Brit. J. Psychiat. (1964), 110, 108–109

Correspondence

BEHAVIOUR THERAPY

DEAR SIR,

A reading of the paper "A case of Fetishism and Impotence treated by Behaviour therapy" by A. J. Cooper (September, 1963, 649–652) gives rise to doubts as to whether such a regime can reasonably be termed medical treatment in the ordinarily accepted meaning of the words. Although I assume that the patient must have agreed to the plan, and note that when he categorically refused to continue the treatment was stopped, the similarity between this approach and brainwashing for other purposes is clear.

Those who uphold brainwashing must surely base their case on the proposition that the end justifies the means, and that the reform of a social or political deviant warrants physical and psychological assaults on him, involving him in degrading and humiliating situations to the point of breakdown but not beyond it.

I find it difficult to distinguish these techniques from that described in the paper. I was relieved to learn that the patient's cardiac condition, a side-effect of the treatment, cleared up, but what, I wondered, of the inward trauma and the shattered self-respect?

I would have to admit that, as a psychotherapist, I have often failed to enable a patient to give up fetishistic behaviour or overcome impotence. But the procedure itself seems to have an ordinary human dignity about it, and to include an element of respect for the inner life of another human being. So far most queries about behaviour therapy such as is described in this paper have been about details of technique, or problems of assessing success or failure. Surely it is not outside our proper concern to ask wider questions about its implications in human terms?

Yours faithfully,

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DEAR SIR,

I am sorry to see that some of the papers you have published recently still tend to say very little in a "scientific" and unnecessarily involved manner, and to show neglect of statistical principles. For example, in the paper on "Social Factors and Neurosis in a Working Class Population" by Dr. D. A. Pond *et al.* (September, p. 587) there are three nice tables which show very little except that the groups taken were too small to demonstrate anything. The calculations of χ^2, even using 4-fold tables and Yate's correction, reveal no hidden subtleties here. The final summary remarks that no meaningful associations were found, but ignores the implication in the table that in the selected population 67/86 of the wives were regarded as neurotic. One wonders what this means in terms of diagnostic criteria.

Passing to the paper on Fetishism and Impotence, by Dr. J. Cooper (September, p. 649) I should like to associate myself with others who condemn this approach to the problem. One might argue that the end justifies the means and that the patient assented to the "treatment", but does this ease the conscience of a doctor? The man was treated with methods as crude as those of primitive surgery without even the excuse that his life was at stake. Can one really feel easy about these ventures into the Pavlovian field without a proper realization of the genesis of symptoms or of the outcome of therapy?

Yours faithfully,

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DEAR SIR,

I wish to endorse some of the important points made by Dr. J. C. Barker in his letter (September, 1963, p. 695). I, too, would regard the patient described by D. F. Clark (May, 1963, p. 404) as a transvestist rather than a fetishist. Experience since reporting a case in 1956 (*Brit. med. J.*, 1956, *ii*, 854–56) leads me tentatively to suspect that transvestists are more difficult to treat and have a worse prognosis than fetishists, and that the two conditions are fundamentally different, notwithstanding the apparent similarity when female garments are involved. Of course fetishists present for treatment much more rarely than do transvestists, and observation over so short a period does not warrant more than speculation.