

IPM DIARY OF EVENTS

Friday May 13 1988, 7.30 p.m.

Clinical Meeting at 11 Chandos Street, London. Margaret Gill will speak on "Listening".

Friday September 23 1988 — Sunday September 25 1988

The Annual I.P.M. Scientific Meeting at Leicester University. Programme will be sent to membership early in July 1988.

OTHER DATES FOR YOUR DIARY

R.S.M.

Friday July 1 1988, 9.30 a.m. — 4 p.m.

Hormone replacement therapy

Saturday October 22 1988, 9.30 a.m. — 4 p.m.

Sexual needs of the physically/mentally handicapped.

N.A.F.P.D.

Wednesday/Thursday October 12/13 1988

Wyeth Current Fertility Symposium. Note changed date.

Saturday January 28 1989. Affiliated Group Meeting, Southampton.

Institute of Marital Studies

Tuesday July 26 — Friday July 29 1988

A programme to show a particular way of working with couples in difficulties. Focus will be on interactive processes and how these are influenced by unconscious motivations.

At Tavistock Centre, Belsize Lane, London NW3 5BA. Tel. 01-435 7111

Institute of Psychosexual Medicine

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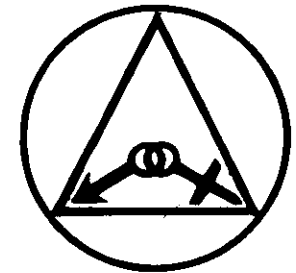
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Council consists of the President and 11 members (E), plus five co-opted members (C-O), one honorary permanent co-option, three ex-officio members (E-O) and one observer.

(C-O) Dr. Jenny Lisle, observer to NAFPD Council; (E) Dr. Anne Smith; (E) Dr. Susan Horsewood-Lee; (E) Dr. Gill Wakely; (E) Dr. Ann Parker; (E) Dr. Dorothy Howell; (E) Dr. Rosemarie Lincoln; 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. 33, MAY 1988

EDITORIAL

One of the most important events for the I.P.M. this academic year was the publication of Dr. Ruth Skrine's book, "Psychosexual training and the doctor/patient relationship". It is of immense interest to us all, but particularly to those who are involved in the training of doctors. It is a unique assembly of small, dramatic pictures of what is going on in the patient/partner, doctor/patient, doctor/seminar and leader doctor/training seminar interactions, which all mirror one another. A review of this book and an account of the pre-publication party are included in this issue. It will be reviewed in *Australian Doctor*, and it is good to know that it has gone round the world.

We are delighted to see Dr. Tom Main back among us after a severe short illness and wish him a very happy, if smokeless, future!

I have been very encouraged by receiving articles on child sex abuse and the doctor/patient interaction. It is interesting to see the variety of effect that sex abuse in childhood has on adult sex relations. Some recover with very short therapy, others recover after years of sporadic therapy, and some are permanently damaged and quite unsuitable for treatment by our members. The patients discussed in the papers here needed no special approach other than using the doctor/patient interaction in the "here and now" situation and allowing the "then and there" situation to be used when the patient brings it forth. This is clearly shown in Dr. Smith's second case.

Although certain similar features can be identified in the child sex abuse cases, each patient still remains unique in his/her interaction with the doctor.

Two poems by a patient are included, which illustrate clearly and beautifully some of the ideas presented in the articles.

Practical advice from Dr. Draper on preventive measures to help abused children will, I hope, be pursued by some doctors so that, in future, some of these children will avoid psychosexual problems. If children are encouraged to talk, as they are nowadays, we hope that they will receive trained, thoughtful help to meet their needs.

It is good to see that there are even more training seminars in operation than when the October 1987 Newsletter appeared.

If any of you have further cases concerning child sex abuse or male sex problems to complement the last Newsletters, please send them before 14th August 1988 and *please* look at the Instructions to Contributors on the back page.

Letters to the Editor, whether critical, controversial or suggesting further subjects to be aired, would be helpful.

Morag Bramley

"WHETHER TO SEE ONE PARTNER OR BOTH"
Report of the I.P.M. Scientific Meeting, November 1987

On 18th November 1987 at Chandos Street, Dr. Robina Thexton gave an excellent thought-provoking paper entitled, "Whether to see one partner or both".

Dr. Thexton began by explaining that although she considers that the patient is the one who comes, it is not always possible to stick to a one doctor-one patient relationship. G.P.s and family planning doctors often refer couples.

The couples sometimes arrive together for the appointment, even when the partner was not invited, with remarks such as, "the problem is for both of us" or, "we always tackle things together". A partner is often dragged along with, "I made him come too" or, "she should suffer as well".

When Dr. Thexton was asked to speak, she decided to take the next two couples who presented at her NHS psychosexual session held in a quiet room in the gynaecology out-patient department of a busy hospital.

A letter dated 3rd March referred the Smiths as a couple, saying that they had been married 11 months of a three-year relationship and Mr. Smith was complaining of premature ejaculation. He was also worried about minor cysts on both testicles and cold feelings on the side of his scrotum. He had seen a psychiatrist in 1978 for obsessive compulsive neurosis. The letter was from the G.P., who had only seen the man. Mr. Smith postponed the appointment sent to him for June because of his holiday plans.

On 29th July both Smiths arrived for the appointment. She came in first, but left the chair facing the doctor for Mr. Smith. Mrs. Smith was a well turned-out business woman of 29, whereas her husband was an appealing boyish 31-year-old in more casual clothes. She attacked with, "We don't make love much now, as John has premature ejaculation". He riposted with, "I hold back, I don't want her to stimulate me"; even his masturbation was quick. Dr. Thexton deflected the quick ejaculation by asking how they had met. Mr. Smith told how they had met through his father, who had introduced them, by inviting Mrs. Smith to supper. They had made love on their second date and she said he had lasted longer then; but he felt that this was less pleasurable than quick ejaculation and retorted by accusing her of never having orgasms.

We all felt sympathy for Dr. Thexton, who had been landed with this warring, tense couple, and were relieved that on the next appointment Mrs. Smith would be away.

More work was done when Mr. Smith came alone; he was free to talk of his worries about his right testicle. Dr. Thexton took the cue and examined him. During the examination he was able to confide his terror and discomfort when, aged seven, his father had taken him to see the doctor about his partially undescended testicle; how the doctor and nurse had laughed at him and there had been talk of an operation. After this the extrovert, insensitive father had never mentioned the testicle again. Dr. Thexton was aware of colluding with the patient over his victim story, and his need to avoid confrontation with his father or Mrs. Smith and she

interpreted that he had had the last word with the premature ejaculation.

There was a third consultation, which was unremarkable. The doctor was left as disappointed as the wife and felt he had not used any of the interpretations she had made. It is hoped that he will return after his exams.

The second case was of Mrs. W who had been referred from the Well Woman Clinic for an urgent appointment. Quarter of an hour prior to her private appointment time she had telephoned in distress to say she could not make her partner come with her: "I can't get there, unless he brings me. It is no use my coming on my own".

Fifteen weeks later they arrived together at the National Health Service session. She was a smart 40-year-old and he was a boyish 36-year-old in sweater and jeans. He said he had switched off after the birth of their daughter Jodie, several years earlier, and they had not had intercourse since; and now lived apart. Steve spoke with happiness about delivering Jodie at home. When Dr. Thexton praised him he said he did not need any praise as Joyce had done all the work. Joyce said she wanted support from him, but he acted like a naughty defiant little boy to his mother in front of Dr. Thexton, who commented on this behaviour and, being an understanding mother, gave him an appointment alone, which seemed a satisfactory outcome for the couple. Again Dr. Thexton had only one patient to study.

In the second interview when Steve came alone he said he found it difficult to commit himself to anyone. Dr. Thexton said, "I wonder what is at the back of this?" The flood gates were opened to a desparately sad account of how his father had drowned when Steve was only nine years old and had himself been on the beach at the time. He had died rescuing others in trouble. Steve had not been allowed to see his mother after the tragedy or attend the funeral and he only had memories of receiving money from a Heroes Trust Fund at a meeting when he was given 10-shilling notes in his hand and he did not know why.

Everyone seemed to be praising him but he had not done anything and knew that it was his father who should be praised. The doctor was crying for the patient, who said he had not been able to talk about his father's death to Joyce; and that he was angry at his mother for re-marrying his father's best friend. The doctor interpreted that he had praised Joyce and praised his father's bravery so maybe he was afraid of losing her as well as his father. He grasped the doctor's hand with both of his, saying, "Before I met Joyce I always ended relationships that were getting too close to another person".

In the last consultation he looked larger and happier and said they were holding hands now. He was surprised he had managed to talk about his father's death: usually, he said, he had ached in his chest and stomach when it was mentioned and had to leave the room. The advantage of seeing this couple together had allowed the interpretation which had released Steve to come alone.

The first couple could not be held together in any interpretation, so no useful work could be done with them together.

Dr. Thexton concluded that all we can do when confronted with a couple is to look at why they are there together and interpret what is happening in the couple relationship in the room. She had also been involved in the treatment of a couple with another Institute doctor, requiring at one stage a meeting between the four of them, which is a complex situation. She wondered if we should be changing our methods or using our known skills in the one-to-one relationship.

The paper was discussed at length, but it was noted that the members tended to gravitate back to discussion of the boyish man in the second couple, who had stirred up maternal emotions, rather than the first uncomfortable, warring couple. Dr. Thexton's work at allowing the man his grief over the father's death by crying in front of him, which he had never been allowed to see his mother do, was appreciated. There were also some feelings that there might be a degree of hate against his mother at her remarriage, which he was using against Joyce. He had ended up disappointing the doctor by delaying his next appointment.

In the first case the castration anxiety of Mr. Smith was interpreted and Dr. Thexton also expressed an anxiety that Mr. Smith might think she and his wife would laugh at him as the practice nurse had done.

Conclusions were drawn that couples will always turn up together if they want to, even if the doctor has only invited one of them. In each of the couples which Dr. Thexton presented it was noted that there was a complaining woman and a little boy, who needed help. By the second consultation in each case, Dr. Thexton was treating the male partner instead of being landed with a couple. She thought that she was not trained to treat marital systems, but to help individuals by interpretations of their feelings, so that they are able to help change situations in their own marital/relationship system. She wondered if we should be altering our techniques or sticking to what we know we can do.

In closing the meeting Dr. Main expressed the hope that Dr. Thexton's paper would be published in full when she had the next instalment in each case to report to the Institute.

