chemotherapeutic agents, with the possible exception of demecolcine, the best palliative therapy for chronic myeloid leukaemia that has stood the test of time is radiotherapy. Myleran at present does not appear to be superior to radiotherapy, but we cannot yet answer the question, "Is myleran an effective substitute?"

We are indebted to Dr. D. A. G. Galton for the initial supplies of myleran, and to Mr. G. W. Blomfield, Dr. H. P. Brody, Mr. W. J. Lytle, and Professors E. J. Wayne and G. M. Wilson for ward facilities.

REFERENCES

- Galton, D. A. G. (1953). *Lancet*, 1, 208.
 — (1955). *Ibid.*, 1, 425.
 Haddow, A., and Timmis, G. M. (1953). *Ibid.*, 1, 207.
 Hansen, P. B. (1954). *Folia clin. int. (Barcelona)*, 4, 267.
 Kurrle, G. R. (1955). *Med. J. Aust.*, 1, 636.
 Petrakis, N. L., Bierman, H. R., Kelly, K. H., White, L. P., and Shimkin, M. B. (1954). *Cancer*, 7, 383.
 Shimkin, M. B., Mettler, S. R., and Bierman, H. R. (1951). *Ann. intern. Med.*, 35, 194.
 Videbaek, A. (1955). *Acta med. scand.*, 151, 295.

THERAPEUTIC AND PSYCHOLOGICAL APPROACH TO CASES OF UNCONSUMMATED MARRIAGE

BY

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In a paper read before the 19th International Psycho-analytical Congress at Geneva I attempted to formulate the scientific findings derived from the psychotherapeutic treatment of about 50 cases of unconsummated marriage (Abraham, 1956). Much of this work was carried out at the South London Hospital for Women, and was made possible by the co-operation of Miss Edith Hall and her department. First I shall give an account of my therapeutic approach. Much of the description may seem to be commonplace, but later I shall demonstrate that each step was taken on the basis of psychological reasoning and that it was through my knowledge of psycho-analytical theory that I was able to understand and handle my patients.

The women referred to me had been married for periods varying from two months to about eleven years. Most of them had been seen by one or several general practitioners, some by marriage guidance centres, and all by a gynaecologist who had not succeeded in carrying out a vaginal examination. Several patients had had a dilatation under general anaesthesia without any result.

Technique of Treatment

My technique was evolved under the pressure of a busy out-patient department, where such patients, so obviously unsuitable for a waiting-list, had to be dealt with quickly. The early cases were handled in a more tentative manner than the later ones and with greater expenditure of time. When the flow of such cases became continuous I gradually shortened and modified my procedure. Two points should here be stressed. First, my success largely depended on team-work, and the understanding and co-operation of Miss Hall and Miss Croxford were invaluable. Secondly, in no case was I content with the achievement of intercourse, for I continued to see the patients until, in most cases, some measure of orgasmic satisfaction was reported, although this naturally varied in degree and in a few cases remained poor. If pregnancy was not desired, birth-control was introduced before intercourse took place, so as to obviate any conscious reasons for apprehension and restraint. If

pregnancy was desired and achieved the patients were seen throughout that time, since it was assumed that women who had denied their femininity so strongly would need help in adjusting to their maternal role. Also, the management of the expected infant was discussed, in the hope that this might protect it from the mother's fate.

When seeing such patients the first efforts must be directed towards gaining their confidence. Often they have had their fears derided by doctors, and are therefore surprised by a sympathetic approach, and the assurance that I have seen other patients with similar fears serves to relieve tension and to gain the necessary co-operation. From the outset it is made clear that my treatment consists merely of a discussion of their anxiety, which I hope may lead to an understanding of the root of their trouble, and that they have been referred to me because I have the necessary time and experience. I then get them to tell me of their marriage and of their home background in their own way, and with as little prompting as possible. This gives me an idea of the strength of the symptom and of the time I shall need to help them to overcome it. As stated below, I have come to recognize two groups into which these cases fall.

At the end of the first interview, which generally lasts about 30 minutes, I invariably ask the patient to refrain from all further attempts at intercourse until we both agree that she is ready for it. This again is contrary to all previous advice, and is received with relief. I always add that it will not take us long to overcome her fears and that she should ask her husband to be patient for a few more weeks. Such a statement has a twofold purpose: it introduces the husband's point of view, and it helps inhibited patients to talk about a topic they have often avoided discussing with their husbands and which has been banned. In psycho-analytical language, we would say that in this way I come to represent a tolerant and permissive mother-figure. This line is followed throughout.

