was in a small village and there were lots of young men and maidens and old men and old women, and people of our own age, and they all had their problems, a lot of them being the sort of problems we are concerned with, and the solutions were not all orthodox, conventional, or acceptable. After a gruelling couple of hours the job was finished. The two priests walked away and the young priest said anxiously: " Well Father, how did I do? " and the old priest said: " My boy, you did splendidly. I've just got one piece of advice for you for the next time. I think from time to time there should be a bit more of the tut, tut, tut, and not quite so much of the phew! " For the doctor, neither of those expressions is appropriate; he should listen as a human being entering into a human situation. What the patient wants is wisdom, kindness, and acceptance. More than that he cannot ask; less than that he cannot, indeed, accept or bear.

THE PROBLEMS

J. Barnes, M.B., B.Ch., N.U. IREL. (*General practitioner, Dublin*)

Mr. chairman, ladies and gentlemen, we have gathered here to discuss several aspects of sex which appear important to us in general practice. Our choice of topics has not been capricious, because our choice has been influenced by the relation these topics bear to marriage, and it is therefore most appropriate that our first guest speaker be Dr John Marshall, who is a medical adviser to the Catholic Marriage Guidance Clinic of London.

Surely all the sexual problems of marriage are brought into focus by such a clinic or guidance centre, and it is my earnest hope that he will not only outline the organization, function and achievements of this clinic, but by the force of his argument convince us that we need such a clinic here in Dublin. To us in general practice he will be speaking to the converted. Our patients will show all the usual causes of unhappy marriage that exist in other countries, but I personally feel that circumstances in Ireland will modify these fundamental stresses so as to give a characteristic Irish slant to them. First and foremost is the absence of divorce and the secondary

effects which stem from it, the most obvious being that if two personalities are at variance then they may continue to squabble and fight for many years and call in the assistance of priest, doctor, relatives and neighbours, their differences are proclaimed from the house-tops, and they seldom agree to differ. This, of course, is a tribute to the solidarity of the marriage bond.

I am also convinced that the non-availability of divorce prevents much marital infidelity which might otherwise take place. In those countries where divorce is more freely available and a couple are at variance, they will often seek intercourse outside marriage with a view to finding a new partner. Such adventurism cannot have this particular purpose in Ireland. It is obvious that the subject of marital infidelity is not amenable to statistical survey, but I feel that the general practitioner is entitled to express an opinion with authority, because there is nothing surer than the fact that an aggrieved and suspicious wife will confide in the family physician. Such cases are not frequent in my practice—not more than two a year. I am evidently not in a position to expound on the problem as it occurs in our emigrants in England. I suppose that the incidence is high, but apart from the occasional deserter, the lost sheep come home wagging their tails behind them and no one is the wiser.

No discussion on marriage can be complete without reference to the abuse of alcohol, and certainly no marriage guidance clinic will be free from the problems that arise from it. This abuse of alcohol is something radically different from alcoholism. Where, in fact, alcoholism would appear to bring out the very best points in a marriage, the abuse of alcohol brings it to the rocks.

I would like to paint a picture of a typical case to illustrate this point. A married man who works hard all day takes a pint or two on his way home. I was told last year by a visitor from England that this is a trait peculiar to Dublin people, and that an Englishman would never dream of having his pint until he has got home and taken his tea and then gone out possibly with his wife. However, the Irishman arrives home with the smell of drink on his breath. The wife, whose father may have been a heavy drinker, resents this and she nags him over his tea. Of course, he finishes it as quickly as possible and hops out to the 'local' with his companions; he comes back with an even stronger smell on his breath and this time he gets a little bit aggressive. It is not difficult to visualize the scene that follows. Everybody has a headache next day—including the general practitioner, who has the wife down with him. On the husband's side, there is the evident abuse of alcohol, the failure to provide any companionship to this wife, and an abnegation of his responsibility to the children. On the wife's part,

there is an intolerance of alcohol and a predisposition to endogenous depression, known to Dublin people as house-decline. She simply stays at home and is determined to stay at home and not go out with him. Particularly she will not enter a public house with him, which is a very sad thing.

