

I.P.M. DIARY OF EVENTS

Saturday June 10 1989, 9.30—1 p.m.

Clinical Meeting in Lecture room A, Postgraduate Centre, Southampton General Hospital. Subject: "Long-term psychosexual effects of termination of pregnancy".

Friday September 22 — Sunday September 24 1989

The Annual I.P.M. Scientific Meeting at Aberdare Hall, University College, Cardiff. Sunday September 24: The 9 a.m. session will be open to invited guests. Those who wish to invite local medical colleagues should contact the Programme Secretary at 9 Alverstoke Road, London NW2 5JS as soon as possible.

Friday September 21 — Sunday September 23 1990

Annual I.P.M. Scientific Meeting at Keble College, Oxford.

OTHER DATES FOR YOUR DIARY

The Balint Society

Friday 19 May — Sunday 21 May 1989

Weekend meeting of group work run by trained leaders for GPs and trainees at the College of Ripon & York St. John, North Yorkshire. Cost £100. Section 63 applied for. Numbers limited. For information contact Hon. Secretary, Dr. D. Watt, 220 Tollgate Road, London E6 4JS. Tel. 01-474 5656.

Friday 15 September — Sunday 17 September 1989

Balint Oxford Weekend.

R.S.M.

Monday 3 July 1989

Evening meeting. Subject: "Religious and cultural aspects of family planning".

R.P.M.S., Institute of Obstetrics & Gynaecology

Wednesday 24 May 1989 at Queen Charlotte's & Chelsea Hospital

Subject: "How to get your message across" (Lecturing and writing papers).

Monday 16 & Tuesday 17 October 1989 at Queen Charlotte's Hospital

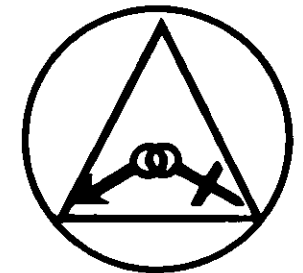
Subject: "Problems in psychosexual medicine". Applications to Symposium Secretary, R.P.M.S., Institute of Obstetrics & Gynaecology, Queen Charlotte's Hospital, Goldhawk Road, London W6 0XG. Tel. 01-740 3904

Institute of Psychosexual Medicine

CONTENTS

LIST OF OFFICERS	Inside front cover
EDITORIAL	page 1
ARTICLES & REPORTS	
The Institute in the Market Place	
Dr. M. Gill	2
Muddle! Can it be Used Therapeutically?	
Dr. R. Skrine	3
Is the Doctor/Couple Interaction Useful?	
Dr. M. Gill	6
The Short Consultation: Report of Joint Meeting of IPM & Balint Society	
Dr. P.J. Barrett	8
The Paralysed Doctor	
Dr. M. Gabbott	11
The Re-constructed Man — Some Thoughts	
Dr. E. Christopher	13
From Frog to Frankenstein	
Dr. M. Roberts	16
Postscript to 'A Troubled Mother' (Newsletter No. 34)	
	17
14th Annual Scientific Meeting of IPM	
Dr. C. Smith, Dr. A. Basketts	17
Meeting of British Society of Obstetrics & Gynaecology	
Dr. H. Montford	22
REVIEWS	
Impotence	
Dr G. Wakley	24

Book reviews	27
From the Journals	28
NOTICES	29
CURRENT I.P.M. TRAINING SEMINARS	30
REGIONAL TRAINING CO-ORDINATORS	31
NEW ASSOCIATES	32
INSTRUCTIONS TO CONTRIBUTORS	Inside back cover
I.P.M. PROGRAMME & OTHER MEETINGS	Back cover



**INSTITUTE OF PSYCHOSEXUAL MEDICINE
COUNCIL AND OFFICERS
MARCH 1989 — 1990**

PRESIDENT: DR. TOM MAIN

OFFICERS

Chairman Dr. Gill Wakley (in post June 1989)
Retiring Chairman Dr. Ruth Skrine
Scientific Director Dr. Prue Tunnadine (ex officio)
Director of Training Dr. Robina Thexton (appointed 1987)
Secretary Dr. Heather Montford (appointed 1987)
Treasurer Dr. Audrey Jones (ex officio appointed 1988)
Editor Dr. Morag Lady Bramley (ex officio appointed 1987)
Dr. Merryl Roberts, Panel Secretary (elected 1987)
Dr. Gillian Vanhegan, Programmes Secretary (elected 1987)
Dr. Rosemarie Lincoln, Publications Secretary (elected 1987)
Dr. Peter Barrett (elected 1989)
Dr. Shirley Snead (elected 1989)
Dr. Shelagh Lucas (elected 1989)
Dr. Susie Horsewood-Lee, Observer to NAFPD Council (elected 1987)
Dr. Ann Parker, Referrals Secretary (elected 1987)
Dr. Dee Howell (elected 1988)
Mrs. Nancy Raphael (Honorary permanent Co-option to Council)
Dr. Ann Morgan (NAFPD Observer on Council)

For information the answer phone is available at the I.P.M. Central Office, 11 Chandos Street, London W1M 9DE. Tel. 01-580 0631.

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 35, MAY 1989

EDITORIAL

We congratulate and welcome Dr. Gill Wakley on her appointment as Chairman of the I.P.M. Council from June 1989 and wish her a happy three years in office.

Our retiring Chairman Dr. Ruth Skrine has in her three years in office accomplished an enormous amount for the Institute with creative ideas and hard conscientious work.

During this period her two books, "Psychosexual Training and the Doctor/Patient Relationship" and "Introduction to Psychosexual Medicine" have been published. The latter using ten contributors is not just another sex therapy manual but a clear indicator that a different way of working and of interacting with the patient is essential to the understanding and treatment of emotional problems.

All levels of Institute doctors can gain from it if only to be reminded that awareness and constructive thinking about every professional encounter we have, must never be abandoned.

It will also be of great value to others in the field who wish to understand the aims and methods of the training and practice of the Institute of Psychosexual Medicine.

Dr. Skrine has also, among many other things, worked to put our Charity status on a sounder footing and enabled the Constitution to be improved.

We wish her a well-earned rest from these labours so freely given on our behalf, and we congratulate her on the honour she has received in becoming a Fellow of the National Association of Family Planning Doctors.

Recently the Members of the Institute have taken part in two multi-disciplinary meetings: the "Couples in Trouble" and the joint Balint Society meeting. They are reported in this issue.

As Dr. Gill suggests, and Dr. Skrine's book illustrates, we are now at a stage in the Institute where we can look at our strengths and weaknesses without being defensive and can crystallise and re-verbalise what our training and working method is about, i.e. the method that keeps our eye unwaveringly on the understanding and use of the doctor/patient interaction resulting from what is offered by the patient or couple in the present moment. We are able now to relate to other organisations with more confidence and I hope we will go on doing this by presenting papers both here and abroad with increasing frequency.

The subject for the next Newsletter I hope may be, "Bereavement, causing or exacerbating psychosexual problems". Please encourage seminar members and others including yourself to put pen to paper if they have well thought out encounters with patients in this category.

Other carefully considered case reports are also welcome as are letters to the Editor or suggestions for future subjects.

Please note instructions to contributors on the inside back cover. August 1st 1989 is the deadline for the autumn Newsletter and February 28th for the Spring 1990 edition.

Morag Bramley

THE INSTITUTE IN THE MARKET PLACE

On October 28th and 29th 1988, twelve of our members took part in a Conference organised by the Standing Committee for Couples in Trouble, called "Sexuality and the Couple". Seventy delegates attended from the organisations involved and met at Kings Fund College in London.

The seven founding organisations were:

- The Tavistock Institute of Marital Studies (I.M.S.)
- The Association of Sexual & Marital Therapists
- Relate - Marriage Guidance
- The Institute of Group Analysis (I.G.A.)
- The Institute of Family Therapy (I.F.T.)
- The Tavistock Clinic
- The Institute of Psychosexual Medicine.

Six 30-minute papers were given by participating organisations, two in each of the three plenary sessions. Open discussion followed the papers. Small groups of mixed representation discussed the papers more fully and explored their own approaches to casework.

Dr. Ruth Skrine and I prepared a paper on behalf of the Institute although, sadly, Dr. Skrine was not able to present her part of it herself for family reasons. We outlined who we were, our origins and training methods. We offered two very different pieces of case material to illustrate our way of working, and ended with some brief comments on our seminar training and guidelines for assessment for Membership.

It is fair to say that the casework, in particular, was very well received. It opened up much discussion in the small groups. Other organisations went for a much more theoretical approach to their work and used little case material. Some videos of work with couples individually and in a couples' group by the I.F.T. and the I.G.A. were shown. More clinical material was requested for another occasion.

The value of this exercise is important though limited. To present our work and training in such a setting feels rather like setting out our wares in the market place! To do so means a sharpening up of our approach as well as an appreciation of its strengths and weaknesses compared with other ways of working. To be accepted and to have our work valued in its own right is reward enough. Clearly our focussed attention on the doctor/patient interaction, and the results that come from its understanding, constitutes our main strength. Our limitations are the strengths of others: for example, the detailed understanding of couples

work (I.M.S.) and the wider dynamics of family and social relationships (I.F.T.).

Training styles differ greatly too, not surprisingly. The eclectic approach of the I.F.T. with active 'up front' involvement by the therapist who enjoys moving from one method of working to another, lends itself to what was termed 'hybrid vigour' — (or possibly 'model muddle!'). In contrast, our way of working is far more appropriate to training those with a similar professional background and work setting.

At the beginning of the conference the question was asked, "Why has it taken so long to get together?" Whatever the reason for the delay, it seems to me that as an Institute we have reached the point of being able to relate to other organisations on an equal footing, respecting their different ways of working whilst being true to our own, without resorting to defensiveness or paranoia. Perhaps this is a good stage to be at.

It would have been helpful to have got beyond the exploration of our differences to the point of being able to sit down in the small groups and have a go at case material. This could have been done in a spirit of real constructive criticism, in order to be better able to select out those patients who do not do so well with us and refer them appropriately. Perhaps, though, given the inevitable caution in such groups at first, we made good progress in the time available. There were certainly some serious enquiries about seminar training from the other organisations!

Dr. Margaret Gill
I.P.M. Member

MUDDLE — CAN IT BE USED THERAPEUTICALLY?

First case study presented at the multi-disciplinary conference on Sexuality and the Couple, October 1988

This case describes a single patient with sexual difficulties, which illustrates the use of the interaction in the room between doctor and patient as a means of identifying and understanding the patient's unconscious communications.

