

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER
No. 6

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29 High Street,
Chipstead,
Sevenoaks TN13 2RW

September, 1976

Dear Doctor,

This Newsletter has been delayed a month so that we could bring you an account of the weekend meeting at Bournemouth. As well as news of meetings, past and future, there are important announcements on registration and research. Like our therapy it calls for active participation of both partners. I know how much mail falls through your letterbox - please save this Newsletter for a time when you can give it your full attention.

1. MEETINGS

- (a) The next meeting will be a joint meeting with the British Section of the International Society of Psychosomatic Obstetrics and Gynaecology. A programme and entrance form is attached. There must be a charge for this meeting as I.S.P.O.G. is self-supporting.
- (b) The ACM will be held on March 18th, 1977 at the Royal Society of Medicine, 1 Wimpole Street, W1. Further details in the next Newsletter.
- (c) A meeting was held at the R.S.M. on July 9th, 1976 with Dr. Main in the chair. After a brief business meeting there was a lively discussion of the possible interpretations of "non-consummation". Dr. Hinshelwood gives an account of the meeting in Appendix B1.
- (d) The weekend meeting took place at Bournemouth from 17-19th September. We are once again grateful to Dr. Hinshelwood for her report, given in Appendix B2.

In addition to their invaluable contribution in administering the conference, and providing an excellent reception and dinner, we must also thank Wyeth for the full report of the meeting which will be sent to all members as soon as it is completed.

We were honoured and pleased that one of our vice-presidents, Professor Norman Morris, was able to join us for the meeting.

(e) Relevant meetings attended by members

Xth International Congress of Psychotherapy in Paris. Two members of the Council, Dr. Blair and Dr. Pasmore, attended this meeting and I am indebted to them for their joint report, given in Appendix B3.

2. NEW REGISTER OF MEMBERS

Dr. Blair has sent the following notice:-

"As you know the FPA used to produce a register of doctors who had attended their psychosexual seminars. There are now no more copies of this register and no one is keeping it up to date. The Council therefore decided that we should compile

a NEW REGISTER OF MEMBERS AND ASSOCIATES OF THE INSTITUTE and I have taken on the task of doing this. I think it would be best to collect the information again and to find out where members are working and who sees private patients. This is particularly useful for me as I am constantly getting letters from GPs all over the country asking where they can refer their patients with psychosexual problems. I therefore ask all of you to complete the following form and return it to Dr. Blair, Waldron Cottage, Waldron Road, Harrow on the Hill, Middlesex."

The Registration Form is given in Appendix A.

3. COUNCIL

Due to a clerical error Dr. Prudence Tunnadine's name was omitted from the list of members of the Council given on p.4 of the minutes of the ACM held on 19th March, which were circulated with the last Newsletter. She is, of course, a member of Council and Training Secretary.

4. RESEARCH

(a) Prospective Study

An outline of the proposed STUDY ON NON-CONSUMMATION is given in the account of the Bournemouth meeting Appendix B2. We hope that ALL full members will take part. The commitment for each doctor will be to complete a Study Form for every case of non-consummation presenting over a period of six months. If you have not already written to Dr. Kilvington, or 'signed on' at Bournemouth, but would like to take part please complete the Section at the bottom of the Registration Form (Appendix A).

(b) Retrospective Analysis

At the meeting on Non-Consummation, in July, Dr. Eleanor Mears remarked that she had been asked to analyse her work using the classification given by Bancroft (Bancroft J., Coles L. (1976) British Medical Journal 1 1575-7). As a result I asked her if she would let me have her comments for the Newsletter, and am grateful for the response given in Appendix C. As you will see she has also included a form which we could all use to look at our last years work. We hope that many members will have the energy and application to summarise the patients that they have seen in the last year and will write to Dr. Mears.

There is a wealth of clinical material buried in our files. We hope in this way some evidence of our work can be published fairly quickly - it will be at least 2 years before the results of the prospective study will be available.

5. SUBSCRIPTIONS

I must apologise for the confusion caused by some members receiving forms for Bankers Orders, and some Covenant Forms, with the last Newsletter. It is an advantage to the Institute if covenants are signed, as the tax can be recovered, and also to the member, who is secured against a rise in subscriptions for seven years.

The sum for subscriptions and covenants is, at present, FIVE POUNDS. Forms can be obtained from Dr. Blair, to whom they should also be returned.

