

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER

No. 7

Editor: Dr. Katharine Draper
29 High Street,
Chipstead,
Sevenoaks TN13 2RW.

January 1977.

Dear Doctor,

Despite all the talk of recession this does not appear to have affected the affairs of the Institute. We have had to pack every page to fit in all the news of future meetings, reports of meetings of the Institute and other meetings attended by members. We are particularly glad to start the New Year with a paper by our President.

1. MEETINGS

(a) The A.G.M. will be held at the

ROYAL SOCIETY OF MEDICINE, 1 WIMPOLE STREET, W.1. on
FRIDAY, 18TH MARCH at 8.0 p.m.

The Agenda and request for nominations for the Council is attached.

It will be followed by a Clinical Meeting at which Dr. Hinshelwood, Dr. Pasmore and Dr. Christopher will present cases which show "Difficulties encountered due to cultural differences".

Members who wish to dine at the R.S.M. before the meeting should make their own arrangements.

- (b) A meeting will be held at the R.S.M. on Friday, 8th July, 1977. Subject to be announced in the next Newsletter.
- (c) A weekend meeting is provisionally planned at Newcastle from 9-11 September, 1977. Would any members who would like to propose a subject for discussion or submit a paper please let me know.
- (d) A joint meeting with the International Society of Psychosomatic Obstetrics & Gynaecology was held at the Charing Cross Hospital on November 11th, 1976. We are grateful to Dr. Thexton for the report of the discussions which links the authors' summaries of the papers given in Appendix A.
- (e) Relevant meetings attended by members.

i. Dr. Tom Main gave the Jennifer Hallam Memorial lecture at the Wyeth Symposium at the Royal College of Physicians on November 26th. This paper, on Female Sexuality, only slightly abbreviated by the Editor, is given in Appendix B.

ii. International Congress of Sexology Montreal. October 1976.

Two of our members, Miss Thompson and Dr. Backer, attended the conference. I am grateful for their reports, which are given in Appendix C, with Dr. Backer's account of her visit to Dr. Helen Singer Kaplans clinic in New York; I feel two reports give a fuller picture of such an overwhelming event.

2. TRAINING REPORT

When the Institute took over psychosexual training from the F.P.A., four groups were in existence. Now there are twenty-nine groups in various parts of the country,

including one advanced group, one research group and a leaders workshop. This represents about 300 new doctors in basic training. Nine new groups are forming in the new year and these are listed below.

A few vacancies exist in the following groups:-

Sharpethorne, Sussex - Basic and Advanced - Dr. Main.
Middlesex Hospital - Basic - Dr. Hutchinson
Kensington - Basic - Dr. Pasmore
Norwich - Basic - Dr. Lincoln

Applications are now also being considered for the following groups in formation for the New Year, 1977. Farnborough/Bromley, Kent; Reading, Berks.; Ashford, Middlesex; Leeds/Huddersfield; City of London (N.E.) (All Basic) Guildford, Surrey (Basic and Advanced).

Basic Training Groups are also projected for the following areas if there is sufficient demand: Chester, Birmingham, Dorchester.

3.

RESEARCH

(a) Prospective Study on Non-consummation.

An application for a research grant to support this study was submitted by Dr. Bramley to Trent R.H.A.

They were interested in the work but felt that the study should be restricted to 15 doctors who would all be asked to attend a Training Day at which further Study Forms would be completed until agreement had been reached. Some of the more subjective questions have also been eliminated. An application has now been resubmitted for a modified study and we hope to hear the result in the next few days.

(b) Retrospective Study.

Dr. Mears received 25 replies from doctors who are willing to participate in this review of their past years work. Forms have been prepared and will be sent out as soon as Dr. Mears has recovered from a recent illness. She would still be glad to hear from any doctor who would like to take part (Dr. Eleanor Mears, EndHouse, 13 Augusta Close, GRIMSBY, South Humberside DN34 4TS).

4.

NEWS OF MEMBERS

A list of new members and changes of address is given in Appendix Di.

We are always glad to hear news of members and thought that Dr. Delles letter to Dr. Blair would be of interest to other members. To save paper and postage this has been printed on the reverse of the Agenda of the A.G.M.

Don't forget to send me reports of meetings, cases or any other contributions for the next Newsletter, to be received by Easter, please. I hope as many as possible will be able to attend the A.G.M. and a Happy New Year to you all.

Yours sincerely,

KATHARINE DRAPER

PENDIX A.

SYMPOSIUM ON PSYCHOSEXUAL PROBLEMS IN OBSTETRICS & GYNAECOLOGY

On November 11th, 1976 many members of NAFPD enjoyed a meeting of the British Section of the International Society of Psychosomatic Obstetrics and Gynaecology. This was organised in co-operation with the Institute of Psychosexual Medicine, who supplied some of the speakers.

In the morning the chair was taken by Dr. T. Main and in the afternoon by Prof. N. Morris. Summaries of the papers are published below, together with reports of the discussion periods by Dr. R. Thexton.

SUMMARY Dr. Lawrence Goldie. LIBIDO A Critique of the value of Love Potions

Libido is seen as a life force whose presence is inferred from observations of behaviour which involve attachment to and the use of objects, living or inanimate, animal or human, or parts of objects for pleasure or the avoidance of unpleasure. This impelling force from its original manifestations in the infant searching for the nipple and following with its eye, propels the organism through the attachments and substitutions that constitute 'development'. The taking in or conceptualisation of an object as a source of pleasure, or for dispelling unpleasure, and the subsequent search for substitutes takes the human through the vicissitudes of what we call sexual development. It is not an accident that words like 'hunger' and 'appetite' are used in this connection and, just as there is a world of difference between eating to survive, to sustain an ebbing life and eating to savour the product of a host's loving care, there is also a world of difference between sexual activity, indiscriminate in its object and love-making. The use of love-potions or philtres derives from a confusion between the two. The potion was given to ensure that one would become the object of another's desire, mistakenly believing that this was love. The confusion is evident in the modern search for 'love-potions'. To satisfy the demand for love-potions we have a proliferation of training programmes in sex, sex counselling, and dissecting manuals of sexual intercourse.

