

INSTITUTE OF PSYCHOSEXUAL MEDICINE

N E W S L E T T E R

Editor: Dr. Katharine Draper,
29 High Street,
Chipstead,
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No. 8

May 1977.

Dear Doctor,

The Minutes of the AGM, enclosed with this Newsletter, contain full reports from all the Officers. The latest developments within the Institute will be found there and therefore this section will be brief.

1. MEETINGS

(a) The next meeting will be held on

FRIDAY, 8TH JULY 1977 at 7.30 p.m.
in the MARCUS BECK LIBRARY, ROYAL SOCIETY OF MEDICINE,
WIMPOLE STREET, LONDON W1.

"Defences against pain. Observations of Group Leaders".
Speakers: Dr. Main and Dr. Backer.

Application has been made for recognition under Section 63.

(b) Weekend meeting

The weekend meeting will be held at Newcastle from September 9-11th.

Provisional programme:-

Friday afternoon - Experiences in different settings - Hospital
Family Planning Clinic
General Practice

Saturday morning - The learning experience in a Basic Seminar
" " " " an Advanced Seminar

" afternoon - Report from Dr. Main's research seminar - Retarded
Ejaculation

" evening - Does social class matter in treatment of psychosexual
problems?

Sunday morning 'Walworth Experience'.
Discussion of working in a co-therapy situation based on
behavioural techniques.

The papers will form a basis for discussion and case presentation in groups.

The meeting will cost £20-5, and will be limited to 160 members. Wyeth are again undertaking the administration, and will write to each member with the full programme and application forms.

(c) Past Meetings

The AGM was held at the Royal Society of Medicine on March 18th. Minutes enclosed.

After the business meeting there were case studies by Drs. Hinshelwood, Christopher and Pasmore, illustrating "difficulties encountered due to cultural differences". I am grateful to Dr. Corin for the full account of the meeting and edited extracts from the papers given in Appendix A.

It was regretted that the length of the business meeting curtailed the presentation of cases and discussion. The Council have decided that in future the AGM will be held from 5-6 pm to allow for a full clinical meeting at 8.0 pm.

(d) Relevant meetings attended by members

Miss Valerie Thompson has sent me the following report of the Congress at which she presented a paper:-

Ninth World Congress of Fertility and Sterility

The American Fertility Society hosted a four day meeting at Miami Beach USA as the Ninth World Congress of Fertility and Sterility.

The disciplines covered included clinical infertility, tubal surgery, endoscopy, immunology, urology, andrology, neuro-endocrinology, genetics contraception, family planning and psychosexual work.

A fuller account of the proceedings will appear in the British Journal of Family Planning but it should be reported that six twenty minute papers on psychosexual subjects were presented including one on 'The use and value of the vaginal examination in the diagnosis and treatment of psychosexual problems'. This statement of the aims and method of work of our Institute aroused some limited interest and will be published in full in the 'International Journal of Fertility and Sterility' in due course and should therefore reach a world audience.

2. RESEARCH

(a) Prospective Study

At the end of the report of the Research Group in the Minutes of the AGM, you will see that the meeting adopted the proposal, by Dr. Butcher, that members should be asked to contribute £10 each. Dr. Butcher has followed this up with an appeal which is published in Appendix B. Since the AGM we have received confirmation of the grant of £300 from Ortho Pharmaceuticals. Doctors Pat and John Shirley-Quirk have generously started the contributions rolling with a gift of £100 and £50 has been received from other members. With a good response the Research Committee would be able to launch their project in the autumn.

(b) Retrospective Study

Dr. Mears has written to tell us that as a lot of replies have been late she will be happy to receive forms until the end of May. All correspondence should still be sent to her at End House, 13, Augusta Close, Grimsby, Lincs, DN 34 2TG. To reduce expenses will any doctor expecting a reply please enclosed a stamped addressed envelope. She is working on the results and we look forward to the final analysis.

3. ASSESSMENT PANEL

The following doctors have been passed by the panel: Dr. Jessie Yorston, Dr. Jane Berry, Dr. Judith Mary Fisher.

