PATHOLOGICAL MOURNING IN A WOMAN REFLECTED IN HER SON

A pregnant woman's father died a few days before her baby was born. Usually a complaining man, he had tried to hide the severity of his illness to shield her pregnancy. Her mother and her husband both told her not to cry or attend the funeral as they feared for her baby. Only after her 5-year-old elder son had repeatedly asked to visit his grandfather was he told of his death. His mother remained unable to talk or let her son talk about it. He became enuretic, refused to sit on his depressed mother's lap, and like her could not cry for several months. Now aged 11 he is underachieving, isolated, and accident prone. He may be carrying the brunt of his mother's failure to get over the loss of her father; a problem of incomplete mourning, pathologically prolonged, for which they are both receiving psychotherapy.

Management of perinatal bereavement

Firstly, the syndrome itself requires recognition. Powerful natural forces have hitherto led to its neglect. A perinatal bereavement presents a family and their doctors with the bewildering predicament of needing to think and feel about a new life and a new death at the same time. The bereaved woman may be helped if we enable her to keep alive the expectation of future mourning once her baby is thriving. She should participate in those activities that help to differentiate between the fetus and the dead and cannot be left until later. It may be more important and valuable for her than for anyone else to look at and touch the corpse, and she should attend the funeral. Death at home and former prevalent ceremonies—the wake, the closing of the coffin—all used to facilitate contact that now has to be reconstructed artificially. Others should not sort out and dispose of the personal effects of the dead person; this should be left for the bereaved woman to do when she feels ready. Letters and photographs should be preserved.

The name of the dead should not be given to the newborn. False ideas that the new baby "looks so like" the dead person should be resisted and recognised as danger signals—the "replacement child" syndrome[4]; the fantasy of reincarnation; and the associated tendency to idealise the dead. These risks to siblings are increased considerably when a child has died.

A bereavement during pregnancy may sometimes be actively circumvented, as when an oncologist agreed to further treatment for a child dying of leukaemia as his mother was pregnant. This gave some fraught time to work with the mother in the puerperium.

The psychotherapeutic focus, both before and after the birth, should be to help the mother achieve a clear psychic separation between her baby and the dead, particularly necessary if a child has died. When the new baby is securely in existence the memories of the dead can be revived to help make the death real. This helps reactivate the normal mourning process inhibited by pregnancy.

References

[1] Lewis, E, *Bulletin of the British Psychoanalytical Society*, 1977, **10**, 24.
[2] Winnicott, D, *Collected Papers*. London, Tavistock, 1958.
[3] Lewis, E, *Journal of Child Abuse and Neglect*. In press.
[4] Poznanski, O, *Journal of Paediatrics*, 1972, **81**, 1190.

(*Accepted 11 May 1979*)

Personal Paper

Sexual dysfunction

ERIC TRIMMER

British Medical Journal, 1979, **2**, 28-30

The treatment of sexual dysfunction presents a persistent difficulty for we do not really know what "normal," "healthy," "adequate," or "inadequate" sexual behaviour really is, and we have, therefore, adopted a patient-centred definition of the problem. So a sexual problem exists when an individual expresses a complaint about one or more cognitive, affective, or behavioural elements of sexual functioning or sexual relations. In addition, behaviour that produces demonstrably harmful consequences for the perpetrator or for others is also defined by society as a problem, even if the patient does not complain of it. Being effective, as a doctor, in making suitable therapeutic interventions in sexual medicine can be a rather complex procedure, and treatment may be considered under three headings: (*a*) anxiety dispersal, (*b*) restructuring behaviour, and (*c*) restructuring people.

A slightly different way of stating this is to suggest that therapeutic strategies may be based on three options.

(1) If anxiety is causing the dysfunction it must be reduced or avoided.

(2) If sexual attitudes and behaviour are unrewarding or damaging they may be restructured by means of psychosomatic or pharmatrophic treatments.

(3) If a dysfunction is maintained by ineffectual interpersonal communication this must be modified in an attempt to reverse the dysfunction—for example, by counselling.

Anxiety dispersal

Unfortunately the classic treatment strategies that have evolved in the world of sexual medicine have been, generally speaking, credo orientated rather than patient orientated. This has led to conflicting and often self-defeating "schools" of treatment developing. The Masters and Johnson credo is an instance of this, and if we examine this in a little detail we can see how slavish application of such a credo can lead to dis-

London WC2R 0HP
ERIC TRIMMER, MB, MRCGP, editor *British Journal of Sexual Medicine*, and general practitioner

appointing therapeutic results. Anxiety and more specifically anxiety about sexual performance is, according to Masters and Johnson, the prime inhibitor of sexual response and needs, therefore, treatment strategies classically focused on anxiety reduction. Thus personal treatment situations are prescribed during which the demand for sexual performance is reduced or eliminated.

