I.P.M. DIARY OF EVENTS

Saturday November 4 1989, 10.00 a.m.—1 p.m.
Clinical Meeting at 11 Chandos Street, London. A discussion on the seminar work at Cardiff.
Friday March 16 1990, 5 p.m.
Annual General Meeting at Chandos Street. Dr. G. Wakley will speak at 8 p.m. on "At the Coalface".
Saturday March 17 1990.
Leader Doctors Workshop at Chandos Street.
Friday September 21 — Sunday September 23 1990
Annual I.P.M. Scientific Meeting at Keble College, Oxford.

OTHER DATES FOR YOUR DIARY

Thursday November 23 — Saturday November 25 1989.
Postgraduate meeting on sex problems in Family Planning Practice. For details contact Mrs. June Laker, S.W. Thames Regional Education Centre, Tooting, London SW17 7DJ. Tel. 01-672 6666.

NAFPD
Saturday January 27 1990
Affiliated group meeting. Old Swan Hotel, Harrogate.
Friday March 30 & Saturday 31 1990
NAFPD AGM/Symposium. Magdalen College, Oxford.

R.S.M.
Monday November 13 1989
Evening meeting. Subject: "Long-term effects of abortion".
Monday January 22 1990
Evening meeting. Subject: "Religious and Cultural Aspects of Family Planning"
Saturday April 21 1990
Whole day meeting on Contraception and Sexual Medicine in the Year 2000
Monday July 2 1990
Evening meeting. Subject: "Sexuality and the physically disabled"

The British Psycho-Analytical Society
Thursday October 5 1989, 7.45 p.m. at the Logan Hall, 20 Bedford Way, London WC1
Professor Peter Gay will speak on: "Serious Jests: on Freud's Jokes". (50th anniversary of Freud's death).

Institute of Psychosexual Medicine

CONTENTS

NEWSLETTER No. 36 **OCTOBER 1989**

INSTITUTE OF PSYCHOSEXUAL MEDICINE
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MARCH 1989 — MARCH 1990

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INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 36, OCTOBER 1989

EDITORIAL

At long last we have an interesting letter to the editor. Is it too much to hope that it will stimulate a response?

In Dr. Skrine's challenging paper on the temptation to regress, she mentioned our flight as an institute from research. As a scientific body we will wither if we do not undertake research and report it for the information of others. Research means to study carefully, find out and express truth about our subject of Psychosexual Medicine. To research our patients' complaints, our treatment and our training by the usual medical statistical method is not usually profitable as numbers do not convey quality (the patient who has managed to consummate her marriage after treatment may still be miserable and be unable to enjoy it). There are also in this field too many variables to get a uniform sample. The results will not then be quantitatively valid. Each patient brings to the consultation a unique experience of previous emotional and sexual life and so complaints and outcome cannot be truthfully standardised. The treating doctor is using him/herself as part of the therapy and this again must produce variables even although they have had similar seminar training.

We need another way of expressing truths old and new in psychosexual medicine which depends less on spurious quantification and more on qualitative insights.

Drama is a way of conveying truths about human behaviour. In the drama of the unfolding doctor/patient relationship which can change from minute to minute and which can be carefully watched in each individual encounter truth can emerge and this can be written down and communicated to other medical workers. This is not for others to copy, but to understand how the drama was entered into and also studied and to see what truth has emerged, and how the conclusion of the drama was understood.

Research groups could approach their task this way, taking particular groups of patients and studying each case thoroughly and perhaps coming up with new insights.

A report of such a group is given in this Newsletter by Dr. Conway. The subject studied was long-term psychosexual problems after termination of pregnancy. Others could follow their example and perhaps study each case more deeply as Dr. Conway suggests. The findings could then be reported in the Newsletter and finally in some appropriate wide circulation medical journal.

Dr. Tunnadine and Dr. Lincoln have studied genital malignancy and psychosexual problems. Three cases are reported. They indicate the need for special awareness of sexual problems arising in such patients and the need to provide appropriate treatment. They also describe the drama of the

doctor/patient interaction unfolding and the understanding of the conclusions of treatment.

In the last Newsletter the subject of bereavement connected with psychosexual problems was suggested. I am pleased that there are four cases reported in which bereavement was an important factor. In the next edition I would like to continue to pursue this subject of psychosexual problems which are precipitated, caused or exacerbated by bereavement; perhaps of a parent or sibling or of loss of health or employment. I look forward to receiving papers on this subject. The last date for receipt of copy is 28th February 1990. Please see instructions to contributors on the inside back cover.

Morag Bramley

SIREN SONGS: The Temptation to Regress

The word 'regression' in the title of this paper is not being used in any specialist psychoanalytical sense but in the Chambers Dictionary sense of "a return to an earlier stage of development; as in an adult's or adolescent's behaving like a child". I am , of course, thinking about our clinical work. The idea I would like to explore is that the pull towards simpler and easier ways of working is particularly strong for the doctor who is trying to work in a psychosexual way with patients. The strongest image of temptation that comes to mind is that of the Sirens singing their seductive songs to lure the labouring sailor on to the rocks. I do not think this is too powerful an image for the temptation I wish to explore.

The question of what song the Sirens sang has been debated down the ages. My Children's Homer suggests that the songs were of safety, comfort and home. Perhaps we should not despise such a translation, even if it is a bit simplistic, as it does try to give some understanding of temptation to the child reader. The idea of safety, comfort and home does seem very alluring, at least to this supposedly adult reader.

I wonder what would have happened if the ears of only one man had been blocked and he had tied up the other rowers as well as Ulysses? Would they all have heard the same songs? I suspect that although the form might have been very different, a Bach Toccata for one perhaps, Hard Rock for another, the underlying themes would have been very similar.

It is on the premise that there is some common ground in our individual clinical temptations that I plan to follow the tradition of this Institute and talk about one or two of the many moments when I was tempted to regress in my work. But for once I do not intend to dwell too long on the clinical event that led to the regression, despite my firm belief that the detailed study of such moments in the doctor/patient relationship must be the core of our work, the basis of our training and the fertile focus of our research work. I propose instead to follow what Dr. Gill has so vividly described as the flight path, but this time in the opposite direction, away from the individual doctor/patient relationship. I want to look at the sort of paths we choose and the implications of this flight for the work of the Institute.

Institute members are indeed subject to regressive temptations, so is it not possible that similar temptations will affect the Institute as a corporate body? I believe it is not only possible but inevitable. As well as looking at one or two individual flight paths, I am therefore going to look at some possible ways that the Institute may find itself responding to the tensions which arise from the particular nature of our work.

I was forcefully reminded of the way our work differs from established medical specialities in crossing existing boundaries when the publisher and I were recently looking for a distributor for the Montana Press books. Most of the major medical publishers produce books aimed at primary care doctors, ranging from the diagnosis and treatment of specific medical problems to the politics, philosophy and economics of medical practice. They did not produce many psychotherapeutic texts. Karnac Books, however, specifically cater for the psychoanalytic, psychotherapeutic and social work markets. Is this where our books belong? Perhaps not entirely, as our work is for those doctors and allied workers who are also concerned with the body and its function: something almost by definition excluded from most of the traditional Karnac clientele.

However, it does seem important to inform those readers about the existence of our work, and Dr. Tunnadine has suggested in the final chapter of the "Introduction to Psychosexual Medicine" that our training method could have some relevance for them. I shall return later to the question of whether the Institute might profit from wider recognition by and co-operation with the psychoanalytic world. Meanwhile I believe that the choise of Karnac as our distributors will serve to remind us of just that part of our work that demands our most developed skills and from which we as doctors, whose professional childhood was devoted to physical medicine, are most likely to regress. I refer of course to the unconscious contents of our doctor/patient relationships.

Regressive flight of the individual doctor

I was shocked to realise not so long ago how often I forget about the unconscious: not only the unconscious parts of my patients but of myself and my colleagues. When trying to understand, with the help of the Leaders Workshop, the various thoughts I had as I drove to a seminar one day, I had to be reminded that the members too were likely to have some thoughts and feelings they were not fully aware of. Why had I not considered this for myself? Perhaps the full-time psychotherapist or full-time worker with groups develops methods of thought that demand constant attention to the unconscious. In my experience as an ordinary primary care doctor, who often has to follow different problem-solving paths such as traditional physical differential diagnosis, or the ever-fascinating puzzle of the relative importance of physical or emotional factors, I find I need constant reminding by colleagues about the very existence of unconscious factors. Logical, sensible explanations are safer and more comfortable.

In our clinical work the task of concentrating on the doctor/patient relationship as a passport to unconscious feelings is difficult because it requires us not to know the answers. We have to put ourselves at the disposal of the patients, just "be" with them, studying all the time what that

"being" consists of. How different from our earlier training where we learnt to know, to act, to teach, and above all to have the satisfaction of feeling useful.

The problem for the generalist doctor is that we must still return to those earlier patterns of behaviour on many occasions if we are to do our job properly. To quote Dr. Gill again, "if a doctor sat by a patient with a perforated appendix in a 'listening and ignorant' attitude he might well face an action for professional negligence". The very nature of our work requires us to move from earlier ways of thinking and working to our more recently learnt skills and then back again in the time that it takes one patient to leave the room and another to enter it; indeed, to move at an even faster pace within one consultation as the patient's physical and emotional needs are revealed.

It seems then that the pressures on us to revert to those earlier stages in the development of our clinical skills are present even before we come to face a particular moment in the doctor/patient relationship. Perhaps, too, the sort of flight path we choose is to some extent influenced by those pressures.