Dr. G.M. Vanhegan
Member, Institute of Psychosexual Medicine

SEXUAL ABUSE

The first doctor-patient relationship I will report took place over a five-year period and was a covert presentation of sexual abuse. The second occurred over a six-week period and was overtly one of sexual abuse.

Mrs. A., a pretty, quietly reserved girl, was 25 years old when I first met her. She was the mother of three boys, the eldest being five and a half years. She frequented my male partner with her children and their illnesses.

My first meeting with her was because of behaviour problems with her five-year-old. He was disrupting school, aggressive at home and playing mother off against father. Mrs. A. was distraught. The educational psychologist was involved with them as a family. Our consultation revolved around Mrs. A.'s distress, inability to cope and the discord in the marriage.

Seventeen months passed before she came to see me again. She attended with her husband for vasectomy counselling. I was surprised by this, but her retort was, "You seem to take more time than Dr. X." All went 'normally' with the counselling until I opened up the subject of their sex lives. Mr. A. immediately said his sex life was good, but Mrs. A. hesitated and said, "Yes, it's all right". We looked at and discussed her hesitancy and lack of enthusiasm which was tangible in her statement. Mrs. A. went on to say that when she was trying to become pregnant she enjoyed sex. Mr. A. told me how his wife cooed and fussed over babies. "Oh", she said, lively and aglow, "If I could be sure another pregnancy would produce a girl, I would become pregnant again". I observed that if these were her feelings, it might not be wise to sterilise her husband just now. "Oh yes, we want vasectomy", she said. Examination and smear followed. They left to discuss the matter further and wait for the smear result. I was not at all happy about this couple having a sterilisation. However, a few weeks later, Mrs. A. appeared in the surgery to tell me they did not wish to proceed. I shared my relief with her and tried to open again the question of her sexual life. I was firmly told to mind my own business.

Nearly two years passed before we met again. I saw from her notes that she had been a regular visitor to my partner complaining of vaginal discharge and irritation. She brought the same symptoms to me. I examined her and found as last time, a normal healthy vulva and vagina attached physically to Mrs. A. but not emotionally to her. It was as though she was not present. "It looks very clean and healthy but it seems to be causing you a lot of trouble. You seem to feel that part of you is dirty and that you are trying to scratch it away — as though you wish it wasn't there". There was no response. She lay passively on the couch looking at the ceiling — not a flicker of emotion. I felt cheap and dirty and as though I was intruding. Mrs. A. kept me strictly out of her feelings. Memories of her attitudes during the vasectomy counselling filled my mind but no matter how I tried to share the feelings engendered between us I was successfully made impotent. Needless to say all her swabs were negative: she returned to my partner for the results.

Four months passed before she re-appeared. This time the appointment was with a very lively healthy three-year-old — her middle son. Suffice to say he was the visiting card. Mrs. A. was sad, dishevelled and agitated. I told her I was pleased to say her son was fine but upset to see her looking so unwell. She burst into tears and sent her son to his father in the waiting room. "I cannot make love with my husband any more. I'm too sore and itchy . . . and dirty! Everybody says there is nothing wrong, but there must be", she wailed. I reminded her that all looked normal physically but that I felt she was upset emotionally about her sexual feelings for pleasure.

Her tears became sobs and she looked at the floor. Then she covered her eyes with her hands and bent forward over her knees, rocking gently as though to comfort herself. "Something is distressing you immensely and your behaviour suggests that it is something you feel is shameful and are

frightened to share". She risked a glance at me — furtive eyes, full of disgust, briefly met mine.

It was at that moment my general feelings of her problem being psychosexual became specific feelings and that we were soon to be discussing sexual abuse. Her past behaviour with me began to make sense: the silences, her desire to hide feelings, her avoidance of the doctor who kept remarking on the interactions in the room, her feelings of disgust and shame about her own vagina.

Recognition of her shame, disgust and furtive behaviour seemed to release the safety valve on her emotions and her story of sexual abuse by her father during her teenage years poured forth.

We met three more times at weekly intervals. During these sessions we both worked intensely yet easily, now that the guilty secret was shared. Each time she attended she looked more relaxed, was less distressed and much more confident with me. The sequence of feelings we worked through began with the dirty shameful feelings, progressed to the doubts as to why she allowed the abuse to continue, fury at her mother for not believing her, then to the eventual recognition of some excitement and pleasure in that relationship.

Our final meeting revealed a sexually confident and happy lady, whose remaining anxieties centred around the possibility of a future baby girl. She feared that, if she produced a girl, her husband might be tempted to abuse her when a teenager. She also acknowledged her motives behind the vasectomy request; if he were sterilised, she could not have a girl and that would have avoided the need to face the possible incest anxieties.

Mrs. A. decided when the work should stop and I have not seen her medically since. However I know that four to five months after our last meeting she had another pregnancy confirmed by my partner and two months ago delivered her fourth baby boy!

The second doctor-patient relationship was different. Mrs. B. and her problems were much more overt and she knew what she wanted. She came to me indirectly in a psychosexual clinic. Several months ago she had found herself an "Incest Users Group" and attended regularly, finding the meetings distressing but therapeutic.

However she felt that there was something more to be unearthed, for which she wanted professional help. Mrs. B. asked her G.P. to refer her; he did; to a male colleague. Mrs. B. had hysterics and refused to attend. With consent from her G.P. and the colleague involved she arrived in my clinic. This lady knew what she wanted and was determined to get it.

Mrs. B.'s appointment time arrived and I went out of my room to greet her. She looked older than her 32 years, was untidily dressed and not particularly attractive. After shaking my hand she rushed ahead of me and slouched down in the chair. Without any comment from me she launched into torrents of words and feelings about her attitudes to men. "Men are awful", she said. "They can always get what they want sexually. I was abused as a child and now cannot enjoy sex with my husband". When her

husband made sexual advances to her she filled with the most intense feelings of hate. Yet amidst this, she expressed immense guilt knowing that she hurt her husband, and also felt distress that she could not enjoy sex with him.

During all this I felt bombarded by contradictory feelings and assumed that she felt muddled and confused too. I shared this with her. Tears filled her eyes, she wrung her hands together and then sobbed furiously. Then, to my surprise, lifted her head and apologised for "losing control and crying". "You seem to be ashamed of your tears and feelings", I remarked. "I'm ashamed of myself altogether. I haven't told you yet what happened to me", she said softly and then proceeded to tell me in great detail 'her story'.

Early in her teens she felt her parents neglected her emotionally. There weren't any cuddles or signs of affection. Nearby lived an uncle who often visited and would often give her a kiss and a cuddle. She liked this attention and began at his request to visit him. The cuddles became sexual play and eventual intercourse. She remembered feeling that it was probably wrong yet she enjoyed the attention and closeness. Mrs. B. told me all this with a confused mixture of shame and excitement yet with a great understanding of herself which she had presumably gained from her group work. I observed with her that although it was difficult for her to talk about these episodes she had been able to do it in a more composed way than when she talked about her sexual relationship with her husband. Tears of distress re-appeared: "He's out there now waiting for me. He wanted to come in with me but I wouldn't let him", she sobbed. "So you have shut him out of the consultation just as you shut him out of your vagina", I said. She acknowledged that thoughtfully, then angrily told me that her whole family were like that: always shutting out feelings or keeping them locked up. Most of the anger here was directed at her mother who teased her with a secret; Mrs. B.'s mother said she had a secret about Mrs. B. which she would take to the grave with her. This frustrated Mrs. B. and added to her shameful feelings of worthlessness. I interpreted these teasing and angry feelings to her, saying, "Perhaps this is how your husband feels when he is shut out of your vagina — not knowing what he has done or said to make you behave so". A thoughtful silence intervened, then she looked up and said, "I've had enough for tonight but next time I insist my husband be present". Her next appointment was at the next clinic two weeks later.

On that occasion it was myself who was disappointed and frustrated when she didn't arrive. However, fifteen minutes late they arrived. Mrs. B. apologised profusely saying that she had wanted to work more with me yet felt frightened to do so. Her husband had persuaded her to carry on. He was not as I expected. He took his chair back a little and sat with his arms and legs crossed, behaving very passively in a defended way.

Mrs. B. opened the consultation with tears. Her partner and I waited. Then came anger directed at herself for crying. "You get very cross with yourself for crying and showing feelings now, just as you did with yourself as a teenager when you returned for more affection". During her sobs she described flashbacks that she had had in the past two weeks whenever her husband had approached her. "Sex shouldn't be like that, dirty and demanding", she said. "It should be romantic and subtle". There followed a tirade of complaints about her partner's overt sexuality. "He just uses me to

get his pleasure". "From what you tell me about your present love-making and your past behaviour, you too can be sexy and demanding. Does that mean that you use him for your sexual needs and pleasure in the same way as you used your uncle for attention?" Mrs. B. was furious with me. Mr. B. was nodding and smiling to himself — the passive observer! Her fury then turned on him: "Don't you agree with her! I can see it's right but I hate myself for being like that". Mrs. B. collected her things and left with Mr. B. trailing behind. She seemed good at walking out when the water was hot. The consultation seemed to have been spent oscillating between the 'there and then' of the sexual abuse and the 'here and now' of the present sexual abuse, as she saw it. All of us were aware of the echoes past and present.

Two weeks later they arrived on time and lulled me into thinking things were better as they came in laughing. I observed that they seemed happier tonight and got a mouthful of anger about his behaviour in the waiting room. "Because people were there I felt unable to tell him his teasing remarks were hurtful". "No wonder you cannot make love with him if you have such fury suppressed inside you", I said to her. "Since the last visit, I have realised that I have used the sexual abuse episodes as a means of avoiding the reality that I have such unpleasant feelings towards my husband. I can now tell him how I feel — but not in public. His attitudes have upset me a lot, but it is only in the last few weeks that I have realised my behaviour has caused some of them. It's not pleasant to see this but since I have admitted it, the flashbacks have stopped and I feel more sexual". She collected her things saying as she left, "I need more time to think". She left me dissatisfied, bewildered and impotent. A taste, no doubt, of how she made Mr. B. feel. However I was certain she was using our work and was motivated to think.

Two weeks later, six weeks after our first meeting, they returned! Both were smarter and Mrs. B. looked a radiant lady, now looking younger than her age. They sat looking at each other and excluding me. I felt relieved — at last I felt there was real improvement. I waited. Mrs. B. opened things: "We are great now and don't need you any more". "Just like your past", I said, laughing with her, "a good defence but no longer useful". She roared with laughter, blushed furiously and said, "Even when he starts things I enjoy it. The guilt about enjoyment has gone, only the pleasure is left. And", she said conspiratorially, "I don't feel like a slut any more for enjoying sex". Mr. B. nodded vigorously and winked at his wife. "I am really pleased to be ousted like your flashbacks, etc. Away you go and enjoy yourselves".

