opinion, for although there was much subsequent discussion in both Houses on the definitions of "severe subnormality" and "psychopathy", resulting in some amendments, not a single reference was made by any member to mental illness in this connection.

The position, therefore, seems clear enough. There is no such things as "mental illness within the meaning of the Act". The term is taken as one of common usage, in the same way as are such words as "mind", "intelligence", "disability", "exploitation", and others occurring in the Act. For the purpose of justifying compulsory treatment we are not required to worry about the borderline between illness and health, because we are concerned only with cases of such severity as to warrant detention. If the symptoms point to such severity, the Courts are not likely to pay attention to sophistries about "neurotic depression"; and this is in fact what happened in the case related by Dr. Haldane. It is to the criteria for the "degree of illness that warrants detention" that we need to address our minds, and here the circumstances justifying detention laid down by the Royal Commission provide a sure guide. For we can first ask ourselves whether the patient's condition is one in which these circumstances are liable to exist, and then secondly whether they actually do exist in the particular case. For instance, in the case of fetishism mentioned by Dr. Haldane in his second letter (above) it is very unlikely that condition (*c*) could be fulfilled.

It is a little surprising that Dr. Haldane should be inclined to revive the bogey of "heavy damages in the Courts" on account of some misinterpretation on our part, since the provisions of Section 16 of the Mental Treatment Act of 1930, re-enacted as Section 141 of the present Act, have for 35 years proved an effective safeguard against such disasters.

Psychopathic disorder, of course, presents a different problem, but here again the reasons for the present limited provision of the law are set out in the Royal Commission's Report; they do not lend themselves to summarizing.

Dr. Howard (January, 1965, p. 283) contends that the central scrutiny of admission documents should have been continued in order to ensure standardization of practice. This is in fact what the R.M.P.A. recommended (Memorandum of Evidence, in *Minutes of Evidence of the Royal Commission*, p. 291, Para. 200) and urged right through the passage of the Bill; but it is difficult to see how the Commissioners, had they been retained, could have evolved their own standard as regards psychopathy, for instance, unless (as in Scotland) they had also been given powers of personal visitation and enquiry throughout the period of detention.

Finally, may I comment on two points in Dr. Schmideberg's letter. If indeed any of our mental hospitals are worse than the worst prisons, they must be unfit to receive *any* patient, however insane. And I cannot imagine that anyone in this country would wish to use the McNaughton Rules—now nearly defunct—for purposes for which they were never intended. Their irrelevance to the problem of compulsory detention was emphasized in the Royal Commission's Report (Para. 152).

When concluding the oral evidence I gave before the Royal Commission as one of the team representing the R.M.P.A., I remarked that in the past the recommendations of Royal Commissions had often been forgotten and the resulting legislation subjected to fresh interpretations and commentaries without regard for the intentions of those who framed it; I expressed the hope that this would not happen now. Lord Percy replied: "I am afraid that always will be so". How right he was!

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POLARIZATION THERAPY IN DEPRESSIVE ILLNESSES

DEAR SIR,

Drs. Costain, Lippold and Redfearn are to be congratulated on their papers on electrical polarization published in the November, 1964 issue of the *Journal*. Clearly, if this procedure turns out to be effective in patients whose illnesses are resistant to antidepressants, E.C.T. and neuroleptic drugs, it will be a valuable addition to existing methods of treatment. In view of this, we read the three articles with interest; and we should like to comment on some data given in Table I on page 782 of the second paper (*Brit. J. Psychiat.*, **110**, 773–785).

It may be that because of the small number of patients included the authors have not felt it worth subjecting the results provided in Table I to statistical scrutiny. Nevertheless, if the data are examined from this standpoint, it would appear that improvement after polarization therapy is related to age, previous history, number of treatments given per week, and maximum current used. Specifically, factors associated with a favourable prognosis include: (1) age over 35; (2) a previous history of mental illness; (3) the administration of three or more treatments per week; and (4) the use of a maximum current greater than 100 μA.

