

The Cuddly Penis

At the 2006 European Federation of Sexologists Conference in Prague my colleague Ruth Hallam-Jones and I presented papers. Although I could report on any number of interesting and stimulating topics that were presented the serious 'stuff' of Conference can be found in EFS publications. Therefore, I thought I would report on one of the lighter sides to our visit, when we introduced the delegates to our latest invention, the Cuddly Penis.

While this 'toy' brought much amusement to the otherwise sombre proceedings, the delegates soon realised how vital this piece of equipment would be to their practice.

The Cuddly Penis was designed in order to demonstrate penile scrotal rings used in the treatment of erectile dysfunction (see Wylie, Hallam-Jones & Steward 2006). Since this treatment involves placing a solid chrome ring around the penis and scrotum, the standard clinical demonstration models of penises, which are rigid and rarely combined with testicles, were not suitable. Therefore, we realised that a penis and testicles made of soft flexible material, that resembled a flaccid penis, was required.

Consequently, we commissioned my 86 year old mother to knit a penis complete with pompom testicles. Having 'tested' it in practice we found that not only was it the only suitable means of demonstrating the penile scrotal rings but, since it was less intimidating than the anatomically correct models, it put clients at their ease. Indeed, when one particularly nervous client saw the Cuddly Penis he smiled and said, "That makes me feel much better".

Lori said delegates from America, Sweden, Denmark, France, Spain, Italy, the Czech Republic and Israel had all taken Cuddly Penises back to their practices. She added that a number had also asked for the knitting pattern, and the delegate from Israel was looking forward to lots of Jewish grandmothers taking up the challenge of knitting penises.

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And More Fun

Crochet – As you've never known it

It would seem that Dr Lori Boul's cuddly penis, has found a mate, yes unbelievably. There is a website called CrochetMyCrotch.com. The woman who crochets these unbelievable representations of female genitalia is called Becki Lee and her claim to fame is that she has won an award at the Erotica Show in London for her creations!



Prevention of Cardiovascular Disease by Early Identification of ED

With the recognition that endothelial dysfunction is the common denominator linking vascular disease to ED has come the realisation that ED may not just be a consequence of vascular disease but the first manifestation of vascular disease which is 'silent' elsewhere.¹ Most of our cardiac risk evaluation methodology is designed to detect obstructive coronary disease but it is the subclinical lipid rich plaques that rupture leading to an acute coronary presentation that are of the greatest concern. ED has now been shown to be a marker of coronary artery disease presenting either chronically or acutely which raises the question as to whether ED should be used in men otherwise asymptomatic for identifying shared vascular disease as a means of not only identifying shared risk factors (diabetes, smoking, hypertension, depression and aggressively hyperlipidaemia, obesity, lack of physical activity) but reducing them.

We accept equivalent diabetes as a cardiovascular without a cardiac recognising that a diabetic non-diabetic who history has the same risk as Can we class ED similarly? The short answer is not yet but we can until proved otherwise use ED as a marker of cardiac risk and where risk factors exist reduce them along the lines of secondary prevention (as if an event had occurred). Whilst we do not have follow-up data confirming intervention will reduce the risk of developing symptomatic CAD we do have good data from cardiovascular (non-ED) studies that men of a similar age and vascular risk benefit significantly from risk reduction in both primary and secondary prevention trials involving thousands of men (and women).² It is inconceivable that a significant number of men in the cardiac studies did not have some degree of ED – no one thought to ask!

In the absence of large scale intervention studies these cardiac studies should represent the basis for current clinical practice. The prevention of CAD or reduction in the risk of subclinical CAD becoming a clinical event involves addressing the blood pressure, lipids, glucose and lifestyle of the individual man. Whilst ED is not a cardiovascular equivalent per se it is in terms of shared vascular risk factors and in turn shared risk reduction.

Graham Jackson, Consultant Cardiologist, Guy's & St Thomas' NHS Foundation Trust, London, UK.

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From the Editor

All good things come to an end, so the saying goes, and my time as editor of this newsletter is no exception. This will be the last time that I have the honour and privilege to bring this newsletter to you on behalf of the BSSM. I am relinquishing my editorial duties for professional reasons. I am most fortunate to have won a fully funded scholarship for three years to read full-time for my PhD. My scholarship is jointly funded by the Welsh Assembly Government's Department for Research and Development and the Health Foundation. This means that I have had to give up some of my other commitments.