Therefore, there would seem to be a ready-made collision course set for many marriages in Ireland, and if I appear to attach undue importance to this aspect of Irish life, you may appreciate my viewpoint better if I explain that my practice is almost exclusively in a working-class suburb. However, on the same basis of personal experience I see great hope for the younger couples who come to my area. They aim at a much higher standard of living and are actually far more mature than their older brothers, and I can foresee that this problem will decrease in the years ahead. I trust that these brief and scattered remarks on marriage will indicate the need that we have in Dublin for a fully integrated marriage guidance clinic. I would emphasize that our problems may not all be the same as those across the sea, and also that such a marriage guidance clinic need not be based exclusively on a medical service. I presume Dr Marshall will also emphasize that the other contributors—social workers, legal advisers and so on—to such a clinic play a very vital role.

The subject of homosexuality is intriguing to us in general practice because we hear so much about it and sense that it must be a real problem to a small proportion of our patients. Yet I venture to say that we meet extremely few cases ourselves; in fact, if we wore blinkers we could conveniently ignore the problem. This came very clearly to me once when a young man, whom I knew quite well and whose house I had often visited, came to my surgery and asked for a note to a psychiatrist but declined to discuss his problems with me. I sent him to a psychiatrist for whom I have the greatest regard, and later discussed with him why this very strongly fixed homosexual had not confided in me. He pointed out the obvious fact that these patients are going to have continuing relations with their family doctor for a lifetime, and they do not want to place this relationship in jeopardy by bringing to light a problem about which they feel great guilt. They elect to unburden themselves to a total stranger. From this, I infer that there may be fields of psychiatric medicine from which the family doctor is debarred by this very intimate and continuing nature of his association with patients. These fields, no doubt, are strictly limited to those whose guilt is deeply felt and the problem is not shared by other members of the family. Problems shared between husband and wife, for example, land on our plate every day. I have no doubt that we should respect this appeal to privacy, and our psychiatrists are admirably suited to

deal with this. We are all aware that psychiatrists must be endowed with the virtue of patience to a degree far above the average, but in dealing with homosexuals they must call on reserves of charity, not of the passive variety but of that kind begotten by the marriage of science and charity; to them, I commend the motto of our own College—*Cum scientia caritas.*

At a very early stage in planning this symposium we all agreed to keep our feet firmly on the ground and recognize the fact that the greatest single problem in marriage is failure to procreate. Accordingly, it was a great pleasure for us to call on Dr Alan Browne, Master of the Rotunda, to speak on infertility. We who practise in Dublin are grateful for the special clinics provided by the maternity hospitals and recognize their great worth, but perhaps I might be pardoned if I suggest that these special clinics are too routine and mechanical in dealing with individual couples. They are perhaps too narrowly conceived in their present structure along the lines of physical investigation. This routine, I think, makes for complacency and fails to provide the stimulus to undertake more active treatment, such as tubal reconstruction and hormone therapy, and more sophisticated forms of investigation and treatment. Perhaps I might illustrate this by suggesting that habitual abortion comes under the heading of infertility. In the past few years I have chosen a number of such patients and had a purse-string suture inserted in the cervix when they were about six to eight weeks pregnant. Out of five cases this measure has been successful in four, but it has to be done by a specialist in domiciliary consultation under the Health Act; you can imagine the inconvenience and the amount of time spent arranging the visit and working under domiciliary circumstances. I do not want to enter into a discussion on the merits of this particular operation, but I am emphasizing that in treating infertility a tremendous effort is needed from everybody and it must be a team effort. The difficulty of bringing this highly technical and sophisticated service to a wide public can be readily appreciated and the responsibility for integrating it in an already overburdened maternity hospital is not easy for a Master to take.