I was delighted with the outcome but in retrospect, as well as at the time, find it difficult to conceptualise the interactions between the patient and myself. I wonder if this is to do with the secrecy that surrounds sexual abuse problems or whether it was just a feature of Mrs. B. who knew what she wanted and would get it for herself leaving me feeling pretty impotent.

Dr. Anne V. Smith
I.P.M. Member

THE DOCTOR-PATIENT RELATIONSHIP IN CONSULTATIONS THAT INVOLVE A HISTORY OF CHILD SEXUAL ABUSE

When selecting cases to report I had in mind Kempe & Kempe's definition, i.e. "Sexual abuse is the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles". I have chosen one showing the agitation which surrounds disclosure and one in which sexual abuse was only a part, although a dramatic part, of a severely deprived childhood.

Miss P.

It was late one evening when I was phoned at home by the child psychiatrist from Guys, whom I knew as a fellow member of the Lewisham Borough Working Party on child sexual abuse. She asked me if I would see, as a matter of urgency, a nurse who had broken down in tears when relating to the Sister of the ward where she worked, that she was shortly to be married, that her father had abused her and she was terrified of what her father would do when she was isolated with him in the car on the way to the church. The Sister had rushed to the psychiatrist for advice, and now she was passed on to me.

I had no space before the date of the wedding, but the distress of the presentation persuaded me to stay late at the clinic on a free afternoon. She arrived early at the clinic and when I went to fetch her from the waiting room I found her sitting head down hunched on her chair. She came and sat in my room, still hanging her head so that her long lank hair obscured most of her pale oval face. She was wearing a blue dress, with a white collar and a white cardigan; her whole appearance was subdued and forlorn. Asked to tell me about herself she replied, hesitantly, that her father had abused her from the age of 10 until she she 15 years old. It had started when he came to say good night, and then he went on trying when they were milking. She had gone to great lengths to avoid being on the milking rota with him. Suddenly she became emphatic as she said that she had never told anyone, she felt so bad, so guilty. These feelings of guilt, and of 'knowing', also made her feel isolated from the rest of her family of three sisters and four brothers.

I listened with a feeling of amazement as she told me of their way of life on a small upland farm, three miles from the nearest village. The father was a lay preacher in a strict non-conformist sect whose rules dominated their whole life. Sundays were spent entirely at Chapel, or reading the Bible; they could never have their hair cut (hence her lanky locks); and the women could never wear trousers. She had been forbidden to take up any training that involved living away from home, but managed to become a nurse by driving to a hospital 25 miles away. As she talked I realised that the little white collar looked just like a picture-book Puritan. She had not even been able to speak to her mother, though she told me she was a 'good mother', but she was close to her and liked helping with the housework, unlike her sisters.

About six months ago, despite fears that he would blame her, she had told Mark, her fiancé. He had listened without remonstrating, but she was still terrified that she would not be a 'normal woman' at the wedding. Her anxiety about her femininity had been increased by the fact that she did not

have her first period until she was 16, and then no more. She went to the hospital and was given clomid, which her father stopped her taking. However, she went back to the hospital and this time did not tell her father! "So you could take your own steps to becoming a woman," I said. She relaxed and told me how she really hated her father, was always uncomfortable when he was in the room, and could never look him in the eyes. She was dreading having to go with him to a chapel some distance away for the wedding. Twice she repeated to me, "I don't know who I am", and talked more of her guilt and the hypocrisy of going to Chapel.

I suggested an examination, as she was worried about being a normal woman. She went slowly to the couch, and when I came to examine her I found that she still had her knickers on. My remark that she was shy about this part of herself precipitated a flood of tears. She lay and sobbed helplessly for several minutes and all I could do was to hold her. When the storm passed and she lay quietly on the couch I asked if she would rather wait until her next visit, but she replied quite firmly that she would rather go ahead. I was able, to my surprise, to insert a finger quite easily; there was no vaginismus. I encouraged her to put her finger on mine and then to explore her vagina for herself. She too was pleased and surprised by the ease of the examination.

She was anxious to make another appointment before the wedding, which she did.

At her next visit she looked much brighter, smiled as she came in, and said she was not so terrified of the wedding. She was wearing her nurse's uniform and had lost her 'little Puritan' look. Feeling that I wanted to understand more about her relationship I said to her, "You have not told me anything about Mark". She told me he was 28 and he lived alone, since his father's death, in a sixteenth century family house on the edge of a village a few miles from her home. His family were members of the same Chapel. When she was about 10 she used to go over to the village for children's tea parties with Auntie Rose. Mark, who was then 16, would come and play the piano and she hero-worshipped him. Later she had only seen him at Chapel anniversaries.

When his widowed father had a stroke he phoned her mother to ask advice, and he was told to ring her as she was a nurse. After that he phoned the hospital every night while she was at work, and then arranged to meet her under the pretext that she was visiting Auntie Rose. Their relationship developed, they became engaged, and when his father was home from hospital she was allowed to spend weekends with them. Then she fell silent and I waited. She hung her head: it was very difficult when Mark became affectionate, she had never had a boy-friend and she could not believe how anyone could think that it was not her fault. Sex was dirty and she was embarrassed by Mark's approaches. . . . At this point I felt really curious about the extent of the abuse and said, "You never told me what happened". It started when she was 10, she was having a bath when the door opened. She thought it was her mother, but looked up to see her father standing there exposing his erect penis; he made her touch it. I asked her if he made her do anything else and she replied angrily, "That was bad enough", which made me feel that I was showing a prurient curiosity and any further inquiries

would in themselves be an abuse. I respected her privacy. She went on to talk about her father's strict patriarchal domination of the family; even now, she was forced to be home by 10 o'clock. I suggested to her that a father who proclaimed such high moral standards must have felt very guilty about his behaviour towards her, that the guilt that she felt about enjoying any sexual feelings was really his guilt that had stuck to her: it was almost as if he had injected his bad feelings into her. She sat back and thought this over.

She went back to talking of their family life, relating an incident when both her parents went out, leaving the mob of children in charge of her elder sister, who buried her head in a book while the rest of the family had an uproarious pillow fight. The parents came back early; all the children were spanked and sent to bed with no tea and no supper. Rebelliously the children agreed that they would not eat any breakfast either, and that would make their parents feel bad! But when it came to the next morning they all tucked in to a good meal. I liked this story, both for the show of high spirits, but also for the indulgence in natural appetites. We laughed together and I said that despite the difficulties she had in the past I thought she could go on to enjoy her sexual feelings in the same way.

She made an appointment for two weeks after her wedding, but I received a letter cancelling the appointment: her fears had proved ungrounded, she had felt so relieved to talk about it, and being married was lovely.

The urgency of the referral, with hints of implicit damage to the victim/child provoke an active response in the doctor; in this case it was limited to the sacrifice of a half-day; but if it is not understood in terms of the complaint can cause sometimes damaging overactivity on the part of the carers. Despite the alleged abuse she was able to write that 'being married was lovely'; as she left she had told me that after her marriage she would not work; she was going to enjoy doing up Mark's lovely but neglected old family house. In the same way she had been able to find what she wanted for herself within the framework of her segregated religious group; in the doctor-patient relationship she had been able to own her sexuality and to explore her feelings of guilt, though in only two consultations it was not apparent whether these were related to the specific incidents with her father or the general repression of the enjoyment of sexuality in her Calvinist background.

Miss B.

Miss B. was referred to the clinic by her G.P. His letter said that he had seen her the previous evening, when she had been tearful and incoherent, complaining that frigidity and dyspareunia had led to the loss of her boy-friend. With a sinking heart I read of her history of two teenage suicide attempts, that her mother was single and alcoholic, that she had had a T.O.P. at 20 and a son later the same year. She had been treated for salpingitis, and a vaginal discharge.

This G.P. has referred unsuitable cases in the past and I sent her an

appointment with considerable misgivings that she was not a suitable candidate for our work.

Re-reading the letter just before her arrival I was expecting a sad depressed young woman. I was taken aback when a petite, pretty, Afro-Caribbean girl walked in. Her heart-shaped face, with large eyes, was shown off by a striking, multi-plaited hair style. She wore well-cut trousers and a smart check coat. With little prompting, she told me that her boy-friend had left her, that she was 'O.K.' when she was first in a relationship, then she just cuts off. She said that it was all because she'd had been molested by an 'uncle' when she was four, and later by her brother; she had kept it bottled up, never told anyone, but it made her feel unworthy of the love of a serious man because she should have stopped it. Asked to enlarge on her experience, she said that when she was four she had been staying with friends while her mother was in hospital. 'Auntie Winnie' was out at work and 'Uncle John' had put Nestles milk on his penis and made her suck it off; he was an adult and she thought he 'knew best', so she did not protest. He tried to have sex with her but he could not enter. After her mother came home from hospital he would linger by his car, pretending to wash it, call her over, give her sweets and cajole her into the house, where he would bully her into a continuation of their sexual activities. She was able to admit that she enjoyed the affection and the sweets, but she hated it when he had an orgasm and ejaculated into her mouth, and there was a 'horrid salty taste'. He told her that she must never tell anyone, and she was too scared to disobey.

During this time she was very naughty at school and was moved to three different primary schools because of bad behaviour.

When she was eight they moved to a different estate and she did not see him any more. She made friends with a girl called Sandra, began to feel a little better, but then Sandra's father started to try and kiss and touch her whenever they were alone in the room. She still could not confide in her mother, who gave all her attention to her 'man friend'; she and Mother just argued all the time and she became quite uncontrollable. When she was 11 she ran away and after sleeping rough and 'using her body' to get a bed for the night, she was taken into care.

The whole of the first session was taken up with this dramatic tale, with little chance for interpretation.

She started the next session by declaring that she was angry that all that had happened was still affecting her; she still could not accept a loving man. Peter had wanted to marry her but she could not let herself believe that he loved her. At first intercourse had been easy, but then she had started to cringe and feel sick when he touched her. Finally she had turned her back and they did not even have intercourse after an argument. She talked again of her mother's inability to give her love, that she never visited her or wrote to her, and once when she was allowed home she turned her out of the house and then reported to the police that she had run away; making me feel sympathetic and protective.

