Title: **Sparing the doctor's blushes: the use of sexually explicit films for the purpose of Sexual Attitude Reassessment (SAR) in the training of medical practitioners in Britain during the 1970s**

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Abstract

The general reluctance of medical practitioners in post-war Britain to 'speak of sex' during healthcare consultations increasingly became a matter of professional concern in the wake of legal reforms and social changes during the 1960s affecting sexual expression and reproductive health, and a growing optimism in the early 1970s concerning the treatment of sexual difficulties. In the mid-1970s, largely as a result of the work of Dr Elizabeth Stanley, Sexual Attitude Reassessment (SAR) seminars were introduced from the United States into some medical schools in Britain, usually as a part of courses that were intended to help students develop the attitudes, knowledge and skills needed to facilitate the discussion of patients' sexual concerns and to treat 'simple' sexual problems. SAR seminars entailed the showing of sexually explicit films as a stimulus for exploring, in small discussion groups, the sexual attitudes and beliefs of students, and the potential impact of these on future professional practice. Drawing on publications by Dr Elizabeth Stanley as well as archival materials, this article examines the aims of SAR seminars, the rationale provided for their inclusion in the undergraduate medical curriculum, and the 'permission-giving', educative approach to sexual counselling that SAR seminars supported. It also explores some of the barriers to the more widespread use of such seminars in medical education in Britain at this time. The behaviourally-informed 'permission-giving' approach to sexual counselling promoted by Stanley and others is also considered alongside the more psychoanalytically-informed 'interpretative' form of sexual counselling provided by some Family Planning Association (FPA) doctors from the late 1950s onwards. This comparative analysis reveals contrasting perceptions concerning the role of medical practitioners' emotions in sexual counselling and elucidates some of the reasons for the fragmented and limited development of this aspect of medical practice in Britain.

(294 words)

Introduction

> 'It is bad manners and bad medicine to force one's own personal moral attitudes and beliefs about sexual matters on patients.' (Adler 1998, 1470)

So wrote Professor Michael Adler in an editorial published in the *BMJ* in 1998, in which he welcomed the imminent publication of the first edition of the *ABC of Sexual Health* (Tomlinson, 1999). In a Foreword to this book, Adler, Britain's first professor of genitourinary medicine, lamented the lack of training in sexual health provided at undergraduate level, which, he claimed, left medical practitioners lacking the knowledge and comfort to effectively help patients who were experiencing sexual difficulties (Adler 1999). This was a claim supported by Dr David Tomlinson, the editor of the *ABC of Sexual Health*, who recounted that his own sex education as a medical student had comprised a one hour lecture 'by the aged pioneer of contraception, Marie Stopes', delivered to a packed lecture hall (Tomlinson 1999, viii). Reflecting on his experience as a course organiser for trainee general practitioners during the 1970s and 1980s, Tomlinson recalled that one of the most frequent requests from trainee general practitioners was for more help with patients' sexual problems, as none of the trainees had received any training in human sexuality. With some notable exceptions, Tomlinson added, at the turn of the millennium, this still seemed to be the case.

In this article, I examine an initiative during the 1970s to provide some medical students in Britain with the opportunity to explore their attitudes to sexuality and consider how these might impact on their ability to counsel patients with sexual problems in their future professional practice.[i] This initiative centred on the use of Sexual Attitude Reassessment (SAR) seminars (sometimes also referred to as Sexual Attitude Restructuring seminars), which quickly became an integral component in the training of sex therapists in Britain (Brown and Dryden 1985; Dryden, Bollinger and Brown 1988). Drawing on several publications by Dr Elizabeth Stanley, who was largely responsible for introducing the SAR seminar to medical schools in Britain (Brown and Dryden 1985, 327), I explore how the SAR seminar sought to reduce the discomfort of medical students with human sexuality. I

also outline the approach to sexual counselling that this process of 'attitude re-assessment' was intended to facilitate. Before doing this however, I provide a brief overview of the development from the late 1950s onwards of a more psychoanalytically-informed approach to sexual counselling by some Family Planning Association (FPA) doctors. I suggest that in both approaches to sexual counselling, the emotions of practitioners were considered crucial to effective medical practice, but in very different ways. Examining the differences between these two approaches to sexual counselling as well as the contexts in which they emerged, also helps to explain, in part, the fragmented and contested nature of sexual counselling by medical practitioners that was evident in Britain from the mid-1970s onwards. While little enthusiasm seems to have existed among the profession generally for incorporating sexual counselling into medical practice, I argue that the provision of SAR seminars in some medical schools signalled a recognition by some medical practitioners and educators of the need for a more inclusive as well as holistic approach to medical care, based on awareness and acceptance, rather than denial or pathologization, of the diversity of human sexuality and its expression.

The emerging imperative to speak of sex during medical consultations

In 1968 the Royal Commission on Medical Education noted that few medical schools Britain included any form of sex education in their curricula and recommended that this 'serious omission' be rectified immediately. Not only was this needed to dispel ignorance and misunderstandings among individual medical students, but 'doctors are frequently consulted about problems of sexual development in childhood and adolescence, about sexual difficulties in marriage, and about sexual deviation. Particularly when there is widespread public discussion of these matters, doctors should be able to treat them with informed understanding' (Royal Commission on Medical Education 1968, 109). The Commission further suggested that 'an important part of clinical education in this field lies in the future doctor's learning how to help his patients to overcome the embarrassment which often

makes it difficult for them to disclose their sexual problems. The doctor can help them in this respect only when he has overcome his own embarrassment' (Royal Commission on Medical Education 1968, 110). This emerging focus on the subjective experience of the (trainee) physician was in part a consequence of the increasing therapeutic importance attached to doctor-patient communication and the quality of the doctor-patient relationship in certain branches of the profession, most notably general practice (Balint and Norrell 1973; Fitton and Acheson 1979; Armstrong 1979). This occurred at a time when, as the historian Hera Cook (2014) has argued, the greater autonomy afforded by the welfare state and by new economic opportunities was eroding deference among the British population, undermining notions of duty and service and promoting a greater preoccupation with one's own needs and feelings. Given this and legislative reforms in the 1960s related to sexual behaviour and reproductive health, such as the Abortion Act, 1967 and the Sexual Offences Act, 1967 (which partially decriminalised some forms of sexual behaviour between men in Wales and England), sexual counselling by medical practitioners could be seen as part of the larger project of regulating subjectivity, which Nikolas Rose (1989) has argued is central to governmentality in liberal democracies.

The historian Lesley Hall (2003, 263) has suggested that the medical profession in the twentieth century tended to engage only reluctantly with sexual matters and typically did so in response to societal pressures. A surfeit of such pressures existed in Britain during the 1960s and 1970s, including the aforementioned legislative reforms, as well as second-wave feminism, gay liberation and the depathologization of gay sexuality, the introduction of the oral contraceptive pill and the provision made in the 1974 NHS Reorganisation Act for a family planning service within the NHS (Leathard 1980; Hall 2000; Davidson and Davis 2014). Pressure on doctors to 'speak of sex' during consultations was further amplified by the publication in 1970 of the British edition of William Masters' and Virginia Johnson's *Human Sexual Inadequacy*, which outlined a comparatively brief and seemingly highly effective approach to the treatment of sexual problems and provided a fillip to the flagging professionalization project of sexology.