The temptation to give advice

When I hear Dr. Main say of some anonymous doctor, "She is still advising cushions under the buttocks", I know he is talking about me. Yet perhaps there are one or two readers who also know he is talking about them? I hope so, or I shall regret my decision to expose myself by writing about the last patient I met to whom I gave just that advice.

Mrs. R. is married to a politician in a neighbouring town. I was asked to see her by a gynaecologist who had not sent a patient to me before, so I wanted to do well.

The referral letter told of a difficult forceps delivery followed by a vaginal repair, since when she had lost all sexual feeling for her husband and all feeling in her vagina. Both the gynaecologist and the physiotherapist who had been treating her weak pelvic floor felt she put up a block which prevented them from having any deep conversation with her.

An extremely attractive woman in her early thirties entered the room. I was conscious of her position, particularly when she quickly told me how upright and 'good' her husband was. She herself had been born into an upper class family, although she had been something of a rebel in her early 'teens. She had taken up archery but had been involved in an accident that affected the sight in one eye.

Her story, together with the details of her delivery and subsequent operation, was given in answer to the questions I found myself asking. The replies were given in a sensible, straightforward way; clearly designed to be helpful to me in my work. I noticed but failed to share with her the fact that the other doctors too had tried hard, but had not been able to do much that was right for her.

When we began to talk about the detail of her sexual life it became clear that she wanted to be able to reach orgasm quickly. She could do this by masturbation, while reading a book (not a sexy one, just any book). She complained that her husband had shown no interest in her clitoris. During vaginal examination she told me how he could last for twenty minutes, but this did nothing for her clitoris. It was at this moment that I regressed to cushions under the buttocks, as well as teaching her pelvic floor exercises, to be done *my* way.

As she left she said they were both shy people and at that moment I felt perhaps a glimpse of the inner woman was revealed. Certainly the intimate moment of vaginal examination had revealed nothing more than a disappointed patient and a doctor so keen to deliver the goods, any goods, that she regressed away from the doctor/patient relationship to give mechanical advice.

At the second interview I felt I did marginally better. She started with her feelings of shyness and her difficulties in making a move towards her husband (there had been no sexual contact since her last visit) but quickly moved back to complain about her husband's clumsiness. At this point, I recommended a book for him! I realised I had given advice again and then managed to stay quiet long enough for her to tell me some more about her feelings. She went back to the accident and how she felt irreparably damaged both in her eye and in her vagina. She felt it was unfair that she should be so damaged at such a young age. My clever efforts to tie this in to a general feeling of vulnerability fell on stony ground until the end of the interview shen she said she did not want to start any love making because she would be disappointed again. "You are afraid of opening yourself to feeling and finding no satisfaction", I said. The truth of this insight has perhaps been borne out in the doctor/patient relationship as she defaulted her third appointment sending no letter or phone call of explanation.

Comment We could consider the difficulties for the doctor with this defended disappointed patient but my concern in this paper is to ask why the particular regressive route of advice about sexual techniques, muscle exercises and book reading was taken. I know as well as you do that for the vast majority of patients such advice is useless. I believe that somehow this patient did want to work on her problems and if only the disappointment in the doctor/patient relationship could have been faced we might have been able to continue to work together.

Perhaps this temptation to give advice lies in our earlier professional training and experience. As an ageing woman ex-general practitioner and a family planning doctor I have 'known' for many years about techniques of sexual intercourse, about the pelvic floor and about the books that are available. The temptation to do something to share my knowledge, to teach the patient and to feel immediately useful was too great — the call of these siren songs to opt for the security of familiar patterns of response prevented me from staying in the bleak and disappointing waters of the "here and now" which, if recognised, might have possibly helped this patient.

The temptation to treat the relationship

As members of this Institute we have spent much energy defending our belief that it can be useful to see one member of a couple, and we have also begun to look at what happens when couples choose to come together. The defensive nature of the decision to "send for the partner" has also been

studied. What makes that particular route so seductive? Again perhaps our training as generalist family doctors is partly to blame. There are many definitions of a general practitioner and one short one is, 'the doctor of first contact for individuals, families and a practice population'. Other more complicated definitions have been used, but none of them suggests that the individual doctor/patient relationship is of prime importance, and indeed in many situations it may not be. However, the psychosexual approach, if we decide to use it, demands that we scrutinise the evidence that makes us choose to see the partner, and assess such evidence to see if it provides adequate reasons for deserting the one-to-one relationship.

Mrs. R. is something of a disappointment to me. We met on four or five occasions and did what seemed to be some good work on the feared strength of her hidden emotions, and her inability to allow herself to reach orgasm with her husband. After each visit I felt she must be on the edge of letting go, for she 'let go' with me, producing some fascinating material and tears that seemed to be important. Towards the end of these meetings she shared her worry that she might have been sexually abused as a child. She remembers that there was a change in her father's attitude to her as she approached puberty but she can remember nothing sexual happening.

At this point in response to a request from her, I agreed to see her husband. I did not fully explore what she hoped to get from such a meeting but I think it was something to do with my explaining her feelings to him. Not a realistic basis for a successful joint interview. Now after seeing them together on three occasions I feel as if I have jumped out of the frying pan into the fire with two patients on my hands, both with personal problems they wish to discuss but neither willing to come alone.

Comment Following the flight path back to the point of departure we can see that it was clearly the belief that she had been abused combined with the total lack of recall that made me run away — but why down the relationship path? Did I feel that this would lead to safety, comfort and familiar ground? If so I was sadly disappointed! Perhaps I just followed the patient down the first path she chose, helped, as in so many cases, by the easy availability of the partner. I suspect however that this path is also seductive because we know that other workers using different systems can work productively with two people. I will return later to the strength of the hope that other people have easier and more successful answers.

The temptation to 'cure the world'

When we try to decide which patients may be helped by our psychosexual methods there are other temptations waiting for us. I am very conscious of Dr. Tunnadine's stricture that to take on patients whose problems are greater than we are trained or equipped to deal with is charlatanism. Yet in general practice we are expected to be able to cure those we can cure, to help others and to comfort everyone. Our psychosexual skills do help us in other areas of our work, so should we not try to treat everyone in our care? Or, in Dr. Tunnadine's words, offer to cure the world? The answer lies in how we define our skills. If we allow ourselves to leave the doctor/patient relationship and its study we can use our improved listening skills to provide support for a wide range of patients. If, however, we hope to use

our skills in a more refined way, to use their cutting edge to reach deeper into a circumscribed area of their inner world, then we need to choose our patients as we would if we had a metal scalpel in our hands. The generalist doctor might be happy to remove a sebaceous cyst in the surgery but is unlikely to undertake an appendicectomy. Unfortunately in psychosexual medicine the differential diagnosis is seldom as easy as it is in that surgical example.

Mrs. T. was referred to me because she had been unable to consummate her marriage of five years standing. Our first few meetings were desperately uncomfortable as she sat turned away from me looking at the floor. After sharing my feeling that somehow whatever I did would be wrong, she began to look at me and we have now covered a lot of ground together. She experienced a particularly violent sexual attack as a teenager which she is quite convinced she brought on herself. Her naturally flirtatious and sexually interested side is only allowed to peep out on very rare occasions from behind a smokescreen of anger mainly directed at doctors. The picture is complicated by some fantasies about her vagina, and also a passionate feeling that if she were to share it with anyone, doctor or husband, she would lose a vital part of herself. So far perhaps she sounds a suitable patient for a brief psychosomatic approach, albeit a rather difficult one. However, I have failed to mention that she is also addicted to pain-killing drugs. Recently her G.P. referred her to a psychiatrist, but she only went once as she did not get on with him. I continue to work with her because I tell myself "there is no-one else".

Comment It took a colleague to point out that the belief that one is the only person who can help is the traditional excuse of those who have been tempted to take on unsuitable cases, but I feel that only time will tell if I have been a charlatan to try to work with this patient.

Having briefly described how one individual psychosexual doctor yielded to several temptations I am going to take my courage in both hands and speculate for a few moments on one or two regressive flight paths that the Institute may be tempted to take.

The Lure of the Boundaries

One of the most vivid images that remains with me from the Leicester conference last year is Lady Bramley's picture of the man drilling too near the boundary of his demarcated patch, and the ground giving way. When preparing this paper I looked at the bibliography to try to detect any trends in our reported work. Surprisingly there are not as many papers specifically about boundaries as I had imagined. Several of those dealing with different settings report work near the edges: work in prisons, with the Samaritans and work in co-therapy, to name but a few. While each of these papers was in itself stimulating and interesting the overall impression is that perhaps it is easier to push at the edges rather than to dig laboriously in our own patch.

It is of course necessary for us to define, and constantly re-define, our boundaries. We have been sharpening our twin tools of the psychosomatic genital examination and the doctor/patient relationship, so why do we not use them more effectively? Surely if we were to dig more vigorously within

our own patch we would find untold riches?

The retreat from research

The absence of even one seminar devoted to research in our subject at the present time does not bode well for the academic future of our Institute, but it is not for lack of interesting questions to ask. Ideas bubble quickly to the surface whenever two or three members start to talk about their work, and yet the occasions when we manage to follow up these ideas and study them in a disciplined way are rare.

Let me take just one example. It is now ten years since Dr. Lincoln and Dr. Thexton first published their paper on men who could not ejaculate. This work as far as I know has never been repeated. I can think of few other areas of medicine in which a paper publishing preliminary findings has not been followed within two or three years by another which confirms, modifies or elaborates those earlier findings. We are all seeing men who cannot ejaculate. How many of them give a history of sibling rivalry or twin-ship? More importantly, do they all fall into the categories of those who can reward the female doctor quickly by getting better, and those who initially excite her but finally frustrate and disappoint? The original paper was based on twenty-two men. How many have we, as a corporate body of doctors, seen since then? Five hundred? One thousand? Why are we not studying them and writing about them?