I have really enjoyed my time as editor, and it has been great fun, but I feel now that I cannot give it the input that it deserves. I am particularly proud of the newsletter because it was upon my suggestion (rashly at a meeting) that the newsletter began. So although it is only two years old, it has gone from strength to strength, and I hope that the new editor when appointed will continue to enjoy producing it.

I am grateful to all those contributors who have kept me supplied with a steady stream of articles, and hope that this will continue. I look forward to reading more of Dr David Edwards' series on the fascinating world of medical anthropology, as well as snippets of news and events from around the UK, plus some of the latest research.

The aim of BSSM is to "recognise the importance of a holistic approach to the importance of human sexuality and its problems". It is therefore poignant to read Barbara's personal account (in this issue) of how illness has affected her sexuality and sadly how health care professionals still don't address the issue with patients. Barbara's article has not been edited at all, and what you read are all her own words. I am deeply indebted to her for sharing this aspect of her life with us.

On a lighter note - as is the editor's prerogative on the last edition - I have included some most unusual knitted and crocheted items (please, no requests for the knitting patterns!). Goodbye, Edna.

NEWS NEWS NEWS

A new and innovative approach to treating sexual problems has been launched in the UK. Novel treatments include short stay residential retreats working with experts in sexual and relationship therapy and most of all a chance to understand yourself. More information can be found at www.restoration-therapy.com

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Contact: Ruth Hallam-Jones or Dr. Lori Boul 0870 350 1764 or (+44) 114 237 4377 email: info@restoration-therapy.com

UK Physician announced as President Elect of International Society for Sexual Medicine

BSSM is delighted to announce that Dr John Dean from Plymouth has been announced as the President Elect of the International Society for Sexual Medicine. We wish him all the best and good luck in the new role.

British men have the worst sex lives

Three out of 10 British men have not had sex in the last 12 months, according to new research. An international study in the Journal of Sex and Marital Therapy reports that only 70 per cent of men in Britain have had sex in the last year and that British men have the worst sex lives, while Canadians have the best.

Systemic vascular abnormalities in Peyronies disease



The precise aetiology of Peyronie's disease (PD) remains obscure. Risk factors (RFs) for endothelial dysfunction and atherosclerosis such as hypertension, hypercholesterolaemia, diabetes mellitus and smoking are commonly seen in patients with PD

¹⁻². These systemic disorders have been hypothesised to have a role in pathogenesis of PD by resulting in a hypoxic micro-environment in the penile tunica albuginea leading to exaggerated activation of transforming growth factor- β and aggravation of the fibrotic cascade. However, PD does occur in absence of cardio-vascular RFs. It is unknown whether a systemic vascular abnormality is seen in PD in the absence of conventional RFs.

In a recent presentation at the British Association of Urological Surgeons at Manchester in June 2006, researchers from the Andrology unit at the Institute of Urology, University of London presented results from their study working on the hypothesis that PD is associated with systemic vascular changes even in the absence of atherosclerotic RFs. This study investigated whether systemic vascular function abnormalities in subjects with PD in absence of RF compared to age-matched healthy controls.

Twenty one, un-operated PD patients within the age range of 31-66 were recruited from consecutive PD patients attending a tertiary referral clinic between 2004-2005 were age-matched with 21 healthy males which served as controls. All subjects were free of cardiovascular RFs (Cholesterol > 6.5, BP > 140/90, smoking, and diabetes mellitus).



Fig.1 Brachial artery being scanned

This study utilised the technique of endothelium-dependent flow mediated dilatation ³ (FMD) to study the systemic vascular function. The brachial artery was imaged using high resolution ultrasound (Fig.1). Reactive hyperaemia was



induced by a 5-minute period of ischemia in the forearm. Changes in brachial artery diameter were measured offline using an automated edge detection system (Brachial Tools) and calculated as percentage change from baseline diameter.

