posed to suggest this to the patient, but as is so often the case with such patients, the motivation to cure derives more from others, his wife, for example, than from himself and he may be unwilling to submit again to a relatively unpleasant regime in favour of a relatively, to him, pleasant fetishism.

Yours faithfully,

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## AVERSION THERAPY OF SEXUAL PERVERSIONS

9 May, 1963.

DEAR SIR,

With reference to the paper by D. F. Clark in the *British Journal of Psychiatry* (May, 1963, **109**, pp. 404–407), I would regard the patient described as a transvestist rather than a fetishist in that he exhibited a morbid predilection to dress in female attire which Lukianowicz (4) sometimes associated with a wish to be regarded and socially accepted as a member of the opposite sex. Also, I would have thought that freedom from symptoms for a period of three months was insufficient time to evaluate the efficacy of treatment, bearing in mind that Raymond's (5) case required "booster treatments" following the original negative conditioning.

I was surprised to see that Dr. Clark omitted to refer to the recent work that has been done at Banstead Hospital on behaviour therapy for transvestism. This was reported by Lavin *et al.* (3) and the patient responded to treatment following the method previously used by Raymond, which was elaborated in great detail. This paper also summarized the literature on the various methods of treating sexual perversions from psychoanalysis to aversion therapy.

The disadvantages of the classical apomorphine/emetine method of deconditioning were reported by Barker *et al.* (1) in a letter to the *Lancet* in connection with the same case.

Following this another transvestist has recently been treated by electrical aversion. This patient was considered to be quite unsuitable for apomorphine treatment as he had previously suffered from a peptic ulcer. The technique was to stand the patient on an electrified grid at frequent intervals whilst he was dressed in female clothes, before a full-length mirror. It was much easier to operate, particularly from the point of view of measuring the time interval between the conditioned stimulus and response, which is of great importance in getting a good result from this type of therapy, and caused the patient far less discomfort than classical pharmacological aversion. The patient and the method used will shortly be described by Blakemore *et al.* (2) in a forthcoming communication in *Behaviour Research and Therapy*.

Yours faithfully,

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## VASOMOTOR RHINORRHOEA

DEAR SIR,

I have just read an article in the January, 1963 issue of your Journal entitled "Psychogenic Factors in Vasomotor Rhinorrhoea" by George Fennell, **109**, 79–80. I feel this article calls for some comment.

I do not presume to criticize the method or conclusions of the drug trial described, as far as it

concerns the efficacy of chlordiazepoxide in the treatment of vasomotor rhinorrhoea. However, I would take issue with the apparent assumption that the failure of a condition to be influenced by a psychotropic drug can be taken as an indication that emotional factors are not involved in its causation.

Furthermore, Dr. Fennell seems to have assumed that any psychotropic drug is equally effective against any psychiatric disorder, which I would not have thought to be the case.

Finally, the article quotes "a full psychiatric examination" of the patients studied, by Dr. Parkin, and this, without a little more elaboration, is surely a somewhat vague basis for the assertion that "no significant evidence of mental disturbance has been found".

I do not wish to be pedantic, or destructively critical, but it seems to me that, whether or not previous claims for a "psychosomatic" element in vasomotor rhinorrhoea were justified (and I agree that in future we should test such claims very carefully), the matter will not be settled by a superficial approach involving dubious assumptions.

Yours faithfully,

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