6. TRAINING

The following seminars will be starting in September:-

ADVANCED	Middlesex Hospital	Leader	Dr. Tunnadine
BASIC	Middlesex Hospital	"	Dr. Hutchinson
	Sharpthorne, Sussex	"	Dr. Main
	Cheltenham (for Gloucestershire AHA)	"	Dr. Backer
	Maidstone (for Kent AHA)	"	Dr. Lucas
Possible Groups:-			
ADVANCED	Guildford	"	Dr. Blair
BASIC	Reading	"	Dr. Pasmore
	Sunbury-on-Thames	"	Dr. Pasmore

Message from Dr. May Duddle:-

"Dr. Duddle is starting a new advanced seminar in October in Manchester. The seminars will be held fortnightly on Tuesday afternoons. Interested doctors should apply to Mrs. Joan Dennison, Manchester AHA(T), Piccadilly House, Manchester 1. The seminars will be held at the FPA premises".

7. CONTRIBUTION FROM MEMBERS

Miss Valerie Thompson has sent us the paper which she gave at the meeting of the International Society of Obstetrics and Gynaecology on December 4th, 1975. We are pleased to include this as Appendix D.

8. NEW MEMBERS

A list of New Members, and changes of address of old members, is given in Appendix E.

9. VACANCY

I have been asked to inform members that there is a vacancy at the F.P.A. Psychosexual Clinic which is held at Hoddesdon (Herts) Health Centre on alternate Thursdays. Sessional fee £13,71 plus mileage.

Please contact Regional Administrator, FPA North Thames Region, 33 Hadfield Road, St. Albans, Herts.

We appreciate that this Newsletter asks you all to complete a Registration Form for Dr. Blair (which should be received by November 1st) and also to write separately to Dr. Mears, with some duplicate information. The Institute at present has no clerical staff or central office, so we hope that you will tolerate this "multiple postage" realising that our economy of administration will avoid a raised subscription.

I hope we will have a good response to Dr. Mears' paper - could I indulge in a fantasy of all our members sending her a year's work for one clinic?

The first issue next year will let you know the reality.

Yours sincerely,

KATHARINE DRAPER

APPENDIX A

REGISTRATION FORM

To be completed and returned by NOVEMBER 1st to
Dr. Blair, Waldron Cottage, Waldron Road, Harrow on the Hill, Middlesex.

NAME in full

PRACTICING NAME (if different)

QUALIFICATIONS

ADDRESS

Telephone Number

ADDRESS for Register if DIFFERENT from above

Telephone Number

Dates and place of BASIC SEMINAR attended.
Name of LEADER

Dates and place of ADVANCED SEMINAR attended.
Name of LEADER

Accredited by PANEL YES/NO
IF YES Date

Appointed
BASIC SEMINAR LEADER Yes/No

ADVANCED SEMINAR LEADER Yes/No

PSYCHOSEXUAL SESSION(S) AT:-

PRIVATE PATIENTS SEEN AT:-

Area Health Authority in which you work

FOR FULL MEMBERS

PROSPECTIVE STUDY OF NON-CONSUMMATION

I would like to assist in the study Yes/No

I have already written to Dr. Kilvington Yes/No

I would like my name to be included Yes/No

REPORTS OF MEETINGS

About thirty members attended a meeting of the Institute of Psychosexual Medicine on July 9th. Dr. Main took the chair.

Official business was conducted very rapidly : apologies were received from Dr. Edge, Dr. Lloyd, Dr. Leather, and Dr. Tisdale ; minutes of the last meeting were agreed and signed ; an early notice was given of a joint meeting of this Institute with the Institute of Psychosomatic Study of Obstetrics and Gynaecology on 11.11.76 ; and a special welcome was extended to Dr. James Carne, our vice president, and Dr. Nesta Crane.

We then moved briskly into the main purpose of the meeting : Towards a Definition of Non-Consummation.

CLINICAL MEETING

Dr. Draper introduced the discussion. Research is urgently needed into psychosexual problems and the methods of treatment need to be evaluated. The Institute is applying for a grant for a specific research project, and non-consummation has been agreed upon by our research committee as a reasonably well-defined, narrow field for assessing success and failure. The study has been planned to be prospective, to include 200 patients or all reported cases over a period of six months, and all members of the Institute.

Dr. Kilvington, on behalf of the research committee, spoke next on the work the committee had accomplished. She explained that as soon as the subject of non-consummation had been agreed it became evident that there was a great deal more to the problem than the stated fact of no sexual intercourse. She illustrated this by four brief case histories. All four women described presented with an inability to have intercourse with their present partner, but had in fact had intercourse in the past on at least one occasion.

We were all invited to contribute to the discussion and responded readily, illustrating points liberally with case histories. To define non-consummation in theory and for the purpose of the research proved to be difficult and the group struggled for a long time. Towards the end of the meeting it became clear that there was little hope of unanimity among members. What followed is a summary of the many ideas that were floated.