In contrast to the previously dominant psychoanalytic conceptualization of sexual dysfunctions as symptoms of deep-rooted unconscious conflicts that were often resistant to therapeutic intervention, Masters and Johnson (1970, 21), considered 'sociocultural deprivation' and 'ignorance of sexual physiology' to constitute the aetiological background for most sexual function problems. Their rapid but intensive couple-based approach to treatment, comprising education, 'permission-giving' and the use of certain behavioural techniques, opened up the possibility of sexual difficulties being successfully treated by suitably trained practitioners from a range of disciplines, and helped to create a new type of 'sex expert', the sex therapist (Brown 1980; Brown and Bollinger, 1985; Cooper 1988; Morrow 2008). Based on eleven years of their treatment programme (and five years of patient follow up), the results Masters and Johnson reported for their therapeutic approach to sexual dysfunction suggested a remarkably low failure rate of only twenty per cent. Although major modifications to this treatment approach were required to enable its use on an outpatient basis in a variety of clinical and therapeutic settings in Britain (Cooper 1988, 131), the publication of *Human Sexual Inadequacy* generated considerable clinical and popular interest in the treatment of sexual dysfunctions (Brown 1980, 193), with patients increasingly asking doctors for help with such problems (Home Office 1979, 61, 138; Brown 1980, 205). More requests for help may not necessarily have indicated an increase in the incidence of sexual problems at this time, but possibly a greater willingness of people in the wake of changing sexual mores 'to confess their disappointments or difficulties' (McLaren 2007, 226). As the health psychologist Jane Ogden has observed: 'Before patients can perceive they have a symptom such as "lacking interest in sex" the salience of their experience needs to be raised above a threshold of recognition' (Ogden 2003, 410). Once detected, a range of psychological and psychosocial processes then determine whether the sexual symptom is labelled a problem that is considered appropriate to present for medical attention, including reference to social and cultural norms as well as the symptom's significance for intimate relationships and self-identity. It is therefore likely that the increasing emphasis placed on improving sexual technique and maximising (hetero)sexual pleasure in advice columns and 'sexual

welfare' articles published in 'family newspapers' during the 1970s (Bingham 2009, 88-95), played no small part in persuading some patients to 'confess' their sexual difficulties.

While the types of the sexual problem that were presented to medical practitioners remains largely a matter of conjecture, referrals to the few specialist services that existed in Britain during the 1970s provide some indicators. For instance, the sexual problems most frequently seen at a recently established sexual dysfunction clinic in Oxford were 'erectile impotence', premature ejaculation and ejaculatory failure in men; and 'general unresponsiveness', orgasmic dysfunction and vaginismus in women (Bancroft and Coles 1976). These presentation patterns were similar to those reported in accounts of the work of other medical practitioners in Britain who provided specialist help for sexual difficulties (Duddle 1975, Mears 1978). Most of the patients who attended the sexual problems clinic at Oxford (which was located within a psychiatric department) were referred by general practitioners and it is pertinent to note that 'homosexuality' was the reason given for a number of men being referred to this clinic (see also Bancroft 1975; Bancroft 2009, 256). A sizable proportion of patients referred to the Oxford clinic either declined the offer of treatment or were considered inappropriate cases for therapy. According to Bancroft and Coles, this, in part, was a consequence of the criteria for treatment associated with the therapeutic approach offered at this clinic, 'a modified Masters and Johnson method' (Bancroft and Coles 1976, 1575). Furthermore, not all patients who sought help from their family doctors for sexual difficulties were troubled by specific sexual dysfunctions. As some later studies have found, the most commonly presented sexual problems in primary care settings often tend to relate to sexual dissatisfaction rather than sexual dysfunction (see Read et al. 1997).

While more people in Britain may have been willing to seek medical help for their sexual problems, this did not necessarily mean that they were prepared to do so directly. For some patients, hinting at such difficulties was preferable to direct disclosure. This was possibly because of embarrassment

or uncertainty about whether such problems were an acceptable topic for discussion during medical consultations. In advice to his colleagues working in general practice, Cyril Gill (1980, 6) observed: 'It is only too easy, however, to respond clumsily to the patient's hints for help, and perhaps to make him feel ashamed of his problem.' Moreover, the findings of a study undertaken by Burnap and Golden (1967) in the United States, suggested that the frequency with which sexual problems were presented to physicians (working in a variety of specialities) seemed to be more closely related to the characteristics of the physicians themselves rather than those of their patients. One relevant characteristic of physicians was whether they routinely asked patients about sexual problems, another was whether they appeared uncomfortable talking about sexuality when being interviewed by the researchers. Those who exhibited greater discomfort tended to report much lower frequencies of sexual problems in patients than those who appeared more comfortable discussing the topic of sexuality. Furthermore, Masters and Johnson (1970) also identified 'inadequate counselling' (that is, the provision of inaccurate information and advice about sexual functioning) by physicians and other professionals with the perceived authority to advise on sexual matters, as a significant contributing factor in the development of some sexual dysfunctions. Overall, as Masters and Johnson (1970) signalled, in the face of new sexual freedoms and increasing optimism about the treatment of sexual problems, the physician in the late 1960s and early 1970s was increasingly seen as in need of specific training to deal with the emerging complexities inherent in her or his role (Levinson and Giami 2006, 351-352).

In publications such as the technical report issued by the World Health Organization in 1975, health workers were encouraged to take a positive approach to human sexuality as it was considered far more important to the health and wellbeing of individuals than had been previously recognized. The purpose of sexual health care, according to this report, 'should be the enhancement of life and personal relationships and not merely counselling and care related to procreation or sexually transmitted diseases' (WHO 1975, 7). While the difficulties involved in arriving at a universally accepted definition of sexual health were acknowledged in this report, its key components were

listed as the absence of disease, dysfunction and disorder, the capacity to enjoy and control sexual behaviour, and 'freedom from fear, shame, guilt, false beliefs, and other psychological factors inhibiting sexual response and impairing sexual relationship' (WHO 1975, 6). Education, counselling and therapy were therefore considered crucial elements of sexual health care, providing the impetus for the introduction of educational programmes in human sexuality for healthcare professionals that sought to develop the 'appropriate attitudes', knowledge and skills needed to provide these interventions (WHO 1975, 7). Attitude restructuring, in particular, was identified as an important aim of such programmes as 'the attitudes of health workers can present an important obstacle to their effective functioning as educators and counsellors in the field of sexuality, and it is not surprising that they are often reluctant to become involved in this area' (WHO 1975, 10). The human sexuality courses for medical students that were developed during the 1970s by Elizabeth Stanley (Stanley, 1977, 1978, 1979) and others, in which the SAR seminar was a core component, aligned closely to the recommendations made in the WHO report.

Sexual counselling in medical practice in Britain before the 1970s

Outside of psychiatry, one of the few areas of medical practice in Britain where some involvement in sexual counselling had occurred before the 1970s was family planning, which, until 1974, existed as a medical specialism largely outside the NHS (Leathard 1980). Between the 1930s and 1950s, a number of FPA clinic doctors, including Dr Joan Malleson, Dr Helena Wright and Dr Sylvia Dawkins began to provide marital and sexual counselling to their patients and in doing so not only helped to medicalise sexual difficulties but expanded the scope of the FPA's services (Rusterholz 2020, 85). Many of these early pioneers of sexual counselling had received no formal training in psychology or psychiatry and were largely 'self-taught', but, following the FPA's invitation in 1957 to Dr Michael Balint to train a group of its doctors in the management of marital difficulties (Friedman 1962, 2), a

more formalised approach to training in sexual counselling eventually developed within the Association (Main 1970).

Balint, a psychoanalyst who had been leading small discussion group seminars on psychological problems in general practice at the Tavistock Clinic since 1949, considered a sizable proportion of patient complaints presented in general practice to have their origins in emotional problems that remained largely unexpressed or only hinted at during consultations (Balint 1954; Balint 1961). The elucidation of such problems, according to Balint, depended on the doctor's awareness and interpretation of such indirect communication and their 'apostolic function', that is, their propensity to try to 'convert' patients to their own way of thinking and acting in relation to illness (Balint 1957; Osborne 1993). In Balint's view, a limited change in the personalities of most doctors was required in order for them to hear and think about the feelings that lay behind patients' complaints (Balint and Balint 1961, xi). Dr Leonard Friedman (1962, 7), described this change in the personality of the doctor as follows:

> 'The doctor has to discover in himself an ability to listen to things in his patients that are barely said, and, in consequence, he will start listening to the same kind of language in himself.'

When, as a result of such listening, the doctor understood something about the patient of which the patient was seemingly unaware, the task was then to communicate this understanding (or interpretation) in a way that was likely to be useful to the patient. This capacity to listen and communicate, argued Balint, could most effectively be developed through regular and careful post-consultation analysis of actual practice undertaken in collaboration with one's peers in a group setting, where the emotions experienced by the practitioner during consultations were *'evaluated as an important symptom of the patient's illness'* (Balint and Balint 1961, 61, original emphasis).