I know that money, time and sheer energy are at a premium among our members. But is this the whole explanation? Is it not also something to do with the difficulty of staying with the doctor/patient relationship, of remembering the unconscious and tolerating the weight of not knowing? Perhaps it is easier not to ask the questions than to have to live with not knowing the answers.

The appeal of other systems

Another tension that arises within the Institute is what our Scientific Director has described as the call for "mixed bathing". She uses this term to describe the sharing of our work with others, and the study of their way of working. From time to time the wish for such cross-fertilisation has become very strong and I believe that it will recur at regular intervals as each new generation of doctors tries to come to terms with this work.

Why is it that such a wish becomes so powerful? Perhaps it is our underlying hope, even belief, that someone else has the answers, hopefully easier answers, to the doubts and anxieties that beset us. Such hope springs eternal, as I discovered when I found a book called "A Psychoanalyst in General Practice". Now, I thought, I really will find some answers. I enjoyed the book but was disappointed at the end to find that the only difference in his practice seemed to be that he could tolerate his difficult patients just a bit longer than some of the rest of us. Alas, there was no magic.

I am not suggesting that we should not share our work from time to time, or learn enough about the language of other workers to be able to appreciate their approach. My attendance at a meeting of the Association of Sexual and Marital Therapists and the participation of several members

in the couples weekend were attempts to do just that. Our work has however developed distinctive methods and has the potential to reveal much about the psychosexual problems of our patients and the skills we need as doctors to help them, provided we can resist the temptation to get diverted away from our subject.

The academics and poets have argued and speculated about what songs the Sirens sang to Ulysses — I have speculated about our temptations — and I am sure you will wish to argue about them. I have mentioned just a few that I recognise in myself: the need to know and thus so often to give advice and to teach, and the safety of familiar patterns of action such as treating relationships and offering blanket comfort to all. I have suggested there may be regressive pressures towards easier paths within the Institute, such as a flight to the boundaries, a retreat from research and a call for "mixed bathing". If we recognise the existence of such forces what should we be doing about them?

I do not have the answers to this question, but I hope that by asking it you will be stimulated to look for answers. I know that it has been suggested that every member should attend a refresher seminar from time to time, but I don't think you improve standards by legislation of this kind. Our leaders do have to attend the Workshops so that their work as leaders can be assessed, and this emphasis on training standards is also present in many other academic bodies.

The content and quality of the Scientific Weekend is perhaps the most important source of stimulus to good work for most members. For me this is the one medical meeting that I can rely on to actually change the way I work in the following week. The opportunity to observe one's colleagues resisting the sort of temptations I have described, or honestly reporting how they failed to resist and then studying *that*, is unique. I hope that the power of these meetings will not be diluted by too much "mixed bathing", or taken over by work from the fringes. It would be heartening if they included more papers that fall into the category of descriptive research.

The opportunity to share one's clinical experience with other psychosexual doctors really can affect one's clinical work. I would like to add a postscript to one of the patients I discussed earlier.

Since writing the first draft of this paper I have seen Mrs. T. again. In response to a family crisis her intake of drugs has increased. The hard thinking that I have had to do for this paper somehow made it possible for me to face her and myself with the reality that I am not experienced in helping people with drug addiction, and that I was not prepared to take the responsibility of helping her with that problem. She was able to accept this and use the opportunity to tell me of her fear that her time for help with her sexual problems has also run out (I had suggested there would be some sort of limit at the beginning). Although I do not usually agree to see people when they are also seeing other therapists, on this occasion I will continue to see her for a while on the understanding that the sexual problem is the focus of our work. I feel that I might have rejected her altogether or continued to try to treat the problems that were outside my field if I had not been forced to review my work in some detail.

Finally, I would like to take you back to my original confession that I often forget about the unconscious. I know that many members have a much better developed sense of unconscious factors than I have and these people must be encouraged to contribute to the Institute as much as possible. They are not necessarily the people who shout loudest or get elected to things and I am therefore particularly glad that we have a scientific advisory board through which their talents can be encouraged. Will this be enough to counteract the back-sliding tendencies of people like myself or should we be looking for more active association with psychoanalysts who are, after all, specialists in the unconscious? Tom Main's particular quality, and Michael Balint's before him, has been his willingness to offer his expertise and bring his experience to bear on *our* problems in our own settings without trying to turn us into second-class analysts. Are there others who would be prepared to work with us in this way, and do we need them? I suspect that we do. Not to take over the day-to-day running of the Institute nor to dictate our future direction, but to share their insights with us as Dr. MacCarthy did two years ago. We can then take what we need to deepen our particular work with the patients we see and hopefully to have the confidence to reject what is not relevant to our needs.

Last year when talking about the future of psychosexual medicine Dr. Tunnadine reminded us of the importance of the question mark. Recently Carlos Fuentes discussing Salman Rushdie in the 'Guardian' quoted Luis Bunuel as saying, "I would give my life for a man who is looking for the truth, but I would gladly kill a man who said he had found it".

As I return to the backbenches of this Institute which has given me so much, after three exciting years as Chairman of Council, I find myself asking what I want of it in the future. Certainly not dogma, but I do want help to resist the temptations to regress, the temptation to fly away from the difficulty of using those tools that can help us in our search for the truth about the sexual difficulties of our patients. I cannot block my ears with wax for the Sirens' songs are within my own head, the themes set by my need to know and to act which are orchestrated by my previous medical training. I can only hope that the Institute will tie me to the ship of psychosexual medicine, using the ropes of the honest study of the psychosomatic genital examination and of the doctor/patient relationship.

Dr. Ruth Skrine
I.P.M. Member

NOTES ON THE CLINICAL MEETING 17th March 1989

The Annual General Meeting was followed, after an excellent meal, by the evening's Clinical Presentation by Dr. Skrine, who was warmly introduced by Dr. Tom Main.

The title of the talk was, "Siren Songs: the Temptation to Regress" and Dr. Skrine explained this in the sense of an adolescent's behaviour regressing to that of a child, i.e. towards a simpler and easier way of working. She went on to speculate that if Institute doctors are tempted, it is inevitable that the Institute itself may also be diverted from its path.

Dr. Skrine referred to the unconscious content of our work and the constant reminders necessary to make the difficult move from the somatic to the psyche and back again, as we use the skills learnt during our training.

She went on to mention three possible flight paths the Institute might make:

1. The lure of boundaries, suggesting that it might be easier to push out the edges, rather than dig at our own patch;
2. The retreat from research. There is no lack of interesting subjects and we could and should undertake to report on and study these more;
3. The call for 'mixed bathing' by studying the work of others in the belief that they have easier answers.

The talk aroused a great deal of interesting comment. Dr. Tunnadine started the ball rolling, not only praising this excellent paper, but justifying the way we examine and criticise the work we do in order to learn more about understanding the doctor/patient relationship and Dr. Backer said that it was to the Institute's credit that Dr. Skrine could look at her 'failures' and share them with us.

Dr. Skrine said that whereas Dr. Tunnadine had previously talked on the future of Psychosexual Medicine, she felt it appropriate to talk here about the Institute and Dr. Main shared the concept that the Institute is a point of view rather than a list of rules to follow; these were hard-won insights and a personal change in methods of practice.

Dr. Lisle said that we identified ourselves too much with the Institute. We were too inward looking. We should be outward looking and open to new ways of doing things. Dr. Gilley replied that we were the only medical society she knew where doctors reported their failures and concentrated on studying them and learning from them. We lay ourselves open to the criticism of our peers by reporting our bad work, then trying to discover with others how it came about. This was digging in our own plot and there was plenty to do without having to go outside.

Dr. Freedman suggested we should look at the unconscious reasons we use for avoiding work and Dr. Main added that regression could be temporary, as we are not always at our best. Dr. Tunnadine added that a relationship involves two people and it may be the patient that causes the regression. Dr. Freedman then said that the more we study the way we differentiate between patients needing our skills and those needing routine medical treatment or advice, the more we learn.

Dr. Tunnadine tried more than once to get discussion going on Dr. Skrine's actual cases but the meeting kept regressing on to general points.

Dr. Main thanked Dr. Skrine on behalf of us all on a most interesting and stimulating evening.

Dr. Audrey Jones
I.P.M. Member

I.P.M. CLINICAL MEETING, Saturday 10th June 1989, Southampton

June 10th was going to be a masterpiece in logistics — husband on call, children's horse-riding, band concert and music lesson running concurrently and my leaving to cross the Solent for an intellectually nourishing morning.

An early start from the Island saw us arriving at the Postgraduate Centre at 9.00 a.m. before the doors were open. No coffee until 11.00 a.m., so we spent the intervening hour on a futile search for refreshments.

With 40 people present including three men and happily some new faces, the meeting began at 10.00 a.m. Dr. Elspeth Williamson had travelled 600 miles to chair it.

Dr. Robina Thexton, Director of Training of the Institute, gave the opening paper.

Dr. Thexton had been impressed by the number of patients who weep in a psychosexual interview and how often Institute doctors appear to be the facilitator of a grieving process. The loss experienced varies. It may be loss of a loved one through death or divorce, of part of self through illness, of independence or employment, of ideal expectations of marriage or confinement and of virginity in the case of rape. It may also be loss of special status as in some cases of child sex abuse.