- (a) Is non-consummation the problem of the woman, or of the man because of his impotence, or should it be seen as the problem of the couple?
- (b) Can non-consummation be diagnosed if the woman has in the past had intercourse with a former lover, but is unable to consummate her marriage?
- (c) If the woman had sexual intercourse premaritally with the man who is now her husband, or if she achieved it once, such as on her honeymoon but never since, is this considered non-consummated?
- (d) In the last two instances, should we employ the term secondary non-consummation, reserving the term primary non-consummation for the woman who is still a virgin at the time of her complaint?
- (e) Should we run two different studies on the above lines?
- (f) Is the legal definition of wilful refusal on the part of the woman applicable to the study?

- (g) Many women are frigid, even after treatment has enabled penetration to take place: is penetration alone the criterion of success?

Brief case histories illustrated various ways that non-consummation might be presented: 'Immaculate' conception; women referred from gynaecologists after hymenectomy and dilatation; women who have imagined labial intercourse to be the real thing for years; and women who mistakenly believe that lack of ejaculation by the man means non-consummation, are but a few examples of the less straightforward presentations we can be confronted with.

The main stumbling block seemed to be between a diagnosis of non-consummation or frigidity in those women who had achieved penetration on occasions in the past. Should we base our definition on the extreme anxiety and fear presented by some women at the idea of sexual intercourse, compared with the anger and resentment shown by the frigid woman, who also has no intercourse.

Dr. Main brought the meeting to a close, thanking all present and regretting that a unanimous decision had not been reached. It was accepted, however, that the research committee would work with the following idea.

"Non-consummation for the purpose of the research project can be considered in the woman who presents, or is discovered, directly or indirectly, to have been unable to have intercourse with her present partner."

BARBARA G. HINSHELWOOD
31.7.76.

APPENDIX Bii

Impressions of a Conference

The first-ever weekend conference of the Institute of Psychosexual Medicine was held this September, at the Carlton Hotel, Bournemouth. Altogether some 70 members attended this major event. Our president, Dr. Tom Main, led the conference and chaired the meetings throughout, and it was a great pleasure to have with us Professor Norman Morris, our vice-president.

Sadly, Dr. Main had to tell us of the death, earlier in the week, of Dr. Lawton Tonge. Many of those present had personal, first-hand experience of the inspiration and support he has been to the doctors in this field of work. He will be very greatly missed.

The formal, serious business of the conference took place in plenary sessions. Doctors will be receiving a full account of the papers that were presented, so what now follows is a brief and personal summary.

Dr. Geraldine Howard presented the first paper on Friday evening, a report on the vasectomy research seminar. She introduced it by saying that all of the doctors in the seminar had probably been, to a greater or lesser extent, biased against the operation initially, and had protective feelings towards the men. She then went on to describe the presentations to a vasectomy clinic. Nine marital situations were discussed: happy, confident and competent couples; the controlling husband, "policeman syndrome"; the crisis of an unplanned pregnancy; the frigid wife; the limits of childbirth; a change of lifestyle, e.g. emigration; on the death of a parent; in sub-fertile couples, after the birth of a long awaited child; the castrating woman. The outcome of vasectomy was seen to be very much related to the quality of counselling. Dr. Howard went on to examine in detail the strategy for this kind of counselling which the seminar found most suitable.

Dr. Howard also reported an interesting group of 14 patients asking for a reversal of their vasectomy. The predominant wish seemed to be for fertility again, rather than for a baby; to be able to use risk-dependent methods of birth control again.

Dr. Blair began Saturday's work with her paper entitled "Clinical Classification of Frigidity - Does a 15 year old Classification Stand up Today?" She initially reminded us of the study of frigidity, published in 1964, the result of work by 8 family planning doctors meeting weekly for 5 years. Over the last 15 years many social changes have taken place. Dr. Blair has put forward a new classification, which is more flexible, being founded on basic problems of relationships. The original classification was based on presentation, which varies with the social mores of the time. The three categories Dr. Blair suggests are: a) patients with problems related to bodily function; b) those with difficulties with the social feminine role; c) those with difficulties in their relationships with men.

The latter half of Saturday morning was taken up with a demonstration seminar. Dr. Main led the seminar, with 10 "volunteers" chosen from the audience. Two doctors presented their difficulties with on-going patients and obtained a considerable amount of help with them. The discussion afterwards concerned itself with seminar technique. The value of a demonstration seminar, either live or on video tape, shown to an unsophisticated audience, was also the subject of much debate.

The title of the first Saturday afternoon session was "Approaches by Different Doctors to Psychosexual Work." Three doctors chose to talk about anxiety in the doctor. Dr. Skrine gave an account of her work, with particular reference to seeing one or both of the sexual partners. She stated her own preference for working with one individual in greater depth, and illustrated her talk with examples from her own practice.