She ran away when she was in care and was sent to a Borstal in the country. She could get along with the other girls of similar backgrounds but hated the work in the factory and garden, where there were parcels of shit that had been thrown from the windows. Finally she absconded and this

time when recaptured she was put in the hospital wing of an adult prison, although she was still only 14. After spending two years in the hospital wing, with 11 other adolescents, they were told that they were going to be transferred to the remand section. They were terrified that they would be victimised and raped by lesbians, subjected to 'gang-bangs'. They therefore barricaded themselves in. The authorities brought dogs and water cannon before they finally gained entry, when the girls were kicked and punched by the screws, stripped and left naked in the cells.

I listened to this account with a feeling of total horror and indignation, wondering how she had recovered from these experiences to become the girl who was sitting with me now, when she told me that Peter, who was a director of a drama group, had persuaded her to write them into a play. It was as a result of submitting this play that she had become a student at the well-known college of drama where she was now attending.

She missed her next appointment, but came back a month later. Again she reverted to her need to have proper relationships. She was not seeing Peter now, but still loved him. He had wanted her to talk, but she had shut herself into her room, and when she came out she wanted 'cuddles not discussions'. She said that her expectations, from her past experiences, were so bad that now she felt everything must be perfect. We discussed this, and her difficulty in letting others help her.

She cancelled her next appointment because her child was ill. I gave her another but she did not keep it. She had failed to develop her relationship with me!

I presented this young woman at Dr. Main's seminar. There was a lot of discussion of the way in which her dramatic presentation had taken charge of the interview, keeping the doctor at a distance and preventing examination of 'the mucky, smelly vagina'. Although I had been horrified by the account of the brutality in the prison, several members of the seminar commented on the lack of apparent distress; Dr. Main pointed out that I was defending against the strength of these feelings in a way that related to her ability to use her tragic past and present herself as a victim.

Although the child sexual abuse was blamed by her for her difficulties, it was but a small part of her deprivation; as Dr. Main said, "It is a sign of trouble, but I am not sure if it is the cause". In this case she was able to 'have sex' but not to 'make love' and develop a lasting relationship.

Both the women that I have described above only reported the incidence of the 'traumatic events' many years after they had occurred. Now that there is more awareness of this problem it is likely that many of our Members will become involved with this work, being asked to see cases at the time of disclosure, especially post-pubertal minors. As this is a new field for many of us I would like to share my limited experience, and hope that others may develop this theme in subsequent Newsletters.

At a study day at the Institute of Psychoanalysis I met the Child Abuse Record Officer for Lewisham, the Borough where I work. Over lunch in the pub we discussed the recent increase in complaints of child sex abuse. I told

her that I thought many of the women I had seen, years later as adults, had seemed to have been more damaged by the investigations after an allegation than they had been by the original event.

As a result of this casual encounter I was asked to join the Working Party on Child Sexual Abuse. Its task was to formalise procedures to be taken after any complaint of sexual abuse. The other members of the Working Party were Dr. Danya Glazier, child psychiatrist, and Dr. Margaret Lynch, both with experience of working with Dr. Arnold Bentovin, a police surgeon (who attended only the first meeting), two senior police officers, and a sergeant from the Juvenile Bureau.

We spent many lengthy hours discussing the sometimes conflicting interests of the police, whose main objective was to achieve a conviction, and the medical and social workers, who had the welfare of the child as their prime concern. Our task was made more difficult by the rate of change of the senior police officers who attended the meeting; no sooner had we convinced one officer of the benefit to the child of carrying out any necessary examinations in a pleasant atmosphere away from a police station with its associations of guilt, than he was replaced and we had to start again on his successor. At the time it seemed that we were wasting a lot of time, but in the light of recent events in Cleveland I have realised that these negotiations meant that we arrived at a mutually agreeable procedure for the handling of complaints of sexual abuse which were acceptable to the police but also protected the welfare of the child.

We ran a one-day course on the handling of disclosure proceedings which emphasised the need for very careful history-taking before proceeding to a physical examination, so that the extent of examination that was necessary was defined.

At a later meeting we were joined by Dr. Frances Lewington, who is the training officer for the Metropolitan Police for forensic examinations. Any doctors who are willing to undertake this work should phone her (01-230 6308). I have not yet been able to find time to attend a course, but I have seen a number of adolescents where the history of abuse is longer than seven days previously, and there is therefore no need to collect forensic specimens. In some cases I have seen girls subsequently, in a family planning clinic or to discuss psychosexual difficulties. Our training gives us valuable insight into the feelings of damage which can result, either from the events or their investigation. If they can be resolved before they have flourished in secrecy, then we have here an opportunity for useful prophylactic work.

Dr. K. Draper
I.P.M. Member

Reference

1. KEMPE, R.S. & KEMPE, C.H. *Child Abuse*. London, Fontana, Open Books. p.60

THE LIE

For thirteen years I lived a lie,
There were silver birds in my sun-filled skies.
But dreams don't last, and innocence dies
And dark clouds came to dull my eyes.

Fear in the dark of a childhood dream
With the burning ache of a silent scream.
I'm the twisted offspring of a broken mould —
I look so young, but I'm years too old.

Adolescence came, and I hid the truth —
The vestal virgin with perpetual youth
Weeps the tears of a martyr from a different mind
Where the rules of the game are ill defined.

Face of a child, with frightened eyes.
When I open my mouth, don't look so surprised,
My head's held high, my gaze is cold —
I look so young, but I'm years too old.

1986

A patient of Dr. S. Buck
I.P.M. Member

WARHORSE

It is always this way that I fight you;
Head flung back like a sparring stallion,
Striking out with a voice as hard and sharp
As hoof-tips, and words that wound deep.

All my banners flying, I can run like the wind,
Screaming cold hatred with every straining line;
Stamping my mood against your yielding ground
With every iron-shod footstep.

But, when it is over, and I have destroyed you,
Spent fury lies cold behind my eyes. I pause,
Clothed for battle — full armour
And a livery of ice and bitterness.

And the colour of your blood in my hoofprints
Damns my every step.

1986

A patient of Dr. S. Buck
I.P.M. Member

A SEARCH FOR COMMON DENOMINATORS

In view of the present climate of anxiety I have recently re-assessed the cases of six women who have complained of sexual abuse in childhood. I looked at them under six headings:

1. Presentation of the patient.
2. Referral. By whom, and why now?
3. Problem summary.
4. Findings on vaginal examination.
5. Feelings of the doctor.
6. Outcome.

Mrs. A. is a woman of 42. She is depressed and defensive of her own feelings even to the point of aggression. She faces the world angry with everyone.

She was referred by a trainee assistant in G.P. The partners, who have supported her for many years, would never have referred her, knowing her to be borderline psychiatric. Perhaps with the trainee she felt that he might listen to a renewed *cri de coeur*. The accompanying letter asked for help not for her, but for the husband, who was said to have difficulty in maintaining an erection.

I spent a great deal of time with this woman before she finally told me of the long history of child abuse by a neighbour. She submitted to sex within the marriage only to have two children, and has never allowed herself to enjoy it.

Mrs. A. has never permitted V.E. She is adamant that no one is permitted to approach her most vulnerable area.

I felt pity and exasperation, which is, I am sure, shared by her husband and other supporting agencies, and reflects her own exasperation. We have talked a great deal about her anger which is targeted on all men, and also more vehemently against her mother who failed to see what was happening. Mother insisted that she should go when the neighbour repeatedly, and over many years, asked for the child to be sent round to run errands for him. This anger is often directed in an abusive way at me, but discussion of it makes little difference. She still remains very dependent.

There has been virtually no change. Her history of hospital admissions, gynae. operations, etc. is a pattern now rapidly being rivalled by her teenage daughter.

Mrs. B. is a woman of 32, young-looking, trendy and cheerful, with a warm and friendly approach.

She was referred by her G.P. to whom she had confided her problem. For ten years she had had a good marriage with good sex, but over the last two years libido had dropped to zero, and she had constant nightmares. This put great pressure on the marriage which made her seek help.

She is the middle one of five children from a poor home where there was no parental support. An older brother had crept into her bed in the early mornings over a number of years. She had managed to blank out this memory for a long time, but two years ago something had revived it and now

the guilt and anger that she felt were her constant companion.

V.E. presented no problems. She was relaxed and showed no discomfort.

I admired the courage with which she faced her problem, and felt very maternal. We talked about her need to share her guilt with the mother figure which she had never had.

A trial separation while she 'sorted out her feelings' ensued, and now the couple are together again, and the sex of the marriage is good.

Mrs. C. is a daintily built daughter of Mediterranean parents. She looks like a pretty 16-year-old, but is in fact 30, and the mother of five children, who are equally beautiful.

She was referred by her G.P. c/o heavy periods and a recent loss of libido after 12 years of marriage.

She was born in England of a tuberculous mother and brought up by her father after her mother's death. Following his death she was cared for by loving grandparents until, at seven years, they also died. She then lived with an older married sister and was subject to constant abuse from her brother-in-law. At 14 she ran away to a children's home.

V.E. was unremarkable. She showed no anxiety. As with Mrs. B., it seemed as though several years of good loving sexual relationship had 'forgiven' her vagina.

Again, as with Mrs. B., she engendered admiration and maternal feelings, and these were discussed as giving her the supportive understanding that she had always craved.

She grew in confidence and was able to take a job, but the marriage broke up for several months. Subsequently the couple are together again, and sex is re-established.

Mrs. D. is a depressed-looking, chain-smoking and slightly scruffy 23-year-old, speaking in whispers and hiding behind a curtain of hair. Only much later was she able to look me in the eye.

She was brought by the leader of an incest support group, a social worker based on a local community centre, and from the start I felt that there was some resentment at being 'brought'. She had little faith in me to see her needs as her own mother had blinded herself to them.

One of a family of four siblings, she was constantly abused by an alcoholic father with some physical violence, and over many years. Several admissions to a psychiatric hospital followed suicide attempts. She married at 17 and though sex was never pleasurable, she badly wanted a baby. There was a further admission to hospital with puerperal depression. She is fiercely possessive of her daughter, but unable to touch anyone other than the child, and the marriage broke up. Her anger with her father is extreme: she would "kill him if it were not for her mother".

V.E. was possible, but she was unrelaxed and apprehensive. We discussed her fear and dislike of her vagina, and her inability to share it even with a trusted person.

While feeling very sorry for a deeply disturbed woman, I could never get close to her, nor feel that I had been able to help her. This, I expect, is how

the group leader felt. I tried to understand and share her bad feelings about herself. She seemed unable to face them or expose them to another, and always denied all feeling other than the anger with her father.

