

I.P.M. DIARY OF EVENTS

Saturday June 16 1990, 9.30 a.m.—12.30 p.m. lunch

Clinical Meeting at Nottingham City Hospital Graduate Dept. on Treatment of Impotence with Papaverine injections.

Friday September 21 — Sunday September 23 1990

Annual I.P.M. Scientific Meeting at Keble College, Oxford. Programme will be sent to membership early in July 1990.

Friday November 2 1990, 6.30 p.m., supper 8.00 p.m.

Clinical Meeting at Chandos Street. Dr. Mervyn Glasser will speak on the Differential Diagnosis of Perversions.

Friday October 11 — Sunday October 13 1990

The Annual I.P.M. Scientific Meeting at Redcliffe House, Warwick University.

OTHER DATES FOR YOUR DIARY

R.S.M., 1 Wimpole Street, London W1M 8EA

Saturday May 19 1990, 9.15.a.m. — 3.45 p.m.

Contraception and Sexual Medicine in the year 2000.

Monday July 2 1990

Evening meeting: Sexuality and the physically disabled.

COUPLES IN TROUBLE

Thursday July 12 — Saturday July 14

Second National Conference at St. Catherine's College, Oxford. Contact J. Cunnington, 76a New Cavendish Street, London W1M 7LB.

INSTITUTE OF OBSTETRICS & GYNAECOLOGY

Monday September 24 — Tuesday September 25 1990

Problems in psychosexual medicine. Contact 01-740 3904/3902.

THE BRITISH ASSOCIATION OF PSYCHOTHERAPISTS

Saturday May 12 1990, 9.30 a.m. — 1.00 p.m.

At R.S.M. Jung's concept of the self.

October 1990

A one year's course. Working with analytical concepts.

October 1990

An Introductory Course on psychoanalytic concepts of work with individuals. Two locations in north and south London.

For above three courses, contact Mrs. J. Lawrence, B.A.P. (sn), 121 Hendon Lane, London N3 3PR. Tel. 01-346 1747.

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Institute of Psychosexual Medicine

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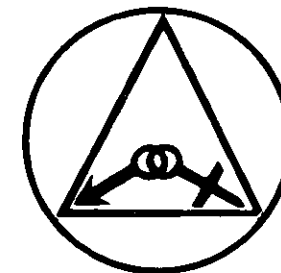
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INSTITUTE OF PSYCHOSEXUAL MEDICINE
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MARCH 1990

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INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 37, MAY 1990

EDITORIAL

The Annual Scientific Meeting of IPM at Cardiff, 1989, is reported in this Newsletter. In the discussion after Dr. Gilley's paper on 'Coming in from the cold' it was felt by some that continuation seminars tended to become too cosy. Are they a wasted opportunity for research and publication?

Dr. Bancroft of the MRC Reproductive Biology Unit, Edinburgh, was heard to say at a public meeting last year, "The trouble with the Institute of Psychosexual Medicine is that it does not do more research and publication". We know that numerical research in our subject is usually unprofitable. I enlarged on this in the Editorial of the October 1989 Newsletter. Even Dr. Bancroft himself has emphasised the problems of controlling variables when trying to find a homogeneous dysfunctional group.

Descriptive research is just as valid in its own way as literary criticism is valid for drama. It would be good if Continuation Seminars would take up the challenge of disciplined thinking and study such subjects as "Effects of unresolved grief on the ability to lead a normal sexual life". Five such cases are reported in this Newsletter and in three the loss occurred at a critical time of maturation of the patient. In one the ejaculatory incompetence seemed like retribution for the recent death of his young wife and his attitudes to her at the time. For another, an abortion followed by a mother's death also makes us think of retribution. It would be interesting to see if any of these findings were repeated in a seminar pursuing this subject further.

The difficulty of the doctor/patient interaction where the patient is a professional carer is looked at in three papers. The doctors were obviously under stress in this situation and behaved in uncharacteristic fashion. This could also be researched further. It has been noticed in training seminars many times but I cannot recollect a publication grouping a number of these together and noting what other insights could be gained.

Another subject raised at the annual conference was "Touching and hugging: are they clinical events?" There are two short contributions on the subject of whether to act out the impulse to touch the patient or to interpret the feelings causing this desire. There are other ordinary types of touching which can be therapeutic. I remember a doctor reporting a consultation with a young man who had a chest infection. She asked him to remove his shirt and as she laid a hand on his shoulder and her stethoscope on his chest he said, "Actually I have got terrible sex problems". It was striking how the touch liberated the patient to say what he had really come for. The touch was part of a routine examination and not specially meant to be comforting, but it seemed to be a clinical event that was therapeutic. A further study of 'touch', if doctors were willing to report it, would I am sure bring interesting findings.

The Department of Health has promised to look favourably at a grant application for a seminar to research "Child sexual abuse as a factor in sexual problems". If successful this could provide support for doctors' time and travel as well as other needs. Two years have gone by, and this offer has not been taken up. If any one is interested in pushing forward such a project, please contact Dr. K. Draper who will give information on how to make a satisfactory grant application.

We congratulate Dr. Main on the publication of "The Ailment and Other Psychotherapeutic Essays". This book makes some of his important papers more available and is very welcome. Chapters 14, 15 and 16 are particularly valuable to IPM members.

We send our best wishes to Dr. Mary Gabbott for a smooth and quick recovery from her recent injuries.

This is my last Newsletter and I would like to thank Members and Associates who have so ably helped me in providing articles, reports and reviews. I also thank Mr. Jimmy Matthews for being so helpful in all production matters. Finally I wish Dr. Merryl Roberts every success as she now takes over the Editor's chair.

H. Morag Bramley

AT THE COALFACE

Do you have patients who say to you, "Doctor, you must have read my mind!" And you say to them, "Well, what you have just said to me was . . . and you looked so sad (or angry, or whatever) that I thought you must be feeling . . . x, y or z". And *you* think nothing of it. But when you try to explain to colleagues, or to trainees, how you obtained that vital information that revealed why Mrs. X has been to see them six times in the last six weeks, they look at you with incomprehension and think that you were just lucky. Occasionally, they have that look of dawning understanding as things the patient said to them now make sense, or they say, with resignation, "patients always open up to you . . ." Perhaps the "opening up" is something to do with the way in which we have changed while undertaking seminar training.

When I talk to doctors about training for psychosexual medicine, they always ask one question: 'How do you find the time to do this work in general practice or in an ordinary Family Planning clinic?' My reply is: "How can you waste so much time seeing people and not finding out the real reason why they are continuing to have problems?"

The trouble is that doctors see activity such as psychosexual medicine in isolation, as a 'specialist' occupation: one that occurs only in referral clinics with half an hour or so set aside for each patient. Most of our published work is written as detailed descriptive accounts of "long cases"; this has tended to give the impression that this is the only 'proper work' that is done. And yet in seminars we are frequently reminded that the long case, seen many times, is often boring and non-productive. The seminar leader is always pleased when a group member says, hesitantly, "Well, I'm not sure whether this is really a case, and I've only seen her/him once . . ."

The insights gained and the progress made with understanding the doctor-patient relationship often makes these the most rewarding cases to discuss. And it is not until we hear others, not exposed to our training, dealing with patients, that we realise how we have changed.

What happens between doctor and patient in brief, unstructured, unselected consultations in primary care is different from the referred patient with the specialist. Many of the things we do are not recognised as 'psychosexual medicine' — and are undervalued as part of our skill as a result.

But it is all too easy to slip back into the unthinking ways of the past; and sometimes things are said without thought and not retrieved.

Mrs. S. had been to see another doctor for her last two check-ups. I felt hurt as I had taken time to sort out various problems with her. When I did see her again I commented on her absence. She said tartly that she did not think that I would want to see her again as I so obviously disapproved of her! What did she mean? (I could think of nothing). She reminded me that she had told me about her infidelity. (It had been a relationship based on lusty sex, which she had enjoyed at the time, but she had worried that she might have caught something from him and had wanted a 'check-up'). I had said, "Who's a naughty girl, then?" I cringed and was about to apologise — and then realised that I had only picked up what she thought about it herself. Fortunately, I was able to work through these feelings with her on this occasion, having failed to notice (or remember) them on the previous consultation.

Unfortunate expressions have a habit of resonating with what patients feel about themselves. How often have we heard, "The *other doctor* said . . ." and then words which imply immorality or other criticism of the patient. In a nervous, and therefore non-lubricating woman, just starting her sexual life, the remarks, "You are very small", or "tight" or "dry", confirm her fears. A woman who is told that her retroverted uterus is "back to front", "twisted", or "the wrong way round", will assume that there is something wrong with her and the remarks may reinforce her fantasies.

A man looking down on his penis always thinks it looks smaller than the next one along, at the urinal, but to be told that "it doesn't look quite right", when he has a very minor abnormality, is very damaging. Other remarks I have overheard, or had repeated to me, are, "What a mess!" (after treatment of the cervix), "everything's falling out here!" (an anterior and posterior prolapse), "someone's cobbled this up" (a poorly repaired episiotomy). No doubt everyone can add their own examples.

If we are always a 'practising psychosexual doctor', we avoid the statement by asking the patient how it feels to them, or if an opinion is expressed, the effect on the patient is observed and can be used to elucidate the feelings.

Miss T. sat on the edge of the couch, the blanket wrapped around her and her legs crossed. She was due for her second cervical smear. She looked very young and vulnerable. "You look very worried about this

examination. What's bothering you?", I asked. She looked at me earnestly. "Will it hurt? It did last time". "It shouldn't hurt", I said, "Does it hurt if you use a tampon?" She looked at me blankly, "No", as she shook her head ("What a daft doctor!"). "What about when you make love?" I asked. She went pink — "Oh, that's all right". I sat next to her on the couch and we went through what we were going to do. She did not want to put the speculum in herself but lay on the couch well covered by the blanket. The examination was easy and painless. While observing her non-verbal signals, I talked about what I could see and feel. The false attentive look she had adopted during the preliminary explanations vanished and she began to ask things about her "insides" (she had quite a few fantasies which were potential problems). When I had finished she sat up and the blanket, symbolically, slipped off.

This is a common scenario and because it is so frequently encountered it is easy to slip into habits — "I always show her the speculum", or "I always show her on the pelvic model". Habits are dangerous and prevent the doctor thinking about what is going on between *this* patient and *this* doctor. This patient showed that she felt young and vulnerable by making the doctor feel old and motherly and by her non-verbal behaviour of wrapping herself in the blanket. Her defences against assault were her crossed legs and her child-like demeanour (the doctor's reaction being a wish to postpone the examination until a later occasion, when she would be more 'grown-up'). She was still behaving 'as a child', obediently attending for an examination she feared. The doctor sitting on the couch demonstrated to the patient that she was on her side; other doctors or other patients may need a different approach — taking the patient over to the trolley so that both are standing, or the doctor sitting by the couch on a chair — but *this* patient was easy with *this* doctor who came very close in a motherly/teacher way. The girl's wish for the doctor to remain in control was evidenced by her wanting the doctor to use the speculum. Only when the examination was going well could she relax her defences to 'open up' and reveal herself and her inner worries.

When this type of 'routine' encounter is scrutinized it can be seen as 'psychosexual medicine of the preventive kind'. Under-valued and under-reported, this is important work. Falling into this category are patients who present with dyspareunia following vaginal infections or treatment for an abnormal cervical smear. The lack of desire in either partner after childbirth, hysterectomy or breast surgery can often be anticipated and discussed *before* it becomes an established pattern. It becomes easy to say, "I expect it's affected your sex life?" after any sort of loss — relative, friend, job or health — or any major life change such as the menopause or retirement (losses of a kind themselves).