Several vaginal examinations were performed, by both doctor and patient. These were not about looking for physical abnormalities, or about teaching the patient her anatomy, but were a means of exploring her fantasies about her vagina and her sexuality.

I was asked to see Miss Smith, aged eighteen years, by a local gynaecologist who thought the problem with intercourse was not a physical one. Three general practitioners had tried to examine her and failed. He had not even tried.

Miss Smith was an attractive brunette, smartly dressed in navy suit and crisp white blouse. Making love with her fiancé was painful. She had no contraceptive at the moment, so she couldn't, even if she wanted to. She mentioned a cerebral haemorrhage following a head injury at 25 years, precluding oral contraceptives. I had to clarify then that she was actually 29, not 18 as the letter said. I felt muddled.

Miss Smith said that she must have a blockage as three doctors had been unable to examine her. She was quite aggressive about the doctors who had failed to “put her right”, and went on to say that she did not know whether her hymen had been broken or needed to be broken: at any rate she felt very small. I offered to examine her and was able to insert two fingers easily and felt no hymen. I invited her to feel for herself and she told me that doing so would be masturbation. She remembered with horror the fuss at her boarding school when two girls were found in bed together. I pointed out that I was not asking her to stimulate herself, merely to feel and see if she could find the blockage. She did so and said with surprise, “I’m not so small, am I?” At this stage, when she left, I believed she was a case of at least partial non-consummation.

Miss Smith opened the second interview by saying brightly that she could get three and a half fingers in and “Where do we go from here?” — wanting me to do the work and have the answers. I said perhaps we could talk about it a bit more, and gradually quite a different story emerged. It turned out that she had made love quite easily for several months, and that the problem had only started when she moved in with her boy friend. She commented, “He wanted it every night — I think I was keeping him out. When I really want it I get moist, but I rush into it because I think someone may come in. I suppose I do feel it is a bit bad”. She told me they would start touching in the sitting-room and then go up to the bedroom, adding, “I suppose you will say, ‘Why not on the sitting-room floor?’” I found myself denying strongly that I would say such a thing, but at this point failed to ask myself why I needed to deny it so strongly — in reality I have nothing particular *against* the sitting-room floor!

Six weeks later she returned and said things were a bit better and again asked, “Where do we go from here?” I felt I was under pressure to do better than the previous doctors. Pointing out again to her that she seemed to need me to have all the answers helped to free her to talk about her need to be in control, both at work as a manager in a big store, and with her fiancé whom she ‘organised’. She said, “Perhaps I should try letting the inside out - be more ‘Mary’ and less ‘Miss Smith’”. She told me she had always been the practical one at home. Commenting on how difficult it seemed for her to allow her feelings out in this interview led to the remark, “If I did that I would feel I needed a psychiatrist or something!”. I remained silent and she added, “Well, if we are talking about feelings, I might as well say that I am afraid I won’t be able to have a baby” — and burst into tears. She sobbed that she didn’t really want a baby — at least she didn’t think she did, but both families would push her into it. She was afraid that “after sex all that time and nothing happening, I might not make an egg cell or something”. I floated the idea that if sex were not for babies perhaps it was not quite proper? She dried her eyes and left a bit thoughtfully. I wrote in my notes: “I don’t really understand the *force* of the tears, but she seems much more human, somehow”.

Six weeks later Miss Smith was more relaxed in the interview and told me she was enjoying the feeling of sex inside and liked it when her cervix was touched. She said she didn’t know where her clitoris was and leapt at the idea of being shown. However, on the couch, she admitted that she had used

it to masturbate as a child, but that masturbation was very frowned on by her school. The idea that she might like more foreplay was accepted eagerly. She said, “It’s like starting a car from cold in the morning”.

I did not see her again for three months. Christmas had intervened, and she had postponed one appointment because she would have a period. “She wants to be examined again”, I thought.

She came in a bit tense and asking the usual question but with a small variation — “What do I do now?” An advance, I thought, from “Where do we go?” I just smiled, and then she started to ask a lot of questions about me and my work.

“How did you start this work? What will you do when I leave? Are you like that doctor who uses naked nurses?” She made me feel far too sexy — altogether too knowing. “No, no”, I started to say, “I’m not *that* sort of doctor”. But then, this time I managed to recover and say, “Perhaps there is a bit of *you* that feels you might be too sexy?” There was a thoughtful silence and then she said that ‘Mary’ inside was like a cat, soft and purry but so passionate that she wants to bite and scratch. She wondered what might happen if she let go?

She added, “My boy friend says, ‘What has that Dr. Skrine done to you?’” Here was a moment when I felt tempted to start wondering about the partner. An advantage of only seeing one patient is that this remark can be regarded as a projection of the feelings of this patient, without having the issue clouded by knowledge of the other. “I wonder if you feel you have changed?” I asked. Miss Smith replied, “Perhaps I am too sexy. I wonder if I am too big inside”. Remembering her change of appointment because of a period I offered to examine her again, and she also examined herself. This time she said, “I’m not really too big, am I?”

She came to her last visit looking radiant, in a flowing flowery skirt and soft pink blouse. She said everything was fine, and sometimes she could let ‘Mary’ peep out also at work without losing control of her staff. She spent the rest of the interview telling me their plans for the new house they were buying. She did not mention her body nor her sexual feelings, and I did not ask whether she had become orgasmic — it was neither necessary nor appropriate. It seemed she had now taken her sexual affairs into the private part of her life where I was no longer needed, and this felt right and proper.

Comment

In this case the patient’s muddle about her sexual desires was shown at the very beginning by the confusion over her age, and the conflicting histories in the first and second interviews. This muddle was confirmed by her vaginal fantasies, first too small, then too big, both of which were refuted by vaginal self-examination.

There was much in this case that was not understood or explored: how she came to be the ‘practical’ one at home, for instance, or even the full meaning for her of her fear of infertility. However, by concentrating on the here and now, the patient was gradually able to take more responsibility for her own change, and the doctor (eventually) realised that her feeling of being too sexy was provoked by the patient. Using this the patient was

helped to change fairly dramatically in five sessions.

*This paper was presented by Dr. M. Gill
on behalf of Dr. R. Skrine
I.P.M. Member*

IS THE DOCTOR/COUPLE INTERACTION USEFUL?

Second case presented at 'Sexuality and the Couple' conference, October 1988

Robert and Barbara

I have chosen to talk about a couple because I wanted to dispel any myths that seeing couples is taboo in our psychosexual work. Couples *do* present, sometimes because they are *told* they must come together by a GP or receptionist, but more often because they choose to bring their difficulty and present it as a joint one. Without rigid rules we examine and work with the couple — moving from the couple to one-to-one if it seems useful and not just to make the doctor feel more comfortable! Having said that, work with couples is not our main strength as an Institute.

This couple illustrate a number of points, some of which are speculative. I do not claim to have understood fully all the levels of communication between us but I offer, in abbreviated form, some of that understanding.

Robert and Barbara were referred by their GP. He said that Barbara had suffered from severe diabetes for most of her life. For the past 15 years she had been unable to respond and enjoy sex. Her Consultant Physician did not think that her diabetes was directly responsible.

What I was not prepared for was that Robert was in a wheelchair. I think he had M.S. but, interestingly, I did not get round to asking him. Certainly his condition did not interfere with his erections.

There were unusual and interesting qualities about this couple: a cohesiveness which was not the same as collusion, and an interdependence which probably had a great deal to do with their physical disabilities.

At our first meeting I listened as Robert prompted Barbara with her story. She had spent all but two weeks of her first pregnancy 15 years ago in hospital because of her diabetes. The baby son born was not expected to live long, but Robert did not tell her until about three months later. Now their son Jason is 15. The doctors said afterwards that she must not have any more children: it would be too dangerous.

Barbara looked angry and fragile, like a wizened child in some ways, old before her time. Her mouth was firmly buttoned up between sentences. It was not hard to recognise and acknowledge her anger towards the doctors who had said, 'No more children', and the conflict of feelings that the dire warning had caused in this couple who longed for a large family.

At some point in the first interview Robert carefully interpreted one of my remarks to Barbara after she had given me a rather blank look in response. He said to me, "She needs to have things very carefully explained by doctors, or she doesn't understand". Suddenly I felt miles away from them, encased in medical jargon and mystique — almost as if a huge oak

desk had materialised between us and I had sprouted spats and a gold watch chain! Realising that, in fact, I had not used any long words or medical jargon, I offered this interaction back to Robert and Barbara hoping that we might understand it. I said, "It seems to me that you need to cut off from hearing what I say because I am a doctor, as if there is a brick wall between us — but it is not *actually* to do with words, is it? And you are clearly an intelligent person, Barbara".

Barbara replied vehemently, "No, I'm not stupid, though I often *feel* stupid with doctors. I get so angry and anxious that for two pins I could run out of the room". She didn't actually do so but looked as if she meant it! Robert sat by as if he fully understood her but was relieved at my response. He said, "We've been trying for 15 years to get someone to *listen* to us!" There was no further need for him to interpret what I said, just venting the anger and having it accepted for what it was was enough.

Barbara had had to place her body in the hands of doctors for most of her life. The worst bit was in pregnancy and afterwards. She didn't know how to get out of the trap of her angry conflicting feelings and she had buttoned herself up sexually, cutting off her sexual thoughts and fantasies from her body, which lay stiff as a board when Roger made love to her. It was as if she had proceeded to give herself fierce warnings about responding as a woman in order to avoid the feelings and longings which could result, in particular for more children. In her own words she was 'Mad — angry' about it. Robert's response was patient, surprisingly so, but he had increasing premature ejaculation and occasional loss of erections.

With this couple, perhaps because of their high degree of physical interdependency, it was as if the usual boundaries between them were less well defined — as if, in fact, there were few secrets that they could not share. It was easy to move from Barbara's own thoughts and feelings to the relationship between them and the effect of her lack of response on Robert without separating them for one-to-one work at this early stage. They included me in their relationship, too, in the trustful way they shared themselves without somehow losing any of their individuality or integrity. They were the kind of couple who seem to leave a 'gift' behind them when they have gone — a gift of themselves.

The third visit produced some movement. They had watched a film in which a girl was letting a chap kiss her outside a cafe — in the street, almost. She had her breasts bare and didn't seem to care at all. Barbara said, "It was as if something exploded in me — I was like a young Barbara again and I didn't care either". It didn't matter then who else was around (or presumably how many doctors had seen and handled her body). Lovemaking had been quite wonderful — though predictably it did not simply go on being so: it needed working out and understanding together. I offered a vaginal examination on the next visit (you can understand why it was not offered too readily!) and Barbara accepted in a relaxed way.