Blood flow was measured continuously using a pulse waved Doppler signal. Increase in blood flow at cuff release was expressed as a percentage change from baseline flow. Endothelium-independent vasodilator response to 400 μ g sublingual glyceryl trinitrate (GTN) was then measured and expressed as % change in diameter from baseline (NMD - Nitro-glycerine mediated dilatation).

The baseline artery diameter was similar in PD and controls. The baseline forearm blood flow and flow response to 5 minutes of ischaemia (hyperaemic flow) was greater in PD. Despite this, Endothelium-dependent vasodilatation (FMD) was impaired in PD patients compared to controls. Endothelium-independent vasodilator response to GTN (NMD) was similar in PD and controls.

The increased baseline flow and hyperaemic response in PD subjects compared to controls but impaired FMD in PD subjects suggests differences in systemic micro-vasculature between PD and healthy controls, which could be due to either a structural abnormality or difference in vasodilator tone. The authors concluded that these wider vascular abnormalities in PD are likely to be of clinical relevance and require further study. This study is the first to demonstrate impaired systemic endothelial function even in the absence of RFs for atherosclerosis in men with Peyronie's Disease.

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Principal Author of the study: Mr. David Ralph (top right)

Update on Statutory Regulation for counsellors and therapists.

The summer months has seen the publication of two important reports around the issues of regulation.

The Donaldson Report "*Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*", was commissioned by the Secretary of State following the report of the Shipman Inquiry (5th Report). This report also takes into account three other inquiries into doctors' conduct and standards of practice and includes the cases of William Kerr and Michael Haslam, whom worked with patients with sexual problems.

The report focuses exclusively on the medical profession. It identifies the problems involved in regulating 130,000 doctors in diverse roles in both private and NHS sectors. The report considers the role of the General Medical Council and the changes that have occurred over the last few years. It also looks at regulation in other countries and professional grouping to see if ideas can be transferred usefully. It concludes with 44 recommendations, and proposes a major programme of reform.

Although the report is over 200 pages long, I found it to be an easy read. For those of you will less time the 8 page summary will give you a good taster.

It seems to support a move away from central statutory or governmental regulators to more devolved responsibility towards regulatory units. The report addresses the need to design and strong and effective interface between clinical governance and the systems regulating individual practitioners. The report challenges the climate of blame and retribution around misconduct and complaints and considers the "off with their

heads" approach may make medical practice more dangerous. The report recommends educational and standard setting bodies have a more formal role in medical regulation. It supports the need for clear standards that are valid, reliable, capable of assessment and transparent to the public, profession and employers. It recommends developing improved methods to assess against these predetermined standards.

The second report is: - "*The Foster Report: The regulation of non-medical healthcare professions*". This report has been conducted over the last 18 months and representation has been requested from various professional organisations involved in regulation. BASRT responded to questions asked in September 2005. This report has clarified that the HPC will be the identified regulatory body for counselling and psychotherapy. However, changes will be made to the HPC to ensure an increase in lay regulators. Professional representatives will be made to appointed roles, rather than being presented following professional elections. The time scales for regulation remain as before with a planned date of 2008 for counselling and psychotherapy.

This report, as with Donaldson, supports the notion of light touch and risk based regulation. Foster also suggests the need for the development of named standards that fitness for practice can be measured against. Generic complaint procedures which are transparent and standardised are advocated. The report does value the role of professional bodies in leading standard setting alongside regulators who hold responsibility for enforcing regulation of those predetermined standards. The report is shorter at only 70 pages but an important read for anyone involved in regulation and the role of a professional body.

Both reports can be accessed and downloaded from the DH website on www.dh.gov.uk

Alongside both these reports, internal work with professional bodies has been active during the summer. UKCP presented to the DH a report in February 2006 entitled "A regulatory and competency framework for the UKCP, its colleges and its registrants". This report reviews previous work by National Occupational Standards (NOS) and is also mapped alongside Qualifications Assurance Agency (QAA) and Qualifications and Curriculum Authority (QCA).

As a follow on to this report, UKCP has requested that all the different modalities within UKCP provide modality specific standards. BASRT has responded to this request and has provided master level competencies that would be expected by a competent psychosexual and relationship therapist. This work has been presented to the training standards committee at the end of August at UKCP and will be used to define the specific aspects of competence that is required by therapist in this speciality as compared to other psychotherapy specialities. UKCP will combine this modality specific competencies and present back to DH a comprehensive review of generic and specific competencies across the range of psychotherapeutic counselling and psychotherapy field.

