this was not such a bad thing. Perhaps our contemporary largely rootless and agnostic generation could, with profit, take a leaf or two out of that 'dim Victoriana'. We have even heard whispers in some psychiatric circles that lack of enthusiasm, lack of faith, may be factors in the modern increase in mental illness and stress disorders of all kinds. What do your readers think?

GEORGE NEWBOLD.
GORDON AMBROSE.

'Golden Hill',
Windmill Lane,
Llantwit Major,
Glam.

DEAR SIR,

The objections which Dr. Newbold and Dr. Ambrose raise to my review of their book are I think largely past the point. No one will deny that a general's blind self-confidence may get men to march to Moscow—heaven help them on the retreat—or assist the practice of the faith healer, but the matter in dispute is in fact quite otherwise: it is whether uncritical self-assurance is an aid to accurate assessment of the results of therapy. To offer a placebo with enthusiasm may increase the chances of the patient's placebo response, but it is no good then arguing that the study of the results of placebo treatment is best helped by wild enthusiasm and the abandonment of all critical faculties.

And surely even two very distinguished practising hynotists are a little over-confident in the power of suggestion when they hope to produce in us the illusion that the desecration of scientific method constitutes a sure bulwark against atheism?

GRIFFITH EDWARDS.

Institute of Psychiatry,
Addiction Research Unit,
101 Denmark Hill,
London S.E.5.

PSYCHODYNAMIC CHANGES IN UNTREATED NEUROTICS

DEAR SIR,

I am intrigued by D. A. Malan's reply to N. McConaghy's letter (*Journal*, January 1969, p. 122).

(1) If psychotherapy is said to have any effect, such an effect must either be demonstrable or imaginary.

(2) If psychotherapy is said to be a *therapy* there must be something which it cures.

(3) Symptomatic relief seems a prime candidate.

(4) If symptomatic relief cannot be shown, this in itself is grounds for regarding psychotherapy as not being a therapeutic procedure.

It is suggested that one of the effects of psychotherapy is that successfully treated patients take on more responsibilities, thus generate more stress, which in turn generates symptoms. Evidence would have to be shown before one could attach importance to this view. One would have to clearly show that the patients 'took on' more. No evidence has been produced. Hypotheses are weakened by contrary facts, not by contrary hypotheses. However, it would be interesting to consider what such effects would in fact show. It seems inappropriate to say that a person has been cured when he persists in dealing with real life situations in a way which generates symptomatic complaints. Stress is a reaction to life, not an object in the world. If a person generates symptoms, his reaction to life is still maladaptive.

The most interesting problem posed by this hypothesis is how dynamic normals could exist. Surely, on this argument, the more normal a subject the more he takes on, the more stress the more symptoms, hence therapies are successful if they generate symptomatic complaints. Finally, what is surely crucial is not the extent of the person's responsibilities but the way he manages them. If he manages them in such a way that he generates symptomatic complaints he is still in need of treatment. Therefore, even if evidence were brought forward to suggest that treated patients 'take on' more subsequent to treatment, there would be small grounds for believing that this was therapeutic, if they continued to generate symptomatic complaints.

J. A. THOMPSON.

Department of Child Psychiatry,
Guy's Hospital,
London, S.E.1

PARENTAL AGE OF HOMOSEXUALS

DEAR SIR,

Abe and Moran (*Journal*, March 1969, 313–7) find that maternal age in their group of homosexuals was higher than expected, and rather surprisingly conclude that 'these observations provide no support for any hypothesis that a cause of male homosexuality may be found in a biological factor related to the mother's age, e.g. by causing a chromosomal abnormality'.

The connection between the higher maternal age and homosexuality is, of course, ambiguous and need not be biological in nature, but this is not the reason for the authors' negative conclusion. They arrive at it because they find that the higher maternal age is secondary to a higher paternal age.

The chromosomal hypothesis of the aetiology of homosexuality, put forward by Slater (1958), is

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based (rather tenuously) on the higher maternal age analogous to that for Down's syndrome, and is independent of what this higher age is secondary to. Abe *et al.*'s dismissal of this hypothesis on the basis of their findings is a *non sequitur*. They simply confirm Slater's findings and neither add to nor detract from his conclusions. They have left Slater's hypothesis where it stood, while their new findings relating to the higher paternal age can be interpreted in various ways and need not supersede Slater's hypothesis at all. Besides, the Romans have taught us '*mater semper certa, pater incertus est*'.