During the first or second interview the question of menstruation and the first menstrual period is raised as a routine matter. It is in fact used as an entry into a discussion of the patient's relationship to her mother and of her own attitude to sexuality. I ask why we have a period, thus helping her again to identify with me. I am usually told from whom or how she found out, and often assured that she knows all about it. I have learnt never to accept this, but to get her to tell me what she knows. This knowledge is as a rule incomplete and quite often absurdly distorted. Most patients are, however, keenly interested to learn something about the anatomy and physiology of their own body, a subject they had hitherto regarded as forbidden. By the end of the second interview most patients are relaxed and ready to ask questions, and in the third a plan of procedure can safely be laid before them. They are told that they will need a vaginal examination and that they would be shown how to use glass dilators—not, it is stressed, because they need stretching, but to help them to gain self-confidence. As a rule I suggest that they might help by investigating these parts of their body by themselves and trying to identify the structures I have sketched for them. This often leads to a discussion about clean and dirty parts of the body. Here I have found the use of the mouth for purposes of analogy very helpful, not merely to correct the existing ideas about clean or dirty body openings, but also for a discussion of their fear of being hurt. They readily understand that it hurts to push any object into the mouth if the lips are tightly pursed and that mouth and vagina alike may become parched with apprehensive fear and so become chafed.

Examination by Gynaecologist

With the first series of patients referred to me I used to be present during their examination by the gynaecologist, because I wanted to observe their reaction and because I believed the use of the transference relationship to me, already established, might help to shorten the treatment. I have gradually cut the preparatory phase from six to one

or two weeks in most cases and have found that, given a friendly and patient gynaecologist or general practitioner, no time is saved by my presence.

A few points about this examination need stressing, for it is crucial and its failure very traumatic. It should always be carried out in the greatest possible privacy, with doctor and patient alone in a room or cubicle. A woman doctor is preferable because these patients expect her—not always with justification—to understand and sympathize, and find it easier to identify with her, especially where their own over-attachment to their mother is at the root of their anxiety. The presence of more than one nurse, of other doctors, or of students is fatal, as is also a hurried and impatient approach. A few friendly words whilst the patient lies down and a cursory external palpation help to make contact. Our discussions have prepared the patient for all that is going to happen. Anxious patients are greatly reassured, however, if the doctor tells them step by step what is being done.

The ensuing vaginal examination should be gentle and short. If there are any doubts it is better to repeat the examination at a later date rather than upset or hurt the patient on this first occasion. She should be told that she seems perfectly normally made. The resultant relief helps her to relax further and to allow the introduction of a No. 1 glass dilator, and she should be shown at once how to slip it in and out by herself. It should be left to her to decide whether she would like to try a larger size or whether she would rather take sizes 1-4 home and try by herself. The pace should never be forced, and if the patient is not ready to tolerate examination she should be given a No. 1 dilator and allowed to insert it with the doctor merely directing her. Vaginal examination is then postponed for some weeks. Usually the whole procedure takes no more than 10 minutes, and the time is well spent, for as a rule no second visit is needed.

The patient comes back to me to tell me about her experience and her progress with the dilators, which she is advised to use twice daily with a lubricant for a few minutes at a time when she is unlikely to be disturbed in her privacy. This gives us a welcome opportunity to discuss residual fears and the position in which she would be most comfortable and relaxed.

A few patients need an excision of the hymen. The principle is the same. The patient is told exactly what is to be done and why. When she comes round from the anaesthetic she should not be given a set of dilators "to get on with at home as soon as possible." Unless she is first allowed to heal up completely the residual soreness will confirm her previous fear of pain. When she is quite healed she must be shown the use of dilators, just as are all the other patients seen for the first time. It is erroneous to imagine that the excision and an assurance that she is now all right will be acceptable to a truly anxious patient. Mishandling at this stage may prevent her from coming back and make her feel that there is no help for her.

Once the patient has passed dilators up to size 3 or 4 without discomfort—that is to say, without anxiety, which is usually after about another two or three weeks—she is as a rule ready and eager to attempt intercourse. It is important to suggest that this attempt should be unhurried and that no real pleasure is to be expected as yet. Her relief on reporting that she has succeeded and felt no pain is the best reward for the time spent, and once she has got so far and no longer feels different from other women, progress towards the achievement of pleasure may often be surprisingly swift.

