted couple. She is a graduate from a professional family. He is a self-employed craftsman, who comes from a stable but unsophisticated background. Her earnings are considerably higher than his.

I encouraged her to talk about herself; about their relationship and their long unmarried togetherness and about the attitude of her family. I had to repress the "French Grandmother"* which is a part of me and which felt an old-fashioned uneasiness. She talked but she denied all anxiety or conflict on her own part or that of her family. Just occasionally she allowed herself a mild criticism of her partner's lack of a very dynamic personality, but I came to believe that she loved him. She assured me that her family — although in general holding conservative views — had fully accepted the situation. Her composure never slipped and the pain persisted.

We met at about monthly intervals for six months. The last time I saw her she came to tell me that she was much better. Intercourse had been resumed with full satisfaction and they were getting married. I hope that I did not show the amazement which I felt. I do not know what has happened, but I assume behind the unwavering control, silent work was going on and that inwardly she was no longer denying but tackling her conflicting feelings. I wish she had let me share them.

The Girl troubled by Guilt

Case 3. Mrs. C. is a teacher in her early twenties who had been married for about three years. She had complained almost from the beginning of profuse vaginal discharge. This had been fully and lengthily investigated at a gynaecology outpatients' clinic. The referral letter from the Consultant indicated some despair.

I saw her twice. The first time she told me her story. The second time she insisted that her husband should be with her. She came from a devout Non-Conformist family. She had enjoyed going out with boys in her teens, but had not had a sexual relationship until she fell in love at eighteen. For a short time she was blissfully happy but then her boyfriend rejected her. There was a period of acute unhappines and despair, which was followed

*"French Grandmothers" are hard-headed and full of practical commonsense. They find it hard to keep up with changing values. — ED.

by intense anger with men in general. She went out with any man who asked her and became sexually promiscuous but allowed no relationship to have any meaning for her. This went on for about two years, until she became painfully aware of how she had been behaving and determined to end this chapter in her life. She went to a Teacher Training College, where she met her husband. She told him the whole story but this did not prevent the growth of their loving relationship. Initially their sexual relationship was very good but soon the discharge intervened.

At our first meeting I wondered aloud whether the physical discharge was a physical expression of her sexual guilt and that perhaps she saw it as a punishment for her misdeeds.

Our second meeting, of which her husband was a silent spectator, had the nature of a confession. Her husband and I both knew of the events of earlier years but she had to tell us almost compulsively, in great detail, all that had happened.

I do not know how she found absolution because I did not see her again. Soon after our last meeting she sent a message saying she did not need to come again because now all was well.

Dr. Alexandra Tobert
Member of the Institute of Psychosexual Medicine

PELVIC INFLAMMATORY DISEASE: conflict of needs or lack of hope?

Lyn came to the clinic with her partner, Bob. They looked a pleasant couple in their mid-twenties. They had recently attended another therapist and undertaken sensate focus, but with no improvement. Lyn had heard from a friend about our clinic. Bob came in with Lyn because he wanted to be involved and give Lyn support. Throughout the consultation he made a few pertinent remarks, but generally left the talking to Lyn.

Lyn told me that her problem had started six months ago; she had gradually lost interest in lovemaking because of pain on intercourse. She also told me that one year ago she had developed salpingitis; this had been diagnosed in hospital by laparoscopy and vigorous antibiotic treatment given. She had had a couple of recurrences since then. After this illness intercourse had always exacerbated her discomfort, but until six months ago it had not been a problem — she could cope with it because she knew what it was. Now it was different.

I also learned that in hospital she had been told she would be sterile. I asked her what she felt about this. In a calm and sensible way she said she could accept this; she had never really wanted children in any case, but she thought it was unfair on Bob. At this, Bob spoke, to say that it didn't make any difference to him — he just wanted her. Lyn's demeanour was so calm and sensible that I began to accept that she had no qualms about being infertile.

We talked about the pain and discomfort. To Lyn there was a difference between her grumbling P.I.D. discomfort and exacerbation on lovemaking

and this more recent pain on intercourse. She readily agreed to pelvic examination, which was easy and uneventful apart from some tenderness. This seemed to round off the session. She made another appointment.

On her next visit Lyn came alone: she had broken off her relationship with Bob — not because of her fertility or the dyspareunia but because of his *"possessiveness"*. She said this word with some emphasis and I commented on it. (I felt surprised at this turn of events as they had seemed an ideal couple).

Lyn responded by telling me about the relationship; they had met at a friend's party and were attracted to each other. Soon afterwards Lyn went abroad on holiday. She was very surprised to find Bob at the airport, to meet her with a huge bouquet of flowers. In the taxi home he asked her to come and live with him, and she agreed. I remember my own feeling of surprise at the swiftness of her agreement, and I asked her about it. She said it seemed right at the time, but looking back on it she realised she made the decision for the wrong reasons — out of pity, and for somewhere to live so she could get away from the family. This last was also the reason that carried her into her first marriage. Her husband was violent to her, and after sticking it for a couple of years she divorced him. I asked her why it had seemed important to get away from the family. I had to say little after this, she wanted to tell me the story.

Her parents were divorced; her mother had walked out on the family when Lyn and her two sisters were in their early teens. Lyn hated her for this at the time, but in recent years had come to understand it. Now they all have a good relationship with Mum. Father was described as possessive, demanding and destructive. Lyn always felt torn between contempt and pity for him, and this was an ongoing conflict. Though he now lived alone he was always 'phoning her asking for contact and money handouts. In different ways her sisters had broken their emotional link with him. Lyn had been unable to do this, and was becoming more distressed by her conflicting feelings towards him. Her mother and sisters were always urging her to ignore him. At this point I allied myself with them, urging her (and perhaps giving her permission) to break the link.