It is as if one advocated dissection of the human body as a way of learning how to make life. The present vogue for counselling in sex, and the ultimate reductio ad absurdum training and demonstrations in sexual intercourse is a sad witness to the ineptitude and gullibility of professionals who fall in with fashion and foster the illusion that this "sexual" activity has to do with 'love-making'. The professionals find it as easy as their subjects to believe that this is the panacea, the easy way to produce and create love. Like hypnotists, they are seduced by their subjects and their responses, and come to believe that they have the power to help people perform as they wish. This collusion between the patient and the 'expert' retards real progress towards adulthood. It inculcates and supports a mechanical view of human beings. People are treated as 'things' and advice is given on how to manipulate 'objects' or parts of 'objects' in 'normal' sexual intercourse. The illusion that this is love spreads because of our passivity as Gynaecologists and Psychiatrists towards this notion. We avoid asking questions, but what makes someone an expert in sex? When the performance is deemed adequate by the experts, and infantile demands for gratification with ease, regardless of expense (to others) are satisfied.....what then?

According to the purveyors of these love-potionslove will follow.

In this paper serious doubt is cast on this, and it is proposed that these developments are the antithesis of 'love-making'.

In the discussion Professor Morris suggested that many women's journals printed articles on sex which contributed to the ideas that Dr. Goldie was criticising, i.e. that sex without love is a disappointment to the participants. Dr. Main wondered if we can apply such a philosophical paper to the clinical work. Dr. Goldie then quoted a young woman referred to

him with an unconsummated marriage. She was immature and self-centred and he treated the traits by psychotherapy; hearing from her G.P. later that she was pregnant. The psychotherapy had enabled her to make love. Institute doctors noted that he had not himself enquired about intercourse after the initial interview - an alternative technique for the treatment of non-consummation to the one they use.

SUMMARY

Dr. Jean Pasmore. Dr. Margaret Blair. A LOOK AT FRIGIDITY

Frigidity is a broad term covering all degrees of disinclination for sexual experience in a woman, varying from terrified or angry refusal of intercourse to inability to respond fully during intercourse. It is an emotional response concerned with the internal world of the woman although inter-acting with the world of external reality. Dyspareunia, with which it is often associated, can be one of the physical expressions of this emotional response. But there are many others and in 1964 we wrote a paper summarising the work of eight doctors doing family planning work who had met weekly for five years under the leadership of Dr. Michael Balint. We found that about 80 per cent of cases of frigidity reported fitted into a clinical classification. In this there were four main groups:-

Group I.

Newly married couples experiencing difficulties of many types in the transition to married life.

Group II.

Women who are uncertain in their femininity and express this by:-

- (a) Limited enjoyment in intercourse;
- (b) Conditional enjoyment in intercourse;
- (c) Difficulty with bodily feminine functions;
- (d) Difficulty with the social feminine role.

Group III.

Women who are angry about their femininity and express this by:-

- (a) Attacking themselves or their partners;
- (b) Being the victim;
- (c) Confusing.

Group IV.

Patients whose anxieties about their sexual functions are so overwhelming that they deny all feelings. This is a mixed group needing further clarification. During treatment these patients often move into Group II or III.

We have now found that for our own clinical purpose we classify frigidity differently - into the following groups:

- (a) Patients who have problems related to their own ideas about their anatomy and their ideas about the function of their genitals;
- (b) Patients who have difficulty with the social feminine role;
- (c) Patients who have difficulty in their relationships, using the sexual interaction as a vehicle for malign projection systems.

We feel that two groups in the original classification - Group I: difficulties in early marriage - and Group IIc: difficulties with bodily feminine functions - are of special interest to this Meeting as these are the most likely to present at gynaecological clinics.

When the original paper was written, premarital intercourse was not generally accepted as the norm and the marriage ceremony symbolised permission for intercourse to take place. Now the marriage can be seen as an expression of commitment for a couple who have usually had intercourse. It follows therefore that many of the problems which used to be seen in

early marriage are now seen in the unmarried. The most extreme is non-consummation which can respond to the use of psychosomatic vaginal examination to explore the fantasies about female anatomy and about intercourse and (?) the relating of these fantasies to reality.

The points made are illustrated by descriptions of patients in these two groups.

Thus in conclusion we think that the earlier classification, if it can be borne in mind, provides a useful picture of the many ways in which frigidity can present, as many women are unable to ask for help directly for frigidity and have to do so indirectly in one or more of the ways described. Having recognised that frigidity is the problem it can then be looked at in terms of the second classification to determine the most suitable focus for treatment.

After Dr. Blair had presented this paper, Dr. Pasmore answered questions on it. Dr. Duddle from the floor, noted that the paper said nothing about the male partner. He might be contributing to the frigid response by premature ejaculation or other difficulty. She said that both partners can be treated, but it is important to understand why unsuccessful women so often choose partners with difficulties of their own. Dr. Tobert said that the woman's difficulties with allowing herself to be vulnerable and dependant could be recognised by studying the doctor/patient relationship. This insight could then be used to help her husband to meet her needs.

Dr. Main underlined the fact that this paper was about diagnosis of the kind of frigidity presenting and the importance of examining the situation. The patient is the one who complains. Dr. Valerie Thompson said that patients come to gynaecological clinics because they can talk about discharges, pains and periods more easily than they can talk about emotional pain. A lot of expensive investigations are done because some gynaecologists don't realise that the woman has a sexual difficulty which she is unable to express.

SUMMARY

Sheila Kitzinger.

SEXUALITY IN PREGNANCY

Pregnancy can be a time when the relationship between the couple is deepened and strengthened or one when it is severely disrupted. Sexual interaction is one facet of the relationship which is affected. The woman's changing shape, foetal activity, pressure on the bladder, tender breasts, feelings of distension when the head has engaged and discomforts of pregnancy all lead to stress which involves modification in sexual behaviour. Some couples welcome guidance on this.

Pregnancy also profoundly affects the woman's and the man's view of themselves and each other. The modern technology of obstetrics and antenatal care may be associated with the woman's feeling that her body no longer belongs to her, and the man too may feel that her body has become a clinical object. Especially when conception has been difficult or there have been previous spontaneous abortions, a couple may need 'permission' to make love.

One function of antenatal classes should be to increase body awareness and help women to know and like their bodies. But more than this, they should provide a facilitating environment for the relationship between the couple. Both in the childbirth education class and in a private consultation offered to all couples I teach Touch Relaxation. This involves one partner (initially the man) resting a hand on the other, who responds immediately by releasing 'as if flowing out towards the touching hand'.

Another occasion when discussion spontaneously turns to sexual awareness is when we do pelvic floor exercises, and I relate these to 'making a kiss inside with the muscles deep in the vagina' rather than drawing the analogy, which unfortunately is the standard one for antenatal classes of 'trying not to pass urine' or to 'wet your pants'. In discussion threaded through the class and in the consultation, couples have an opportunity to

discuss any sexual difficulties and also to communicate with each other about related subjects which they may have avoided previously.