4. MEMBERSHIP

There are now nearly 200 members and the list of new members, and changes of address of old members, is given in Appendix D.

5. CORRESPONDENCE FROM MEMBERS

Dr. Jane Kilvington has sent us a description of her visit to Dr. Helen Kaplan's clinic. Although we have heard Dr. Backer's account of the clinic her book is so widely read that I thought you would be interested in this vivid report (Appendix C1).

Dr. Christopher has written us a challenging letter (Appendix C2). I hope you will let me have your replies for the next Newsletter.

Yours sincerely,

APPENDIX A

REPORT ON THE MEETING TO DISCUSS THE DIFFICULTIES THAT DOCTORS
HAVE EXPERIENCED IN TREATING PATIENTS FROM OTHER CULTURES

Three doctors presented cases that had arisen in their practice and the meeting discussed these after the presentations. Unfortunately, owing to the length of the business meeting the presentations and discussions had to be very much curtailed.

DR. HINSHELWOOD said that about 28% of her patients were immigrants.

Case 1. Mr. A. was a 36 year old Sudanese business man. He looked smart, spoke perfect English and was here on a business trip. He complained of impotence. He had been married in December 1975 to a 19 year old Sudanese girl. The marriage was an arranged one, with an elaborate ceremony lasting several days, after which 3 days were spent in an hotel. The marriage was not consummated. Because of business, much time was spent away from home and then his wife lived with her family. When his business brought him to England he brought his wife with him. The marriage was still not consummated, and the idea came into his mind that his wife was not a virgin. He came asking for medicine for potency. He had been to a sex shop and tried ointment and tablets with no success. It would be an insult to him and to his family name if he had married a woman who was not a virgin. He said that she knew too much. He had had much sexual experience and had never been impotent before. He came from a healthy wealthy family.

He did not answer questions easily and said that he wanted medicine so that he could find out if his wife was not a virgin, as if she was not he could divorce her and take another wife. Unless the marriage was consummated the shame would be his and he would not be able to get another wife. When feelings and fears were raised he dismissed them as irrelevant.

He had not returned to the Clinic.

Case 2. A 20 year old Chinese boy in England since the age of 6. His problem was difficulty in getting erections when he was with his girl friend, and premature ejaculation for previous 6/12. His girl friend was West Indian and had seduced him from his previous partner. He was fond of her. She was on the dole, on drugs, and squatting somewhere, and was critical of his settled position in life and of his sexual failure.

His parents had separated when he was 10. He had been brought up by a nagging mother. Twice he had lived away from home, but had gone back. His cousin was a good Chinese boy and lived at home. For the last 6/12 he had been drinking heavily and was depressed. Two years ago he had met his father again and felt disappointed. It was rare for Chinese families to break up. He said his father was critical of his Afro hairstyle and of his having a West Indian girl friend. He felt cheated because he had not had a Chinese upbringing. He had been offered Group Therapy by a psychiatrist 6/12 before and asked the doctor if she thought this was good.

On his last visit he said he wanted to rob a bank. He was ashamed of his own culture and was trying to get into European culture. His father had chided him for leaving his mother and for not going to College. He found Chinese friends boring. He was not keen on 'easy lays'. He was no longer seeing his girl friend. The doctor wondered if he was trying to be a good Chinese boy.

DR. PASMORE reported that in three recent cases, three points had struck her:-

"1. The patient's attitude to the doctor, is even more important than when both belong to the same background culture, for example, the extreme deference shown by the two Ugandan Indian patients to be described makes the underlying hostility unapproachable.

2. The significance attached to the presenting symptom is different, both in quantity and in quality, in differing cultures, and unless what it means to this particular person

can be discovered, interpretations will not make sense to him.

3. These patients seem to think things with all their minds, not only with part. Their fantasies are much more concrete. The symbols are in themselves solid and all seen as realities, without the chink of doubt which allows for the possibility of interpretation. When I say that they think things with all of their minds, not only with part, I mean that there is less of the normal healthy questioning with which one can make contact in treatment. My guess is that they are more childlike and perhaps we should be able to learn from our Child Guidance colleagues how better to approach them.