Lyn wanted to make another appointment. She returned a month later looking very happy. She had a new boyfriend, and the relationship seemed just right. She wanted intercourse and enjoyed it, but ten minutes later developed pain deep inside. The pain was not present during intercourse and was gone by the morning. She had also had her background pain for the past two weeks and was due to see her gynaecologist the following week.

I remember comparing Lyn's symptoms to other patients I had met with acute salpingitis, and she did not match. I could only think of one other patient who had repeated recurrences of P.I.D. pain, but her pain and description of it seemed different to Lyn's. I wondered what her gynaecologist made of it. Lyn had seen him several times since her initial illness. I asked her what he had said. Lyn replied that he had warned her about recurrent or persistent pain because the tubes had been badly infected. She had said she'd like "the tubes taken away" and then she'd be free of the pain. He had replied that he wouldn't consider operating, or if he

did it would be a hysterectomy. Lyn said she didn't want it "all taken away". The word "all" caught my attention, and I asked her what she meant by "all". Lyn thought this meant that the uterus, tubes and ovaries would be removed. This would deny her the chance of test-tube babies. (Obviously her thoughts had been running ahead, seeking a solution for the infertility she professed not to be too worried about). She told me she had talked about being put on the list for test-tube babies, and the consultant's secretary's reply was that it was a two year wait. Lyn never was put on the list. She sounded disappointed when saying this, and I asked her about this feeling. She replied slowly, "I never seemed to hear what I wanted to hear". This phrase seemed to me to encompass not just that incident, but to span all her hospital encounters.

I asked her if she wanted a baby. She didn't answer. I asked if she was using contraception. "Funny you should ask that", she said, "A friend of mine has recently asked me the same question". She was silent again, and after a short while I talked about other patients I had seen who had had P.I.D., had been told they would be sterile, therefore used no contraception, but did get pregnant — not always at the best time in life, which then caused other difficulties.

Lyn thought for a while, and then said perhaps she should have some contraception as it would not be right to get pregnant now. We talked about contraception, and I prescribed the pill.

Her next visit was brief. She was "fine". The pain that came after intercourse had gone. She still had her chronic, grumbling P.I.D. pain and, though it troubled her occasionally, she knew what it was and could cope with it, as she always had done. She and her boyfriend were engaged to be married. "I know it's right this time", she said.

She had also got Dad into perspective. She had not abandoned him but dealt with him on her terms, and interestingly he was contacting her less often.

I seemed to do very little except listen in this case. I guess that's what Lyn wanted as she had abandoned the advice and instruction approach. I tried to work out why she had got better — what were the pertinent moments in our meetings?

The first session appeared to show a warm and sensible caring couple. Her supposed sterility was apparently only "unfair to Bob", or was this Lyn's excuse to end the relationship? Did she find it hard to hurt Bob? — as she found it hard to hurt her father. Was Bob's comment that he "only wanted her" relevant to her later charge of possessiveness?

In the second visit I learned about the feelings in her relationship with Bob and her family, relationships that were draining and destructive, and built on pity and guilt. Lyn had discovered these herself between visits.

The third visit was about the pain again — the two different pains: the known pain of P.I.D., which she could cope with, and the other pain of unknown origin. I learned I think about her feelings re the P.I.D. and her communications from the hospital. It seemed to me that what was lacking was "hope", and by exploring what had happened at the hospital we were able to see Lyn's desire not for certainty re her fertility — she was too sensible for that — but for hope. We had not discussed hope directly, but in

retrospect it seemed to me that this was what our conversation was about — hope and possibilities. Once she had hope, her troublesome pain disappeared.

Dr. Beryl Tully
Member of the Institute of Psychosexual Medicine

ABSOLUTION?

This patient was referred to me following the birth of her baby, by the nurse from a Family Planning clinic, because she complained of dyspareunia and aching in the perineum after a forceps delivery and an attack of haemorrhoids which were very painful. She had been seen in the post-natal clinic but nothing had been found to be abnormal and she had been told that it would eventually settle.

She came with her baby and I was impressed by the fact that he was such a happy little child, smiling, quiet and obviously very settled in general. She began to tell me that, although she had enjoyed having him, ever since the birth she had this constant ache in the perineum. She did not want to have sex and found every excuse to get out of it. Her husband had been very pre-occupied with his job and was unhappy with his work.

She felt that she could not do very much to help him. Talking about her past life I discovered that, as a child, she had been rather a 'shrinking violet' and she volunteered the information that her mother disliked her for this. To me, she came over as a person who liked to be in control and we discussed this. She told me that eventually she became a hotel receptionist and had gained a great deal of confidence but, as she talked, I felt that she was wanting someone to love her.

I asked if the pain had been there constantly and she replied that no, it hadn't; she and her husband had been on holiday and it had disappeared completely. This intrigued me and I asked who had taken the responsibility for organising the holiday. She said her husband had done everything and looked after her. I interpreted this saying maybe she felt cherished and loved if he was prepared to take the responsibility and look after her and that she had not found it necessary to be in control in this situation.

In view of her symptoms, I did examine her but found nothing wrong with the perineum and no pelvic discomfort and in fact she exhibited no signs of distress on having a vaginal examination.

I gave her another appointment, thinking to myself, 'I don't think this will take long to sort out'. How wrong I was! She came back a week or two later and had thought a lot since her last visit. She had talked things through with her husband, but then he had had to go to the general practitioner because of pains in his chest and had been given tranquillisers.