Of the last 60 couples I have taught, more than half chose to discuss some aspect of their personal sexual interaction.

Some felt that pregnancy had enhanced their sex relationship, and a number wanted information on practical matters. But many were anxious about intercourse, and themselves associated this with a particular crisis of fear and the possibility of bearing an abnormal child, or believed that doctors disapproved of sex in pregnancy.

The contemporary culture of childbearing lifts birth out of everyday living and things that people do for themselves and makes it a specialist task directed by obstetric consultants and monitored by machines. The more that labour is isolated from the normal patterns of life, the more it is that pregnancy, too, tends to be perceived, by doctors and patients alike, as an abnormal and potentially dangerous state. This view of pregnancy affects the marriage, and may be associated with anxiety about sex and sexual dysfunction.

Breathing, relaxation and other exercises in body awareness for the couple preparing together, together with an opportunity to talk about emotional aspects of pregnancy, can focus on childbirth, not as a clinical crisis, but as one aspect of a woman's psychosexual life and an integral part of the developing relationship between the couple.

Mrs. Kitzinger's summary of her paper gives some idea of the passion with which she speaks as a National Childbirth Trust educator. She said she "shares with women" rather than being like a doctor who treats women. She feels very strongly that the 'medical' model of childbirth has superseded the 'natural' one and that women's emotional changes in pregnancy have been misnamed 'neuroses'. Sex in pregnancy is not usually dangerous, abnormal or unwise. In the discussion Professor Morris said that as semen contains prostaglandins it is just possible that it could start labour and where there is a history of abortion or premature labour it might be unwise, at any rate without using a sheath.

It is also possible to marry modern mechanics and humanised obstetrics. Ambulant monitored patients often feel glad that their foetus is being so well cared for. Dr. Main added that women have deep anxieties during pregnancy about trespassing on their mother's ground, about the imagery of mothers not being sexual beings, about whether her body will be alright for sex afterwards. Husbands also have anxieties about whether their wives will still love them as much when the baby arrives.

SUMMARY

Dr. K. Draper.

POST PARTUM SEXUALITY

This is a discussion of the effect of the experience of childbirth on a woman's ability subsequently to enjoy her sexuality. Some women resume sexual activity soon after parturition. Most women regard the post-natal examination as 'permission' to return to an active sexual life. A majority resume love-making with pleasure, but others have difficulties. In a family planning clinic we hear many such complaints; some are simple cases of discomfort and hesitancy, but others are more extreme. I will describe several and then go on to draw some conclusions.

CASE STUDY 1.

Fourteen months after the birth of her second child Mrs. W. could not tolerate intercourse, and felt she would scream if she was touched. Before any birth intercourse had been enjoyable. That she did not want her husband present at the birth and resisted self-examination, suggest a dislike to the 'messy' side of sex. Both births were painful, and she had some vaginal discomfort but even more traumatic was her anxiety and confusion, and her shame at losing control both of herself in the first labour, and of her medical attendant in the second. She also shows some effect of her role as a mother on her feelings.

CASE STUDY 11.

Mrs. C. complained that she was unable to have intercourse because she had been stitched up too tight. At first it appeared that Mrs. C's dyspareunia was the result of her delayed and traumatic stitching, and the examination in hospital, but it gradually emerged that she had deeper anxieties about her sexuality.

CASE STUDY 111.

Mrs. D's apparent complaint of dyspareunia and dry vulva, due to a forceps delivery, in fact masked a more deep-rooted vaginal fantasy.

CASE STUDY 1V.

Mrs. S. presented as complete refusal of intercourse after childbirth but the problem had developed immediately after conception. Part of the rejection of sexuality was her anger at her marriage and way of life that had resulted from her pregnancy. She also felt it had completely ruined her bodily attractions.

All these women blamed the damage resulting from childbirth for their retreat from sexual activity. In some cases the patient at first focused her idea of damage on the vagina and complained of dyspareunia. Another feels that the whole of her body has been degraded by child-bearing and the exposure of labour. But there are hints of previous difficulties, a dislike of undressing, a difficulty in discussing sex. It was only on examination and the suggestion that they touch themselves that the extent of their failure of full sexual acceptance was revealed.

We also see many women who complain of loss of libido in the post-partum period - not a difficulty in intercourse but simply a lack of interest. This is more often connected with a woman's over-absorption in her new role of mother, perhaps due to her feelings of uncertainty and inadequacy; her feelings of dullness when confined to the house and nappies, and missing her contacts with work and friends. Sometimes her motherhood reinforces her identification with her own mother, whose sexual life she feels was not successful. Finally we must not forget that loss of libido may be part of a puerperal depression.

CASE STUDY V.

Mrs. V., a young Greek girl, was brought to the clinic by her husband because she had refused intercourse since the birth of her child. Having got her 'man' and escaped from the Greek women's way of life, the care of the baby had completely absorbed her attention. She had no interest in the sexual role of a wife.

The cases we have discussed all showed that beneath a tenuous sexual adjustment that permitted a pretty, unblemished girl to enjoy intercourse there was, sometimes a considerable fantasy, sometimes a dislike of the 'messy' side of sex that was reactivated by their obstetric experiences.

A woman's first step to sexual maturity, her first intercourse, is taken in privacy. The final step, that of childbirth, is supervised, and increasingly institutionalised, by the medical profession. Dr. Bischoff¹ in her 'Personal View' describes the atmosphere of a small French-Canadian hospital - 'Birth is a fertile thing, hard work - joyous'. The intense individual experience of one can run side by side with the routine work of another. So it must be when women are giving birth in a large hospital. If we can be alert to the anxieties and feelings of women in childbirth and respect their individuality, if they can feel that childbirth is a natural process in which they are encouraged to take an active and understanding part, then they can accept themselves as women in the fullest sense.

During discussion the subject of episiotomy was raised. This often gives discomfort, but is sometimes used as an excuse to cover up loss of libido.

¹Bischoff, R. British Medical Journal 1975 (4) 755.

Puerperal depression was also discussed and is obviously a big problem for general practitioners. A therapeutically successful depressed mothers group in a Sussex practice was mentioned.

Dr. Main then gave a paper on psychosomatic factors leading to hysterectomy. He described five cases reported in a general practitioner seminar which he had lead. They were all women who had no use for men or for their femininity and who were very determined to rid themselves of it, going to great lengths to get the operation done, often against the recommendation of their medical attendants.