Dr. Thexton produced two illustrative cases showing how we as Institute doctors can listen, share and understand the nature of the loss by studying the doctor/patient relationship in the here-and-now and allowing the grieving process to take its course.

The paper was enthusiastically received and following a pregnant pause was filled with audience anecdotes. The loss of "being useful" begged the question of why usefulness appeared to be so necessary. At last we were brought back to the doctor/patient relationship. Dr. Thexton was congratulated on her handling of the couple in her second case and yet staying with the presenting patient. Livelier seminar-style discussion followed.

The contrasting second paper was an attempt to quantify our work. "Long-term psychosexual effects of termination of pregnancy" was presented by the Southampton Support Group. Experienced Institute doctors met monthly in their own time sharing their work and nominating a leader in rotation.

There were three aims to their present study: to find out what were 1. The effects on patient's sexual attitudes one year or more post termination of pregnancy, 2. The frequency and severity of sexual problems, and 3. What factors hindered resolution.

One hundred and one cases were studied between September 1986 and September 1988. The patients were subdivided by the presence or absence of a psychosexual problem related to termination and the place of presentation — Well Women/Family Planning Clinic or Psychosexual Clinic.

The cases were studied using a form and the results and conclusions drawn were presented. With such small numbers these were not statistically

significant.

Twenty-three cases demonstrated psychosexual problems directly related to termination, some having been carried for 30 years. There followed five illustrative cases given by group members. The doctors had regretted the lack of time given to each patient in depth and hoped to rectify this in the future.

The paper was well received and a question-and-answer time followed. Post-termination counselling not necessarily by a professional was deemed beneficial, but of even more value was being aware in the routine situation when the patient is ready to receive help. Religious faith sometimes brought its own absolution but conversely could hinder resolution. Only one case of termination and infertility was studied.

Some results from a previous two-year prospective study of 200 cases were at variance with this study. Perhaps problems continue to emerge after this time. Reference was made to Margaret Blair's paper[1] studying the reasons for termination.

Once more our attention was drawn to the moment of truth in the illustrative cases and the shift of the doctor's work to fulfil the criteria of a scientific study.

It had been a fascinating morning followed by a most enjoyable lunch.

At a performance of Schubert's Unfinished Symphony that evening I mused on a common allusion of two speakers that morning . . . Our work is never finished and it is not perfect, but as Institute doctors we hope to give enough of a good thing for the patient to be able to face the future with confidence.

Dr. Jane Botell
I.P.M. Member

Reference

1. Draper, K. (1983). *Practice of Psychosexual Medicine.* London: John Libby. Chap. 31, p. 196

LONG-TERM PSYCHOSEXUAL PROBLEMS FOLLOWING TERMINATION OF PREGNANCY

(Abbreviated version of paper for I.P.M. Meeting, 10th June 1989)

The Southampton Seminar is a group of seven Institute-trained doctors who meet monthly. We were seeing a number of women referred to us, for whom a Termination of Pregnancy (TOP) had been a major contributory factor in their psychosexual problem. This warranted further study and we also decided to ascertain the frequency of psychosexual problems following TOP in the routine population of Family Planning and Well Women Clinics. Following a pilot study we clarified our *aims* as follows:

1. To study a group of women who have had a TOP *at least one year* prior to the time of presentation, to see what adverse effects, if any, the TOP has had on their sexual attitudes and feelings;
2. To try to form some idea of the frequency and severity of any sexual

problems associated with TOP;

3. To study those women presenting problems in greater depth to try to discover the factors which have prevented resolution of their problem.

The study population comprised 22 patients seen in psychosexual referral clinics and 79 patients seen in Family Planning (F.P.) or Well Women Clinics, making a total of 101 patients who had had a TOP at least one year previously and were seen between September 1986 and September 1988. A form was devised and filled in for each patient with relevant details about the TOP, their present situation and sexual attitudes. At each seminar we allocated the patients into one of four groups, according to their mode of presentation and whether a psychosexual problem existed or not.

The groups were:

No TOP-related psychosexual problems (78)

Group 1. Routine F.P./Well Women patients (65)
Group 2. Psychosexual referral patients (13)

Psychosexual problems related to the TOP (23)

Group 3. Routine F.P./Well Women patients (14)
Group 4. Psychosexual referral patients (9).

Results

(While realising that the numbers are too small to warrant statistical analysis, we have used percentages to show trends).

Patients with psychosexual problems related to the TOP comprised 17.7% of routine F.P. patients and 42.5% of the psychosexual referrals. We were disturbed by the proportion of routine F.P. patients with problems and also by the duration of the problems (for many years — in one case 30 years).

Women under 21 and those over 35 were more likely to have problems than the middle group. Nine women had TOP for medical reasons and all but one had come to terms with it, whereas 24% of the "social" TOP patients had problems. We felt this reflected better counselling for the medical group and the ability to put a more justifiable reason for the TOP, especially retrospectively.

One of the most significant trends we found was that women who were still with the same partner were more likely to present problems. If we confine our analysis to the social TOPs we find 35% with the same partner had problems in their sexual relationship. Many reasons were postulated: the discovery that her husband never wanted children, causing resentment in the continuing relationship; others expressed the feeling that the decision was left to them to bear alone; there also seemed to be a subtle rejection of each other in terminating a baby. In other cases the casual nature of the relationship or the breakdown of an unsatisfactory one after the TOP helped to put a seal on the episode, making it easier for her to put it behind her and so build a good relationship with a new partner.

We looked at the degree of support women received and the problem group had less support and more difficulty with partners, family and friends. Medical support on the whole was good.

There were quite significant psychological problems, not of a sexual nature, which also stemmed from the TOP in some patients. Examples were: "never forgiven herself"; "paranoid about becoming pregnant again", "blames herself for her father's illness" (punishment for sin), "nurse of sick children who could not understand how she could have killed her own baby". Eleven of those were in Group 1 (routine patients with no psychosexual problems) and if we add them to those routine patients in Group 3, we find that 32% of routine patients had a psychological problem attributable to the TOP.

In summary:

1. Twenty-three of 101 patients had a psychosexual problem related to the TOP, 17.7% of routine patients and 42.5% of referred patients.
2. Women carried their problems for up to 30 years.
3. The under-21s and over-35s were more likely to have problems.
4. Medical TOPs were more adjusted.
5. Late TOPs had less effect than imagined.
6. The same partner hindered adjustment.
7. Degree of support important, also absence of aggravation.
8. Other pregnancies had no consistent influence.
9. Problem group showed more disruption of life.
10. Eleven women in Group 1 had other psychological problems.

When we completed this study and started to analyse results, we realised we had not concentrated sufficiently in the seminar on individual women and tried to understand in more depth why those with a problem had failed to come to terms with it, thus not really completing our third aim. Conversely, we had not identified what positive factors had helped women to accept their need for a TOP and continue with a healthy attitude to their sexuality. This is to be the future direction of our study: to study cases in more depth, seeking an answer to these questions.

Meanwhile, the following cases give examples of our study to date:

Group 1 case history Ms A was a casually dressed dark-haired traveller in her early forties. She was passing through the clinic to have her coil checked and seemed happy with her contraceptive method, life-style and relationships. It was an easy consultation and she talked freely about her past including her unplanned pregnancy 21 years before which ended in a back street abortion and subsequent emergency admission to hospital for an evacuation of retained products. Although her story suggested lack of support and total isolation at the time, she appeared well adjusted and unscathed by the episode, maybe supporting our studies' findings that people in ongoing relationships appeared to have more problems after termination of pregnancy.

M.T.

Group 2 case history Mrs. B., aged 26, appeared as an unhappy, plump young woman, with a very low self-esteem and I found myself having to coax her into telling me about herself with some difficulty. Her referral letter mentioned post-natal loss of libido, but she said, "I've always had problems because of my weight".

Since her early teens she had felt fat and unattractive and her developing sexuality was an acute embarrassment to her. Her first boy friend was a tearaway in trouble with the police, "but I could only expect to attract someone with problems because I was so unattractive myself". I felt sad for this girl.

Her next relationship was also unsatisfactory. Sex occurred but she felt so embarrassed about it that she "couldn't possible go to a clinic for help". Her mother guessed when she became pregnant and was very supportive, allowing her to make her own decision about the pregnancy outcome. Although Mrs. B. was upset about having become pregnant, the termination seemed far less upsetting. Her main feeling was of relief that it was over, tinged with regret about upsetting her parents. The impression I had (and continued to get) was that that pregnancy and termination were irrelevant to her now and, indeed, almost forgotten.

Soon after, she met her husband who "made me feel valuable and loved". She felt sufficiently encouraged to attend Weight Watchers and lost four stones. Sex became enjoyable and when she became orgasmic she was so delighted that she overcame her embarrassment and talked about it. Life was good.

However, after her first baby her weight problem returned and her libido decreased. This became much worse after her second delivery which was a difficult one followed by re-admission to hospital with retained products, which she found extremely upsetting — "all these examinations!" she said with a shudder. It was during a follow-up examination at home by her midwife that Mrs. B. had burst into tears and told of her problems.

At her second visit Mrs. B. talked more easily and was able to tell me about these examinations in hospital. She said that, although sex had embarrassed her, at least her vagina had been private, but at that second birth it had become public property; there seemed to be a "never-ending series of intrusions into my privacy". Sex was now also seen as an intrusion although she did want to get close to her husband again.

I felt protective towards her and felt it was important to say that I was not going to examine her. I suggested that her husband must also feel like an intruder and might continue to do so until she herself felt able to value her vagina again as their private place for sharing pleasure.