If homosexuality can be described as a disease narrow in extent but deep in effect, frigidity must be accepted as both extensive and affecting all levels of the personality. Frigidity almost defies definition and classification because it is so frequently only one expression of the patient's basic personality interacting with her husband, rather than a disease *per se.* We all are aware that it is nearly always present in anxiety states, hysteria and depressive states. We have not brought Dr Rosen all the way from London to deal with this aspect of frigidity; rather do we look forward to his dealing with those cases of primary frigidity where there is a

true defect of the basic personality, and perhaps dealing with cultural influences in addition. There is one form of frigidity that should never reach a psychiatrist, namely, vaginismus in the newly married. The family doctor is admirably placed to deal with this common problem and is entirely competent to do so. The family physician in Ireland appreciates that this problem is not only one of coital technique but also has a far more important background of cultural influences, predominant being the misinterpretation of the virtue of modesty in the transition from the state of virginity to the married state. Our churches have fostered a deep regard for chastity and modesty in Irish youth throughout the ages, and the teaching of the churches has been confirmed by parental authority. No small wonder, therefore, that many Irish girls find the transition between the two states difficult, and even go through a period when they have a positive distaste for intercourse. Equally, it can be seen that if the doctor dwells only on coital technique he is doomed to failure. He must approach the problem by an explanation of its true genesis and guide the couple towards the true union of their bodies, minds and souls.

I would like to sound a warning note based on my own experience about cases of longstanding frigidity. Only a few years ago, a married but childless couple came under my care, and after visiting their home on a few occasions I felt confident enough to enquire into the reason for the sterility of the marriage. It immediately became apparent that despite 15 years of marriage, intercourse had never taken place. This appeared to be a very simple case of vaginismus in the newly married which had been left untreated. It had gradually become the accepted state between this very good couple. The husband and wife were now in their late thirties and very united and I, in my inexperience, launched into a series of consultations designed to help consummation of the marriage. However, after a few such sessions I came to my senses and recognized that this man and wife were entirely happy and contented in their relationship, and that for me to attempt to make a change in their established pattern of living could only end in failure and possibly disaster.

It is most appropriate that the problem of adolescence be discussed within the context of this symposium. In fact it gives a completeness to any sensible discussion on marriage. However, if the choice of subject was easy, the choice of speaker was not immediately apparent to us. We cast about in all the specialties of medicine and in social science and even the law, but we were not satisfied that any one specialist could handle this topic comprehensively. The light of day reached us in the form of our esteemed colleague, Elizabeth Doherty. The problems of adolescence are so numerous and varied that I will not attempt to set them out individually; I

would like to suggest that the fundamental issue is the transition from utter dependence to complete independence. This intermediate stage of development in a human personality takes place largely within the family, where most of the tensions originate. Society and the community outside the family are affected by adolescent problems but do not themselves have a prominent or directional influence on the individual children. Hence our choice of a fellow family physician, I feel, will meet with your approval. Most of us in general practice see relatively little of children between the ages of 12 and 20. Statistically it is the most healthy period of their lives, and they never depend on our services in the sense that other sections of the community do. This independence from our services makes them a more difficult group to study, but Dr Doherty will illustrate how she has overcome this difficulty.

MARRIAGE GUIDANCE

J. Marshall, M.B., Ch.B., M.D., F.R.C.P. (*Consultant Physician, The National Hospital for Nervous Diseases, London*)

I do not think one can speak about marriage guidance without first of all saying something about who is to do it. In the Marriage Guidance Commission of the International Union of Family Organizations one meets many different kinds of people engaged in this work. In many countries it is mainly a medical concern, largely the work of psychiatrists who have increasingly in their practice concentrated upon marriage guidance. In some other countries, clergymen have been trained specially for this work; for instance, in the Roman Catholic archdiocese of Chicago about a dozen priests a year are put through a year's course in marriage counselling. But it is about the work of the laity, by which I mean both the non-clerical and the non-medical marriage guidance counsellors, that I wish to speak. I wish to speak of them first of all because it is their work with which I am most closely acquainted, and secondly because I think they have a very important contribution to make in this field. I was gratified to hear Dr Barnes in his introduction suggest that a marriage counselling centre was a desirable thing because I myself am convinced of this.

Marriage guidance counsellors are lay people of a considerable standard of education, of about university level or equivalent, care-