I wish I could tell you that things went from good to better, but not so. Ten days ago I glimpsed these two, together as ever, standing in the sun probably waiting for their son to come out of school. A few days after that I had a phone call to say that Barbara had been killed in a road accident the next day. Robert had taken it badly, not suprisingly. I couldn't help hoping

that there might have been a few more explosions of fun before Barbara's death and if Robert cares to come and talk later perhaps I will hear.

I have used this case for a variety of reasons:

1. To show that in the Institute we see those who present *as* they present and understand the dynamic without altering it to make ourselves more at home!
2. To illustrate how people self-select their treatment setting for reasons of their own. Probably in this case these two had something to say that had to be said to a doctor, which they had not previously been able to say in such a way as to be heard!
3. It seemed to me that the turning point with this couple came when we recognised the barrier that came between us when Robert explained my remark to Barbara and we saw that the barrier was not *actually* caused by my using long words or by her stupidity, but was a re-living in the present — with this doctor — what had so often happened with doctors (and others) in the past. This time the feelings were explored, with consequent changes in our relationship, paving the way for the couple's own sexual progress.

Dr. M. Gill
I.P.M. Member

THE SHORT CONSULTATION

A Report of the Joint Meeting of I.P.M. Members with the Balint Society, 22nd November 1988

A splendid room at the Royal College of General Practitioners was the venue for an occasion which would allow exploration of the similarities and differences of our working methods. The last Joint Meeting had been some time ago, so it was good that the room was full to capacity. Four cases of short consultations were presented and a brief discussion followed each presentation.

Dr. Selinsky presented a 25-year-old man who arrived very late for his appointment at the surgery. The patient's complaint was one of impotence with his girl friend. He was insistent on having some medication to alleviate the problem. His doctor declined and asked more about the situation with the girl. It turned out that she had another man who was regarded as a much better performer. He readily interpreted the patient's anxiety about performing well, but following this got little further with the problem. He asked a great many questions about his family and childhood. Although he obtained a good deal of information about the man's background, he got no further with solving the problem. It was getting late so the patient was asked to come back the following week with his girl friend. In the discussion Dr. Selinsky was the first to recognise his precipitate interpretation of this man's problem and his subsequent seeking of refuge by asking lots of questions. The nature of the circumstances surrounding the consultation was examined and it was felt by some that the doctor's irritation at being kept late had influenced his judgment. In the case presentation and in the

discussion that followed, very little in the way of emotion came through. The discussion, like the consultation, was rather hurried and lacking in feeling, perhaps because the meeting had started late just like the consultation.

The second presentation was that of a middle-aged man seen by Dr. Barrett. The receptionist had asked if he would see a temporary resident at the end of his evening surgery. A tall, distinguished man, in a three-piece suit, knocked loudly on the door and strode into the room. He moved the waiting chair, sat down and then moved the small collection of materia medica from the path of his alighting elbow. When quite comfortable he told the doctor that he had a sore throat and needed some antibiotics. The doctor was feeling more than a little irritated by this controlling chap but busied himself with the task of examining the throat. When finished and the antibiotics duly prescribed (it was even more annoying that he did need a prescription), the patient remained bolt upright on the chair. "There is one other thing you can do for me. Can you recommend a specialist?" Dr. Barrett asked, "What kind of specialist?" The patient went quiet and then, as if gathering courage, said that he was having problems with his erection and please could he just have the name of a specialist. There was certainly an urgency in this man's manner. Dr. Barrett said, "Well, before referring you, I would like to examine you and perhaps talk a little about the difficulty you're having". Rather reluctantly the patient slipped his trousers down and climbed on to the couch. As the doctor began the examination the patient seemed to crumble and for the first time seemed openly vulnerable. Dr. Barrett said, "It must have been awful for you when you found you couldn't make love. Can you tell me a bit about it?" As he dressed, the patient was able to tell the doctor about himself. He had been married for twenty years and then his wife "had just upped and left". He maintained that he had no idea that she was going. He said to himself that he was not going to let it affect him at all and described a series of one-night stands which were quite successful. He had then met his present girl friend who was "absolutely wonderful". He would do anything for her. "In what way?" asked Dr. Barrett. "Well, I usually give a cash Christmas present, for example, £2,000". "And what does she feel about that?" "Well, it's a funny thing but this year she said she would rather have a fur coat". "How much was that?" "Well, it cost rather more, about £3,000 in fact". "It seems you can never do enough for this woman. I wonder how you feel about that?" On saying this the patient suddenly seemed to realise his anger with the woman and went on to express his surprise at these feelings which seemed so much out of his control. He returned next week to tell the doctor that his sore throat was much better and, by the way, "the other problem has resolved".

The discussion seemed to polarise at this point. It seemed rather difficult for some members to accept that this sort of encounter could result in such a rapid recovery. A prediction was made that the patient would soon be back with similar difficulties as the described process did little to tackle the fundamental anxieties of the patient. It was thought rather too 'slick'. Nevertheless a rapid improvement in this patient's complaint was reported and it was noted that the doctor was not asked by the patient for prolonged

psychotherapy, nor was the doctor in the position to provide this. A short consultation had resulted in a significant resolution of symptoms by the use of applied psychoanalytic techniques.

The third case presentation was by Dr. Paul Julian and concerned Sharon, a good-looking girl aged 28. She was from a large family who seemed well known to the doctor. Sharon came along to the surgery with her boy friend. She complained of difficulty when making love. It seemed hard to relax with him. The doctor noted his dislike of the boy friend whom he described as a mummy's boy. It was difficult to get very far with the problem as the doctor received a call to see Sharon's mother who had been taken ill with severe chest pain. A good deal of family history was then described. The doctor noted that Sharon's mum had been left all on her own despite having marked pain. There was a homosexual sibling and the rape of another sister was reported. The case history seemed to leave the group in some confusion. It was thought that the doctor had been prevented from delving into Sharon's problem by the presence of the boy friend. It was also felt that the doctor may have been rather protective of both Sharon and her sick mother. The essential questions — whose problem was it? whose idea to come? and why now? — could not be answered at this stage. There was some sympathy for the very honest account given by Dr. Julian of a typical general practice scene and its attendant confusion.

Dr. Wakley gave the final presentation of a self-contained middle aged woman dressed in rather old-fashioned clothes. She had come for a cervical smear and a cap check. The routine went ahead without event, until the doctor was inspecting the cap and remarked to the patient that it was in very good condition. Two red spots appeared on Mrs. C's cheeks — her first sign of emotion. "It doesn't get used very often now", she said defensively. The doctor took her elbow and together they walked back to sit by the desk. "Why is that, then?" asked the doctor. Looking past the doctor, she said, "I expect it's the change, isn't it?" The doctor felt shut out after the previous moment of closeness and looked enquiring. Mrs. C. catalogued a long list of symptoms while the doctor thought, 'that doesn't sound very menopausal, and why is there this shut out feeling: is she doing this to her husband too?'

The spots of red on her cheeks were glowing again and she looked close to tears. "Have you talked to your husband about it?" "He says it's only since I've been working full time that I've felt like this, but it can't be that, because I feel much better at work". The doctor raised her eyebrows and the patient looked suddenly aghast at what she had said. "It *is* the change, isn't it?" "Why should it be better at work, then? Did something else happen at the same time as you went to work full time?" the doctor asked.

She explained that her husband took early retirement due to ill-health. She had gone to work full time to supplement his pension. Now he wanted to move to rural Wales so that they could live on his pension only. But she did not want to leave her home, her friends, family or her work. Could she not tell him all that? She had told him, but it was her duty to obey her husband, and she reminded the doctor that she was a Jehovah's Witness.

The doctor felt reprimanded and put down. "So you withdrew from the sexual relationship instead?" "Yes, and he doesn't seem to mind at all!" This was said with such feeling and anger that the doctor felt paralysed

(impotent?). The doctor reflected, "Perhaps he felt it was a just punishment for not being able to be a proper husband and support you?" Mrs. C. looked horrified, the spots of red disappeared from her cheeks and she looked for a moment as if she would flee the room. There was a long silence. She blinked hard and sat up straighter. She said, "I shall have to talk to him". The subject was obviously closed and they passed on to mundane matters before she left.

The doctor, reflecting afterwards, was left feeling as though she had intruded without invitation. She felt uncomfortable about leaving the patient with so much unexpressed emotion and yet pleased to have shared an insight into what was happening between the couple.

There was general approval for the accurate and lively description of the doctor/patient relationship given by Dr. Wakley. Several members expressed their surprise that such an outwardly trivial observation of a barely used cap had led to such a consultation. There was admiration for her detective powers and some envy of the ability of 'psychosexual' doctors to focus their attentions on one particular area of patient distress (would that were true!). The differences in the cases presented and in their mode of presentation were of course in part due to the fact that all encounters between patients and doctors are unique. So perhaps we should not generalise about different methods or outcome. However, it was noticeable that we (the Institute-trained doctors) were much more aware of the dynamics during examination and were prepared to use these observations when appropriate. Despite this, the increased awareness achieved by attending Balint or Institute seminars was evident in the thoughtful and sensitive discussion that followed each case.

Dr. P.J. Barrett
I.P.M. Member

THE PARALYSED DOCTOR

A shamefaced sage and senior Institute doctor told, in horror, how "years of experience flew out the window".

There was great intrigue among the staff of this cosy Family Planning Clinic when *a man* asked to come with . . . *another!* Gays perhaps — with AIDS?

The day came, amid great expectations, but an unremarkable blondish man in his early thirties appeared. Looming behind him, framed in the doorway though, was a massive figure, draped in black, with long hair hanging over her shoulders. She sat down demurely, eyes downcast, pale and inert. Even so, she towered head and shoulders above him — a caricature of a couple.

Nonchalantly leaning back on his chair, he put one foot over his knee and, clasping his hands behind his head, said loudly, "I have had sexual relationships — Jane has not. We are marrying in September and don't want children — " (pause) "Can you tell me about contraception?" He mentioned he was ex-Merchant Navy.

The doctor, fully aware of his outward aggression, launched nevertheless into a routine explanation of contraceptive methods, only to be shot down in flames. Statistics were queried, facts challenged and war was declared! The doctor noted her increasing anger and her powerlessness to act as an Institute doctor. "A woman can't be fitted with a cap until she's had a child", he asserted. The doctor struck back, "Any woman who uses a tampon can be fitted". "Well, she can't get one in!" was the retort.

