

IPM DIARY OF EVENTS

Tuesday November 22 1988, 8.00 p.m.

Autumn Meeting with the Balint Society at the Royal College of General Practitioners. The subject is, "The Short Consultation".

Friday March 17 1989, 5.00 p.m.

AGM at Chandos Street. Dr. Skrine will speak at 8 p.m. on "Siren Songs — the temptation to regress".

Friday September 22 — Sunday September 24 1989

The Annual I.P.M. Scientific Meeting at Aberdare Hall, University College, Cardiff.

OTHER DATES FOR YOUR DIARY

Queen Charlotte's Hospital

Monday & Tuesday October 17 & 18 1988.

Conference on Problems in Psychosexual Medicine. Dr. Thexton will be a speaker.
R.S.M.

Saturday October 22 1988.

All day meeting on Sexuality and Mentally Handicapped people

Saturday April 15 1989.

All day meeting. Sexual Abuse. Part 3.

Kings Fund College

Friday & Saturday October 28 & 29 1988.

Sexuality and the Couple. Alternative perspectives in therapeutic work. There are limited places. Apply to Relate: Marriage Guidance, Drayton House, 30 Gordon Street, London WC1 0BE.

N.A.F.P.D.

Saturday January 18 1989.

Durley Hall Hotel, Bournemouth. Affiliated Group Meeting (to be confirmed).

Friday May 5 1989.

N.A.F.P.D. AGM and Symposium. At R.C.O.G.

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. Any work, article or book referred to should be given a reference at the end in the Vancouver Style. References should be numbered consecutively in the order in which they appear in the text. Please send two copies of the unfolded manuscript 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 May and October letters 1989 should reach the Editor by February 28th or sooner and 1st August 1989. The address is: Greenhills, Back Lane, Hathersage, Sheffield S30 1AR.

Institute of Psychosexual Medicine

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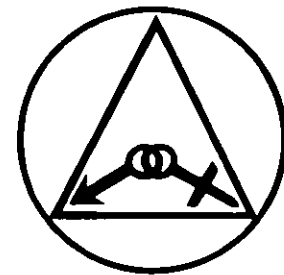
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MARCH 1988 — 1989

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INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 34, OCTOBER 1988

EDITORIAL

Three important changes have taken place in the IPM over the last year. A new larger office in Chandos Street and a computer have been acquired to make Institute affairs more centralised and efficient as the work expands.

Mrs. Margaret Gilbey has replaced Mrs. Judith Green in the Chandos Street office. We are very grateful to Mrs. Green for her faithful service to the Institute.

Our Chairman Dr. Skrine is to be congratulated on completing the tedious task of obtaining acceptance of our constitution by the Charity Commissioners.

The leader doctor seminars now occur once a month instead of fortnightly and have been much better attended. The transcripts of these are greatly valued by the participants. Other members who would like to benefit from them should read Dr. Skrine's book, "Psychosexual training and the doctor/patient relationship" which was derived from such transcripts.

In this issue there are three articles where child sex abuse was a factor, but it seemed that inadequate mothering made more contribution to the difficulties than the sex abuse. For those of you who wish to pursue other aspects of this subject, a book list is included.

Dr. Tunnadine's "Whither Psychosexual Medicine?" reminds us that no matter what new medical discoveries, innovations and procedures lead to psychosexual and related emotional problems, the using of the "here and now" situation is still vital to the individual treatment of patients. This is always a continual challenge to constructive thinking. As usual she has lively interesting case illustrations.

Dr. Gill's paper helps us in a unique way to look at how our unconscious hang-ups and difficulties can relate to those of our patients and hinder understanding. In her reported cases, three out of four presented as couples. In the first, the doctor/patient interaction was with the man. The wife was present but rather passive. The second was again with the man and the wife eliminated herself. In the third, an unconsummated colluding couple, it was a doctor/couple interaction, which worked well. It resulted in both partners maturing and intercourse being achieved.

For the next Newsletter I would be very pleased to receive articles studying the doctor/patient relationship when couples present by chance and not choice. Understanding why we treat one or both, or one after the other, or none, and what was useful and why, will be interesting. The deadline for copy is 28th February 1989. Please read contributors instructions on the back page.

Letters to the Editor whether critical, controversial or suggesting further subjects for articles would be welcome.

Morag Bramley

WHITHER PSYCHOSEXUAL MEDICINE?

How long does it take to make a tradition? In recent years speakers after the AGM have taken the opportunity to stray from our usual rigid discipline of strict case reporting into philosophy and speculation. Dr. Main shared with us — most movingly, I thought — something of his earlier work. Dr. Freedman traced our history from Freud through Balint and Main. Those of you who were at Cambridge will know that this year Dr. Main has been increasingly insistent that the torch must pass, and I therefore want to look to the future.

The only growth point of human knowledge is the question mark. My title tonight has a question mark which will be my theme. We owe to Freud, Balint and Main that they were all innovators. Main's contribution — to my training at least — perhaps to the Institute itself — is, I propose, that of challenge to thought rather than obedience to doctrine. And yet what makes their innovative inheritance so difficult is the perpetual question mark. We all — doctors and patients alike — long for certainty. Arguably — I have said this before and no doubt will say it often again — uncertainty is of the very nature of sexual difficulty.

We need to decide what is psychosexual medicine before we can speculate together about its future. It is, I suggest, a method of individual doctoring for individual patients. We shall each have different definitions and why not? I can only offer my own.

Is there a "method" at all? I believe yes, but not simply to do with getting people's pants off in order to show them how their bodies work, as some of our critics postulate. Nor is it merely about getting them on a couch to see how they react to intimate exposure, though that is perhaps at the heart of our innovation. Mrs. Raphael, who is always worth listening to, found the phrase "Applied psychoanalysis" in the Prospectus pretentious. And yet the concept which Balint and then Main dared explore with us — that psychoanalytic insight could be applied to physical body doctoring, and of such intimate and rude kind — is indeed revolutionary.

Rather is our essence that of awareness of the here-and-now doctor-patient interaction as diagnostic (and our sharing of such perceptions with the patient as therapeutic) *whatever is going on*.

Thus for example, one cannot examine the doctor-patient interaction in a Masters and Johnson ritual or in a hypnosis session since the method is fixed. One can, however, study how one came to suggest such ritual on the one hand, or how the patient responds to such offers on the other. Thus in hypnosis a doctor-patient relationship in which the doctor is in total command and the patient totally passive is of considerable interest!

This concept is, however, applicable to all analytically based psychotherapy. What then are we *not*? For in looking to our future, defining our limitations is at least as important as our potential development.

Woody Allen speaks of his quarter century of analysis as being great to have an hour every day just for yourself. This is not us, is it? Nor are we about Balint's cradle-to-the-grave doctor-patient relationship of general practice, though our general practice members do have that to contend with

in addition to the brief encounter. Perhaps we are nearer to the Balint-Norell "six minutes"¹, or the Courtenay "flash"². Certainly the doctor-patient relationship I study is something which is evident and changing from moment to moment; which may be transformed by their action or mine, for good or ill, several times in the course of ten minutes.

Sometimes, trying to illustrate the doctor-patient relation, I quote the very old analytic joke in which the analyst is fast asleep and the patient is whingeing on . . . "and another thing: everyone says I'm so boring". There was another in *Punch* recently. This time the patient was a businessman and the analyst was taking notes. The patient is saying, "Yes I know. I'm aggressive and self-centred and dictatorial and I relate poorly to other people. Now read that back!" But this is not of course the whole story; only the patient's, or "transference", half. We are not passive receptors but play our own part in perpetually modifying the dynamics of the interaction.

This leads me to recent arguments about the importance of history. Of course history is not bunk in our work; almost all our patients have reasons or triggers from their past which throw light on their present condition. For me what matters is how this history is elicited. If in response to questioning, we get perhaps the answer they feel we want to hear; or perhaps a denial of the negative elements. Both may be relevant but the evidence is already loaded. If in contrast the history comes in response to an interpretation of the "here and now" it is more likely to be directly relevant to the patient's present attitude.

A young man who actually introduced himself as "Williams the gentleman's gentleman" concealed his obvious fear of all close or dependent relationships by lugubrious over-politeness. Having offered long stories about his "wonderful" childhood in which all his relations and multiple foster parents had been so good, he returned the following week and at once ejaculated an apology for some, he felt, out of order remark at the previous meeting, which had been too guarded for me to notice. On interpretation of this he began to drop heavy hints as to the need for genital examination — doubts of "adequacy" — but refused the offer snappishly with flashing eye. On my wondering why this should be he responded that he had been much embarrassed by an earlier "wonderful" Institute colleague. Offered that he must feel the same here, and yet a bit of him seemed to crave reassurance about his manhood, he burst into tears. A different view of his childhood poured out. His father had died when he was three; his mother at eight. "No-one but my mother", he wept, "should have touched me there, not even grandmother". We then heard of the series of foster-homes, and that his first "real friend", in the Army, "who didn't think him odd" had deserted him for "rougher chaps". We got in touch with the rage behind the tears; the need to inhibit this to survive, and male assertiveness along with it, and arranged for more intensive psychotherapy, parting on reasonably honest terms.

Whither, then, shall we take our use of this training? Williams' sexual difficulty was the merest symptom, yet we began to work with the sort of person he was more generally. I have often compared our work to exploratory, as distinct from planned, surgery; yet exploratory surgeons

sometimes have to close up as inoperable. Perhaps we stay within safe bounds if we always refer our perceptions of the patient back to the presenting problem; comparing their reaction to us always with those in their outside world. Certainly by harping on the doctor-patient relation *without* so doing we are in danger of inviting dependency. But so, of course, does providing their answers instructively! What a delicate path we tread! And how rewarding are the brief “unclever” things we do.