In view of the foregoing, it is puzzling that these factors were not taken into account in designing the controlled trial reported in the third paper (*Brit. J. Psychiat.*, **110**, 786–799). The most likely explanation would seem to be that the small size of the sample

precluded stratification by any of these variables. We hope, therefore, that in their subsequent studies, the investigators will be able to assemble a sample large enough to provide results from which an optimal plan for treating specific groups of patients can be developed.

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California Department of Mental Hygiene,
Bureau of Research and Statistics,
Sacramento, California.
13 January, 1965.

DEAR SIR,

We would like to thank Drs. Hordern and Weeks for their kind interest in our work. The three papers taken together were intended to show that passing small currents through the brain could, in suitable circumstances, give rise to detectable effects in normal subjects and moreover *might* be of use clinically. The ethical and technical problems involved in performing a large trial are considerable and we did not prolong it unnecessarily.

We think that the assumptions (1) to (4) are correct and we hope that other workers will carry out larger trials than ours along the lines suggested. We are also starting another trial in which comparison is to be made between E.C.T., polarization and anti-depressant drug therapy.

However, we still think that the method of polarization as a treatment used in the way we have described may not be the most useful from the clinical point of view. It would be a pity if pre-occupation with the double-blind trial technique were to hinder experimentation with different voltages, waveforms, electrode placements and other parameters involved in the polarization procedure.

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O. C. J. LIPPOLD.
J. W. T. REDFEARN.

University College, London.
18 February, 1965

ESSENTIALS OF PSYCHOTHERAPY

DEAR SIR,

In your stimulating editorial (January, 1965, pp. 1–3) you comment on Eysenck's severe criticisms of psychotherapy, in particular on the disturbing fact that no serious attempt has as yet been made to assess its value. In this psychotherapy differs from any other specialty of medicine. It is normally taken for granted that before any method of treatment is practised on large numbers of patients it is carefully and specifically described, checked and evaluated for curative or deteriorating effects.

I do not feel, however, that statistical controls or occasional follow-ups are very meaningful, Whilst spontaneous recovery is relatively frequent, at least in this country, we would have to study in detail the type and combination of specific factors favouring it, (e.g. the helpfulness of the environment, the type of patient more likely to recover or relapse, etc.) before drawing conclusions.

More important still, we would have to study what "psychotherapy" means. I am not so happy with Eysenck's definitions. "That one of the participants has special experience in or had received special training in the handling of human relations" means little, unless we know specifically what his training consisted in. Again, "the methods employed are psychological, e.g. explanation and suggestion . . . " seems inadequate since "explanation" or "suggestion" may cover almost anything. (Explanation of consequences, of motives, of conscious or unconscious thoughts—here again very many possible motives or consequences and innumerable thoughts may be chosen.) The effect of the explanation will differ according to the aspects stressed, the spirit in which it is done, the manner, tone of voice, the relation with the therapist, etc.

Admittedly, it is difficult to categorize the many possible aspects and to relate each of them to specific therapeutic improvement, deterioration or unchangedness, and obviously this can only be done by practising psychotherapists, and not by statisticians. Arithmetic is a relatively simple procedure but its results are meagre. What we need is a clarification of thought, constant reformulation and testing of assumptions, relating them to clinical observations, and therapeutic experimentation. This is a difficult task, but certainly no reason to ignore the fundamental issues of psychotherapy.

Behaviouristic therapy as well as straight hypnosis are only suitable for a small proportion of co-operative and monosymptomatic neurotics. Most patients asking for help find it too difficult to cope with their lives and need a less simple-minded approach.

Incidentally, large-scale statistics on psychotherapy do exist. British probation officers are successful with 75 per cent. of their probationers, many of whom are difficult, unco-operative and abnormal. Over the last 25 years several hundred thousand cases have been followed. We should study the probation officers' approach, which is essentially a psychotherapeutic one, to find out why they seem to be more successful than some psychiatrists.

Admittedly, too much has already been published in psychiatry and allied subjects, yet not enough