In the 'research-cum-training' FPA seminar initiated by Balint in 1958, a psychosomatic approach to sexual counselling was honed, in which the provision of reassurance and direct advice to patients was generally eschewed, the emotions of the doctor were viewed as a potential source of valuable clinical information, and the gynaecological examination was reformulated as an opportunity to undertake a psychological examination of the patient's emotions and fantasies centred on the genitals and their functions (Giles 1961; Dawkins and Taylor 1961; Friedman 1962; Tunnadine 1970). Given that FPA clinics 'almost totally neglected men' (Leathard 1980, 230), the sexual problems discussed in these seminars were typically the sexual anxieties and difficulties presented by women (but see Courtenay 1968), and, reflecting psychoanalytic thinking of the time, such complaints were seen largely as manifestations of maturational difficulties and conflicting emotions about sexuality that existed largely outside of the patient's conscious awareness. The historian Caroline Rusterholz (2020, 118-119) has observed that in contrast to the radical perspectives on women's sexuality espoused by many of the doctors who established sexual counselling within the FPA, the view of female sexuality propounded by such seminar training (and sexual counselling) tended to promote and reinforce traditional gender roles in marriage. Moreover, even within the FPA considerable ambivalence existed about the provision of sexual counselling (and the training provided for it), with some doctors who undertook such work reporting that they were considered by some within the Association to be part of its 'lunatic fringe' (Rusterholz 2020, 118). Only a minority of FPA doctors participated in the seminar training scheme and it was openly acknowledged that many clinic doctors had 'no interest in or aptitude for psychosexual problems' (Main 1970, 11).

FPA doctors undoubtedly did help to establish sexual counselling as an aspect of medical practice in Britain before the 1970s, but only in a very specific (and limited) context. Most patients who presented with sexual difficulties in FPA clinics were married women and the Balint-style seminar training that doctors received from the late 1950s onwards tended to reinforce traditional gender roles in marriage and construe penis-in-vagina sex as both a marker of emotional maturity and a requirement for marital (and therefore social) stability (see Main 1970). In the wake of social and

legislative changes that occurred in Britain during the 1960s, which signalled a seemingly more permissive state, such an approach to sexual counselling was arguably not best suited for responding to the sexual concerns and difficulties presented by patients who were more sexually and demographically diverse than the typical users of FPA services.

The SAR seminar

At first sight, it is difficult to conceive of a seminar format more diametrically opposed to the Balint-style FPA seminar than that of the SAR seminar. Developed by the National Sex Forum (NSF) in the United States, SAR seminars typically involved showing a series of sexually explicit films as a stimulus for small group discussion. The NSF itself had begun in 1968 as an outreach service of the Glide Foundation at the Glide Memorial Church in San Francisco, under the direction of Ted McIlvena (Bullough 1994, 276; Barratt, 2008). The NSF films depicted a range of human sexual activities and relationships and were developed as part of a humanistic tradition in sexology/sex therapy that aimed to promote sexual growth and fulfilment rather than focus on symptom removal (Cooper 1985; Bullough 1994, Tiefer 2006). In the United States, SAR seminars delivered as part of 'sexual enhancement' programmes for the general public were fairly commonplace (Cooper 1985, 389), with a survey undertaken in the mid-1970s of 11 directors of SAR seminar programmes, estimating that approximately 90,000 Americans had attended such seminars (Wollert 1978). Where SAR seminars were incorporated into human sexuality courses for health professionals, the primary objective of the seminar was to enable participants to analyse their personal attitudes to sexuality and consider the impact of these on their professional practice (Wollert 1978; Cooper 1985; Sitron and Dyson 2009).

One of the first documented screenings of SAR films in Britain appears to have occurred in October 1972, when Dr David Mace, a former Secretary of the National Marriage Guidance Council (NMGC),

visited the Council's headquarters in Rugby, bringing with him some early films from the (then) National Sex and Drug Forum which he used in his teaching of medical students in the United States (Heisler 1983, 18), where the number of courses on human sexuality in medical schools had increased dramatically during the 1960s and early 70s (Dickerson and Myerscough 1979, 433). The person considered largely responsible for introducing the SAR seminar to medical schools in Britain, however, was Dr Elizabeth Stanley, who in 1975 initiated a course in human sexuality at St George's Hospital Medical School in London (jointly hosted by the Department of Obstetrics and Gynaecology and the Department of Psychiatry) with the support of the Nuffield Foundation (Stanley 1977). Having previously taught human sexuality to medical students at the University of Pennsylvania, Dr Stanley brought back to the UK her own copies of the SAR films and was one of three 'eminent practitioners' in the field of sexual dysfunction who had received permission from the Department of Health and Social Security (DHSS) in the mid-1970s to import and use such material (DHSS 1980, point 2).

According to Stanley, the subject of human sexuality was fundamentally different to other subjects taught as part of the medical curriculum:

> 'No other subject is so emotionally charged that it can prevent objective application of learned facts, and in no other area are the feelings of the physician so likely to interfere with adequate history taking, diagnosis and treatment' (Stanley 1977, 16)

The aim of the St George's course was to enable students to deal with simple problems themselves and to learn 'how to recognize the limits of their own therapeutic skills and how to make an appropriate referral' (Stanley 1979, 184). Stanley suggested that the most important non-organic contributing factors to such problems were ignorance, cultural taboos and sexual myths, and communication problems. This constellation of factors typically led to 'performance anxiety', arising from unrealistic conceptualizations of sexual 'success' and fear of sexual failure (Stanley 1982a).

The SAR seminar was delivered early in the St George's course and in the course's initial iteration, the eight-hour seminar comprised the concentrated screening of 17 sexually explicit films (some were shown simultaneously) in six sequences, interspersed by small group discussion (usually lasting 30 to 50 minutes), in which the focus was on sharing personal feelings rather than intellectual responses. Stanley suggested that:

> 'Through the process of verbalising feelings, many students develop a new level of self awareness and are frequently surprised to discover the extent of conflict that exists between their feelings and intellect. By becoming more honest with themselves they often find that they are considerably more prejudiced than they had previously realised, and discussion reveals how commonly such prejudices are based on ignorance and fantasy rather than on factual information.' (Stanley 1977, 16)

Among the films shown as part of this SAR seminar were those which depicted men and women masturbating (alone and with partners), a man having sex with his long-term male partner, two women relating to each other 'in a variety of non-sexual and sexual ways', a pregnant woman and her partner who 'share their relationship and sexuality', a man with paraplegia who was unable to have an erection having oral sex with his partner, and an older couple in 'alternating sequences of energetic and leisurely love-making' (Stanley 1978, 442). In addition to showing actual sexual acts, in many of these films there was a particular focus on touch, sensuality, and communication. It would seem that not only did the SAR seminar encourage medical students to reassess their attitudes to various sexual behaviours, same sex relationships, and the sexuality of older people and people with disabilities, but it sought to broaden their conceptualisation of sexual intimacy.

In addition to delivering SAR seminars as part of the human sexuality course at St George's, Stanley was also invited to organize SAR seminars for medical students at the Royal Free Hospital in London,

the University of Sheffield and the University of Edinburgh (see 'acknowledgements', Stanley 1978, p. 445), where the SAR seminar was incorporated into the human sexuality course that had been established in 1972 (Dickerson and Myerscough 1979). In articles describing the St George's course, Stanley stressed that the NSF films were made and distributed solely for educational and research purposes and emphasized the ways in which the films differed from commercially-available 'blue movies', drawing attention to the quality of the relationships depicted and stating that all participants in the films were unpaid volunteers who believed in the educational value of the films (Stanley 1977, 1978 and 1979). This 'boundary work' to differentiate the SAR films from pornography was not made any easier by the fact that since the 1960s the already contested boundary between sexology and pornography had become increasingly porous (Cocks 2004, 483).