Mr. W. bustled into the surgery. A great one for organisation, he had made himself a double appointment as the cardiologist had suggested that he had a talk to me about his problem. He looked very fit and said that he had completed his rehabilitation programme after his triple bypass heart surgery. He was reluctant to come to the point of the consultation and directed me to the most recent letter from the

specialist. His problem was impotence: the specialist thought the problem unlikely to be physical. As I looked back up at him from the letter, he had shrunk in his seat. He looked older and defeated. He told me how he felt put on the scrap heap by his firm, who had given him early retirement at fifty-four; how his wife followed him around everywhere and checked up on him like a child; how he had sold his caravan and abandoned his dreams of touring the continent when he retired. He wept hot, angry tears. I was able to help him to see his wife's fear that he would die. He had been given a second chance at life, to build another one *now*, not after retirement some time in the future. He left looking confused and still distressed and I thought, 'If only there was more time!' When he returned for his next appointment he looked his previous confident self: he did not need any more help; he was sorting it all out himself with his wife. They were setting up tea dances for the retired folk; they both loved to dance and it would keep them fit. And he had got himself a job on the local newspaper. Pleased as punch with himself he was, and "no more trouble with the little man".

Here was a man who had had every possible care taken of his physical health. This had diminished him and made him impotent. The doctor felt helpless (and impotent) to do anything to help, and the patient had to do it all himself. Understanding the problem was its own cure. Surgery had run a little late, but no more than if he had had to have another ECG performed!

Sometimes having 'brief encounters' can be an advantage. The prospect of a 'special long appointment' can make a problem seem overwhelming or too important.

Mr. H. came to surgery complaining of fatigue. He could not explain his symptoms and wanted a check-up. Physical examination and simple investigations were negative and it was possible to push him harder on what had happened around the date this started. A story emerged that his younger brother, whom he had always admired as 'a bit of a lad', had been accused of raping a girl from work. He and his brother worked in the same industry as platers; the girl worked in the accounts office. He had felt very badly about this, especially when his wife had commented that the girl "must have asked for it". He had gone off sex ever since and could not bear even to cuddle his wife — and she did not seem to care at all. I arranged to see him again for a longer appointment and we explored his admiration and desire for this innocent-looking young girl, his wife's feelings of jealousy when he so vigorously defended her and the conflict between his approval of his brother's macho behaviour generally and his condemnation of this assault. He failed his next appointment but turned up in ordinary surgery. When I commented that there would only be a limited time to talk, he said that he would rather it was short as he had felt too confused by all the things that we had covered last time, and could we sort out one thing at a time? He has returned for short appointments at intervals since, to do just that.

This patient of limited education could not intellectually deal with

several conflicting and new ideas at a time. The concept that how he felt could affect him in such potent ways, was a new and difficult one for him to accept. He needed time, not with the doctor, but time to assimilate fresh ideas and mull them over himself to make sense of them. The availability of a doctor, with particular skills, in small doses, and in a familiar setting, enabled this process to continue without undue drama or importance.

The aim of training in psychosexual medicine is not to turn doctors into specialists in this field. Only those with special interest and aptitude should follow that path. Training is to enable doctors to acquire basic skills in dealing with patients who have sexual problems, overt or covert. These skills enable them to help patients in the course of everyday practice in whatever field of medicine they work, especially in primary care, when the decision to consult is made by the patient. Consultations about sexual problems will be encountered whether the doctor wishes to deal with them or not. Patients quite reasonably expect the doctor to offer treatment of both body and psyche. Where the symptoms involve the 'private parts', doctors have access to parts other workers cannot reach.

Dr. G. Wakley
IPM Council Chairman

An abridged account of the paper delivered at the AGM on 16th March 1990

REPORT ON THE 15th ANNUAL SCIENTIFIC MEETING OF THE INSTITUTE OF PSYCHOSEXUAL MEDICINE

The *Friday evening* session opened with **Dr. Judy Gilley** speaking on "Coming in from the cold". She described how, as a GP, she had anxiety about losing touch after leaving her seminar group.

There are difficulties in finding regeneration when you are working in isolation with chronicity or unsuitable referrals, but the shape the doctor is in is a pointer to the doctor/patient relationship and this is improved by exposure to new ideas and experiential understanding in groups. Dr. Gilley read extracts * from papers and books as an example of how we can trigger ideas and creativity from sources other than each other. Real learning comes at that moment when we link an abstract idea with practice and think "Aha!" This releases endorphins and causes a mini-orgasm!

Dr. Gilley told of an Asian woman with non-consummation apparently as a result of circumcision at the age of five years. The patient was cool and controlled and the doctor felt put down by constant reminders of the patient's achievements.

Self-examination confirmed to the patient her normality. Circumcision was not the issue. Eventually the doctor felt able to tell the patient of her need to remind the doctor of her past successes.

Tears fell as the patient described her parents' bad marriage and her own violent and chaotic upbringing.

The patient had difficulty showing her vulnerability and softer feelings; her problem had been to control chaos and uncertainty. The

patient later told the doctor that to examine herself was a big step in taking control of her body. She was pleased that the doctor recognised the desire to do the work for herself and had facilitated it.

There followed a discussion about how to keep in touch, perhaps by seminar, meetings or the Newsletter. It was felt that seminars could become too cosy, when what was needed was stimulation. Maybe everyone needed a time in the 'wilderness' to develop new ideas, but the real danger at any time was in not noticing that you had stopped thinking.

Long discussions took place about how detailed a report should be sent to the GP. It was suggested that the reply should be in the nature of the referral, although there is a responsibility to inform colleagues who do not know about our work and what we are not capable of doing.

Saturday brought discussions about referrals and ways of working.

The morning session opened with **Dr. Bozena Davies** speaking on "After accreditation".

She told of her encounter with a man who was referred as suicidal over his obsession with sex. This was belied by his easy manner. The doctor never saw this, her first patient, again and failure was painful.

There followed many changes in the doctor's life and she resigned from general practice and joined the Brook Advisory Service in Birmingham where the expected relationship was counsellor/client rather than doctor/patient. Feeling herself to be an outsider in the support group the doctor had struggled with 'cold' patients who had been on the waiting list for many months.

She saw a middle-aged couple where the man complained of impotence. The moment of truth came when he lay on the couch, naked and vulnerable after examination. "I hate her", he said. He was angry with his wife but did not think he would come back to the clinic. At this time the doctor was told to attend the peer group supervision which she had been avoiding. She began to realise that the object of counselling was to accept and value and promote change and growth. Empathy not sympathy was required.

A man of 60 dressed in autumn browns came to the clinic. He said he had impotence and had just been divorced after 35 years of marriage. The doctor felt she made too facile and early interventions but by the sixth session he had a bright red tie, had had "stirrings" and his new relationship was working out.

The doctor exposed her anxieties about seeing men and about difficult work and clinic situations.

She said that in life you can adapt or die but the Institute doctor, like an invalid, can walk with a wide stance supported by the Institute on one side and peer supervision on the other.

The following discussion was around the value of working on a 'hot' case as it presents, as opposed to one which has been waiting several months on a waiting list. The work was very different in each situation.

Dr. O'Brien, who spoke next, had been thrown "In at the deep end", accepting a job in a new psychosexual clinic. It was held in a chiropody

room and the clinic secretary was unhelpful.

Gary and Sarah had referred themselves. She was sullen and he did all the talking. He had been sent. They had been investigated for infertility but Sarah had lost interest in sex and they were a couple at war with each other.

There followed a cancelled appointment and at the next interview sex was not mentioned.

The doctor became aware of her dependency on her seminar group. She felt shut out by the couple, they said nothing about feelings. In the next session as they argued she banged the table top and told them to stop. She did not understand why she had been so angry or needed to show it.

When the vaginal examination was suggested, Sarah said to Gary, "You get out", and he did. Sarah refused self-examination and told the doctor to get on with it. The doctor asked if love-making was like that. Sarah shed tears: "I've never been alone, I've always had someone to take care of me". She then got busy dressing, as if softness was a weakness. The doctor put this back to her.

Sarah said she wanted to be left alone. The doctor felt deflated, failed.

The next time, Gary was seen alone as Sarah was sick. Gary described how love-making usually ended up as a marathon. His retarded ejaculation was a way of holding back. He also mentioned his low sperm count for the first time.

Sarah's sickness proved to be pregnancy and everyone was pleased. Dr. O'Brien felt they had all been saved by the baby.

With reluctant patients there is no winner.

Dr. Mary Gabbott followed with "With my body I thee worship".

Geoff was 52, married, and complained of partial erection and impotence. He was on medication. He was tall, taut, wary and cold, like a cobra. His wife had all the menopausal "rubbish" and he always had to ask for sex, it was that or rape. He said the doctor must be thinking that he wanted to rape someone, but half his workforce were women and he wouldn't get away with it. He gave the doctor a dissertation on fear of loss of control.

The doctor felt too scared by his anger to think. There was fear of violence.

The next time, however, looking subdued, he described how he had forced himself on his wife, once. He could never face that humiliation again. He was comforted by the doctor. As he left the consulting room he made a remark as the door jammed, about them being stuck in the room together. The doctor felt de-doctored and thought, "He's not impotent!"

The next time, he complained of pain and the doctor referred him to a GU colleague for tests — was this flight from the problem or

genuine? When she examined him he tapped his head and said, "It's all up there".

The GU surgeon suspected a vascular cause for his impotence and offered injections. Afterwards, Geoff said it had been ghastly, but it had to be done, he felt strangely peaceful, maybe he could now have the opportunity of being himself. Did he now believe that although not physically potent, he was still a man?

The doctor had unease with the patient's anger, the fear of violence and the sexualising of the doctor/patient relationship. The man had come to terms with his problems only after accepting that formal medicine could not help. Had the doctor, as a wife, been used to increase his self-esteem in response to the fear beneath his bluster?

There followed a hot debate about whether patients should actually be physically comforted or whether the need to comfort should be used for discussion and interpretation.

Should the male examination be carried out with the man lying down or standing? Standing was felt to be more physically useful but lying down put the man in a more infantile position and perhaps more readily led to the moment of truth.

At the end of the session there was a tribute to Dr. Davies for being brave enough to show the importance of concurrent problems with employees, life and work.

In the afternoon **Dr. Sonia Robertson** opened with "Saying no to referrals".

Dr. Robertson had a referral of a student with problems of impotence. He was relaxed as he spoke of his loss of interest in sex with his girlfriend and his masturbation with drugs and women's clothes. The doctor, however, was uneasy. This was a situation where the referrer was more worried than the patient and felt better by referring.

Perhaps we should only see the patients we feel we can help and not feel guilty about saying "No" to the others.

Dr. Robertson proposed that this could be done by discussion with the referrer using guidelines related to good prognosis, the patient performing well in other areas of life and anxious to get better. Where there is a personality disorder, passivity in interview, increasing age and chronicity or homosexuality or transvestism, the outlook is poor.

There are warning signs too if the doctor is too eager to make a referral. The doctor/doctor relationship becomes important and it may be better just to acknowledge to the other doctor that it is awful to be left holding a problem. Dr. Robertson gave examples of discussion with doctors who had referred inappropriate problems where it became clear the doctors had felt guilty and inadequate about not helping, or had run out of ideas and were keen to pass the patients on. Psychosexual counselling was not necessarily the answer and in one case Relate was more appropriate.

Dr. Robertson also spoke of the difficulty of getting referrals from her GP partners where there were pressures to be helpful and successful.

These ideas raised many opposing opinions; sometimes referrals are suitable when they do not initially appear so and perhaps everyone should be seen once; homosexuals have psychosexual problems like anyone else and labelling stops the doctor thinking; even hopeless cases may be helped to come to terms with their problems; sometimes a psychosexual problem was suitable but the patient was not ready yet.