The doctor persisted, "A cap could be fitted —" to receive the broadside, "Why should you have the pleasure of breaking her in, instead of me?"

Reeling from the blow, the doctor riposted, "Remember, you will not be in your destroyer with all guns blazing, but a husband making love to his wife. From your description of the breaking-in, I presume you will hang the sheets out of the window to demonstrate your potency!"

The interview terminated soon after. "Will you need me here?" he asked on leaving. "That's up to Jane", said the doctor briskly.

The doctor was aghast, the seminar riveted. Ideas ricocheted — "The girl frightened you" — "She made you attack her fiancé" — "You were angry with this girl for contributing nothing, letting you do battle on her behalf" — "You were furious with this man's attitude". Finally — "This couple paralysed you — why?"

"I was scared of angering him further", suggested the doctor. She was, though, fully aware that the man made her feel 'male' and he probably had homosexual instincts. In allowing herself to be distracted by his barrage, she turned away from the tragic creature before her. There was no engagement with the girl, yet the doctor defended her fiercely and furiously. Her reasons for this behaviour were not examined.

At the second interview she came alone, still in black but softer somehow and more girlish. The doctor found herself being unduly considerate — to make up for her previous bad behaviour, of course! The pill was selected and business was nearly done. Then, a bolt from the blue: "Will you examine me?" Mmm . . . — "Why?" "Just to make sure everything is normal. I can't use a tampon". "Of course — *hop up!*" (The seminar smiled beatifically).

No attempt was made to examine the misgivings behind the request. Only later was the doctor able to acknowledge her ominously confused doubts about the patient's femininity. She fled into the safety of the vaginal examination, relieved to find things "easy" and "normal". Imagine her horror, on parting the labia, to see a thick, impenetrable hymen with pinhole os; then excruciatingly, driven to look her in the eye and see the mannish face and body, the stunted vagina . . . the warped upper genital tract . . .

The patient, however, seemed relieved to have a physical examination. The doctor felt the patient "knew" her disability, dressed appropriately and selected a sexually ambivalent partner (the seminar fantasy being: probably impotent with a secret wish for her sterilisation, rather than contraception, in order to preserve his status).

As before, however, the psychological needs of the woman were not addressed, and the doctor fled again into the efficient organisation of a

gynaecological referral. Her distress about the girl's "breaking-in" by a gynaecologist brandishing dilators, and the effect of this upon her husband, could not be acknowledged until later.

In retrospect, it seemed the doctor failed to confront her *worst* fear and acknowledge the grotesque deformity before her. Easier by far to engage oneself on the verbal battlefield and shelter behind medical frontlines.

So, what drove this lioness of a doctor into battle? Perhaps, the instinctive need to protect one of nature's weaker fledglings, as befits the wise and strong. A helpless case? — small wonder, then, she found a helplessly paralysed doctor.

Dr. M. Gabbott
I.P.M. Member

THE RE-CONSTRUCTED MAN — SOME THOUGHTS

I have recently been pondering on what I think is a new phenomenon (or perhaps an old phenomenon in a new guise?) being seen in the psychosexual clinic, and wondering if others have noticed it too.

This is the dilemma posed by the 're-constructed man' (that is, the man who under the influence of feminism has changed his behaviour) and the effect he has on his partner.

One of the main 'symptom' complaints of women attending the psychosexual clinics is a loss of interest in sex. This symptom is like the tip of the proverbial iceberg, covering a complex area of muddle and confusion both inside the woman and in her sexual/loving relationships. Trying to understand what is really going on is the essence of our work. Although Institute training rightly emphasises the uniqueness of the individual and each doctor/patient relationship, sometimes there are certain similarities in some patients' complaints.

For example, several women recently seen have shared some common features, namely being strong feminists involved in a long relationship with a 're-constructed' man whom they no longer find sexually exciting, and a powerful attraction to a man (or men) of whom they disapprove on ideological grounds. This would seem to be a new phenomenon or pattern of relationships.

I want to describe three such cases and offer views on what I think is going on:

Miss A., in her early thirties, was referred to the psychosexual clinic by her GP with the complaint that her loss of interest in sex was spoiling an otherwise happy relationship. Almost as an afterthought, the GP added that she has an exacting job.

The patient took me by surprise. Expecting a smartly dressed business woman, I was startled to see a woman with long, fairy-tale hair cascading in waves almost to her waist, wearing jeans, boots and carrying a crash helmet. She looked at me both defiantly and timorously. At first she began telling her story confidently. She and her partner, Tony, had been living happily

together for seven years. He was a wonderful man, everything a feminist like herself could want. "We live an alternative lifestyle", she said. She was an architect, he was in the caring profession. "He cooks, washes, does the shopping, has a meal on the table when I get home. He's sensitive and understanding and we can talk about anything. There's absolutely nothing wrong with our relationship" — (was she protesting too much?) — "and so I can't understand it". The tears were beginning to well and started to flow down her cheeks. "I just don't want him any more sexually; I cringe when he touches me. It's awful, I don't want to be like that. I've tried to work it out but I just can't". She dissolved into helpless tears and I felt very maternal, wanting to comfort her.

"What was sex like before?" I asked gently.

"Oh well, it's never been marvellous. Of course, I've had a lot more sexual experience than Tony. I've tried to tell him what to do, but he just doesn't want to do things my way, so I just let him get on with it" — (his one area of protest? I wondered, finding my sympathy diminishing) — "but anyway", she continued, "it was O.K., we got along all right. It wasn't the problem it is now". When did that change? — "Well, you see", (the tears began again), "I went to a conference as part of my work and found myself attracted to a man there. I almost went to bed with him. I can't understand it, because he's not my type. He was aggressive, a bit of a show-off and inconsiderate, but I felt excited whenever he was near. Since then I just can't get aroused by Tony at all". She began crying softly again in a helpless, bewildered sort of way. I felt torn, split in two, reflecting perhaps what was going on inside her. There was Tony, the nice, kind but unexciting man whom I believe she loved but felt some contempt for, and then the exciting stranger who I found myself wanting to know more about. On the other hand, why couldn't Tony make more of a stand? — But if he did, what would she do — throw him out? He was in a double bind.

Eventually I said quietly, "It's a pity your partner can't be a caveman in bed while still being the gentle person outside the bedroom. Perhaps he can only show his strength in a negative way by not doing what you want sexually". She stopped crying and looked at me intently. I steeled myself for an attack. Instead she said, "My parents were always quarrelling — when my father was there, that is: he was away working a lot. I used to blame my father for the quarrels and felt sorry for my mother, but later I found out she had other men friends. She used to flirt a lot. I decided I'd never get married and if I lived with a man he'd have to be 're-constructed' ". What did that mean? "Well, thoughtful, non-aggressive, sharing the household chores. I used to think — well, I still do — that I was lucky I'd found Tony. He was what I wanted. Then when things went wrong sexually, I didn't know what to do".

The expression 'the re-constructed man', or 'feminist man', has since come up quite frequently.

Mrs. B. had been married several years with one small son. Her initial complaint was a loss of interest in sex. Sex had been exciting in the early years of marriage, though it had now deteriorated. Her husband, too, was quiet, considerate, as adept if not more so that she was at household tasks.

Joining a women's group she began to pride herself on her husband not being like all the other terrible men she heard about. Her husband changed nappies, did the ironing, never shouted: he was a 're-constructed man' without her realising it.

Why did she find herself becoming depressed and miserable, losing interest in him sexually and in sex itself? Nothing turned her on. She had no sexual fantasies. The marriage continued to deteriorate and finally ended when one night her quiet, mild-mannered husband tried to make love to her in a desperate attempt to save it. She cried 'rape' and he left feeling humiliated and guilty.

Several months later she returned to tell me about an exciting man in her life. She knew he was an absolute MCP (male chauvinist pig). He would promise to ring, forget, then send flowers and arrange an intimate dinner for two. Passionate love-making would follow and then she would not see him for weeks and the cycle would be repeated. Part of her despised herself for tolerating this behaviour, but another part found it exhilarating. She was aware she could not live with this man, he would not give her the emotional support she needed, but she now got that from her women friends. Her father had been a quiet, undemonstrative man who would repair to his garden shed and make her exquisite toys.

Miss C. referred herself to get 'this' sorted out. 'This' was her loss of interest in sex. She was a smart business woman with padded shoulders, tight skirt and high-heeled shoes. She was an ardent feminist whose career was central to her life. Her father, a working class man, dull and stupid, had kept her mother down so she could not achieve her potential. This would not happen to her. She then talked about her sexual relationship in a business-like way. Her partner, with whom she lived for ten years, was a divorced older man. She used to be attracted to men who treated her badly; then she met Mike. He was a bit of a male chauvinist, but she'd tamed him. Sexually she had been the pursuer and sex had been fun at the beginning. Then she got bored. She couldn't understand it. She didn't like it if he made advances. What was wrong with her? Was it hormonal? She found herself being attracted to some of the powerful men she met at business meetings.

I found myself alternately admiring her and being repelled. My attempts to make advances in the form of interpretations about her difficulty in allowing vulnerability met with a rebuff. She found it hard to take in anything, although occasionally her lower lip would tremble and I would feel I was getting through. The turning point came when she went on a business trip to Paris and Mike joined her and gave her a ring. She was quite flabbergasted at her reaction — "all girlish and weak at the knees!". It was, she supposed, a sort of engagement ring and she eventually wore it as such, shyly and proudly showing it to me. I was allowed to take pleasure in it too.

I shared these patients with some feminist student social workers at a sexuality workshop, curious what they would make of them.

"Oh", said one, "That's all right, women are treating men the way men have always treated women. Serve them right!" What did she mean? "Well, men divided women into madonnas and whores. Women are doing the

same, dividing men into household re-constructed men and the sexy male chauvinists with whom they can have fun without commitment". The group seemed quite happy with this. And yet . . . the women I had seen were not entirely happy; they were confused by their feelings. Twenty years ago women's groups were saying that if only men could be more like women, sensitive, thoughtful, caring, non-aggressive, then relationships between the sexes would be better. But having got their 're-constructed' man they no longer 'fancied' him. He was not allowed to use and enjoy his penis with them. Women used to be angry that men divided *them* into two kinds, thereby denying their sexuality, so that 'nice girls didn't enjoy that kind of thing'. Now it seems the tables are turned, so that there are nice, kind, but asexual men who may express their anger in a negative way by avoiding sex or suppressing their sexual feelings, and sexy male chauvinists who are attractive and dangerous.