At that time she realised that she wished to be in control but that she could now allow her husband to take charge sometimes and sex had improved. Unfortunately, the more they talked about their problems, the worse sex began to be and, eventually, she ceased to want sex at all.

On the third visit, he came with her; things were improving but were not

quite right. She still felt she had to control everything; she said things were going round in her head. I asked her what was upsetting her and she talked a lot about her mother and how insensitive she had been to her needs when she was growing up. She complained that sex was never discussed and that she could not confide in her mother at all. I felt that she had found a new kind of mother in me and I put this to her, pointing out that she had been able to discuss sex with me. She cried quite a bit and I felt that maybe I had at last given her permission to be 'sexy'.

On the fourth visit, she came along and said that throughout all her life she felt that she had to be perfect because mother would be so disappointed if she was not. All the other children in the family had followed their natural inclinations but she felt that she had to behave absolutely perfectly if she wanted her mother to approve. I remember talking to her at this visit about her baby and about the fact that he would not grow up to be perfect and that, in fact, he would be quite naughty at times but that it was important not to have too great expectations of children but just to love them.

By this time, I was getting quite desperate, as we did not seem able to resolve the problem at all and, at that point, I suggested that she should come on a weekly basis. The following week, she said she felt very uptight after the last visit, and the pain had returned to her pelvis. She talked again of her mother and her mother's aggression and how painful it was to dislike one's parent. I pointed out that it was not absolutely essential to please everyone, but I felt at the end of the interview that we had not really got any further, so the following week she came back again.

She said there was something still worrying her and that she was quite certain there was something in her past which caused her to be like this. I was struck at the same time that the baby seemed to be very agitated, crying and fretful, so that we talked instead about whether or not he was getting a tooth. She said, 'I am sure that there is something that has happened to me that has caused me to be like this'. I asked her to tell me, then waited. After a few minutes, she said that as a child of about twelve or thirteen, she and her sister had accompanied her father to his allotment. They had wanted to make a truck and, as the man in the next allotment had some wheels, they went to borrow them. When she got there, the man put his hand down her trousers and touched her.

At this point, she cried bitterly and said that she had not been able to tell her mother what had happened because she was so ashamed. I wondered about the guilt she felt. Did it come later as she grew up and realised the implications? Perhaps she had sexual feelings at the time but later learned to be ashamed of them. I shared my thoughts with her.

She left very upset and miserable and I arranged to see her again, in a month's time, at her request, because she felt she could not go through the trauma of talking each week.

To my surprise, she arrived looking cheerful, happy, calmer, with a very happy baby and said that everything was now quite all right and that sex had never been better. I asked if she could possibly explain why she felt as she did now and what had happened in the previous interview to make her change so radically. She said that as we talked about the guilt that she had always felt, she 'felt the knots untying in the pit of her stomach'. She felt absolved and she felt free. As her troubles had resolved, so had her husband's tension lessened and he was now happy at work and they were happy at home.

Dr. Lorna Sykes
Member of the Institute of Psychosexual Medicine

A MEETING WITH THE ACCREDITATION PANEL

The day started quietly, a rainy November morning and, still sleepy from an early start, I was taking a late breakfast with my family before parting, they for the Cromwell Road and the Science Museum, and for me, the Panel meeting in Chandos Street. The morning hurry had prevented me from worrying unduly about the day but, now that I was alone, I had time to reflect on the cases I had chosen, consulting my notes lest I should forget a vital date or particularly piquant quote. I had not visited Chandos Street before and its quiet grandeur was both impressive and comforting. I soon found Number 11, a simple doorway let into the wall but which had a perturbingly impenetrable quality and seemed strangely offputting. So with an air of self-assurance which belied my waning confidence I approached the door, rang the bell firmly, and waited. There was no reply. All confidence evaporated. Was this the right place, or indeed the right day? Was I too late or too early, had I missed a late cancellation? I checked my papers and, reassured by their unchanged instructions, resolved to try next door.

The entrance here was altogether more inviting with its prominent glass porch through which I could see the inhabitants busily engaged within. With confidence restored I went in and approached the desk, only to be told that they had nothing at all to do with the doctors and, rather mysteriously, that they were not always there. I hurried back to Number 11 and this time was rewarded by a prompt and most courteous reply and was ushered in.

The Main Hall had a splendour and elegance which proved a sharp contrast to the simplicity of its entrance. There was a fine black and white tessellated floor with a large gently curving stone stairway rising from it. This was embellished with an iron balustrade and mahogany rail. The high ceiling with decorative plasterwork and some columns completed the scene; a sense of scale prevailed. I was warmly welcomed and shared a most pleasant conversation about the dreadful weather, the traffic and the hazards of early-morning travel, before being directed to the cloakroom with the advice that I should go upstairs when I was ready. I hung up my coat and umbrella, took a last look at my notes and went upstairs. The day had begun.

When I reached the landing I confronted an elegantly decorated central room with fine white plasterwork, pink walls and an impressive chandelier, or so I remember it. A short but wide flight of steps led to the well of the

room where the four panel members and my three fellow candidates were gathered. I was welcomed into the room where we shared introductions over coffee and biscuits. We had all had to contend with the morning's congestion but now that we had arrived we were able to relax a little. Forming naturally into our two groups we began to get to know one another before tentatively sharing our thoughts about the day. We each had been invited to bring three pieces of work to present: one in which we felt fairly satisfied with our understanding, another where we felt less so, and an example of our ongoing work. By now my good case had assumed a new mystery which made my earlier understanding seem superficial, even banal. My bad case was awful — what would people think of me? — and I could not remember my current case at all. With my notes downstairs and the meeting moving towards the first session it seemed that I was stuck with it. Happily we had all admitted to the same and so although vulnerable I was at least among friends.