Five weeks later she returned, looking happier. She had gone back to Weight Watchers and had already lost a stone. Sex was much better and she said, "I expect I'll always be a bit embarrassed — but it's getting better".

This patient's termination was, to some extent, caused by her psychosexual problem, rather than vice versa.

J.C.Y.

Group 3 case history Mrs. C. came to a family planning clinic asking for a cap. I had a trainee midwife with me that evening and they recognised each other from a previous nursing course. Mrs. C. was 28, had three children aged 5, 4 and 9 months, and had had two miscarriages. I also noted that she had a termination when aged 16. She wanted a cap, had always used a cap since marriage and was happy with it, but since the baby they had used sheaths unsatisfactorily; all quite straightforward. I talked about her contraception and obstetric history and then said, "I see you also had a termination a long time ago. How do you feel about that?"

Suddenly she became angry. She said she had only come for a cap fitting. Why was I asking personal questions? — and she didn't want to talk about her past. Was I going to get on with it or not? Clearly it was a sensitive area and I thought that the presence of the midwife might have provoked the reaction. I begged her pardon quickly, chatted on for a minute, to give her time to calm down, and then took her into the next room without the midwife.

I then said that I was sorry that I had upset her but that I had brought up the subject deliberately as many women felt so bad after terminations. Mrs. C. was sitting on the couch and I thought she might go for me again; but suddenly she burst into tears and it all came pouring out.

She had been very angry with herself for allowing the pregnancy to happen. It was a casual affair, she had not cared much for the boyfriend and in fact they had broken up soon afterwards. Her family had supported her and organised the termination. Organised was how she felt; pushed into it. Nobody wanted to talk about it beforehand and certainly not afterwards. "Thank goodness that's over!" and "You're a lucky girl!" had been the attitude. The hospital was a horrendous experience. The staff were unsympathetic, she was made to feel stupid and dirty and she had no counselling. It was a long time before she could contemplate a sexual relationship again.Eventually she met her husband and they were very happy, sex was fine and she wanted a family. Each time she became pregnant, however, these awful feelings came back. She could not stop thinking about the baby she had lost and she could not enjoy sex during pregnancy at all. She had never told anyone about this as they would just think she was silly. She knew it had been the right decision but she could not get it out of her mind.

What struck me most was how fresh and painful these feelings still were; 12 years, a happy marriage and five pregnancies later.

When she stopped crying she said that she had accepted her problem. She had felt bad with the last pregnancy and been unable to enjoy sex, but now the baby was nine months old and she felt she could start to enjoy it again; hence the request for the cap. She was grateful for the opportunity to talk and said she had never been able to do so before.

One can only speculate as to how much better she might have been if she had had the chance to talk at the time of the termination, or even during pregnancy, when her pain returned so forcibly.

J.S.G.

Group 4 case history Mrs. E. was 21 and her husband was in his mid-twenties. They had married when Samanatha was six weeks old. They had been together for three years and everything was "perfect" until Mrs. E. became pregnant due to forgetting her pills. Once they got used to the idea, they were both thrilled. As soon as pregnancy was confirmed, Mrs. E. had gone off sex but they both felt things would be fine after the birth; but that was a year ago and still it was no better. The actual delivery was "fantastic" and Mr. E. was with her throughout.

They came together; Mrs. E. looking younger than 21, with long blonde hair and big blue eyes that smiled at me: I felt she was giving me her problem. Mr. E. sat down purposefully — he expected results! He opened the batting, volunteering that he had sone *everything* Dr. B. had suggested, taking pressure off Mrs. E., but it had done no good at all. Pressure on Dr. H.!

I saw Mrs. E. alone at the second visit. She talked easily. She had confided in Mum and there were plans for an evening out while Mum baby-sat. She accepted the doctor's feelings that we must release Mr. E's "exciting girl-friend" as Mrs. E., "the mother", had taken over.

Samantha came next time and as I remarked on what a good mother Mrs. E. was with such a gorgeous child, the tears flowed and it all came out. She wanted to be the "perfect mother" to make up for the baby she had killed. She had felt she would never be worthy to be a mother. She was only 16 at the time — it was after a party — the boy didn't mean anything really — her parents were wonderful and arranged everything. As soon as the terminations was over, they had said, "Well, that's that!" and it was never mentioned again. She told Mr. E. during her pregnancy with Samantha and he had "b——— well flipped his lid", as he "felt it was murder too . . ."

Mrs. E. heaved a big sigh. We smiled silently at each other. Could she put all this guilt away?

A fortnight later Mrs. E. reported that she had really enjoyed sex at the weekend. Her husband had been delighted when she made the first move. They both came shortly afterwards to tell me they planned a second pregnancy in the near future.

Dr. B. telephoned me 18 months later, as Mr. and Mrs. E. were having problems again. Mrs. E. came with Vicky, six months old, another lovely babe. Mrs. E. volunteered even before sitting down: " I *am* a bit off sex since Vicky, but I don't feel the same as after Samantha — I hardly ever think about the termination now — only sometimes — when I'm holding Vicky's perfect little hand, and I think of that other baby . . ." I felt very much the medical mother, as we discussed the tensions at home. Vicky was wakeful, finances were tight as Mr. E. had had a spell of unemployment and they "argued about nothing" as they were both tired and frustrated.

When I saw her again, Mr. E. had started a training scheme for plasterers. He had always wanted to have a skill and was a changed chap. "He doesn't switch on the TV when he comes in now, he's so busy telling me about it all"; "He was so thrilled when *I* suggested going to bed early! It was great!"

This couple have matured enormously since we met initially, but above

all, Mrs. E. has been able to accept responsibility for her termination, put away her previous guilt, and enjoy her femininity.

D.S.H.

Dr. M. Conway, I.P.M. Member
Dr. S. Bolt, I.P.M. Member
Dr. E. Cooper, I.P.M. Member
Dr. J.S. Gibbs, I.P.M. Member
Dr. D.S. Howe, I.P.M. Member
Dr. M. Thomas, I.P.M. Member
Dr. J.C. Yorston, I.P.M. Member

INTERNATIONAL SOCIETY OF PSYCHOSOMATIC OBSTETRICS AND GYNAECOLOGY, Amsterdam, May 1989

Prue Tunnadine and I attended the 9th International Congress where we presented a combined paper on psychosexual medicine and genital malignancy. We participated in a symposium entitled "The quality of life of patients treated for gynaecological cancer".

Dr. L. Goldie presented a paper which discussed psychotherapeutic work with patients who had gynaecological cancer. Another paper described the effects on the sexual life of both the patients and their partners. Most of the other speakers quoted information from large statistical studies, which were interesting and in great contrast to our detailed case studies of several individual people.

There were a great variety of symposia and workshops on the psychosomatic aspects of obstetrics and gynaecology. One particularly interesting workshop was about the training of obstetricians and gynaecologists in this field. The opening paper was presented by Wendy Savage. It was thought-provoking and her ideas were supported by doctors from France and Holland. Dr. Areskog-Wijina from Sweden spoke about the development of special training programmes in Sweden showing a very progressive and enlightened approach.

The participants at this congress were interested in emotional problems and had listening ears for their patients. Unfortunately the truth is that this orientation is rarely found in our hospitals.

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

SURVIVOR GUILT AND THE "WRATH OF THE GODS" SYNDROME

A dignified academic "gentle-man" (in both senses of the word) aged 80 complained of secondary impotence. He attributed this to an operation for prostatic carcinoma nine months before. He had, he said, been told this would be a minor procedure but had wakened to find both testicles had been removed. He would never have given consent for this; for him "life without sex was no life at all".

His rage at this was evident but he presented the story to his woman

doctor with studied calm and courtesy. She interpreted this in terms of his need to control turbulent feelings. It must be difficult to trust a new doctor. We often, she said, describe helplessness in the face of impossible odds as "impotence", particularly in relation to "impotent rage". Trade Unionists, whose only weapon is the withdrawal of labour, "down tools" — a rude pun indeed in this context!

The patient was relieved by this and able to speak more freely of his rage at the doctors and to wonder whether testicular transplants were yet available. His dearly loved wife had died from uterine cancer some two years ago. He had nursed her to the last. It had not been a sexual marriage ever. She had never "liked it" and after the births of their children she had understood his need for "lady friends", but it had never disturbed the warmth of their life together. Recently he had met again a dear friend from his youth, whose atrophic vaginitis the doctor had treated successfully; hence the referral, for she had wondered if her "tightness" was at fault.

The doctor now noticed and mentioned that he seemed apologetic when speaking of his continued wish for a sexual life; as though he expected her disapproval. He burst into tears. "I felt it had killed my wife — my sexual need, I mean ... Even as I speak I see how crazy that is ..."

Expecting the need for extensive psychotherapy as to, perhaps, self-castrative tendencies, etc., a further appointment was made. Meanwhile the doctor arranged for serum testosterone and prolactin and explained that hormonal replacement if necessary would be more practicable than transplant.

The patient returned two weeks later, saying shyly that they had managed successful penetration several times. "Not quite as I once was of course", he said grinning almost boastfully. "I knew there wouldn't be an ejaculate but I did get the feeling of orgasm". In response to the doctor's pleasure and question as to whether he wanted to pursue the tests he replied that it didn't seem necessary. "The transplant idea was pure fantasy", he said. "I thought on the way home of a young man doing a 'ton' on the motorway. I realised it was a wishful metaphor for the lad I used to be".

