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AVERSION THERAPY

DEAR SIR,

I have read with interest the article by Marks and Gelder (*Journal*, July, 1967, p. 711). They treated five transvestites and fetishists by faradic aversion. I wonder why.

Kinsey noted that there are many magazines for men featuring nude women, none for women featuring nude men. There is a great difference between the sexes in their capacity for psychic sexual stimulation. Women are aroused by physical contact with an acceptable man, and show little interest in representations of sexual material or in looking at male genitals. They lack the imagination to fantasy vividly. Men on the other hand may be aroused entirely by imagined objects; by direct contact with female genitals; or by any combination of reality and fantasy.

Women have used calculated exposure from time immemorial to arouse the male, for all manner of reasons. It is normal for a man to be aroused by female underclothes because they strongly suggest the sex organs they cover. It is only abnormal if he is not also roused by the female body itself, and this can only be determined if he has willing women at his disposal. Otherwise his "deviation" is only for want of something better. In a society which severely limits sex opportunity by taboos and economic sanctions, no wonder "deviants" occur.

Of the cases reported, only one, "A", had ever had an opportunity for anything like normal sexual outlet. "A" would probably never have sought treatment but for a transient episode of impotence which cleared up almost at once. Unlike many non-fetishists, his marriage was happy. Why the fuss over his foible? "B" had been completely without normal sex outlet. Given a female sex therapist with whom he could practice and perfect the art of love, would he have bothered to cross-dress?

"C", poor man, had only a frigid wife. How could he help thinking about his daughter? How pathetic that he should have been "tempted by her clothes"? "D" was sexually quite uneducated and deprived. "E" was also deprived, but had shown himself capable enough in his brief marriage.

The behaviour of all these people was simply an adaptation to the unnatural difficulties and restrictions which society places on normal sexual outlet. By means of their imagination they were able to make this adjustment. To set about callously to destroy it, and put nothing in its place, is like criticizing a one-legged man for walking with a limp, and then taking away his crutch.

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DEAR SIR,

We read with interest Dr. A. B. Goorney's excellent article on the treatment of a compulsive horse race gambler by aversion therapy (*Journal*, March, 1968, pp. 329–333). In reference to our earlier work (Barker and Miller, 1966a and b), Dr. Goorney claims that "aversion of imagery was not included in the techniques employed". We consider, however, that this point requires further elaboration. McGuire and Vallance (1964) and others have recommended the use of "conceptual deconditioning" alone for treating cases of sexual deviation. While this offers many practical advantages we are not yet convinced whether it is as effective as aversion therapy directed towards the maladaptive behaviour itself or to reproductions of such behaviour, using films, coloured transparencies, tape-recordings or video-tape. Furthermore, in our experience, perverse fantasies would appear to be more important to the sexual deviant than are fantasies of gambling to the inveterate compulsive gambler.

We have now had the opportunity of treating several compulsive gamblers, including "one-armed bandit", "pin-table" and "betting-shop" addicts (Barker and Miller, 1968). They have all denied that they are able to produce realistic fantasies of their particular gambling habits in the clinical atmosphere of the treatment room and particularly when fearfully anticipating the next shock. We have therefore resorted to treating the gambling behaviour itself, or have reproduced the patient's gambling before him, using films and photographs. In some cases we have supplemented this by pre-recording the patient's own account of his gambling on tape, which is then conveniently replayed during aversive sessions contemporaneously with the visual cues, coupled with "betting-shop" sounds, etc., where applicable.

Dr. Goorney seems to have been fortunate in finding a gambler whose compulsive behaviour had a precise initiation and stereotyped pattern which favoured treatment largely on an imaginal level. In our experience such gamblers are rare. The majority of our gamblers have been quite unable to reproduce realistic fantasies of the "betting-shop" or "dog-track" atmosphere during treatment sessions, since they seem to experience much difficulty in imagining

https://doi.org/10.1192/bjp.114.511.785-a Published online by Cambridge University Press

these situations when they are not there. Our conditioned stimulus for aversion therapy has therefore tended to be essentially visual, supported with a taped pre-recorded commentary on gambling made by the patient himself together with appropriate sound effects wherever possible.

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"COLLEGE PSYCHIATRY"

The RMPA report on the training of child psychiatrists (*Brit. J. Psychiat.*, Vol. 114, No. 506) sets out the special training needed for psychiatrists who will deal with the special problems of children. Many of the points made can be translated, without much modification, to the training of psychiatrists who will deal with the special problems of adolescents and young adults, with students in particular. In the U.S.A., "College Psychiatry" is a recognized sub-specialty. In many of the major centres (Harvard, MIT, Yale, Berkeley etc.) two years of the normal four-year residency required for a Board Certification in Psychiatry can be done in student health work.

It would be premature to make such arrangements here; we are still sending a much smaller proportion of our young people into higher education than are the Americans. Eventually, however, some such moves will be necessary, and one hopes that the new College will keep this in mind when it is considering future developments in psychiatry.

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ERRATA

Maternal Age and Parental Loss, by P. A. P. Moran (*Journal*, February, 1968.) The figure for mean maternal age for the period 1911–1915, quoted on page 209, should be *29·890*, not 28·890.

A Comparative Trial of Mandrax and Dichloralphenazone, by Ijaz Haider (*Journal*, April 1968), Summary and Conclusions (page 467): The dose of Welldorm (dichloralphenazone) used to compare with Mandrax was *1,300* mg., not 650 mg.

A Survey of Treated Psychiatric Illness in Lebanon, by Herant Katchadourian (*Journal*, January, 1968). On page 27 in the second column under the heading "Age", the reference in the third line to the 32–34 age group should read *30–34* age group. In Table IV the last figure of the last column should be *37·6*, not 7·6.

https://doi.org/10.1192/bjp.114.511.785-a Published online by Cambridge University Press