SUMMARY

Professor Norman Morris.

HYSTERECTOMY

The main indication for Hysterectomy is Menorrhagia; other symptoms include Intermenstrual bleeding, Dyspareunia, Dysmenorrhoea, Abdominal and Pelvic Pains, Backache and Pre-menstrual Tension.

The associated pathological condition which may be associated with these symptoms are:- Fibromyomata, Adenomyosis, Subacute Salpingitis, Cystic Hyperplasia of the Endometrium, Cancer of the cervix, uterus and ovaries.

When the pathology is reviewed after operation, at least 50 per cent of women do not have conditions listed above. It is tempting to assume that this group therefore includes a high percentage of women whose symptoms are due to psychosomatic factors. At this stage however it is probably dangerous to reach too far a conclusion about the relationship of psychosomatic factors to these symptoms, since it is just possible that future research may reveal a perfectly reasonable endocrinological or metabolic explanation.

Whatever may be the factors leading to hysterectomy there is no question that this operation constitutes a major crisis which, as with mastectomy and sterilisation requires very careful psychological management.

Every surgeon has a slightly different approach from that of his colleague, but my personal philosophy is to delay hysterectomy (unless it be for cancer) until the patient comes pleading for the operation to be carried out.

Before and following the operation, every attempt is made to ensure that the patients know

- 1) Precisely why the operation is being performed.
- 2) What they can expect physically and emotionally during the days, weeks and months that follow operation.

Hysterectomy is associated with a substantial incidence of depression - higher than most other operations. Therefore, women who are found to be at risk for depression should be singled out for more careful follow up by their general practitioners. Frigidity and loss of libido are other post-operative problems.

Therefore all women having had a hysterectomy performed should receive adequate follow up attention, otherwise these reactions may go undiagnosed and relieved.

SUMMARY

Prudence Tunnadine.

POST OPERATIVE PSYCHOLOGICAL PROBLEMS RELATED TO
HYSTERECTOMY

Attention is drawn to difficulties arising in ill-prepared patients after hysterectomy.

1. The nature of orgasm. Patients are commonly assured that hysterectomy will not affect this. Recent laboratory work by Masters and Johnson now widely publicised as Holy Writ,

confirms the belief that only the lower third of the vagina and the clitoris are relevant. Existential experience of patients suggests that either these findings or our interpretation of them are false. The stimuli which lead to orgasm vary widely, and many patients are accustomed to sensations from the uterus and adjacent structures; many of their partners are similarly accustomed to the sensation of contact with the glans of these. Such patients need to relearn sexual techniques; if this is not forewarned severe emotional trauma and sexual failure may result. We need to explore what this may mean to the individuals concerned.

2. Hormonal adjustment. Patients are commonly assured that hysterectomy without oophorectomy will make no difference to their hormones. Many read this to mean that their hormone troubles will be over. Those who then inevitably find hormonal changes in mood, libido etc. without the menstruation to relate to, may suffer anxiety, depression and sexual failure as a result.

3. What does the loss of the uterus mean unconsciously to patients? Many women who have gone into hysterectomy rationally and open-eyed find that their sexual confidence or appetite diminish none the less; since they attribute this to an irreversible physical operation, they present with despair. In addition to the factors mentioned in 1 and 2 above, we need to examine with the individual what her uterus means to her in these unconscious emotional terms. In order to elicit such fantasies, it is usually necessary first to understand and pay tribute to the mourning syndrome. This may present as despair (which, if it is the uterus she mourns rather than what it symbolises, is indeed beyond help) and rage (often projected on to the surgeon or 'they' who failed to defend her). We may notice that these represent an irrational bit of herself and then try to understand what it is she mourns.

This will vary from patient to patient. Commonly met are:-

- a. Her lost capacity for motherhood - even though rationally she wants no more. Specially at risk are those who see intercourse as for babies c.f. Catholics, "sporting chance" contraceptors, sub-fertiles previously or by choice, those who have had early terminations or have lost a baby, c.f. post-sterilisation regrets, post-termination regrets, pill difficulties.
- b. Her "femininity" in the sexual sense. Some women see the uterus as a symbol of this and may suffer the "it's all over" or "old enough to know better" syndrome, c.f. menopaussal frigidity; frigidity of children's adolescence; career girls regrets. Specially at risk are those who see, or whose husbands see, sexuality as for the young, not for mothers. Also at risk are those Dr. Main has described who hate their femininity; removing "it" may only bring them face to face with their deeper problems.

At the end of the afternoon, the Charing Cross medical students were thanked for helping with refreshments and handling the microphones. It had been rewarding for all to hear the papers and discussions of how the practical and psychological aspects of obstetrics and gynaecology need to be considered together.

APPENDIX B.

ON FEMALE SEXUALITY

T.F. MAIN, M.D., F.R.C.Psych., D.P.M., Member British Psychoanalytical Society

For this communication I propose to discuss some effects on adult sexual functioning of the girls' early relation to the mother.

The very word "mother" itself is often sentimentalised because it can so easily evoke in everyone images of tender care, devotion and sweetness. Such images pay tribute to the states of bliss, of which all infants must have a minimum if they are to survive, and to the infant's total unguarded helpless adoration of the mother at such times. This serene Madonna image therefore enshrines a truth about early human experiences, but sadly only a one-sided truth. There is also the other side of the mother-child relationship, the infantile rages and hatreds and terrors which every mother regularly inspires in her child because of the inevitable frustrations she is experienced as imposing. Such experiences temporarily blot out the love for the Madonna mother and lead the infant to different equally distorted images. It now knows it has an evil monstrous mother who hates, starves and gloats at the terror of the helpless babies. The Madonna and the Witch; each is a derivative image of the mother as she is variously felt to be; and each is extreme, simply because in early life states of love and hatred are themselves extreme. With children there are no half-measures. Mummy is not fairly good; she is the most lovely mummy in the whole world and we love her for ever. And now she is the most horrible mummy anybody ever had and we hate her and will only be happy after she's dead and will never forgive her.