First of all, sensuous touching in which no expectations of arousal occur is advised, together with the forbidding of genital stimulation or attempts at coitus. As treatment proceeds, to minimise anxiety a hierarchical order of tasks is prescribed beginning with the one that is least likely to provoke anxiety and which allows patients to "act easy" sexually before progressing towards tasks likely to produce a little more anxiety. Such treatment assumes that the more frankly erotic exercises are (the more closely they approximate to coitus) the higher the likelihood of anxiety being provoked. In many instances this assumption may be valid, especially if coitus is viewed as a demand for performance or has been the point in sexual activity at which previous failures have occurred. The nature of the anxiety-provoking stimuli, however, may greatly vary from one person to another, and if this is forgotten treatment will fail. For example, a man may feel greatly threatened by having just to stroke his partner in a gentle and non-demanding manner if she has repeatedly criticised him on previous occasions for his sexual ineptitude or lack of real (genital) sexual drive. Anxiety in sexual situations can often be triggered not by worry about coital performance but initially by an individual's perception that he or she is not becoming aroused when or as they should. In such cases it would appear logical to prescribe treatment likely to produce heightened levels of arousal, on the assumption that this would serve to obviate the problem. Thus Patricia Gillan and her co-workers evolved a seemingly paradoxical type of sex treatment—the so-called stimulation treatment.

Behavioural restructuring

Most sexual-dysfunctions can be cured without too much difficulty by matching the symptoms, obtained during thorough sexual-history taking, towards the right kind of treatment—be it anxiety dispersal, behavioural restructuring, or drug treatment.

Experience shows that eclecticism in sexual medicine may lead to therapeutic bonuses and considerable time saving so far as the physician and his patient are concerned. In other words, certain dysfunctions seem to lend themselves (more or less) to certain types of treatment. An example is relevant in the dysfunction of premature ejaculation. It is possible to treat premature ejaculation effectively by using classic behavioural treatment (using the squeeze technique) or through restructuring behaviour. Both of these therapeutic approaches are time consuming, however, and in the face of a very effective psychopharmacological treatment—for example, clomipramine or thioridazine—a behavioural approach seems unnecessary. In other dysfunctions very simple physical treatments bring rapid and rewarding results, as for example in vaginismus. If this is treated logically, as a conditioned avoidance response to intercourse, by relaxation treatment and digital self-penetration lengthy counselling can often be avoided.

The effective treatment of erection failure, and what may be considered to be its female counterpart, orgasmic failure, involves the widest range of sex therapy. Poor results are due to a lack of appreciation of the aetiological factors and a lack of realisation that both these conditions are symptom complexes and not diseases as such. A full history of the complaint and a clinical examination will exclude certain important iatrogenic factors and indicate those cases in which the essential pathology behind the symptomatology is organic. Sometimes the nature of the pathology excludes any possibility of behavioural or counselling techniques succeeding, and to embark on such treatment is unjustifiable as well as unrewarding. At times prosthetic treatment or therapeutic intervention along pharmacological lines are indicated.

Restructuring people

Sometimes the diagnosis indicates that a degree at least of personality manipulation or psychosexual counselling of a more or less behaviouristic type is indicated, in which case the type of treatment most likely to succeed must be selected. Therapeutic bonuses can occur if treatment options are kept flexible.

PLISSIT

Jack Annon's PLISSIT type of treatment is particularly useful in general practice. The object of this simple exercise is to provide an "errorless" learning maturation process and thereby increase the patient's sense of self-mastery, which in turn inhibits anxiety. Care is taken to work in a no-fail context. Patients are instructed to undertake any behavioural modification should they be employed with no rigid expectations of improvement and to welcome any outcome as an opportunity to learn more about their responses.

PLISSIT is a mnemonic for a simple therapeutic exercise. Permission (P) is first granted, by an authoritarian figure (the doctor), to the patient to behave sexually. Sometimes this is necessary to break down anxiety-laden taboos. Sometimes indeed the permission relates to a paraphilia or a deviance. At times sex therapy ends satisfactorily at this early stage. A further extension of the PLISSIT therapeutic intervention is the provision of limited information (LI). This information may range from the facts of sexual anatomy and physiology to, for example, a better understanding of the process of aging or the psychopathology of a paraphilia. Specific suggestion (SS) covers all physical therapeutic interventions, whether they be purely empirical or on a more finely structured level. Annon, who has pioneered this simple management stratagem, finds that only in one case in fifty is intensive therapy (IT) necessary, and in such cases reference to a consultant in sexual medicine (if such an animal is within easy reach) is indicated.