Extending the provision of the SAR seminars in undergraduate medical education was complicated by two factors related to this boundary work: the first concerned the difficulties associated with the importation of the NSF films, the second was the resistance to the introduction of such seminars from some medical schools. As the NSF films depicted actual sexual acts, they could only be officially imported from the US by obtaining a 'waiver' from the DHSS to prevent Customs & Excise seizing and destroying the films as 'indecent and obscene' material. In 1978, two films ordered from the United States for educational purposes were indeed seized at Prestwick airport (DHSS 1978a), but the Department was reluctant to make any decision about the granting of such waivers (DHSS, 1978b, 1978c, 1978d, 1978e). Recalling the controversy generated in the early 1970s by the sex education film *Growing Up*, which had also included footage of people engaging in real sex acts (see Limond 2009), a Departmental official argued that it would be difficult to convince both Parliament and the public that the films could be easily differentiated from commercial pornography. Given both the explicitness and content of some of the films (specifically, it was noted, those concerned with homosexuality, oral sex and group sex), any waiver would most likely lead to adverse publicity for the Government and open up the possibility of the issue being tested in the courts, something to be avoided before a General Election (DHSS 1978f). Despite SAR seminars taking place in Britain at

this time (DHSS 1978g, 1979a, 1979b; Winn 1979), the Department continued to put off making any decision about the granting of waivers until after the 1979 General Election when an advisory panel was eventually established for adjudicating on whether any films that were the subject of a waiver request were indeed *bona fide* educational resources (DHSS 1979c, DHSS 1980).

While most medical students who attended SAR seminars evaluated them very positively (Stanley 1978; Dickerson and Myerscough 1979), some medical schools in Britain resisted their introduction on the grounds that cultural differences between medical students in the US and medical students in Britain might make the seminar unacceptable to British students (Stanley 1978, 443). Whether, and to what extent, such cultural differences existed is not possible to determine, but Stanley (1978, 444) noted that on some occasions individual students did show signs of distress during the SAR seminar, 'but always on the basis of some pre-existing problems'. Recognition of such distress by discussion group leaders, according to Stanley, meant that students could be offered individual counselling and 'thereby an ultimate benefit' (Stanley 1978, 444). While opinion was divided in student evaluations about whether taking part in such seminars should be a requirement for medical students (Stanley 1978, 443), Stanley argued that attendance at such seminars should always be on a voluntary basis and that potential attendees should be given clear information about the nature and purpose of the seminar before they attended (Stanley 1979, 185).

Quite high proportions of medical students attending SAR seminars reported that they felt they had previously lacked an accepting and understanding attitude 'towards homosexuality, sexuality and ageing, and sexuality in the physically handicapped' (Stanley 1978, 443). Not only were each of these aspects of human sexuality represented in the NSF films used in SAR seminars, but they were further explored in the courses on human sexuality in which the SAR seminar(s) were embedded. On the St George's human sexuality course, the SAR seminar helped to position same-sex attraction as 'a variation of sexual expression' rather than a sexual deviation, and the session on 'homosexuality' (which included input from gay men and lesbians) was regarded by many students as one of the

most helpful parts of the course (Stanley 1979, 188). A similar finding was reported by the conveners of the course on human sexuality at University of Edinburgh, who noted that the topic of male homosexuality tended to be associated with 'more frequent, strong, negative reactions' in the medical students who attended this course (Dickerson and Myerscough 1979, 435). The students on the Edinburgh course also appeared to be considerably helped in the reappraisal of their attitudes to gay sexuality by the inclusion of members of the Scottish Minorities Group in the group discussion of this topic. It should be noted that a partial decriminalization of homosexuality did not occur until 1981 in Scotland, where, it has been suggested, policy in relation to the governance of sexuality during the third quarter of twentieth century 'continued to be shaped by a traditional medico-moral sexology that focused on the control of the sexual instinct, on the conflation of sexuality and pollution, and on a hierarchy of normality and deviance' (Davidson and Davis 2014, 294).

The SAR seminar and sexual counselling in medical practice

Although the SAR seminar (and the human sexuality courses in which it tended to be embedded) differed in many ways to the FPA seminar training scheme, both approaches sought to bring about a limited change in the personality of the practitioner. While the stimulus used to achieve this was different (the self-reported practice of qualified physicians in FPA seminars and the viewing of sexually explicit films in the case of SAR seminars for medical students), in each approach emotional responses were shared and scrutinized in the 'confessional' of the small discussion group. In the context of sexual counselling training, the discussion group was an important technology for regulating the subjectivity of those practitioners, who were themselves to deploy a particular 'expertise of subjectivity' (Rose 1989, 2).

The small discussion groups convened during SAR seminars were seen as the crucible for expanding students' awareness of the diversity of human sexuality and promoting understanding and

acceptance of sexual practices outside of their own range of personal experience (Stanley 1977, 16). The success of the SAR seminar therefore depended in considerable part on the qualities of the group leaders, who were required to be empathic, demonstrate a warmth of personality and be sufficiently comfortable with their own sexuality to share their own personal feelings with the group (Stanley, 1979). Group leaders were seen as valuable role models for students as these qualities gave students 'permission' to share their feelings at a more personal level (Stanley 1978, 442; 1979, 186). While participation in SAR seminars was typically associated with an increase in knowledge of, and a liberalizing of attitudes towards, human sexuality, it provided 'no shortcut to the acquisition of clinical skills' required to assess and treat sexual difficulties (Dickerson and Myerscough 1979, 436). It did however provide medical students with direct experience of the type of attitudinal environment that was considered conducive to the disclosure and discussion of sexual concerns during healthcare consultations. 'Permission-giving' was seen as the foundation for sexual counselling in healthcare consultations and was communicated by physicians who could listen and talk about sexual matters in 'a frank and open way, with no more embarrassment or discomfort than we would feel about any other medical topic' (Stanley 1982b, 24). 'Permission giving' not only helped to counter the 'inhibiting cultural taboos' implicated in the development of sexual difficulties, but was integral to the treatment strategies considered part and parcel of the clinical management of 'simple' sexual problems in medical practice. These included patient education, teaching communication skills (Stanley, 1982b), the prescribing of activities to enhance sensuality, known as sensate focus exercises (Stanley 1982c), and teaching patients behavioural techniques to modify certain sexual responses such as vaginismus and premature ejaculation (Stanley 1982d, 1982e).

This emphasis on helping patients through permission-giving and (re-)education very much reflected the ethos of Masters and Johnson's approach. It also aligned with a brief behavioural approach to the management of sexual problems, the PLISSIT model, developed by the American psychologist Jack Annon during the early 1970s (Annon 1976), which was seen a framework for brief sexual counselling in healthcare settings in both Britain and United States (Reamy 1984; Hawton 1985, 230-

235; Trimmer, 1989). The first three elements of this stepped care model ('permission', 'limited information', and 'specific suggestions') were viewed as brief therapeutic interventions that could, in theory, be provided by knowledgeable clinicians, whereas the final element, 'intensive therapy', remained the province of sex therapist/clinical sexologist. Annon (1976, 50-56) argued the 'permission' level of this framework, which entailed offering reassurance to patients concerned about the 'normality' of their sexual thoughts, fantasies and behaviours, and permission to continue engaging in consensual sexual activities they enjoyed (or, in some cases, not to do what they did not feel comfortable doing sexually), was often sufficient to resolve many sexual difficulties and helped to prevent the development of more intractable sexual problems.

A recurring theme in Stanley's articles and indeed many of the articles on managing sexual problems in general practice that were published in the *BMJ* during the early 1980s (subsequently revised and republished as *Sex Problems in Practice,* Lock 1982), was that medical practitioners were not expected to be 'sex experts'. Rather, physicians were required to have a level of comfort in discussing sexual matters sufficient to create an environment conducive to the disclosure of sexual concerns by patients, a knowledge of brief interventions for 'simple problems' that require 'little more than common sense once the causative factors are understood' (Stanley 1982a, 10), and the ability to recognize when referral to specialist services was indicated.