At the Islington seminar we heard two such in one afternoon. One doctor at a family planning clinic reported honestly feeling somewhat shocked to be asked about a partner who had suddenly revealed a taste for beating. She had struggled to hide her reaction and be “very liberal” about it. The group had rich discussion as to how deeply pathological this might be, but at the return visit the patient was much relieved and the beatings had stopped! The next was a referred patient who also demanded the doctor’s opinion about sado-masochistic practices, to which the doctor responded, “It is not what I think but how you feel that matters”. Again this had sufficed to help the patient return to a more “normal” sexual life. We should not fear, surely, to express our clinical judgment provided we also allow for interpretation. One of my own was a distinguished career woman who had become involved with a divorcé of a different culture. He had pursued her extravagantly but once they had been to bed had begun to treat her as a “possession”. She said on the couch, “By the way, he has introduced me to anal intercourse. Is that all right?” I replied, “Not if he has AIDS”. We were then able to discuss why she should be so abject in her inability to say no; to need my opinion. She had been the daughter of a serviceman, always on the move, forever losing friends.

In asking whither, these anecdotes draw attention to the changes in our field already; in public mores as to what is acceptable in sex and in presentation. Even in contraception attitudes come full circle. In my youth, to carry sheaths in the wallet was a macho thing to do, even for those who might have run a mile should we take them up on it! Today, after a generation of female contraception for which we must take some responsibility and even pride, we want sheaths to be used and they are now regarded as unmanly. I doubt whether “show you care” will attract condom use; rather, I guess, we should be saying, “*Real* men use condoms”, with plenty of black leather and revving motor bikes!

Despite this, men have come increasingly for help. None of us would wish away, I am sure, women’s increased aspirations for pleasure and choice, but these in themselves have increased performance pressure — on women themselves as well as on their less confident partners. If there is any good at all to come out of the horror of AIDS, perhaps it may bring back courtship, and remove the pressure on boys and girls alike to “make it” as an automatic response to the first shared hamburger.

Thus with increased openness, visiting cards too have changed and will change. I would not pre-empt the Sexual Abuse Research Seminar, but in my own practice I already see not only increased freedom to confess; I meet too “Oh by the way I was abused as a child of course . . .” as a kind of entrée to the discussion of what I have called “justified frigidity” — anti all men,

having no right to refuse. Others I have met with such history seem to have turned their sexuality into a kind of “little nurse”, dispensing-largesse system, able to find pleasure only thus; having to deny pleasure-seeking. Others — non-abused siblings — sometime reveal not so much envy, as a sense of failure; of not being a “real” sexual person*. We need to be careful here, I believe, of seduction by the hard luck story: the “hearts and flowers”. By “agreeing” what an awful thing this is, we lose the opportunity to be in touch with the forbidden excitement; the “mothering” that might *not* wholly condemn.

We meet too now the syndrome by which pregnancy, so carefully planned, is in danger of becoming a “big deal”. Those who have reason to worry about their mothering capacity — whose own mothers have been either shaky or too bloody marvellous: hard acts to follow — may be at special risk of post-partum frigidity or depression. And every media hype, each “flavour of the month”, brings its own crop of anxieties for which our brief psychosomatic approach can be helpful, often in one short consultation, trained as we are to see behind the face value presentation. Pill and coil scares; herpes, HPV, AIDS; “natural childbirth” and abortion; IVF; HRT — we shall not be short of future applications.

To return to our special application; our interest in the unconscious facets of physical examination may also have further application than to the genitals. I have spoken before of my impression that women offer anxieties at breast examination — too big, too small, whatever — which may benefit from similar symbolic interpretation, and often relate to their maternal vision of themselves. What of other “body image” problems? Anorexia seems to me a good example of what may and may not be within our bounds. I meet some adolescents, shape-conscious and diet-obsessed, who seem simply to be retreating from the challenges of adulthood; ambivalent about rebellion; the wish to keep a “child’s” body interpretable in the doctor-patient relation much as we might in virginal anxiety. Conversely, if an emaciated woman looks in the glass and sees fat, that is surely psychosis, if psychosis means an inaccurate perception of reality.

Similarly I have met some transvestites whose chief problem would seem to be the shame, or their partner’s intolerance, maybe only needing an unusual fantasy to masturbate to. Such may be helped quite easily by noticing this in the doctor-patient interaction. Others seem deeply confused as to their nature, while the transsexuals I have met, plausible and intelligent though they may be, seem to me quite unresponsive to interpretive work. They too perceive reality, if not psychotically, then certainly through strange eyes, in that they believe themselves to be in the wrong body.

And yet — *plus ça change*. . . .

A young woman of the strict Jewish Hasidic sect wanted her period altered for the wedding, since she had to keep the 13 days. We had to strengthen the pill since she had an absorption problem, having lost part of her colon for some congenital abnormality. She was easy to

*Footnote: here I invited Dr. Main to give a personal anecdote: during family discussion of the frequency of child sexual abuse his psychoanalyst daughter joked, “I can see I must have been a very unattractive child!”

examine despite the hymen, and it was not until about the tenth early morning phone call, counting on our fingers together, that I finally said, "It seems to me you are worried about something. . . ?"

And then there was the Irish Yuppie. Successful in the City, designer-clothed, she said of her three-years-married non-consummation, that she came from "the bog" and was one of eight. Her Catholic mother had told her it was disgusting but that once she wanted babies she would manage. No, she didn't want further treatment, thank you, just the smear. (They say non-consummation gets easier to treat; not in my experience!)

An elegant Muslim couple had not made love for 13 years of their 14 year marriage, apart from briefly when their son was conceived. She had had long analysis elsewhere, so that her husband was none too keen on the prospect of further prolonged therapy. Her seduction by a servant in childhood had been much explored, explaining her sense of the dirtiness of her own desires. Among all this apparent insight the fact that she had found her husband's courtship wildly exciting had somehow been forgotten. On the couch she remarked shyly that she was afraid her labia were very black. This led to discussion of colour in general; of "dirtiness" and fastidiousness; of second class citizenship; of worthlessness. Her husband had apparently taken her fear of premarital intercourse as a sign of her lack of desire for him. The mutual projection of "unattractiveness" was even clearer when he himself came, revealing he could not believe such a beautiful on-a-pedestal woman could truly find him desirable. He had his own reasons for feeling himself only fit for the whores of the Lahore bazaar. They are making love again; I hope, soon, with confidence.

In "A Passage to India" the character Charles Fielding, the schoolmaster, is talking of going on the road as a holy man. Forster has him say this:

"... my job is education. I believe in teaching people to be individuals and to understand other individuals. It's the only thing I do believe in". He goes on to say, "At Government College I mix it up with trigonometry and so on. When I become a siddhu, I shall mix it up with something else".

I believe that if we stick to our task, the here and now of the doctor-patient interaction first, last and always, then what we choose to mix it up with in future will be for each of us to decide.

Dr. P. Tunnadine
Scientific Director of I.P.M.

This paper was given to the I.P.M. Scientific Meeting on 18th March 1988

References

1. NORELL, Jack, BALINT, Enid. *Six minutes for the patient*. Tavistock Press. 1974
2. COURTENAY, M.J.F. *Patient-centred medicine*. Chapter 33, The Flash. R.D.P. 1972

LISTENING

This talk is about listening in the context of my current psychosexual work.

Firstly, it seems to me that good listening is the very baseline of our work — it is the point from which all else flows — interpretation, examination, changes made by the patient, and so on.

And yet — it is *hard* to listen well and to stay with the 'here and now' and not to be distracted by the many things that get in the way. As we all know, we may be listening at times, but not actually *hearing*.

Secondly, there is a deepening awareness of all that is around in our work to be listened to, if only we can clear the space to hear it; and an acute awareness also of how much I *miss* for a variety of reasons — some of which I hope to explore with you.

If I am to be fully present and available here, with you in this room, now, in this Doctor/Colleague relationship, I need to be fully present in *myself* — available to myself. I need to listen carefully to what is going on in me and to what is going on as I relate to you. How do we 'impinge' on each other? I need to be aware of what I bring to this moment, in order to be *more* available.

As I listen to myself now I note:

Physical effects of having to speak like this.

Fear — of your reception of what I am saying, of being misunderstood, of drying up completely, of missing a page and of earlier influences from the day.

If I take note of these carefully, I can set some aside, deal with others and simply *be with* you in the state I am in.

Some of the patients I have seen recently have challenged me to listen more carefully to the boundary of the interaction between us. Dr. Marshall Marinker reminded us that the most interesting things in life happen on the boundaries!*

I have had to ask myself whether I am prepared to open myself further to my patients in listening — to offer more space to them in which they can explore their difficulties. As I have listened to what is happening between us I have noticed a number of areas where listening was particularly hard, where I had to pay close attention to my side of the interaction in order to be able to hear the patient more clearly.

Listening in this way, as we all do in our work, must produce change in the doctor as well as the patient. It requires us to be vulnerable at times, to let go of control, to be helpless with our patients in order to reach more understanding together.

To listen to ourselves in this way is not an introspective luxury.

It is not an invitation to personal therapy instead of creative work with patients, though growth and change in the doctor will result from it inevitably.

*Workshop on research and communication. Dr. Marshall Marinker. IPM Newsletter 30, 1986, pp. 7-20

It is a *necessity* if we are to stay with our patients in the here and now and not opt out when the going gets tough and uncomfortable. It is demanding!

This is familiar ground in that it is the basis of our seminar training and of our work with patients — *and* it is also new territory all the time.

T.S. Eliot succinctly puts this idea of constant re-discovery of the new in the old:

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And to know the place for the first time.

We are *different* people from our patients, with a different function in the working relationship, but there is an *equality* in our working together which is to do with our mutual search for understanding and our shared humanity.