In summation, each one of us must be conscious of our limitations and decide if we can help, and not offer treatments outside our specific limits.

Dr. Caroline Albiston continued the theme with "The reluctant referral". Some patients come so that they can say, "Look how hard I've tried". They come to satisfy someone else and not for themselves and have no motivation to improve. Patients who feel judged by their partner feel judged by the doctor and we may never find out why.

1. She told of a man whose marriage had not been consummated and whose wife was parted from him until he improved his sex life. He had lost interest. Vaginas disgusted him.

2. A lady had been brought by her husband to have her vaginismus cured, for his benefit. She kept the doctor out, like her husband. The doctor hoped she may be ready to seek treatment for herself one day.

3. A girl was sent by her boyfriend because she was refusing sex. She said her brother's friend had touched her vulva when she was a child. The vaginal examination had felt like abuse. If she had got better she would have had no excuse to refuse intercourse. She did improve, however, when she came for herself, not for her boyfriend. She said she had always allowed other people to tell her what to do but when the doctor had sat in silence she decided she would have to do something for herself.

4. Another lady had been treated unsympathetically by a doctor during a vaginal examination ten years previously. She had seen two psychosexual doctors because of her refusal to be examined. This doctor was solicitous but could not persuade her and suggested she might like to return for psychosexual counselling later. The patient made the appointment for herself and said that people pressurising her had made her determined not to give in. She allowed examination on this occasion. If you stop trying to help, people accept help for themselves. It is uncomfortable in any case offering services not solicited by the patient.

The discussion again centred on referrals. In a self-referral clinic where problems come to light, there are no reluctant patients. A referral puts pressure on the patient and doctor.

In Nottingham, where all the patients on the psychosexual waiting list were written to, 70% did not want to come for an appointment.

Suggestions were made for testing the motivation of patients, such as asking them to phone for or confirm appointments. When to start or stop in counselling could be the subject of a research seminar but ultimately had to be decided with the patient.

Professionally we should be clear about what is offered so that if necessary an avenue can be closed for the patient. Can only 'hot' problems

be treated? We were challenged, "What makes you think that dealing with referrals should be easier than anything else at the Institute?"

In the Saturday group work each group found its own style and identity.

Sunday was devoted to the study of child abuse.

Dr. Hanna Backer opened the session with "Child abuse: who is the victim?" She gave case histories to illustrate her view that children who are abused in a loving relationship, and who are never hurt physically, may have a good prognosis. Those children who are abused without respect and with violence have a poor prognosis.

Dr. Backer also pointed out that although sexual abuse happens under varied circumstances, it is unfortunately dealt with universally by the abuser going to prison.

1. Mary had a loving relationship with her abusing father but was angry with her mother who had told her to continue the relationship when at the age of 22 Mary had wanted it to stop. Vaginal examination was normal and self-examination comfortable. Mary eventually made good progress.

2. Clare had been scared of her abusing father. He had been a drinker and was violent towards Clare and her mother. Clare had led a promiscuous, wandering life and trusted no one. She refused vaginal examination and never returned to the clinic.

3. Helen had never been her mother's favourite child and was blamed for her mother's divorce and change in circumstances after it was revealed that Helen's father had had intercourse with her. The family split up and Helen lost the person she had always loved the most, her father.

The importance of the vaginal examination was talked about in the following discussion. Where previous child sex abuse had occurred in a loving relationship there was often a normal examination. The violently abused were difficult to examine, if at all. They felt dirty and often found solace in safe homosexual relationships. Heterosexual relationships were often unsatisfactory as the adult recognised with guilt the sexual feelings in the illicit childhood relationship. In all families which are split up, all are in part guilty, in part victim, and in need of help.

In "Fearful futures", **Dr. Anne Morgan** looked at a series of adult victims of child sexual abuse in which sexual intercourse had taken place. The ability to recover was linked to the quality of the relationship with the adult.

She presented case histories relevant to this.

1. Denise presented with lack of interest in sex having been sexually abused by her brother. When she had told her mother about it, her mother had said she had a wicked imagination. She felt dirty and angry with her mother and was still being treated.

2. Ruth complained of lack of libido since the birth of her child five years earlier. As a child she had been disbelieved by the rest of the family when she complained that her stepfather had abused her and

she was sent to live with her aunt. When the abuse was proved her mother and stepfather separated. Ruth refused self-examination but eventually recounted how her overwhelming jealousy of her stepfather had led him to desire her. She improved, although she felt that her mother had failed her and she had doubted her own capacity to be a mother.

3. Sally was living with her boyfriend but was not interested in sex. The only girl in a family of boys, she was expected to do the housework and was sexually abused by her father, her mother being away much of the time. Sally was angry with her mother and fearful of her father. She could have asked for help but could not hurt her father. She left home at 18 to live with her boyfriend who was very understanding yet angry that her family had made her a victim and not cared for her as he would. With this support Sally was able to grow and assess the situation as an adult.

4. **Dr. Joan Coombs** then spoke about Julie who had been referred to her and had greeted her with, "Are you Joan Coombs?" at the first meeting. Julie was already attending group therapy and talked without prompting at the first interview which lasted over an hour. Interventions had been impossible. Julie had been encouraged by her social workers to write down her feelings which she insisted the doctor must read. It was like popular light fiction describing the sexual abuse by her father and including a painful, venomous letter to her father.

In the next session the doctor felt unable to get close to Julie's feelings as Julie was so damaged. She was still a demanding child but the doctor said that she was not going to be her mother. Dr. Coombs offered a four week appointment. Julie was angry, she had expected better than this — the doctor had failed as a mother. Julie had not heard her disclaimer.

When Julie did not attend next time Dr. Coombs wrote to her and received a reply beginning, "Dear Joan". Julie said she was not in need of sex counselling, she had an emotional need. She could not find the technicalities of the vaginal examination helpful. She had been upset by Dr. Coombs' feelings of revulsion at her letter to her father and could not handle this rejection.

Dr. Coombs saw that Julie rejected people before they rejected her and that she had been rejected by her parents at a time when her father became sexual with her. If the problem was sexual abuse, could Julie have coped better with containment and denial? Have therapy rituals harmed or helped? Was the doctor wrong to abdicate from the role of surrogate mother? Is mothering only useful when it comes from the real mother?

Dr. Tunnadine then reviewed the whole meeting and discussion continued until lunch time. She said that what is missed in sexual abuse stories is the doctor/patient relationship. Child sexual abuse is a new topic and the task is forgotten. There is too much listening at the expense of thinking and making interpretations. The anger in the doctor/patient

relationship is often to do with the mother. Someone who has been abused has had their capacity for loving destroyed and we feel it in the doctor/patient lack of relationship. Sometimes, however, child abuse may be used as a visiting card for other problems.

Many feelings and experiences in working with the sexually abused were shared.

On the subject of touching and cuddling, if the Institute is revolutionary, it is about body contact, the vaginal examination. It is a precise diagnostic entry into the patient's attitudes. Even refusing is a clinical event. Is cuddling a clinical event?

Again there was the question of boundaries. The Institute trains in a precise, limited technique and if we work in a designated psychosexual session taking referrals, we must do something precise and defined.

Dr. S.M. Searle
I.P.M. Associate

Dr. M.E. Leng
I.P.M. Associate

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DR. MARY GABBOTT: A DEFENDED CUDDLE

Cardiff attenders will recall the lively paper after which this doctor defended her "cuddle" of a male patient — though she and I agreed later that to interpret the doctor/patient relationship which tempted her to do so would have been better still! Indeed, since perhaps our chief true breakthrough in applied psychoanalysis is our application of it to physical doctoring of the genitals, this common evocation by patients of our temptation to express physical tenderness would be a fruitful field for future study. It does however of course require doctors having courage to report such "shameful" goings-on, to colleagues who would respond with professional examination, rather than mere attack.

All members will wish to join her colleagues in Kent and in the Sussex seminar in wishing her as complete and speedy as possible recovery from the dreadful road accident she suffered before Christmas. We hear it may be a year before she is ready for full work, but we at Ditchling do not plan to spare her incisive and provocative contributions for as long as that. Every group needs someone like her!

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

A CAUTIONARY TALE OF A CALAMITOUS CUDDLE

At the Cardiff Scientific Weekend (1989) the subject of 'therapeutic cuddling' was raised.

I occasionally hold a patient's hand or touch their shoulder, but I have only once given a patient a real hug and cuddle, and that was years ago. It quickly became apparent that she had strong lesbian feelings, unacknowledged by her and unrecognised by me. She became over-attached to me, and although she struggled with her feelings she eventually required psychiatric help to disentangle herself.

Despite moving house three times since then I receive a regular Christmas card from her, on which she puts nothing but her name. I hope she is happier, and I am grateful that she puts no address, thus demanding nothing from me.

Every year, at the season of goodwill and love towards all men (and women) her card reminds me of a serious clinical misjudgment, when I acted on strong feelings in the consultation instead of pulling back and thinking about what they might mean.

Dr. Ruth Skrine
I.P.M. Member

GRIEF HINDERING SEXUAL MATURITY

Sally and Angela: two cases where issues about grieving had to be faced before other work could continue.

We were asked by our editor to think about cases where grieving had been part of the distress brought to the doctor. As I began to do just that I remembered these two girls (yes, girls, for that is how they presented themselves), each losing a parent at a very critical time in their life, one needing help in allowing herself to express her sadness, the other permission to lay it aside. This needed to happen before we could begin to look at all the other issues that related to moving on to accepting their adult sexual selves. I remembered how parental I felt, and thought what a handicap it can be for someone to be without the real live parent at this particular stage of personal development, involving as it often does a temporary loss of the surviving parent as well.

Sally of the broad shoulders

Sally was a picture of health, a very likeable warm, young teacher who slipped into an easy relationship with the doctor and began to tell how she had very gradually gone off sex over the last three years. It had been great at first — indeed, they had been so active they wondered if other couples were like that too — but now, "It's disastrous, we both know I'm just gritting my teeth every six weeks or so. He says it's just tiredness but I know I'm holding him at bay". She told me about their courtship and how he first noticed her from behind, thinking he had never before seen any one with such broad shoulders.

I was puzzled by her description of him as a "dear little chap". I heard about the slow waning of the original excitement, about her work and

about how neither of them wanted babies — "Well, not yet, because I'm not ready to give up work and look after it properly". Then gently on in the same matter of fact tone, to how mother had worked, but then she had been forced to do so, because father and grandfather had died very suddenly within a week of each other; father from a coronary, grandfather collapsing with a C.V.A. at the funeral. I heard how mother and gran had then expected her to slip into father's shoes and be the strong practical person of the household, mending fuses, sorting out bills, etc. I murmured that that must have been very difficult when she really just wanted to cry and grieve like a small child — but still no tears came . . . We went on to draw some parallels about needing to be strong now. She said, "I like to be in control — to be on top" (and as was so often to happen with Sally it was hard to know if she was talking about sex or life in general). "I used not to be like that — I'm too domineering now". I suggested perhaps she was afraid, so stayed in control to stop something happening; and commented on how she hadn't felt able to let go today. I asked if she wanted to come and talk again.

(When reviewing I had a wry smile, for scribbled under my notes was: "I found 40 minutes was enough — what about her?").

I learnt on her return that, yes, indeed she left me feeling very heavy herself and she had had to organise a quiet period in school to stop and think, because she hadn't shared her feelings like that for a long time. (Surprised doctor: if 'shared', then certainly not shown by her. But then, how much of the doctor/patient relationship is experienced like that, unspoken, undisplayed, beneath the surface defences?). "I thought about how I needed to call Peter a 'dear little chap' — and I was so relieved that you hadn't told me to pull myself together: I am telling myself that all the time".