The first session was a group seminar, the same as the many that I had attended during my training. The panel and candidates participated equally, although we were to provide the material.

We moved first to a conference room where we were surrounded by eminently dour faces who looked down upon us enigmatically from the large oil paintings which adorned the walls. Would these physicians of the past approve our day's work? They had little time to consider their judgment since shortly after we had settled down to our work we were disturbed again to be told that the room was already booked and so we must move across the landing to the lecture room. We adjourned in a manner that was just perceptibly surly.

This other room which we now entered was large and imposing and of altogether more heroic proportions. There were ranks of comfortable chairs arranged along a central aisle, an oak desk with latticed sides was raised above the rest of the room and so dominated the scene. I also seem to recall large pillars to the right and maybe a gallery at the back above the door. The room was served by comfortably massive cast-iron radiators, the only incongruity being the slim loudspeakers, slung loosely from the pillars. We settled ourselves into a circle, burrowing into the front left-hand corner of the room, arranged alternately panel member and candidate and, sitting by one of the radiators, I felt warm and comfortable.

My anxiety had already demanded that I volunteer to present the first case which, after an uncomfortable start, was going well. The discussion was interesting and seemed to flow freely. We considered two other cases and they too proved to be stimulating and provoking. We found ourselves limited by time in the two hours given to this session, not by our material. By now I was relaxed and, with a sense of exhilaration creeping in, I was looking forward to the first individual session.

These sessions last for three quarters of an hour at a time, with two pairs in each room. My venue was the conference room. I returned to this impressive room with some pleasure; we settled ourselves to the right of the door, needing only to disturb two chairs this time. The rather larger indentation of the previous session was still plainly evident, its size accentuated by the occupation of the other pair. I had decided to present

my best case first and found that I did understand it and, in discussion, rather better than I had thought. The individual attention seemed to allow thoughts to crystallise, a process nurtured by the friendly interest of the assessor. I did not feel examined but rather that I was being given the opportunity to explore my work, and to an extent myself, more fully and in so doing taking stock of the depth of my understanding. When the session, all too brief, was over I discovered that besides being assessed I had assessed myself and found it a most rewarding experience.

We returned to the central room for a fine buffet lunch with dips, small pies and delightfully delicate sandwiches which seemed to fit the elegant charm of the room. We drank fruit juice and later coffee while talking together about ourselves and the morning's work. The two earlier camps were now less distinct. As candidates we seemed to agree that it had been a good morning and that perhaps everyone should do it. We could each bring to mind people whose work we respected but who had felt daunted by a day with the panel and had not felt ready to present themselves. It seemed a loss. The strength of our Institute is in its membership and the more skilled people we have as members the greater will be our chance of progress and development in our ideas and ultimately our influence.

It was the afternoon already and only the final individual session was left to do. The time was split into two sessions and I had the first one free, and so time to go out for a walk around Cavendish Square and down Oxford Street. The rain had lessened over the morning and the weather was now mild and quite pleasant. My mind was full of thoughts from the morning which generated a sense of excitement within me which found no encouragement in the busy streets of Central London outside. I soon returned to Cavendish Street to pass the rest of the time in pleasant conversation and discussion until my final session of the day. This was due to start promptly in the meeting room at a quarter to three and so I would end the day where we began. However I was so deep in conversation that I was unaware of the passage of time. I had to be found and, while I hurriedly joined my final assessor, I reflected that to be late for the final session of a busy day where I was to present my bad case was probably not a good idea.

I had no reason to worry. The courtesy and friendliness which had become the hallmark of the day continued. Sitting comfortably by the doorway, surrounded by images from the past, we spent a pleasant time gently teasing apart what had been for me a very testing piece of work. When we had finished I felt an enhanced sense of self-confidence and strength; my understanding had been more complete than I had allowed myself before and my clinical instincts had stood close scrutiny. I was left feeling that I must be better than I had thought.

Now at the end of the day and with dusk gathering prematurely outside, we gathered again together in the main room which had grown familiar over the day. Fully integrated now we shared tea and talked together about the day, the Institute and much else besides. Two of the gathering had already left and with the end of the day now close at hand I reflected that I had learned a lot about myself, about the Institute and about the people who make up the Institute. It had been a most successful day.

Now other matters were more pressing and we rose to leave by common

consent. For some a journey home, for others a visit to the theatre and a late meal and, for me, a rendezvous in the Toy Department of John Lewis. I rejoined my tired but reasonably happy young family who still seemed keen to do the Christmas rounds: the Selfridges Grotto, where a rather forbidding Father Christmas made us choose the back way out surrounded by rhythmically nodding Munchkins; down South Molton Street with its stark black displays; and out into Regent Street which provided a startling contrast with layer upon layer of vivid flashing traceries. With fatigue now overcoming enthusiasm we wandered slowly back, past Snowmen and Snowqueens, frost and ice; past Oxford Street with webs of tiny lights entwined in every tree; and finally Regents Park, our car and the journey home.

Gently lulled by the hum of the road and warmth of the engine I quietly reviewed the day. I had felt anxious and threatened at the outset, carefully, even minutely, preparing my cases while feeling vulnerable and angry at times at the imposition of it all, but now how unnecessary all that had been. I had had a good experience which had interested and stimulated me and, whatever the outcome, I now had a greater sense of confidence in my work, with a true coming together of all the threads of experience and understanding that my training had offered me. It was a good feeling which had not faded with time. It seems that I had no reason at all to fear my day with the panel.