OTHER METHODS

Are the elaborate methods that have developed mostly abroad (notably in the United States) to treat the psychosomatic sexual dysfunction, often by using a multidisciplinary approach compounded into a set therapy programme, really necessary? In such therapeutic situations couples are typically treated first by the assignment of graduated exercises. At other points in their treatment, implosive or flooding techniques (which do not utilise the graduated approach) may be used. Couples may attend film viewings during which they are exposed simultaneously to several films depicting themes that are capable of eliciting high levels of anxiety or arousal. This SAR (sex attitude restructuring) technique is now being offered in this country. Other therapists use elaborate anxiety-reduction methods based on extinction rather than on the graduated counter-conditioning approach, while still others report reversal or orgasmic dysfunction through the use of implosion, a technique that floods the client with anxiety-provoking stimuli to induce maximal levels of anxiety and thereby extinguish it. This implosion may include symbolic or realistic themes. Finally, psychoanalytic psychotherapy of a more classical (Freudian) type is also used.

Some years of experience have now convinced me that sexual dysfunction is no more difficult or easy to treat than, for instance, cardiac dysfunction. For many years a therapeutic nihilism has dogged sexual medicine coupled with a "gut feeling" among doctors that the subject is not perhaps something that sits well on our much loved pharmacological basis of therapeutics. New knowledge in sexual medicine has, however,

"thrown up" several drugs that appear comforting to our need for prescription remedies including not only hormone treatments of wide-reaching usefulness but certain new specific drugs, like cyproterone, bromocriptine, and potassium aminobenzoate to mention only three of more recent interest.

An eclectic method of practice is always mandatory in sexual medicine, and no one has the authority to assume that he may enter the "mystery" of sexual medicine through the exclusive door of, for example, behaviourism or even experientialism, any more than he may enter the Church only through the portals of the Catholic or Anglican Faith should he feel spiritually so inclined. The most successful and effective practitioners of sexual medicine graft their skills on to and draw their power from a thorough and enjoyed practice of medicine generally.

(*Accepted 11 May 1979*)

MATERIA NON MEDICA

Orkney wisdom

In these days of EMI-scans and silicon chips, when a senior medical citizen puzzles over such things as a "pharmacokinetic analysis of oral bioavailability" or "serum content of eicosapentaenoic acid in vegans," it is encouraging to discover evidence of simpler wisdom in non-medical man in an isolated rural community.

The Orkney Islands are said to show a high incidence of multiple sclerosis, and my wife goes to visit sufferers on behalf of our local MS society. So we drove out to middle-aged Angus one Sunday, a bachelor living in a "but and ben" miles from anywhere in particular. Angus has a dog called Gyp, an 8-year-old collie. He had trained this animal, and showed us the result. He offers no command but speaks softly and patiently: "Close the door, Gyp," and Gyp pulls a strap on the inward-closing door and shuts it. Cigarettes first and then matches are fetched from the top of a lowish fridge and returned somewhere else after use, according to instruction. Pieces of peat are brought and placed in the basket. An old pilchard tin is produced from a bucket for his milk and then put back. Angus, on his bed, is handed slippers, shoes, and socks, and clothes are pulled from one room to another for him. The pièce de résistance is reached when Gyp pulls the bed clothes over Angus and then gets under them himself. When our friend was in hospital recently the dog got annoyed with the telephone and took the receiver off to get some peace.

Our tradition has it that dogs guide the blind but they may well serve others as well. For years, Angus has given himself this occupational therapy of dog training. He enjoys the permanent company of another living thing, which has become a focus for his existence. And the dog has become an appliance performing such acts as Angus cannot perform himself. Long did we speak about Gyp on the way home. Should he be the only one of his kind?

Other evidence of wisdom comes by way of the traditional Orkney chair. This has a back of parallel horizontal straw rows, one inch wide, bound with sisal twine. A good chair back has a convexity fitting the lumbar curvature. To achieve this, Orkneymen work two straight rows at the bottom, then ten rows inwards, two further straight up again and the rest gently outwards, producing a convexity of about 160°.