J. HOENIG.

Department of Psychiatry,
Faculty of Medicine,
Memorial University of Newfoundaland,
St. John's Newfoundland, Canada

PSYCHOTHERAPY AND BEHAVIOUR THERAPY

DEAR SIR,

The article on behaviour therapy which Dr. Doris Mayer published in the April 1969 issue of the *Journal* (p. 429) aroused my keen interest. The main trend of her argument is one which would be agreed by all thinking psychoanalysts and behaviour therapists, but I was astonished at the narrow view which Dr. Mayer took of behaviour therapy. Many techniques, apart from aversion therapy, are used by behaviour therapists: systematic desensitization (Wolpe, 1958), implosive therapy (Hogan, 1968; Stampfl and Levis, 1968), assertive training (Wolpe and Lazarus, 1966), operant conditioning (Ayllon, 1963), and emotive imagery (Lazarus and Abramovitz, 1962) being a few of these.

Behaviour therapists, in recent years, have acknowledged in their writings their debt to psychoanalytic theory (Brady, 1967; Kraft, 1967, 1969), just as well-informed psychoanalysts are aware of developments in the behaviourist field (Weissman, 1967; St. Blaize-Molony, 1968).

I would certainly agree with Dr. Mayer that the mother who cured her child of fears of the dark was using behaviour therapy successfully, and I should like to point out that there are several reports on mothers who have been trained to act as therapists for their children (Wahler *et al.*, 1965; Lal, 1968).

As far as therapeutic efficiency of behaviour therapy is concerned, this largely depends on the personality of the therapist carrying out the treatment. In their study on smoking, Koenig and Masters (1965) found that the amount of change in smoking behaviour was significantly related to the therapists but unrelated to the particular therapy administered. This observation raises important questions as to the precise role of the therapist during a course of behaviour therapy. Transference is certainly an extremely important component; in fact, one housebound housewife, who made an excellent recovery through behaviour therapy, developed a fully erotized transference during her course of treatment (Kraft, 1967, 1969).

In conclusion, I should like to say that behaviour therapy, though only recently introduced into the psychiatric field, is particularly useful in bringing immediate relief from distressing symptoms. In conjuction with analytic thought concerning the unconscious material which emerges during a course of treatment, it can be most valuable in restoring the patient to health.

T. KRAFT.

Claybury Hospital,
Woodford Bridge, Essex

REFERENCES

AYLLON, T. (1963). 'Intensive treatment of psychotic behaviour by stimulus satiation and food reinforcement.' *Behav. Res. & Therapy*, **1**, 53–61.

BRADY, J. P. (1967). 'Psychotherapy, learning theory, and insight.' *Arch. gen. Psychiat.*, **16**, 304–11.

HOGAN, R. A. (1968). 'The implosive technique.' *Behav. Res. & Therapy*, **6**, 423–31.

KOENIG, K. P., and MASTERS, J. (1965). 'Experimental treatment of habitual smoking.' *Ibid.*, **3**, 235–43.

KRAFT, T. (1967). 'Behaviour therapy and the treatment of sexual perversions.' *Psychother. Psychosom.*, **15**, 351–7.

—— (1967). 'Treatment of the housebound housewife syndrome.' *Ibid.*, **15**, 446–53.

—— (1969). 'Behaviour therapy and target symptoms.' *J. clin. Psychol.*, **25**, 105–9.

—— (1969). 'Erotisierte Übertragung in der Verhaltenstherapie.' *Z. psychosom. Med. u. Psychoanalyse*, In press.

—— (1969). 'Psychoanalysis and behaviourism: a false antithesis.' *Amer. J. Psychother.*, In press.

LAL, H. (1968). 'Therapy of chronic constipation in a young child by rearranging social contingencies.' *Behav. Res. & Therapy*, **6**, 484–5.

LAZARUS, A. A., and ABRAMOVITZ, A. (1962). 'The use of "emotive imagery" in the treatment of children's phobias.' *J. ment. Sci.*, **108**, 191–5.

STAMPEL, T., and LEVIS, D. J. (1968). 'Implosive therapy —a behavioural therapy?' *Behav. Res. & Therapy*, **6**, 31–6.

ST. BLAIZE-MOLONY, R. (1968). Personal communication.

WAHLER, R. G., WINKEL, G. H., PETERSON, R. F., and MORRISON, D. C., (1965). 'Mothers as behaviour therapists for their own children.' *Behav. Res. & Therapy*, **3**, 113–24.

WEISSMAN, P. (1967). Personal communication.

WOLPE, J. (1958). *Psychotherapy by Reciprocal Inhibition.* Stanford, California: Stanford University Press.

—— and LAZARUS, A. A. (1966). *Behaviour Therapy Techniques.* Oxford: Pergamon Press.

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