With these three points in mind, I would like to give brief accounts of first interviews with three patients. They are not success stories.

Mr. K, a Ugandan Indian, felt that he was 'sent' to the hospital by his wife. The referring GP asked for assessment and advice for the couple's longstanding history of matrimonial disharmony. Mr. K. told me at once that there was no trouble as far as he was concerned, he had only come because his wife insisted that he needed to see a psychiatrist. He spent most of the time trying to assure me of his good intentions, stable work record, two delightful children, nice house, in fact that he had justified himself as a man. He had been deeply hurt by his wife's two affairs some years back. After the second affair he took her back to her parents, who live in north London, but she then took an overdose and so he accepted her again. He said their sex life was enjoyable for both, and they have intercourse two or three times a week. Although he admitted losing his temper at times, he was quite out of touch with his own anger, and any attempt of mine to interpret his difficulties with this part of himself only drove him to adopt an even more placatory attitude towards me. We were only able to make any real communication on the basis of the difficulties for his wife in the change from the extended family in their African homeland to the isolation of their lives here. In other words, he managed to get me to fall in with his need for approval, and to see all the trouble as in his wife.

Mrs. K. was seen by a colleague, who reported that he found her feeling helplessly caught up in the difficulties, some of which had been contributed to by her cultural naivety. She had not yet been able to come to terms with the realities of her marriage as against her basically idealised expectations of it and he found one of the most difficult things to unravel was the contribution of the arranged aspect of the marriage.

Mr. K's attitude to me as the memsahib was so fixed that it prevented any possibility of working with his difficulties in coping with his own aggression.

Mr. T is a West Indian telephone engineer who complained that the "semen comes out on its own after one or two minutes" and "a tendency to lose my temper". He was extremely deferential in a skilful way, even appearing to be a good candidate for psychotherapy when he said spontaneously that his symptom made him feel "not enough of a man", but somehow I felt that we were not really engaged with each other. At the second interview he said, "Oh, the sex thing isn't important", he had other things on his mind. His wife wanted to see her family back home, he needed a holiday, his newly acquired car was defective, and so on. The significance which I, in a psychosexual clinic, attached to his presenting symptom was quite different from its significance for him, where apparently it had only served as a label, allowing him to be a complainant. His wife's second confinement was due in a few weeks' time, but he was completely vague when asked about his plans for this - "I may take some time off work or I might not".

In spite of his apparent sophistication and his offering of a tempting psychotherapeutic focus, the only understanding I achieved about this man was his need to be parented by a kindly firm responsible adult belonging to the culture in which he now found himself.

With Mr. S, a little more contact was made. He is another Ugandan Indian complaining that he could only hold an erection for about a minute, whereas the books said that it should last for 15 minutes. At first it seemed that it was his girlfriend's disappointment that mattered more than his image of himself, then there was the aspect of his much respect-

ed parents in India who would certainly disapprove of his living with his girlfriend if they had known, and upon whom the question of eventual marriage seemed to depend. At first the session had been a painful struggle between question and answer, but gradually he became a little freer, and eventually was able to volunteer his enormous anxiety about masturbation, which he thought had physically damaged him so that his penis would no longer work properly. In this case at least some of the anxieties had been touched on, but I felt obliged to treat this patient in a much more directive way than usual, giving him some facts about sexuality, both male and female, and also about contraception, with which they were having difficulties, so that at the end he characteristically asked me if there was not some medicine he could take. He left apparently satisfied with my explanation that the trouble was in his feelings and eagerly accepted the offer of a further appointment, with or without his girlfriend.

For this man his fantasies about damage from masturbation were real, and although intellectually he did seem to accept my alternative explanations, it is doubtful how much they really meant to him.

After writing this I waited for his second visit with interest. He neither came nor cancelled, thus expressing his revolt against me as a 'respected' but also resented parent who had 'directed' him."