She let us look at the anger she felt at the way Mother and Gran were needing her strength one minute, but the next were telling her to "be careful", to be sure to come home early when out with the boyfriend, and how they disapproved when she and Peter began to live together before marriage. Then at last she let herself talk about her relationship with the missing men, and slowly the tears began to flow — "So silly after all these years". She could accept losing Grandpa, but Father was only 50, had so much to live for and anyway she was his "special". They shared a stubborn streak and had little secrets, like smoking in spite of Mother. "He would have been so proud of me and the work I do now" — and then she really did let go and wept and wept. After a while she said, "I used to think it was weak to weep, but my colleague lost his wife recently, and I did so feel for him".

(Ah, thought doctor, that's why you've presented now).

Once this delayed mourning process had begun she really settled down, and in spite of it, started to work on all the other issues, including her need to baby Peter. She began to find that sex could be fun again and, as she allowed herself to stay in touch with her more childish needs, she said that she had decided Peter was a big boy now and she was blown if she was leaving meetings early to rush home and look after him.

Angela: "with the debt to pay"

The referral letter asked me to see this couple "who are having problems with intercourse". But it was Angela who crept quietly into my room, a pretty young woman with close cropped, blonde hair and wearing a crisp loose cotton frock. She might have stepped straight from a Mothercare catalogue. I noted with surprise that she was already 31 and had a two-year-old child. There was an irritating blink-cum-flutter of the eyelids and throughout our contact I was aware of her need to please.

"I don't have any feelings at all — I don't even want him to kiss me". I heard that sex had been fine until about six months before marriage: "You see, that was when my mother died", and her tears began to tumble, as they did for most of that first session. Mother, or rather adoptive mother, had been an invalid for many years, with rheumatoid arthritis and heart problems: in and out of hospital many times. Angela remembered so well the last admission: "The nurse tried to tell me how ill she was, but I had heard it all before and she was always out again by the end of the week. But this time she went into a coma — if only I had listened — there was so much I wanted to tell her. My father went completely speechless and left me coping with phoning relatives and arranging the funeral. My wedding was only a short time away and they all expected me to cancel it and were shocked when we went ahead as planned. I still can't visit her grave because I get too upset . . . You see, she never knew me as a married woman".

She went on to tell me how her mother had not told her anything about sex and had not prepared her for marriage. She had said, "Be careful" in meeting exciting boyfriends and had liked all the "safe" ones. I dared to ask which sort she had married. She began to reply, "The safe —" but then changed her mind and said, "Of course, she didn't know we were already having sex". I heard what a marvellous mother she had been and how hard Angela was trying now to be good at all the homely skills mother excelled at — and of course, about how being adopted made her feel she owed something to her mother. I asked if it would be difficult to return here and trust another older woman who might not always be there? She replied, "Funny you should say that: my mother-in-law is always trying to take her place, but I can't let her".

She returned to say that she felt as if a load had gone. She realised that she had a long way to go, but they were making love again and maybe in time she would be able to stop holding back as she knew she still was at the moment. We talked of the grief again and something — no, of course *someone* — made the doctor comment that sometimes people need permission to stop grieving. Angela then began to tolerate looking at her sexual needs, at her longing to be able to seduce him, and how she had started to lose that weight so that she would look more like the carefree person that she said she used to be.

She said that she didn't think she would need the other appointments because she thought she was going to go on getting bolder in her own time, and anyway they were moving away as her husband had finished his course at the Poly. I felt glad that she didn't want me with her as she re-entered her adult sexual life; but anxious enough to give her the name of a colleague in

her home town in case! As she left she said, "You know, I came here feeling that I owed an enormous debt, and you somehow offered to pay it for me".

Dr. J. Tisdall
I.P.M. Member

A BROTHER'S SPIRIT LIVES ON

The referral from Barbara's G.P. said, "This girl has had lack of libido for about two years. Her brother died of leukemia two years ago. This may be significant. Can you please help".

The girl was a young-looking 27-year-old, wearing a tee shirt and trousers, with a restrained expression on her face. She and her boyfriend, Paul, lived in their own house. It was a long stable relationship. But for the previous two years she had had no sexual feelings. Everything was numb, she said. She enjoyed a kiss and a cuddle, but then she would pull away from her boyfriend at the thought of sex.

Barbara told me then of her brother Graham's illness. He had died two years ago. He was an idolised elder brother who had always been the 'centre' of the family. He was fun and everyone looked up to Graham. Barbara visited him every day for six months during his illness and sat by his bed. As she told me this she fought away her tears. Then she said, "Why did he have to suffer so much pain?", and the tears flowed briefly. Her grief and the sadness in the room were overwhelming. But I did not feel that I could touch her to comfort her, nor move closer to her. I felt like an intruder, coming between her and her dead brother.

The tears were soon controlled and I told her how I felt, and that perhaps her boyfriend had felt an intruder too. Her brother was still very much a 'presence'. For a few months after Graham's death, she felt he was watching from the corner of the bedroom, she told me. He would have been 35 years old, and Paul was 36 years old.

"It must be difficult to lose hold of someone you have loved so much?" I commented. "Perhaps you are not ready to let Paul take Graham's place in your affections yet. As they were the same age it must be difficult not to make comparisons?"

Then Barbara told me of her regular visits to a clairvoyant with her mother. They were desperate to keep in touch with Graham, and to know that he was not suffering. "But at the same time you are keeping Paul 'out of touch'. Perhaps he feels as I feel, that he must not get too close, while you are still clinging on to Graham?"

Barbara seemed to understand. In spite of the intense sadness that she felt, her feelings were well controlled during this consultation after the initial tears. We began to get nearer to them when she thought about Graham's suffering, and she cried briefly, but then a barrier came down. It was the same in bed with Paul. A kiss and a cuddle and then the feelings were pushed away.

This was a long interview with a lot of silences. Barbara seemed to be a young girl whose brother's spirit was still haunting her and preventing her

from being a normal, sexual adult. It ended rather matter-of-factly, but Barbara put out a hand for me to shake as we parted, and she smiled. Was this to reassure me that I was not intruding after all?

Barbara returned a few weeks later. She was relaxed and happy. She talked only of her boyfriend. She had become very "emotional" with Paul after her last visit, she said. Her sexual feelings were now back when she was with Paul. I commented on her not having mentioned Graham this time, and she told me that she had not been to the clairvoyant since her last appointment. She had understood how these visits had stopped her from getting on with her own life. She was now able to accept that Graham was no longer central to her life.

It took Barbara two years to seek help for her sexual problem. Perhaps she needed those two years of grieving for her much loved brother, and perhaps she needed someone to allow her to stop grieving and that it was not wrong to do so.

Dr. R. Bradbury
I.P.M. Member

PUTTING A BRAVE FACE ON THINGS

"Could you see a couple for psychosexual counselling today? I saw them for assessment interview yesterday. He is on two weeks holiday — he would find it very difficult to come when he is back at work". The Social Worker had stopped me in the corridor. I wondered about the wisdom of two sessions so close together, but found myself agreeing to see them.

She told me a bit about the case. Stephen's wife had died two years ago after a long fight with cancer. He had met his new partner, Helen, five weeks ago and found that he couldn't have full intercourse. He could get an erection but did not ejaculate. Helen is divorced with three children. She is willing to work on the problem with him. She finds their sex life satisfactory. Stephen's only child, a girl aged seventeen, is still living at home. These were the bare bones of the case.

So, later that afternoon, I called them in from the waiting area. I called his name, but they chose to come in as a couple, Stephen and Helen. I can't remember how either of them was dressed at our first meeting, but I remember his tight face and her air of quiet confidence. I invited him to sit at the side of my desk and found myself drawing up a stool for her next to me.

To my opening gambit of "Tell me about the problem", he said, "I can't make love", but she quietly corrected him: "You can make love", she said, "but you can't come". "Can you tell me about it", I said. "What do you want me to say?", he said between clenched teeth, "What do you want us to do?" During the silence that followed he blurted out, "I don't feel guilty" and Helen, sitting beside me, said, "I get on very well with Stephen's daughter".

It was like getting blood out of a stone. Slowly, I dragged out the story of his wife's death: "I don't want to talk about Kay". However, his anger

burst through: "She was too young to die". He was angry with her too for neglecting to report the lump in her breast. She had known about it for months before she sought medical advice. When he told me that she didn't know the diagnosis I couldn't hide my disbelief. He had stuck to his fantasy because "she would have lost the will to live". I asked specifically about sex when she was ill. He had wanted to love her, but she rejected him.

He wasn't going to tell me about his feelings. When I pointed this out he said, "That's how I am, I put a brave face on things".

I made him talk about Kay. He sat there with his pent-up anger, shooting glances at his new love at my side, glances that pleaded, "Help me — get me out of here", but Helen didn't stop me. She was my quiet ally.

When our time was up, he said he would come again, but he wanted Helen to come with him and she nodded her assent. He couldn't get out of the room quickly enough. I held out my hand. For a moment he hesitated, then shook it.

When we met the following week, I hardly recognised him. He was smiling and it struck me what an attractive man he was with his green eyes and fair hair. Helen was wearing a dark red dress which was very becoming.

"How are things?" I asked. "Fine", he said, "I've done it". But that wasn't enough for me. How often, I wanted to know, and what did he think had happened? They had made love twice successfully, he told me. He had felt that a pressure had been taken off him. Helen added that after seeing me they had talked a lot about Kay. Stephen told her something that he hadn't been able to tell me. Not only had he had to live this awful lie, not only had she rejected him sexually, but in the last phase of her illness she had chosen to stay with her sister when she came out of hospital for the last time.

When they had gone I sought out the Social Worker who had recognised the need to help Stephen while his problem was hot off the press, I told her the good news and we did a little jig in celebration.

Dr. B.Z. Davies
I.P.M. Member

A CASE OF UNFINISHED BUSINESS

A 32-year-old woman was referred by her Family Planning Clinic doctor for loss of libido of about one year. The referral letter had questioned whether the termination of a pregnancy could have been the aetiological factor. The patient, who was a professional press photographer, was a little sad in demeanour and lacking in vivacity, but very articulate. She too wondered if the termination was relevant to her sexual disinterest. She was on the brink of tears as she began to present the problem to the doctor but soon gained control and was able to discuss very rationally her decision not to continue with her pregnancy, of which she became aware while taking photographs in the war-stricken area of Ethiopia!

She returned to Zimbabwe, where she and her boyfriend, who is a

geologist, had been living and working for a time. After discussing it with him she flew to the U.K. for the operation. She felt that it was the right decision because the relationship with the potential father had been brief and she did not feel ready for bringing up a baby in view of her professional lifestyle.

The sexual relationship with her boyfriend had been mutually rewarding until then, but now she never felt that she wanted to have intercourse and never enjoyed it fully when she did. She was puzzled why this could be, because the relationship in all other ways seemed to be giving no problems. They had now moved back to the U.K. and were both employed and shared a house together. They had both had other long-term relationships, but this one for her was the most satisfactory except for her poor sexual libido.

She went on to tell the doctor more about her life and work and how she had been banned from Zimbabwe because of political problems over some of her work. The ban was very quickly lifted, but nevertheless it was a great shock at the time. It probably was a factor in the decision to return to England about seven months ago. The doctor pointed out how barriers seemed to have been put up around her and she said, "I do not even seem to be able to talk to my friends as I used to. There seems no point".