Sally Openshaw, MSc, BEd, RNT, RGN

UKCP Registered Psychotherapist
BASRT Accredited Therapist
CPC Registered Member
Chair of BASRT

A Patients Perspective on Sexuality and Illness

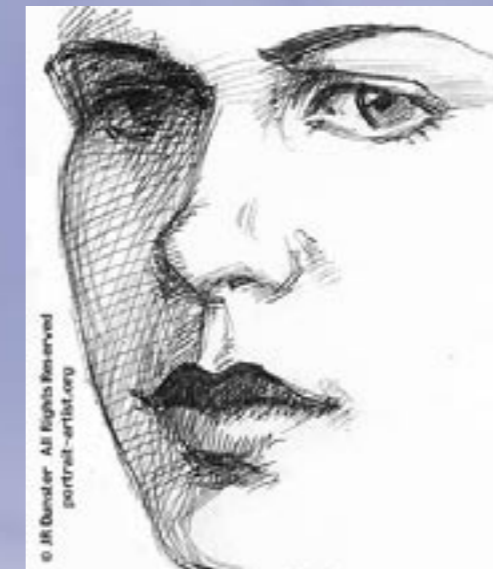
Having enjoyed a fulfilling and varied sex life, the confines of osteoarthritis in my hips came as rather a shock. However I looked forward to hip replacements and an eventual return to a wider range of movements, and a better degree of suppleness.

This was not to be the case. I raised the subject of my sex life with both physio and specialist, and met either amusement or a degree of embarrassment. The "I expect you'll manage," type of attitude. Having very little abduction, plus difficulty turning over, proved rather inhibiting, in fact I was surprised at how much I was affected emotionally. I tried to discuss it to no avail. Eventually I found a booklet in an Arthritis Charity Shop, referring to sex after replacements, but found it more 'Janet and John' than 'The Joy of Sex' --- so, I 'managed'

Some time later I discovered I had breast cancer and I had a mastectomy and node clearance. The hospital tried to persuade me to have re-construction surgery, which I declined having seen patients on the ward with infections following such an operation. Despite the fact that I have never been shy about nudity and that I liked my body, I was shocked to find it difficult to look at myself one breasted. Again I felt a big blow to my once confident sexuality. At this point I would really have appreciated some advice and support from the hospital staff on this sensitive subject. In fact there was none, and I recall one night nurse was quite brusque with me on the subject, appearing quite surprised that I had actually voiced such concerns.

Fortunately for me I had by then a new partner who was quite unfazed by my appearance and appreciated me as I was, lovingly encouraging and supporting me throughout this period. I have found out since that many women return home to find that their partners cannot even look at them, causing great

distress. Lately I have developed an autoimmune disease named Lichen Sclerosus. This incurable skin disease only affects the genital area, destroying their profile, causing painful itching and general discomfort. The least one can hope for is to slow the progress of the disease down with steroid creams. This has been extremely upsetting as I am now 65 years old and the treatment is exacerbating the 'thinning' effect of the skin ageing. I cannot use oestrogen-based products to counter this effect, as my cancer was oestrogen dependent.



I still feel desire, have fantasies and want lovemaking. Once more I have tried to discuss these various aspects with my clinic. I am lucky to be a fairly forthright person, not afraid to question things that do concern me. Even so I have been unable to engender a positive or helpful response to my questions, other than vague expressions of sympathy. A shy or more reticent person would clearly receive even less support in these circumstances. I do feel it is very important for both women and men who's sex lives are inhibited, or even curtailed following treatment for illness or disease, to have access to clear, sensitive and fully comprehensive advice. Addressing not only the mechanics of their changing sexual relationships, but also

how to counter the emotional and psychological problems that impact on them. A lack of self worth, depression, and of course frustration itself, are often the after effects of such treatments, on both the partners concerned.

I would strongly emphasise that I believe that age has nothing to do with the way advice is presented on how to enjoy and manage one's sex life after debilitating illness or radical surgery. I was only 54 when I had my first hip operation, but what of a much younger person faced with many years of frustration at a time when they are most sexually active. I do feel it is essential that sexual therapy should become part and parcel within the overall remit of postoperative care and rehabilitation for people of all ages. Let's not forget the healthy partner who really needs to know how to face life with their incapacitated partner, to learn to make adjustments both physically and emotionally.