It is as we are prepared to reflect on our differing life experiences, including those specific to what is going on in the room with the patient, that we go beyond those differences and reach the common ground of human experience that is the seed-bed of empathy. Then, and only then, can we truly 'feel into' the experiences of our patients and in time stand back and offer our understanding of it.

This process must change us, as doctors and as human beings. How can we expect changes in our patients without significant changes in ourselves?

Jung has suggested that in the therapeutic relationship, if the doctor is unaffected by what is happening, nothing significant will come out of the relationship.

There are three particular areas of listening in recent cases that I wish to explore and illustrate:

Firstly — a process going on in the patient which 'hooks into' a similar unrecognised one in the doctor.

Secondly — a look at some of the difficulties in listening to the genital examination.

Thirdly — some of the difficulties experienced in listening to the spiritual communications of patients.

This first case illustrates the difficulty of listening to a patient whose defence against uncertainty and fear of failure was very similar to my own. It was not until I stopped and heard *myself* clearly that I was able to 'unhook' my process from his and hear *him* properly. All I noticed at first was that this couple produced in me fairly familiar reactions but with a degree of intensity that was not readily explainable and was interfering to some extent with the work.

Unconscious hooks with patients: The Expert Patient

In this presenting couple the husband initiated the appointments, experienced the difficulty and was the most 'active' of the two in the consultations: I felt that he was the patient. I did offer him time alone, but events overtook that!

Dr. & Mrs. M. asked for an urgent appointment, cancelled it, and

came a few weeks later. Seeing a colleague of any kind gives rise to the feeling that something extra special is required. In the first few minutes it becomes clear that the patient is a human in need, and work begins. In this case, however, my apprehension increased.

Dr. M. was tall, well dressed, elegant, *and* a Management Consultant with a doctorate in Psychology! His wife was attractive, articulate and desperate to be pregnant at 33. It was his second marriage, his first wife having left him after ten years. Dr. M. had been finding it increasingly hard to get an erection over the 18 months they had been trying to conceive. This was deteriorating, and linked with a loss of sexual interest in general. Ten months' sub-fertility treatment had been given.

Dr. M. felt cold and professional to me as he voiced his contempt for the 'ordinariness' of sex and the 'animal nature' of it. He thought of himself as a 'stud' or a 'bull', required to perform to order. He did say that he also felt embarrassed sexually, something he put down to a clerical upbringing and a boys' boarding school. I felt that there was a genuineness about that which drew the only spark of real warmth from me. His wife, listening to this, sat quietly but with a sense of respect and understanding for him, contributing occasionally her feelings but without criticism or blame. She seemed to like him!

I felt wary, very conscious of what I was doing as a 'professional', somehow needing to 'get it right' for both partners but especially for Dr. M. At the end I suggested blood tests 'just to cover all possibilities' but actually to be a more competent doctor, to be seen to do something other than just go on listening. Dr. M. said that would be great, he would come the *next day* to have blood taken. He did not come at all. I also said I would examine him next time. Before the next visit, to my considerable surprise and annoyance, I received a letter from his G.P. saying he had been to him for examination and all was normal! He eventually got his blood tests done at a private hospital.

I found I was dreading their next visit and wondered why. I offered the case to our support seminar and their conclusion (evidently prompted by mine at one level) was that this man was a 'cold fish'.

And yet . . . I knew that was not the whole story. Somewhere I knew there was a 'soft centre' here and so, clearly, did his wife. I recognised that there was something in me 'muddying the water' in this case, but did not know what it was. My fear was of not having anything to offer.

They cancelled one visit and arrived for the next suntanned from their holiday. Sex had been impossible at first after a long flight but as it was Mrs. M.'s ovulation time they had 'used bottles'. After that it was good — Dr. M. had decided on a target of three times per week and kept to it. He felt better. Perhaps, he admitted, it was OK to be a bit ordinary after all. Sex didn't have to be 'animal' just because lots of people did it. He did say, though, that he did not dare to care too much about a baby and whether he could father one because Emma cared *so* much. *He* needed to keep a check on his feelings or he would be swamped by her anxiety. I began to warm to them and to lose some of my need to be an expert as he let go of his. I still found, however, that I

needed to hear from them that the time was useful and that they wanted to come again.

On the third visit Dr. M. hailed me from down the corridor where they were sitting. I think he said, "Hello, love!" but it may have been, "Hello there!" — at any rate it *felt* very different. Mrs. M. was pregnant! We shared the joy of that and laughed at the unpromising circumstances of the conception. Dr. M. was tender, relaxed, soft. He said sex was fine now, he could simply show his wife how he felt. There was no erection problem. She glowed with pleasure.

Although all credit went to the 'infertility boys', both partners said it had helped greatly to talk. Mrs. M. said how good it was to hear Jim voice his feelings in this way and Dr. M. said rather sheepishly that it had been hard to let himself show feelings when 'in the business himself'.

I had a sense of being 'saved by the baby'. There was much that was unresolved here, but I had hung on with difficulty and been helped out this time.

Why had it been such a hard one? I did not quickly see that this man needed his professional competence and needed his contempt of his sexuality to cover his very real fears of not being able to give his wife a baby. These fears hooked into some of my own uncertainties at that time. I was making changes in my professional life and was uncertain of myself professionally at that time. The feelings were not straightforward enough to be obvious until later — and I was picking up the same thing — uncertainty about being adequate to the task — from Dr. M. It was the *strength* of feeling that should perhaps have warned me that I needed to do some listening to myself here in order to be better able to hear the patients. If we don't listen to what is going on in ourselves we will act on the feelings, as I did at the end of the first interview, instead of thinking about them.

Listening to the Genital Examination

I have never doubted the value of this examination in exploring the patient's communications with regard to their sexuality, but I confess that I have never found it easy to use in this way either with men or with women. My unease is to do with anxiety about going through the motions of a physical examination while listening to the psychodynamics. I can feel slightly dishonest at times — as if the physical bit is a 'cover' for the rest, though I usually explain to the patients the purpose of the examination. This is obviously completely different if the sexual difficulty comes up during a routine physical examination.

Two points of interest struck me in the following patient:

1. The way we handle the communication about a 'small penis' when the examination shows a physically normal one and reassurance to that effect is clearly not going to be heard. How do we listen further to this whole area of what *this* man's small penis means to him?
2. The ability to stay in touch with the patient during a physically normal genital examination in an appropriate way at this very vulnerable and sensitive interface long enough for two human beings

to meet, and listen, using both touch and words, to what is going on sexually. If the doctor can let go of *her* anxiety about that, how much more clearly can she hear the patient's anxiety — or lack of it — and relate that to the sexual difficulty.

Much attention in the Institute has been directed to the timing of the *start* of the genital examination, but less to the timing of it as a whole or to the ending of it. Does it finish abruptly, for example, for the patient's sake or for the doctor's? In this case it did not end abruptly but continued and ended in a leisurely way, which had its own significance.

Mr. M. was in his mid-thirties. He and his wife were referred by their doctor because of premature ejaculation. Mrs. A., it turned out, could have orgasms very satisfactorily with her vibrator but hadn't said so to her husband. She claimed to want to improve things but did not manage to come again, being too busy at work. Mr. A. came alone. He was a highly anxious individual with widespread feelings of failure beyond the sexual — a real 'Eeyore'.

Sexually, he said, he felt like a teenager who had not got beyond puberty. He felt his penis was too small. It was something that he thought about every day with anger and misery — it was the reason he was a failure. His brother had a normal penis; he compared it in the swimming baths. He was stuck with his small one. His wife said it was OK, but she didn't have to live with it!

I felt his despair and his anger at himself for not getting on in life, for just being 'stuck', small and inadequate. I felt his anger at his brother for having a normal penis, and at his wife for not understanding. I strongly resisted the temptation to tell him to get off his backside and stop being such a wimp! His wife had given up on him: was there anything that could be done in this unpromising doctor/patient relationship? I noted that there was sexual excitement around also — especially when we got anywhere near to his anger about how his wife and others treated him. "Oh yes", he said, in response to my commenting on his sexual wishes, "I have to hold it in. If I let it out it would explode violently". It seemed that the only safe thing to do was to hold in all his anger and his sexual wishes and ejaculate prematurely.

I offered to examine his penis. In this case all was well, his penis being on the small side of normal. I said something like, "It looks physically normal to me, but I hear that to you your penis is too small and we need to understand that better".

He lay in the examining chair and I sat beside him. Together we simply looked down at his penis. It seemed to be for a long time but he made no move to get up. I noticed that he was near to tears. There was an expression of deep hopelessness in his eyes and something else — contempt for this part of him. I said that it was as if he wanted to cut this penis off for causing him so much pain. I noted in myself then a strong urge to reach out and gently put my hand on his penis. To touch the hurting place rather as I would a hurting vagina. It wasn't a sexual feeling, neither did it seem particularly motherly. I just wanted to say, "It's OK, I can touch this part of you and not have to dismiss it, or cut

it off". I didn't do so. I felt soft and silly and not a doctor. In any case, I thought, it could well be misinterpreted! I think, though, that by simply sitting with this man and listening to what was around between us, there was a point where I recognised and *felt* within me some of the depth of his anger and pain. If I had had the courage to use it, touch might have said more than words could; but I was a coward.

It is possible that Mr. A. felt some of this because he shared, as he got dressed, a fantasy of being able to undress in the open changing room in the swimming baths — of not having to hide his small penis away in the cubicles. He did risk that in the next week, but not for long.

In the next session he said, "I always belittle myself. I think I do it to get pity". I pointed out that this was what he did with his penis as well. There was also the hatred of it we had recognised. What would it mean to him to be big rather than be little? A lot of risk, he thought. He would be angry and assertive and would not be liked. It was a big risk to take, especially with his wife.

I do not think this man made much change in his sexual functioning as a result of our three sessions. I did not feel it right to spend a longer time with him as I had a very long waiting list and he was only able to make limited use of my interpretations.