At this moment in the consultation the atmosphere was such that the doctor said, "It sounds to me as though you feel that you have been kicked in the stomach". Then the tears fell as she said, "Well, you see, my mother died. I came home from Africa three months before she died, but she had never told me how ill she was. She was a really super and interesting person and often used to write to me while I was away. She would not have wanted me to have left my work and come home, which is probably why she did not tell us that she had cancer. I cannot talk about it to anyone because my sister has had post-natal depression recently and my father manages very well, but I do not want to upset him.

The tears were settling so that the doctor could interpret the unfinished business of mourning which was being re-lived since she had come back to England, and that it was painful to her again because always previously when visiting England her mother was there and she could enjoy her company. Putting this woman in touch with her unfinished grieving may help her to understand her loss of libido and to be able to complete the mourning process.

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

TOO RISKY TO TRY AND TO FAIL

Dear Doctor,

re: Mr. & Mrs. G.

After our discussion about your patients, I thought you might be interested to hear, in some detail, the result of my two interviews with them.

At the first interview I found that Mrs. G. tended to do most of the talking and Mr. G. to be diffident and hesitant, even when invited to speak — a mirror of their problem?

The presenting symptom was his premature ejaculation. Fear of failure had led to the virtual cessation of any attempt at intercourse. Although she expressed sympathy with his problem, Mrs. G. was obviously fed up with the situation. She wanted and expected to be made love to, yet at the same time was not going to make the initial move as she felt he ought to want to make love enough to approach her first — an impasse!

It is Mrs. G.'s second marriage and she is appreciative of Mrs. G.'s greater sensitivity and kindness compared with her first husband. Mr. G. in turn expressed his affection and love for her and they both obviously want the marriage to work.

As they talked I was aware that Mrs. G. is the dominant character who makes most of the decisions. As the only child of a father who, amongst other things, taught her to strip down a car engine and to be largely self-sufficient, she has tended to belittle and be impatient with her husband's unskilled attempts at D.I.Y. (for which he admitted no real aptitude) even before he starts a project, thus indicating to him the futility of his unskilled attempts at sex even before he starts. His opting out is not therefore surprising! She was quite happy that he should do most of the mundane domestic chores during the evening, however, with little expression of appreciation for his help.

On reflecting this back to her she was chagrined to hear put into words what effect this was having on her husband. He equally realised that his difficulty in expressing the resentment this gave rise to was merely compounding the problem.

The first interview ended at this point and they went off to think about what had been discussed.

They returned three weeks later looking happier and had made love on a few occasions. They said it had been helpful to discuss in a 'neutral' atmosphere certain things which otherwise each would have felt unable to say about the other.

I had indicated at the outset that I was not there to apportion blame, but rather to try and gain an understanding from the feelings engendered in the consultation of the way they were reacting to each other in their daily lives and interpret this to them. It was then up to them, if they felt these rang true, to make the changes needed to improve matters and this they had begun to do.

During this second interview, although we tended to go over some of the same ground as previously, Mr. G. was noticeably more ready to have his say. Mrs. G. said it had been quite upsetting and painful to realise that she had had a large part to play in Mr. G.'s difficulties, but she was beginning to learn her lesson!

We made another appointment for a month later, but Mrs. G. rang to cancel it as she felt their problem was now solved. She would get in touch

should they need further help. Although some improvement had occurred, she still has to be the manager.

Yours sincerely,

Dr. E.A. Hood
I.P.M. Associate

THE CHARISMATIC CARER AND THE PARALYSED DOCTOR

She came through the door of the clinic looking as if she had stepped out of a pre-Raphaelite painting: flowing tawny hair, beautiful, long skirt and leather sandals.

"Mrs. M. said I might have a word with you. I work with her". This group of people work together as very professional carers. They are intelligent, articulate, professional and 'good' in the best sense of the word. I felt anxious.

She said she was going to see a gynaecologist in about three months and wanted to know what he might do or say. She had had a vaginal discharge for several weeks and it had been treated by her G.P. with pessaries.

"It's so messy", she said, and one tear rolled down her cheek.

"This is a psychosexual problem", I thought. "Is there a problem with intercourse because of the discharge?" I asked.

"Yes", she said, "It's terribly sore."

'This is a psychosexual problem', I thought.

Her G.P. had suggested this was a menopausal problem. I was amazed; she looked about 28. She told me she was over 40! She wondered if her sterilisation a few years ago could have triggered the menopause as she had had sore breasts continually for six months after the operation.

Thankfully I took flight into the mechanics of tubal ligation and the symptoms of the menopause. I felt more relaxed.

She didn't look much more relaxed.

'This *is* a psychosexual problem', I thought.

I said that sometimes there were problems if people regretted sterilisation. She said she understood that and had thought very carefully about it, but she didn't regret it.

I said that the menopausal vagina was sometimes sore and dry and this could be seen on examination. What had her G.P. said, when he examined her?

He hadn't examined her. I offered to examine her, not with total commitment, I suspect. She declined; the gynaecologist would be examining her soon, and anyway she had a period.

'This is a psychosexual problem', I thought.

She wanted to know what the possible diagnosis and treatment were. I fled into explanations about infection.

"Anything else?" she asked.

The pressure was intense.

"Well," I said, gathering courage: it was now or never, "sometimes when you are cross or angry with a partner it can be expressed as a discharge or soreness".

Silence.

"Yes", she said. "I see your point. . . . How would I get help with that?"

Surprise left me at a loss for words for some moments. I gave her all the local options, with myself bottom of the list. I knew what I had done and rallied by saying I would be very pleased to see her if she would like to come back to see me.

She said she would go to the gynaecologist first, but added, "I may well be back, I may well be back".

She gathered her soft leather sac and left the room.

Dr. S.M. Searle
I.P.M. Associate

A TURNING OF THE TABLES

Mrs. H. is a 60-year-old vicar's wife of German extraction. She has been my patient for about a year and seen me mainly concerning her thyroid condition. In previous consultations she has made me feel inadequate and I felt incompetent since the day she had asked me if the needles I used were blunter than those of the doctors in her previous practice! Her consultations always seemed to take the form of my trying to get all my blood reports together in a frenzied effort to explain the overall picture to her, stuttering nervously as I did so.

It will therefore be no surprise to you that I was not feeling confident when Mrs. G. entered the room last October. I seem to remember hurriedly getting out her latest thyroid result in case I had got it wrong again, and straightening up the few things on my desk so that it would look tidier and more orderly.

I was somewhat pleasantly surprised that this time she had come about her sore throat and I was hurriedly writing out a prescription for penicillin when I realised, glancing over her notes, that we did not have a recent blood pressure reading, or indeed a recent smear.

On questioning her about this, she told me that she had had a hysterectomy some years ago, and then continued to tell me that since this time sex had been difficult and she wondered if she had been stitched up too tightly during the operation, as her husband felt that he could no longer get fully inside her. She mentioned that she felt quite guilty about this. She had said to the gynaecologist at the time of the operation that she wanted everything to be fixed, in particular her prolapse, and that it didn't matter whether or not she could have sex afterwards as she and her husband were becoming older and sex was no longer important. Now she wondered if these had been careless words.

I listened somewhat spellbound as the tables turned and she became the more vulnerable person in the consultation and suggested that it would be best if I examined her to see exactly what her vagina was like.

She became quite agitated and explained in her stilted German accent that she could not possibly stay for an examination as her bus was about to leave and that she must hurry. I explained that the examination did not have to be today, but that it would be the best way of assessing the situation and perhaps helping her with her problem. She thanked me very much and left as quickly as she could taking her prescription for penicillin with her.

After she had gone I thought a lot about the consultation and wondered if she would return or whether she would choose to see one of my partners in the future. I recall having felt embarrassed talking about sex to a vicar's wife — and was left feeling a rude doctor who had frightened her away. I was quite surprised when a month later she turned up again, this time with pain in her shoulder which I examined and explained was probably a touch of arthritis. We discussed the pros and cons of treatment for arthritis and she felt that as long as she knew what it was she could happily live with it.

While examining her I wondered if I should bring up the topic of her vaginal examination. I had decided to let sleeping dogs lie, when she said to me, "and, doctor, you promised you would examine my vagina today". I felt as if a weight was being lifted from my shoulders and happily agreed to examine her. She was relaxed during the examination and the vagina felt spacious and normal for someone who had had an anterior repair and hysterectomy.

I explained to her that I had inserted two and three fingers into her vagina and that she seemed to feel quite comfortable. She looked at me and asked, "But why then, when I have longed for sex, has it been so difficult?" I asked her what she meant by "difficult" and she said, "Oh, maybe it's just that my husband is clumsy". I allowed her to get dressed and asked what she meant by clumsy. She explained that when they had sex, often he would seem to miss the vagina and go too high or too low and it felt clumsy. I wondered if she had ever helped him or guided the penis. She said no and blushed.

We talked of her longing for sex and agreed that this was normal feeling for someone in her sixties. I said that I would see her again if she wanted to talk further.

Reflections

I was left wondering at the powerful changes during both consultations. At first the doctor was very much the underdog, being made to feel that it was not appropriate to talk about sex to a vicar's wife, then suddenly as the doctor struggled on, the roles reversed revealing a patient so vulnerable she could not possibly stay for an examination. Again in the second consultation the doctor was faltering — could she be brave enough, or rude enough, to mention sex and the patient's vagina one more time? — when suddenly the whole unmentionable subject was taken out of her hands by the patient baring her innermost thoughts.

At present I am awaiting her return, eager to share with her, her progress.

Dr. Valerie S. Whitaker
I.P.M. Associate

WHEN A CARER NEEDS CARE . . .

I felt sure that I had, at some time, met Mr. B. whose G.P. had suggested he discuss his problem with me. I *had* met him, he reminded me, when I had talked to a group of social workers on attitudes to sexuality.

Mr. B., a senior social worker, had recently opted to take early retirement, at 62, because of management changes and he had looked forward to a normal and happy relationship with his wife; but he is impotent. He had never been a satisfactory lover to his wife of more than thirty years as he had never managed to give her an orgasm, and now he rarely manages an erection.

He had read recently about injections to cure impotence and his hope was that if he could present his wife with a potent penis she could be able to use it to her satisfaction and that would make him happy too. What about all the years when his penis had been potent and she had not been able to make use of it to reach an orgasm? Had anything changed?

He had not come to criticise his wife when she was not present to defend herself. She might see things differently. She *did* not know about this visit. Neither had he come for a shoulder to cry on, he added, with a choke in his voice.

He was so obviously discomforted, this slimly-built man with a deeply-lined yet kindly face. I said how difficult it must be for him to seek help for a sexual and emotional problem. He was looking for a practical solution to his impotence but his associated problem of "never having got it right" might not be resolved if he concentrated on physical treatment only.

We shared the irony of the erstwhile helper "who is supposed to have all the answers" now being in need of help. Could this be the reason for his apparent acceptance of the total responsibility for his wife's dissatisfaction, and his reluctance to apportion any of it to her? Perhaps *she* might have difficulties with fear of losing control? After a period of silence he remembered that once, years ago,, on returning home after an evening out, she had said, "I wish I could just throw myself on the bed and forget about everything, but it wouldn't work with you". "How hurtful!" I interjected; but again he parried by commenting that perhaps she had married the wrong man. She seemed to have formed this idea when she took up a new job, about two years ago, involving younger women who were uninhibited in discussing their sexual activities. Impotence began to become a problem about that time as she implied that he did not know how to make love properly. She charged him with doing it for his rather than her satisfaction, yet she was not prepared to co-operate with any of his attempts to make things better and appeared merely to endure his approaches. Waiting for her to approach him as she had requested did not

work either.