We can easily note that these two extreme images - which are indeed the child's reality - contain another interesting blindness. The mother, be she Madonna or Witch, is simply a woman whose only interest in life is loving or hating the child. But as in the pre-Renaissance pictures of Madonna and Child there is a missing figure; there is no man. These primitive mothers of the infant, marvellous or evil, have no sexual partner. This is the result of the belief of the infant that it is the centre of the world and that the mother - good or bad - belongs only to him and that her sole motive is to arrange things perfectly or abominably for him. He is her one and only and it is inconceivable that she could have any other interest. Father too is only a father; that is his job; and he too belongs only to the child and functions only for him. The fact that woman is primarily a wife and not a mother and the man primarily a husband not a father, and that they belong primarily to each other with the child a mere by-blow of their relationship is not known to the infant. Later the growing evidence that his parents can and do relate to each other more than they relate to him is outrageous and humiliating. This idea rocks the whole comfortable world of the infant and is therefore hotly resisted. The first arrangement, with the infant the supreme centre of the universe and the others as his satellite possessions is something to fight for now. The growing child now rages at and resents any parental pairing which excludes him. His rageful refusal to contemplate exclusion gets noisy testimony at bedtime in many homes with children of one to three. Sleeplessness, the wish to be in Mummy's bed, requests for a drink of water, and so on are common results of this struggle against the two.

But another development coincides more or less with this onset of rage and jealousy at the idea that the parents are owned by each other and that the child is small fry. By the age of one most normal children have found their own genital and as the months pass they can rely on it to give pleasure as well as comfort in times of trouble. This makes the situation better in the sense that the child no longer depends only on the mother for comfort, and yet it also makes it worse. The growing child eventually suspects not only that each parent can give himself the same genital pleasure, but eventually worse still that they do blissful and rude and exciting things to each other when they are together without him. As he grows and his interest in genitals grows many signs will confirm his highly imaginative suspicions about their other secrets, including their capacity to make babies, and now the fat is truly in the fire. His Majesty the centre of the world, is deserted and betrayed by those very people he worshipped and trusted and depended on. Degraded to unthinkable satellite status

is left at the mercy of new murderous rages at the newly-perceived triangular situation. This situation is the more enraging and painful because the toddler, still helplessly dependent on his parents, has now grown an active sexual curiosity which is inevitably unsatisfied and unsatisfiable. Their selfishness is criminal. These wicked parents shut their lovely child out of their disgraceful conspiracy of mysterious ecstasies. In its loneliest rages the child hates them and grows envious fantasies in which he fashions revenge with his own genitals and bottom to destroy their pleasures and filthy up their joys.

From this basic situation, inevitable because of the developments of love and hate and egocentricity and bodily functions and growing sexual interest, many developments may flow. I will mention a few extreme possibilities.

First - and we must remember this - the child also loves its parents, and thus it may get frightened of its rages and destructive thoughts and seek to control these. The girl child may develop a concerned over-protectiveness towards her mother. Overly good and devoted the girl may worry about how Mummy will be if the girl is not there to protect her from catastrophes. Now, clinging and fearful of parting from Mummy, the girl is set for phobias about school, and about the crime of growing up and away into sexuality of her own. She may be set never to be free, always to look after and consult Mummy, to live always near, and never to enjoy her own body except with anxiety and guilt about trespassing into Mummy's territory.

Second, the girl may be so ambivalent about her mother, especially if the maternal care is indifferent, that her love is regularly swamped by hatred so that she comes to fear and expect just retaliation for her sexual jealousies and rages. She may now see in her mother's discipline, evidence that her mother hates her and especially her femininity, her sexual curiosities and her early maternal ambitions. The way is now open for later terrors at sexual growth because it is felt to be anti-mother, rivalrous, forbidden and punishable.

A third possibility is that the toddler's love for her mother may be so steady in spite of her hatred that it can mitigate her destructive energy and in place of envy there grows admiration of the mother for having such marvellous and beautiful bodily powers and sexuality, together with a wish to be like her, loving and lovable. Because of this love she may come, by projection, to believe that her mother in turn is equally friendly towards her own feminine ambitions and will support this as she grows up. Such a girl acquires an early blessing within herself and confidently welcomes her later feminine developments with the same pride as she had in her mother's achievements.

A fourth possibility, is that, in rage at a mother who prefers doing rude and filthy sexy things with a man to caring for sad and lonely little girls, the infant may come to see her mother as a faithless prostitute. This hating picture of the mother who, I remind you, is also loved, is usually so unbearable that desperate mental defences against it are set up.

The commonest is a regressive step to the earlier idealised image - the Madonna, sweet, immaculate and clean, a two-body figure only, without the man of the painful eternal triangle. This mother loves only babies and never enjoys rude behaviour with Daddy. It gives her no pleasure - in fact it hurts her and when she does it, it is only to appease a brute. When she conceived the girl she was not thinking of enjoyment with man - only about the little baby girl to come.

This fantasy of mother, sweet, suffering and anti-sex is a fairly common model for girls. Indeed this model may govern her later life - whereby she too suffers the dirty appetites of men, sex and childbirth in the noble sacrifice of mothering. Such women are devoted to their children and to mothering, but give their husbands no status and no joys. One variety of this development is the Polly Garter women, promiscuous but always getting pregnant, occupied essentially with baby-making and despising men and sexuality.

These are four extreme illustrative possibilities of development. These extreme pictures are not very common but minor elements of all four are to be found frequently. Moreover

all four can alternate - depending on the current life situation of the image-maker. Such developments are however usually fateful for the girl's final development as a woman. This is because by the age of six most of this imagery has become unconscious and is therefore relatively unmodifiable. A bias of the girl about her mother and about her own femininity is thus laid down early in life, and the ways she will view and understand later experiences are heavily affected by this bias. This bias will dog all of her feminine developments including her relations with men and she will escape from it only by rare good luck in such matters as her choice of husband.

There is of course great variety of bias, of kind and intensity, but in general it is the way a little girl surmounts her mother's essential infidelity which leads her either to pride and pleasure or to imagined reproaches and disapprovals and sufferings by her mother as she grows her own sexual functions and enjoyments. No woman is quite free from these early biases; for they are part of early life itself.

Two facts are important for us. The first is that, because of these early fantasies about maternal rivalry, vengefulness, or need for extra-devotion because of the daughter's sexuality, some degree of shame, guilty about offending mother, remorse, disgust or sense of impending punishment is inescapable at every new step in feminine development, no matter how permissive the world around her, and no matter what counter-balancing features of love, pride and joy she may have in achievement.

The second important fact concerns maturational crises. Growing girls suffer variously the many problems of growing up, yet by the time they are women many achieve in their daily lives fair control over and commonsense adaptation to these internal biases; but at critical maturational hurdles these controls are liable to fail dramatically. The early maternal fantasy relations acquire renewed force at puberty, at courtship, at consummation, at marriage, during pregnancy, at childbirth and in the puerperium, at lactation and at the menopause.

