

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.

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#### 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.

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#### 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