What do the 're-constructed' men feel? Mr. B., the only partner who came to see me, was confused and bewildered. He didn't know where he had gone wrong.

Has the 'new' woman made the same mistake that the 'old' man made: dividing sex from love with all its painful consequences?

Dr. Elphis Christopher
I.P.M. Member

FROM FROG TO FRANKENSTEIN

He plucked anxiously at his beard as he told me of his impotence. His eyes were wary but supplicating. I felt powerful. He had been seeing a psychiatrist "for ages", he said, humbly. His wife was "a very positive woman, very controlling". I found I felt angry. He wasn't only criticising his wife! He was uncomfortable when I used all this to explore his feelings, continually trying to return to the awful power of women, uneasy with his own need to placate, to be controlled. He became more and more agitated, plucking away. "I think I need to be safe, to be quiet", he said.

My errant brain produced a poem and, interested, I fell into my own trap. "Have you read the poetry of Stevie Smith?" I asked. He looked aghast. "One particular poem . . . The Frog Prince . . ." I mumbled, cross with myself.

When he came back he looked at me carefully: "I read it". We were silent. "I have had sex", he offered. "and I kept going for a long time for me and then suddenly I came and I think it's because my wife was getting excited". "You fear what will happen to you if she loses control?" I said. "I fear the beast in me", he replied sombrely. He was able to talk about his anger and violence — "If she is defenceless, I may hurt her, even *mean* to . . .". The beast prowled around the room but became less threatening. "Let's face it", he said, "the princess will have to change too". He cancelled his next appointment.

Dr. M. Roberts
I.P.M. Member

Postscript to A TROUBLED MOTHER: Newsletter No. 34, October 1988

When "Catherine" read my contribution about her before I sent it to the Editor, I watched her get angry and want to scrumple it up. She said her feelings were of fury that the abuse had happened. I thought it was anger with herself for being immature and unable to get out of the situation with her stepfather as her sister had done. I thought also that she was angry that I knew of her part in it. I said this.

She took my typescript home, and her husband read it. Later she reported happily that it had "shone a light for him". He now showed more appreciation of her, and they had had totally fulfilling sexual intercourse on several occasions.

I said she was free to give and get good feelings at home now, and should give up coming to see me. She accepted this, and we planned a last meeting. This time she indicated that she was much relieved at breaking off her relationship with her mother, and she brought another poem:

At last I've solved the puzzle,
I've searched and found the key;
I've collected all my thoughts,
And now at last I see.

I've so much love to give
My family now with me;
And deep down in my heart
I'm content and very happy.

The next words I will write
Will not dwell upon the past,
But of life today and tomorrow.
I have inner peace — at last!

The publishing of her previous poem, for which she had given permission, had increased her sense of self-worth.

I think about her from time to time — as when her Christmas card arrived, and I wonder if the improvement has been maintained.

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

FOURTEENTH ANNUAL SCIENTIFIC MEETING OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE AT VILLIERS HALL, LEICESTER UNIVERSITY

What a relief to have arrived safely, after a dreadful battle with Friday traffic, followed by total confusion in Leicester city centre! Villiers Hall is in the leafy suburbs, well away from the city bustle. It was true that the nearest kettle for early morning tea was five flights down, and the University had cunningly provided round-pin electric sockets so that no-one could use their hair-dryer/iron, but these were but minor irritations compared with the triumph of successful arrival. Supper was excellent and by 8-o'clock all were

ready and eager to begin the weekend's work.

Dr. Morag Bramley: "The Travelling Salesman"

Dr. Bramley reviewed her world-wide travels as a family planning and Institute doctor, describing her talk as a sandwich in which the gist of her lecture material was offered between two slices of highly entertaining world tour.

In Iraq and Hong Kong she was assured by administrative doctors that family planning patients experienced no psychosexual problems, but the response to her own careful questioning of the Iraqi and Chinese doctors on the ground, via an interpreter, gave the lie to this.

In Los Angeles family planning and GUM clinics are staffed mainly by specially trained nurses, working to strict protocol, and referring to the doctor anything outside the norm.

In Thailand package holidays come complete with a girl and a visit to the GUM clinic!

In lecturing abroad, Dr. Bramley tried to open a window on to a "different kind of medicine", not geared to specialisation but to the understanding of the here-and-now of the doctor-patient relationship which can be used as a scientific tool, and the use of the physical examination as a psychosomatic event. She used case illustrations. Here the doctor's knowledge is secondary to skill, each consultation requiring a fresh start and a mind open to what the patient is saying, doing and trying to communicate consciously and unconsciously.

Dr. Anne Shaw: "Catch me if you can"

Dr. Shaw described a difficult case where the patient's defences were so well developed that the doctor felt helpless and repeatedly locked out. The patient was a pretty Oxford graduate in her thirties; her husband a European banker. She had an uneventful first pregnancy, but during the labour suffered a third degree tear. This was repaired but five days later broke down, with the development of a recto-vaginal fistula. There was a particularly harrowing description of the patient's horror at finding faeces in her vagina and then being left in this state, without any apparent medical interest, for 24 hours. She eventually needed a colostomy for six months. One disastrous attempt at intercourse was followed by apareunia, and a painful four-year history of increasing irritation from the husband and gynaecologist as she failed to respond to "treatment". There followed a description of months of patient work by the doctor as she showed a refusal to be rejected by the patient, as the patient had felt rejected by everyone else. At last the patient began to recognise the powerful defences she was using every time the discussion became too painful: she would change the subject; there would be family illness; her daughter needed her; she needed to travel to Europe with her husband. The next difficult hurdle for the doctor was helping the patient to "own" her vagina again: it had been such a dirty place full of faeces, and so public with so many examinations. She was at last able to express her fantasy that there might be a new fistula which would get bigger if she resumed intercourse, and the whole beastly business be repeated. This was a most moving presentation of a doctor's refusal to give up on a patient, and the patient's gradual acceptance of the doctor's help.

Dr. Shirley Snead: "Back to grass roots"

Dr. Snead described five cases in which the patient had been encouraged to take part in the vaginal examination. In each case penetration by the partner had been difficult or impossible, and vaginal examination was approached by the patient with apprehension. These women needed to control their partners, and Dr. Snead recognised this as she coaxed them on to the couch, promising to persist only as long as they allowed, not to hurt, and to take things by small stages. On the couch she followed gentle examination by an invitation to the patients to explore their own vagina. During self-examination patients were moved to share past painful experiences relating to the vagina or sexual intercourse: violence, forced examination by a doctor, rape or termination. In this way they came to terms with the psychological barriers at the same time as confronting their fantasies about the physical characteristics of the vagina.

Dr. Dee Howell: "Silence is golden"

Louise and Kevin are a sweet young couple presenting a devoted picture to the doctor; coming to clinic with irritating regularity, refusing to be seen separately, always tightly holding hands. After a silence deliberately left by the doctor, Louise was able to say, "What about Australia? — sex was wonderful there". When the doctor wondered what was different about Australia, Kevin sharply answered, "That's *your* job!" One day, after Louise, an only child, had expressed her sadness at loss of contact with her father since her parents' separation, she broke down in the car park outside the clinic and was brought back in great distress. She was then able to talk about her father's sexual abuse of her up to the age of nine. She had never told of this before, even to Kevin. The doctor felt that this long, painful road to truth would have been travelled more quickly with more silences.

Mark and Alison were a very different couple, coming with an urgent referral ('please sort out before Christmas!'): he a tall, confident, sexually experienced business man; she a postgraduate chemist, younger than Mark, and very inexperienced in sexual matters. Sex was very infrequent and painful, and Mark couldn't understand it at all. He presented as a person dissatisfied with faulty goods, and managed to make both his wife and the doctor feel inadequate and inferior. Having presented the problem, Mark did not come to the sessions. After examination one day, Alison was able to talk about a brief affair she'd had a year before, and was able to imply her feelings about Mark's constant references to previous happy sexual liaisons: he wasn't the *only* one to have enjoyed it before! A long silence followed while doctor and patient digested these feelings. The doctor felt that Alison was able to grow up during that interview, and not to need her 'mothering' doctor any more.

These were two very vivid presentations full of powerful evocations of doctor and patient feelings.

Dr. Mary Wigfield: "Exploring boundaries in the doctor/patient relationship"

Dr. Wigfield looked at boundaries between body, mind and spirit. In psychosexual work, we are accustomed to dealing with mind and body, but spiritual matters impinge on both. In a survey she found that 42% of

consecutive psychosexual patients made passing reference to faith and religion. For 12% it was a subject of deep interest; and in 5% it had seemed right to discuss the patient's problems of personal faith. Dr. Wigfield presented four cases in which patients were experiencing conflicts in their relationship with God, alongside their sexual difficulties. In each case, a common background of religious experience enabled the doctor to recognise and identify with their sense of estrangement. Dr. Wigfield recognised the dangers of working at this particular frontier. It was important to follow the patient there, never to lead, and to be wary of a religious smoke-screen obscuring "dirty, earthy sex".

Dr. Jenny Tisdall: "Link with Samaritans - why so different?"

The doctor took referrals from Samaritans with great reluctance, and worried about her management of them. The link began because of a talk given in the 1970s to the C.A.B. The local director of Samaritans was there, and asked for a link with the psychosexual counselling clinic. The volunteers said sexual problems did not crop up very often, but when they did, they felt helpless and angry at the lack of suitable professional help. They most often asked for help with telephone masturbators. The patients presenting were mainly men, with severe behavioural problems which made them feel ashamed. There was 'Mr. Blackstockings' who wanted his wife to wear black stockings, not for sex, but in her everyday life. She refused, saying, "You must accept me as I am". He had had treatment for severe depression, but was left with his desire for black stockings. He resolved his problem by leaving his wife, but still remained with his needs.

Johnny was a young man who constantly exposed himself to the volunteers. He refused to see a psychologist. He came across as a cocky young man who said he was "educating the young girls". Actually, he was shy and insecure and finding difficulty making relationships.

Mr. X., a tall distinguished man in his fifties, felt humiliated by his wife. His pattern of behaviour had been set by his mother and sisters who would regularly hide his clothes to humiliate him for punishment. He had become obsessed with nudity, both male and female.