At each venture into territory that has so far been only her mother's the girl's varying degrees of pride and pleasure at the identification with the approving early mother images are liable to be hampered by guilts and fears apparently illogical but derived much from the other unconscious early images of the faithless or damaged or revengeful or prostitute mother.

Where the early developments have gone well minor disturbances of anxiety or loss of confidence can be expected, but when they have gone badly severe disturbances resting on guilt, panic, depression may appear at the developmental crises already mentioned.

Human beings deal with guilt and anxiety in different ways. Some try to defy and fight these feelings, bluff them out frantically, deny and disown self-disapproval within themselves and carry out deeds which they feel are forbidden and more or less delinquent; but we may notice how often by this flouted defiance they get others to be condemning about them so the condemnation is not abolished - merely redistributed; others bravely seek out the very field which arouses anxiety in a struggle to act sensibly and be "with it" and now overcome their sexual uneasiness in new ways. But the commonest way surmounting guilt about or fear of the early mother figures over sexual enjoyment is to limit the amount of feminine pleasure to dull sober proportions. Women with severe guilts renounce feminine joys and live more or less grimly or, worse still, lead lives of sexual suffering; all these in attempts to appease the asexual or forbidding or wounded or terrifying maternal figures which were internalised in childhood.

Where such appeasements of forbidding internal figures and the consequent spoiling of femininity are insufficient to assuage guilts and terrors then these may break out as frankly emotional crises, usually of panics and depressions, at the various steps in feminine development. Minor crises are the stuff of common family life which faces and copes with emotional difficulties in growing girls, courting women, young brides, young mothers, mothers of adolescents, menopausal women. Larger emotional crises are the stuff

of the non-medical helping professions, school teachers, youth leaders, police, probation officers, social workers, the Samaritans, clergy, youth counsellors, solicitors, barmaids, health visitors, midwives, neighbours, relatives. Both mild and severe crises are met by obstetricians, GPs, paediatricians and psychiatrists. Last, as we doctors know only too well, bodily sacrifices may also be offered, varying from dysmenorrhoea to vaginal anaesthesia or dyspareunia, from abortion to fearful and difficult labour, from horror at breast-feeding to secondary frigidity, from searches for sterilisation to problems with all contraceptives, from menorrhagia to hysterectomy. The guilts and terrors so far outlined and the need to offer sacrifices are of course not the only possible causes of medical events in women but they are often complicating causes and sometimes basic ones.

With the major feminine step of puberty the upsurge of sexual longings, driven by the endocrines, brings an accompanying upsurge of the old guilts and fears which the child has more or less successfully repressed during her school years. These longings and the guilts and fears now take more sophisticated forms and are no longer associated only with parental figures, although they usually include them. The unconscious relation with the early mother figures can again be discerned in distorted beliefs which the girl now will hold not only about her present mother but also about other older women. The frigid sweet Madonna, the Prostitute, the hateful punishing Witch, the reproachful damaged mother, the jealous resentful rival etc. all reappear in her relations with older women, school teachers, neighbours, mothers and sisters, friends, public women, film stars and television figures. For example the school teacher may be feared as a hateful punishing witch, the mother as reproachful, worn out and never to be left, the health visitor as a sweet devoted Madonna, the neighbour as a frigid, jealous and resentful rival, the brother's wife as a grasping prostitute. There is always a grain of truth in these beliefs but all these figures get classified in pretty absolute terms on small and rarely corroborated evidence. It is of interest that these same figures can also be fairly easily noted - with all the emotional responses to them - at the other crises or marriage, pregnancy, labour, puerperium and during early motherhood, as well as, although less distinctly, at the menopause.

At her marriage, some older woman may be suspected as regarding her as too young (or too old) or marrying above (or below) her station, or being callous about leaving her poor Mother just when she needs her. During pregnancy the old bag across the street is felt as always peering at her through the curtains. In labour the young black nurse was an angel, but the ward Nursing Officer was an old witch who just enjoys women's sufferings and won't let them see their babies out of spite and jealousy.

Around the menopause the girls of today may be seen as sex mad, no sense of control, disgusting, should be stopped. In such pictures it is sometimes not difficult to see the old early images in modern dress.

If we ignore the complicated developmental struggles of puberty and how these may be blighted when early developments have gone ill and turn to survey briefly other adult crises one matter is clear: some women - those who as infants grew a loving admiration for their mother's femininity - surmount the various crises of feminine development with relative ease. They anticipate eagerly and welcome each new development, and can confidently and sensibly ask their mothers and other helpers as one grown woman among others for tips and ideas over each new development, while retaining their own autonomy and dignity. They are not uneasy at owning their private sexual wishes and their private sexual parts and at learning without envy from the experience of others and they do not have to prove anything by being strainfully fabulous or super at sex or at marriage or at mothering. The less guilt the freer is enjoyment in all aspects of female sexual life, and the deeper and less frantic or defiant their pleasures. Such women can love and trust others without clinging dependence, and can co-operate gladly and gratefully but not subserviently with their men; and so with their babies (and incidentally with their obstetricians). Not only are they loving but they are lovable; truly they make love, for they bring out the loving side of mothers. If they disagree and quarrel they do so early and honestly without sulks or malice. And if they suffer losses they mourn with love but recover (eventually) without seeking to blame others or make them feel guilty.

Doctors, whose job is trouble, meet less than their fair share of such women, so it is useful to be reminded that they exist. To come down to earth, many women are capable of many of these states of mind, if their lives go well, but they are rarely absolute states, and like all achievements are usually a bit rocky, liable to come and go, and to be under strain at crises. The truly unfortunate women however rarely achieve them but come to the fields of femininity more as lifelong trespassers, with guilts and fears of trouble, so that their lives as women are chancey and limited in greater or lesser degree. Many have difficulties in consummating their relationship with a man, and some girls cannot consummate at all and are even innocent of knowledge of their genital area. Some dare not touch it - and it seems for them to be still only dirty or the banned property of a sexually selfish mother who keeps all knowledge for herself. Some girls even say reproachfully, "My mother never told me anything," as if the bookstalls and cinemas were not blatant with the facts of life, but also as if she is forbidden to know for herself and still resents her mother for not sharing her secrets. Other young women seem anxious to remain innocent children not only in knowledge but in physique, and to yield the field of womanhood to their grown up mothers; some of them seek to live with or near their mothers even after marriage; others may believe that their vaginas are too small for intercourse and that this will tear them apart. (Although it is remarkable how quickly many inherit their adulthood and their vaginas if a woman doctor can introduce them to their vaginas).