He said that years ago he had considered counselling when he had been blamed for "not getting it right", but then as now she had considered it to be his problem and he had felt it would have been unproductive if only one of them had attended at that stage. He had felt that because of her naiveté with regard to sexual matters it would have caused her embarrassment to pursue it further. (That it might also have involved personal loss of face for him evaded my thoughts).

I felt an exasperated protectiveness towards him and suggested that these were the feelings he had towards his wife. For this reason he had felt the onus on *him* to make sensible emotion-denying decisions about injections to his penis and that it was up to him to make things better. At this the emotion he had barely managed to contain caused his lower lip to tremble and my acknowledgement of his obvious distress by touching his hand allowed him to cry freely. As he composed himself he remarked that he had "probably been needing to do that for years"; then commented wryly that he had allowed himself one wracking sob during childhood — as he had driven away from his mother's funeral. "But it's a cultural thing, isn't it?". I concurred, but expressed regret at its negative effects.

The mood of the interview changed as two professionals shared the difficulties of admitting to personal problems when work is geared to helping others.

He then asked about the possibility of penile injections and I agreed to discuss this with his G.P. I commented that we had reverted to practicalities and I hoped he was going to talk more freely about his emotional needs and feelings with his wife. This, or perhaps the impending end of the interview, seemed to free him to blurt out the most recent cause for feeling hurt and rejected — his wife had resorted either to masturbation or to using a dildo to gain sexual satisfaction and spurns all his offers of assistance. I felt compelled to comment on how angry he must feel.

I have seen Mr. B. once since the reported consultation. He persists in attending because the overall day-to-day relationship with his wife is much warmer than the impression gained from the bleak description of their sexual problems, although thoughts of these do occupy much of his time. He is pursuing the option of Papaverine injections. At the end of another long interview during which I felt several insights had been shared and accepted as relevant, I was left feeling that these had been less than helpful when he asked for tips as to what he might do to try and get an erection between now and seeing the consultant urologist. However, he readily accepted the offer of a further appointment. Later, I wondered whether my sense of despondency at this seeming rejection of my efforts mirrored his feelings.

In the meantime I am left pondering whether it is as difficult for this professional carer to accept and use help at an emotional level as it has been to acknowledge his need for it.

Dr. E.A. Hood
I.P.M. Associate

PROBLEMS IN PSYCHOSEXUAL MEDICINE: Course held at the Royal Postgraduate Medical School Institute of Obstetrics & Gynaecology, October 1989

This two-day multi-disciplinary course was designed by Dr. Lawrence Goldie for those taking the RPMS Institutes Diploma in Sexual Medicine, two of whom attended. This was the second such course. There were about 50 participants including four I.P.M. members and two in basic training. Last year there were two speakers from I.P.M. This year none had been invited.

The programme was interesting but, if intended as an overview of psychosexual medicine, ill-balanced. There were four lectures on ageing (including the menopause); several on 'fringe' subjects such as fetishism, children in lesbian families, sex education; very little on female sexuality. The accent was on theory rather than practice. Most lectures were illustrated with a plethora of slides and statistics and (literally in the case of a lecture on historical perspectives of incest), 3,000 years of references! Only Valerie Sinason, a psychotherapist from the Tavistock Clinic, showed us in graphic and searing detail, the way she works with sexually disturbed children.

Nevertheless, for the Institute-trained doctor, there were some pertinent reminders. We were reminded that the Institute does not have the prerogative of listening to patients. Dr. Ruth Porter, in particular, from Hammersmith Hospital gave a moving account of the way she works with elderly patients — listening, understanding, interpreting, not asking questions. We were reminded by Robert Winston of the sometimes devastating effect on sexual feelings of modern infertility techniques, and the need for help and understanding of these patients especially when treatment has failed.

We were reminded that 58% of male impotence has an organic cause even though there may be a psychological component also. Especially we were reminded of the important areas of psychosexual medicine where the Institute has produced nothing in the way of publications, still less research. Perhaps the benefit to us of such a meeting is not what it teaches us but how much we have to learn and to share.

Dr. Heather Montford
I.P.M. Member

Report of the Winter Meeting, 4th November 1989 at Chandos Street

Members met to discuss the Annual Scientific Weekend. Comments, criticisms and suggestions had been received from those fortunate enough to be present at Cardiff in September 1989.

There was a division of opinion between those who were prepared to pay a little more if the weekend was in a hotel suitable for conferences and others who felt the more spartan but excellent value university accommodation fairer to everyone. It was felt the Membership as a whole

should decide. A questionnaire would be sent out to everyone asking for opinions and, at the same time, accurate cost comparisons should be obtained.

At Cardiff some had felt that the programme was too closely organised; more time for sight-seeing, to discuss in an informal manner and to sort out individual thoughts was suggested. The majority opinion was that there was already a lot of opportunity to meet and discuss and any sight-seeing could easily be done either before or after the official programme.

Dr. Main talked about the function of the Weekend Meeting. It is a time when we meet and formally identify with one another — a sort of bugle call for Institute Members and Associate Members. This social contact with cross-fertilization is very important, particularly for those who no longer attend seminars and feel they work in isolation. It is however a scientific meeting where scientific and research findings are reported and, as such, is essential for our training. It is equally important that a balance is kept between papers which push at the boundaries of our work and those from younger Members reporting their work and thoughts. Everyone felt that this balance had been well maintained in recent years.

Dr. Gillian Vanhegan, the Programme Secretary, reported some feedback she had received in Cardiff. Many had wanted more discussion between each paper and not at the end of the session. This of course was time-consuming. On the whole the seminars are very successful and everyone felt that the idea of a theme was very productive. Much valuable work was done in these seminars and all of it is lost at the end of the meeting. It was suggested that one person in each seminar should be appointed to keep some sort of record and all such 'reporters' could meet and produce a general account to be published in the Newsletter.

The eternal problem of finding speakers was raised again. The Programme Secretary asked all group leaders to encourage members of seminars at all levels to present their work and asked anyone interested to contact her via Chandos Street.

The Meeting ended with a vote of thanks to Dr. Vanhegan for an excellent Cardiff meeting and for all her hard work throughout the year.

Dr. Merryl Roberts
I.P.M. Member

Review of the Conference on Mind/Body in Sexuality and Reproduction

I really should know better by now, but this Psychosomatic Research Society conference did sound likely to have at least some 'answers'. Hopes of hearing these shrank as a list of studies reported the levels of distress in sub-fertile patients, rose again as a prospective multi-centre study (Dr. Golombok) comparing findings in couples receiving donor insemination, in-vitro fertilisation, adopting or conceiving naturally, went on to describe the use of relaxation and an increase in conception rate following this.

I was fascinated by a study on psychiatric morbidity/grief reaction

following IVF (Dr. Davidson). No association was shown with the duration of infertility, nor age or level of initial distress. There was however a marked increase in 'caseness' with each IVF attempt; and this was associated with previous psychiatric history, childlessness and dissatisfaction with work. There was also an increase (perhaps under-reported) in marital problems. It was suggested that all these may be pointers towards selecting positively those patients who would be helped by extra counselling.

In a study on obstetric outcome in women at high risk of psychiatric illness, previous depression and negative attitudes to self, pregnancy, etc., were unexpectedly associated with shorter than average labours. These patients were at higher risk of post partum maternal breakdown. It was a pity that this on-going study was so poorly presented.

Of more immediate interest to our Members was a short-term outcome report of 154 couples, categorised by presenting problem, given combined sex therapy and counselling (Dr. Hawton). The percentage of patients showing a good outcome varied between 50% and 81% (the latter for those with vaginismus); the lowest figure (0%) was for patients whose complaint was of impaired interest. Further consideration of the value of such studies (Dr. Bancroft) pointed out the problem in satisfactorily measuring outcome, of allowing for the immense number of variables and of selecting a homogeneous dysfunctional group. It was suggested that perhaps noting the effect, on both anxiety and communication, of different treatment methods might be a more useful way of proceeding. It was good to hear that co-operation with Institute doctors is now seen as a welcome prospect.

Although describing physical methods of treatment of impotence, research in those patients diagnosed as having a psychogenic problem (Dr. Gregoire) confirmed previous studies of post-treatment improvement and confirmed his hypothesis that a re-discovery of sexual satisfaction could cut short the vicious circle of failure.

Dr. Montgomery, reporting on operative results in transsexuals, commented that satisfaction was present in 70—89% of patients, although many regret a poorly functioning result; patients do less well the older they are and many manage without actual surgery.

The case against such surgery (Dr. Temple) talked about the pathological mother/child relationship as denying a separate existence for the son whose sexuality then was both a symbol of revolt and anxiety-provoking. He saw the self-mutilation of surgery as a very painful way of dealing with the conflict this engendered.

Did you know that — a primitive artist's drawing of a Hottentot holding a cow's tail actually demonstrates his blowing into her vagina to cause oxytocin release and lactation?

Did you know that — western society moulding us towards male/female styles pushes men into type A behaviour associated illness, and women towards food and body image problems and an increased rate of anxiety-related doctor consultations (Dr. Helman).

Did you know that — a midwife can be seen as a warrior, enabling woman, as she gives birth, to pass the test of maturation (Kitzinger).

Did you know that — Anorexia nervosa is linked to genetic vulnerability: there is a 50% incidence in cozygotic as opposed to only 7% in dizygotic twins. The abnormal tolerance of a low weight is often preceded by abuse or sexual trauma (actual or fantasy) (Dr. Treasure).

Did you know that — pre-menstrual syndrome is a symbolic inversion of expected female behaviour; women can voice their complaints against society only at such a moment as to invalidate them (Dr. Helman).

An interesting two days was tinged with shame that so few of our Institute were present (and apparently none asked to speak) and equally sad that so few of my colleagues in gynaecology or using hypnosis in psychosomatic medicine were there. I concluded that although not having the 'answers' we are probably all asking the same questions.

Dr. R.A. Hinton
I.P.M. Member

CORRESPONDENCE

Dear Madam,

At the Annual Scientific Conference at Cardiff (1989), Dr. Robertson presented a paper "Saying No to Referrals"¹. This followed up a theme of Dr. Skrine's paper². Dr. Robertson was concerned to use her clinic time effectively and she discussed the filtering of referrals.

The paper and lively discussion prompt two inter-related questions. First: *Is Institute training broad enough?* Family Planning doctors still form the nucleus of those in training, but many other doctors with different backgrounds and skills are involved. Basic seminars have not changed in their aims of understanding the doctor/patient relationship and using it. Dr. Main has often said that if the sexual problem is taken away and the patient is normal, our method should be helpful. Dr. Tunnadine has suggested that the attempted treatment of those conditions for which one is not qualified is charlatanism. Dr. Robertson emphasises the importance of guiding the patient to the correct agency. Several at Cardiff felt we should accept every case presented ("We might do some good" . . . "Where else would they go?").

If the Institute attempts to treat all cases then the training is too narrow. If we stick to what we do best then we need to understand when to advise a different agency.

The Institute is the largest provider of psychosexual therapy skills in the U.K. Recently there has been consumer-led demand for our skills. Many Associate Members are tempted to undertake expert sessions before they are sufficiently skilled. Becoming an 'expert'³ is daunting. For these doctors the Institute should look at the need for 'more advanced' seminars to re-emphasise basics and to look at referrals in the light of our therapeutic ability.