Given that some patients would inevitably need to be referred to such specialist services, more sex therapists were needed to support the 'stepped care' approach to sexual counselling by medical practitioners suggested by Stanley and others at this time. In October 1981, following five years of teaching human sexuality to medical students, Stanley and colleagues at St George's Hospital Medical School launched a postgraduate Diploma in Human Sexuality course, which provided practitioners from various health professions with the opportunity to develop the skills and competencies need to treat patients with sexual problems (Stanley *et al* 1986). This course together with other programmes established during the 1970s, such as the University of Edinburgh's Human

Sexuality Course (Dickerson and Myerscough 1979) and the NMGC's psychosexual therapy training programme (Barkla 1977; Heisler 1983), helped to create and sustain a multidisciplinary community of sex therapists in Britain (Bancroft 2005).

Sexual counselling as a contested and fragmented aspect of medical practice

At a time when 'sexuality' and 'health' were increasing being yoked together in the emerging concept of sexual health (Epstein and Mamo 2017), the medical profession, with some notable exceptions, still seemed generally ill-at-ease when communicating about sexual matters. As with the FPA's seminar training, in the SAR seminar (and the courses on human sexuality in which it was typically embedded) there was a concern with the 'doctor-as-person', that is, the influence of the personal qualities of the doctor on the medical consultation (Mead and Bower 2000, 1090). Indeed, the importance attached to changing the 'doctor-as-person' in order to create a 'permission-giving' attitudinal environment that was conducive to the disclosure of patients' sexual concerns could be seen as an acknowledgement of Balint's idea of the doctor's apostolic function. But the behaviourally-informed, educative approach to sexual counselling that the SAR seminar supported, was the antithesis of the interpretative approach to sexual counselling promulgated in FPA seminar training. While sexual ignorance and misunderstandings (and the feelings they engendered) were considered important contributing factors to sexual difficulties in the approach to sexual counselling outlined by Stanley, in FPA seminars, a patient's ignorance of sexual matters tended to be construed as a defence against conflicting emotions about sexuality and doctors were cautioned not to collude with this defence by trying to 'educate' such patients (Friedman 1962, 34).

In the FPA seminar training method, uncomfortable emotions experienced by medical practitioners during consultations (providing they were analysed and not acted on) could help the doctor to listen to things in patients 'that are barely said' (Friedman 1962, 7), whereas for advocates of the SAR

seminar, difficult emotions and sexual prejudices evoked in doctors by matters pertaining to human sexuality potentially prevented the 'objective application of learned facts' (Stanley 1977, 16). These facts were likely to be the products of scientific research, such as Kinsey's (1948, 1953) surveys of sexual behaviour in the United States and the laboratory-based studies of human sexual physiology undertaken by Masters and Johnson (1966). In contrast to Balint-style seminar training, where the emotions experienced by doctors during consultations tended to be viewed as a potential source of valuable clinical information, the SAR seminar (and courses on human sexuality of which it was a constituent part) arguably remained more closely aligned to the traditional medical model, in which clinical assessment, diagnosis and treatment were seen as essentially objective issues, with any 'interference' caused by practitioner's subjective responses and sexual prejudices being remediable through education (Mead and Bower 2000, 1091).

Seen from the perspective of Rose's putative project of regulating subjectivity in the interests of governmentality, the provision of sexual counselling by medical and other healthcare practitioners (and the role the SAR seminar played in supporting this) could be seen as further evidence of what Rose terms the deployment of psychotherapy in the service of regulating subjectivity through the colonizing of other professions, creating new sets of 'problematizations' and 'extending and increasing the sites for the operations of therapeutic encounters' (Rose 1989, 244). Yet sexual counselling made only very limited inroads into British medical practice. While the NMGC established a network of sex therapy clinics, partly as a result of funding received until 1981 from the DHSS (Heisler 1983, 19-21), the systematic development of specialist sex therapy services within the British health service was never supported at a policy level (Bancroft 2005, 572; Irwin, 2009), ultimately undermining the 'stepped care' approach to sexual counselling envisaged by Stanley and others. The provision of sex therapy in the NHS was at best patchy and unstable, with clinics that had been set up by enthusiastic individuals often closing when those individuals moved on (Heisler 1983, 13). This situation was not helped by a lack of clarity about the place of sex therapy in

medicine: some doctors viewed it as part of psychiatry, some associated it with gynaecology or family planning, while others considered it to have no place at all (Hawton 1985, 247).

Furthermore, by the start of the 1980s, the initial enthusiasm for sex therapy was already being tempered by the first trenchant methodological critiques of Masters and Johnson's evaluations of their treatment programme (e.g. Zilbergeld & Evans, 1980) and by the more modest outcomes reported in subsequent studies of sex therapy (Hawton 1985, 200-214). Indeed, the failure to replicate the high success rates reported by Masters and Johnson led some commentators to conclude that cultural changes (such as a growing acceptance of sexuality and the greater availability of sexual information), meant that sexual dysfunctions caused by negative attitudes, lack of sexual information and deficits in sexual skills had been replaced by sexual problems with more complex aetiologies that were less responsive to permission-giving, education and directive behavioural techniques (LoPiccolo 1994).

While this article has focused on the introduction of the SAR seminar into some medical schools in Britain and the approach to sexual counselling this development was intended to support, it has not examined the efforts to preserve and extend the seminar training approach made by members of the Institute of Psychosexual Medicine (IPM), which was founded in London in 1974 by a group of FPA seminar-trained doctors led by Dr Thomas Main, following the transfer of the FPA's clinical services to the NHS (Draper 1975; Draper 1983). The work of these doctors (IPM membership was restricted to only those with a medical qualification), provides another important narrative in the history of sexual counselling in Britain. While some medical practitioners, such as the psychiatrist Dr C.M. Duddle, sought to incorporate aspects of the FPA approach and sex therapy into their professional practice (Duddle, 1975), it would be a mistake to assume that a 'unified' approach to promoting sexual counselling in medical practice existed among the comparatively few medical and other healthcare practitioners in Britain who saw the value of such work (see, for example, Brown 1984; Tunnadine 1984; Bancroft 1985).

In a commentary entitled 'Whatever happened to sex therapy?', Dr Eric Trimmer (1989) suggested that the activities of the IPM may have acted as 'another unconscious "brake" on the GP sex therapy vehicle' (Trimmer 1989, 341). But Trimmer also noted that Masters and Johnson's claim that sexual dysfunctions were almost entirely psychogenic also did little to endear sex therapy to physicians and recalled often hearing sex therapy being dismissed by general practitioners because 'it was "all psychosexual counselling" '(Trimmer 1989, 341). While it has been argued that psycho-social world of the patient emerged as a new focus of medical perception and intervention during the twentieth century (Armstrong, 2002), the 'psychologization' of sexual problems, seemingly did little to position their remediation as a legitimate medical concern.

The SAR seminar as a vehicle for promoting a more inclusive approach to sexual health care

While never widely used in medical education in Britain, the introduction of SAR seminars into some medical schools during the 1970s can, however, still be considered a radical and significant development in undergraduate medical education. The use of sexually explicit materials in educational contexts tends to generate controversy (Brewster and Wylie 2008), and among the medical voices publicly expressing disquiet at the use of the SAR seminar in medical education, was Dr Prudence Tunnadine, one of the co-founders of the IPM. In a letter detailing her responses to Stanley's (1977) article, Dr Tunnadine expressed concern about the potentially damaging unconscious group dynamics that might arise from 'exposing captive audiences of less mature people to saturation by film and the necessity to express their attitudes among their peers' (Tunnadine 1977, 23). Tunnadine considered this process to be more akin to personal therapy than clinical training and reported that leaders of training seminars for doctors organized by the IPM did not expect trainees to 'air their sexual attitudes', indeed, trainees were actually '*protected* from unwittingly doing so' (Tunnadine, 1977, 23, original emphasis). If, however, during the exploration of trainees' 'blind spots' as doctors, trainees became more at ease with their own sexuality then all

well and good, but, Tunnadine noted, this seldom happened. Tunnadine also questioned the evidence for the use of SAR seminars as well as their purpose, asking whether 'desensitizing' practitioners to sex was actually a desirable outcome and if 'watching films, of whatever merit, helps us with any aspect of our sexuality beyond voyeurism?' (Tunnadine 1977, 23).