There is no real improvement. She has had a second brief marriage, and several admissions to hospital for gynae. symptoms. She continues to attend the incest support group sporadically.

Mrs. E. is a neat, tidy, tense woman of 25, open in manner and able to talk quite freely.

She was referred by her G.P. after she had complained of R.I.F. pain, had two D. & C.s and various investigations which I am sure were expressions of her pelvic 'pain'. Ultimately she was able to hint to him of her real problem.

The daughter of educated parents, she had two younger brothers. Mother had a Saturday morning job, and once a week, from aged 13 to 15, Father sent the boys out, and abused her. Subsequently he was treated in a psychiatric hospital. She married at 16 to escape from home and, while never enjoying sex, had one child. Her guilt and misery were such that she hid away at home, scarcely daring to go even into the garden in case she might encounter the neighbours.

V.E. was perfectly manageable, but tense and anxious. We talked about this being how she felt about her sexual experience with her husband.

Her friendly manner, openness and ready insight made me feel optimistic. She was ready to examine her guilt and understand that her father was the damaged personality, rather than herself.

There was a gradual and tremendous increase in confidence. She told her husband about her history, and he complained that he did not like the new and positive woman. The marriage has survived the crisis; sexually it is more relaxed and occasionally even enjoyable, and they have embarked on a second pregnancy.

Miss F. is a neat and tidy, quietly dressed 20-year-old, articulate, but shy in manner at first.

She was referred by her G.P. after the television programme 'Childline' had convinced her that to share her problem might help.

The only child of a middle class home, she is devoted to her mother, and was abused by her father from aged five to 14 years. He "wanted to teach her what good sex was like, so that, unlike her mother, she might enjoy it". Now she is quite unable to face any social situation unless accompanied by one trusted girl friend, nor can she talk to a man except on a business basis, in shops, etc. She suffers from insomnia and constant nightmares.

V.E. was very tense and guarded, and we discussed her anxiety about her vagina.

Again my feelings are optimistic, engendered by her insight and determination. We have shared her greatest conflict. She hates half of her father, but the other half is a 'good' father, and her anger is directed at him that he has ruined a relationship that she feels entitled to. "If I had been raped by another man I could have gone to my parents for support. Now I have no-one". She can not admit that the mother she loves and needs, lacks

perception.

She is still in therapy, but has made her first solo venture into a social situation, with great difficulty, but with tremendous satisfaction afterwards. I think she is beginning to feel acceptable in the outside world, having found a doctor able to accept her damaged person.

All these women were convinced that the mother had no knowledge of the problem, and most were adamant that she must never find out. It seemed that none dare admit to themselves that the mother was unable to see their need and protect them, although several were angry with their mothers for not doing so.

All six suffered loss of libido, perhaps not while the first experience was exciting and overwhelming, but gradually increasing over a period of time. I failed to find a precipitating factor in the latter; it seemed a gradual resurgence of old guilt and misery.

Most frightening of all for the counsellor was that in three out of the six cases the treatment led to a temporary break-up of the marriage. This seemed to stem from their having chosen partners who could give them support and caring and who enjoyed taking responsibility for their lack of confidence, but when this was restored found great difficulty in coming to terms with a marriage of equal partners. The women seemed also to want to widen their horizons now that they were no longer dominated by, and locked into, their problems.

I discussed this problem with Mrs. E. It was her carefully considered opinion that even if the change in her ability to face the world had meant the loss of the marriage, she could not have lived for the next 40-50 years in the state in which she had been.

Dr. Lesley Bowen
I.P.M. Member

SEXUAL ABUSE OF CHILDREN

The Forum on Sexual Medicine and Family Planning held a second meeting on Child Sexual Abuse at the Royal Society of Medicine on Saturday 24th October 1987.

The meeting was divided into four sessions:

1. The Courts' approach to child sexual abuse cases.
2. The Perpetrator.
3. The Hidden Victims.
4. Adults who were abused as children.

Session 1 — The Courts' Approach

This session was addressed by Lady Ralphs, Vice President of the Magistrates Association, and Christina Gorna, a Barrister.

A balance must be sought between the evils of child abuse and the claims for justice for the defendant. All cases go first to the Magistrates Court and

98% begin and end there, only 2% going on to the Crown Court where greater sentences can be imposed. The Magistrates Court is responsible for issuing care orders but is always mindful of the trauma of removing the child from the parental home and particular care is taken when emergency place of safety orders are applied for.

The reliability of the child's evidence is crucial to the system of justice. The interrogation that the child may face can be worse than the original assault. Children are confused by their dislike of the abuse and the affection for the perpetrator and also have difficulty in distinguishing between fact and fantasy. Suggestions made towards reducing the stress for the child, thus making the evidence more reliable include:

1. Screening in court.
2. Training in the interrogation of children.
3. Reduction in the delay in cases reaching court.
4. Visits to the court before the trial and leaflets to parents about court procedure.
5. Video interviews.
6. Recorded interviews soon after the offence, thus avoiding distorted evidence resulting from nightmares following the assault. These interviews could be shown to the defendant and his solicitor probably resulting in an increased number of guilty pleas and thereby rescuing the child from an appearance in court.

Concern must also be shown for the abuser and the possibility of rehabilitation and re-establishment of the family since the breakdown of the family often contributed to the guilt and trauma of the abused. Video two-way links were being considered in Parliament in the Criminal Justice Bill, but was not yet law. Christina Gorna, in spite of her evident concern for children in court, felt that nothing could replace live evidence but children could be helped by hearing cases in rooms and not in court, a configuration, as well as the wigs and gowns, which was alarming to most of us.

Child abuse cases were decided on probabilities; as in many other cases, there could be no certainties.

Session 2 — The Perpetrator

Dr. Brendan McCarthy's (Consultant Psychiatrist, The Portman Clinic) paper was read in his absence by Dr. Fay Hutchinson.

An attempt to categorise perpetrators could not be simplified but incest perpetrators were usually father, grandfather, brother or uncle, rarely mother. Extra-family perpetrators are usually paedophiles but may be step-fathers, co-habitees, baby sitters or lodgers. Incestuous fantasy often precedes the baby's birth but the child may be six or more years old before any advance is made. The paedophile is more opportunistic, driven by intense compulsions, needing a compliant, frightened and dependent object who is totally non-judgmental.

Perpetrators have no specific character structure to help identification. At least one in three have a history of being sexually abused themselves. Homosexual abuse in childhood can lead to heterosexual abuse in adult life.

In the extra-marital situation there may be great bitterness and hatred directed towards children, who are not his; there may be no positive feelings and no remorse. Alternatively the incest perpetrator, often rejected by a powerful wife, and frequently with failures in other areas of his life, may have an adoring relationship with a daughter and later feel enormous guilt. The former situation is likely to be untreatable and the latter much more hopeful.

When treatment is undertaken it requires a very dependable structure. A cancelled session may result in assault on another child; absence of the therapist must be carefully negotiated. A long history of persistent abuse makes successful treatment unlikely, but a history of sexual abuse of the perpetrator in childhood may be hopeful, because it puts him in touch with the child within and helps him to increase his understanding and insight and lead to some control of his behaviour. The therapist should never underestimate the unconscious prejudices which may make it difficult to maintain neutrality and emotional availability. For this reason the therapist should be quite separate from the investigative team. The importance of treatment is the prevention of the cycle of sexual abuse where the child victim later becomes the perpetrator.

Session 3 — The Hidden Victims

Dr. Eileen Vizard, Consultant Child Psychiatrist, The London Hospital, talked under three headings:

1. Assessment.
2. The meaning of the experience for the child.
3. Group Treatment.

For the child there is the secrecy resulting from the lack of understanding about what is happening and the denial. The secrecy is increased by the perpetrator — "This is our secret" — and the threats — "I'll be sent away if you tell".

In some sick families the child abuse stabilises the family and spares marital breakdown. When disclosure occurs there may be much professional scapegoating as the police, doctors and social workers are seen as the cause of the family breakdown or the reason for the failure to stop the abuse without disrupting the family.

Assessment takes a lot of time and must be unhurried. Information must be collected, remembering that no sign is diagnostic. The information must be considered and confirmed or refuted so that a consensus is reached leading to conjoint action to protect and treat the child.

The experience for the child is divided into the bodily, the external world and the internal world experience. Bodily, most, but not all, are damaged. There is physiological arousal and quite small children can be orgasmic so that their body learns to respond although the mind does not like it. This frequently leads to over-sexualised behaviour.

The external world experience is worse when the perpetrator is known to the child and when the abuse is chronic. Stranger abuse, the one-off assault, is less traumatic.

The internal world experience often involves other deprivations but the

greatest is the impossibility of 'checking out' because of the secrecy. Children find out what is O.K. and not O.K. in social behaviour by questioning peers and adults in their lives. Because this is unavailable the experience is internalised and produces persecutory fears.

A video of the group treatment used with very young children was shown and illustrated how children learnt to talk about what had happened and went on to learn about meeting strangers, what was acceptable touching, good and bad secrets and the need to tell and go on telling.

Dr. Dora Black, Consultant Child Psychiatrist, The Royal Free Hospital, said that 49% of reports of child abuse were reliable, 4% were withdrawn later, 24% were unsubstantiated suspicions, in 17% there was insufficient information, 5% were fictitious reports from parents and 1% from children. Fictitious reports from adults could be suspected when minimal details were given, when the reporter was involved in custody disputes or were the victims of child abuse themselves. Fictitious reports from children could usually be recognised by the flat affect of the reporting. Physical evidence of abuse was only present in 10% of cases.

When risk factors were being considered there was little evidence for a relationship with socio-economic class or racial colour. In fact, the risk factors covered the whole spectrum of society.

Session 4 — Adults who were abused as children

Dr. Sandra Buck, a member of the Institute of Psychosexual Medicine, talked about the victims of incest with whom she worked.

She described stages to consider in child sex abuse:

1. The Accommodation Syndrome. "Keeping our little secret" may progress to blackmail or threats and put a burden on the child to keep the family together. Secrecy then gives the promise of safety or perhaps more pocket money.

2. Guilt feelings. The adult feels they allowed it to happen, forgetting the helplessness of the child and so feel guilty at consenting.

3. Self hate. There is a need to believe one's parents are good. These victims turn their shame on to themselves. Some become withdrawn, some run away from home and others take an overdose. They may become aggressively self-mutilating.

4. Disclosure. This is often delayed until another sibling is abused, or there is an increase of sexual demand with violence. It may occur as a challenge to Father when he tries to prevent their normal social life and anger bursts out with the secret. This pressurises mother to disbelieve the daughter and support the denying father.