Dr. Tunnadine followed with a lively account of her greater anxiety in dealing with male patients, who are now presenting in increasing numbers. She discussed the question of the medical examination, and outlined the problems that she has learnt to recognise and help.

Dr. Tobert spoke about the effect of the doctor's anxiety on technique. She mentioned signs of her own anxiety that she has learned to recognise, such as asking questions. She stressed the importance of the doctor patient relationship, and her belief that if the doctor takes prime responsibility for the doctor-patient relationship, the patient will take care of the content of the information.

It is difficult to do justice to these three honest and moving accounts of striving towards a better understanding of the techniques involved. The audience responded very warmly and from this point the conference seemed to become a much more united body. There seemed to be more acceptance of the need to understand techniques, rather than campaign for their use, a definite change from earlier discussions.

Dr. Barne and Dr. Clitheroe used the second part of Saturday afternoon to talk about the problems of leadership. Dr. Barne began by outlining the aims of seminar training. She feels that a leader should ideally be able to interview prospective members to clarify issues and dispel various myths about seminar training. The function of the leader doctor within the group was then discussed, and Dr. Barne mentioned various situations needing sensitive and skilful handling.

Dr. Clitheroe gave us a lively account of how she became a leaderdoctor in response to the great demand in her part of the country. She outlined some of the problems that seminar members have which restrict their inability to use the seminar, and also referred to some of her success as leader doctor, members who have expressed the value of the training in their work.

Sunday morning was devoted to research. Dr. Draper outlined the difficulties faced by the research group in designing a prospective study of our treatment of unconsummated relationships, and referred to previous studies. Dr. Bramley then introduced us to the prototype of the forms we will be using to collect the data. We then had an unexpected treat. Our "drama subcommittee" acted a treatment situation, which received great applause, and we had a party game with a serious purpose; a trial run of filling in the forms. Many good practical ideas came out of this, and progress will be reported in due course.

As well as serious study the conference had an equally enjoyable lighter side. We were staying in a pleasant seaside resort, with good weather. The Carlton Hotel catered for all our needs in a most expert, unobtrusive way. Members of the Institute from all parts of Britain were able to relax, enjoy each other's company and exchange news and ideas. As well as business meetings, we all came together at a most magnificent celebration dinner.

A few lucky members also had the chance to play a new board game. This has been devised by the Health Education Council as an aid to encouraging adolescents to talk about personal responsibility in work and pleasure relationships. The assessment of the game had its serious side and on the whole we were enthusiastic. It also provided us with amusing entertainment at the end of a long day.

Dr. Main brought the conference to a close on Sunday midday. Grateful thanks go to the members of the committee, especially Dr. Hutchinson, for the enormous amount of time and energy spent on the organisation of this very successful weekend.

We also extend thanks and appreciation to John Wyeth and Bros. Ltd. for their generous financial assistance enabling the conference to take place, particularly thanking Mr. Paterson, their representative, who worked closely with the committee at all times.

APPENDIX Biii

Xth International Congress of Psychotherapy in Paris

We attended this Congress, held in the Faculty of Medicine of Paris, from 4-10 July. Invited lecturers spoke for the first half of the morning session, with simultaneous translations. We then broke up into small groups, speaking one of the official Congress languages, ie French, English, Italian and Spanish, and the afternoon sessions, starting at 3.00, were taken up with 'round table' presentations of short papers and discussions, various short papers, films and videotapes, etc.

Dr. Pasmore acted as co-Chairman for the 'round table' discussion following the presentation of three papers by Dr. Becker and Dr. Nadelson, both from the USA, and our own on 'The moment of change in marital work'. There was a very lively discussion at this meeting, especially on the papers of the two colleagues from the USA.

Our hopes were that we would not only gain some new insights and ideas for our own work, but also that discussion with colleagues from other disciplines might help us to crystallise some of the half formed ideas that are always floating about at the back of our minds as we work. In both of these we were rather disappointed. The language difficulties and the very uneven quality of the translations were only in part responsible; more serious were the differences in viewpoint about the aims, as well as the techniques, of psychotherapy.

We, who are used to working with the doctor/patient relationship as our main tool in therapy, felt that this gave us a rock-like basis for our work compared with other approaches founded on more abstract theory, which therefore seemed to us superficial and undynamic. These intellectual theories were often defensive or based on trial and error, for example, some of the papers on behaviour therapy and the popular cults of relaxation etc. seemed often to be used as routine without a real understanding of the patient's problems.

We could not but contrast the work done in our ordinary seminars, where we can give and get from each other, leading to a deeper understanding of the patient, with the presentation of intellectual theories in the papers given to the Congress which did not allow for this exchange.