Clearly, father coming home from his work on the croft enjoyed having his lumbar spine firmly gripped when resting, looking at the kettle hanging above the fire, with mother at the spinning wheel. Any low back pain was relieved, or even prevented.

My own Orkney chair has served me well. It may even have cured my own back trouble which affected me sorely—until I went native. —PETER KONSTAM (retired consultant surgeon, Kirkwall, Orkney Isles).

Canoeing

I bought it only last summer and had a fascinating time collecting accessories as some collect stamps. Though I had mused about it on and off for several years, in the end it was "impulse buying." A lucky impulse it was, and now I'm a canoeist. Not for me, certainly at present, the bold ride down white water on rushing rivers. But it has opened a new dimension in my outdoor life: lakes, lochs, canals and even the sea.

With no difficulty I lift it from my roof rack and launch it single-handed. I can sail it in dead calm or in storm conditions stronger I think than a dinghy would tolerate. It carries me, faster than appears, over deep sounds or on water inches deep. With careful packing it will accommodate adequate light camping gear for me to plan nights on off-shore islands.

In October I made my way over a choppy sea to Maiden Island near Oban. Last Monday, with waves crashing over foredeck and the cockpit skirt, I worked up Lake Vyrnwy among the mountains of mid-Wales to sheltered peaceful headwaters. There I watched snow storms sweeping over the lake, blurring the shapes and colours of distant hillsides. I had a helicopter visit all to myself!

Complementary to walking in its environment, it is complementary too for weather conditions. Ullswater, Bassenthwaite, Derwentwater, and Loch Etive all were delicious and peaceful on days of lowering cloud, chilly dampness, and frequent light rain.

Shropshire Union canal crosses rolling country for 17 miles without a lock. What surveying! Try it on some weekday when Fishermen are absent.

I am waiting patiently for the Severn flood to quieten down and in June plan to explore the waters of west Scotland.—KEITH NORCROSS (consultant orthopaedic surgeon, Birmingham).

The charms of Devon

Down here in Devon we do not ordinarily extol our countryside, because we prefer to keep it to ourselves. We guardedly welcome newcomers and wonder which of them will go prowling around vacant properties. From my experience of three years in this picturesque village, I am convinced that husbands have little say in the acquisition of homes for pending or ultimate retirement. The wives arrange these things, but they do not always know what they are letting themselves in for. The settling-in period usually goes smoothly, allowing at least six months for adjustment to a simple way of life.

Some advantages are immediately obvious. Things like shopping and car repairs can be undertaken with equanimity. Anyone with a sense of history may saunter along the coastal path, gaze out to sea, and imagine the line of Crusader ships going down the Channel from Dartmouth or the Armada being chased by Drake in the opposite direction. He may like to know that 200 years ago the coastal strip, now a golf course, belonged to the Earl of Devon and that he allowed selected tenants to graze a total of 352 sheep on it. For example, a Mr Longman was allowed to graze two. How the numbers were adjusted in the lambing season I have not been able to find out.

Golf is now our important attraction. We do not have a championship course but we like it and we resent criticism from strangers. I soon learnt there is a world of difference between a friendly contest and a match with a stickler for the rules. Take our ninth hole for instance. A well-struck second shot, especially with the wind behind, can easily finish in a ditch running alongside a fence behind the green. Without being too specific about the niceties of the rules, a player has three choices. He can go back and play another but may be disinclined to do so if he is being pressed by tigers who are looking for an opportunity to go through. He may drop the ball within two clubs' length but not nearer the hole. This is impossible because of the fence which marks the "out of bounds" and anyway I would not wish to play a wedge shot off the well-kept lawn beyond: it belongs to some very nice people I have known for years. The last alternative is to drop the ball laterally and not nearer the hole. Here is where the stickler may have some views. In rainy weather the ditch becomes a torrent and the ball may come to rest anything up to 50 yards down stream—if it does not then disappear into a drain. Although one has some freedom of choice in where to drop, there are some rather nasty bunkers and it is possible to choose a spot between them, giving an easy run up. Such behaviour might be interpreted as unsporting. I do not know the answer but would suggest to a newcomer a little underclubbing when he plays his second shot to the green.

When a guardedly welcome couple have been down here a couple of years, the husband is likely to have settled into a comfortable routine. What his wife thinks about it depends primarily on links with her children and grandchildren. Despite excellent roads, we are rather a long way away and she would do well to ponder before submitting to the charms of Devon.—NEVILLE OSWALD (retired consultant physician, Thurleston, Devon).