Although questions still persist about the extent to which SAR seminars facilitate both attitudinal change in participants and sustained changes in their professional practice (Barratt 2008; Sitron and Dyson, 2009), such seminars (albeit using a broader range of stimulus materials and learning activities to facilitate reflection on personal feelings and beliefs) continue to be used in educational settings to raise awareness of, and broaden, the 'sexological worldview' of practitioners who provide sex education, counselling or therapy (Sitron and Dyson 2009, Barratt 2008). Sitron and Dyson (2009, 173) define 'sexological worldview' as a perspective held by a person about the world with regard to sexuality. They suggest that this modifiable but seldom examined perspective typically comprises values, attitudes, beliefs, and concepts related to sexuality that have been shaped by a person's socialization process. It seems plausible to conclude that medical educators who organized SAR seminars during the 1970s sought to enhance sexual health care not only by 'desensitizing' medical students to a wide range of sexual behaviours ('sparing the doctor's blushes', so to speak), but also by providing students with the opportunity to become more aware of their sexological worldview and to reflect critically on the likely impact of their sexual assumptions and prejudices on their future professional practice. The use of the SAR seminar in medical education during the 1970s can therefore be seen as a strategy for promoting and supporting an approach to medical care that was more inclusive as well as holistic. The emergence of the HIV epidemic in the early 1980s starkly revealed the pressing need for such care, drawing attention to the negative attitudes of many medical students and practitioners to gay and bisexual patients and the considerable discomfort experienced by many doctors in Britain when faced with the prospect of having to discuss sexual matters (Davenport-Hines 1990, 347-348; Evans et al 1993; Rose 1994; Berridge 1996, 138 & 218).

Even in the United States, where the provision of SAR seminars in medical schools was more widespread, the use of such seminars has declined considerably since the 1970s, partly, it has been suggested, as a consequence of the demise of many courses on human sexuality in an over-crowded medical school curriculum, but also because the showing of SAR films increasingly seemed redundant in an age when most young people were exposed to sexually explicit material through various media platforms (Leiblum 2001). In Britain, teaching about human sexuality still continues to be incorporated into the undergraduate curricula of some medical schools, albeit somewhat sporadically and often as part of initiatives to develop the cultural competencies of future practitioners (e.g. Baraitser et al 1998; Dixon-Woods et al 2002; Wylie et al 2003). But many doctors and other healthcare professionals in Britain continue to report experiencing discomfort and embarrassment when talking to patients about sexual matters (Dyer and das Nair, 2010), and nearly fifty years after the first use of SAR seminars in medical education, questions continue to be asked about how best to help health professionals overcome their reticence to discuss patients' sexual concerns and difficulties (O'Connor *et al.* 2019).

Conclusion

The therapeutic optimism surrounding the introduction of sex therapy to Britain during the early 1970s amplified existing societal pressures on doctors to 'speak of sex' during medical consultations. One response to this was the provision of SAR seminars in some British medical schools, typically as a component in courses designed to prepare students to provide sexual counselling in their future professional practice. SAR seminars (and the human sexuality courses in which such seminars tended to be embedded) were very different to seminar-based approach to experiential learning in patient-centred medicine pioneered by Balint and others, which, from the late 1950s onwards, had supported the development by some FPA doctors of a psychosomatic/interpretative approach to sexual counselling in reproductive healthcare settings. While small discussion groups played a

pivotal role in facilitating learning during SAR seminars, the use of sexually explicit films as a stimulus for small group discussions that focused on students' personal affective responses, values and beliefs, was a radical innovation in medical education. Among those who questioned the appropriateness of using such films in educational settings were some former FPA doctors whose approach to sexual counselling was premised, in part, upon the idea that the uncomfortable emotions evoked in practitioners by patients during consultations sometimes helped (suitably trained) practitioners to understand better the nature and origins of patients' sexual anxieties and difficulties. By contrast, those medical educators who were advocates for the SAR seminar and the more 'permissive' educative approach to sexual counselling that it supported, saw the embarrassment, discomfort and sexual prejudices of medical students as barriers to the provision of effective sexual health care. In the context of sexual counselling, the emotions of practitioners were therefore considered central to effective medical practice, but in very different ways. Unlike in Balint-style seminar training for sexual counselling, the small group discussions that took place during SAR seminars were considered a vehicle for personal development and raising awareness in medical students of their sexual prejudices. In addition to helping students overcome any embarrassment or discomfort when discussing patients' sexual concerns, the aim of the SAR seminar seems to have been to promote a more inclusive as well as holistic approach to medical care by challenging the tendency of practitioners to deny the sexuality and sexual health care needs of certain groups of patients (such as older patients and those patients living with physical disabilities) and to pathologize same-sex desire and its expression. Sexual counselling, however, remained a contested and fragmented enterprise on the margins of medical practice in Britain during the 1970s, with little enthusiasm for its widespread deployment evident among either the medical profession generally or policy makers, and, perhaps crucially in the British context, no framework established within the NHS to support its development and delivery.

References

Adler, Michael W. 1998. "Sexual health." *BMJ* 317: 1470.

Adler, Michael W. 1999. "Foreword." In *ABC of Sexual Health* edited by John Tomlinson, viii. London: BMJ Books.

Annon, Jack. S. 1976. *Behavioral Treatment of Sexual Problems. Brief Therapy.* New York: Harper and Row.

Armstrong, David. 1979. "The Emancipation of Biographical Medicine." *Social Science and Medicine* 13A: 1-8.

Armstrong, David. 2002. *A New History of Identity. A Sociology of Medical Knowledge.* Basingstoke: Palgrave.

Balint, Enid and J.S. Norrell. 1973. *Six Minutes for the Patient: Interactions in General Practice Consultation.* London: Tavistock Publications.

Balint, Michael. 1954. "Training General Practitioners in Psychotherapy." *British Medical Journal* 1, 115-120.

Balint, Michael. 1957. *The Doctor, His Patient and The Illness.* London: Pitman Medical Publicatons.

Balint, Michael. 1961. "The Other Part of Medicine." *Lancet* 277 no. 7167, 40-42.

Balint, Michael. 1969. "The Structure of Training-Cum- Research Seminars: Its Implications for Medicine." *Journal of the Royal College of General Practitioners* 17, 201-211.

Balint, Michael. 1962. "Foreword." In *Virgin Wives: A Study of Unconsummated Marriages* by Leonard J. Friedman, vii-x. London: Tavistock Publications.

Balint, Michael and Enid Balint. 1961. *Psychotherapeutic Techniques in Medicine*. London: Tavistock Publications.

Bancroft, John. 1975. "Homosexuality and the medical profession: A behaviourist view." *Journal of Medical Ethics* 1, 176-180.

Bancroft, John. 1985. "Psychosexual medicine." *British Journal of Sexual Medicine* 12, 30-31.

Bancroft, John. 2005. "A History of Sexual Medicine in the United Kingdom." *Journal of Sexual Medicine* 2, 569-574.

Bancroft, John. 2009. *Human Sexuality and Its Problems,* 3rd edn. Edinburgh: Churchill Livingstone Elsevier.

Bancroft, John and Lesley Coles. 1975. "Three years' experience in a sexual problems clinic." *BMJ* i, 1575-1577.

Baraitser, Paula, Lynne Elliott and Alison Bigrigg. 1998. "How to talk about sex and do it well: a course for medical students." *Medical Teacher* 20 no 3, 237-240.

Barkla, David. 1977. *An Account of the NMGC Marital Sexual Dysfunction Project.* Rugby: National Marriage Guidance Council.

Barratt, Barnaby B. 2008. "Evaluating Brief Group Interventions in Sexuality Education and Enhancement: Do workshops really work?" *American Journal of Sexuality Education* 3 no 4, 323-343.

Berridge, Virginia. 1996. *AIDS in the UK: The Making of Policy 1981-1994*. Oxford: Oxford University Press.