To sum up I would like to see a sexual therapist made available in all hospitals and clinics on a similar basis as a physiotherapist. Why not include the teaching of sexual therapy techniques as an integral part of the full training course for a physiotherapy qualification. Alternatively include this discipline within the training for all local surgery nurse practitioners so that advice is available both at hospital immediately after treatment, and ongoing after the patient returns home.

Satisfying and happy sex makes our lives richer, and surely aids our well-being and recovery, whatever our circumstances!

Barbara

The role of ethnographic interviews in medical research on sexual dysfunction

It 'disputes with the human intellect, and sometimes has intellect it-self, and although the will of a man may wish to stimulate it, it remains obstinate and goes its own way'



Leonardo da Vinci
(commenting on the
penis)
(1452-1519)

Although the above statement was written many centuries ago, it still remains true to the present day! Conversely anthropology and cross-

cultural sexual research are relatively recent bedfellows (Gebhard 1971); earlier anthropologists have studied and published on various sexual topics, arguably one of the most well read being Malinowski (1929). Some ethnographies had a label of being 'erotic and exotic' (Davis & Whitten 1987) but Caplan (1987) commented that sexual activity was 'natural, innate, and instinctual'. Ortner & Whitehead (1980) discuss the 'sex roles' that men and women have from culture to culture mentioning, but question the general tendency to equate men to the 'culture' terms of 'warrior, hunter, statesman, elder' as compared to the 'nature' ones of 'wife mother, sister'.

The importance of the penis to mankind

Herdt (1996) mentions Freud's (below) theory of the primacy (pre-eminence) of the male sex (the phallus). The Shorter Oxford Dictionary (2002) defines phallus as 'the penis, especially as an organ of symbolic significance; an erect penis'. I would propose that the erect penis is of immense importance to mankind, albeit that each



generation gives the debate a contemporary twist. (Schultheiss 2005). On the other hand, all of the above depend on the man's sexual function being normal... what then if he cannot achieve an erection?

Ethnography

Coming from a medical background I was aware of an overwhelming process of evidence based medicine utilising both qualitative and quantitative data in its approach to research (Savage 2000). Ethnographic study is slowly but surely becoming a research tool in healthcare (Oliffe & Bottorff 2006, Savage 2000). Nevertheless it has come from a long and infamous pedigree in anthropology. The word ethnography according to Barfield (1997) was introduced in 1771 by Schläzer; a German linguist and historian who used it interchangeably with 'Völkerkunde' in the 'descriptive and historical study of peoples and nations'. Prichard was perhaps the first to write in English concerning ethnology in 1813. Lack of space and relevance to this newsletter prevents much expansion on the word's development albeit that monographs by Rivers, his student Radcliffe-Brown and seminal works by Malinowski are prime examples of ethnography (Barfield 1997, Kuper 1996).



Methodology

The principle methodological qualitative data collection tool has been the interview; of which there are many formats crossing the boundaries of many disciplines. Whereas some interviews are designed to 'test a priori hypotheses'

(DiCicco-Bloom & Crabtree 2006) with set questions and analysis; Anthropological research explores the perceptions of life experiences and other social and cultural aspects of the actors. The fieldnotes obtained enable one to obtain a better understanding, generate hypotheses and provide insight for future research. There have been many varieties of interviewing techniques. Malinowski (above) one of the early

Report on World Association for Sexual Health, Mexico, April, 2006

An expert consultant meeting was convened by Professor Eli Coleman, in Oaxaca, Mexico. From the UK, Kevan Wylie (Sheffield) and Sarah Hawkes (London) represented sexual medicine and sexual health. The purpose of the meeting was to build a meaningful declaration on the promotion of sexual health in alignment with the millennium development goals. A generous grant by the Ford Foundation allowed the World Association for Sexual Health (WAS) to organise the process bringing together a group of 45 experts from around the world. The Declaration on the promotion of sexual health which was made at the World Congress of Sexology in Montreal 2005 will be developed with substantial strategic documents. As the United Nations and the International Community begin to implement targets based on the millennium development goals the explicit advocacy on behalf of sexual and reproductive health and rights is essential. The millennium development goals derived from the United Nations millennium summit in 2000 are substantial in both breadth and scope but are virtually silent on the key sexual and reproductive health and rights issues with the exception of HIV and AIDS. WAS, the international expert consultation will together in partnership with PAHO and WHO lead the way to promote sexual health. Many of the background papers will be published and once the declaration is completed it will be disseminated to all relevant agencies and divisions within the UN system as well as through other international health and education agencies.