Dr. Chris Sage
Member of the Institute of Psychosexual Medicine

ONE BLOCKAGE CREATES A LOGJAM: A Case Study

Ian is a 23-year-old soldier in the Regular Army. I was asked to try and help him by his Army Medical Officer. His complaint was that, although he could achieve a normal erection, he had failed ever to ejaculate.

He came to see me always wearing battledress and army boots, and sat in an easy and relaxed way with his feet sticking out in front of him, and spoke of his problems easily but with very little show of any real emotion. Asked what had prompted him to come now, when he had had the problem for eight or nine years, he said that he had not felt able to talk to previous M.O.s. His present M.O. is a caring and approachable man.

Ian told me about the girlfriend he had had from being 14 to 16 years, of whom he had been very fond and, although very close, they had never attempted intercourse. I tried to explore the reason for his fear of physical expression but he said only that he supposed that he had been too young to feel confident.

When Ian was 15-plus, he had been expected by his classmates at school to take part in a mini-orgy where three or four of them had had intercourse in turn with a girl who was quite willing to co-operate, but when it was his turn he felt totally inexperienced and copied what they had done, but faked orgasm.

At sixteen Ian joined the Army. I asked him why he had chosen the Army, and although he said that it was what he had always wanted, I failed to pick up that it was a rôle in which he need not take responsibility for his own potency and aggressions.

In the last seven years he had served in Germany, Northern Ireland and the Falkland Islands, and has had numerous brief encounters and a few more serious affairs, but had never admitted to anyone that he could not ejaculate and has always faked orgasms.

When I examined Ian he was relaxed and unembarrassed and seemed relieved that there was no physical abnormality. I was surprised that he seemed to need further reassurance after his M.O. had already examined him, and supposed that he must have had deep anxiety about his physical normality. Looking back, I think that this was symbolic of his anxiety about himself as a competent sexual adult, but as I had failed as yet to understand the real anxiety, reassurance did nothing to help him to ejaculate.

I had three or four sessions with Ian. I found him friendly, easy to talk to, and steeped in what I imagine is the fashionable Army attitude to women as a source of readily available satisfaction with no commitment. He said that he liked talking to me, and found it helpful, but I failed utterly to get him to express any real feelings or even to admit that he had any, or to recognise his pain. I felt that he was making me feel as frustrated as his girlfriends must feel when he encouraged a relationship but failed to 'deliver the goods'.

I was desperate, and he was becoming irritated by my questioning approach. Why was I asking about his father's attitudes, what had that got to do with him, and why had I not got some magic hormones in my pocket?

So, in a despairing attempt to get through to him, I said, 'Let me paint you a picture. . . Supposing there is a small boy, playing under the table with his Dinky Toys, on a day when his mother is at the end of her tether. She had got her old mother-in-law in bed upstairs banging on the floor with a stick, the two older daughters are in bed with measles, the washing machine has flooded the kitchen floor, the cat has been sick and the milk has just boiled over. At this moment her husband walks in, tired after a day's work. He can do one of two things. He can say, "Good God, woman, I don't know what you women do all day long — no tea ready when I come in after a hard day. . ." and he can slam the door and go out to the pub until closing time. Alternatively, he can take one look at the situation and say, "Hi, love! — you look as though you have had a bit of a hell of a day. Make some coffee and I will be back in two minutes with some fish and chips. . ." So you can understand that the child under the table is unconsciously absorbing the message of how, when he is adult, he should respond to a difficult situation'.

Somewhere about halfway through this narrative a glazed look came into Ian's eyes, he stared at the ceiling, and I felt that now I had finally lost him altogether. Then, after quite a long silence, he slowly looked at me, and said, 'But it wasna' like that. When me Gran was ill she lived up the road, and when me Da came in he smashed the display cabinet'. I asked what his mother did when his father had one of these violent tempers, and he said

that she went out to the scullery and banged the saucepans about and cried a lot. This led to a long discussion about how he felt about women, why until now he had never felt able to show aggressive potency with a woman, and what he would look for in the relationship with the woman he would marry.

After this Ian missed three appointments, and eventually I rang up the M.O. and said that I understood that it was difficult for men to keep appointments when there are manoeuvres, etc., but that I would like to see Ian again as I felt that we might have made some breakthrough.

Two weeks later Ian came in like a whirlwind, ten minutes late, and said, 'I canna' stop, I told my girlfriend I'd be home for me tea, but Oh it's great! and I canna' get enough of it, and me girlfriend is pregnant, and I'm going to marry her, and Oh it's great! and the first time she had an orgasm she cried and cried and she pissed the bed and I just lay and cuddled her and Oh it's great! and I canna' stop now — Goodbye!'

I reported this case to my seminar group, feeling shamefaced about my bedtime story approach, but pleased with the outcome. We looked at my questioning approach to his history and his feelings, especially with regard to his father's relationships and aggressions which had not helped him to see that his fears lay partly there. I had not been able to use with him what he was doing with me in the doctor/patient relationship, and while the question and answer approach would be valid in a purely physical illness, it did not lead either doctor or patient to understand his feelings about sexuality and aggressiveness in this case. I had failed to verbalise his conflicts with him, but had been able to dramatise his fear of male aggression to which he at once responded, and was thus able to get down to understanding his real problem. I might have gained results more quickly if I had been able to show him how he was not 'letting go' with me in the same way as he failed with his girlfriends.