Bingham, Adrian. 2009. *Family Newspapers. Sex, Private Life & The British Popular Press 1918-1978.* Oxford: Oxford University Press.

Brewster, Marnie and Kevan R. Wylie. 2008. "The use of sexually explicit material in clinical, educational and research settings in the United Kingdom and its relation to the development of psychosexual therapy and sex education." *Sex Education* 8 no 4, 381-398.

Brown, Paul T. 1980. "The Development of Sexual Function Therapies after Masters and Johnson." In *Changing Patterns of Sexual Behaviour* edited by W.H.G. Armytage, R. Chester and John Peel, 193-209. London: Academic Press.

Brown, Paul T. 1984. "The Making of Love." (Book Review). *British Journal of Sexual Medicine* 11, 125 and 130.

Brown, Paul T. and Charmian Bollinger. 1985, "Training non-psychologists in the treatment of sexual dysfunction with specific reference to the training of marriage guidance counsellors." *British Journal of Medical Psychology* 58, 257-265.

Brown, Paul and Windy Dryden. 1985. "Issues in the Training of Sex Therapists." In *Marital Therapy in Britain, Volume 2: Special Issues* edited by Windy Dryden, 327-337. London: Harper & Row.

Bullough, Vern L. 1994. *Science in the Bedroom: A History of Sex Research*. New York: Basic Books.

Burnap, D.W. and J.S. Golden. 1967. "Sex problems medical practice." *Journal of Medical Education* 42, 673-680.

Cocks, H.G. 2004. "Saucy stories: pornography, sexology and the marketing of sexual knowledge in Britain, *c.* 1918-70." *Social History* 29, 465-484.

Cook, Hera. 2014. "From Controlling Emotion to Expressing Feelings in Mid-Twentieth-Century England." *Journal of Social History* 47 no. 3: 627-646.

Cooper, Alvin. 1985. "Sexual Enhancement Programs: An Examination of Their Current Status and Directions for Future Research." *The Journal of Sex Research* 21 no. 4, 387-404.

Cooper, Grahame F. 1988. "The Psychological Methods of Sex Therapy." In *Sex Therapy in Britain* edited Martin Cole and Windy Dryden, 127-164. Milton Keynes: Open University Press.

Courtenay, Michael. 1968. *Sexual Discord in Marriage. A Field for Brief Psychotherapy.* London: Tavistock Publications.

Davenport-Hines, Richard. 1990. *Sex, Death and Punishment. Attitudes to Sex and Sexuality in Britain since the Renaissance.* London: Collins.

Davidson, Roger and Gayle Davis. 2014. *The Sexual State. Sexuality and Scottish Governance, 1950-80.* Edinburgh: Edinburgh University Press.

Dawkins, Sylvia and Rosalie Taylor. 1961. "Non-Consummation of Marriage: A Survey of Seventy Cases." *Lancet* 278 no. 7210, 1029-1033.

DHSS. 1978a. Letter to Dr A. Yarrow, Principal Medical Officer DHSS from Phillip R. Myerscough, The Royal Infirmary, Edinburgh, 30th May 1978. MH156/493. The National Archives.

DHSS. 1978b. Letter to Dr C.M. Duddle, Chairman of the Association of Sexual and Relationship Therapists from D. Brereton, 7th July 1978. MH156/493. The National Archives.

DHSS. 1978c. Letter to D. Barkla, Development Officer, NMGC from D. Brereton, 7th July 1978, 'Importation of Films from Multi-Media Centre' MH156/493. The National Archives.

DHSS. 1978d. To S. Thornton, HM Customs and Excise from D. Brereton, 7th May 1978, 'Importation of Sexually Explicit Film Material' MH156/493.

DHSS, 1978e. Letter to Dr K.E. Hawton from D. Brereton, 29th August 1978. MH156/493, The National Archives.

DHSS. 1978f. M. Hartley-Brewer, 7th June 1978, 'Mr Rogers – Importation of Sexually Explicit Films for Therapy Purposes'. MH156/493. The National Archives.

DHSS. 1978g. To S. Thornton HM Customs from D. Brereton, October 1978, 'Importation of Films for Use in Sex Therapy. MH156/493. The National Archives.

DHSS. 1979a. To Mr Brereton from P.B. Grange HM Customs & Excise, 6th February 1979, 'Importation of Films for Use in Sex Therapy – P.B. Marshall'. MH156/493. The National Archives

DHSS 1979b. To Mr Grange from D. Brereton, 13th February 1979. MH156/493. The National Archives.

DHSS 1979c. To B.A.R. Smith from D. Brereton HS1A, 17th January 1979, 'Importation of Sexually Explicit Films for Therapeutic Purposes'. MH156/493. The National Archives

DHSS. 1980. To Mr K. Parsons DHSS from P.B. Grange HM Customs, 11th March 1980, 'Draft Submission: Importation of Sexually Explicit Film Material'. MH156/493. The National Archives.

Dickerson, M. and P.R. Myerscough. 1979. "The evolution of a course in human sexuality University of Edinburgh, 1972-1978." *Medical Education* 13, 432-438.

Dixon-Woods, Mary, Joanne Regan, Noelle Robertson, Bridget Young, Christine Cordle and Martin Tobin. 2002. "Teaching and learning about human sexuality in undergraduate medical education." *Medical Education* 36, 432-440.

Draper, Katherine. 1975. "The Institute of Psycho-sexual Medicine." *The Journal of Family Planning Doctors* 1 no. 1, 8.

Draper, Katherine. 1983. “Introduction.” In *The Practice of Psychosexual Medicine* edited by Katherine Draper, 1-3. London: John Libbey.

Dryden, Windy, Charmian Bollinger and Paul T. Brown. 1988. “Sex Therapy Training.” In *Sex Therapy in Britain* edited by Martin Cole and Windy Dryden, 303-336. Milton Keynes: Open University Press.

Dryden, Windy and John Bancroft. 1987. “Sex Therapy: Education or Healing? An interview with John Bancroft.” In *Therapist’s Dilemmas*, Revised edition, 17-25. London: Sage.

Duddle, C.M. 1975. “The Treatment of Marital Psycho-sexual Problems.” *British Journal of Psychiatry* 127, 169-170.

Dyer, Kerry and Roshan das Nair. 2013. “Why Don’t Healthcare Professionals Talk about Sex? A Systematic Review of Recent Qualitative Studies Conducted in the United Kingdom.” *Journal of Sexual Medicine* 10, 2658-2670.

Epstein, Steven and Laura Mamo. 2017. “The proliferation of sexual health: Diverse social problems and the legitimation of sexuality.” *Social Science & Medicine* 188, 176-190.

Evans, J.K., J.S. Bingham, K. Pratt and C.A. Carne. 1993. “Attitudes of medical students to HIV and AIDS.” *Genitourinary Medicine* 69, 377-380.

Fitton, Freda and H.W.K Acheson. 1979 *Doctor/Patient Relationship. A Study in General Practice*. London: HMSO.

Friedman, Leonard J. 1962. *Virgin Wives. A Study of Unconsummated Marriages.* London: Tavistock Publications.

Giles, Alison. 1961. “Learning to Deal with Sexual Difficulties.” *Family Planning* 10 no 2, 9-13.

Gill, Cyril. 1980. “Diagnosing sex problems in general practice.” In *Sex Problems in Practice* edited by Stephen Lock, 6-9. London: British Medical Association.

Hall, Lesley A. 2003. “The Sexual Body.” In *Companion to Medicine in the Twentieth Century* edited by Roger Cooter and John Pickstone, 261-275. London: Routledge.

Hall, Lesley A. 2000. *Sex, Gender and Social Change in Britain since 1880.* Basingstoke: Macmillan Press.

Hawton, Keith. 1985. *Sex Therapy. A Practical Guide.* Oxford: Oxford University Press.

Heisler, Jill. 1983. *Sexual Therapy in the National Marriage Guidance Council*. Rugby: NMGC.

