General. Firstly, we did not extract the year of birth of our patients, so that their allocation to the periods used by the Registrar General would have been of uncertain accuracy. Secondly, as there is evidence that the seasonal distribution of births may vary significantly from one part of a country to another, we did not think it appropriate to compare in this respect the population of our patients, domiciled largely in South London (and of unrecorded place of birth), with that of the population of England and Wales.

However, through the kindness of Dr. E. R. Bransby and Mr. T. A. Dibley of the Department of Health and Social Security, we have recently been able to study month of birth, by diagnosis, of all first admissions to psychiatric wards in England and Wales during the year 1970. These figures may appropriately be compared with those of the general population. The tables show the results of this comparison (using James' method), and these clearly support our findings of an excess of birth in the first quarter of the year for both schizophrenia and manic-depressive psychosis. The quarterly comparison (3 degrees of freedom) gives a χ^2 of 6·53 for schizophrenia, 7·87 for manic-depression and 9·92 ($P < 0·02$) for these functional psychoses taken together; while for all non-psychotic diagnosis, χ^2 is 2·37 $P = 0·50$). It remains to be seen whether the figures for subsequent years will confirm this pattern.

TABLE I

First admissions to psychiatric beds, England and Wales, 1970, for those born 1921–53

Year of birth	Schizophrenia	Manic depression	Neurosis	Personality disorder	All non-psychotic diagnoses
1921–	542	794	1,444	263	3,928
31–	294	253	823	191	2,043
36–	362	229	963	246	2,274
41–	460	215	1,005	372	2,497
46–	606	184	1,110	598	3,137
51–53	237	56	394	340	1,540
1921–53	2,501	1,731	5,739	2,010	15,419

TABLE II

Observed distribution of season of birth for first admissions to psychiatric beds, England and Wales 1970, compared with the distribution expected from that of the general population, 1921–53

Diagnosis		Quarter			
		1st	2nd	3rd	4th
Schizophrenia	Exp.	627·8	653·4	629·4	590·5
	Obs.	653	687	582	579
Manic-depression	Exp.	434·0	452·0	435·0	409·9
	Obs.	484	429	417	401
Neurosis	Exp.	1,438·7	1,500·8	1,446·5	1,353·1
	Obs.	1,416	1,518	1,399	1,406
Personality disorder	Exp.	505·5	524·6	504·8	475·1
	Obs.	489	526	545	450
All non-psychotic diagnoses	Exp.	3,870·0	4,031·3	3,883·2	3,635·0
	Obs.	3,834	4,114	3,850	3,621

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THOUGHT-STOPPING TECHNIQUES

DEAR SIR,

The helpful articles by Stern—September 1970, Vol. 117, p. 441, and by Kumar and Wilkinson, September 1971, Vol. 119, p. 305, offer great promise in the treatment of the phobias of 'internal stimuli', and no doubt many psychiatrists will now be applying these methods. A small modification of the method has been found helpful. The patient is equipped with a plastic hollow cylinder with many prickly projections on its outer surface; the cylinder is a hair roller, costing one penny. This is held lightly in the hand of the relaxed patient and the unpleasant thought sequence is evoked as described by the above authors. At the therapist's command 'Stop' the patient grips the plastic cylinder for about one second. After this a pleasant scene is evoked to re-establish relaxation. The slight discomfort caused by gripping the prickly roller is a very effective thought-stopper and the device is easily carried by the patient in the pocket for practice in everyday situations.

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TRANSSEXUALISM WITH GONADAL DYSGENESIA

DEAR SIR,

The paper on this subject which appeared in your issue for September 1971, Vol. 119, p. 391 is embarrassingly naive, and the authors appear inexperienced in the research problems of transsexualism.

They describe a male with breast development,

atrophic testes, a normal-sized penis, sparse body hair, XY karyotype, high oestrogen level, and low 17-KS level; their conclusion is that a primary failure of androgen led to the desire for sex change. They describe a female who stopped menses at 28, developed acne, hirsutism, had a deep voice and an enlarged clitoris; their conclusion is that an elevated androgen level led to the desire for sex change.

Unfortunately for the authors' hypothesis, both these clinical pictures are typical of the anatomically normal male and female after a period on oestrogens (for the male) and androgens (for the female)!

Had the authors fully read the references they cite, they would had learned that a case to which they refer of a male transsexual with 'oestrogen-secreting testicular tumour' (Stoller *et al.*, 1960) confessed years later to having secretly taken oestrogens since puberty (Stoller, 1968).

The clinical picture of transsexualism may indeed be, in some or even all cases, contributed to by a deficiency or excess of androgen at a critical developmental period. However, before anyone other than these three authors seriously cites this report as evidence, they had better get proof that these patients were not receiving contra-sexed hormones before the study. Many transsexuals do just that, and present themselves as biologically intersexed so as to mobilize the otherwise static hand of the surgeon.

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PENILE VOLUME RESPONSES, SEXUAL ORIENTATION AND CONDITIONING PERFORMANCE

DEAR SIR,

I should like to criticize the article by Barr and McConaghy in the October 1971 issue of the *Journal* (Vol. 119, p. 377).

The method of measurement described is somewhat inaccurate because of the difficulty in standardizing the volumetric strain ratio of the average penis. Because of this one is not interested in volume change, rather in volumetric strain, i.e. $du/_v$.

A more accurate method than the use of a finger stall and tin can would be to skin glue a soft material strain gauge in the axial direction of the penis. This would then give the linear strain. Presuming that a penis has isotropic properties, the volumetric strain will be approximately three times the linear strain.

This has the advantage of digital read out, and the technique could also be used for measurement of female responses.

I wish to thank Mr. James Forfar, B.Sc., for his technical help.

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MENTAL HEALTH RESEARCH FUND LECTURE

DEAR SIR,

I should be most grateful if you would once again publish an announcement about the Fund's annual lecture.

Professor Sir Denis Hill will be giving the 1972 Sir Geoffrey Vickers Lecture at 5.30 p.m. on Wednesday, 23 February 1972, in the Edward Lewis Theatre, Middlesex Hospital Medical School, Cleveland Street, London, W.1. His title will be *The Purposes and Organization of Psychiatric Research.* Admission will be by ticket only, which can be obtained from the Secretary, Research Committee, Mental Health Research Fund, 38 Wigmore Street, W1H 9DF.

J. M. TANNER.

Mental Health Research Fund,
38 Wigmore Street,
London, W1H 9DF.

LONG-ACTING PHENOTHIAZINE PREPARATIONS IN THE TREATMENT OF SCHIZOPHRENIA

DEAR SIR,

Recent reports in the literature (1, 2) have commented upon the efficacy of long-acting phenothiazine preparations in the treatment of schizophrenia. Our experience in County Down, where we have started 250 patients on these drugs, has confirmed these impressions. All except a very few have been in-patients. Of the 200 remaining on these drugs, half are out of hospital and half are still in hospital.

The two main problems which have arisen have been extrapyramidal side-effects and depression. The extrapyramidal side-effects which have caused most trouble have been dystonic reactions such as facial spasms and grimacing. Perseverance, modifying the dosage of fluphenazine, and anti-parkinsonian medication usually deal effectively with these. We have found an increased incidence of suicidal attempts and a tendency for more violent methods to be used. Of the first 80 patients started on this treatment, a total of 18 have made suicidal attempts. Seven had made these attempts before starting treatment with fluphenazine; 14 made suicidal attempts after treatment was begun. These figures include three who made suicidal attempts both before and after treatment with fluphenazine.

There have been no successful suicides among our