The Psycho-analytical Approach

I want to introduce the theoretical part of this paper by a brief description of the first case of this kind ever referred to me. A well-built woman of 39 decided, after much hesitation, to seek help because she wanted a child. Her mother had died giving birth to her and she had heard this tragic tale many times from her maternal grandmother.

Nevertheless her early childhood was a happy one. She lived with her father and was looked after by her mother's sister until she was 3½. Then her father remarried and her life changed. Her stepmother was at first merely indifferent, but after having borne several children she became actively unkind to her stepdaughter, who began to hate her. My patient left home at 18 and lived with relations until at 29 she married. She was very fond of her husband but afraid of intercourse, and after some time he became less pressing and finally lost interest. She came for help on her own initiative after seeing her doctor without result and having a dilatation of the introitus under anaesthesia, which, however, made no difference to her fear. In describing this fear she said, after some hesitation: "I know it sounds silly, but I feel I am too small." When we considered this statement in detail, it was easy to trace it back to her father's remarriage, which at the time she believed to be due to the fact that she was still too small for him. After discussing this childhood fantasy she improved rapidly, and I was in fact surprised by the speed with which in this and in certain other cases a long-standing anxiety was overcome.

This case led me to draw some conclusions which I later found confirmed again and again. First, I observed that with few exceptions the women referred for vaginismus showed no other serious neurotic symptoms and were well able to make object relations. Secondly, I found that, where several months or even years had elapsed without the husband urging his wife to seek help, the husband might generally be assumed to be a latent homosexual. In the above case this was undoubtedly true, and my patient was deeply disappointed that when she was able to have coitus her husband showed little interest and tended to give up altogether. He, as well as some other husbands of such marriages, found compensation in work with other men, in Civil Defence, football, or similar activities. The statement of these women that their husbands are good and do not bother them should be received with dismay. Whether their choice of such partners is unconsciously motivated will need further and deeper inquiry.

From the point of view of response to treatment I came to divide these patients into two groups, which could be considered irrespective of the period the marriage had existed. Although, with one exception, all my patients were able to overcome their anxiety far enough to permit marital relations, the further course they took obliged me to make this division.

The larger group, to which the patient whose case is described belonged, consisted of those women who seemed to need little further help once the first big step had been taken. This can readily be understood in the light of psycho-analytical theory. According to Freud (1950), the boy's development towards adult sexuality is a relatively simple one. His first love-object is a heterosexual one—namely, his mother—and it only remains for him to transfer his early feelings towards his mother on to other women. In girls this process of maturation is far more complex. They have to go through two stages. From the mother they have to transfer their love to the father, and later, during adolescence, to other men. The first stage is called the Oedipal phase, a concept too generally known to need further comment. This biphasic psychological development has its biological counterpart in the fact that sensation is first centred in the clitoris and, during or after adolescence, must be transferred on to the vaginal introitus, a complex process in comparison with masculine development.

It can easily be understood that the women belonging to the larger group had reached the Oedipal level but had remained libidinally fixated to the father. This was confirmed by the history as well as by their mature and intact personality. The missing step, the transfer from father to husband, was therefore not too difficult to achieve. For the same reason these patients attained orgasmic satisfaction of varying degree and adjusted quickly to motherhood and its demands.

The second, and smaller, group consisted of women fixated to their mothers. They had never reached the Oedipal level or, having reached it, had regressed to their pre-Oedipal mother-fixation for some reason or other. In a few cases this reason was clearly apparent. Where the history showed the father to have been weak, quarrelsome, cruel, unfaithful, or unkind from the outset, or where he had died early, it might be assumed, in Freud's words, that "one has to give full weight to the possibility that many a woman may remain arrested at the original mother-attachment and never achieve the change-over to men." A relevant example is that of a patient aged 31, who had been married for four months. Her father had been killed when she was 3 years old. As an only child she remained under the domination of her mother-fixation and had failed to change the sex of her love-object. In another case the patient's father had died when she was 7, and here a regression to the original mother-fixation might well be assumed. This case was of long standing and was, in common with a number of others, enhanced by the mother's rejecting and negative attitude towards sexuality. It must be stressed that a rigid and Victorian attitude towards sexuality is common enough, especially among the less educated, but it is only in cases where fixation to the mother or identification with her is very strong that it does real harm.

