adequately recognize the large areas of interest that we share with other professions and disciplines (education is especially ignored) and to accept that these disciplines may have more productive theoretical models and more practical experience in some of these areas. Where groups are concerned, the tenacity with which we hang on to the hallowed doctor/patient relationship may well have a bearing on this.

Nothing of this is intended to indicate that psychiatry has little to offer in the development of Training Groups. In the areas of selection, protection and follow-up it is reasonable to assume that psychiatric experience would be particularly valuable. Such a 'responsible' contribution however, is probably best made from within the organization, and it could be argued that in these circumstances psychiatry has as much to gain as it has to offer. It is certainly not enough, to suggest that 'the way in which Training Groups are conceived bears some relationship to cults which have developed in the past'. The very fact of the popularity of Training Groups and other group activities in education, industry and other institutions surely indicates a 'need' that may have relevance both to the aetiology and the management of large areas of emotional disturbance.

The fact is that we live and work in a complex matrix of groups, and, H. Osmond (*Journal*, November 1970, p. 607) notwithstanding, mental hospitals provide one and many types of group. Understanding of the abnormal proceeds from understanding of the normal. At very least, if we are to further the understanding and practice of mental health we must be to able show that we can distinguish between unbiased scientific enquiry and professional 'group maintenance'.

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PRISONERS OF XYY CONSTITUTION

Dear Sir,

In a recent paper, Griffiths (1971) reports on the questionnaire scores of prisoners of XYY constitution and controls equated for height; he concludes that of the three variables measured (P = psychoticism, E = extraversion, N = neuroticism), the only significant difference occurred with respect to E, XYY karyotypes being more introverted. The scoring key used by Griffiths has been supplanted by a different key based on a number of factor-analytic investigations on various groups of prisoners and controls, and hence it may be of interest to see whether similar differences are apparent when the new key is used. In searching for an appropriate control group it seemed undesirable to confine ourselves to that used by Griffiths; although he tried to equate this group with the XYY group for height, there was a difference between the two groups significant at the 1 per cent level, which may rule out the possibility of regarding this group as matched for height with the experimental group. Fortunately the very small control group did not differ significantly from our large prison standardization sample of 603 with respect to P, E or N, and consequently we have compared the experimental group with this much larger group (Eysenck and Eysenck, 1970). Of the original 12 subjects, records for rescoring were made available by Mr. H. Marriage, senior prison psychologist at Wandsworth, for 10; their mean scores and SDs and those of the control group, are given below

XYY:	N = 10	P = 8·40 ± 3.86	E = 9.40 ± 3.53	N = 12.2 ± 5.65
Controls:	N = 603	P = 6.25 ± 3.01	E = 12.75 ± 3.52	N = 11.04 ± 4.75

Significant differences were observed for E ($t = 2{\cdot}98$, $p < {\cdot}005$), and for P ($t = 2{\cdot}23$, $p < {\cdot}05$). XYY karyotypes are significantly more introverted and higher on psychoticism than the normal controls; there are no differences on N. It is the addition of P to the previously noted difference on E which caused us to write this letter; this additional difference is very much in line with prediction (Eysenck, 1971). The number of cases on which this difference is based is of course small; it is to be hoped that future studies will make it clearer just how much confidence can be had in these relationships.

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SCHIZOPHRENIA AND SEASON OF BIRTH

Dear Sir,

We should like to reply to Dr. James' letter (*Journal*, August 1971, Vol. 119, page 229). There seemed to us good reasons for not comparing the season of birth of our Maudsley patients with those of the general population given by the Registrar

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,