His first love at fourteen to sixteen is very relevant. He lived in an environment where sexual experience at a very early age was the norm, and the fact that he treated his first girlfriend with care and with no sexual pressure is the beginning of his expression of fear of damaging women. This was a fear that had always been present which eventually both he and I understood, thus freeing him from the blockage.

Dr. Lesley Bowen
I.P.M. Associate

THE PATIENT IN CONTROL

Mrs. X. aged 45 was referred by her own doctor because of loss of libido over the past eighteen months. At her first visit I met a neatly dressed, depressed and weepy woman and felt desperately sad with her. She was bewildered because. . . 'I can have anything I want. My husband's very generous and my sons are good company. I normally like clothes but I'm not even interested in looking for a new dress. . .'

What was the sadness about? Mrs. X. had never enjoyed sex, and two years ago there had been many arguments about this at home, with the possibility of a divorce. Leaving her husband did not bother Mrs. X. too much, until one day her 14-year-old son had asked if, in the event of a divorce, he could stay with his father. Since then Mrs. X. had been facing the difficulty of her disinterest in sex. Intercourse had not taken place for several months, and an uneasy, teasing truce had developed with her husband, but Mrs. X. no longer felt secure. I asked how she felt about intercourse, and she screwed up her face in disgust. . . 'Men have untidy private parts, and women are not much better. . .' I asked if I could examine this untidy bit of her, and was refused very decisively with the excuse of menstruation. I made a comment about perhaps next time. We then went on to discuss her feelings of disgust about her body, and why she felt that way. She had had a very strict upbringing, the youngest of four children. When she started her periods her mother had been upset because she wished it had not happened yet, and left her to find out from her sister how to cope. Mrs. X. had learned from her mother that sex is something men need, and women submit to. She had always been rebellious, smoking and dyeing her hair against parental wishes, and leaving home at sixteen. *No way* was she going to submit to anyone. Her first husband was an invalid and made few demands, and her second husband works away a lot. She has two sons, one from each marriage. She adores them both. I got the feeling of a very sexy lady under all her sadness and told her this. She looked very sceptical as she left.

On her second visit Mrs. X. told me she had not been able to have intercourse the night before because of seeing me. Was this because she expected to have a vaginal examination? I asked, and before I could comment further, she became very angry. Her problems were all her wicked mother's fault. She would rather be dead than like her mother. The hatred poured out with a long list of complaints. Although the baby of the family, she had never been cosseted and felt neglected, un-mothered. 'She's such a selfish woman. She gets everything she wants', she said about her mother. In some trepidation, I reminded Mrs. X. that she was given everything she wanted also. There was a long silence as she thought about this, then sadly agreed. 'Your mother has never allowed herself to enjoy sex either', I commented, and suggested that one way she could be different from her mother would be to allow herself to enjoy her own body. She left looking thoughtful.

On her third visit I met a triumphant, smartly dressed lady. She had first refused her husband and then seduced him, allowing genital touching for the first time ever. To her surprise she had enjoyed it. 'There does not seem

to be any need for me to examine you now', I commented, and she smiled. We talked about how she had controlled my actions by using her period, getting angry and telling of success. She acknowledged her need to be in control, and further demonstrated her ability in this direction by thanking me and telling me she could cope now. I was dismissed.

DISCUSSION

Mrs. X. is obviously a powerful lady. The first moment of understanding occurred when I could show her her similarity to her mother, and she was able to make use of my suggestion of a difference between them. I failed to explore the reasons for the mother's sadness at signs of her baby growing up. What about her anger in her second visit? I felt the intensity of this and some fear. Did this reflect Mrs. X's own fear of being like her mother? Was her anger a reflection of this? I failed to explore further. A second insight developed when I showed Mrs. X. how she had controlled me in resisting vaginal examination. In fact we were able to explore a lot of her feelings of disgust without it, so the physical examination may not have been important. I failed to verbalise her need to be in control with her husband. It might have been useful to her to do this. There was obviously a lot more to explore with this patient. She was offered a further appointment if she would like to come back, but I do not expect to see her again.

Dr. Margaret Wheatley
I.P.M. Associate

"NO SMOKING PLEASE"

Mr. & Mrs. W. who were a couple in their mid-forties were referred by their G.P. for treatment of the man's impotence. They had been married for five years and it was the second marriage for both of them. They came into the room together and were both equally talkative and pretty much at ease in the presence of the doctor. The atmosphere between them was hostile and the wife very soon began to express her anger at the feeling of rejection caused by her husband's impotence which had existed for six months. She said fiercely, 'There seems nothing left in our marriage at all now'. Between them they gave a description of a pretty stormy marriage relationship but up until now the storms had never affected their sex life. She accused him of spending a lot of time outside the home, enjoying himself fishing and watching football while she was left behind. He agreed that he escaped into these occupations when the going got rough at home. This led to her comment that the sexual relationship being absent there seemed to be nothing left.

During the consultation his anger towards her for continuing to smoke after he had given it up was expressed, and she retorted, 'However much you nag me, I shall not do it'. The doctor felt intimidated by this depressingly hostile atmosphere and felt the need to separate them and see them individually and the husband came for the first appointment.

Although in the first place he had attended the doctor to placate his wife, he did realise that his impotence had an emotional cause, and when the doctor posed the question as to why he needed to go on a sit-down strike at this time, he very soon expressed his resentment about his wife continuing to smoke. He talked about the dirty ashtrays and the smell of smoke on her clothes and her breath. This, of course, he had tolerated while he himself smoked until six months previously. He spoke quite fondly of his wife and her volatile temperament and seemed to value the marriage much more than during the previous joint interview. The possibility of the hostile sexual failure being related to the no-smoking conflict was discussed and a further appointment arranged.