One of us (Dr. Pasmore) had attended the Balint International Congress in Paris some weeks previously, where more satisfying exchanges were experienced, leading to some clarification of our aims in seminar training. Here again, however, it seemed that the British contingent felt freer to acknowledge confusion and admit to failures in their work than some of the Continental members, who tended only to report success.

We are aware that this report sounds smug. This was not what we had hoped for when we went to the Congress, but we have to express what we felt, for what it's worth. We are here speaking of the formal aspects of the Congress; in informal discussions with many people from all parts of the world things went very much better and ideas could be exchanged. Perhaps we should add that Paris in the nineties was not conducive to effort on anyone's part!

Jean Pasmore
Margaret Blair

ASSESSING PSYCHOSEXUAL COUNSELLING

Eleanor Mears

Most members of the Institute will have seen the paper by John Bancroft and Leslie Coles of the Oxford University Department of Psychiatry 'Three Years Experience in a Sexual Problems Clinic' published in the B.M.J. of 31st July. Details of 200 consecutive patients or couples treated in the clinic over the period January 1974 to April 1975 were analysed. 275 patients were referred during that period but 52 cancelled or failed to keep their appointments and were therefore never seen and 23 were not accepted because they lived too far away. Of the 200 patients seen 98 were men and 102 women - in the case of a couple the sex of the partner with the principle sexual difficulty was recorded - In 86 cases treatment was either offered and rejected or considered inappropriate and in all 97 completed treatment. The 200 cases seen generated 1200 hours of clinical work.

The treatment was based on a modified Masters & Johnson method with brief counselling and when appropriate drugs provided by members of the clinic staff.

The cases are analysed according to the type of male and female problems and the number of sessions required on average for each type. An assessment of the outcome of the treatment is made by the therapist concerned and some two-thirds of those who completed treatment are regarded as having a successful outcome or worthwhile improvement.

I was asked to attempt an analysis of my own cases on the lines of Bancrofts in one new NHS clinic for psychosexual problems in Scunthorpe which the DHSS has been funding, on an experimental basis, for one year. In the light of this experience in using Bancrofts paper as a model I offer the following comments on assessing the value of psychosexual counselling in this way.

COMMENTS

The treatment offered and given was obviously variable in that it was sometimes given by a psychiatrist, sometimes by a health worker in training and these are not analysed separately.

The assessment of the effect of the treatment was made by the therapists. This does raise doubts about how valid it is - however we must accept that assessing the outcome of sex therapy is difficult and that even if the assessment were to be done by an objective expert who has not been involved in the clinic concerned there are great difficulties. Patients circularised or visited, or called for interview sometime later for such an assessment are liable to be influenced in their reply by how they feel on that particular day or week or how lovemaking was the previous evening, or to give the answer they think the interviewer wants or not to want to remember that bad spell in their marriage.

But to me the most difficult question was classifying the various problems. Bancroft did so into 'traditional' types of sexual dysfunction without defining them. I found I could classify the male problems in this way without much difficulty but I found it very difficult with female problems. The categories seem to be based on the woman's complaint not on the real problem - on how the problem is presented without giving any clue to the root of it - the presenting symptom of stress not its origin. How can we classify in this way the woman who enjoyed sex before marriage or before a pregnancy or before mother-in-law came to stay but has since been aggressively paying her husband out by withholding sexual feelings - 'others' seems an unsatisfactory category for such a common and dynamic problem - yet it cannot be labelled 'general unresponsiveness' and 'orgasmic dysfunction' does not suggest a marital tussle. But indeed this classification seems to me to leave out of account entirely the interaction between the couple on which so many problems are based.

I felt dissatisfied too that no difference is made between primary and secondary problems. Is not the prognosis for either male or female problems better for those who have had a satisfactory relationship for some time before the problems arose compared with those who have had them throughout with no good memory to revive? The man who complains of erectile impotence for 3 or 4 months after many years of normal functioning may well be helped in only one or two sessions to restore his confidence when the source of the precipitating anxiety is relatively easy to trace. But the man who has had the problem on and off throughout his relationship will need much more help.

I felt that I should like to know the duration of the problem and the duration of the relationship.

A further difficulty has been over allocating a couple to 'treatment refused or inappropriate' or to 'dropped out'. Bancroft calls them 'dropouts' when they do so before the treatment has any chance to make an impact. I would have thought that any visit to the clinic made an impact. He fails to distinguish between those who 'dropped out' because they are ambivalent about wanting help of the kind that is offered and those who begin to see the real problem but don't want it dealt with. Often couples seem to want to be helped but when after a preliminary three or four treatment sessions they find there is no magic wand to solve their problem and that they can only be helped to solve them for themselves they don't come again. I have classified these as 'drop outs' but I am not happy about this as it is partly the therapist's decision that the treatment is inappropriate and making them face up to this. But it seems kinder to leave them to make the final decision over whether they will come again rather than reject them - so I would want to classify these differently or stick them all into one column.