I wondered what it was that allowed me to sit beside this man in this way, looking for quite a time at his small penis, listening to what was going on. Was it that he had so 'cut off' his sexuality, belittled it, that there was no sexual spark around between us to drive one or other to retreat rapidly to a safer arena? Perhaps — and yet I felt quite powerful feelings from him at that time which did not seem to be, as is sometimes the case, those of a little boy. He felt more like an adolescent — as indeed he had described himself sexually.

Perhaps it is when we allow ourselves to get to that soft silly place in the examination of feeling into the patient's difficulty, while still retaining the ability to *think* that we can really hear what is going on. But it is a very tricky area — fraught with difficulties — some of which are our own. Our ears need to be wide open — and it may well be safer to stay on firm safe ground — but far less interesting!

Spiritual Communications and their Meanings

My last two patients illustrate the difficulty of listening in an area which is either of particular interest to the doctor personally or on the edge of their own experience. We can fail to hear because we over-identify with our experience *or* because we can barely identify at all.

There are many possible examples of our own experience cluttering the space we need to listen to our patients — loss of a loved person through death or separation, physical illness, such as cancer in ourselves or someone dear to us, our own experiences of childbirth, and so on. Most of us will have had practice in screening this out, setting it aside, in order to hear what that life event meant to *that* person.

I am not sure that it is so straightforward when it comes to belief systems. Other people's religions *are* fascinating. I am helping to train people in

church-based groups in listening skills and am meeting a variety of Christians with very different approaches to their faith and to their worship. When a patient mentions God or their faith my ears tend to prick up and I can fail to hear what that communication is saying in the here and now of the consultation. Very often it has less to do with 'things spiritual' than with the present interaction in the room. Our own belief or disbelief can cause us to react in such a way that we fail to hear what the patient is saying.

In this area, as usual, what is brought into the consultation must come firstly from the patient. Then it must be examined by patient and doctor together for what it *is*, with respect and with a healthy questioning uncertainty. It should neither be dismissed as rubbish nor regarded as too sacred to be unpacked because of the doctor's own belief system.

Two very different cases illustrate this kind of communication.

The first concerns a young couple referred by the family planning clinic to which the wife went — for 'lack of arousal'. There was a kind of 'rosy glow' around these two. They held hands lovingly throughout the first visit, looked into each other's eyes, and he told me that they were 'committed Christians' busy most evenings with committees in the Methodist church. I felt like a rather rude doctor as I persisted in trying to discover the reality of what was going on. Eventually I realised they had not consummated, but I had to ask directly if this was so.

Mrs. K. was afraid she was too small for her husband's huge penis. Her vagina would only stretch to 5—6 inches at most lengthways. There would be more pain if he entered her. When she felt pain she ought to stop or she would get hurt, as she would in exercise. She got on to the couch, lovingly attended by her husband. She did allow a two-finger examination with coaxing and seemed quite pleased. Mr. K. had massaged her to help her to relax. It was useful but lengthy, he said.

I liked this pair but also found them 'too good to be true' and found that I was being a rather permissive 'earthy' doctor, somewhat irreligious if anything in my challenging of their evening church commitments as a defence against getting to grips with the sexual difficulty.

Penetration had been achieved by the next visit and although Mrs. K. had not had an orgasm that way she was very pleased. Mr. K. was a bit fed up with the time it took to get his wife 'ready'. He was able to say he felt frustrated, but had to soften the blow by taking her hand again. They slipped in that they would be spending part of Christmas at home because of their links with church. I felt I was meant to see what a clean-living pair they were. I was beginning to wonder what all this was covering up — why did they need to mention it? I felt cynical and my reaction was to want to debunk all this 'goodness'.

Next time Mrs. K. reported increasing enjoyment of sex. It was time we heard how Mr. K. really felt; his eternal saintliness was wearing to me and I suspected to them also. I said so. He heaved a sigh of relief, his eyes filled with tears, not entirely of sadness, and he expressed his

fury at being cut off from the expression of his sexuality which he had always felt to be a good and 'alive' part of him. I noticed he blamed his wife for her penetration difficulties and the effort needed to relax her. I wondered if he found it easier to be a patient saint, with its consequent loss of enjoyment of sex, than take charge of his own frustration and sexual wishes (for example, for mutual masturbation when his wife didn't want full penetration) and be sexually alive again. He did admit to feeling that he had to please her — as he had the doctor — with his goodness. He saw that to be cross and fed up and want his own way some of the time was all right. As he relaxed his wife took charge of herself more and was able to have an orgasm when he penetrated her.

In this case the communication about being committed Christians was a way of saying, "Don't look at our nasty bits, we would prefer you to see us as good and caring, without anger or frustration or any of those kind of feelings". They did use the consultations to get in touch with those feelings and became much more rounded and human as a result. I can only hope that their church benefited too — but they stopped telling me about that!

The final case is a man who was referred privately. He was unable to achieve intercourse with his girlfriend. His GP said he had little sexual experience and was an anxious man. Her letter in no way prepared me for the first interview.

Mr. S. was a tall good-looking man in his mid-thirties. He had a slow manner of speaking, almost as if speech had to be wrung out of him. At times, in spite of the emotional interview I found myself thinking impatiently. "Oh, do get on with it!"

He couldn't sustain an erection with his girlfriend. On the very rare occasions when he did so long enough to touch her vagina, he panicked and lost it. He said he had to keep a sort of control in case he was 'taken over'. He had one previous girlfriend some years before with whom intercourse had been normal, but he had felt criticised and rejected in other ways and had stopped seeing her. He had turned to the occult but hadn't actually taken part in sexual rites. Recently he had seen a priest for this. He said his faith was important to him but his *fear* was what came across in the room. I asked what would take him over and he said it was like a wild beast on his back; if he penetrated he might go on and on until he split his girlfriend and eventually killed her. Showing shame he said he had used porn and masturbation to express himself sexually between his last girlfriend and this one.

I was now listening very carefully indeed — and felt some fear, as I was alone in the house with this man and did not know what I was handling. Was my fear due to his intense anxiety or to a left-over involvement with the occult, which undoubtedly has a power all of its own? I thought that perhaps this was a job for the priest after all, or one in which I might need his assistance!

At some point the patient mentioned his father looking over his shoulder and remarking that he the son never went with girls. He felt he had to keep sex reined in or he would be coarse like his father. I said, "Like a powerful stallion, once you let go the reins, he will be off at a

gallop". Suddenly he went quite pale. He said he had a horse phobia. He asked to use the lavatory. When he returned I got him a glass of water. He sat down leaving the door open. To my horror I saw our very dark brown Burmese cat stroll in to see what the fuss was all about. Fantasies of witches' cats and a fear of anaphylactic shock made me make a grab for her, but he had seen her and simply reached down and stroked her saying calmly, "Hello, puss".

I was very worried that here was a man I couldn't help at all. Something made me go on. I really wanted to find out what all this was about. Next time I arranged to see him in the local health centre! To my surprise he seemed no larger than life and had managed to penetrate his girlfriend on several occasions with some anxiety and some enjoyment. He said he had been able to talk to her much more easily. Neither the occult nor the fantasy of splitting and killing her were mentioned again. I wondered what had made me so alarmed the first time.

After three sessions he was doing well and said he would get in touch in a few months. He wrote sending me his cheque and referring to his engagement, which surprised and pleased me. He said he still panicked occasionally but it was no longer anything he could not manage. He thanked me for all my help.

On reflection the communication from this man about his occult involvement and subsequent faith and help from a priest was all part of a need to let me hear all his worst fears. I certainly did, judging by the state I was in at the end of the session!

His fears were: of satanic influence to the point of killing and rape; of being overwhelmed by his father, unable to escape and express himself sexually; of being judged for his sordid escapes into pornography.

Having shared his deepest fears and fantasies in this way and finding that the doctor could hear them and still want to see him, he was able to relate sexually to his girlfriend, if not brilliantly, at least with some enjoyment.

I certainly was alarmed by what I heard, but took steps not to be alone with him on the second occasion, reported the case to my seminar group for support and hung on!

Conclusion

The work we do is fascinating. It never ceases to amaze me what people say and do and feel. Even more amazing is what they are prepared to share of themselves with us. In our relating to them, with the focus on understanding and easing the sexual difficulty they bring as their reason for coming, we owe it to them to listen as openly and as deeply as we can. In listening in this way we will constantly bump into our own boundaries — between personal and professional parts of ourselves, and between resolved and unresolved parts of ourselves. The joy of this kind of work, and its pain, is that we never 'get there'; we never arrive, even though some of the track may seem familiar. We never know in advance what we will find. When we do not understand we can dodge, as we frequently do, back on to well-known pathways, to avoid the struggle of trying to find out. We can remain closed to ourselves and to our patients at that point *or* we can open ourselves

to the pain and uncertainty of 'not knowing', even sometimes not knowing where our boundaries are, and perhaps increase our understanding just a little by so doing.

A poem sums up perfectly this hard choice:

The Wayfarer
by Stephen Crane

The Wayfarer,
Perceiving the pathway to truth,
Was struck with astonishment.
It was thickly grown with weeds.
'Ha', he said,
'I see that no one has passed here
'In a long time'.
Later he saw that each weed
Was a singular knife.
'Well', he said at last,
'Doubtless there are other roads'.

Dr. Margaret Gill
I.P.M. Member

This paper was given to the I.P.M Scientific Meeting on 13th May 1988

PSYCHOSEXUAL WORK BY O. & G. PHYSIOTHERAPISTS

A leader's thoughts on a one-year seminar

I am ashamed to say that before 1985 I had never heard of the Association of Chartered Physiotherapists in Obstetrics and Gynaecology (ACPOG). That year their AGM was held in Bristol and I was asked to speak about the psychosexual problems of women. The audience were the most receptive I had ever met, and I was forcefully reminded of the feelings among family planning doctors before seminar training was available: an intense interest and longing to be able to offer more help to patients. Following that lecture I was asked to spend an evening with some of the local members, and this taste of a seminar-type meeting led to the formation of a group run on the lines of those organised by the Institute.