Before the date of that appointment the patient phoned the doctor to say that the problem was solved!

It is doubtful whether he had persuaded his wife to give up smoking, but perhaps he communicated with her about it a little more tolerantly and she made her smoking habits less intrusive. One the other hand, he may have decided that his impotence was an inappropriate weapon to use to encourage her to try and 'knock the weed'.

Dr. Rosemarie Lincoln
Member of the Institute of Psychosexual Medicine

SOLECISMS

Referral letter from a doctor to Dr. H. Montford

"I would be grateful if you could see this patient who is complaining of dyspareunia. . . On examination her vagina emits two fingers and a speculum. . ."

With all that inside no wonder it hurt!

* * * *

A letter to Dr. Gilley

"Thank you for your further letter about this lady with more left-sided pain. As you know we had investigated her earlier in 1986 when we felt that the mass in the left kidney was a cyst. I am sure the appropriate thing to do now is to perform an ultrasound scan of the kidney and puncture the cyst for psychological analysis. This is being performed and I shall see her again shortly".

The ultimate in psychosomatic medicine!

LETTER TO THE EDITOR

Dear Editor,

Doctors in the Institute may not be aware a nurse has been attending the Leaders seminar in London. I am that nurse. First under the leadership of Dr. Margaret Blair and, after she died, Dr. Tom Main.

Doreen Clifford in central London led a nurse seminar for some years. I joined this group for two and a half years until it ceased in 1979. In 1980 there was an opportunity as the Clinical Teacher for Family Planning at that time in Lewisham and North Southwark to initiate psychosexual nurse training. This allowed me to incorporate the seminar training into an approved post-basic course for nurses (Basic Principles of Psychosexual Counselling Course 985) under the English National Board.

I had never led a group and only Doreen Clifford at that time ran a group. I needed guidance and training for myself and was encouraged to apply to Dr. Blair who interviewed and accepted me. Here I found the training, criticism, study and support essential to my ability to lead the group. I value the liaison with these leader doctors. I would ask doctors who work with nurses who have undertaken training to acknowledge and encourage their day-to.day work in this field.

The E.N.B. course 985 continues at the Midwifery School, Lewisham Hospital. I lead a seminar at Stoke Mandeville Hospital initiated by myself but organised by the Continuing Education department in the School of Nursing. We organised two meetings in London in 1986. Here nurses who had participated in seminar training had a chance to present and discuss their work as well as the opportunity to look to the future and the possible formation of an association of nurses.

During the leaders seminar we recognised that the difference in the rôle of the nurse and the doctor is such that a shared group between the two disciplines was not always productive. However, when the task of the group is specifically to examine leadership skills, the mixture of disciplines produced positive results. I am grateful for the help I have been given and will, I am sure, need in the future. The experience has been invaluable and could have been gained in no other way.

Jane Selby, R.G.N.

NOTICES

PANEL PASSES, November 1986

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

Dr. Amanda Robinson
Dr. Michael Erith
Dr. Diane Gurd
Dr. Christopher Sage.

Congratulations! - Ed.

JOB OPPORTUNITY IN PSYCHOSEXUAL CLINIC

The Elizabeth Garret Anderson Hospital.

One session per week which could be expanded to two or three. IPM-trained doctor preferred.
Enquiries to: Dr. Elisabeth Mackie. Telephone 0698 26291

LIST OF NEW ASSOCIATES

Applications received and accepted between 20th September and 1st November 1986

Dr. Alessandra Bispham	2 Gladstone Place, Summer Road, East Molesey, Surrey KT8 9LZ
Dr. Catherine Coulson	The Towers, Church Road Stoke Bishop, Bristol, Avon BS9 1JS
Dr. Diane E.P. Gurd	2 Ocean View Road Bude, Cornwall
Dr. D.E.P. Lawes	2 Rose Neath Close, Orpington, Kent BR6 7SR
Dr. Rosalie M. Lloyd Jones	Sherwood, 10 Kirkby Road Ravenshead, Nottinghamshire NG15 9HF
Dr. Ian M. Millington	586 Pentregethin Road, Ravenhill, Swansea SA5 5ET
Dr. Diana Sladen	*New address not yet available*

CHANGES OF ADDRESS

Dr. R. Akhtar	32 Whitburn Road, Cleadon Village, Sunderland, Tyne & Wear
Dr. Sharon J. Bodard	'Marieke', 2 Court Road, Horfield, Bristol, Avon BS7 0BT
Dr. Gita Chandra	19 High Laws, South Gosforth, Newcastle upon Tyne NE3 1RQ
Dr. Janet D. Milne	16 Greenway Road Redland, Bristol, Avon BS6 6SG
Dr. Christopher H. Sage	28 Archfield Road, Cotham, Bristol, Avon BS6 6BE
Dr. Gillian M. Vanhegan	18 Oval Road, London NW1 7DJ