DR. CHRISTOPHER reported on 2 West Indian patients seen at home in the Domiciliary F.P. Service. Experience working in different cultural groups had shown her two extremes in attitudes to sex and the vaginal examination; one, the Irish, with vaginismus and modesty about sexual matters, and the other, the West Indian, with no anxieties at all like this.

Case 1. Mr. and Mrs. S., West Indians, both 24. Mrs. S. was a Baptist and S.E.N. and Mr. S. Roman Catholic and had been in the Army. They had 3 children. Mrs. S. was seen for Family Planning for 1 year before sex problems were mentioned. Sterilisation had been asked for first, but the appointment was failed. Then the cap was tried, but she messed about with it, and then the O.C. She needed a lot of help to take it. She complained a lot about her husband and said that he was unfaithful, beat her and gave her no money.

The doctor called to do a routine O.C. check on Mrs. S one day, but she was out. However Mr. S was there and said he wanted to talk to the doctor. He said he could not please his wife and made many complaints about her. He said he could not get an erection. At that time the doctor identified with the husband, because she felt the wife had made him impotent, and the doctor felt angry with Mrs. S.

Next visit both were seen and there were angry exchanges between husband and wife and the doctor felt tossed between the two of them. He complained of being unappreciated and unloved. She said he beat her and would kill her and that he was a bad husband. The doctor tried to negotiate a contract but the husband flounced out and back again twice because he was angry with her, and she wondered if he felt he could only get to her by being violent.

The result of the interview was that the wife said she did not want any more help and she would go to the West Indies.

At the next visit the wife seemed happy and told the doctor that her husband had tried to seduce her violently.

Case 2. Female 32, male 34, Jamaican, married 1964. She had 3 children by him and 2 by another man before this relationship. Contraception had been messed about. He was allergic to sheaths and could not get an erection wearing them. The problem presented as irregular periods and she saw a gynaecologist who suggested I.U.C.D. Then she said her husband had been impotent for 1 year and she did not want I.U.C.D. and asked for a visit. The wife was very obese, and the husband a small dapper man. He took the doctor into a room on his own and told her he had not been able to get an erection for the past year and that this was due to a back injury sustained at work 7 years previously. He was going

back to Jamaica if he got no help in this country.

On the next visit the husband was out and the wife complained that he was no help to her with money or with the children and they slept separately.

Next visit both were present. A contract was not negotiated and they would not talk together. Both wanted the doctor on her own.

Problems encountered by members in seeing patients from different cultures were then discussed generally.

The experience of one member working where the majority of patients were immigrants from the East was that all patients wanted 'pills, injections and cure within 1 week', and it was suggested that the Institute should encourage doctors from the same cultural background as these patients to come forward for training to try and help them. This would also be of help with the language problems encountered. One member had had a male patient referred from a colleague with 'a note and 20 words of English'. Another said she had been presented with a male patient whose words to her were 'No man', when asked his complaint. It was suggested that work could be done with an interpreter, if he was a sensitive one, but another member thought the relationship could be destroyed by this.

Cultural differences were commented on by members and one member thought it important that these differences should be acknowledged by the doctor to the patient. Some cultures were noted to be matriarchal with fear of women, and others were male-orientated and females never appeared. In European cultures a couple is never seen with no relationship before marriage, in contrast to the arranged marriages of some of the immigrant couples. The extended family and arranged marriage supportive to the immigrant in his own culture, brought difficulties for him here.

'The patient's attitude to the doctor is what makes these cases difficult', 'Patients don't see doctors in the same way' and 'Expectations of patients from another culture who come to us are different' were all comments made by members when discussing difficulties in helping these patients. Members recognized and emphasized the problem of 'cultural shock' experienced by immigrants coming to this country.