One road open to the girl fixated to her mother is that of identification with the father, as might well happen where unconscious incestuous wishes towards him had been particularly strong and had been rejected. Her identification will then lead her to assume the masculine role as her mother's protector. The second road is that of passivity in relation to a strong and dominating mother. I recently saw this attitude in a woman of 35, an only child. She was very attached to her father, but it was the mother who ruled supreme and always got her own way. Whilst in the Army, she met a man, and married him although her mother did not like him. Her conscious rebellion went no further, but unconsciously she upheld her mother's prohibition: she had not been able to have intercourse during the eight years of her marriage. It is not surprising that this type of patient proves more resistant to treatment and takes longer to help.

Of the two roads, that of identification with the father is particularly characterized by a sadistic attitude towards the husband, which is another point I wish to stress. In my investigations I was struck with the ease with which these patients recognized and understood the sadistic meaning of their attitude. They knew about their husbands' suffering, and pleasure in this suffering was often but thinly veiled by praise of his kindness in not bothering them. In some cases this understanding was driven home by observation of the husband's anxiety and partial or temporary impotency when intercourse eventually took place. Often the punishment of the husband for the father's shortcomings was clearly apparent. This material must be handled most cautiously, and with regard to each patient's individual needs.

It would lead too far to discuss in detail the contributions to psycho-analytical literature by authors such as K. Abraham (1920) and Fenichel (1946), or to go into the implications arising from their work. This would be incomprehensible or tedious to all but psych'atically trained readers. It should be said, however, that these two authors in particular describe a "revenge type" of female sexual behaviour which unconsciously aims at destruction of the husband's potency through the wife's plainly shown aversion to his approaches.

One last example may serve to illustrate this type of behaviour. It is that of a woman referred to me by the antenatal department in the fifth month of pregnancy. She had never tolerated penetration, and had in fact an intact hymen. She had loved her father, who died when she was 12. Her mother, who had left him years before, then took her young children to live with her, and my patient had to

witness her mother's relations with other men, on one occasion while she was on the same bed. The man smacked her for looking instead of reading her comic. The achievement of a pregnancy without gratifying the husband seems to me a clear sign of unconscious revenge.

Conclusion

In giving this detailed account of these cases and their management I was prompted by several motives. First, by the fact that many patients might find help much sooner if their first attempts were not so often met with lack of understanding and impatience, if not derision and sarcasm. Second, by my conviction that a busy surgery, out-patient department, or marriage guidance centre cannot hope to tackle any but the lightest cases. More anxious patients—that is to say, all those who have been married for months or years—should be managed by general practitioners or gynaecologists on the one side and by psychotherapists on the other. My last and most important aim was to show that where no anatomical abnormality is present the approach should be psychological and not physical. The knowledge of the basic principles of psycho-analytical theory enables us, as has been shown, to understand and treat the great majority of these patients successfully.

Summary

An attempt is made to show the therapeutic approach to cases of unconsummated marriage derived from the results of treating 50 such cases. It is stressed that where no anatomical abnormality exists the approach should be from the psychological side and that gynaecologist or general practitioner should co-operate with psychotherapist.

In the theoretical part it is shown that the larger group of these cases consists of women who have reached genital maturity but have remained fixated to their father, and these are the cases which can be tackled quickly and easily. The smaller and more difficult group consists of women who have either remained fixated to their mothers or who have regressed to such fixation because of their disposition or because of external circumstances. These subjects need more time and more expert handling. All cases treated continued to be seen not only until consummation had been achieved, but until some degree of orgasmic pleasure had been attained. Where pregnancy had been desired the patients were seen from time to time throughout pregnancy and puerperium.

My thanks are due to Miss E. Hall for her co-operation and support, to Miss V. Croxford for examining a great number of the patients, and to Dr. W. Hoffer for permission to quote from my earlier paper.

REFERENCES

- Abraham, Hilda C. (1956). *Int. J. Psycho-anal.* In press.
 Abraham, K. (1920). *Selected Papers on Psycho-Analysis*, p. 338.
 Fenichel, O. (1946). *Psycho-analytical Theory of Neuroses*. London.
 Freud, S. (1950). *Collected Papers*, 5, 186, 252. London.

The British Standards Institution has issued a Sectional List of British Standards for Hospital Equipment (P.D.2383, dated January, 1956). The Standards, with details of identifying number, date, title, and cost, are listed under the following headings: medical and surgical apparatus; laboratory glassware, scientific apparatus, etc.; furniture and fittings; textiles and clothing; photography and radio-graphy; methods of testing materials, etc.; symbols, tables, definitions, etc.; electrical equipment; and general. Copies of the list may be obtained from the Sales Branch, British Standards Institution, 2, Park Street, London, W.1.