Setting up the group

It is known from experience with doctors and nurses that the way a group is formed is important for its success. The wish to start should come, not from an over-enthusiastic leader, but from the members who feel the need for further training from within their own working experience. The group is most successful if the members are trained professionals who are taking full responsibility for their own work, and who come to the group to deepen their understanding of what they are doing, rather than for any sort of supervision or didactic teaching.

From my point of view the setting up of this group was ideal. One of the members collected names, arranged finances and organised time for me to

see each person individually. By mutual agreement one member did not join at this time as it seemed unlikely that she would have many cases to present. The other nine physiotherapists decided to join and the attendance was good throughout the one year which was the planned life of the group. We met fortnightly in term-time.

What the leader learnt

I am grateful to Dr. Main for pointing out that one cannot study the work done in a new setting unless one knows the details of the treatment methods used. My ignorance of the treatments used in obstetrics and gynaecological physiotherapy was profound, and for the sake of any reader who may be in a similar situation I include these short notes.

Vaginal Faradism

This is a low frequency current which stimulates voluntary muscle via its nerve supply. An electrode and pad are placed under the sacrum. The patient lies on her back with her knees bent and an internal electrode is placed in the vagina. Some physiotherapists hold on to this during treatment, while others prop it up and may even leave the room. The electrical surge and pause make the muscles contract and the patient is encouraged voluntarily to contract her muscles at the same time. Each treatment lasts about five minutes and there would normally be three to six treatments in a course. This is used for re-educating the pelvic floor.

Interferential therapy

Two medium frequency currents act at right angles to each other. Where they cross a low frequency effect is obtained. Again the patient lies on her back with her legs supported, but this time keeps her pants on. Two electrodes are placed on the lower abdomen and two high on the posterior aspect of the thigh. Each treatment lasts ten to fifteen minutes and is usually given two to three times a week for about twelve treatments. The physiotherapist can stay in the room but does not need to do so. A slight sensation is felt under the electrodes but not much in the pelvic floor. The treatment is used for stress incontinence and prolapse.

Ultrasound

A quartz crystal in a transducer vibrates at a very rapid rate producing ultrasound waves. A neutral jelly is used to make good contact between the head and the patient's skin. The physiotherapist holds it all the time while massaging the affected area. It is used for treating a damaged perineum in the immediate post-partum period when it reduces oedema and bruising. It is also used later for dyspareunia to soften scar tissue and reduce pain.

Megapulse

This is pulsed Electromagnetic Energy, which generates much less heat than the old short wave treatment. The drum head is put very near the patient, but not touching, and the treatment can be given through clothes. The patient normally lies on her side with a pillow between her legs, and she feels nothing during treatment. Each treatment lasts about ten minutes. It is

used immediately post-partum to aid healing and for the treatment of haemorrhoids. It can also be used for deep dyspareunia.

It can be seen that the degree of vulnerability of the patient and the physical involvement of the physiotherapist varies with the treatment, but there is also some latitude for individual variation in practice. The pressure of time is considerable, but within this time constraint there is scope for studying the detailed practice of individual physiotherapists with individual patients.

The clinical work studied

Cases were presented in the usual way, and the symptoms for which the patient was referred, or about which the patient first approached the physiotherapist, are shown in Table I.

TABLE I

Symptom for which patient was referred or sought help	Number
Urinary symptoms	23
Stress incontinence	
Frequency	
Urgency	
Post-partum dyspareunia	12
Post-sterilisation pain and difficulty	3
Other pains	
Painful clitoris	1
Abdominal pain in pregnancy	1
Vaginal pain in woman of 70 years	1
Complaint of passing vaginal wind	1
	<hr/>
	42

I give these figures to indicate the sort of balance of patients discussed. The frequency of urinary symptoms probably reflects the case load of the members. Much of their work with individual patients, in contrast to their group work with ante-natal patients, is concerned with stress incontinence. However, I had not appreciated how often this symptom is associated with psychosexual problems.

It quickly became apparent that the very intimate contact between a female patient and a trained professional woman, who had licence to examine and treat the genital area in a number of different and interesting ways, provided a unique opportunity for sexual matters to be discussed. Some of the sexual anxieties and problems revealed during these discussions are shown in Table II.

TABLE II

Some of the underlying sexual problems revealed to the physiotherapist

- Sex never liked
- Sex not liked since marriage

- Sex not liked since delivery
- No sexual intercourse since delivery
- Lack of orgasm
- "Feels dead"
- Husband not interested since birth of baby
- Sex not wanted since laser treatment to cervix
- Patient thought she was sewn up too tight
- Patient had asked to be sewn up tight for 'boy friend'
- Husband unable to ejaculate since birth of baby.

There is not space for me to do more than give a small taste of the clinical work discussed in the group.

I was struck by the number and vividness of the body images that were revealed, such as, "I feel my body is a battle ground", said by a patient who had suffered an episiotomy and tear, who had been stitched, stretched, given physiotherapy and was waiting to be stretched again. Or the woman whose child had been born two years before who said, "My vagina is like an old Wellington boot". Pelvic floor exercises produced a miraculous cure, perhaps helped by sharing the phantasy? Another woman who felt there had been a 'blockage' in her vagina when she was pregnant, now felt she was too small for her boy friend. On self-examination she found it was "black and meant nothing". The full sense of these remarks as symbols of the feeling about the total self was not always brought out with the patient, or even fully discussed in the group, but perhaps this is not surprising at this early stage of training. Yet the fact of sharing these vivid pictures, even if not fully understood, was important and helpful for patients.

Case 1

A woman in her twenties had received laser treatment to her cervix, and had not wanted intercourse since. At her follow-up visit the gynaecologist remarked on a slight prolapse. In reply to questions she agreed she had wet herself, so she was referred for physiotherapy. It turned out that the incontinence had only been one occasion of slight dampness during strenuous exercise. The physiotherapist did a careful, slow, listening vaginal examination, and asked the patient to examine herself. The result was startling. The patient leapt up radiantly saying, "I feel marvellous, I thought I was crumbling away inside and coming down". How long would this muddle between the 'cancer' and the 'prolapse' have lasted if she had not been lucky enough to meet someone who could examine her fears and phantasies at the same time as her body?

With several patients it appeared that a remarkable improvement, greater than could be expected or explained as a result of the physical treatment alone, took place following a discussion of painful or angry feelings.

Case 2

A middle-aged lady was referred with stress incontinence of three years duration. She quickly told how she disliked sex, and how her husband had also gone off it. She went on to talk about the loss of a much beloved animal, and also of her husband's view that sex was expected to stop at forty. The

discussion was somehow all about the loss of things that had been important. The physiotherapist listened, and suggested the patient could encourage any kissing, cuddling advances her husband might make. At the second visit the patient was not so forthcoming, although she looked smart in a casual way. She said there had been no time for kissing and cuddling, and anyway she had to accept that this was how she was. At this visit the physiotherapist did a vaginal examination which was described as 'matter-of-fact. Rather efficiently clinical'. She also reinforced the idea of pelvic floor exercises that she had suggested at the first visit. Despite feeling somewhat rebuffed she offered the patient the opportunity of another appointment which was rather surprisingly accepted. By this visit everything was marvellous and the stress incontinence cured.

As with so much psychosexual work it was not easy to understand exactly what happened. Is it too fanciful to suppose that the ability of the physiotherapist to share the pain, encourage the sexuality and withstand the rebuff was enough to allow the patient to do these things with her husband?

Case 3

This patient had suffered for eight years from stress incontinence, which was so bad that she could not go out because she felt that she was smelly. She told the physiotherapist that she had originally gone to the doctor, who had suggested that she had marital problems. Both she and her husband had been, and still were, furious at this suggestion, and she aired this fury at some length. Referral to the physiotherapist was via a hospital department, and a short course of interferential treatment was followed by an improvement that was so rapid and complete that it was hard to believe. This case also involved animals, and not only could the patient now run with her animals in the show ring, but the animals had become sexier. The physiotherapist felt inhibited from discussing the patient's sex life until the final visit. When she did raise the subject the patient said, "I could never have answered that a few weeks ago, but now I feel so much warmer towards him that it is all right for you to ask".

Both these last two cases illustrate areas of tension between the physiotherapist and the patient, at particular moments in the relationship. This feeling of an almost palpable barrier was also present in other cases, and although it was discussed to some extent in the group it needs much more study. Could it be that the particularly vulnerable open relationship made possible by the nature of the treatment, which creates its own particular therapeutic opportunities, also at times leads to a need for particularly strong defences? Or is it that these lively workers were reporting this feeling more forcefully than I am used to? Or are they themselves feeling particularly vulnerable and in need of barriers in this new work?

The Training

There were many similarities between this group and others that I have led or heard discussed, but also some interesting differences. From the beginning the members were very conscious of the fact that they are traditionally very active therapists, telling patients what to do in the form of exercises and doing things to them in the form of treatments. Yet this very

self-awareness of their authoritarian role contrasted with some doctors, who, because of the demands made on them by traditional medicine, have come to accept the fact that they are expected to have the answers and take the responsibility, and find it difficult to question or relinquish this role. It was as though the physiotherapist, with a more limited area of responsibility, could more easily open her ears to hear the patient's story, and more easily tolerate the likely consequence: that is, that having heard the story she would not know what to do. She was helped in this by actually having at her disposal a range of physical things that she could do for the patient, so that she was seldom left to tolerate the sense of hopeless impotence felt by the inexperienced doctor when she/he first learns to listen, and feels there is little to offer other than a prescription or a referral.