Les was a tall, thin, stuttering young lorry driver, who felt compelled to expose himself to women in lay-bys, pretending to be caught urinating. He had a deep-seated feeling of anger and rejection against his mother, who was mentally retarded following illness during his babyhood. She had doted on his baby brother, born years later. The doctor encouraged him to sit in his cab and write angry letters to his mother when he felt the need to expose himself.

The doctor felt very dissatisfied and unhappy about all these cases, and wondered if they could have been handled differently, indeed whether these were suitable cases for Institute methods at all.

After a rewarding and hard-working day, there was a scramble for the bathrooms so that we should be ready for the coach taking us to Belvoir Castle for dinner. The journey was full of twists and turns and we arrived feeling distinctly queasy; however, the magnificence of the Castle and a

reception complete with Buck's Fizz and a lady harpist did much to restore morale. A lightning tour of the Castle was followed by dinner in the magnificent dining hall. The memories of the evening are a wonderful kaleidoscope of chandeliers, huge mirrors, wonderful paintings and a great sense of history.

Dr. Mary Thomas: "Talking to medical students about Institute work"

Dr. Thomas talked about teaching medical students in family planning and psychosexual medicine. They were like many of our patients: eager to learn, expecting quick unequivocal results. She teaches them in seminar groups, encouraging recognition of their own reactions and embarrassment. She directs them away from generalisation towards what is happening in the room. Specific cases are discussed, attention being paid to the feelings generated, not simply to facts elicited. They are not expected to know answers in advance, therefore do not need to hide behind stethoscope and desk. They must be prepared to listen to what the patient wants to say, and learn with the patient about what neither understood at the beginning. Their new skills can forestall problems after childbirth, coronaries, hysterectomy and vaginal repair.

"Brief encounters"

This presentation was given by members of the Southampton continuation seminar, who work variously in family planning, well women, genito-urinary clinics and general practice. The encounters with patients presented were brief, unplanned and unselected, and ranged from a menopausal lady complaining of vaginal dryness, who was mourning for her dead daughter, and feeling guilt at her own desire for a sexual life, through an overbearing lady who was frightening her husband out of his libido, to a lady with spastic legs who was allowed to feel normal, and a lady whose medical history was so interesting that the doctor almost forgot to look at the patient and her feelings. The value of these brief encounters was summed up by another member of the group. She said that they had learned to be realistic about the limitations of their premises; the attitudes of some of their members of staff; and the scepticism of colleagues. They had sometimes been reluctant to face psychosexual problems when presented, but had found that the brief encounter had often been useful. They now had heightened awareness of feelings, and of the barriers put up by patients, and relevant, rather than exhaustive, history taking. Often follow-up appointments were necessary only as reassurance for doctor, not patient! The brief encounter may become even more relevant and important with continuing clinic closures.

"Childhood sexual abuse"

Report by members of a research group based in London. The group hopes shortly to re-convene, and is interested in recruiting new members.

Dr. Jennifer Peebles introduced the group's work. Pointers had been identified for further research, and these were illustrated in cases from Dr. Sage, Dr. Hutchinson and Dr. Draper.

The doctor is under pressure from the referring agency. Three misapprehensions are common: that bringing abuse into the open achieves a cure, that confrontation between abuser and abused is the key, and that the doctor's role is as an exorcist.

Referrers are usually anxious, their own skills clouded by the "fearful thing", so that once identified, it is held responsible for all current problems.

Often there was a long period between abuse and presentation. Sexual problems, or childbearing, were common triggers. In youth work, where the abuse is recent or current, working with the individual can be hindered by the drama or hysteria of the situation, by family problems, or by deprivation and an atmosphere of emotional sterility. The relationship of the abused with the mother seems to be important. Doctors frequently found themselves in a 'mothering' role.

There is little relationship between the extent and duration of the abuse, and the subsequent ill-effects. The damage sustained seems to be dependent on the nature of the abused person, the emotional background, and other events during the same period of time.

The doctors found Institute techniques appropriate if they looked at the person in the 'here-and-now', not at the damage. In the reported cases, abuse had occurred in a context of emotional and physical deprivation.

We have not mentioned the group work done during the weekend, because each group was unique. As usual, a great deal of useful, thought-provoking discussion took place.

It was a privilege to be present at this weekend and to listen to the excellent presentations, but most of all, once again, to share that sense of comradeship and common purpose with people who work in the same field. The psychosexual clinic late on a rainy evening, struggling with a particularly difficult case, can be a lonely place, and we all need our annual, uplifting dose of Institute medicine to carry us through next year.

Claire Smith
I.P.M. Member
Anne Basketts
I.P.M. Associate

MEETING OF THE BRITISH SOCIETY OF PSYCHOSOMATIC OBSTETRICS, GYNAECOLOGY AND ANDROLOGY on 7th January 1988 at the Royal Society of Medicine

The International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) was formally re-structured in 1986 as a Federation of National Societies. This was the inaugural meeting of the British Society convened by Norman Morris, a multi-disciplinary meeting which members of the Institute were invited to attend. The title was, "Stress in Obstetrics and Gynaecology" and considering the Institute's interest, not to say expertise,

in this subject, it was a pity that no paper was invited to describe the use of the doctor/patient relationship, although several members made contributions from the floor.

After a brief introduction by Norman Morris the morning session was devoted to pregnancy. Marie Johnston, a psychologist from the Royal Free, spoke on the anxiety concerning pre-natal diagnostic and screening tests even where the foetus is found to be healthy. Laurence Goldie then discussed the psychological problems arising from the discovery of an abnormal foetus and following termination of pregnancy for this reason. Those who appear to "take it well" often need the most help. This was followed by an interesting paper by Emanuel Lewis on the problems associated with stillbirth where the joy of achievement becomes the sadness of loss and the particular types of pregnancy loss which produce the most confused feelings such as the death of a twin when one survives, the blighted ovum, foetus papyraceous, malformations and selective foetal reduction. Faith Haddad, a member of the Institute, described a study in which she showed that high anxiety levels during pregnancy do not, as had been previously believed, affect the obstetric outcome. The latter part of the morning was devoted to two papers on post-partum depression and psychosis; the need to identify those most at risk and offer help from the time of delivery was stressed. A paper by Luke Zander ensued championing the cause of home versus hospital confinements. The morning ended with a fascinating account by Estela Weldon on the more perverse aspects of motherhood.

The afternoon began with Wendy Savage, who saw doctors' failure to understand women's anxieties as being the result of male-dominated education in medical schools. Her plea seemed to be for more integration in medical training on the one hand, but divisiveness on the other: Women's Deans for women, for example. This was followed by three papers concerning the stress of infertility. An excellent paper by Mike Pawson described the need of patients to have an object, a fantasy child, to mourn; and how valuable was time spent in allowing patients to talk and share their feelings so that their concept of themselves as parents might change. What an opportunity for an Institute-trained doctor here! In addition there were papers by David Bromham and Marie Johnston, again on the stressful aspects of I.V.F.

The two final papers were concerning hormonal treatment. John Studd spoke on the treatment of pre-menstrual and menopausal depression with oestrogens. Although there was a marked placebo effect there is little doubt that hormone levels are a significant factor in these conditions. David Morris described the treatment of infertility in men using pulsatile LHRH alone and LHRH + gonadotrophin. Two interesting points emerged: the severe depression in men whose treatment had failed and the marital disruption arising from successful treatment. Two female partners refused intercourse and one developed weight-related amenorrhoea. The necessity for joint counselling was stressed.

With such a full programme there was little time for questions. It was interesting that perhaps in avoidance of discussion of the painful anxieties of patients, the most lively argument concerned such "safe" subjects as

home confinement versus hospital, and women's place in society.

The meeting ended with a discussion among those few staunch souls who remained, as to whether there should be further meetings of this newly founded British Society or whether its function was duplicated elsewhere. It would seem that its multi-disciplinary nature might prove unwieldy. Psychologists pressed for more involvement. The addition of Andrology to the title was approved. Although any group whose aim is to increase gynaecologists' awareness of women's feelings is to be welcomed, those gynaecologists present clearly had such an interest — which was why they were there. Nevertheless, it is strongly advocated that Institute members will again support and contribute to any further meeting which might be held.

Dr. H. Montford
I.P.M. Member

IMPOTENCE — A REVIEW

Recently a booklet called "Impotence: causes and treatments"¹ was included with the British Journal of Sexual Medicine. This states: "There are two major causes of impotence: physical impotence and psychological or emotional impotence". It goes on to say: "As recently as the late 1970s, it was believed that psychological problems were the cause of nearly 90% of cases of chronic impotence. With improvements in diagnostic techniques, we now know that as many as half of all cases of chronic impotence are caused by physical problems". The doctors at whom these booklets were aimed were invited to send for further copies so that they could be handed out to patients. (Unsurprisingly, the booklet was sponsored by American Medical Systems and more than half is devoted to information about penile prostheses!).

A better article in the British Journal of Sexual Medicine was by Dr. W.R. Guirguis in January 1988². He writes: "Having ascertained that the case is one of genuine erectile inadequacy, the professional has to assess the relative contribution of all possible aetiological factors. The dichotomy of physical versus psychogenic is not only incorrect, but is also misleading and could even be harmful. There is adequate evidence that psychological factors are present even in the most obviously physical causes of erectile failure".

As Blake in "Diagnosis and management of impotence"³ points out, "psychogenic impotence" has been regarded as a diagnosis of exclusion. His paper goes into some detail on nocturnal penile tumescence measurement by various workers and concludes that the contradictory results obtained militate against this being a useful indicator of a "non-organic" cause. He concludes that all factors should be sought for in their turn and the existence of one contributory cause should not exclude a search for others.

In the article by Guirguis referred to above², there is a useful table, setting out the risk factors and clues to investigation. Preservation of morning erections is no longer recognised as a useful test of physical normality, as they can continue in both neurological lesions and the pelvic steal

syndrome. Just as confusingly, patients with a predominantly psychogenic profile may lose all erectile function. Impotence may be the presenting symptom in diabetes, multiple sclerosis, cardiovascular disease or hyperprolactinaemia.

In a study of men with hyperprolactinaemia⁴, partial or total impotence had been present for up to 11 years before medical advice was sought. All eight patients presented with advanced disease and symptoms such as headache and epilepsy were common, although none of their series had visual field defects. In this small series treatment with bromocriptine either restored potency (five patients) or improved erections (one patient). The serum prolactin fell to within normal limits in all but one. In the article in the Institute journal⁵ about screening for hyperprolactinaemia, Joan Coombs comments that, despite the low incidence of abnormal results, it was a useful procedure in that, once normal hormone levels had been found, it allowed patients to examine the emotional factors. This illustrates the difficulties patients (and doctors) have in talking about feelings as a possible cause for their symptoms.