Dr Kevan Wylie in Oaxaca

Dr Kevan Wylie, Consultant in Sexual Medicine, Porterbrook Clinic, Hallamshire Hospital, Sheffield

PERSISTENT GENITAL AROUSAL DISORDER (PGAD)

Nearly 400 women worldwide have logged in to Sandra Leiblum's website affirming that they have this syndrome. It was initially described as persistent sexual arousal syndrome (PSAS) but PGAD seems more appropriate because women with this disorder complain of genital arousal that is unbidden and not preceded by sexual desire.

Many of these women spend hours a day masturbating in order to try to get relief from their symptoms, though in fact it seems orgasms do not diminish the unpleasant sensations. It was first recognised and described in 2001. PGAD has been described in association with depression, withdrawal from Selective Serotonin Reuptake Inhibitors (SSRI) antidepressants, high intake of phytoestrogens, local arteriovenous fistulas and raised levels of atrial natriuretic peptide (a profound vasodilator).

The author has seen the syndrome in association with local vasocongestion, lichen sclerosis and possibly candidiasis. It is therefore important for these women to be screened thoroughly both physically and psychologically.

In spite of PGAD seemingly being an attractive syndrome to have i.e. to be genitally aroused, it seems the majority of women with it are distressed or very distressed by their symptoms. However there are a subgroup of women who have entered Leiblum's PGAD website who are not distressed by this syndrome- indeed they welcome it in that they find the spontaneous arousal pleasant.

Dr Kevan Wylie and his colleagues in Sheffield have found PGAD in one woman which was associated with objective evidence of increased vaginal pulse amplitude. In my unit (St Mary's Hospital, London) we have seen a woman with a complex cardiological condition (atrial septal defect) who had raised levels of atrial natriuretic peptide (a profound vasodilator) and PGAD after going onto fludrocortisone to raise her blood pressure.

There are a few cases where specific causes of PGAD have been found. These include consumption of large amounts of soya in their diet, local arteriovenous fistulas or lichen sclerosis. Such conditions should obviously be treated. Where it is associated with SSRI withdrawal, time may help the condition to resolve. One woman who had severe PGAD with suicidal depression received electroconvulsive therapy and found temporary relief from the PGAD. Cognitive behaviour therapy and mindfulness meditation may be used to help patients to decrease their repeated masturbation . This may be very helpful as it may encourage patients to be more accepting of their distress. Psychotropic medications such as antipsychotics may also be worth considering.

Dr David Goldmeier, Clinical Lead, Sexual Dysfunction, St Mary's Hospital NHS Trust, Praed Street, London

*For those interested there will be a satellite symposium on PGAD just before the next ISSWSH meeting in Orlando, Florida in February 2007.

Conference round up

De Vere Mottram Hall Cheshire



Part 1 -THE ANNUAL MEETING OF THE PRIMARY CARE ED SOCIETY

The 3rd annual meeting of the Primary Care ED Society was held at Mottram Hall, Cheshire on the evening of Wednesday the 6th June and Thursday 7th June. The meeting was attended by 65 delegates with a good mixture of General Practitioners, Primary and Secondary Care Nurses, a lone Urologist together with Dr Mike Cummings, Consultant Diabetologist, who is a member of the Advisory Board to the Society. The meeting started with a champagne reception in the grounds of the Hotel on a lovely summers evening.

The meeting started with a welcome from the Chairman Dr Mike Callander who introduced the first speaker Dr Emile Morgan, Consultant in Genito Urinary Medicine who gave us a clear explanation of what is on offer at a GUM clinic. His talk was followed by dinner, an after dinner speech by Dr Tony Buckland and then a disco where many of the delegates showed their true spirits by fully engaging with the moment.