Points arising from the discussion so far mentioned were problems seen as arising from the patient. Other matters discussed were those seen as coming from the doctor side of the relationship. These could arise, for example, if the doctor became too anxious about cultural problems. The doctor needed to recognize that in seeing patients from his own culture he made automatic assumptions of shared common experiences which had no relevance when seeing immigrant patients. Other suggestions were that we should learn how the external world is internalized in different cultures, and that we should note that culture was a sociological definition and not a psychological one. Dr. Tunnadine asked if there was anything in these patients that could not also be seen in a white Anglo-Saxon family, and Dr. Pasmore said that similar attitudes to those seen in her immigrant patients were seen in her English patients, but that they were commoner in certain cultures compared with ours.

Sheila Corin

NON-CONSUMMATION - PROPOSED RESEARCH PROJECT

Carol Butcher

Those of you who like me were at the AGM on 18th March at the R.S.M. may still be wondering if there has been or will be any outcome, consequent on the proposal I made concerning fund raising for our research and statistics project. The vote of approval given as to the way the money should be found has still left the implementation of its acquisition firmly on our laps and I will take this opportunity of reiterating the following fundamental point.

Amongst ourselves we think we know what we achieve in psychosexual medicine but it still comes as a surprise to many of us, myself included, to realise from time to time that our medical colleagues in general, very often do not have too great an awareness of the benefits that may accrue due undeniably to the casework and research that we undertake. There is no way that I know that we can advertise our findings to the profession other than the way that it has always been presented i.e. by embarking on a scientific research programme and publishing factual conclusions. It is equally simple to realise that no one will offer us money for research into pie in the sky and flights of fancy.

I feel that we have to bear the initial financial burden ourselves even if you like to test our own viability. I understand that the research committee's idea of the amount required has to be in excess of £2000 to launch the project and I hardly need to tell you that unless we can muster the finances, even our actual future as accredited individuals could well be in jeopardy.

It is only simple mathematics to establish that a contribution of £10 per head from approximately 200 members will give us our £2000, and this should be appreciated in the realisation that to date and after some 19 meetings the unstinting and enduring efforts of the committee members, financed entirely at their own cost, has amongst other things at least resulted in tentative tho' as yet unconfirmed offers of financial assistance, including £300 from Ortho Pharmaceuticals. Currently we have an application to the Nuffield Foundation but then who hasn't