5. Retraction happens in the face of threats and blackmail or the implication that she is abnormal as other girls had liked it.

These stages were highlighted with poems written by a patient who had been abused.

A video followed of a woman who had great difficulty in disclosing what had happened and what she felt about the abuse she had experienced. When she found that she was loved and accepted instead of being condemned and

criticised she was then able to deal with her anger at her parents and grieve for her lost childhood.

This was a moving and fitting conclusion to the day.

Dr. R. Coles
I.P.M. Member

THIRTEENTH ANNUAL SCIENTIFIC MEETING OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE AT SELWYN COLLEGE, CAMBRIDGE

Friday 25th September 1987 saw the start of the Thirteenth Scientific Meeting of the Institute.

For many of us, Cambridge was a new experience and an additional reason for our pleasurable anticipation. We arrived in the sunshine and the quiet leafy streets, the mellow brick and stone of the colleges, with the green lawns and timeless air of the quadrangles, all lived up to expectation. The joyful welcoming encounter with the porters at Selwyn College must have made generations of students feel among friends, as it did us. We were accommodated in Cripps Court, a modern block with typical student accommodation, comfortable, but stark, as we saw it, with only the faint lingering aroma of sweat and books to remind us of more regular occupants.

We gathered for dinner in the Hall, from whose traditional panelled walls the past Masters looked down on a "monstrous regiment of women" (for the most part). The Diamond lecture hall where we had all our lectures contrasted strangely with its modern design and wood panelling. There we repaired after dinner and were regaled, not by brandy and cigars, but a delightful illustrated discourse by Dr. Rosemarie Lincoln on Culpepper, Stoppes and Wright, Seventeenth to Twentieth Century. Contraceptive methods from the condoms of fish bladders and sheep's caeca to stem pessaries and the modern pill were described. Such a history was a survey of women's attitudes to their sexuality, and their right to a fulfilled and active sex life unencumbered by feelings of guilt and anxiety about conception.

Dr. Mary Rees spoke on Saturday morning on helping HIV patients. Her courage and commitment to the work were clear. She made us face our own feelings about homosexuality and helped us to understand that promiscuous and casual sex were often an expression of inadequacy and loneliness. When Gay Liberation was given to homosexuals, they expressed it wildly, in a comparable way to women in the 1960s with the oral contraceptive. We can thus understand their anti-feelings about the condom, the challenge they feel in dodging the disease, their masochism, or sadism, in face of the disease.

The support offered by the gay community may be claustrophobic, and rejected. The HIV positive men may project their fear, anger, guilt and grief on to others, including the doctors. The mixed hostility and dependency felt towards their mother may often be projected on to the female doctor or counsellor. The counsellor may find herself their protector, but may then be in need of support herself.

It was a stimulating and thoughtful talk which made us look within ourselves for change before we could thoroughly understand the problem.

Swift on its heels followed "Promiscuity" as seen by Dr. Penny Oakley. Its causes were considered — genetic, or cultural as in West Indian studs, or peer group behaviour, or pressure. Bonding with sex was discussed, how touching creates affection but how with sex there is more excitement. It also involves other qualities with the possibility of reaching for the moon. The promiscuous will settle for less. They will not reach for what they cannot attain. Trivialised sex cannot hurt — as is seen in promiscuous homosexual relationships where there is fear of a 'bonding relationship' even with another man.

G.U. Clinic patients and F.P. Clinic patients were compared. The F.P. patients were good at contraception, in constant stable relationships, and had exciting sex; the reverse being true in all three criteria in the G.U. Clinic patients, despite their presumed variety of sexual experience.

It might have seemed that the next talk, 'Aids and Young People', would have drawn the preceding talks together, but Dr. Fay Hutchinson immediately dismissed this. Young people at the start of their sexual life, with a similar partner, are not in a high risk group.

At the Brook Clinic, there are three facets to the service provided — counselling, giving information and provision of free condoms. Aids need not be discussed with everyone, as routine. The information provided must suit their needs. The young are not aware of their mortality and 'the fear of death' promotion is not relevant or effective. The Brook's Aids Concern leaflet, 'Love carefully, use a condom', is geared to these youngsters.

The revolution in attitude to sex education material was illustrated by the Brook leaflet on 'How to use a Condom' — once branded as obscene and pornographic, now being recommended as ideal for distribution by the D.H.S.S.

Other changes have come with Aids as well as a more cautious attitude to sex. The male is no longer under pressure to perform on demand. Regrets are expressed by the older generation at the young no longer able to enjoy the freedom they themselves had. The fear of Aids has become a new excuse for avoiding sex. A plus, however, is the re-appearance of the young men in the clinic, requesting condoms, once again providing the opportunity for counselling.

Group work followed this with discussion of cases relevant to the talks.

Dr. A. Stewart
I.P.M. Associate

Dr. Janet Perrin started off the afternoon session by sharing her feelings about becoming an Institute doctor. She vividly described what it was like to join a seminar group comparing it to the start of an intimate relationship. Letting go, losing control and sharing feelings is risky and can be very painful. To avoid the pain she would give long histories of her patients, with no exposed feelings, and always keeping control of the situation. Rejection by the panel led her to retreat into domestic duties for a while before venturing into another seminar group. Here she discovered new faults in her

approach and became labelled as a problem-solving doctor by other members, who seemed very powerful, uncompromising women. She felt that she'd never fit in. This seminar was a no-man's-land where she couldn't let go because it would be too revealing. She found that she was only able to explore her patients' feelings as far as she could explore her own. With perseverance, however, the seminar group has now become the safe place to be, and with the loss of a medical model a changed doctor has emerged.

Dr. Christopher Sage mused on the insertion of "all" into his title of "mistakes along the way". He started with his experiences as a young graduate when language used could be a barrier to understanding. His reassurance to a man with gynaecomastia was interpreted by the patient as meaning that he would be better as a woman. Patients complaining of non-consummation produced discomfort in the doctor, and he resorted to Masters and Johnson for advice. Dr. Sage admitted that at this stage he had known a lot of facts, but not much about people. A description of being trapped in a full railway carriage listening to a young patient's problems aroused a mixed response of censure and sympathy from his audience. He has learnt that the patient may not always want help when we perceive problems. He summarised the talk by looking positively at mistakes made, and using them to reassess ideas and approaches.

After these two talks, we divided again into seminar groups to experience for ourselves the changes in practice we are trying to achieve. The autumn sunshine then tempted many into pleasant walks around Cambridge. In the evening, refreshed and renewing old acquaintances, we were treated to a delicious dinner in the old hall, with superb service. One felt part of a long tradition of diners in this cloistered atmosphere. The John Madden Players provided a lighthearted entertainment to round off the evening.

Sunday morning provided us with four very different papers.

Dr. Tom Main started off with an ever-fresh lecture on the Institute approach. He talked about the beginning of group training started by Dr. Balint, where the trainer listens and thinks about what is happening in the room, but does not solve the doctor's case, nor run the case for him. To start with, trainers were also psychoanalysts, but later other doctors were trained to pass on their skills. In the seminar we met to study the truth of a situation, with no evasion of feelings, or rushing to conclusions, and to make efforts to understand feelings revealed by the patient of which he or she is unaware. There is always a danger of reverting to the traditional medical model, moving from a listening to a telling method of work. 'Human trouble medicine' was contrasted with disease medicine and with behaviour therapy. The latter, such as Masters and Johnson, knows the norm and imposes it on the subject. The therapist takes responsibility for the patient, putting him in a childlike position. In the Institute way of working we study what the patient is like to be with now, and try to understand what this tells us about his other relationships. As doctors we have a privileged access to the patient's body which can give useful insights into his problem. Dr. Main concluded by reminding us that there is no room for an easy life in the Institute, but that it is always interesting.

Dr. Caroline Wilkins discussed non-consummating patients who experience distress. These patients became skilled at avoiding the risks of

closeness. They express or suppress feelings of anger and inadequacy at being unable to progress into a sexual relationship and be like everyone else. Dr. Wilkins coined the term 'dys-consummation' to describe patients who still suffered distress even though able to achieve intercourse. Pain shows a need for a defence, and we must understand the underlying anxiety which leads to this, and the fear of the consequences of exposure.

Dr. Horwood-Lee described the stages in the breakdown of a relationship. In the first stages during intimacy there is informal negotiation as each partner brings their own rules into the relationship. These are not articulated, and partners are often ignorant of their own rules. As the relationship deteriorates, both collude and the normal routine becomes a cover-up. One partner begins to withdraw, but keeps dissatisfaction secret from the partner. Dissatisfaction is displayed by deeds not words, and sexual intimacy deteriorates. Re-negotiation may be initiated either to save the relationship or to prove that it is unsalvageable. The partner may think that it is the initiator's fault and send her/him to the doctor for a cure. If both recognise the trouble and try to change, the relationship can be saved, but often the doctor is involved late on in a terminal relationship.

Dr. Katherine Draper gave an interesting talk about the changing nature of patients complaining of non-consummation. She described her first doctor/patient interaction with a lady, when she solved the *doctor's* anxiety by referring the patient to a colleague. When first investigating patients with non-consummation, success was achieved with a large number by encouraging self-examination and exploration of the fantasies revealed. Patients presenting now seem more difficult to help. Many attend, then withdraw from treatment, likened to maturation then separation from the parent. Some patients with personality problems cannot be helped at all. Dr. Draper described the seductive satisfaction in treating the first group, while recognising the reality of the second and third groups.

As usual, the weekend provided much food for thought, and an opportunity to re-assess ideas and insights. The amicable atmosphere makes one feel safe enough to expose one's own vulnerability. It is always stimulating to join a new seminar group, whose members bring different ideas to the work and initiate the process by which acquaintances become friends. Each year the presented papers seem to make more sense to me as my own experience develops, and this year was no exception. I left looking forward to next year's challenge.

Dr. M. Wheatley
I.P.M. Member

PRE-PUBLICATION PARTY AT CHANDOS STREET

On Tuesday 20th October 1987, Ruth Skrine and Jimmy Matthews gave a party at 11 Chandos Street to which members of the Leader Doctors' Workshop, the Council and other guests and spouses were invited. This was a pre-publication celebration of Ruth's book, "Psychosexual Training and the Doctor/Patient Relationship" and also to mark the foundation of the Montana Press. Jimmy Matthews' first contact with the Institute was by

printing the Prospectus. Since then he has printed the Bibliography and the Newsletter. Ruth's book is his first venture into medical publishing.