The morning of Thursday June 7th began with Professor Mike Kirby giving us an erudite up to date talk on the developments and the links between ED, Cardiovascular disease and Diabetes distilled from presentations at the ESSM in Copenhagen. Victoria Lehmann and Susan Quilliam presented the prospective of ED from the couple's side both male and female. There followed a lively debate between Dr Pat Wright and Dr John Tomlinson about the role of testosterone. John was for the motion this house believes that we need to know testosterone levels proposed by Pat who when a vote was put to the floor convincing won the debate. The conference then had an open discussion about the relevance and importance of Practice Based Commissioning and it was clear from the discussion that there were huge variations around the country, which came as no surprise. The conference broke for lunch and to allow people the opportunity to network.

The afternoon session commenced with Simon Williams, Consultant Cardiologist at Wythenshawe Hospital, Regional Cardiothoracic Centre who presented the evidence for the use of Procoralan in patients with Angina. This is most useful as it gives us a useful alternative to the use of nitrate therapy in patients with ED thus allowing us more extensive use of PDE5 inhibitors. Dr Sanjay Aryam, consultant Cardiologist from Wigan Hospital gave us an entertaining and provoking presentation on Sex and the Heart. Conference then broke into two workshops, one lead by Dr David Edwards on prospectives in Erectile Dysfunction, which was an interesting and novel approach to Practitioners perceptions of erectile dysfunction. The second workshop was lead by Mike Callander, Michael Spencer and Pat Wright and attempted to unify the assessment examination and treatment of erectile dysfunction by using software that is being developed to capture data in patients with erectile dysfunction in the United Kingdom. This is presented in detail in another part of the newsletter.

The Conference concluded following tea with Dr Tom Robinson presenting Research on Erectile Dysfunction and in fact Tom is heading up a Sub-Committee on Research in ED in the UK. Dr Tony Buckland brought the educational part of the meeting to a conclusion with a comprehensive presentation on Premature Ejaculation and where we are now.

Dr Mike Callander brought the Conference to an end by thanking all the Speakers, Delegates and Sponsor's.

The Society is open to all Practitioners both Primary and Secondary Care who have an interest in developing care pathways for patients suffering with erectile dysfunction. Please visit our Website www.primarycareedsociety.co.uk or contact Dr Mike Callander directly on 07909 964751 or alternatively by email – drcallander@hotmail.com.

pioneers of ethnography (Kuper1996, Malinowski 1929) tended to use unstructured interviews using key informants. I used this approach predominantly during car journeys, mealtimes and post- prandial 'veranda discussions' among family members, friends and employees of Lasantha my host whilst carrying out my ethnography. This provided me with a background of 'life' in Sri Lanka across a variety of religions and class structure. It also created a logistics problem in either remembering... or writing and eating with your right hand!

Focus groups

On the other hand Morgan (1988) pointed out that:

'Focus groups are useful when it comes to investigating what participants think, but they excel at uncovering why participants think as they do'. Furthermore Fetterman (1989) maintains that 'an open mind also allows the ethnographer to explore rich untapped sources of data not mapped out in the research design'.

Quantitative data

Medical research (and I am as much to blame for this) very often takes qualitative comments from hundreds of participants, very often on a European or global scale. A research assistant that commonly has a paucity of language skills processes the data obtained; this is then analysed by computer to produce quantitative results that the scientific world is so hungry to consume. On the other hand historically anthropologists are not totally blameless; Lévi-Strauss (1969) sent informants out into the field who would then relay the data back to the anthropologist for analysis. Increasingly both medical research and anthropological ethnographies need to have a solid foundation of evidence on which to build (Gash 2000).

Sampling

Although the quantitative protagonists might argue that my texts come from a relatively small number of actors by using my experience and knowledge previously gained I could depend on the 'truthfulness, accuracy and memory' (Clanmer 1984) of such participants. Furthermore the spoken word is only one piece of the ethnographic jigsaw; other pieces include facial/hand/body expressions, cultural, geographical, historical, religious, political and economic considerations.

Of paramount importance is to convey a sense of being there; in order 'to grasp the native's point of view, his relations to life to realise his vision of his world' (Malinowski 1922).