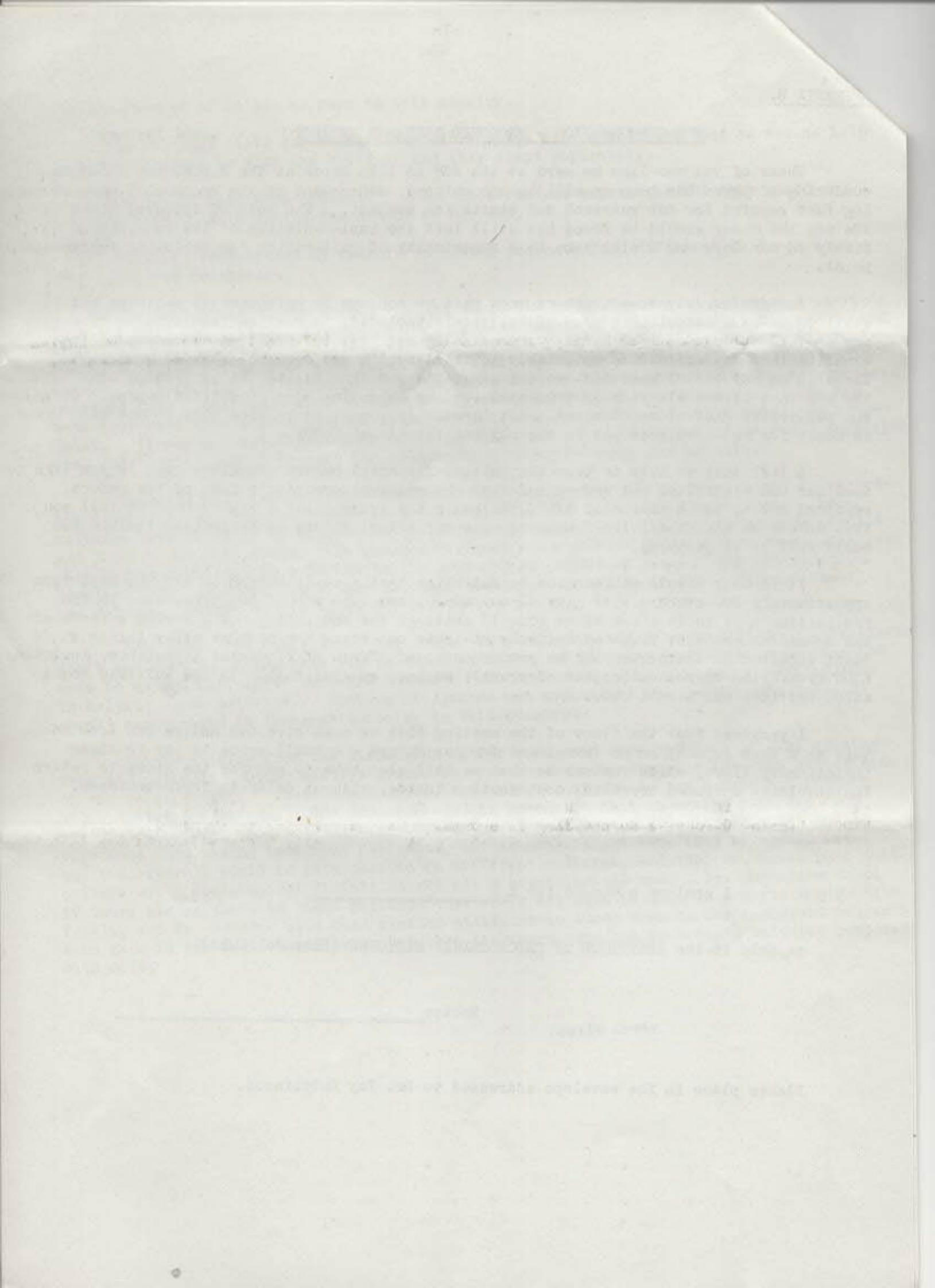
I proposed from the floor of the meeting that we each give £10 and we can look on this as a down payment on an investment for our future - a small price to pay in these inflationary times, which reminds me that we will also have to pay for the stamp to return the envelopes enclosed herewith, contribution inside, without delay to Fay Hutchinson.

I enclose a cheque for £ _____

payable to the INSTITUTE OF PSYCHOSEXUAL MEDICINE (Research Fund)

Doctor _____

Please place in the envelope addressed to Dr. Fay Hutchinson.



APPENDIX C.

(1) A visit to the Payne Whitney Clinic - New York

Jane Kilvington

Dr. Helen Kaplan is a small lively woman, her face constantly changing expression. When she was opposite her patient, behind that two-way window we have heard so much about, she registered concern, pleasure, kindness and command; afterwards in the seminar, delight, laughter, quite intelligent thought, disapproval, agreement, authority. I found the clinic and made my way into the Thursday class of students, mostly doctors in training, but at least 5 of them practicing analysts. Soon "Helen" arrived. She was quite informal and friendly and reminded the group of the history of the patient about to be interviewed, then closed the communicating door.

A man entered the consulting room and sat with his back to the window. Dr. Kaplan faced him and us. I had always been worried about the ethics of this form of teaching, but I learnt afterwards that it was done with the patients consent and with remission of fees - quite a consideration in that country. We could hear him and see his gestures, but would not be able to recognise him afterwards.

The complaint was one of non-emission. The patient described his recent love making with his girlfriend in a slow uncertain way. Dr. Kaplan encouraged, reassured and congratulated. I thought she was being very motherly and trying to lessen his anxiety by pleasing him. She repeated several times that she felt he was destroying his own pleasure, not able to get close. She said what a really marvellous thing it was that he had been able to offer the gift of orgasm to his girlfriend by giving her clitoral stimulation. Frankly, I thought she overdid the support but my thoughts were subsequently modified by hearing that on previous occasions the patient had been shy to the point of being hardly articulate. It was said that he had made much progress.