The phenomenon of *survivor guilt* is well recognised in war. Those who have had comrades killed beside them; those unfit to serve; those taken prisoner, often suffer guilt and depression over and above their grief, at the feeling of having "failed to save" those who died. Perhaps Japanese hari-kiri is the ultimate expression of this. Similarly recent UK civilian disasters such as railway accidents and the Kings Cross fire; aeroplane crashes and the sinking of the Zeebrugge ferry, leave survivors — even heroes — depressed after initial euphoria and in need of counselling or psychotherapy.

It is proposed that in counselling the partners of terminal cancer patients heed be given to this phenomenon and preventive skills developed.

This case also demonstrates the *wrath of the gods syndrome*, which requires a different paper. Suffice it to say here that this patient felt, less than consciously, that his sexuality had caused damage. This led by inhibition to impotence which, despite his age and lack of testicles, responded to a single session of brief psychosomatic interpretative therapy. **

One meets a similar process in women who fear their unbridled sexuality merits "punishment" when, for example, an abnormal smear is detected. They may express undue fear of sexually transmitted disease, cancer or AIDS when there is no rational indication. Similarly girls who have had past terminations of pregnancy, however rational at the time, often show undue anxiety about conception, pregnancy and childbirth until their healthy baby is safe in their arms, or even after, as to whether they will be adequate "undamaging" mothers.

This syndrome too may respond to brief psychosomatic therapy ** but may be aggravated by ill-judged "reassurance" since this reinforces those "careless" attitudes which they unconsciously feel do indeed merit "the wrath of the gods".

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

**Bibliography of publications of the Institute of Psychosexual Medicine and training information from 11 Chandos Street, Cavendish Square, London W1M 9DE, UK

PSYCHOSEXUAL MEDICINE AND GENITAL MALIGNANCY

Cervical dysplasia and malignant disease are known to be related to early adolescent sexual intercourse, multiple partners and also a male factor. Knowledge of these risk factors may have a profound emotional effect on patients and their partners who have this pathology. Health professionals need to be aware of the possible consequences to the sexual relationships and to give psychotherapeutic help when needed.

The following two cases show the kind of non-structured consultation which can sometimes help the patient with their future sexuality:

Jennie, an attractive, intelligent girl in her late twenties was referred from her Family Planning Clinic with complete loss of libido. She had had cervical dysplasia and laser treatment 18 months before. She lived with her boyfriend with whom the relationship seemed settled, rewarding and satisfactory, but she was completely off sex. She and the doctor explored her attitude to the relationship and her life in general, but there didn't appear to be anything outstandingly wrong, except for the absence of sexual libido. She told the doctor that in her late adolescence she had had a very rebellious and promiscuous phase; the rebellion seemed to be against her mother and she said, "My mother is always shouting", and that she felt that her sister had always been preferred by her mother. After three visits, during which doctor and patient puzzled together, she volunteered that she just seemed to feel fear when she thought of having intercourse. At this point it was possible to interpret to her the disgust she felt about the promiscuous stage of her life and her disapproval of her passionate but superficial sexuality and her guilt about the previous malignant disease of the cervix. Jennie was able to discuss her ambivalent feelings when it came to the point of having intercourse. She really wanted to enjoy it and yet she shut down on these feelings of enjoyment and retreated from it and switched off at the last

moment. Having shared with the doctor her feelings of disapproval of herself and also her fear of the recurrence of the dysplasia, her libido began to recover and gradually her sexual pleasure is returning.

The chronic sickness or terminal illness of a well-loved, long term sexual partner may change the sexuality. Libido may be suppressed in consideration of the partner's ill health and later may be overwhelmed and inhibited by grief. Recovery will not occur until the mourning process is completed, but if the terminal illness is caused by genital cancer, then the sexuality may be particularly vulnerable.

Mr. Bird approached his general practitioner with a sexual problem of inability to achieve intercourse after his second wife had sent away for a leaflet from a women's magazine. Very interestingly, his job had been working in a power station and he had now retired at age 59. He had married his second wife two years after the death of his first wife from cancer of the cervix. He was a tall, good-looking man for his age and very determined to get his problem resolved. He was not an impotent man in character. His present wife had previously married twice and they both agreed that they had married too soon after the death of their partners and early in the marriage intercourse had been very difficult. His wife had given him a picture of her previous husband as a super-stud, but in fact he had been an alcoholic. In contrast, Mr. Bird thought that his new wife was quite inhibited sexually and sex always had to be on her terms, in bed and at night. She could not stimulate his genitals or accept clitoral orgasm for herself. In his determination and with great embarrassment he visited a sex shop and bought two different appliances which were mechanically supposed to make him potent. One of them, a BLACO ring, retards the return of blood flow from the penis once an erection has been established. Both these appliances made no difference and he later attended his general practitioner again, who referred him to the Department of Urinary Medicine. There he was given a Papaverine injection to produce an artificial erection, proposing that in the future he might learn to do this for himself. In fact, the injection was only partially successful and a further appointment was made, which in fact he never kept.

After the visit to the urologist he felt very defeated when he visited the doctor, who interpreted to him his depression and suggested that he should talk a little more about the death of his wife and whether he knew about the relationship between cancer of the cervix and sexual activity. This association did trouble him, but when the tears appeared and he wept, the feeling he expressed was of sadness because his wife had said before she died that the greatest compliment he could pay her was to re-marry happily. He seemed to feel that he had let her down.

At the next visit he said that he had had the courage to approach his wife on his terms, that is to say, on a Sunday afternoon and in the living room, and they had had sexual intercourse and he had been potent, and since then everything had been all right and they had both enjoyed it. The doctor noticed that this patient had taken the trouble to come back and tell her that he was so much better. This man's conflict was between accepting his first wife's blessing on his future sexuality and his guilt and sadness at her genital cancer. This case history demonstrates the disturbances within the man's

inner world which affect sexual relationships. Bereavement may affect sexuality, but death from genital cancer is particularly likely to do so.

Rosemarie D. Lincoln
I.P.M. Member

COMMUNICATING OUR WORK: A Personal Account

Talking to GPs

"Could you give your talk on psycho-sex to our Intensive Week for GPs?" My heart sank. "And let me know what aids you need?" How I would love to hide behind the latest video technology, or even those little blue and white slides. "No aids: only me!" What vulnerable words they are. Even worse — I cannot talk from notes or guidelines. If I try, I develop a speaker/notes relationship which seems to exclude the audience. I have to venture on to the high wire *sans* pole *sans* net: which means a lot of planning.

Most of these GPs will have little or no contact with the Institute or our work. They will find what I have to say quite shocking. Therefore, I must structure my talk with care — or else they will go away confused, threatened and angry. I need a framework, a skeleton. This can be very simple, merely one or two struts, or more complicated, and I can add to it or not as I go along, taking my cues from the audience. To these bare bones I shall attach the meat of my message: case histories. These will be utterly unlike anything else that they will hear in the week: no past history, no differential diagnosis, no clever new treatments; just the power of the doctor/patient relationship in action.

I decide on one main strut. Patients conceal sexual problems within a host of other presenting symptoms or calling cards. If necessary, I can stick with this alone. It is an important message to get across. If I feel the audience can take it, I will add another strut: that we doctors collude, and we encourage patients to do this. This is more provoking. I sort out in my head a suitable "cast" of case histories: the ones I actually use will depend on the responsiveness of the audience.

I face them at 9.30 a.m. They see a "sex expert". I see a group of passive baby birds, beaks wide open, waiting for me to push in juicy "facts" ('The six most common sexual problems presenting in general practice are . . .' — cue for slide). I decide to wake them up and tell them a joke[1]. While they are laughing rather uncertainly, I slip in a quotation: "Search then the ruling passion . . ."[2]. I now have their attention.

I raise strut one: "Last week, every single one of you saw several patients who were trying to tell *you* about problems in their sexual life, although you probably did not realise it . . ." — and so on. I illustrate my points with case histories and I begin with quite a complex one, Doris and her persistent

[1]This is a joke I have shamelessly stolen from Dr. Main. I hope he has not got it under copyright and I wish to offer my thanks to him.

[2]Search then the ruling passion: there, alone,
The wild are constant and the cunning known.
Alexander Pope

dyspareunia. This case provides an opportunity to describe a psychosomatic vaginal examination. They find this intriguing. The second case concerns Fred, a jolly milkman, who hid his impotence inside a complaint about his demanding menopausal wife. As I finish, a voice from the back cries: "I saw him yesterday!" and the audience laugh. I finish with bossy Bessy, a dramatic moment of truth from a Well Woman clinic where a sensitive use of the vaginal examination revealed an old painful past history of father-daughter incest. The room is completely silent.

Into this silence, I place strut two. Yes, I say, I agree it is painful, it is messy, it makes us feel angry, upset, useless: no wonder we are tempted to collude with our patients and settle for a simple physical problem with a simple physical cure.

I feel I have their interest still and I introduce a little buttress. "We defend ourselves against our pain in many ways". I talk about history-taking, a clinically dispassionate pelvic examination, flight into treatment, prescription or sending for the partner, the use of a diagnostic label to de-individualise the pain. I can feel some hostility to these thoughts and I produce my last case history. I present two young men, same age, same type, who went to their respective GPs with very different initial complaints. It took several visits before the GPs discovered that neither could ejaculate inside their girlfriend's vaginas. A history produced very similar backgrounds except that one was a diabetic. A genital examination and blood test were all quite normal. They were referred to me and I produced the doctor/patient relationship with both which underlined their huge differences. They got better for completely different reasons. They were individuals.

Time to wind up, to pull all the strands together. I introduce another little buttress. GPs' patients are like boomerangs. You can refer them as hard and as often as you like, but eventually they return to you for you to sort out. Send Doris to a gynaecologist and she may well return without her womb but still with her dyspareunia. Put Fred's wife on hormone replacement therapy and you ensure merely that he will return with perhaps a bad back. When the mouse complains that his Ferrari lacks power, refer it off to a garage, but it will not be until you *listen* to his fear of being trapped inside a woman's great hole of a vagina with only his little penis to rely on that you will get anywhere.