The retreat of a physician into the 'medical model' is clearly shown in a paper by E. Douglas Whitehead on the treatment of diabetes-related impotence⁶. Under "initial treatment" he states, "Before starting any specific treatment for impotence, the patient's general nutrition should be good and his diabetes well controlled". Why? Is there any evidence that eating better improves impotence? Would a physician delay treatment of other conditions until the diabetes is well controlled? And if this is done will it improve the impotence? Better control of diabetes may well prevent the onset of vascular or neurogenic components of impotence but cannot cure an established deficit. He goes on to say, "Any underlying inflammatory genital disease, urinary tract disease, or other medical condition should be treated". Well, yes, but what about treating the impotence?

The enthusiasts for injection treatment give a glowing account of their activities in a paper from Hammersmith Hospital by Williams, Mulcahy and Kiely⁷. They report on 125 men with "psychogenic or organic impotence" who used auto-injection of the penile corpora cavernosa to achieve penile erection. In 23 patients investigation revealed no organic cause. The others were all classed as "organic" (How easy it is to fall into the dangerous mind/body dichotomy!). The most inconvenient complication was prolonged erections and they emphasise that access to decompression in a specialist unit must be available at all times. Other complications were localised areas of fibrosis, haematomas and bruising. Twenty patients stopped injecting (were they asked why?), five lost their partners, four were lost to follow-up, and in eleven potency returned (plus a further seventeen whose potency returned after just one injection). A similar paper from USA⁸ comments, "This study provides no indication that self-injection treatment should supplant individual or couples therapy as first line treatment", although they found that 96% of their patients initially achieved satisfactory erections with injections.

A technique requiring sophisticated surgical back-up and injection of potentially toxic drugs is not an adequate substitute for a holistic approach by one doctor using the expertise of others where relevant for that patient. It

is excessively enthusiastic to suggest that this technique might be used to treat all erectile failures without examining the interacting causative components. However, surgical implantation of a prosthesis is probably even more hazardous, cannot be discontinued, and does not allow for a return of spontaneous erections.

James Allen in his article on "Psychiatric treatment of erectile dysfunction"⁹ sums up the situation when he states that "there is no one right way" and that "the best way depends on the patient, his partner, their situation and the personality and expertise of the therapist".

Possible treatment concomitant to psychosexual help has been described here because it is best read about rather than discussed inappropriately in a seminar (where the members are escaping from the work by asking for teaching). That it is often a subject for enquiry does illustrate both a lack of knowledge and an ambivalence about the worth of what we do. The importance of looking at the feelings of these patients is amply demonstrated by the cases presented in seminars and more of these should be published, so that all can learn from them. The fifty cases reported by Jane Berry and Jessie Yorston, together with Barbara Devereux's case study of an impotent diabetic, and Prudence Tunnadine's "Doctor-patient relationship in a man with recurrent pituitary adenoma", all brought together in "Practice of Psychosexual Medicine"¹⁰, set high standards. However, we should not be deterred from reporting just because we cannot reach such heights of insight and interpretation.

The opinions expressed here are idiosyncratic, do not represent 'Institute thinking' (if there is such a thing) and are presented to stimulate debate.

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

References

1. Booklet. *Impotence: causes and treatments*. (1987). Available from Impotence Information Centre, Freepost, Staines House, 158-162 High Street, Staines TW18 1BR.
2. Guirguis, W.R. *Erectile inadequacy: a guide to diagnosis*. Br.J.Sex.Med. (1988). 8-11.
3. Blake, D.J. *Issues in psychiatric diagnosis and management of impotence*. Psychiatric Med. (1984). 2.2. 109-130.
4. Prescott, R.W.G. et al. *Hyperprolactinaemia in men - response to bromocriptine therapy*. Lancet (1982). 245-249.
5. Coombs, J. *Hormonal and psychological studies of men presenting with sexual difficulties*. Inst. of Psychosexual Medicine Newsletter (1982). 21. 12-16.
6. Whitehead, E.D. *Diabetes-related impotence and its treatment in the middle-aged and elderly*. Geriatrics (1987). 42.8. 77-85.
7. Williams, G. et al. *Impotence: treatment by auto-injection of vasoactive drugs*. BMJ (1987). 295. 595-596.
8. Althof, S.E. et al. *Intracavernosal injection in the treatment of impotence: a prospective study of sexual, psychological and marital functioning*. J.Sex. & Marital Therapy (1987). 13.3. 155-67.

9. Allen, J.R. *Psychiatric treatment of erectile dysfunction*. JOSMA (1987). 80. 19-22.

10. Draper, K. (Ed.). *Practice of Psychosexual Medicine*. (1983). Published John Libbey & Co., London.

BOOK REVIEWS

Vaginismus: understanding and overcoming the blocks to intercourse. Linda Valins. Pub. Ashgrove Press, Bath, 1988. pbk £6-95.

Linda Valins suffered from vaginismus and this is very much a personal book. It recounts the difficulties she, and other sufferers, had in finding help and treatment. The chapters on the disorder itself and the sources of help will be of much assistance to those suffering and feeling very alone with their ill-understood disability.

Included are thumb-nail sketches of the various therapies that are available, with thought-provoking comments from their practitioners (among them well-known names from the Institute). There is a more detailed description of her own treatment by psychoanalysis, and accounts of how others proceeded with their various therapies.

Typical of the writer's approach is her statement that, "Whilst I describe the many ways in which vaginismus may be treated by a professional, this does not necessarily imply that all the expertise is exclusively held by the specialist. I see treatment as a process of sharing and learning rather than one which re-inforces the woman as a patient with little power and no sense of her own expertise". As this accords with my own attitudes, I thought this an excellent book!

I would particularly recommend this small book to those starting to learn how to treat psychosexual disorders. It presents the problem from the patient's point of view (one we are apt to forget in our own anxiety to 'do the right thing'), warns against seeing the disorder as a homogeneous one, and makes it clear that the vaginismus is the presenting symptom of the underlying difficulty which requires resolution.

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

Sexuality and birth control in community work. Elphis Christopher. Published by Tavistock Publications

This book is useful for health professionals who wish to extend their knowledge and understanding of sexuality and contraception. It is particularly suitable for doctors and nurses working in the community and for social workers. The content is comprehensive and informative and easy to read apart from the frequent use of parentheses in the earlier chapters. The author, in accordance with her training and experience, emphasises the importance of the emotional aspect of the subject and reinforces the dictum that a method of contraception is as effective as the user makes it. The chapter on the influence of religion and culture is particularly interesting as

are those on rape, sexual abuse and AIDS. Dr. Christopher has used her 'Institute' ear and eye in writing this book. She expresses the importance of being aware that each client has unique needs which may not be overtly expressed as they lie in the realms of the unconscious. Special skills are needed for successful community work and this book is a very useful background to the development of these skills.

Dr. R. Lincoln
I.P.M. Member

FROM THE JOURNALS

Warner, P., Bancroft, J. & members of the Edinburgh Human Sexuality Group. *A regional clinical service for sexual problems: a three year survey.* Sexual & Marital Therapy (1987), Vol. 2, No. 2, 115-130.

A survey of the 1,194 patients referred during 1981-1984 to the various clinics in the area is described. The majority of the referrals were from general practitioners (56%) with 10% coming from family planning clinics, 10% who were self-referred and 3%-6% each coming from specialists on marriage guidance. 45% of those referred were male, 48% female and 7% were referred as couples. Male referrals were made to clinics in the main psychiatric hospital (229), the gynaecology out-patients (173), the family planning centres (80), Bangor Village Hospital (37) and Marriage Guidance (14). By contrast the gynaecology out-patient venue (227) and family planning centre (199) were most popular for female referrals.

The men were significantly older in their age distribution than the women. In the complaint of low sexual interest there were many more men in the older age groups and more women in the under-21, 26 and 31 years. (Does this represent a real difference when the numbers compared overall for this complaint were 34 men and 205 women?) It is not surprising that the men presenting with premature ejaculation were younger than those with erectile dysfunction and most of the other results were as would be expected (such as two peaks for dyspareunia, in the under-21s and the over-45s).

67% of referrals were offered treatment with a further 16% being offered advice only at the initial consultation. Couple therapy (Masters & Johnson type) was offered to 51% of those with a current partner: of the 478 who accepted, 40% completed treatment and 35% had dropped out by the completion of the study. The completion rate for individual therapy was similar (173 accepted, 40% completed and 37% dropped out). The number of sessions for those completing treatment varied from about seven to twelve. The high drop-out rate is familiar to us all, as is the failure to attend for a first appointment after referral.

The outcome of treatment was rated by the therapist at discharge from the clinic as either "good" or "moderate/better". No details were given of how this rating was achieved or whether any standardisation between clinics or therapists was attempted and its value is therefore dubious. However in the women who presented it seemed to have made little difference in the outcome rates whether they were treated as a couple or individually. (Too few men had been treated as individuals for comparisons to be valid).

Riley, A.J., Steiner, J.A. et al. *The prevalence of sexual dysfunction in male and female hypertensive patients.* Sexual & Marital Therapy (1987), Vol. 2, No. 2, 131-138.

A questionnaire containing questions on sexual functioning was sent to 800 patients identified from computer records of the Oxford Hypertensive Clinic with a response rate of 68.3%. The prevalence of male sexual dysfunction was similar to that reported from other surveys with treated hypertensives having a higher incidence of both erectile and ejaculatory dysfunction than those untreated (although, of course, those untreated had lower levels of hypertension to confound the issue).

In the women, treatment did not appear to have a significant effect on the prevalence of arousal or orgasmic dysfunction. The high level of sexual dysfunction reported by the women, treated or untreated, might have hidden any disease or drug-induced problems.

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

NOTICES

From: THE ACCREDITATION PANEL SECRETARY

The Accreditation Panel met at 11 Chandos Street on 23rd November 1988. Five brave colleagues brought their work to share with the Panel and each other. The Panel Secretary brought her knitting — a homely and innocuous occupation, she thought, but found herself likened by the candidates to Madame Defarge! As ever, the day was exhausting but everyone found it stimulating, interesting and enjoyable. The following five doctors have been accepted as full members of the Institute:

Dr. Ian M. Millington,
586 Pentregethin Road, Ravenhill,
Swansea, West Glamorgan SA5 5ET

Dr. Susan Smith,
Five Oaks, Sandy Lane,
Henfield, E. Sussex

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

Dr. Sonia Robertson,
37 Cholmley Park, Highgate,
London N6 5EL

Dr. Rosalind Hinton,
Tower House, Clifton Down Road,
Bristol BS8 4AG.