Dr. Kaplan made a few enquiries about the job situation (the patient was a PhD) and offered to write a letter of recommendation to support his latest application. She said afterwards this may have been a mistake, that to offer too much help sometimes produces a rebuff for the doctor. She also suggested his girlfriend "call" her during the week so that she could keep in touch with her thinking. The patient was sent away with instructions to give and receive pleasure but on no account to attempt intercourse more than once a week.

At the discussion afterwards, Dr. Kaplan explained the principle of therapy with this patient. He is so anxious, she said, that nothing more than simple techniques will help him. To interpret the transference, indeed to give any sort of insight would overwhelm him. Simple, directive counselling is enough. Then she looked to the ceiling and exclaimed "What would my analyst friends say to this constantly repeated suggestion that he was spoiling his own pleasure - five times I said it". And then: "I will be an analyst when I give the annual lecture to the American Analytical Association. Today I am a psycho-therapist." She said she thought that future therapists would all carry several skills. Just as an endocrinologist prescribes several different hormones, so she would be a behaviourist a doctor, prepared to give brief psychotherapy or an analyst, according to the needs of the patient.

After this case, discussion became wider. She asked her group for their advice in a difficult situation which she had uncovered. A previous colleague had screwed one of his patients. What was she to do? She was concerned for the reputation of her clinic who had trained him. Fucking was fine with patients but not while they were in therapy, vulnerable. Three months afterwards, yes, screw if you like. She said she was very concerned.

She then mentioned another case. A physically handicapped man had been referred to her for therapy. She didn't often find surrogate partners but on this occasion she had. She asked 'Tiger Lily' to report. Tiger Lily turned out to be a gentle girl of Malay extraction, handsomely made up, who rather hesitatingly said that she had found the patient sexually quite intact. She was hoping to make contact with the New York underworld organisation to help her find a suitable partner for her patient. Even those

apparently unshockable sex therapists were stirred by this statement. Are there really women interested in disabled partners? "Oh yes", said Tiger Lily, she was confident that she could find someone whose fetish was severe physical abnormality.

It is quite difficult to recapture the feelings I had. I was greatly impressed by Dr. Kaplan. During discussion she was permissive and accepting, enjoying the comments of her group, but could react negatively when she disagreed. The doctors were very articulate, mostly thoughtful - very unshy about speaking. Most of all, uninhibited about sexual discussion. I thought it was a privilege to have been one afternoon with them and I am extremely glad I added that experience to all the others during my brief holiday in the States.

(2) Letter from Dr. Christopher

Dear Dr. Draper,

I am writing to express my concern for the future viability and credibility of the Institute of Psychosexual Medicine. I do so with an awareness that what I write will not be very popular or welcome.

I shall have to preface the reasons for my concern with some personal information in my own development as a psychosexual doctor. I did my psychosexual seminar training in 1968-1971. In 1973 I became a sex educator training teachers for the F.P.A. lecturing on the psychology of sex and adolescent sexuality. In 1974 Professor N. Wagner of the University of Washington spent a sabbatical with the F.P.A. to assist in developing sex education courses and to train F.P.A. sex educators. He is a Professor of Psychology in the department of Obstetrics and has been involved for a number of years in the training of medical students in all aspects of human sexuality. Through him I became aware of what was happening in the States in this field and also of the importance of the work of Masters and Johnson. At about this time Lee Doyle, one of the original women co-therapists who worked with Masters and Johnson and who now works on her own as a sex therapist in Dallas, Texas, came to lecture in England. I was impressed by the way she worked and by her emphasis on feelings and attitudes that to my mind answered the criticism and M and J were merely 'quasi' physiologists. From my own work the criticism beginning to discover the limitations of my training in dealing with male disorders. The emphasis on dealing with the presenting partner rather than the couple also seemed to prolong treatment unnecessarily. Another aspect of sexuality that has all but been totally ignored by the Institute is the role of social conditioning and the attitudes towards sex by society at large particularly in referring to female sexuality. Dr. Main's talk excellent as it was ignored the double standard of morality and its effects over hundreds of years regarding female sexuality. 'Nice women' were not supposed to be interested in sex nor even to be sexual beings. This was not just mothers view but grandmothers and great grandmothers and so on because society held that belief. The conflict between Madonna/whore that has so bedevilled (if that is the right word) female sexuality is enshrined and maintained by the Catholic Church (see 'Alone of all her Sex, the Myth and the Cult of the Virgin Mary' author Marina Warner, published by Weidenfeld. The Institute also seems to follow strict orthodox views on the vaginal reaction - that is the formation of the orgasmic platform and the rhythmic contractions of the vaginal muscles in the orgasm with sexual intercourse, indirect stimulation of the mons area or clitoral body stimulation. What may vary is the duration and intensity of the orgasmic experience and I suspect the perception at a psychic level of where the orgasm takes place since the vagina is to all intents and purposes a non-existent sexual organ for the first fifteen to twenty years of a woman's life, i.e. before she has intercourse.