Home Office. 1979. *Marriage Matters. A Consultative Document by the Working Party on Marriage Guidance.* London: HMSO.

Irwin, Robert. 2009. “‘To Try To Find Out What Is Being Done To Whom, By Whom And With What Results’: The Creation of Psychosexual Counselling Policy in England, 1972-1979.” *Twentieth Century British History* 20 no. 2, 173-197.

Kinsey, Alfred, Wardell B. Pomeroy and Clyde E. Martin. 1948. *Sexual Behaviour in the Human Male.* W.B. Saunders.

Kinsey, Alfred, Wardell B. Pomeroy, Clyde E. Martin and Paul H. Gebhard. 1953. *Sexual Behaviour in the Human Female.* W.B. Saunders.

Leathard, Audrey. 1980. *The Fight for Family Planning: Then Development of Family Planning Services in Britain 1921-74*. London: Macmillan.

Leiblum, Sandra B. 2001. "An Established Medical School Human Sexuality Curriculum: Description and Evaluation." *Sexual and Relationship Therapy* 16 no.1, 59-70.

Levinson, Sharman and Alain Giami. 2006. "From sexuality to sexual health: the use of history in psychosocial training programmes for physicians." *Sexual and Relationship Therapy* 21 no. 3, 347-357.

Limond, David. 2009. "'I hope someone castrates you, you perverted bastard': Martin Cole's sex education film, *Growing Up*." *Sex Education* 9 no.4, 409-419.

Lock, Stephen. 1982. *Sex Problems in Practice. Articles published in the British Medical Journal.* London: British Medical Association.

LoPiccolo, Joseph. 1994. "The evolution of sex therapy." *Sexual and Marital Therapy* 9 no. 1, 5-7.

Main, Thomas F., 1970. "Training in psycho-sexual problems in marriage." *Family Planning,* 19, 7-12.

Morrow, Ross. 2008. *Sex Research and Sex Therapy.* New York: Routledge.

Masters, William, H. and Virginia E. Johnson. 1966. *Human Sexual Response.* London: Churchill.

Masters, William H. and Virginia E. Johnson. 1970. *Human Sexual Inadequacy.* London: Churchill.

McLaren, Angus. 2007. *Impotence. A Cultural History.* Chicago: The University of Chicago Press.

Mead, Nicola and Peter Bower. 2000. "Patient-centredness: a conceptual framework and review of the empirical literature." *Social Science & Medicine* 51, 1087-1110.

Mears, Eleanor. 1978. "Sexual Problem Clinics. An Assessment of the Work of 26 Doctors Trained by the Institute of Psychosexual Medicine." *Public Health, London* 92, 218-223.

O'Connor, Sean R., John Connaghan, Roma Macguire, Grigorios Kotronoulas, Carrie Flannagan, Suniel Jain, Nuala Brady and Eilis Mc Caughan. 2019. "Healthcare Professional Perceived Barriers and Facilitators to Discussing Sexual Wellbeing with Patients After Diagnosis of Chronic Illness: A Mixed-Methods Evidence Synthesis." *Patient Education and Counseling* 102, 850-863.

Ogden, Jane. 2003. "What do symptoms mean?" *BMJ* 327, 409-410.

Osborne, Thomas. 1993. "Mobilizing Psychoanalysis: Michael Balint and the General Practitioners." *Social Studies of Science* 23, 175-200.

Read, Simon, Michael King and James Watson. 1997. “Sexual dysfunction in primary medical care: prevalence, characteristics and detection by the general practitioner.” *Journal of Public Health Medicine* 19, no 4, 387-391.

Reamy, Kenneth. 1984. “Sexual Counselling for the Nontherapist.” *Clinical Obstetrics and Gynecology* 27 no. 3, 781-788.

Rose, Lynn. 1994. “Homophobia among doctors.” *BMJ* 308, 586-587.

Rose, Nikolas. 1989. *Governing the Soul. The Shaping of the Private Self.* London: Routledge.

Rosser, Simon B.R., Margeretta S. Dwyer, Eli Coleman and Michael Miner. 1995. “Using sexually explicit material in adult sex education: An eighteen year comparative analysis.” *Journal of Sex Education & Therapy* 21 no 2, 117-128.

Royal Commission on Medical Education. 1968. *Report of the Royal Commission on Medical Education, 1965-1968. Cmmd. 3549.* London: HMSO.

Rusterholz, Caroline. 2020. *Women’s Medicine. Sex, family planning and British female doctors in a transnational perspective 1920-70.* Manchester: Manchester University Press.

Sitron, Justin A. and Donald A. Dyson. 2009. “Sexuality Attitudes Reassessment (SAR): Historical and New Considerations for Measuring its Effectiveness.” *American Journal of Sexuality Education* 4, 158-177.

Stanley, Elizabeth. 1977. “A Course in Human Sexuality for Medical Students at St George’s Hospital.” *British Journal of Family Planning* 3 no. 1, 16-17.

Stanley, Elizabeth. 1978. “An Introduction to Sexuality in the Medical Curriculum.” *Medical Education* 12, 441-445.

Stanley, Elizabeth. 1979. “The Way We Teach…Human Sexuality.” *Medical Teacher*, 1 no. 4, 184-189.

Stanley, Elizabeth. 1982a. “Non-organic causes of sexual problems.” In *Sex Problems in Practice* edited by Stephen Lock, 10-16. London: British Medical Association.

Stanley, Elizabeth. 1982b. “Principles of managing sexual problems.” In *Sex Problems in Practice* edited by Stephen Lock, 21-26. London: British Medical Association.

Stanley, Elizabeth. 1982c. “Dealing with fear of failure.” In *Sex Problems in Practice* edited by Stephen Lock, 27-33. London: British Medical Association.

Stanley, Elizabeth. 1982d. “Vaginismus.” In *Sex Problems in Practice* edited by Stephen Lock, 34-40. London: British Medical Association.

Stanley, Elizabeth. 1982e. “Premature ejaculation.” In *Sex Problems in Practice* edited by Stephen Lock, 41-45. London: British Medical Association.

Stanley, Elizabeth, John Kellett, Bert Falkowski, Margaret Ramage and John Sketchley. 1986. “St George’s Hospital Medical School Course for the Diploma in Human Sexuality.” *Sexual and Marital Therapy* 1 no. 1, 75-88.

Tiefer, Leonore. 2006. “Sex therapy as a humanistic enterprise.” *Sexual and Relationship Therapy* 21 no. 3, 359-375.

Tomlinson, John. 1999. *ABC of Sexual Health.* London: BMJ Books.

Tunnadine, Prudence. 1970. *Contraception and Sexual Life: A Therapeutic Approach*. London: Tavistock Publications.

Tunnadine, Prudence. 1977. “Human sexuality for medical students.” (Letter) *The British Journal of Family Planning* 3 no.2, 23.

Tunnadine, Prudence. 1984. “Sex therapy in practice.” (Letter). *British Journal of Sexual Medicine* 11, 182.

Trimmer, Eric. 1989. “Whatever happened to sex therapy?” *British Journal of Sexual Medicine* 16 no.9, 341-343.

WHO. 1975. *Education and Treatment in Human Sexuality: The Training of Health Professionals. Report of a WHO Meeting*. Geneva: World Health Organization Technical Report Series No. 572.

Winn, Denise. 1979. “The New Way of Looking at Sex.” *The Guardian* (1959-2003) May 8th, 1979. ProQuest Historical Newspapers The Guardian and The Observer, p. 9.

Wollert, Richard W. 1978. “A Survey of Sexual Attitude Reassessment and Restructuring Seminars.” *The Journal of Sex Research* 14 no 4, 250-259.

Wylie, Kevan, Ruth Hallam-Jones and Brian Daines. 2003. “Review of an undergraduate medical school training programme in human sexuality.” *Medical Teacher* 25 no 3, 291-295.

Zilbergeld, Bernie and Michael Evans. 1980. “The Inadequacy of Masters and Johnson.” *Psychology Today* August 1980, 29-43.

[i] It was not possible to involve patients or the public in the design, or conduct, or reporting, or dissemination plans for this research.