There were a lot of immediate reactions. They mainly want to discuss two aspects: this interesting way of doing a genital examination and its implications for the male GPs; and the concept of defences against pain. They ask me questions but I manage to put them back and most of the talking is done between the GPs. They want to talk about the doctor's vulnerability both in listening to pain and in doing vaginal examinations. The usual things crop up: not enough time, what do you actually do, etc.; but in the end, I have to leave them still talking about it, with the next speaker waiting in the wings.

I have mentioned the Institute and seminars, but I did not take literature and I feel I ought to have done. Later probably, they would be interested in reading about us.

Is it only my impression or is there much less hostility to the way we work nowadays? Perhaps it is time to be more adventurous when talking to GPs.

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

THE ANNUAL GENERAL MEETING

The Fourteenth Annual General Meeting of the Institute of Psychosexual Medicine was held at 11 Chandos Street on 17th March 1989. About 40 members were present and apologies were read.

The minutes of the 13th AGM which the members had received were signed as being a correct record.

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

Dr. Montford thanked Mr. Ron Trowbridge for the great help he had given in re-organizing the office.

Dr. Thexton, the Director of Training, announced that Seminar Leaders could collect printed letters to hand to seminar members on completion of their second term. In the letter she invites them to become Associate members of the IPM.

Dr. Jones presented the Treasurer's Report which was proposed and seconded.

Dr. Lincoln said the Bibliography was out of print. After some discussion it was decided that a revised bibliography with a subject heading format should be printed.

Dr. Filshie said that among 250 letters answered, 80 had come as a result of an article on non-consummation in the Sun newspaper. She gave good wishes to Ann Parker who now replaces her.

The Scientific Director Dr. Tunnadine congratulated Dr. Skrine on the appearance of her new book, "Introduction to Psychosexual Medicine", published by Montana Press and distributed by H. Karnac (Books) Ltd., 58 Gloucester Road, London SW7 4QY. She also said that she was available to all members to talk over subjects they might wish to be discussed by the Scientific Committee.

The Chairman Dr. Skrine gave her report. She said that she had great confidence in the future of the I.P.M. although sadly no charitable fund approached would donate money for capital purposes. The Sheridan Trust support had been doubled and Mrs. Raphael had been thanked for her efforts on our behalf. The DHSS had turned down our request for general funding but had promised to look carefully at any applications for research help. Dr. Skrine urged the members to take research more seriously.

She thanked Dr. Montford and Mr. Trowbridge for making order out of chaos in the new office, and warmly thanked three members of Council who are retiring. Dr. Lisle had been NAFPD Observer, Dr. Filshie had tirelessly and sensitively answered hundreds of enquiring letters and Dr. Draper had given advice and support out of her long experience.

Dr. Skrine talked of our association with other bodies, mentioning the Couples in Trouble meeting where Dr. Gill gave one of the papers, and the joint Balint meeting where Dr. Barrett and Dr. Wakley presented papers. Dr. Skrine herself had been asked to address the Association of Sexual and Marital Therapists. Dr. Skrine thanked Dr. Gilley and Dr. Montford who had facilitated the day-to-day working of the I.P.M. so efficiently while she had been Chairman.

She then welcomed Dr. Wakley as the new Chairman taking office in June.

Election of new Council members then took place. Dr. Peter Barrett, Dr. Shirley Snead and Dr. Shelagh Lucas were proposed and seconded.

The question of changing auditors was discussed. Mrs. Raphael proposed that this decision should be delegated to the executive committee. The meeting then closed. A good supper was then enjoyed and thereafter Dr. Skrine presented her thought-provoking paper which is included in this Newsletter.

H.M. Bramley
I.P.M. Member

REPORT OF THE LEADERS WORKSHOP held at 11 Chandos Street, London, 18th & 19th March 1989

The work and sharing of experiences in the Seminar Leaders' Friday Workshops could be described in many ways, but I think that 'stimulating' will cover a multitude of feelings that I have escaped from the West London Hospital with, over the past six months. Having also come to know more of the people behind the familiar names in the Institute, I had begun to be aware of an air of disquiet about the forthcoming annual Seminar Leaders' Workshop and I knew that the dissatisfaction felt by those who had attended last year's Workshop, had led to the gathering of ideas in an attempt to make this year's Workshop more valuable. There was also to be an informal discussion on the Sunday morning on the appropriateness of the Panel as a form of assessment for Institute work.

The Workshop took place on the same weekend as the AGM and Clinical Meeting where Dr. Ruth Skrine spoke on " Siren Songs: The Temptation to Regress". Many of us who live outside London were offered welcoming and generous accommodation for the two nights with Institute 'Londoners' to bridge comfortably the gap between the three days.

Saturday's plan was for a more structured Agenda than before:

— an initial administrative meeting;
— a two-hour seminar (divided into three groups led by Drs. Main, Tunnadine and Freedman);
— a half-hour 'reporting back from each group' session;
— lunch;
— a report from the Scientific Research Group;
— a seminar with a different leader;
— the final report back.

We had been asked to bring work for discussion: a description of a seminar either in its initial or final phases of development, or of situations when anger or irritation had arisen with a group.

The day started with an informal gathering over coffee but work soon began. Dr. Thexton welcomed the gathering of 24, including two possible Nurse Leaders of the future. The Workshop enables as many Leaders as possible to have the opportunity to participate fully in administrative ideas and gain more insight into the way they work as a leader within their groups. The Saturday yearly Workshop is an alternative for those unable to attend the Friday monthly meetings. The administration over, we divided into our seminar groups.

It appeared, from the discussion afterwards, that plenty of work had been brought to the seminars for the available time. The reporting back session was a disaster! It was painfully obvious very quickly that, although an excellent account of one group was presented, it was only one person's opinion and (surprise, surprise!) everyone else had different ideas; and it also spoiled the seminar for the reporter who was concentrating on the report and not the work!

After a delicious lunch we gathered to hear the Chairman of the Research Advisory Committee, Dr. Katherine Draper, provide us with an up-to-date account of our research project: the difficult task of finding a way to assess the effectiveness of the Institute seminar training by detecting change in the doctors keen to alter their techniques in treating people with sexual difficulties. There was a lot of discussion about the exact methods of gathering the information by the Seminar Leaders, and whether we were all following the initial guidelines. Whatever the situation is, from the scientific point of view, we must stick to the original agreements because moving the goal posts around during the research could nullify the results.

The final seminar was followed, not by the planned feed-back but by tea and biscuits! Our visitors, the prospective Nurse Leaders, said they found the whole day fascinating, but only time will tell whether the immediate anxieties of jumping from the training 'fat' into the leading 'fire' will deter or spur them on! From personal experience of jumping from one to the other without really looking where I was going, I found that it is only when you leap around with lots of good ideas about 'leading a group' that you get third degree burns! Sitting back and listening to the group do the work leads to a gentle scorching which needs plenty of polishing at the Leaders Workshops to obtain the brightness needed to be an effective leader.

Dr. Robina Thexton did a splendid job of making this weekend a success. Thanks go to her, and all those who helped with the arrangements, including Wyeth for their continuing generous hospitality spreading over the whole weekend.

Dr. P. Allen
I.P.M. Member

Sunday morning 19th March

A well attended meeting of panel members and leader doctors discussed the nature of the Panel, assessment of candidates and how to improve

communication between the Panel, leaders and members of the Institute. It was felt that increasing the number of doctors on the Panel would add greater flexibility and allow a system of rotation and a defined period of office. Many leaders felt that a Curriculum would help candidates, who often feel that they do not understand exactly what the Panel wants. Others felt that this would be too constricting. The question of feedback, both to candidates and leaders, was raised: would this help candidates to know why they had passed or failed? Is this the job of the Panel? All present realised that the Institute has grown to the point where assessment of our complex work needs to be re-defined with new guidelines.

Views of members and associate members sent to the Scientific Director will be very welcome.

CORRESPONDENCE

Dear Madam,

I listened to Dr. Ruth Skrine's paper at the AGM of the I.P.M. and the subsequent discussion with great interest. I regret that I did not have the courage to join in the discussion at the time; but I hope that it may be possible to add this contribution in your Newsletter.

It seems to me that members of the I.P.M. do need to talk about the 'Institute' and the 'Institute method' in the same way as in acting actors can follow the 'Method' of Stanislavski. I quote from 'The Empty Space' by Peter Brook: "Acting is in many ways unique in its difficulties because the artist has to use the treacherous, changeable and mysterious material of himself as his medium. He is called upon to be completely involved while distanced — detached without detachment".

It seems to me that using the 'Institute method' a doctor is not in the business of learning how to do psychosexual therapy but of sharpening herself and at the same time of making herself more vulnerable to be used as a tool in the treatment of the patient.

During the discussion I heard one doctor comment that other medical meetings are 'different'. In other medical disciplines doctors are not in the business of using themselves, of becoming more vulnerable and of sharing their 'failures'.

I should like to take this opportunity of thanking Dr. Skrine for a remarkable paper.

Yours, etc.,
Dr. Elizabeth Forsythe
I.P.M. Member

OBITUARY

Dr. Sara ("Sally") Waters
I.P.M. Member

Her untimely death on 22nd April 1989 at the age of 56 has brought great sadness to the family, friends and colleagues of Sally Waters.