The second question is: *Is the Institute ready for NHS re-organisation?*

The spectre of internal markets and audit may not daunt an Institute

alive *because of* its self-audit in structured seminars. At Cardiff Dr. Davis described her work with the Birmingham Brook Advisory Centre⁴. She told of peer group internal audit on a monthly basis and an annual personal audit of her case load. It felt oppressive. My experience in a District General Hospital clinic was to be asked to provide an annual audit (to the Unit Management Group). This included numbers of old and new patients seen, number of defaulters among new referred and old patients and discharged patients who are cured or referred on. Things are going to get worse. We are to become 'accountable', will have to prove our 'value' and show our efficiency of management and efficacy of treatment. At Cardiff Dr. Skrine talked of her own self-audit of 150 cases and she and others mentioned "so much that we don't know about our work". We will need to know. Many feel the speciality cannot be classified by only counting heads of cured, not cured or defaulted, etc. If the Institute thinks the same, and does nothing, it will be done for us by managers. There is much work to be done that is foreign to us and our Institute.

Dr. Robertson's paper has very great relevance for those working in psychosexual therapy clinics. We must learn how to say 'No' to referrals and use our time for the good of those we *know* we should be able to help, making the referring doctor accountable for appropriate referrals.

Yours faithfully,
Dr. Keith R. Stewart
I.P.M. Member

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3. The expert: a cautionary tale. Stewart, K., Albiston, C., Robertson, S. *Inst. Psych. Med. Newsletter*. 1987, 32.
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FROM THE JOURNALS

Skrine, R. Sexual problems in primary care: psychosexual medicine skills and training. *Sexual & Marital Therapy*, 1989, 4, 1, 47-57.

This is a clear succinct account of how doctors obtain a training and qualification with the I.P.M. and how they work thereafter. Similarities are pointed out between psychosexual medicine and general practice (in their consideration of the patient's problem in psychosomatic terms, weighing up the interaction between emotional and physical factors). Case studies are used to illustrate the main points with an emphasis on the essential descriptive nature of any account of the study of the doctor/patient relationship. The paper concludes with a short section on training and qualification. Anyone asked to give a talk on Institute training and the

work done would find this a useful paper to consult.

Black, J.S. Sexual function and dyspareunia in the otherwise normal pelvis. *Sexual & Marital Therapy*. 1988, 3, 2, 213-221.

What a pity that this article was not published in the *Journal of Obstetrics & Gynaecology*! Unfortunately this gynaecologist from Sydney, Australia, is probably preaching to the converted in this journal, but it is refreshing to hear, "The doctor who pronounces 'I can find nothing wrong with you' creates an ambivalent and confused patient"; and, "The pain is very real to the patient". He emphasises how important it is to avoid surgery which "panders to abnormal illness behaviour" or to the doctor's "abnormal treatment behaviour".

He gives suggestions for the management of chronic pelvic pain which include using the examination as treatment and suggesting patients should look for themselves (!) He highlights the dangers of comments made by doctors such as "tight/small down there" or referring to the womb as being the "wrong way round". He concludes by pointing out that a doctor is not omnipotent and must not be afraid to say, "I don't know what the pain is, but I can definitely tell you what it isn't". It is a pity that more gynaecologists cannot look at these problems in this psychosomatic way. Perhaps we should all send a copy of this paper to our gynaecologist colleagues!

Adler, E. Vaginismus — its presentation and treatment. *Br. J. Sexual Medicine*. 1989, 16, 11, 420-424.

This sexual and marital therapist who works at St. George's Hospital finds that patients referred to her with vaginismus are no longer the "straightforward, easily helped, textbook vaginismus" but have a "more disturbed emotional psychology requiring an eclectic approach". It is good to see that she describes "patient strategies" not treatment schedules, and much of the work she described is familiar to Institute members. There is an interesting division of patients into categories: Sleeping Beauty (the emotionally immature woman awaiting sexual awakening for which she has no responsibility); phobia (the phobic avoidance of penetration); power struggles within a relationship; scapegoat (where the woman takes responsibility for her partner's dysfunction), and physical causes causing pain on penetration. "Treatment strategies" are described for each, but she saves the day by a sentence at the end: "The therapist should never progress with treatment without first explaining and checking with the patient, *constantly reinforcing the patient's responsibility for her own progress*" (my italics). Comparing these categories with the case reports written by Institute members would suggest that it is not so easy to put patients into one or other and most patients show some, or all, of the features outlined in the article. However, it is an interesting and thought-provoking paper.

Heal, M.R. Treatment of impotence. *Update*. Feb. 1989, 235-242.

This article is, regrettably, entirely about the physical aspects of treatment as though the penis was an autonomous piece of apparatus which just happened to be attached to a man. Even the "careful history" which he emphasises is so important does not mention any psychological factors and there is no mention of what the patient, or his partner, might *feel* about it.

He says, "even in patients where the impotence is believed to be psychogenic in aetiology it may be worth trying the papaverine injections", thus perpetuating the psyche/physical split. For those who would like information on the physical aspects of this treatment, the article is clear and concise, but it seems unlikely that this surgeon ever looks the patient in the eye! It seems such a waste that this effective physical treatment should not be used in selected cases together with treatment of the rest of the patient.

Williams, G., Gregoire, A. Psychosexual counselling: is it still justifiable in the treatment of impotence? *Sexual & Marital Therapy*. 1988, 3, 2, 145-147.

The treatment of erectile failure by injection is becoming more popular and there are those who are questioning the need for counselling. These two consultants (who offer this treatment at the Hammersmith and at King's College) give their opinion. Williams concludes that "intracavernosal injections can overcome the failure of erection but not the causative and associated psychological and marital problems". Gregoire reinforced this by closing his contribution with: "The suggestion that sex therapy can be wholly replaced by new treatment options comes from an ignorance of the psychological issues involved and a misunderstanding of the research data so far available".

Woody, J.D. The reality of an integrative sex therapy. *J. Sex. & Marital Therapy*. Spring 1989, 15, 1, 62-73.

This marital and family therapist has dared to point out that the emperor has no clothes! Despite claiming in their written accounts that sex therapists always treat couples, and that an absence of relationship dysfunction is a requirement before proceeding to treat sexual dysfunction, they behave quite differently in their work. She emphasises that most clients have more than one problem and no single explanation is sufficient to account for the dysfunction — "more honest focus on the whole of therapeutic work would reveal even more eclecticism and *the use of self*" (my italics) "than is ever acknowledged".

She points out that most sex therapists work in other fields, such as family therapy, and that they use the skills and concepts acquired in other settings. There is a long section on various theoretical concepts which might be of use, but more relevant to the Institute is her proposal that providing a detailed case description can demonstrate the therapist's

actual thinking and how theory is translated into practice. The case study presented resembles strongly many of the cases presented in early seminar work and demonstrates clearly how much the Institute has to offer in this field.

Kellett, J.M. Sex and the elderly. *Br. Med. J.* 1989, 299, 934.

This leading article was prompted by the publication of a sex manual for the elderly by Age Concern (Greengross, W., Greengross, S., *Living, loving and aging*. Mitcham: Age Concern, 1989).

There is a long list of things that doctors should *tell* their patients — explanations about drug side effects, about the effects of aging on sexual responses and the effects of diseases such as diabetes or arteriosclerosis. He concludes that “the sexuality of the elderly is no place for the evangelist” (of what?) and suggests that elderly people should be allowed to make their own decisions, “unpressurised by those who are younger” — the only mention of any contribution from the patient! The article is about the anxieties doctors have about the sexuality of “patients” and “the elderly” and about the physical effects of disabilities rather than the feelings that elderly patients might have about their sexual problems.

Collier, J.L. Surgical impotence clinics: preliminary use of GRIMS and GRISS in initial assessment and efficacy of treatment. *Sexual & Marital Therapy*. 1989, 4, 1, 27-33.

This paper describes the use of questionnaires to determine the psychosocial problems of patients referred to different clinics either for psychological treatment or for surgical treatment. Unsurprisingly, they found the two groups identical and concluded that referral to different clinics was the result of how the referring general practitioner saw the problem. They concluded that all who are referred for surgical treatment should also have their psychosocial problems examined.

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

The Journal of the Association of Sexual and Marital Therapists, Vol. 4, No. 2. A review.

I found this a most surprising read and, finally, a disappointing one; more so since one of the editors is a much respected psychologist in my own health authority.

Gerald Caplan's leading comments on ‘Parental divorce without harm’¹ (surely a tautology) were idealistic and unreal: with divorce as gracious and caring as this, who needs marriage? — “Parents . . . must make a special effort to support their children in mastering expectable psychosocial burdens . . . should allow their children to express freely their feeling of upset . . . hurt, sadness, anger and insecurity and should support them in the months to come”. — Is divorce ever over in months? “Parents must learn to exchange information freely about the children as a basis for operating as parental partners even though they have ceased to function as marital partners”.

Irritated, I moved on to a paper by Dixon & Lord, two British surgeons, about sexual function and prostatectomy.² A worthy review of the literature occupied the introduction; but then there was no more. The paper ended there, and the potency-preserving Madigan's prostatectomy (an open procedure) proved to be an unpublished method received by the authors only as a personal communication.

Marita McCabe from Australia followed with a paper attempting to evaluate the influence of childhood and adolescent attitudes and experiences on sexual function and dysfunction in adulthood.³ Fifty-nine women who presented to a clinic with sexual dysfunction agreed to take part. They completed one questionnaire which was then analysed. From about thirty questions, the author scored the following: emerging sexual desire, current sexual desire, religious influence, childhood and adolescent sexual attitudes, childhood and adolescent traumatic experiences, and adolescent experiences. It all seems so easy, but is it valid? Variables significantly correlated with sexual dysfunction were: religious influence, adolescent attitudes and adolescent traumatic experience. The questionnaire experience worsened as I read further into the journal; the urge to measure and score seemed to be irresistible.

Two psychiatrists and a psychologist from Edinburgh suggested that the usual modification of Masters & Johnson needed to be changed further to deal with women incestuously abused as children.⁴ They obliged the women to have five individual therapy sessions before the usual joint sessions. (All women were in a current relationship). The GHQ-30 (Goldberg, 1979) and the modified Sexual Experience Questionnaire were filled in before therapy, after therapy, and at follow-up, and demonstrated a dramatic improvement in all cases. The authors concluded that the purpose of the individual sessions was to obtain enough details of the abuse to allow them to modify the ‘homework assignments’ during joint therapy. Also “the co-therapy relationship provides a model of openness in a male-female relationship and an experience of a non-exploiting male” — this is just too apple-pie and I cheered for ‘Lisa’ who, during therapy, “suddenly announced that she was not sure if she was having sex because she wanted it or because the therapists were forcing her”.

Now I could not take seriously a Spanish study of couples' problem-solving skills.⁵ It concerned coding the communications observed in videos of ten happy and ten unhappy couples. (A parable for modern sex therapists?) The unhappy couples were clinic patients with marital problems and the happy ones those with *only* sexual problems: apparently an improved selection method from previous researchers who used their *friends* for the happy couples. The hideous torrent of questionnaires (six in all) made a sort of assault course for the couples, and it was not surprising to learn that many of them were arguing with each other outside the video room. I started skimming, but was arrested by the results pages which consisted only of a sort of algebra, which showed that not much difference was found between the two groups.

I felt very sorry for Ronan O'Carroll, a Newfoundland psychologist.⁶ A court order suspending an offender's sentence if he underwent behaviour therapy landed him with a real lemon of a case. ‘David’ stole children's

socks and shoes in great quantity but denied any sexuality at all, and at most "tucked the objects inside his pyjama waistband". Despite the best efforts of Mr. O'Carroll, he did not get better: "This case left the author feeling rather uncomfortable". Such honesty cheered me up: then there was no end to the rage and disappointment of this benighted psychologist. The court, the system, the patient and the diagnostic uncertainty were severally and severely blamed. He finally puts the boot in with his recommended "more routine use of the penile plethysmograph". Yes, in mild modern Canada, sex offenders' progress, or lack of it, is estimated by enforced measurement of their penile volume while being made to watch erotic material.