Some can have a sexual life only so long as it is young and guilt-laden and irresponsible but once committed to marriage have to retreat from joy and become frigid, unable because of old wicked rivalry to become happily married women. Others become frigid only after childbirth - because mothers are Madonnas. Some frigid girls simply avoid marriage with its rivalry of mother and live in respectable but unsatisfied sin, while others, unable to enjoy any aspect of sex, rush into marriage hoping desperately that its respectability will take away their sense of sin about sexuality and magically cure them of pre-marital frigidity. Others are able to enjoy intercourse fully only if contraceptive precautions are absent or unreliable so that they can enjoy the fantasy that they do it essentially to get babies. Many honeymoons and later marital pleasures are wrecked by guilt-driven frigidity; sex is cruel, painful, or dirty and disgusting, or animal-like; or unless it is for babies. Suffering by being too tired or having a headache at the prospect of bed is all too well-known. Certain women can enjoy intercourse fully only after provoking and suffering a painful row or a beating which can assuage their guilt for the time being. Others create rows the next day to atone for the wickedness of the night before. Many is the child who dreads Sundays because that is the day for the parents to quarrel.

Friendly encouragement and goodwill from others that she should enjoy her man, together with patience and love from a husband who is confident of his masculinity are needed by many women to counteract this sense of guilt; but when the guilt is massive no reassurances are effective; indeed the woman may regard her husband and other encouragers only as evil-minded tempters requiring her to commit disgusting acts of concupiscence.

Going further and permanently into womanhood and actually bearing a child can be the greatest trespass of all. Maternity, the peak achievement of sexual growth, tests the whole early system of the mother-girl relations and it carries the greatest potential of all for arousing the rages and reproaches of the internalised mother. Where the guilt-laden woman was liable to be anxious or frigid or hostile about intercourse, she will have related feelings about pregnancy. Where she was docile, obedient and clingingly anxious to please mother over her marriage, she will now show related anxious obedience at antenatal classes and procedures but will not decide for herself nor be adventurous. Fears of miscarriage; expectation of punitively painful childbirth; labour as a fearful experience in which she can lose her life or her baby's; and many problems over enjoying the baby afterwards; arise out of unconscious guilt feelings towards the early mother. Far from enjoying her baby she may be afraid or averse to him, unable to own him fiercely as her own. Some may even seek her mother or some other woman to adopt the baby and they thereby surrender their motherhood altogether. Advice to enjoy the baby is difficult for such young mothers to listen to but they are all too vulnerable to criticisms about their various incompetences

with the baby. It must be admitted that young mothers rarely lack advisers but only those who are confident of their rights to be mothers can view these advisers as helpful and rather envying assistants rather than harrasing and hostile parents to be disobeyed at peril.

Throughout adult womanhood the internalised relation to the early maternal figure has major influence on whether or not the wife and mother copes gladly and confidently with each new development task or has to feel guilt, depression, timidity and anxiety; and whether she feels internally free and supported or alone, unblessed, criticised. For other tasks lie ahead of her. Can she enjoy her body and her baby as a wife and mother? Can she build a family, a home? Can she rejoice in her husband's masculinity, strength and successes? Can she continue to feel loved by and loving towards her older mother? Can she be glad to be a forty-year-old woman, sexually, domestically, socially? Does she experience both regret and pride as her children grow up and can she be glad to be their mother? Can she welcome her own daughter's menstruation, and be friendly to this new rival's growing interest in sexuality? Or will the old rivalries now lead her to anger, the old jealousies to sulks, the old envies to destructiveness? Can she accept with admiration the younger generation which begins to take over as the repository of sexual femininity - just as her mother was in her childhood? Will she admire them for it as she once admired her mother, or will she feel she herself is again too sexy and must renounce all sexual interest and feel jealous of the younger generation, bitter and discarded once again? And what when her daughter has babies; and her daughter-in-law?

All these are hurdles of development, potentially enriching experiences but liable to be tormenting because of the biasses mentioned earlier and their accompanying rages, envies, fears of criticism, and depressions.

And now the menopause and the loss of the capacity to have babies. Will it revive old infantile rages and hatreds at the sexual vigour of the women who can have babies, with wishes to spoil and filthy up their joys, or will it be accepted with love and goodwill and admiration of these others? Will she become an admiring grandmother, glad to be a minor assistant to the new vigorous adults? Or will she be interfering, invalid, jealous, spoiler, bitter, reproachful and lonely?

The answers to these questions will be much based upon how the woman fared in the inevitable earlier experiences, real and fantasied, with her own mother years ago.

And now, to redress the inevitable distortion of emphasis which arises from the selection for examination of any single aspect of female development, it needs mention that many other influences than the early relation with the mother will promote or mar the development of femininity. The relation to the father is an obvious one, especially in fashioning later relations to men. The luck of brothers or sisters, of friends and aunts and uncles and grandmothers, or early health and illness, and above these the actual relations between the parents are also obviously important. But behind all of these is the early primary fantasy-ridden relation with the mother and all the child's inevitable struggles with love and hatred of her in the first relation of all.

APPENDIX C

THE INTERNATIONAL CONGRESS OF SEXOLOGY. MONTREAL. OCTOBER 28-31ST 1976.

Report from Miss Valerie Thompson:-

The theme was one of international progress in sexology under the patronage of the Department of Sexology of the University of Quebec at Montreal, the Quebec Federation of Planned Parenthood, the Society for the Scientific Study of Sex, the American Association of Sex Educators, Counsellors and Therapists and the French Society for Clinical Sexology.

Contributions had been sought and were given by multi-disciplinary representatives from most parts of the world but there were no papers from the United Kingdom and Dr. H. Backer and I appeared to be the sole British representatives who had discovered the Congress.

The simultaneous interpretation services were faulty and although a potentially useful advance in selling cassette tapes of the speeches was available, in practice many of these proved faulty too.

The multidisciplinary attack on human sexuality was formidable and it is difficult to classify the presentations which included scientific summaries of physiological and psychological research, social studies and selected population groups, evaluation of every conceivable type of therapy, case presentations, surgical techniques, evaluation of educational projects and even political and philosophical evaluations.

Most suffered from the not uncommonly encountered disease of saying too much, too fast, but one outstanding paper was "the role of fantasy in pair-bonding and erotic performance" given by Prof. John Money.