A particular strength of the group was their ability to observe and describe the non-verbal body language of their patients. Not just the manner of dress, which by itself can be such an unsatisfying and incomplete answer to the question, "What is she like?", but the way the patient moved, sat and responded. On many occasions the group member, almost without realising it, would physically act out the appearance of the patient. When I commented on this it was suggested to me that the physiotherapist is particularly conscious of such things as posture and muscle tension, and this heightened awareness seemed to provide them with additional signals that they could use to read the underlying emotional tensions.

As with all groups the leader's job was to concentrate on getting the group to work at the task. As a psychosexual group our task was to study the relationship between the professional and the patient, and to see what light this relationship shed on the patient's problem. As with all groups we were frequently diverted from the task, the leader into teaching and being clever, the group into speculating about the patient and seizing ideas out of the air in search of explanations. The difficulty of learning to examine each individual consultation in detail, and to comment on what was going on in the room, was only beginning to be overcome as the year came to an end.

An underlying theme throughout the year was the whole question of, "Is this physiotherapists' work?" As the first group of this kind the question was important and legitimate, but it was also on occasions a very clear defence against the difficulty of broaching sexual matters. In particular the idea of discussing sexual pleasure with a patient, rather than just whether or not it worked, was a most difficult area. Perhaps this was the subject that led to most cajoling, indeed the group might say bullying, by the leader!

This was the most exciting and excited group that I have led. Indeed the recognition and handling of the group excitement, a subject that has been discussed in the leaders workshop digests¹, was one of the most difficult problems as leader. My attempts to trace it back to the patient and the consultation were not always successful. Given the genitally focussed nature of the therapy and the very personal, physical involvement of the physiotherapist, this demonstration of excitement felt and feared was perhaps not surprising.

Evaluating the Training

During my absence on holiday the members decided to meet to evaluate

the year's course. With the permission of the writer I quote from a letter written by their spokeswoman:

"Everyone felt that they had gained a great deal from the year's work. It was felt that we were now better able to interpret patients' statements and reactions. We felt more confident in pursuing problems and we listened more constructively.

We are beginning to view the physiotherapist/patient relationship more objectively. We now feel we each make further appointments that are not necessarily for physical treatment".

At the next meeting I encouraged some discussion about the training method, and was not surprised to find the picture was somewhat less rosy. I value highly those members who were able to verbalise their feeling that if only they had been given a proper explanation of the method at the beginning they would have got more out of it. How many of us, after one year in a seminar, did not feel that if only the leader had done better we would have learned more? This method of learning, or self-learning, is not easy and takes time. Michael Balint, the pioneer of this kind of training, found it took at least eighteen months for the "limited but considerable change in personality" that was necessary to acquire these new skills². I feel that one or two members of this group, who had presented most cases and thus had the opportunity to move ahead in their own work, were beginning to make this change, even at the end of only one year.

What Next?

I am not a physiotherapist and it is not for me to answer the question of what happens next. As I hope this report shows, I am convinced that these specialist physiotherapists work in a setting where psychosexual skills could relieve much patient suffering and unhappiness. However, I do not know how much they and their colleagues will want to do the work, or commit themselves to the extra training needed. Certainly some individuals are hoping to join further groups, and their training needs appear to have much in common with doctors and those nurses who work in the genital area. May I take this opportunity to ask Institute members, and particularly leaders, to support their work and help in training if asked, provided of course that their commitment to the training of doctors allows them to do so.

Finally I want to thank all those who came to this group and allowed me to share in both the frustration and uncertainties of their work, as well as the fun and excitement of their discoveries.

Dr. R. Skrine
I.P.M. Member

References

1. SKRINE, R.L. *Psychosexual training and the doctor/patient relationship*. Montana Press, P.O. Box 67, Carlisle CA4 9DE. 1987. II B, p. 150-166.
2. BALINT, M. *The doctor, his patient and the illness*. Pitman Medical Publishing Co. Ltd., 46 Charlotte Street, London W 1. 1957, revised 1964.

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A TROUBLED MOTHER

Catherine is a pretty, 29-year-old mother of two small girls (aged three and two years), who was referred to a hospital psychosexual session by her G.P. She already had a good relationship with the practice psychiatric social worker, who told me that Catherine had been sexually abused by her stepfather when she was 11 years old, at a time when her mother had gone into hospital to have a baby (her stepbrother). She needs help now with post-natal loss of libido as she feels repulsed by her husband's lovemaking.

During the first interview I became a listening ear to her story. Her mother had taken Catherine and the two younger sisters on holiday, with another man, and stayed on and finally married him. Catherine observed the great distress this caused her father — she was seven at the time. Schooling was disrupted and Catherine was used to manage the younger children. Later she went to live with her mother and stepfather.

She did not tell me the details about the abuse, only how she dreaded going to bed if mother was out in the evenings (playing badminton, etc.). At a later interview she explained with distress that her stepfather kissed her genital area and put his fingers into her vagina and said he was doing it for her. She feels she was weak and should have said no. Once he tried to penetrate, and then left the room in a hurry. Now she realises he rushed off to ejaculate elsewhere. When she told the family G.P., he said, "It's best forgotten, and best not to tell anyone". She was sure her mother would not believe her, anyway.

At 15 years she was refusing to go to school, and was sent back to live with her own father, now re-married and having more children. She said, "I'm always looking for a mother who approves of me — my mother always put me down". Catherine brought photos of her two daughters, and told me over several interviews how much she does for and with them — arranging birthday parties and outings. Her standard of child care is high, but it tires her out. She does a lot for her husband too, especially when he is unwell and overworked. Her domestic achievements are praiseworthy, and I have said to her, "You want to be told that you are a better mother than the one you had, and you want me to care for you as a mother would".

I broke my rule of rounding off a doctor/patient relationship after about six interviews, and keep giving her three consecutive dates after a break of two months. She has not so far freed herself from the past, and I act out her need for a devoted, interested mother. She expresses anger that I have so many other patients distracting my concentration from her. It annoys her that she cannot call me during the intervals between appointments. She would like me to be continuously available to her. I said, "Your need for a mother figure is insatiable at the moment. I cannot meet it, and that makes me feel cruel and withholding, and you resent me". She said, "You are the first person who has ever really been interested in what I say, but I'm waiting for you to criticise me". I pointed out that she criticises herself, and tries to be best at everything, as only that way will people like her enough. She admitted that often she feels like an outsider and that she does not belong anywhere.

She now sometimes has pleasurable intercourse with her caring husband

again, if she initiates it. We confronted her need to be in control of sex. She says she cannot tame her compulsion to be explosively frustrated a lot of the time. Her rage is with her mother — and with me, for not supporting her more, and for having a life of my own without her (her own mother went out playing badminton and having a good time). Did she express her rage by failing to say 'No' to the abuse, and was the frustration perhaps the thought that her mother wouldn't care anyway? (She learned that her younger sister refused stepfather's advances). The worst state for her is to have her needs ignored again, and this sometimes happens with her husband and children.

My aim is to free her from punishing herself, and from her wish to punish her mother. I need to make it clear to her that I protect myself from being taken over by her, and that she can have her own good life without me, and enjoy her sexuality again, as well as being a mother herself.

From time to time she brings a poem she has written about her feelings:

To be wanted in life is what we desire,
 To be loved is something we don't all acquire.
 To be hurt by our loved ones right from the start
 Is the pain of a dagger aimed at your heart.
 The loneliness in my mind —
 I cannot touch it, but it is there;
 I cannot see it, yet it smiles at me;
 I cannot hear it, but how it laughs at me,
 And how I feel it — this loneliness, in my soul.
 In the days when I'm lost and confused by it all,
 I search almost blindly — who can I call?
 I'm searching for someone — I just don't know who,
 Someone to guide me and comfort me too.
 My stomach's all knotted, my muscles are taut,
 My mind's in a whirl, I'm completely distraught,
 I just wish I could solve this enigma of mine.
 How long will I search? — seems forever to me.

Just recently, a more optimistic note has crept in:

Can the light at the end of the tunnel
 truly be meant just for me?
 To end all this time of confusion, and look forward
 to what is to be?
 I can only guess at the future,
 I must learn to cope with the past
 And live for today, not tomorrow.
 Yes, the tunnel is lighter at last!

Dr. R. Thexton
 I.P.M. Member

CHILD SEX ABUSE — CAUSE, FACTOR OR RED HERRING?

I report this case in response to the Editor's request for cases involving child sexual abuse. I saw this patient regularly over three years, and from time to

time was assailed by doubts as to whether it was an appropriate case for me to see. My doubts began on reading the referral letter, and were compounded by comments at Institute meetings about the inability of patients with deep-seated pathology to benefit from our approach. It also became obvious that she was not amenable to brief psychotherapy. However, I took her on, motivated by two thoughts: firstly, I was apparently a last resort, and if I didn't try, that would be another rejection for her. Secondly, it seemed to me that by not trying, an opportunity to extend the boundaries of knowledge and skill already gained from Institute techniques would be lost.

Child Sexual Abuse was not then a Headline Subject, and though I was told about her experience I did not latch on to it but continued to work with her along Institute lines — looking at the doctor-patient relationship. Had I latched on to the child sexual abuse aspect, would she have got better sooner? Having heard a local Child Sexual Abuse Counsellor lecture, it seems that in her experience these patients require long term support. So perhaps three years is okay.

The manner of Ann's referral is of interest, considering her difficulties and the role I came to play. Her G.P. wrote saying he hoped I could help Ann. It was obvious I was a last resort and he had his doubts. He enclosed Child Guidance Clinic notes, and included were more recent notes from the psychiatrist, whom Ann had seen about her sexual problems. These stated that she had a personality problem and was aggressive. I really wondered what I could do, but I said that I would see her.