In 1989 the Panel will meet on 24th May and 15th November. Would anybody interested in attending please contact the Panel Secretary, I.P.M., 11 Chandos Street, Cavendish Square, London W1M 9DE.

The Panel currently consists of: Dr. M. Roberts (Secretary), Dr. A. Tobert (Chairman), Dr. G. Hinshelwood, Dr. M. Gill, Dr. S. Lucas (Reserve) and Dr. R. Freedman (Reserve for November 1988).

ERRATA

Newsletter 33, May 1988, p. 33-34.

The following new associate members were listed incorrectly under 'new subscribers':

Dr. Deirdre A. O'Brien
Dr. Veronica Pearson
Dr. Sian L. Williams

BIBLIOGRAPHY

A new bibliography is being compiled. Details of any published material by members or associates should be sent to: Dr. R. Lincoln, I.P.M., 11 Chandos Street, Cavendish Square, London W1M 9DE, by June 1989.

From: THE MEMBERSHIP SECRETARY

Any member knowing the current location of the following members/associates (whose mail has been returned as "gone away"), please inform the Membership Secretary:

Dr. Patricia Haddad
Dr. Michael Lane
Dr. Magdy Ishak.

I.P.M. CURRENT TRAINING SEMINARS

BASIC SEMINARS

REGION	LEADER	PLACE	DAY/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
	Dr. R. Thexton	Cambridge	Mon.eve
N.W. Thames	Dr. A. Tobert	Chandos St., W1	Wed.pm
N.E. Thames	Dr. R. Sampson	Finchley	Fri.pm
S.E. Thames	Dr. A. Jones	Bromley	Th.eve
Wessex	Dr. H. Montford	Southampt'n	Fri.pm
S.Western	Dr. R. Skrine	Bristol	Tue.pm
	Dr. P. Allen	Bristol	Wed.pm

CONTINUATION SEMINARS

E. Anglia	Dr. B. Devereux	Norwich	Wed.1230
S.Western	Dr. H. Backer	Gloucester	Th.eve
	Dr. J. Tisdall	Plymouth	Mon.eve

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
S.Western	Dr. R. Skrine	Bristol	Wed.p.m.
Sussex	Dr. P. Tunnadine	Ditchling	Fri.p.m.

OTHER

E. Anglia	Dr. R. Lincoln	Norwich for FP & Practice Nurses
	Dr. R. Thexton	Cambridge for FP & Practice Nurses
S.Western	Dr. J. Tisdall	Plymouth for Nurses

Seminars RECENTLY COMPLETED include those led by —

Dr. H. Backer, Swansea	Dr. T. Main, Sharpethorne
Dr. J. Tisdall, Plymouth	Dr. J. Coombs, Bradford
Dr. R. Thexton, Southampton	

Seminars in planning:

Basic		Chandos Street, W1 Manchester
Continuation	Dr. S. Snead Dr. R. Thexton	Kidderminster Southampton
Advanced	Dr. M. Bramley	Sheffield
Nurses Gps.		Bristol Nottingham Plymouth
Physioth'sts		London

REGIONAL TRAINING CO-ORDINATORS

Northern/ N.West & Mersey	Dr. A.V. Smith, 6 The Crescent, Longbenton, Newcastle-upon-Tyne NE7 7ST. Tel. (091) 2662554
Yorkshire	Dr. D. Anderson, 4 Newstead Road, St. Johns, Wakefield WF1 2DE. Tel. (0924) 372836
Trent	Dr. S. Filshie, 2 Pembroke Drive, Mapperley Park, Nottingham NG3 5BG. Tel. (0602) 625632
East Anglia	Dr. R.D. Lincoln, 67 Yarmouth Road, Norwich NR7 0EW. Tel. (0603) 31628
N.W. Thames	Dr. D.M. King, 5 Churchill Gate, Oxford Road, Woodstock, Oxon. Tel. (0993) 813114
N.E. Thames	Dr. J. Gilley, 42 Avondale Avenue, London N12 8EN. Tel. 01-445 1654
S.E. Thames	Dr. A.J. Jones, 1 Minshull Place, Park Road, Beckenham, Kent BR3 1QF. Tel. 01-658 6185

S.W. Thames	Dr. R. Thexton, 41 Hillcroft Crescent, London W5 2SG. Tel. 01-997 1748
Wessex	Dr. M. Thomas, Cliff House, Cliff Way, Compton Down, Winchester, Hants. SO21 2AP. (0962) 712183
Oxford	Dr. J.E. Rogers, 11 Turners Road, Slough, Berks. Tel. (0753) 22495
South Western	Dr. R. Skrine, Castanea House, Sham Castle Lane, Bath BA2 6JN. Tel. (0225) 65440
Devon/Cornwall	Dr. J. Tisdall, 23 Furzehatt Road, Plymstock, Plymouth, Devon PL9 8QX. Tel. (0752) 42356
West Midlands	Dr. S. Snead, 30 Church Road, Lilleshall, Shropshire. Tel. (095284) 4560
Wales	Dr. D.A. Morgan, The Gables, Llangenny Lane, Crickhowell, Powys. Tel. (0873) 8100176
N. Ireland	Dr. J.G. Neill, 42a Cadogan Park, Belfast BT9 6HH. Tel. (0232) 662861
Scotland	No co-ordinator at present (Inquiries to Northern Region).

NEW ASSOCIATES

Dr. Simon Oakley-Fradd, 147 Tollerton Lane, Tollerton, Notts. NG12 4FT
 Dr. P.K. Pattani, 72a Pinner View, Harrow, Midd'x HA1 4QD
 Dr. Mary E. Brown, Hucknall Health Centre, Curtis Street, Hucknall, Notts.
 Dr. Carole Solomons, Longrove Surgery, 70 Union Street, Barnet, Herts. EN5 4HT
 Dr. Katy J. Shroff, 75 Spencer Road, Isleworth, Midd'x TW7 4BN
 Dr. K.V. Reddy, 16 Middleton Close, Seaham, Co. Durham SR7 0PQ
 Dr. Mary E. Leng, 47 Park Lane, Cottingham, North Humberside HU16 5RX
 Dr. Anne de Gay, Green Home, Bowbridge Road, Newark, Notts. NG24 4BZ
 Dr. Anne P. Knox, 12 Aston Hall Drive, North Ferriby, North Humberside HU14 3EB
 Dr. Susan Thomas, 74 Canford Cliffs Road, Poole, Dorset BH13 7AB
 Dr. Valerie J. Sullivan, Croft End House, Woodend, Egremont, Cumbria CA22 2TB
 Dr. S. Jill Buchanan, Hastings, Pennymead Drive, East Horsley, Surrey
 Dr. Susan M. Clancy, 69 Princes Road, Brunton Park, Gosforth, Newcastle upon Tyne, Tyne & Wear
 Dr. D. Parthasarathy, Annfield Plain Surgery, Durham Road, Annfield Plain, Co. Durham
 Dr. Rebecca Ball, 126 Nacton Road, Ipswich, Suffolk IP3 0NS
 Dr. Margaret Clamp, The Health Centre, Main Road, Radcliffe-on-Trent, Notts. NG12 2GD
 Dr. Anna Wilson, Maples, 3 Palm Hall Close, St. Giles Hill, Winchester, Hants. SO23 8JL
 Dr. Ann England, 12 Highlands Close, Crowborough, E. Sussex TN6 1BE
 Dr. Lucille Kay, 10 Chalgrove Gardens, Finchley, London N3 3PN
 Dr. Margaret E. Jack, The Rectory, 3 Hylands Close, Barnston, Essex CM6 1LG
 Dr. Janet Steer, 3 Abbotts Way, Southampton, Hants. SO2 1QU
 Dr. Denise M. Harrison, Chapel View, The Street, Nolpham, Norfolk
 Dr. Shamin Akatar, 60 Elm Avenue, Eastcote, Ruislip, Midd'x. HA3 8PA

Dr. Stella M. Searle, 17 Church Street, North Cave, Brough, North Humberside HU15 2LT

Dr. Christopher Nye, 81 Gladstone Road, Broadstairs, Kent CT10 2JA

Dr. Barbara Phillips, 51 Watling Street, St. Albans, Herts, AL1 2QF

Dr. Ann Greener, Abbey House, Cockfield, Bury St. Edmunds, Suffolk IP30 0LB

Dr. Angela Clark, 2 Lingwood Close, New Hill, Huddersfield HD7 7NN

CHANGES OF ADDRESS

Dr. Penelope S. Oakeley, 23 Taymount Rise, London SE23 3UG

Miss Valerie Thompson, The Fieldings, South Moreton, Didcot, Oxon. OX11 9AH

Dr. D.M. King, 5 Churchill Gate, Oxford Road, Woodstock, Oxon. OX7 1QW

Dr. N.P.G. Dave, 27 Stoneway, Hartwell, Northants. NN7 2JY

Dr. Susan Horsewood-Lee, The Wisteria House, 37 Bywater Street, Chelsea, London SW3

Dr. Alessandra Bispham, 58 Weston Park, Thames Ditton, Surrey KT7 0HL

Dr. Rosalind M. Oliver, 47 Summercourt Drive, Ravenshead, Notts. NG15 9FT

Dr. Jill M. Tattersall, 1 Brackenbarrow Cottages, Smithy Hill, Lindale-in-Cartmel, Grange over Sands, Cumbria LA11 6LT

Dr. J.M. Street, Bush House, Romsey Road, East Wellow, Hants. SO51 6BG

Dr. Sarah H. Wilson, 23 Lilac Close, Keyworth, Notts. NG12 5DN

Dr. M.S. Denman, 83 Kingston Road, Oxford OX2 6RJ

Dr. Rosalind Anderson, 18 Beach Road, Emsworth, Hants.

Dr. Shelagh Lucas, 18 Champneys Walk, Newnham, Cambridge CB3 9BN

Dr. Susan M. Smith, Five Oaks, Sandy Lane, Henfield, W. Sussex BN5 9UX

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 October 1989 and May 1990 letters should reach the Editor by 1st August 1989 and 28th February 1990 or sooner. The address is: Greenhills, Back Lane, Hathersage, Sheffield S30 1AR.