The party was a delightful family affair. Jimmy and Ruth's husband Ralph poured the wine to accompany Ruth's delicious food. Introducing spouses to colleagues promoted a certain anxiety. Our training encourages us to keep our private lives private — and Institute doctors never stop working! Much of the conversation was about groups and cases. Nevertheless it was a very happy and enjoyable occasion.

Ruth thanked the members of the Workshop who had allowed her to put their private thoughts and feelings into print, and Tom Main and Prue Tunnadine, the leaders who had allowed their names to be used. She remarked that it was like asking a lot of middle-aged men and women to undress in public when they were neither too happy about their bodies nor the state of their underclothes! She also thanked Jimmy Matthews for his courage and integrity in publishing the book. Tom Main then thanked them both on behalf of the guests.

The Montana Press is situated in the mountains (or rather fells) of Cumbria. Its name comes from the shrub *Clematis Montana*, a climbing plant of rampant and vigorous growth. Perhaps an appropriate model for the Institute, too — even to its many gentle blooms! It is to be hoped that Jimmy Matthews' interest in publishing our work might encourage some of the rest of us to follow Ruth's excellent example.

Dr. Heather Montford
I.P.M. Member

BOOK REVIEWS

Psychosexual training and the doctor/patient relationship. Edited by R.L. Skrine, M.B., Ch.B., M.R.C.G.P.. Montana Press, P.O. Box 67, Carlisle CA4 9DE. 392 pp. £17-50.

This book must surely be unique. It allows the reader to be an observer of leader doctors working during a training Workshop as they share their difficulties and vulnerabilities with Drs. Main and Tunnadine. The text of the book is taken directly from transcripts of leader workshops run in the style of Balint groups.

The editor makes it clear in the introduction that her objectives were to capture original thought and ideas, and to record an exciting method of acquiring leadership skills in Psychosexual Medicine. She has surely succeeded in those objectives.

Dr. Marshall Marinker's foreword gives an illuminating overview of the book's content and the experiences the reader is about to share.

To help the reader, the book is divided into three sections. The first concerns itself with the individual doctor and his learning. The second looks at the learning of the group and the final section concentrates on the acquisition of leadership skills.

It is not a book for those who like didactic teaching. The reader will not find lists of facts but a report, in conversational style, by leaders as they are

helped to think through the interactions in which they find themselves. In the words of Dr. Tom Main, "Thought is like wool and there is no substitute for it". This book needs careful and considered thought as it is read, if benefit is to be gained.

The workshop leaders highlight some of the defences doctors use to avoid work, e.g. history taking, inappropriate examination and multiple investigations. This book may become a defence against getting involved in training — beware the reader who uses the book as a teacher instead of allowing the live situation to stimulate thought.

Without doubt this is a superb reference book for those already involved in the training of doctors in Psychosexual Medicine. It will also whet the appetites of those doctors dissatisfied with more widely known methods of acquiring new skills with their patients.

Dr. Anne V. Smith
I.P.M. Member

Sexual abuse of young children. K. MacFarlane, J. Waterman et al. Holt, Rinehart & Winston. 355 pp.

It will come as no surprise to those used to trying to obtain information from very young children that special techniques need to be employed and that to use a face-to-face spoken interview is doomed to failure. How to employ play material is described several times in this multi-author book and is an indication of how, by trying to appeal to everyone from judges to specialists in this field, the verbiage conceals the useful information. Much of the information presented is, in fact, about older children and demonstrates that little work has been published about the younger age groups. Such evidence that is presented does show that there may be considerable differences between the abuse of very young children and that occurring in those who are older, both in the response of the child and the type of abuser.

The use of video-taping is examined carefully. The advantages of having a permanent record when retractions of initial disclosures are common, is balanced against certain disadvantages. The assessor may be accused of using leading questions. This and the inconsistencies often found in children's evidence may be used by defence counsel to discredit the child's whole account. The use of a video-tape therapeutically with the abused, the abusers and the family is also well described and provides much food for thought.

Despite the legal procedures being so different (and so varied) in the States, many of the suggestions for reform could be adopted with advantage in this country. It is clear that the trauma to the child may be magnified greatly by the ordeal of testifying in a criminal case and the establishment of the facts of the abuse should be the main aim in order to provide treatment for all involved.

The types of treatment outlined in the book will have little relevance to the work of Institute-trained doctors and years of treatment and group therapy with rôle-playing by therapists is hardly likely to be widely available anywhere.

In the present enthusiasm for identifying sexual abuse little thought has been given to what we do with the information. To quote from this book, "All over the country, new programmes are being instituted that encourage children to tell us if they are, or have been, sexually abused. Will their disclosures be met with sensitivity, support and competent intervention that feels like help, or will they learn that it is not only individual adults that they cannot trust, but our protective, therapeutic and legal systems as well?"

An interesting book, worth recommending for the postgraduate library.

Dr. G.M. Wakley
I.P.M. Member

JOURNAL REVIEWS

Whitehead, A. & Mathews, A. *Factors related to successful outcome in the treatment of sexually unresponsive women.* Psychological Medicine, 1986, 16, 373-378. (from the Dept. of Psychology, St. George's Hospital, London).

Forty-eight couples were treated by the modified Masters & Johnson approach and assessed blindly at completion of treatment. Seventy-nine couples were assessed initially and offered treatment. Eight declined and twenty-three dropped out before completion. 33% of the presenting couples, i.e. 54% of the treated couples, improved. Of the pre-treatment predictors, only a good quality of the couple's general relationship and couples who rated themselves as more sexually attractive were significantly associated with a successful outcome. Age, the chronicity or severity of the problem and other ratings made by the couple or the assessor were not related to the outcome.

In the discussion, it is suggested that satisfying sexual behaviour cannot be re-established in an essentially soured relationship and that 'proper compliance with homework assignments' was crucial in determining a successful outcome with this treatment.

This study demonstrates clearly the difficulties inherent in treating sexual difficulties as though they are similar to difficulties in reversing a car round a corner. Sensate focusing may be useful in helping couples to look at their feelings but if these are of revulsion or apparent indifference, this will undoubtedly hinder progress using this technique. Use of the doctor-patient interaction to help both understand what is going on must be of more use in this situation than trying to interpret what went on between a couple when you were not there.

Morokoff, P.J. & LoPiccolo. *A comparative evaluation of minimal therapist contact and 15-session treatment for female orgasmic dysfunction.* Journal of Consulting & Clinical Psychology. 1986, Vol. 54, No. 3, 294-300 (Texas A & M University).

The women treated were those who did not achieve orgasm in any type of sexual situation. Fourteen couples were treated by minimal, i.e. monthly, therapist contact (MTC) for four sessions. Twenty-nine couples were enrolled in full therapist contact (FTC), i.e. weekly therapy for 15 sessions.

Both groups were given homework involving masturbation and behavioural sex therapy. Both groups improved but the MTC group did better. The authors speculate that this might be because the women in this group saw themselves as active and responsible for change rather than being acted upon by a therapist. They conclude that orgasmic dysfunction is a skill deficit which can be improved by assignments (and a vibrator, despite the reservations the therapists had about using this!) rather than something requiring psychotherapy.

From our own work, I would conclude that the most important factor was that the women found their own solutions, being able to take from the programme presented what *they* wanted to do. Imposed solutions rarely, if ever, work!

Dr. G.M. Wakley
I.P.M. Member

THE ANNUAL GENERAL MEETING

The 13th Annual General Meeting of the Institute of Psychosexual Medicine was held at 11 Chandos Street on 18th March 1988. Thirty-four members were present and apologies were read.

The minutes of the 12th A.G.M. which the membership had received were signed as being a correct record.

The following comments were made by the officers whose reports had been previously circulated:

1. Dr. Thexton, the Director of Training, said that a new basic seminar led by Dr. A. Tobert at 11 Chandos Street would start in May 1988 on Wednesdays at 1.30 p.m. All interested should contact Dr. Thexton.

2. Dr. Yorston, the Treasurer, said that in simplifying the accounts, the conference fund was being transferred to an investment reserve account and the training fund would be amalgamated with the general account. The current assets may appear high but computer purchase and necessary office changes will shortly diminish it. Dr. Yorston said that Mr. Ron Trowbridge will stay on a little longer to facilitate the handing over of duties. She reminded the meeting of the tremendous help he has given since 1981 when Dr. Jane Benry died, and the meeting applauded his efforts.

Dr. Morag, Lady Bramley, the Editor, said that she had been pleased to receive articles on childhood sexual abuse. She urged members to keep submitting pieces mindful of the instructions to contributors inside the back page of the Newsletter. The next issue deadline is mid-August.

Dr. Lisle's report on the NAFFPD Council was circulated. The Council had discussed during the year: 1. a possible Faculty of Family Planning, which might also cover Reproductive Health Care; 2. the D.H.A.'s proposals for cuts in F.P. services; 3. screening for cervical cancer and the need for freedom of choice as to where it should be done; 4. Aids guidelines; 5. J.C.C. Certificate requirements; 6. DHSS paper on 'Performance Indicators'; 7. the 'Alton' Bill. A research award is to be established in Dr. Margaret Jackson's memory.

Dr. Skrine was congratulated on being awarded an honorary fellowship of N.A.F.P.D. She then gave the Chairman's address.

She said it had been an exciting and a frustrating year. At last the Constitution had been accepted by the Charity Commissioners with only minor adjustments. It had involved a lot of work.

Dr. Skrine said the new office was now open although there is still some anxiety as a sub-tenant has not yet been selected. She thanked Mrs. Green who is continuing until a successor can be found to replace her.

Fund-raising activities to support the work of the Institute had been disappointing up to now. The DHSS had been approached but they were only interested in helping the research seminar on childhood sexual abuse. Unfortunately this seminar has been suspended because of lack of support. The DHSS offers no other support for training. Dr. Skrine has written to Mrs. Edwina Currie about the closure of family planning clinics and the impact of this on psychosexual work. She also asked for financial help. The letter has not yet been acknowledged.

Ms P. Taylor and Ms Sue Barnett had been very helpful with the launch of the book, "Psychosexual training and the doctor/patient relationship". They had suggested a small press conference for medical journalists. The book has so far been reviewed in 'Doctor', 'Pulse' and the British Journal of Family Planning.

Dr. Skrine said that local medical councils could make proposals to the B.M.A. about the furtherance of psychosexual work and training. Three proposals would be sufficient to include the matter in B.M.A. policies. The deadline for proposals is very soon, so perhaps this could be a project for next year as the wording of proposals is crucial.