Ann came. She was twenty-three and had been married for two and a half years. Her complaint of lack of libido and dyspareunia had been present for eighteen months.

My first impression of her was of a small pretty doll-like girl. She was talkative, and with a bright smile told me that she had an "ugly past". There had been an episode with a brother when Ann was six to seven years old. He had been baby-sitting and got Ann to masturbate him, saying he would let her stay up late if she did. Wanting to stay up, Ann complied. Other similar incidents occurred. It was only a few years later that she realised it was wrong and felt guilty about the episodes. She had some years later told her mother but was disbelieved and scolded for saying such things.

When she was in her teens Ann got friendly with an older man and enticed him to bed in his house. She remembers enjoying this at the time. A little later she got a boyfriend nearer her own age, and eventually ran off to London with him. This was a violent and unhappy time, and she eventually came home. After this her mother virtually locked her up, but Ann did see her boyfriend again and became pregnant. She approached her then G.P. for termination, but this was refused as she was "young and healthy". In anger and frustration Ann hit him. This event led to her attachment to her present G.P. — when visiting her during a flu epidemic he jokingly stood at the foot of the bed asking if it was safe to approach, as he had heard she sometimes hit her doctors. From that moment he and Ann got on well.

Ann's stepfather eventually arranged termination. It was what Ann wanted and was a great burden lifted from her. Eventually Ann's mother "let her out", but this mostly meant going out with Mum and Stepdad to the

local pub. It was in this way that Ann met her husband. Mother encouraged the relationship, hoping, Ann thought, that something of this nice boy would rub off on her daughter. Ann and Alan married and things were fine until six months after the wedding when Ann's problems began. During this tale it seemed to me that Ann was trying to shock me. I put this to her and she replied, "I like to be the centre of attention". I felt she was saying she could only get attention by being shocking, and something made me say, "Perhaps you feel the real you wouldn't get attention". She answered, "I don't like the real me". I thought we had got to the root of the problem. Certainly this was one of her fears — she was afraid the real Ann was not very nice.

My first impressions of a child-like being were confirmed in subsequent consultations. On her second visit I suggested an examination, and she said brightly she was prepared for this — she hopped up on the couch and examination was done with no problem and no response. My suggestion of self-examination brought the remark that she didn't want to "do that" — she had "never masturbated". I said I hadn't asked her to masturbate, but perhaps she thought putting a finger in would cause sexy feelings. She became tense and on edge and began to prattle on about a completely different topic. This had me stumped for a moment. I then put it to her that she seemed tense and that I felt this sudden tension was covering something. I wondered what. She answered, "the real me". There was visible relaxation as she said this, and she continued that she had purposely come this time with no make-up and no smart clothes. I felt she was saying that she was showing me the real un-camouflaged Ann. We looked at this, and linked it to her vagina and her not wanting to show sexy feelings.

While still lying on the couch she began to tell me about what she did at home; this was not very much. She did little housework, cooked as little as possible and spent her time having coffee with various neighbours and their children. Here again was the picture of a child, avoiding responsibilities, always playing. She agreed, she didn't want to grow up, adults seemed to have a horrid time. She particularly didn't want to be like her mother, whom she described as an alcoholic. Her feelings towards her mother were ones of almost hatred. She felt that her mother had never praised her but had always criticised, blamed and corrected her. Yet from time to time Ann had tried to obtain Mum's love, taking her flowers or gifts, but never getting the response she desired. Ann's father had left her mother before Ann was born. All Ann knew of him was from Mother, whose descriptions of him were derogatory and full of venom. Ann had fantasies of travelling the land to find him. She pictured him as a tall, likeable man, who had left a trail of children all over England.

Ann's visits over the first eighteen months were fairly frequent. Each time another feeling, fear or fantasy would emerge and be explored. Sometimes there was a little progress in that she felt warmer and closer to Alan, and once or twice even had sexy feelings. Much of the time she avoided getting to grips with the problem by talking about all sorts of other things. I found her pulling back, time and again, to the real feelings, difficult and wearing. Sometimes she would be near to tears and pleadingly ask, "How can I change?" This made me feel at first quite hopeless as I had no magic wand to

wave. Repeatedly we re-capped on all we had discovered and looked at what she was doing. She had spurts of progress but could not sustain these. On one visit she was particularly tense and angry. I put this to her, likening it to the time she had been angry with her first G.P. who wouldn't help her, and with the psychiatrist who she felt had rejected her by passing her on to a Psychiatric Social Worker. I said I felt she was angry with me for not doing something. She pointed out that it was her desperation speaking; she had seen so many people and no one could help. I seized on her despair, and raised just a little controlled anger of my own. I said I felt she was in a way threatening me — telling *me* to do something, or else. At this she changed her manner, lost some of the anger and said she wasn't telling me but was pleading with me.

I felt this change indicated her need not to alienate me, but I had to use this new approach of hers constructively. I suggested she was again behaving like a child — desperate, but metaphorically stamping her foot and wanting someone else to solve the problem. She was trying to avoid the painful fact that she would have to solve it herself — not run away from growing up, from responsibilities, from sex. However much I believed in her she would have to believe in herself. She then admitted that she feared to be sexy because in the past any sexual expression had led to trouble.

After this consultation there was improvement, but it didn't last. She felt she was always waiting for the crash, life had always been unfair to her, anyone she had cared for she had lost. In this category she included her father and her G.P., who had now died at a young age. At this point she actually said to me, "You won't die, will you?" We discussed this also.

Our pattern of progress, relapse and re-cap went on. New fears to emerge were fears of not being good enough for Alan, fears of not being able to sustain recovery, fears of damage due to the abortion, feelings of being a "bad girl" because of having an abortion. By now I had been seeing her for two years. I felt we had uncovered everything and Ann just had to believe in herself. But how could she do it? was her plea. I began to think perhaps I should get more expert help; was I missing something? Could someone else turn the key? Ann knew of these feelings, and in retrospect I think we both knew them not to be valid. However, we decided to enlist help. A sympathetic psychiatric clinical assistant saw Ann with me. The consultation between the three of us was friendly and easy but nothing came out of it *except* that when I next saw Ann she was better. I think that consultation really made her see there was no-one else. She came looking happy, intercourse was pain-free and she had come off "the pill". If she got pregnant that would be fine. She was still frightened of pregnancy and childbirth, but she would have to cope with these fears. She did get pregnant; Alan and she were delighted. She saw me three times during her pregnancy. She was happy, still frightened by injections, venepuncture and the thought of childbirth; but she was determined to go through with what she had taken on and was coming to me now not for help but to report progress. She did cope and had an easy delivery at 36 weeks.

I heard no more for several months, but then learned that Ann and Alan had separated. It was her decision to part. She seemed different — mature and confident, feeling for Alan's distress but knowing they were not right

for each other. She had nothing but praise for him and was firmly determined the baby would learn what a good dad he was and would see him regularly.

At this meeting the relationship between Ann and myself was completely different too. She was now an adult meeting me on equal terms and telling me she was all right and could face the future confidently.

Dr. B. Tully
I.P.M. Member

ABSENT MOTHERS

Mary and Ellen both came to us very early in the current wave of sexual abuse referrals, and appeared in one week. They left a lasting impression.

Drama about this supposedly new group of referrals was still running high and during a busy morning clinic I received a telephone call, from a normally cool clinic secretary, asking if I could possibly come early to my afternoon session as "the Rape Crisis lady" had a girl who needed help.

I arrived to find an agitated clinic staff, a more agitated referrer and a very calm and positive Mary. She was a large and very dark striking girl, beautifully dressed and made up, with a cherubic two-year-old boy in pale blue and an immaculate three-week-old son in a Moses basket lined with white organza. I suggested that she left the children but she wished to bring them with her. I felt they were part of the theatrical set and found myself irritated.

In the consulting room surprise continued as she began to speak in a very small, childish voice with a lisp. Within moments the perfect make-up was running down her face in a waterfall of tears. She had been to "the Rape Crisis lady" to ask if they would speak to her mother for her and they had felt it more appropriate that I should do this! They had also — she said — felt that this should be done urgently. I was under pressure to get on with it.

She did not really want to waste time on why her mother did not understand her. Her sons were going to be deprived of a grandmother, which caused her great grief. "It's all right for me to miss out, but it's not fair for them". The children could not be taken to her mother's home because "that horrible man" would be there, and her mother would not come to babysit without bringing him too. He wanted to be a grandfather to them and pretended great affection but only to "envelope them in evil".

Mary's own father had left home when she was four, leaving her mother with herself and a small sister. "He was a tall, wild, dark Irishman". Very exciting; just like her, she had been told. She was a complete outsider in the family, unlike her little sister. Her mother had been an exquisitely beautiful woman, "kind and loving"; she looked like "the little fairy on a Christmas tree". This was explained very quietly and wistfully with a temporary cessation of tears. She married this dreadful man when Mary was six. He was well known in the town and everyone loved and admired him, but he was evil and had destroyed her mother who was now fat, large and too unhappy — tears again — to love Mary or her children. This stepfather had abused Mary and expected her "to play with him and his beastliness all over the home, day and night all my childhood" — her exact words. She finally

left home at sixteen and went to live with the man who was now her husband. Her mother had not known the reasons and had been upset and angry and never really loved her since. This was the problem. If only her mother understood all that she had suffered she would surely love her and care for her. If only I could explain to her. Mary did not want to hurt her.

It was not possible to examine any of the feelings in the room. This was her mission and she did not want to waste any time talking of anything else. She was angry that I suggested she come back and discuss things a little more, but agreed reluctantly. I noted I was angry too. I had been manipulated, my care and concern had been rejected; worse still, I knew my duty as a doctor was to examine with her the pain of the sexual abuse and she did not want to, not because this pain was too great for her or me, as surely should have been the case, but because she was impatient of my attitude.