Review of Experience in two local NHS Clinics for Psychosexual Counselling

When the new clinic in Southorpe was started a year ago, funded by the DHSS on an experimental basis, all GPs were circularised and all patients are referred by them or ancillary health workers. In the beginning they tended to send their problem patients many of whom were too disturbed or too drugged or too satisfied with the drama of psychoneurotic illness and marital battle to want help - for this first year I did not refuse treatment to anyone although I have had to terminate it sometimes without having been able to give much help. The clinic runs concurrently with a training seminar for doctors but I have only included cases dealt with by myself in this review.

This analysis has been suggested as part of the DHSS assessment of the value of the clinic and the training seminars.

Apart from the problems of classification outlined above I found this analysis fairly simple to carry out. So out of interest and to increase the numbers to a more significant level I decided to repeat it for problem patients who have attended a Grimsby Clinic, which was started under FPA auspices when I first came to live here but since April 1975 has been supported by the local Authority.

The analysis which follows is the combined analysis for these two clinics.

Grimsby and Scunthorpe Combined

TREATMENT ANALYSIS TABLE 1

Problem	Treatment completed	Offer of treatment refused or inappropriate
	Women	
1. General unresponsiveness	16	1
2. Orgasmic dysfunction	15	0
3. Vaginismus	15	1
4. Others	3	3
	Men	
5. Erectile impotence	5	1
6. Premature ejaculation	7	
7. Ejaculatory failure	3	
8. Others	2	
Total	66	6

OUTCOME AND DURATION OF TREATMENT TABLE 2

	Successful outcome		Worthwhile improvement		No worthwhile improvement		Dropped out	
	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions	No (%) of patients	Mean No of sessions
	Women							
General unresponsiveness	3	7	13	5	4	7	7	2
Orgasmic dysfunction	6	5	7	6	1	5	2	2
Vaginismus	10	4	3	2	1	3	2	5
	Men							
Erectile impotence	2	2	4	3			6	2
Premature ejaculation	3	3	3	4			5	3
Ejaculatory failure	2	3					1	2
Total	26	4	30	4	6	7	23	2½

92 cases generated 272 hours of clinical work which is on average 3 hours or 4 to 5 sessions per case.

56 showed successful outcome or worthwhile improvement for an average of 4 sessions

6 showed no worthwhile improvement - on an average 7 sessions.

23 dropped out (see above comments) after an average 2 to 3 sessions.

A comparison of these results with Bancrofts is interesting although not valid because of the small numbers. Of Dr. Bancroft's 200 referrals 86 either refused treatment or were not considered suitable, 97 completed treatment or dropped out. These cases generated 1,200 hours of clinical work. 53 patients derived real benefit. So my results compare favourably with those obtained at Oxford and the mean number of attendances to attain these results was generally lower.

Your committee has suggested that I might arrange for all members of the Institute who would be interested and willing to co-operate to carry out an analysis along these lines of the cases they have seen in Psychosexual Clinics within the last year or two.

Please read on if you would be willing to help.

The reason for attempting analysis of the work we are doing in clinics for psychosexual problems is to demonstrate the value of this work and to provide useful evidence of this for applying for grants.

For this reason it seems wise despite the difficulties I have already outlined to follow Bancroft's assessment and classification as far as possible. Bancroft's analysis of his work and results coming from a reputable University Hospital Psychiatric Department obviously has appeal as a standard by which the work of others in the same field can be judged by the 'Powers that be'.

However, I think we can simplify it. I see no reason why we should include patients on the waiting list, or those given advice only? are there really any of these in our problem clinics - or those patients still receiving treatment. Instead I suggest that we should include all cases completed in one year including those who started earlier. I suggest that for our interest we ought to include the duration of the marriage or relationship, the duration of the problem distinguish between primary and secondary problems and note the presenting partner.

However, I think we must use Bancroft's classification of the type of problems if any comparison is going to be valid. But we must clarify this so that we all use it in the same way.

So I am writing now to ask for your reactions and for your support. You will be surprised how interesting it is and how little time it takes once the documents for recording are prepared and these of course will be supplied.

So I invite members to consider Bancroft's paper and my own analysis and comments above and to consider whether you would be prepared to analyse your own cases over the past one or two years in this way. If only half of our members agree to this we should have sufficient members to make a most useful assessment.

Opposite you will see the Record Sheet I suggest for doctors to analyse their own cases, from which the combined analysis into Bancroft's tables would be made by us.

Try it out now on a few of your current patients to find out if it will work for you.
Take particular care over Bancroft's classification which I have numbered 1 - 8 (see table) to simplify recording on this sheet.

Then fill in the form and send by 31st October.