Dr. Skrine thanked Dr. Kilvington, the programme secretary. One-third of the membership always attend the annual clinical meeting. Dr. Kilvington's organisation has been impressive. Her gracious and charming persuasiveness will be missed as she now ends her term of office.

Dr. Skrine thanked Dr. Jessie Yorston for her meticulous care in managing the accounts. She had performed a remarkable task in converting modest means into a healthy financial state. She had always provided solid support and sensible advice.

Dr. Skrine also thanked Mr. Ron Trowbridge for keeping the membership updated. We have been lucky and privileged to have had his dedication.

Dr. Audrey Jones was welcomed by the Chairman as new Treasurer and Dr. Vanhegan as Programme Secretary.

Dr. P. Tunnadine, the Scientific Director, gave her report. She has appointed a committee to provide a 'Think-tank' to oversee standards and provide advice on contentious issues and which will be available for help to all officers of the I.P.M.

The committee has already met and will do so tri-annually. It consists of Dr. S. Filshie, Dr. M. Gill, Dr. J. Gilley, Dr. A. Parker, Dr. A. Smith and Dr. G. Wakley.

The committee will have three consultants: Dr. Main to advise on psychiatric matters, Dr. Freedman on general practice, and Dr. Skrine.

The election of Council followed. Because of the new constitution there was only one vacancy. Only Dr. Dorothy Howell had been nominated. Dr.

S. Gibb proposed her and Dr. Jessie Yorston seconded the proposal. Her nomination was accepted.

Dr. Roland Freedman then spoke about a conference to be held on 28th and 29th October 1988 in Bayswater on 'Couples in trouble'. Various disciplines were to be represented including the I.P.M. There were vacancies for about ten. Interested doctors should contact Dr. Freedman.

Dr. Fay Hutchinson reminded members of a meeting at the Royal Society of Medicine on 23rd April 1988 entitled 'The quality of sexual life'.

The business meeting was then concluded.

A delicious buffet supper with wine preceded the address by Dr. Prudence Tunnadine, which will be reported in the October 1988 Newsletter.

Dr. J. Coombs
I.P.M. Member

NOTICES

PANEL PASSES, November 1987

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

Dr. Pauline Allen,
Brook Cottage, Church End, Eastington,
Stonehouse, Glos. GL10 3SB

Dr. Lesley Bowen,
Back Street, Alkborough,
Scunthorpe DN15 9EY

Dr. Beatrice Campbell,
Beacon House, Beacon Road,
Ivybridge, Devon PL21 0AG

Dr. Jeanette McGorrigan,
16 Robertson Drive, Walkley,
Sheffield S6 5DY

THE ACCREDITATION PANEL

Doctors wishing to present their work for assessment should write to: The Panel Secretary, Institute of Psychosexual Medicine, 11 Chandos Street, Cavendish Square, London W1M 9DE.

The next meetings of the Panel will be at the above address on 25th May 1988 and 23rd November 1988. Early booking to avoid delay in being assessed is advised. Those wishing to present in May should contact Dr. Roberts directly (*see inside cover*).

The Panel currently consists of:

Dr. M. Roberts (Secretary)
Dr. A. Tobert (Chairman)
Dr. G. Hinshelwood
Dr. M. Gill
Dr. S. Lucas (Reserve).

FROM THE PUBLICATIONS SECRETARY

The Institute Bibliography is out of date and needs early amendment. Please will any Member or Associate who has an article or book published, let me have a copy for the office at Chandos Street.

In future we hope to sell reprints of articles and to hold an accurate list of subject information with journal references.

Speakers presenting papers at meetings are requested to submit them in written form, taking account of confidentiality and literacy so that presentations can be published if thought to be suitable by the Institute and the author.

Dr. R. Lincoln

JOB OPPORTUNITIES

Eastbourne F.P. Clinic, 2 Psychosexual sessions per month, preferably Thursday morning. Apply for details to: Dr. M. Wigfield. Tel. 0323 27121.

Woking One Psychosexual session per week, on Thursday but moveable. Apply for details to: Dr. J. Peebles. Tel. 01-783 1452, or write to 14 Riverbank, East Molesey, Surrey KT8 9BH.

NEW ASSOCIATES

Dr. Caroline Albiston	33 Cedar Road, London NW2 6SN
Dr. Carole Ashton-Jennings	20 Cargagh Road, Annacloy, Downpatrick, Co. Down BT30 9AG
Dr. Zia A. Fareedi	53 Owls Lodge Lane, Mayals, Swansea SA3 5DP
Dr. Ruth C. Fear	118 Buryfield Road, Solihull, W. Midlands B91 2DP
Dr. Shareyu Kumar	Prashanti, 9 Mizen Way, Cobham, Surrey KT11 2RG
Dr. Heather Mellows	28 Snaithing Lane, Sheffield S10 3LG
Dr. S.A.V. Thillainadarajah	2 Sporhams, Basildon, Essex SS16 5TS

NEW SUBSCRIBERS

Dr. Yuri Levy, M.D., Lic. es Sciences	Poria Eilt, 15208 Israel
Dr. Deirdre A. O'Brien	18 Carlton Road West, Westgate on Sea, Kent CT8 8PL
Dr. Veronica Pearson	The Vicarage, Woolley, Wakefield WF4 2JU

Prof. Jorge J. Serapiao Rua Marques de Abrantes 177, Apto. 303
Flamengo, Rio de Janeiro ZC 22230,
Brazil

Dr. Sian L. Williams 84 Ringford Road, Wandsworth,
London SW18 1RR

CHANGES OF ADDRESS

Dr. Alessandra Bispham to: 51 The Woodlands,
Esher, Surrey KT10 8DD

Dr. Edna Clitheroe to: Woodland Lea, 1 Somerby Road,
Cold Overton, Leics. LE15 7QB

Dr. Linda Egdell to: Gelli Gynan Lodge,
Llanarmon-yn-lal,
nr. Mold, Clwyd CH7 4QX

Dr. Jean C. Marfleet to: 11 Fitzwalter Road,
Colchester, Essex CO3 3SY

Dr. Veronique Moens to: 6 Sibley Park Road, Earley
Reading, Berks. RG6 2UB

Dr. Jennifer Peebles to: 14 Riverbank
East Molesey, Surrey KT8 9BH

Dr. Jane Price to: 24 Castle Crescent,
Reading, Berks. RG1 6AG

Dr. Joan Stephens to: 1 The Glebe,
Cumnor Village, Oxon. OX2 9UJ

Dr. Anita J. Taylor to: 2 Yew Tree Avenue, North Anston,
Sheffield S31 7EW

Dr. Valerie Thompson to: 80 Harley Street,
London W1N 1AE

Dr. Gail S. Young to: 38 Moorside South
Fenham, Tyne & Wear NE4 9BB

I.P.M. CURRENT TRAINING SEMINARS

BASIC SEMINARS

REGION	TERM	LEADER	PLACE	TIME
Northern	2nd	Dr. A. Smith	Newcastle	Wed.eve
	2nd	Dr. J. Munro	Penrith	Sat.am
Yorkshire	6th	Dr. J. Coombs	Bradford	Wed.eve
	3rd	Dr. D. Anderson	Hull	Th.noon
Trent	Ongoing	Dr. J. Tattersall	Sheffield	Tue.eve
	2nd	Dr. S. Filshie	Nottingham	Fri.pm
East Anglia	Ongoing	Dr. B. Devereux	Norwich	Fri.1230
	2nd	Dr. R. Lincoln	Bury St. Ed.	Mon.1230
	4th	Dr. R. Thexton	Cambridge	Mon.eve
N.E. Thames	2nd	Dr. R. Sampson	Finchley	Fri.pm
	5th	Dr. S. Lucas	Romford	Wed.pm

S.E. Thames	2nd	Dr. A. Jones	Bromley	Th.eve
	2nd	M. Roberts	Canterbury	Th.pm
S.W. Thames	5th	Dr. S. H.-Lee	Wimbledon	Th.pm
	Ongoing	Dr. T. Main	Sharpethorne	Fri.pm
N.W. Thames	1st	Dr. A. Tobert	Chandos St.	Wed.pm
Wessex	2nd	Dr. H. Montford	Southampt'n	Fri.pm
S. Western	4th	Dr. J. Tisdall	Plymouth	Mon.eve
Wales	Ongoing	Dr. H. Backer	Swansea	Th.pm

CONTINUATION SEMINARS: Post Basic

E. Anglia	Dr. B. Devereux	Norwich	Wed.1230
Wessex	Dr. R. Thexton	Southampt'n	Fri.pm
S. Western	Dr. H. Backer	Gloucester	Th.pm
	Dr. J. Tisdall	Plymouth	Mon.eve

ADVANCED

Northern	Dr. R. Freedman	Newcastle	Wed.eve
N.E. Thames	Dr. P. Tunnadine	Islington	Mon.pm
N.W. Thames	Dr. T Main	H'smith	Th.pm

RESEARCH

N.W. Thames	Dr. T. Main	H'smith	Wed.pm
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OTHER

E. Anglia	Dr. R. Lincoln	Ipswich	
		for F.P. and Practice Nurses	
	R. Thexton	Cambridge	
		for F.P. and Practice Nurses	

PLANNED for the future

Basic groups in Leeds and Manchester

Seminars RECENTLY COMPLETED include those led by —

Dr. S. Snead in Birmingham (basic)
Dr. M. Bramley in Sheffield (advanced)
Dr. R. Skrine in Bristol (for physiotherapists)

REGIONAL TRAINING CO-ORDINATORS

Northern	Dr. A.V. Smith	6 The Crescent, Longbenton, Newcastle upon Tyne NE7 7ST Tel. 091 2662554
Yorkshire	Dr. D. Anderson	4 Newstead Road, St. Johns, Wakefield, Yorks. WF1 2DE Tel. Wakefield 372836

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INSTRUCTIONS TO CONTRIBUTORS

Articles on all aspects of psychosexual medicine where the doctor/patient interaction is studied are welcomed for publication in the Newsletter. Manuscripts should be typed on one side of A4 paper, double-spaced and with wide margins. Pages should be numbered.

The first page should include the title, the name and qualifications of the authors and their appointments. Each page should bear the title and author's initials. Please send two copies and retain an identical one. Patients' names, locations, jobs and other identifying features should be disguised.

Letters to the Editor are welcome. Correspondents should state their qualifications and address.

Contributions for the October 1988 edition should reach the Editor by **14th August 1988**, preferably much sooner. The address is: **Greenhills, Back Lane, Hathersage, Sheffield S30 1AR.**