INSTITUTE OF PSYCHOSEXUAL MEDICINE TRAINING SEMINARS

REGION	TYPE	TERM	LEADER	PLACE
Northern	Basic	Fourth	Dr. A. Smith	Newcastle
	Advanced		Dr. R. Freedman	Newcastle
Yorkshire	Basic	Second	Dr. J. Coombs	Bradford
Trent	Basic	Ongoing	Dr. J. Tattersall	Sheffield, Jessops Hospital
	Basic	Second	Dr. S. Filshie	Nottingham, City Hospital
	Advanced	Ends July	Dr. M. Bramley	Sheffield, Hallamshire Hosp.
East Anglia	Basic	First	Dr. R. Thexton	Cambridge, Addenbrookes Hospital
	Basic	Ongoing	Dr. B. Devereux	Norwich
	Continuation		Dr. B. Devereux	Norwich
NW Thames	Basic	Fifth	Dr. M. Gill	Marylebone, Lisson Grove
NE Thames	Basic	Second	Dr. S. Lucas	Romford
	Advanced	Second	Dr. P. Tunnadine	Islington
SW Thames	Basic	Second	Dr. S. Horsewood-Lee	Wimbledon, Patrick Doody Clinic, Pelham Road
	Advanced		Dr. T. Main	Sharpthorne
	Research		Dr. T. Main	Hammersmith, West London Hospital Nurses Home, Bute St.
	Advanced		Dr. T. Main	" " "
SE Thames	Basic	Second	Dr. A. Jones	Bromley, Post-Grad. Centre, Farnborough Hospital
Wessex	Basic	First	Dr. M. Thomas	Winchester
	Continuation		Dr. R. Thexton	Southampton, East Park Health Centre
S. Western	Basic	Fourth	Dr. G. Wakeley	Bristol
Devon and Cornwall	Basic	First	Dr. J. Tisdall	Plymouth, Post-Grad. Medical Centre
	Continuation		Dr. J. Tisdall	" " "
W. Midlands	Basic	Fourth	Dr. S. Snead	Birmingham
Wales	Basic	Second	Dr. H. Backer	Swansea
	Basic	Ongoing	Dr. D. Morgan	Newport

IPM SEMINARS IN PLANNING

For further information about training seminars contact the appropriate regional training co-ordinator

REGION	TYPE	DATE?	LEADER	PLACE
Wales	Basic	May	Dr. A. Parker & Dr. D. Morgan	Newport
	Basic	May	Dr. S. Snead	Chester
NE Thames	Basic	May	Dr. J. Gilley	Finchley
NW Thames	Basic	September	Dr. M. Gill	Lisson Grove
SW Thames	Basic	September	Dr. H. Montford	Mortlake
SE Thames	Basic	September	Dr. M. Roberts	Maidstone
Yorkshire	Basic	September	Dr. J. Coombs	Leeds
	Basic	May	Dr. D. Anderson	Hull
N. Ireland	Basic	?	Dr. H. Lyons	Belfast
Mersey & N. Western	Basic	?		Manchester

PLUS — Dr. Ruth Skrine leads a group of Obs. & Gynae. Physiotherapists in Bath; Dr. Rosemarie Lincoln leads a group of nurses in Ipswich.

REGIONAL TRAINING CO-ORDINATORS

Northern	Dr. A.V. Smith	6 The Crescent, Longbenton, Newcastle upon Tyne NE7 7ST Tel. Newcastle upon Tyne 66254
Yorkshire	Dr. D. Anderson	4 Newstead Road, St. Johns, Wakefield, Yorks. WF1 2DE Tel. 0924 372836
Trent	Dr. S.E. Filshie	2 Pembroke Drive,Mapperley Park, Nottingham NG3 5BG Tel. Nottingham 625632
E. Anglia	Dr. R.D. Lincoln	67 Yarmouth Road, Norwich NR7 0EW Tel. 0603 31628
N.W. Thames	Dr. J. Kilvington	122 Marshalswick Lane, St. Albans, Herts. AL1 4XD Tel. 0727 53156
N.E. Thames	Dr. J. Gilley	42 Avondale Avenue, London N12 8EN Tel. 01-445 1654
S.E. Thames	Dr. A.J. Jones	1 Minshull Place, Park Road, Beckenham, Kent BR3 1QF Tel. 01-658 6185
S.W. Thames	Dr. R. Thexton	41 Hillcroft Crescent, London W5 2SG Tel. 01-997 1748
Wessex	Dr. Mary Thomas	Cliff House, Cliff Way, Compton Down, Winchester, Hants. SO21 2AP Tel. 0962 712183
Oxford	Dr. J.E. Rogers	11 Turners Road, Slough, Buckinghamshire Tel. 0753 22495
S. Western	Dr. R. Skrine	Castanea House, Sham Castle Lane, Bath BA2 6JN Tel. 0225 65440
Devon & Cornwall	Dr. J. Tisdall	23 Furzehatt Road, Plymstock, Plymouth, Devon PL9 8QX Tel. 0752 42356
West Midlands	Dr. S.M. Snead	30 Church Road Lilleshall, Shropshire Tel. 095 284 4560
Mersey/N. Western	Dr. M. Upsdell	85 Church Road, Woolton, Liverpool L25 6DB Tel. 051 428 5637
Wales	Dr. D.A. Morgan	The Gables, Llangenny Lane, Crickhowell, Powys Tel. 0873 810176
N. Ireland	Dr. J.G. Neill	42a Cadogan Park, Belfast, N.I. BT9 6HH Tel. Belfast 662861
Scotland	No Co-ordinator at present — inquiries to Northern Region	

NOTES FOR CONTRIBUTORS TO THE NEWSLETTER

Articles on all aspects of work in psychosexual medicine are welcomed 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 name and qualifications of the authors and their appointments. Each page should be numbered and also bear the title and the author's name.

Patients' locations, jobs and other identifiable features should be disguised. Patients should be referred to as Mr. A., Mrs. B. and Miss C. in order to preserve anonymity.

Contributions for the November 1987 edition should reach the new editor by 1st September 1987. Her address is:

'Greenhills'
Back Lane
Hathersage
Sheffield S30 1AR