Until three weeks before her death she was actively engaged in her regular work as Family Planning Instructing Doctor and in the treatment of psychosexual problems in Maidstone and Medway Health Authorities.

Since 1980, together with her husband, she counselled in the Kent Family Conciliation Service and herself was a trainer of conciliators. She continued to play a significant role in "FOCUS", the Christian Counselling Service for Maidstone which she helped to set up in 1987.

The third of a family of four girls, who were all educated at Edgehill College, North Devon, Sally and her younger sister (Dr. Janet Hosegood) went on to study medicine. Sally and her husband, Tom, a consultant psychiatrist, met and married as undergraduates at Bristol, where they qualified in 1957. After hospital posts in gynaecology and paediatrics, Sally devoted herself to their young family, resuming her medical career when their third child started school. She and Tom were very happy to see their son, Stephen, and two daughters, Gillian and Rachel, all qualify in medicine.

As a doctor who was generous in giving her own time at the end of Family Planning Sessions, to help patients with psychosexual problems, Sally eagerly joined Dr. Shelagh Lucas' seminar in Maidstone in 1976, following on to join the seminar led by Dr. Pat Roberts and in 1979 she became an enthusiastic member of Dr. Tom Main's Sharpethorne seminar. Her style was unassuming and gentle but her presentations revealed a perceptiveness and perseverance which was much respected resulting in her accreditation to the Institute.

Sally inspired loyalty and affection in both patients and colleagues and her genuine empathy and quiet humour made her a delightful companion. The courage with which she and Tom faced the sudden knowledge of her terminal illness and the strength they derived from their Christian faith was an inspiration.

To all her family, we send our condolence.

Brenda Rowntree
I.P.M. Associate

NOTICES

The Accreditation Panel will meet on Tuesday 14th November 1989 and on Tuesday 15th May 1990. Doctors who wish to present their work for assessment please contact the Panel Secretary, Dr. Jessie Yorston, at 11 Chandos Street, London W1M 9DE.

From: THE MEMBERSHIP & SUBSCRIPTION SECRETARY

Members who do not pay their annual subscription by Bankers Order or by covenant are reminded that annual subscription payments were due for the current year on 1st September.

It is emphasised that if each member were to be written to about annual subscriptions then the postage bill would increase and reduce the amount available for use in other ways.

You are reminded that annual subscription rates are at present:

Associates £25 per annum
Members £35 per annum
Subscribers £35 per annum
Retired Members Contributors 50% of current rate.

Please notify any change of address at once to The Secretary, 11 Chandos Street as I.P.M. Newsletters are still being returned by the Post Office as "gone away".

CHANGE OF DIALLING CODES FOR LONDON

We give below for the convenience of members some of those contact telephone numbers in the London Area for which the dialling code changes with effect from 6th May 1990:

	Currently	*Will be*
Office, Chandos Street, W1	01-580 0631	071-580 0631
Dr. Tom Main	01-788 1696	081-788 1696
Dr. Prue Tunnadine	01-636 9896	071-636 9896
Dr. Robina Thexton	01-997 1748	081-997 1748
Dr. Fay Hutchinson	01-504 1451	081-504 1451
Dr. Susan Horsewood-Lee	01-589 2940	071-589 2940
Dr. Audrey Jones	01-658 6185	081-658 6185
Dr. Gillian Vanhegan	01-459 2311	081-459 2311
Mrs. Nancy Raphael	01-235 3880	071-235 3880
Dr. Heather Montford	01-979 6922	081-979 6922

CONGRATULATIONS

We congratulate Dr. K. Agrawal, MBBS, MRCOG and member of I.P.M., on her election to FRCOG while practising psychosexual medicine only.

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 ✓	Leeds	Thu.eve
Trent	Dr. P. Barrett ✓	Sheffield	Tue.eve

East Anglia	Dr. B. Devereux ✓	Norwich	Fri.1230
N.W. Thames	Dr. A. Tobert ——	Chandos St., W1	Wed.pm
Wessex	Dr. H. Montford ✓	Southampt'n	Fri.pm
S.Western	Dr. R. Skrine ——	Bristol	Tue.pm
	Dr. P. Allen ——	Bristol	Wed.pm

CONTINUATION SEMINARS

N.E. Thames	Dr. R. Sampson ——	Finchley	Thu.pm
E. Anglia	Dr. B. Devereux	Norwich	Wed.1230
S.Western	Dr. H. Backer ✓	Gloucester	Th.pm
Devon	Dr. B. Campbell	Plymouth	Mon.eve
Midlands	Dr. S. Snead	Kidderminster	Fri.pm

ADVANCED

Northern	Dr. R. Freedman ✓	Newcastle	Wed.eve
N.E. Thames	Dr. M. Gill ✓	Islington	Mon.pm
N.W. Thames	Dr. T Main ✓	H'smith	Th.pm
S.Western	Dr. R. Skrine ——	Bristol	Wed.p.m.
Sussex	Dr. P. Tunnadine ✓	Ditchling	Fri.p.m.
Wessex	Dr. R. Thexton ✓	Southampt'n	Fri.p.m.
Trent	Dr. M. Bramley ✓	Sheffield	Mon.eve

OTHER

E. Anglia	Dr. R. Lincoln ——	Bury St.Ed. for doctors & nurses
	Dr. R. Lincoln	Norwich for FP & practice nurses
Devon	Dr. J. Tisdall ✓	Plymouth for nurses

Seminars RECENTLY COMPLETED include those led by —

Dr. D. Anderson, Hull
Dr. A. Jones, Bromley
Dr. S. Filshie, Nottingham
Dr. R. Thexton, Cambridge (for nurses)

Seminars in planning:

Basic		Chandos Street, W1	
	Dr. G. Wakley	Leominster	Mon. eve
Continuation	Dr. M. Roberts	Canterbury	Thu.p.m.
Nurses Gps.		Bristol	
		Nottingham	

REGIONAL TRAINING CO-ORDINATORS

Northern	Dr. A.V. Smith, 6 The Crescent, Longbenton, Newcastle -upon-Tyne NE7 7ST. Tel. (091) 2662554
Yorkshire	Dr. D. Anderson, 4 Newstead Road, St. Johns, Wakefield 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) 813115
N.E. Thames	Dr. R. Sampson, 27 Oakleigh Park South, London N20 9JS. Tel. 01-445 6272
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. D.M. King, 5 Churchill Gate, Oxford Road, Woodstock, Oxon. Tel. (0993) 813115
South Western	Dr. R. Skrine, Castanea House, Sham Castle Lane, Bath BA2 6JN. Tel. (02254) 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. (0952670) 408
Mersey/North West	Dr. A.V. Smith, 6 The Crescent, Longbenton, Newcastle-upon-Tyne NE7 7ST. Tel. (091) 2662554
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. Philippa Barnard, 33 Earlham Road, Norwich NR2 3AD
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Dr. Catherine M. Bidwell, 45 Woodlands Road, Cleadon, Sunderland SR6 7UD
Dr. Jennifer N. Bloomer, 46 Lancaster Gardens, London N2 9AJ
Dr. Arthur P.K. John, Brookside Cottage, Tickow Lane, Shepsted, Leics. LE12 9EY
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Dr. Cheryl A. Collett, Bramley Cottage, Bullhouse Lane, Wrington, Bristol BS18 7NY
Dr. Gillian M. English, 37 Moorlands, Wickersley, Rotherham S66 0AS
Dr. Joy C. Marshall, 182 Mays Lane, Barnet, Herts. EN5 2LT
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Dr. Gail Ord-Hume, 12 Holly Road, Ashurst, Hants. SO4 2BA
Dr. Anne E. Parkin, 63 Canada Drive, Cottingham, Humberside HU16 5EH
Dr. Judith B. Pell, Moffat's Close, Romsey Road, Winchester, Hants. SO22 5PQ
Dr. Helen Penfold, 6 Connaught Road, Havant, Hampshire
Dr. Angela Pickrell, 60 Compton Road, Shepton Mallet, Somerset BA4 5QT
Dr. Anne Curtis, 1 Lime Mews, Dravers Lane, Bullbridge, Ambergate, Derby DE5 2EZ
Dr. Margaret J. Denholm, 9 Seppings Way, Thorpe End, Norwich NR13 5DF
Dr. Nabil A. Naroz, Old County View, Hett Hills, Chester-le-Street, Co. Durham DH2 3JT

CHANGES OF ADDRESS

Dr. Sarah H. Wilson, 8 Meadow Way, Kinoulton, Nottingham NG12 3RE
Dr. Beatrice Campbell, 10 Garfield Terrace, Stoke, Plymouth, Devon PL1 5NU
Dr. Gill Wakley, c/o 8 Carlton Close, Cheadle, Stoke-on-Trent, Staffs. ST10 1LB
Dr. Janet Steer, Bush House, Romsey Road, East Wellow, Hants. SO51 6BG
Dr. Denise M. Harrison, Flat Four, Shore Court, Shore Lane, Sheffield S10 3BW
Dr. Valerie Whitaker, Tout Pres, Little Lane, Wrawby, Brigg, South Humberside DN20 8RW
Dr. Jeanette L.R. McGorrigan, 59 Dransfield Road, Sheffield S10 5PP

INSTRUCTIONS TO CONTRIBUTORS

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

The first page should include the title, the name and qualifications of the authors and their appointments. Each page should bear the title and author's initials. Any work, article or book referred to should be given a reference at the end in the Vancouver Style. References should be numbered consecutively in the order in which they appear in the text. Please send two copies of the unfolded manuscript and retain an identical one. Patients' names, locations, jobs and other identifying features should be disguised.

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

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