PENDIX D

The Role of a Gynaecologist

What is the role of a gynaecologist?

To those of you in the audience who are gynaecologists and presumably know your role, I apologise, for either boring you or sparking off incredulity at my naivete for daring to suggest the way I see my role is any different from the way you see yours.

But the audience today contains representatives of many other disciplines who admittedly brush with us, but do, I know, frequently wonder at our attitudes and peculiarities. Now the Shorter Oxford English Dictionary defines 'role' as the part or character which one undertakes, assumes or has to play. How does one assume this particular role? Few doctors can state truthfully why they took up medicine and even fewer gynaecologists would be able to say why they took up gynaecology. But even if like myself it was because it was inextricably welded to the more fascinating option of Obstetrics, we still had to learn how to be Gynaecologists. We learnt just as we had learnt to be doctors a few years earlier by serving a long apprenticeship with seniors whose methods and manner governed our work. I would suggest that for better or for worse we identified with chiefs whose knowledge, techniques and results could be admired.

The work was exclusively practical, demanding dexterity, concentration, a capacity for making immediate life-influencing decisions and great physical stamina. Clinics were always overbooked and chiefs came late and went early - we did not ask whether to a committee or a private patient - it was all work and they were seen to work hard and we did too. Registrars and housemen started and finished the out-patient clinics, frequently called away to deal with obstetric emergencies, sometimes to a separate hospital or out on the district or on the flying squad. Clinics worked on an open-plan system for convenience, speed of work, and easy communication for consultations of junior and senior staff; or to see quickly some interesting pathology on another couch. Letters were dictated in the clinic within hearing of the patients to the lay secretary who decorously sat with her back towards the patients. Students might have a separate desk but they too took histories in the same open-plan clinic. All was bustle and efficiency and all could be overheard and supervised. No thought was given to patients feelings in this situation, strange as it may sound to some today, but the problem was always to cope with the physical needs of the patient to the best of one's ability in the light of good established practice. A flash of occasional sympathy was the only permitted recognition that our patients were human beings with feelings.

As a houseman and registrar one learnt to take a rapid history by asking questions that could be answered preferably by 'Yes' or 'No'. Hesitation, diffidence or uncertainty by the patient was sometimes, under all the pressures, met with ill-concealed impatience. One learnt to think fast, examine accurately, write up investigation requests expeditely, to make terse notes, to arrange admission and to tell the patient the minimum necessary to get her off the couch quickly, sometimes only "I will write to your doctor". Always sister's queue of ladies in dressing gowns with stockings rolled down around ankles grew shorter very slowly.

In the wards patients were admitted in batches one or two days prior to the operating list. To have three admissions after clinic before the visitors arrived was bliss. To have seven or eight was not uncommon and one's supper waited on the hot plate. Operating sessions were often 4 to 5 hours in length. Emergency operations completed most evenings and obstetrics interrupted every night one was on call.

On our evenings and weekends off duty we studied and wrote up case commentaries for the book we submit before we are permitted to sit the MRCOG. Our days were brightened by the dispensations of hard-won approval for our efforts from skilled senior registrars and consultants. The jockeying for good recognised hospital appointments, the slog for higher Senior Registrar appointments, all these are common to all doctors seeking consultant independence.

By virtue of this prolonged disciplined apprenticeship the resultant gynaecologist is invariably a skilled diagnostician and surgeon; he may be a competent teacher too although he will have received no particular training in this art, and he may be an adequate scientist capable of some research. He will need to develop further skills to manage his inheritance. He will perforce have to undertake administration to run his department in the light of the needs of his locality. He must maintain an adequate through-put to cope with his waiting lists. He is now responsible for the training of junior staff and he must delegate to permit them to acquire their own skills. All these he will attempt to do, drawing on the precepts and examples of the chiefs he has worked for in the past and in whom he has consciously or unconsciously seen acceptance or denial of parts of this role. This, I think, can be seen as the traditional role and although I have drawn liberally on my own training in describing this, I am reasonably certain that today's training is factually much the same, thanks to the Royal College of Obstetricians and Gynaecologists who maintain a demand for certain requirements, material and time before giving approval to training posts. I suspect that identification with one's elders continues as a basic psychological phenomenon although the present generation of junior hospital doctors are more vocal than we were in protesting against exploitation.

Meanwhile great changes have come about which have had a profound effect on this traditional gynaecological role. The evolving demands of society, together with scientific progress, have produced a need for a comprehensive contraceptive service. The Family Planning Association which so splendidly pioneered a national service is being integrated into the National Health Service and this work inevitably falls into the sphere of gynaecology. Let us say that we do not find this work agreeable. We have not been trained to do it, although the present generation in training may be acquiring these skills; we have only experience of dealing with the complications of contraceptive techniques and therefore tend to have prejudiced views and we possibly feel that work that has been done on a part-time sessional basis without higher qualifications is not quite for us. Yet contemporary Obstetric and Gynaecological care demands a comprehensive knowledge of contraception and in particular how to help a patient to choose the most satisfactory method for her. Without counselling skills abortion recidivism will remain.