A Buckinghamshire therapist describing mis-diagnosis of oestrogen deficiency;⁷ and the effect of Ayurvedic posters on attitudes to semen loss⁸; were studied in the last two papers.

The journal also included some essays,^{9, 10} a useful literature update and book reviews. Ruth Skrine's *Introduction to Psychosexual Medicine* is, alas, damned with faint praise. Acknowledging first the superiority of listening to traditional questioning, the reviewer regrets the implication that "the Balint is the only method". She advocates mixed behavioural and analytic approaches: "This book should be read alongside some of the recent works explaining all the available tools of the trade of the sex therapist".

In the end, I found the descriptive articles in this journal, the essays and case studies, more reasonable and interesting than the questionnaire-ridden research studies. I feel that the behaviourists' tools, both in clinical practice and research, are a way of distancing therapist from patient. We eschew the medical model, and I think that we should avoid the scientific model for our research. Descriptive and critical papers on psychosexual therapy are as valid as literary criticism is for drama. It would be absurd to judge Beckett by scoring questionnaires handed out to age/sex matched groups in audiences. The I.P.M. would be foolish to tag along with other 'social sciences' by trying to emulate the natural sciences. The understanding and use of the doctor/patient relationship can demonstrate the art of medicine at its best.

Dr. Roseanna Pollen
I.P.M. Member

References

1. Parental divorce without harm. Gerald Caplan.
2. Sexual functioning following prostatectomy: can impotence and retrograde ejaculation be avoided? Anthony R. Dixon & Peter H. Lord.
3. The contribution of sexual attitudes and experiences during childhood and adolescence to adult sexual dysfunction. Marita P. McCabe.
4. Sex therapy for women incestuously abused as children. Anne R. Douglas, Ian C. Matson & Stephen Hunter.
5. Experimental study of couples' problem-solving skills: are we striving in the right direction? Jose Caceres.
6. The difficulty of dealing with deviance: an illustrative case study. Ronan O'Carroll.
7. Post-menopausal touch impairment presenting as sexual avoidance: a

case report. Alan J. Riley.

8. The loss of semen syndrome in Sri Lanka: a clinical study. P. De Silva & S.A. Dissanayake.

9. The emergence of modern sexuality in modern societies. Gunter Schmidt.

10. Sex therapy in context. Nia A. Pryde.

OBITUARY

Dr. Geraldine Howard (Jolly)
I.P.M. Member

It is with much regret that we announce the sudden death of Dr. Geraldine Howard (Jolly) in a fatal road accident on Monday evening 12th March 1990. She leaves two sons and a daughter. Memorial services will be held at Lanercost Priory, Cumbria, on Friday 18th May at 3 p.m.; and at St. Andrew's Church, Ham Common, London, on Wednesday 30th May at 2.30 p.m. An appreciation will be published in a later edition of the Newsletter.

NOTICES

The Accreditation Panel

Panel passes November 1989:

Dr. Caroline (Albiston) Hunter,
33 Cedar Road,
London NW2 6SN

Dr. Gillian Baker,
3 Argyle Road,
London N12 7NU

Dr. Roseanna Pollen,
62 Malvern Road,
London E8 3LG

Dr. Keith Stewart,
'Veseys', Corpus Christi Lane,
Godmanchester, Huntingdon PE18 89HW.

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

The next meetings of the Panel will be at the above address on Tuesday 15th May 1990 and Tuesday 20th November 1990. Early booking to avoid delay in being assessed is advised.

The Panel currently consists of: Dr. P. Allen (Secretary), Dr. S. Filshie, Dr. K. Friedman, Dr. J. Gilley, Dr. M. Gill, Dr. J. Hinshelwood, Dr. A. Smith.

PRIVATE PATIENTS PLAN

Accredited Members of the Institute of Psychosexual Medicine who wish their patients who subscribe to Private Patients Plan to have fees reimbursed, can apply for recognition to: The Director of Health Services, Private Patients Plan, P.P.P. House, Tunbridge Wells, Kent TN1 2PL.

Criteria: The applicant must -

1. Be a fully registered Medical Practitioner of at least six years standing;
2. Have a Certificate of Accreditation and have full Membership of the Institute of Psychosexual Medicine;
3. Have a satisfactory reference from a N.H.S. Consultant from another specialty, e.g. gynaecology, psychiatry, etc.;
4. On application send I.P.M. Certificate and reference;
5. Subscribing patients must be referred by a General Practitioner or Consultant for out-patient services only.

Please will members write to me with addresses of other insurance agencies who refuse to pay benefits and I will try and draw up agreements with them in the same way.

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

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:

| | <i>Currently</i> | <i>Will be</i> |
|----------------------------|------------------|----------------|
| 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 |

SITUATION VACANT

A Psychosexual session held in a health centre in Battersea is vacant. It can be arranged at any time to suit the applicant. Please apply to: Dr. Jenny Lisle, 57 The Chase, London SW4 0NP. Tel. 01-720 2588.

I.P.M. CURRENT TRAINING SEMINARS

BASIC SEMINARS

| REGION | LEADER | PLACE | DAY/TIME |
|----------------|------------------------------------|------------------------------------|------------------|
| 1. Northern | Dr. A. Smith | Newcastle | Wed.eve |
| 2. Yorkshire | Dr. J. Coombs | Leeds | Thu.pm |
| 3. Trent | Dr. P. Barrett | Sheffield | Tue.eve |
| 4. East Anglia | Dr. B. Devereux Dr. R. Lincoln | Norwich Bury St.Ed. | Fri.1230 |
| 5. N.W. Thames | Dr. A. Tobert Dr. F. Hutchinson | Chandos St., W1 Chandos St., W1 | Wed.pm |
| 6. N.E. Thames | Dr. R. Sampson | Finchley | Fri.pm |
| 7. S.E. Thames | Dr. M. Roberts | Canterbury | Thu.pm |
| 11. S.Western | Dr. R. Skrine Dr. G. Wakley | Bristol Hereford | Tue.pm Mon.pm |

CONTINUATION SEMINARS

| | | | |
|----------------|-----------------------------------|------------------------|------------------|
| 4. E. Anglia | Dr. B. Devereux** | Norwich | Wed.1230 |
| 8. Sussex | Dr. P. Tunnadine | Ditchling | Fri.pm |
| 9. Wessex | Dr. M. Conway** | Southampton | Mon.pm |
| 11. S.Western | Dr. H. Backer Dr. B.Campbell** | Gloucester Plymouth | Thu.pm Fri.pm |
| 12. W.Midlands | Dr. S. Snead** | Kidderminster | Fri.pm |

ADVANCED

| | | | |
|----------------|-------------------|-------------|----------|
| 1. Northern | Dr. G.R. Freedman | Newcastle | Wed.eve |
| 3. Trent | Dr. M. Bramley | Sheffield | Mon.eve |
| 5. N.W. Thames | Dr. T Main | Hammersmith | Thu.pm |
| 11. S.Western | Dr. R. Skrine | Bristol | Wed.p.m. |

OTHER

| | | |
|----------------|----------------|-----------|
| 4. E. Anglia | Dr. R. Lincoln | Norwich* |
| 11. S. Western | Dr. J. Tisdall | Plymouth* |

Seminars Recently completed include those led by —

| | |
|------------------------------|------------------------|
| Dr. J. Munro, Penrith | Dr. P. Allen, Bristol |
| Dr. H. Montford, Southampton | Dr. M. Gill, Islington |
| Dr. R. Thexton, Southampton | |

Seminars in planning:

| | |
|-------------|--------------|
| Wessex | Warrington |
| Cambridge | Nottingham § |
| North Devon | |

**=Convenors

*=for F.P. and practice nurses

§=for nurses

NEW ASSOCIATES

Dr. Jeannette A. Cayley, 17 Conolly Road, London W7 3JW
 Dr. Ruth M. Clancy, 42 Grena Road, Richmond, Surrey
 Dr. Jean Cox, 83/85 Hall Road, Hull HU6 8QL
 Dr. Hazel C. Davies, 4 South Ridge Heights, Weston-super-Mare BS24 9SH
 Dr. Juliana Eccles, 16 The Drive, Newcastle-upon-Tyne NE3
 Dr. Jane Howells, 80 Hadley Road, Barnet, Herts. EN5 5QR
 Dr. Karine Nohr, 44 Southbourne Road, Sheffield S10 2QN
 Dr. Phyllis E. Partington, 326 Millhouses Lane, Sheffield S11 9JD
 Dr. Susan M. Royce, Top Farm, Barking Tye, Ipswich IP6 8JD
 Dr. Paul R. Shepherd, 2 Colepike Hall, Lanchester DH7 0RW
 Dr. Z. Sayed, 'Bait-ul-Sayed', 67 Moorgate Road, Rotherham, S. Yorks. S60 2TP

NEW SUBSCRIBER

Dr. Rosamund Vallings, 101 Waller Avenue, Bucklands Beach, Auckland, New Zealand

CHANGES OF ADDRESS

Dr. Shamin Akhtar, 43 Butler Avenue, Harrow, Middlesex
 Dr. Mary C. Gabbott, Tithe Barn, Clay Hill Road, Hook Green, Lamberhurst, Kent TN3 8LS
 Dr. Caroline Hunter (previously Caroline Albiston), 2 Oaklands, Hillsborough, Co. Down BT26 HZ
 Dr. Susan M. Clancy, 3 West Brunton Farm Cottages, Brunton Lane, Gosforth, Newcastle-upon-Tyne NE23 7NX

From: MEMBERSHIP & SUBSCRIPTION SECRETARY

The previous issue of the Newsletter has been returned to us as 'Gone Away' or 'Not known at this address' by the Post Office, in respect of Newsletters sent to the last recorded addresses, of the following members:

| | |
|----------------------|-------------------|
| Dr. Cleanth Jones | Dr. K.R. Manilal |
| Dr. Christopher Sage | Dr. E.H. Sandeman |

Will anyone knowing the whereabouts of these members please let the Membership & Subscription Secretary know so that current issues of the Newsletters may be sent to them as well as other correspondence being circulated.

Would those members who have expressed a wish not to pay their annual subscriptions to the Institute by Banker's Order please 'pencil in' in their diaries the **1st September** as being the due date for subscriptions, as additional administrative work is imposed where reminder letters become necessary.

Members are reminded that the current subscription rates are:

| | |
|------------------------------|---------------------|
| Associates | £25 per annum |
| Members | £35 per annum |
| Subscribers | £35 per annum. |
| Retired Members Contributors | 50% of above rates. |

(continued from outside back cover)

ADLERIAN WORKSHOPS

Saturday June 2 — Sunday June 3 1990

On Child abuse

Friday April 26 — Thursday June 5 1990

On Working with loss and grief. Contact 38 The Pastures, The Coppice, Aylesbury, Bucks. HP20 1XL. Tel. 0296-82148.

THE MARCE SOCIETY

Tuesday September 4 — Friday September 7 1990, at University of York

Fifth international conference on Child Bearing and Mental Health. Contact Bell Howe Conferences, 1 Willoughby Street, Beeston, Nottingham NGN 2LT.

SIXTH INTERNATIONAL CONFERENCE ON THE MENOPAUSE

Monday October 29 — Friday November 2 1990, Bangkok, Thailand

Contact 8 Avenue Don Bosco, B-1150 Brussels, Belgium.

INSTRUCTIONS TO CONTRIBUTORS

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

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

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

Contributions for the October 1990 and May 1991 letters should reach the Editor by 1st August 1990 and 28th February 1991. The address is: 16, Ethelbert Road, Canterbury, Kent CT1 3NE.