measured by the Minnesota Multiphasic Personality Inventory (joint work with K. Silzer); further work, including transcultural studies will be necessary to clarify the appearance of this relationship in North American populations, but its apparent absence in England.

The question of the exact diagnostic specificity and symptomatology associated with group O blood (homozygosity for gene $I^0$) also demands further clarification, particularly in respect to the inter-relationships between involutional melancholia and manic-depressive psychosis. Parker's group did not report on involutional melancholia; while we confirmed their relationship between group O and manic-depressive psychosis, we found and continue to find a more striking association between group O and involutional melancholia. Masters' data do suggest that involutional depression may also be associated with group O (his "Involutional-Senile Depression" group had the second-highest incidence of group O bloods among all his psychiatric categories), but his incidence of group O was still higher for manic-depressives. This is a recognized area of difficult differential diagnosis. What does seem assured is that at least some forms of psychotic depression *are* related to blood group O. Special studies, including a number now under way in Saskatchewan (Irvine, 1967) will be needed to provide a detailed clinical picture of the psychotic depression(s) found in $I^0I^0$ homozygotes, and to determine *inter alia* whether there may possibly be a valid "new" disease entity involving this genic structure.

We have published to date only on schizophrenia and various depressions in relation to blood groups, but detailed tabulations of blood-group frequencies have been prepared for practically all psychiatric diagnoses, not only for admissions but also for resident in-patients of the Saskatchewan Hospital, North Battleford. The salient features of these distributional tables will be reported in due course. But I would comment here on Masters' finding of an excess of D-negative subjects among the involutional and senile depressions and apparently among the older psychiatric admissions in general. Among 668 admissions, we found the highest incidence of D-negative blood (25·8 per cent.) among senile psychotics, and the second-highest incidence among involutional melancholics (20·6 per cent.), in good agreement with Masters. In contrast, the overall incidence for all admissions was only 16·9 per cent.

While the trends are not statistically significant, it is interesting that the excess incidence of group A blood among schizophrenics (reported earlier by Lafferty *et al.*) has also been seen in our Saskatchewan material, and now in the Lancashire data. Further work on A, $A_1$, and $AD^+$ blood groups in relation to schizophrenia and schizophrenic symptoms may be productive. In general, work on blood types in psychiatric illness appears promising; the present approaches should perhaps be extended to include more comprehensive grouping or patterning (especially Rh), use of more psychological and neurophysiological measures, and deliberate structuring of transcultural investigations.

D. G. Irvine.

*Psychiatric Research Unit,*
*North Battleford,*
*Sask., Canada.*

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## TEACHING PSYCHIATRY BY CLOSED-CIRCUIT TELEVISION

Dear Sir,

Professor W. H. Trethowan, in a recent article in the *Journal* (April, 1968 p. 520) states that "closed circuit TV offers an opportunity for trainees to observe a series of psychotherapeutic sessions". Along with its undoubted advantages we have to bear in mind the limitations of this aid to teaching. Often I have wished that I could make tape recordings of psychotherapeutic interviews with my patients in order to use these educationally afterwards. It would be so much easier, and even more life-like, than having to write down conversations from memory; yet I have found no way of overcoming the objections. To persuade patients verbally to exteriorize their most intimate feelings in free association and to accept interpretations that are emotionally stressful requires every ounce of the therapist's capacity, and if the patient's co-operation were additionally taxed by the knowledge that recording was in progress the effectiveness of our techniques would be impaired. As therapist I should find it more difficult to be

quite spontaneous in my own comment to my patient, and would feel under pressure to choose words discriminatingly. Rapport with the patient might be damaged. These complications would apply with even greater force to closed circuit TV, where it was known that others were listening. To employ such means without the patient's knowledge, unless in the case of young children, appears to me to be out of the question.

This issue was recently brought firmly to my attention when, after the opening of the Charles Burns Clinic for Nervous Children here in Birmingham, we found in the principal play therapy room obtrusive evidence of preparations for closed circuit TV, whereas equipment for play therapy was far short of requirements.

I believe the moral is that these new and powerful teaching aids must be assessed with regard to their limitations as well as their capacities.

DAVID T. MACLAY.

*65 Fiery Hill Road,*
*Barnt Green,*
*Birmingham.*

## THE *JOURNAL* AND ITS CONTENTS

DEAR SIR,

Part of the final paragraph of a letter from Belfast in the current issue of the *Journal* reads as follows—"Psychiatry is not a branch of medicine but an evolving science in its own right—it's time we stopped leaning on medicine for basic sciences and evolved our own—it's time we moved out of the nineteenth century into the twentieth."

If and when that has been accomplished I presume the next logical step would be for those responsible for training psychiatrists to reconsider how far medicine ought to be part of the curriculum for aspiring psychiatrists: and those responsible for fixing salary scales would probably wish to reconsider the entitlement of psychiatrists to be graded as *medical* specialists.

What would be the effect of psychiatry ceasing to be "a branch of medicine"—a psychiatric Arcady, or anarchy? My guess is that it would be the latter once psychiatric thought was freed from the disciplines of clinical medicine and from the restraints on fancy imposed by its "basic sciences".

Fortunately for the safety of individual patients and the future of psychiatry, such idyll or nightmare is not likely to materialize. The Universities are more likely to agree with Professor Henry Miller when he says—" . . . the psychiatrist should not only first be a physician but ideally a superlative physician."

As for psychiatry being an "evolving science in its own right"—sciences nowadays do *not* evolve in their own right. They are inextricably interwoven. In recent years scientific advance is demanding more and more that specialists in its different departments should be closely in contact and conversant with the work of each other, so as to be *au fait* with discoveries or lines of thought which increasingly overlap departmental boundaries. In this context I would commend Sir Peter Medawar's book *The Art of the Soluble* to the attention of your correspondent.

The self-sufficiency implied in evolving "our own" basic sciences (whatever they may be) is *not* modern: it is not even scientific. It is medieval. It is the outlook of pre-Renaissance scholastics, for whom the scientific revolution in the seventeenth century was still far in the future. In their Natural Philosophy they wallowed in speculation and metaphysical modification of what Aristotle had taught 1,500 years before. Sir Charles Sherrington commented on this sort of thing in *Man On His Nature*, referring to the attitude of some Freudians.

It is odd that anyone claiming to be in tune with twentieth-century outlook—said to be the third and most revolutionary era of man's thinking—should advocate a dualism of body and mind more rigid than anything conceived by Descartes three hundred years ago.

I am sorry that a letter of this sort should have come from Belfast, where the philosophy of those who arrange and give effect to the medical curriculum is so obviously holistic. At the same time one must recognize that the letter may serve a useful purpose if it makes all of us pause to consider where some of the present trends may be leading.

WILLIAM MCCARTAN.

*45 Demesne Road,*
*Holywood, Co. Down.*

DEAR SIR,

It would be unfortunate if the assessment of the psychiatric scene made by J. D. Sutherland, and his helpful suggestions for getting better representation and discussion of it in the *Journal*, were to be blurred by the kind of argument in Peter Sainsbury's letter. Since I have a fairly extensive knowledge of editing, may I be permitted to comment on the confusions in his letter?

The standard of the *British Journal of Psychiatry* overwhelmingly depends upon the research being conducted in this country, the quality of the papers submitted for publication, and the assessors. Not being omniscient, the Editor-in-Chief and his co-editors and assistant editors mainly depend on them to arrive at a decision on the acceptance for publication or rejection of any particular paper. As there are ample good papers being presented and