Which brings us to the second most serious pressure on the traditional role. I do not need to elaborate too much on the demands that abortion has made on routine gynaecological work. Despite Professor Hirsch's gloomy survey of abortion facilities it says much for the humane attributes of most contemporary gynaecologists and their willingness and ability to adapt to society's needs, that a reasonably efficient abortion service is available under the NHS today. We have achieved much without additional monies or building and have in the main integrated the operative and nursing care into every-day gynaecological work. Here we use our trained talents in surgical and administrative skills. Nationwide availability will surely become adequate in time in response to our society's needs. But do not imagine that the individual gynaecologist's willingness to engage in this work has come without much heart-searching. One does not abandon the habits of a life-time attitudes or security of established practice easily and certainly not willingly when under pressure by society and parliamentary action.

Three other factors in demand for abortion have had to be recognised as implicit. First, the patient's frequent control of the doctor; secondly, the time-crisis, and thirdly, the doctor's ignorance and frustration about the basic motivation behind the unwanted pregnancy. These have tended to push the gynaecologist into the role of a technician and here he will have to remain unless he is prepared to learn new skills in diagnosis using psychological techniques. Only if he is prepared to do this will he be able to understand and then possibly counsel usefully. By doing so he may take on the role of a doctor again if he wishes.

Another aspect of our work with profound psychological implications is sterilization of either the wife or the husband. It is a simple operation for a skilled gynaecological or general surgeon and does without doubt meet the needs of many couples admirably, but how often does a gynaecologist ask a patient whether she realizes it will alter the way she sees herself as a woman and possibly the way her husband sees her too? Today

a patient of mine sat with tears running down her cheeks saying she wants her husband but cannot let him touch her since he had his vasectomy. Perhaps sterilization may become satisfactory reversible but this is not yet something one can guarantee. The urologists have appointed vasectomy counsellors; perhaps we should do the same and then comfortably remain technicians absolving ourselves from the end-results. We shall no longer be doctors. Further demands are to be made on gynaecologists which also hint at change of role. The boundaries of knowledge in Fertility work are being pushed forwards in exciting ways. Menopause clinics to monitor HRT are not far away and there is a demand for Well Woman clinics and now pre-pregnancy clinics.

In all these situations gynaecologists are now being confronted by women patients who not only want to be physically well; they ask that their anxieties be understood and met therapeutically. They also wish to have recognition of their need to use organic symptoms in their diffident sad search for help with psychosexual difficulties. Surely it is in the gynaecologists own interests to be able to make such a diagnosis to avoid adding unnecessary investigations and operations to an existing and increasingly heavy work load. Sensitive and sensitised doctors can quickly unravel many emotionally charged problems. But sensitization must come from training which is not yet generally available but only through seminar training.

Now this is not something the traditional role encompassed at all. Knowledge of the psychological relationship between a woman and her uterus and vagina, the delays and arrests of psychosexual maturation and symptom-formation and the effect of obstetric and gynaecological events on her sexuality are not included in the training of a gynaecologist. Recognition of anxiety and its sequelae in relation to consultation and pre- and post operative counselling, detection of risk and depressive illness, the ability to understand transference situations and the mechanisms of the basic doctor-patient relationship are all alien to the traditional gynaecological role. Much is now expected of gynaecologists by their patients and it is evident that their needs are not being met - hence banner headlines in reputable papers saying "Do Gynaecologists Hate Women"? You may have noticed that gynaecologists have a bad press at this moment in time.

What then is our future role to be? More and more that of a technician entrenched in surgical expertise? I would suggest that this direction is unrewarding in a society demanding more sophisticated attitudes to functions which determine well-being and personal happiness. I am not suggesting that every gynaecologist should be a skilled psychosexual counsellor as this work is not for everyone. I am suggesting that knowledge of feminine psychology, and development of psychological skills appropriate for their working tasks would make diagnosis more accurate and therapy more successful. Conventional time-saving reassurance of the traditional kind is useless, sympathy is not enough. "Common-sense" is inadequate for good work because the doctor's own personal attitudes, prejudices and moralities however important to him may not fit his patient's needs. Empathy, an insufficiently used word in medicine, is a step in the right direction but it must be followed by constructive action and I hope that the speakers that follow, including those of you speaking from the floor, will consider what can be done to fit the gynaecologist to play his role of the immediate future more adequately.

APPENDIX E

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