How true this is when we see the poor patient with his sexual problem sat before us in our busy surgeries.

Over the forthcoming newsletters I hope to share with you my various experiences ranging from sampling herbal remedies for sexual dysfunction, to knickers, dancing girls and their relevance to erectile dysfunction!

Dr David Edwards. GP and author.

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Hurry up: her interest's waning

A woman's sex drive goes off the boil almost as soon as she's got her man, says study

According to an article in the Sunday Times, August 13, 2006, by Maurice Chittenden and Roger Dobson, the female sex drive starts to splutter to a halt as soon as a woman has got her man, according to a new study. Researchers have found that women's libido plummets so rapidly when they believe they are in a secure relationship that after just four years the proportion of 30-year-olds wanting regular sex falls below 50%.

There are few things that appear able to keep a woman sexually interested, the study found, but living apart for extended periods can help. The findings for women contrast with those for men, whose sexual appetite hardly flagged at all up to 40 years after marriage. The study, by researchers at Hamburg-Eppendorf University in Germany, challenges the popular image of modern women as equal to men in sexual appetite. "Female motivation matches male sexual motivation in the first years of the partnership and then steadily decreases," concludes Dietrich Klusmann, the medical psychologist who conducted the study. "Male motivation remains constant regardless of the duration of the partnership." The results may suggest why the characters played by Billy Crystal and Meg Ryan in the film *When Harry Met Sally* feared whether having sex would ruin their friendship. Klusmann questioned more than 500 people about their sex lives in order to measure changes in their libido. Klusmann found that within a year of a relationship starting, female libido moved into steep decline. While 60% of 30-year-old women reported wanting sex "often" at the start of a relationship, the figure fell to below 50% within four years and to around 20% after 20 years. Klusmann, whose work will be published this week in the journal *Human Nature*, has compared his findings to the sexual habits of prairie voles and offers an evolutionary explanation. He believes women, having found a man with whom to procreate, keep "resources" scarce to keep the man interested. Men, on the other hand, maintain a higher sex drive in the hope of keeping their mate faithful and other men at bay. The Germans found, however, that living apart slows the decline in female libido, confirming the maxim "absence makes the heart grow fonder".

Women whose husbands or boyfriends have higher educational qualifications than their own also maintain their sex drive. This, speculates Klusmann, is because such men are regarded as a "valuable mate of choice" by other women. The German study is reinforced by an investigation by Mary Carole Pistole of Purdue University in Indiana, whose work suggests the healthiest relationships are among people whose loved ones live hundreds of miles away. According to an article in the Sunday Times, August 13, 2006, by Maurice Chittenden and Roger Dobson, the female sex drive starts to splutter to a halt as soon as a woman has got her man, according to a new study. Researchers have found that women's libido plummets so rapidly when they believe they are in a secure relationship that after just four years the proportion of 30-year-olds wanting regular sex falls below 50%.

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The Sunday Times asked other experts to comment on the research.

Dr Petra Boynton, a sex psychologist, agreed: "Surveys like this don't always tell the real truth. Women are more likely to divulge their problems while men feel under pressure to say they are good in bed because their masculinity requires it."

But Paula Hall, a sexual psychotherapist with Relate, the couples' guidance service, backed the study. She said that in the first two years of a relationship both partners produced phenylethylamine, a natural amphetamine that has been called the chemical of love.

"After those two years the woman's sexual drive changes," said Hall. "She becomes receptive rather than proactive and unless there is a trigger she will prefer to have a cup of tea and watch *Coronation Street*."

Klusmann's researchers also asked respondents whether they agreed with the statement "I just want to be tender". On this measure, men's performance fell off as quickly as women's sexual desire. Women's desire for tenderness remains an almost constant 90% whatever their age and regardless of whether they have been with the same man for one year or four decades. Men claim to be just as doe-eyed as women at the start of the relationship, but this wears off very rapidly. Only a quarter of 30-year-old men who have been in a relationship for 10 years are still seeking tenderness. "Cuddling is important for women and they may say they want tenderness because they do not like to express sexual desire and can only do so from the dialogue of romance," said Boynton.

Editors comment: Hmm never thought of myself as a prairie vole