Dr. William H. Masters spoke on "Ethics in sex research and sex therapy" and impressed by his integrity in his concern for the problems, difficulties and dangers in this work. Unfortunately he did not make a tape of this paper but one could well have been handed to every participant for future reference.

Two evenings were devoted to film schedules, many of which will be familiar to some of our members who have experienced Dr. Elizabeth Stanley's "total immersion" film sessions.

Dr. Mary Calderone, President of SIECUS (Sex Information and Education Council of the United States) spoke on "Human Sexuality: peaceground or battleground" and as this was an impressive paper which received a great ovation it was heartening to realise that she of all the speakers came nearest to us in our methodology in being happy to talk about feelings and caring and loving and understanding and communication with patients who are saddened or angry with their sexual lot.

Altogether it was cheering to see all the varied disciplines united and communicating and to sense the pioneering spirit in holding such a Congress at all.

Report from Dr. Hannah Backer.

Visit to New York and Montreal

The main purpose of my travel to the New World, was to attend the International Congress of Sexology held in Montreal. En route I stopped in New York and contacted Dr. Helen Singer Kaplan.

I visited the Payne Whitney Clinic in New York, where I had arranged to meet Dr. Helen Kaplan. On arrival I was met by a secretary, who showed me into a small room, already almost full with people. A one way screen dominated the room and that was the first indication I had, that I may be able to see Dr. Kaplan in an interview with patients. As time progressed the room filled up even more, with standing room only for the late arrivals. The audience, as I found

at later, was a training group and consisted of doctors, social workers, psychologists and nurses. When Dr. Kaplan arrived, she briefly reminded the group, about the patients she was to see, the lights went on in the adjoining room and the stage was set.

The patients were a couple in their early thirties, a truck driver and his wife. From the discussion that followed I gathered that the husband suffered from lack of interest in sex. This was a fifth follow-up visit with little progress made. In the previous session they were advised to practice sensate focusing. When asked how they were getting on, the wife did most of the talking and with considerable anger, reported on her husband's persistent avoidance of sex. He was rather on the defensive using pressure of work as an excuse. Dr. Kaplan proceeded to work out in detail a plan with the couple, as to when they should make time available for their sex activity. The wife seemed delighted with these arrangements, the husband reluctantly agreed to try again and the interview was brought to a close.

When the patients had gone, we all moved to a larger room to discuss the session. Dr. Kaplan introduced a fellow visitor, a Psychologist from Australia, who like myself was en route to Montreal and myself. We were asked how we would have handled the interview - the Australian stated that his approach would have been the same, I explained that my method of treatment is far less directive. Dr. Kaplan answered that normally she would have been less so, but that she felt she had to do something, in view of the slow progress.

The group was then asked to give their views on the interview. Discussion was very free and open. Questions were asked and suggestions were made. Dr. Kaplan admitted to her own feelings of frustration at the husband's avoidance of the issue, but feelings as such were not discussed and the discussion centred more on practical advice.

Throughout the interview with the patient and during the group meeting, Dr. Kaplan came across as a warm, vivacious, sensitive and most sympathetic person, who was obviously held in high esteem by all those present, me included. I am very grateful to her for allowing me to get a glimpse of her in practice and to witness a different approach to patients and to training.

At the Congress there were about 1500 participants and 106 papers were read. The delegates came from various disciplines, ranging from doctors, social workers, psychologists, marriage counsellors, school teachers, surrogates to self appointed sex therapists to Women's clubs in the USA and others. This made it very difficult to make contact with people whose interests one would share. Papers were given simultaneously in two lecture halls, which were separated by nine floors. However my main criticism of the conference, which was shared by many others was the total absence of discussion of the work presented.

I find it difficult to pick out papers to report on in detail for many proved valuable, even if in some instances I disagreed with their contents. The majority of speakers followed Masters and Johnson techniques or their modifications, many used a combination of directive techniques with dynamic therapy; very few relied on psychotherapy only. The main objective appeared to be to improve performance, with little or no reference to relationships and feelings. A number of papers were concerned with raising the erotic levels by artificial means as a therapeutic aid. Dr. Gillan, the only U.K. speaker presented a paper on the use of audio-visual stimuli in the treatment of both male and female sexual dysfunction and reported favourable results.

W.H. Masters in his paper and also some other USA speakers expressed their fears about the varying standards of sex therapy practiced in their country and accreditation of therapists is planned in the future.

Many schools of sex therapy were represented and throughout the Congress my one regret was that the Institute of Psychosexual Medicine had no voice. We have been engaged in this field for much longer, than many of the speakers. In two years time a Congress is planned for Rome, in four years time in Tel Aviv - hopefully this should give us time to catch up.

APPENDIX D.

NEW MEMBERS AFTER NEWSLETTER 6

T. Z. Aung,
The Surgery,
1, Third Avenue,
Canvey Island,
Essex. SS8 9SU.
037-43-3758.

Michael Cohen,
44, Holmdale Road,
London, N.W.6.
01-435-8019.

D. L. F. Dunleavy,
Psychological Medicine,
Royal Victoria Infirmary,
Queen Victoria Road,
Newcastle upon Tyne. NE1 44P.

G. Clifford Gould,
27 Ravens Road,
Shoreham,
Sussex.
Home - 5065.
Health Centre - 61161.

Elizabeth Halifax,
Highfields Lodge,
Highfields,
Ashted,
Surrey.
27-75071.

Joyce Jenkins,
Marlake House,
Murcott,
Oxford. OX5 2RE.
086-733-284.

Elizabeth Miller,
23 Hill Crest,
Cranwell,
Sleaford,
Lincs.

Ann Morgan,
Three Queens,
1 Deep Street,
Prestbury,
Cheltenham,
Glos. GL5 23AW.
0242-7633.

Dorothy Morgan,
Health Offices,
Watton,
Brecon,
Wales. LD3 7ED.
0874-2456.

Jean Parry,
Bridge House,
Rowton Bridge Road,
Christleton,
Chester.
0244-32066.

Mary Rees,
31, Court Lane,
London SE21.

J. C. White,
18, Overbury Road,
Hereford.

Jessie C. Yorston,
Luiberg,
Gardiners Lane,
Romsey,
Hants. Romsey:512054.

Change of Address:

M. Nankivell,
Queen College,
Somerset Road,
Edgbaston,
Birmingham 15.
021-455-7579.

Telephone No. to be added:

R. D. Sampson.
01-445-6272.