able at the time of publication two years ago. Since then others, or references to reliability, have appeared, which I would be pleased to make available to anyone interested.

The value of the Systematic Interview Guides has been demonstrated in a small way from a recent study of 'Inconsequential' (minimally brain-damaged) children in Ontario. It gave highly significant correlations between the pregnancy stress scores derived from the above and, on the one hand, the indications of pre-school maladjustment recorded on the same instrument, and, on the other, the subjects' scores on the Bristol Social Adjustment Guides some twelve years later. This report has been submitted for publication, and duplicated copies of the article are available.

It seems to me, in short, that although Dr. Rutter is right in drawing attention to the lack of published norms, his indignation about these instruments being published is unjustified. Moreover, he gives no grounds for his verdict on them as 'unsatisfactory'.

D. H. Stott.

Centre for Educational Disabilities,
University of Guelph,
Guelph, Ontario, Canada.

References

(Publications by D. H. Stott)

(1956). *The Bristol Social Adjustments Guides* (with E. G. Sykes) London, University London Press; Toronto General Publishing Company; San Diego, Educational Industrial Testing Service.

(1957). 'Physical and mental handicaps following a disturbed pregnancy.' *Lancet, i,* 1006–12

(1959). 'Evidence for pre-natal impairment of temperament in mentally retarded children.' *Vita Humana,* **2,** 125–48.

(1966a). *The Social Adjustment of Children* (*Manual to the Bristol Social Adjustment Guides*). Third edition, London, University London Press: San Diego, Educational Industrial Testing Service.

(1966b). *Studies of Troublesome Children.* London, Tavistock Publications, New York, Humanities Press, Toronto, Methuen Publications.

CLASSIFICATION AND GLOSSARY OF MENTAL DISORDERS

Dear Sir,

I refer to the letter from Dr. Peter Sainsbury (*Journal,* June, 1969, p. 743), in which he appeals to psychiatrists to use the new Revision of the Classification of Mental Disorders.

In July 1964 the Ministry of Health wrote to hospitals for the mentally subnormal and asked these hospitals to introduce the classification devised by Rick Heber in 1959 for the American Association on Mental Deficiency and to use it in completing Box 16 of the Mental Health Inquiry Hospital Index Card A. So far Heber's classification has generally proved to be more useful and acceptable to workers in mental retardation than the International Classifications. The American Classification has three parts 'Clinical', 'Behavioural' and 'Intelligence Levels', although only the clinical section is being widely applied in hospitals for the mentally retarded in this country at the present time.

For psychiatrists not immediately involved with mental retardation and who may be unfamiliar with Heber's Classification, the reference is: *A Manual in Terminology and Classification in Mental Retardation* by Rick Heber. Monograph Supplement to the American Journal of Mental Deficiency, September 1959. Published Albany, New York State, 1959.

In practice the expression of Heber's Classification in terms of an equivalent International Classification Code is not difficult and can be readily standardized, so that the two systems of classification can be regarded as complementary.

D. A. Spencer.

Stansfield View Hospital,
Todmorden, Lancs.

PSYCHOTHERAPEUTIC STATUTORY INSTRUMENTS

Dear Sir,

In the past ten years in one locality, I have occasionally been struck, as must others similarly elsewhere, by remarkable degrees of failure to protect psychiatric patients (from the worst excesses of their lack of insight or loss of judgement) because of a reluctance to initiate compulsory admission to hospital. Thus, hypomanic patients have been allowed irrevocably to squander their livelihoods, and comparatively well-to-do schizophrenics to live for months or even years in conditions of unchecked squalor, before the psychiatric services were eventually brought sufficiently to bear to permit others to manage the patients' affairs and the latter to receive the modern effective treatments available.

Admittedly, it can be difficult at times even for the expert, on insufficient acquaintance in a busy out-patient department, to distinguish mild hypomania from the hail-fellow-well-met, or degrees of schizophrenia from eccentricity, especially if the family doctor or others whose acquaintance with the patient may be longer have themselves failed to

recognize and do not stress relevant aspects of the change in behaviour; but there is also, I believe, some hesitation due to lack of appreciation that detaining such patients in their own interests is no worse than insisting that a child take a foul-tasting but beneficial medicine. There may still be a tendency to equate such use of statutory instruments with custodial care and therapeutic nihilism.

Is it possible that this important aspect of our subject is receiving insufficient attention at 'teaching centres' which (despite the Mental Health Act, 1959, having made compulsory admission possible to any hospital) may for various quite valid reasons still prefer to deal with informal patients only? If so, is this not a matter to which a College of Psychiatrists should pay particular attention, through peripheral postgraduate tutors, especially as the kind of practice concerned may be encountered most in populations served by such psychiatric hospitals? The dynamic humane management of some patients would be quite impossible without such aids, although the non-medical role of the social disciplinary services must not be usurped.

J. P. CRAWFORD.

Newhouse,
New Road,
Ide Hill,
Kent.

TRAINING OF PSYCHIATRISTS

DEAR SIR,

I was concerned to read the suggestion of a Senior Lecturer in Psychiatry (*Journal*, May, 1969, pp. 630–1) that psychiatry was perhaps not the best background discipline to subnormality.

In the present climate of legitimate concern at the state of subnormality institutions, to consider diminishing the position of the psychiatrist in this field seems an unconstructive notion. Rather is this the very time for psychiatrists to exercise their expertise gained over the past decade in developing community care and therapeutic milieux.

The reasons for referral of most subnormals are deviant behaviour or abnormal psychological development; both are primarily the responsibility of the psychiatrist. The advances in the field of ontogenics present exciting possibilities for psychiatric research and modification of developmental handicap.

Dr. Pilkington is of course correct in stating that the D.P.M. has little relevance to subnormality (nor do many D.P.M. courses give greater emphasis to alcoholism, children or offenders). This is not an argument for removing subnormals from the care of behavioural medicine, rather for hoping that the awaited Membership examination will include community techniques and the theories of Piaget, Inhelder, Bühler and Luria in its requirements for the specialist in subnormality.

WILLIAM IRVINE FRASER.

Lynebank Hospital,
Dunfermline.

AVERSION THERAPY FOR SEXUAL DEVIATIONS

DEAR SIR,

I have been prompted by recent referrals of homosexuals for aversion therapy briefly to report the results of this treatment in various sexual deviations based on a follow-up study conducted in 1968. Aversion conditioning with apomorphine had been used in each case, and in some had been combined with the electrical technique.

Five homosexuals were treated, and one homosexual fetishist (also included under fetishists). All had been referred specifically for aversion therapy. None of the five showed any change in response to treatment. The homosexual fetishist showed a partial response to treatment, but although he had for just over a year avoided the overt activity which had previously brought him into serious conflict with the law, he was still in a precarious position. His treatment could not be regarded as successful, for his attitude and the direction of his sexual drive had not changed.

Of ten transvestists who presented for treatment, only seven accepted it after the method and rationale had been explained to them. Of the seven who were treated, two showed no change at all in attitude. Of the five who showed an apparent change in attitude, one relapsed after three months, one after five months, one after two years, and one after three years. The remaining patient regarded his treatment as successful, but when seen for the purpose of follow-up only four months had elapsed since his treatment.

Of twelve fetishists referred, one was excluded from treatment because he was dementing, and another because he objected to entering a psychiatric hospital. Of the ten who were treated, only one showed no change in attitude. He had a severely disordered personality, and his treatment was interrupted by violent outbursts of aggression and by depression requiring ECT. He has since been diagnosed as schizophrenic. Of the remaining nine patients, one had a relapse after six years, and after further treatment had continued for eight years without relapse. The others had had no relapse after six years, five