However, setting aside these disputes and to return to the concern I expressed at the beginning about the Institute, members may be unaware of what is happening in the field of teaching about human sexuality in medical schools that may determine our future or non-future. Dr. Elizabeth Stanley brought to this country a collection of explicit sexual forms, the so called glide films, together with training programmes used for several years at the University of Pennsylvania Medical School. These films have been shown to about 300 medical students to help them devise training courses. My personal feeling about these films is that they are useful for getting people to examine their sexual attitudes provided that their

group discussion leaders are sensitive and skilled. Medical schools alas have been tardy about the teaching of human sexuality. They are beginning to become aware of the deficiency and are anxiously looking for curriculum a.v. aids and ways of teaching it. Many psychiatric departments have opened sex therapy clinics that have tacked on so to speak M and J behaviourist techniques complete with instruction sheets usually handed out by para medicals.

I regret that the Institute was slow to appreciate what M and J have done and to incorporate their techniques which would have been the logical extension of our work adding to our basic psychosexual counselling skills, behavioural approaches that have much in common with our use of the vaginal examination. Perhaps this can be remedied. Meanwhile can we not publicize ourselves more and try to become involved in undergraduate teaching in medical school (I am aware that 300 doctors are now doing their seminar training with the Institute). Unless we do I fear that what we have achieved will be ignored and relegated to the position of the dodo, extinct and forgotten. For once sexuality becomes a subject on the medical schools curriculum in the psychiatric and obstetric departments (the logical place for inclusion of courses on sexuality) it will become male dominated. I am not for the domination by either sex, but pessimistically I see a future for the treatment of psychosexual difficulties rather similar to that of family planning - an activity initiated and maintained largely by women and subsequently taken over by men. In the field of sexuality where we have much to contribute for the good of our patients and society can we not try to find ways of sharing this.

Yours sincerely,

Dr. E. Christopher MB.Bs D.ObstROCG DCH
Senior Medical Officer Family Planning

APPENDIX D

NEW MEMBERS SINCE NEWSLETTER 7

Sue Adams,
The Old Rectory,
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Avon. BA 26JU.
0225-4577.

John Limbert,
New Bradwell Surgery,
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New Bradwell,
Milton Keynes. MK13 0AA.
0908-313221.

Carole Robertson,
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Swindon,
Wilts.

A. Tothill,
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N.W.8.
624-9186.

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Brockenhurst 2146.

Mavis Mary Conway,
St. James Close,
St. James Villas,
Winchester,
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0962-4651.

Mary Griffin,
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01-6528.

Margaret Miller,
Delfryn Maudlam,
Nr. Bridgend,
Mid. Glamorgan.

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0528-22419.

Eric Trimmer,
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Pinner Hill,
Middlesex.
836-8586.

CHANGE OF ADDRESS

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Egypt Lane,
Farnham Common,
Bucks. SL2 3LF.

Elizabeth Gregson,
The Priory of St. John,
Wells,
Somerset BA5 1SW.
Wells 72148.

Anne Tonge,
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0732: 52046.

Valerie Bradburn,
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