On the second visit she resigned herself to discussing her feelings in order to buy my co-operation and was dissatisfied with what she received.

The result of this was evident on her third visit. A very different and dishevelled Mary came in without the children. As we had all let her down, she had confronted her mother alone. Now she really cried and could not contain her anguish. Her mother was not going to leave her stepfather. She had not even put her arms around Mary and she did *not care*. "She told me I had always been a drama queen and just like my father. She thought I had led him on". I wanted, for the first time, to put my arms around this lass, but sympathised with her mother!

We at last had an honest relationship. I have seen Mary frequently, mothered her a good deal and seen improvement. My hopes were slightly dashed last time when she wondered whether, now I really knew her (and loved her?), I would explain to her mother what her feelings were.

Ellen was different. She was preceded by a reputation for being an efficient, capable and slightly fierce nursing sister. She was referred, after a rather late first child, by her Health Visitor who felt she "had a post-natal depression" and sexual abuse was mentioned.

Another surprise awaited me. Ellen arrived early and anxious for her first visit. In came a tiny dark-haired woman with a tired grey face almost concealed by the upturned collar of a huge grey raincoat. She sat hunched in the chair and the misery was suffocating. She told me in a hard Northern voice that she had longed to talk to someone. Her pregnancy had been a nightmare and no one had known why. If the child had not been a son she would have killed herself. She could not have let a girl have her bad experiences. She could not have borne the responsibility of watching her continually.

Her misery now was the result of nine months terror and she could not bear it alone any more. She had obviously prepared her story and rehearsed it. It was very long. I will give a much abbreviated edition, and I spoke not a word.

Her father had been an alcoholic and had committed suicide when she was three, leaving her mother with herself and a younger brother. She knew her mother had tried but she had not been able to cope. Ellen was sent to

stay with an aunt and because she was homesick and wept at night she was allowed to sleep with her aunt and her husband. He had been very kind and gentle and she had enjoyed his fondling in bed, but one night he had tried to put a finger inside her and she had cried out with pain. There had been a tremendous row and her aunt had packed her cases in the morning and had walked Ellen home. There was another storm when her mother heard: "everyone shouting but noone spoke to me. I did not know what I had done, but noone talked to me for weeks and my mother did not care that I had been hurt". Again I clumsily pursued the sexual experience and again was dismissed with impatience. Didn't I hear what she was saying? Her mother had not cared, she had worked hard and helped, but she still had not cared for her or her brother either. Ellen had had to mother him but he had always been in trouble. He had attempted suicide and was on drugs. Her mother just had not bothered.

I heard what she was saying and felt what she was feeling and, as she said it out loud, so to her horror, did she! She had not known she could be so angry.

On further sessions my need to mother and protect her were very obvious. On her fifth visit Ellen came in with her face visible for once and looking prettier and happier. She and her husband had decided not to ask Elsie (her Mum) to the christening and it was a relief. She could not go on wanting her to be something she could not be any more. She would not, however, relinquish her last three appointments. Uncharacteristically she was late for the next two sessions and professed to have forgotten the second one. She was offhand with me and rejecting. I was consequently taken aback when, as I showed her out on her last appointment, she put her arms tightly round me, kissed me on the face, thanked me and ran away. Had I been a good mother even when she was difficult? I do not know.

We did talk of both these women's marriages and they seemed to be caring and warm with a satisfying sexual relationship. I have not written of them because they were not seen by either Mary or Ellen to be relevant to their problems.

These were early cases and I learned several things. The first was that I had difficulty in allowing the sexual abuse to take a place in the background. I knew from all around me that this was a profoundly damaging experience and my desire to do my duty and examine feelings about this in depth very nearly destroyed the normal doctor-patient relationship.

I was intrigued, and continue to be so, by the persistent feeling among referrers of all sorts that confrontation between victim and abuser must clear the air.

Most of all I became aware, as I am sure most of my colleagues did long ago, that this anger and grief about these women's own mothering was a recurrent and consuming problem. I suggest it was not coincidental that Mary and Ellen both elected to come when their own children were born and they were moving into motherhood themselves.

Finally, they both expressed anxiety that they knew from "the authorities" that children of abused parents were more at risk of abuse themselves. They had been too frightened to think about this sensibly.

Perhaps this is something to which we should be addressing our thoughts, not just to prevent the circle, but prevent an often unrealistic fear of it.

Dr. J. Peebles
I.P.M. Member

Child sex abuse: further reading

1. The blue booklet, *Diagnosis of child sex abuse: Guidance for doctors from the DHSS* (1988) has 15 references for further reading in Appendix G. p. 43. H.M.S.O.
2. *Sexual abuse. Incest victims and their families*. John Wright. P.S.G. Inc., Boston. Bristol, London. 1982. £22-00.
3. *Child sexual abuse within the family*. Ruth Porter. Tavistock Publications. London. 1984.
4. Novels on this subject:
 - I know why the caged bird sings*. Maya Angelou. Virago Press. 1984. 0 860685 11 X. £3-95.
 - The unbelonging*. Joan Riley. The Women's Press. Fiction. 0 704339 59 5. £2-95.

NOTICES

PANEL PASSES, May 1988

Dr. B.Z. Davies, 412 Barrows Lane, Sheldorf, Birmingham B26 1QL
 Dr. Jean McLellan, 208 Abbots Road, Abbots Langley, Herts.
 Dr. Janet Perrin, 21 Alexandra Road, Gloucester GL1 3DR
 Dr. Clare Smith, Foxborough House, Sapiston, Bury St. Edmunds, Suffolk IP31 1SA

The above Doctors have passed the panel of assessment and are now accredited and full members of the Institute of Psychosexual Medicine.

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 three meetings of the Panel will be at the above address on 18th November 1988, 24th May 1989 and 16th November 1989. Please book early to avoid delay in assessment.

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 SCIENTIFIC DIRECTOR

I wish to emphasise that I am available to discuss clinical or academic issues with *any* member of the I.P.M. and for such issues to be discussed at a scientific advisory board meeting.

Prue Tunnadine

The Scientific Advisory Board consists of: *Scientific Director*: Dr. P. Tunnadine; *Members*: Drs. S. Filshie, M. Gill, J. Gilley, A. Parker, A. Smith, G. Wakley; *Consultants*: Drs. R. Freedman, T. Main, R. Skrine. (*Officers with special scientific responsibilities*: Director of Training, Editor, Panel Chairman, Programme Secretary, Secretary of Research Committee).

NEW ASSOCIATES, 1st September 1987—31st July 1988

Dr. Alicja Barnett, 34 Station Road, Okehampton, Devon
Dr. Anthony C. Fincham, Crow Plain Farmhouse, Collier Street, Tonbridge, Kent

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Dr. Josephine Emmerson, Sherwood House, Sparken Hill, Worksop, Notts. S80 1AX

Re-instated: Dr. Shielagh C. Finlay, 8 Sunnycroft Road, Leicester LE3 6FT

CHANGES OF ADDRESS notified or confirmed 1st January 1988—31st July 1988

Dr. V.E. Annandale, 22 Burma Road, Old Catton, Norwich NR6 7AA
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Dr. D.G. Delvin, Haven House, Langley Green, Norwich NR14 6DG
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Dr. Gita Chandra, 19 High Laws, South Gosforth, Newcastle upon Tyne NE3 1RQ

Dr. Mary C. Gabbott, Tithe Barn, Clay Hill Road, Hook Green, Lamberhurst, Kent TN3 8LS

Dr. Christopher H. Sage, 28 Archfield Road, Cotham, Bristol BS6 6BE
Dr. Susan Smith, Five Oaks, Sandy Lane, Henfield, W. Sussex BN5 9VX.

CHANGES OF ADDRESS

Please will any member or associate notify the office at Chandos Street at once of any change of address as many Newsletters have been returned as "Gone away".

I.P.M. CURRENT TRAINING SEMINARS

BASIC SEMINARS

REGION	LEADER	PLACE	TIME
Northern	Dr. A. Smith	Newcastle	Wed.eve
	Dr. J. Munro	Penrith	Sat.am
Yorkshire	Dr. J. Coombs	Bradford	Wed.eve
	Dr. D. Anderson	Hull	Th.noon
Trent	Dr. P. Barrett	Sheffield	Tue.eve
	Dr. S. Filshie	Nottingham	Fri.pm
East Anglia	Dr. B. Devereux	Norwich	Fri.1230
	Dr. R. Lincoln	Bury St. Ed.	Mon.1230
N.W. Thames	Dr. A. Tobert	Chandos St.	Wed.pm
N.E. Thames	Dr. R. Sampson	Finchley	Fri.pm
S.E. Thames	Dr. A. Jones	Bromley	Th.eve
	Dr. P. Tunnadine	Ditchling	Fri.pm
	Dr. M. Roberts	Canterbury	Th.pm
Avon	Dr. R. Skrine	Bristol	Tues.pm
	Dr. P. Allen	Bristol	Wed.pm
Wessex	Dr. H. Montford	Southampt'n	Fri.pm
S. Western	Dr. J. Tisdall	Plymouth	Mon.eve

CONTINUATION SEMINARS: Post Basic

E. Anglia	Dr. B. Devereux	Norwich	Wed.1230
Wessex	Dr. R. Thexton	Southampt'n	Fri.pm
S. Western	Dr. J. Tisdall	Plymouth	Mon.eve
Avon	Dr. R. Skrine	Bristol	Wed.pm

ADVANCED

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

RESEARCH: In Planning

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
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Seminars RECENTLY COMPLETED include those led by —

Dr. S. Lucas in Romford
Dr. S. Horsewood-Lee in Wimbledon
Dr. T. Main in Sharpethorne
Dr. R. Thexton in Cambridge

Seminars in planning: Basic in Manchester