explanation. Predictions are made during the course of analysis which may turn out to be correct or incorrect. Freud used the data gathered from his analysands to modify his original theory: he moved on from the 'affect-trauma phase' during which he studied cases of hysteria and conjectured that they were the result of affect being repressed due to a major trauma, to the 'topographical phase', in which he evolved the theory of unconscious, pre-conscious and consciousness, when it became apparent that his patients had rarely suffered the actual trauma (initially thought to be incest). Later he developed the theory of ego, superego and id, thus elaborating the 'topographical phase'.

Turning to Anderson's concern that psychoanalysis explains 'whatever happens'; all disciplines attempt to explain 'whatever happens' within their frame of reference. As the physical sciences attempt to explain the physical world, so psychoanalysis attempts to explain the intra-psychic world. Both have levels of explanation which can be likened to Bhaskar's 'generative mechanisms'.

Returning to an early point in my article: a Popperian cannot allow the possibility of psychoanalysis being a science: all my critics suggest that this does not matter. I disagree, since I think that it is important to transcend the limitations of Popperianism and find an adequate philosophy of science that can include psychoanalysis, because if useful research is to be done, it needs to be supported by a coherent philosophy.

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(This discussion is now closed. *Eds.*)

A community group in the State Hospital

DEAR SIRS

Dr Cantor, in his comment on Dr Novosel's paper on a Community Group in the State Hospital (*Bulletin*, December 1986, **10**, 360) rightly stresses the importance of being critical of "any treatment modality that is expensive in terms of staff resources". I would go further than this and stress the importance of being critical of any treatment modality, irrespective of cost. Dr Cantor goes on to criticise Dr Novosel's group, and says that he could find no evidence in the paper to support Dr Novosel's claim for the group's success.

I continue to agree with Dr Cantor that it is important to determine by what criteria success can be judged. This is the difficult part.

Unfortunately, Dr Cantor illustrates his plea for an empirical approach to assessing such groups, by giving the sort of caricature of a scientific attitude that gives statistical research a bad name. He writes that the group, if tested by a depression rating scale, would be likely to have registered "a profound increase in depressive symptoms", as if this shows the group was not successful. It seems to me that if a group of people, "the majority having a diagnosis of schizophrenia", most of whom have committed crimes, are to become depressed, this might be seen as a sign of progress and maturation. I would call this "success".

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The Folly of Deterrence

A reply to Ian Deary

DEAR SIRS

Ian Deary's support for the 'Wisdom of Deterrence—a reply to Jim Dyer'[1,2] combines a little psychology and a lot of political opinion on defence policy. Albert Einstein displayed greater psychological wisdom when he noted—"The unleashed power of the atom has changed everything except our way of thinking, and thus we drift towards unparalleled catastrophe. We shall require a substantially new manner of thinking if mankind is to survive".[3] Deterrence is a pre-nuclear concept mistakenly applied to nuclear weaponry. It assumes that the threat of massive destruction will restrain the 'enemy'. If deterrence is military policy, what is the justification for the accumulation of 50,000 nuclear weapons, the equivalent of 4 tonnes of TNT for every man, woman and child on earth?

A further illusion of Dr Deary is that nuclear weapons have kept the peace between the US and USSR in the past 40 years. This is a very blinkered view of history. These two nations were allies in World War 2 and were not adversaries before the nuclear age. Dr Deary's apparent conclusion that nuclear weapons have conventional political uses is based on the premise of a limited nuclear war and not deterrence.

The World Health Organization has identified nuclear war as the greatest threat to the health and welfare of mankind, it is not just Dr Dyer's view. Palaentologists remind us that of all the species that have existed on this planet, 99% are now extinct. The nuclear syndrome may well be our Achilles heel. Nuclear war carries the threat of omnicide—extinction of the species *homo sapiens*, as a real possibility.

In psychological terms, nuclear weapons are the symbol of power. Britain, having lost its empire, spends enormous sums to preserve the symbol, while its National Health Service and educational system crumble and unemployment soars. To suggest that nuclear weaponry is not expensive is a fallacy. The British Trident submarine programme is costing £10 billion. One trillion dollars is the price tag of SDI (Star Wars).

Costa Rica in the political turmoil of central America provides an example of Dr Dyer's argument for social versus military expenditures. Costa Rica has been demilitarised since 1949. Although without many natural resources, it enjoys health, educational and economic indicators equal to many European countries. There is a clear cause-effect relationship between socio-economic injustice, poor health and educational standards and militarisation in less developed countries. A further indicator of this phenomenon in the developed nations is that Japan and West Germany, virtually demilitarised since World War 2, have dominated the world economically.

The problem of deterrence is that a nuclear weapon 'exchange' would be an Armageddon for all—the ultimate pyrrhic victory. What deterrent value does Mutual Assured Destruction (MAD) have on NATO's defence policy? Is Dr Deary assured by the thought that obliteration of the 'enemy' will follow or precede his own demise in a nuclear war? In using the analogy of the 'bighorn sheep', Dr Deary again exposes himself as a pre-nuclear thinker—the bighorn sheep will not survive a nuclear war either.

On deterrence Dr Deary adds—"If we tamper with it, we risk lighting the fuse of a time bomb". If we do not tamper with it, with the advent of launch-on-warning systems etc., it will light its own fuse. The mystique of such matters has left deterrence in militarist thinking, hence our present dilemma. Dr Deary knows as a psychologist that it is healthier to be in control of one's life—helplessness leads to depression.

Dr Deary castigates Dr Dyer for not using intellectual arguments to support his plan; he misses the point—deterrence has no rational basis. It is based on primitive instinctual emotions which served our ancestors well, but now threaten our very existence. We cannot afford to express our aggression with nuclear weapons. Dr Deary's defence of deterrence demonstrates denial, sanitary language use and the irrationality of military pre-nuclear thinking.

It will take more than intellectual argument to deal with this problem. It will take moral outrage of 90% of the world's population who live outside the superpowers to end this menace. The possession of nuclear weapons alone is a crime against humanity, the stockpiling of weapons of genocide.

Dr Bernard Lown summed up the scenario where we now find ourselves:- "We physicians, guardians of health and life, have an ethical categorical imperative to expose the bleak immorality of the policy of deterrence. We must not acquiesce to stockpiling weapons of mass extermination as the guarantors of national security. We must not permit the search for peace to proceed through overt flirtation with death. There are no conceivable circumstances which can justify the use of genocidal weapons".[4]

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ECT given to people with pacemakers

DEAR SIRS

I have recently been faced with having to arrange ECT for a man of 72 who was depressed and who was fitted with a cardiac pacemaker. I naturally informed our local anaesthetist and she was anxious about this and got in touch with the physician who had inserted the pacemaker. He, too, was concerned about the safety of ECT under these circumstances and hesitated about giving the go-ahead for it until he had seen the gentleman himself.

I got in touch with Dr J. Pippard and he was able to provide one reference to ECT given to a person with a pacemaker. There do not appear to be many references in the literature but I have taken soundings in our Region and it appears that several psychiatrists have had experience of administering ECT to people with pacemakers. However, it is probable that there have been one or two in most psychiatrists' experience but that nobody has had many patients who have had a depression severe enough to require ECT whilst also having a pacemaker fitted.

The gentleman referred to has done very well and I would be interested to hear from other people as to whether they have had problems or a satisfactory result from such treatment. I am well aware that there are different types of pacemakers and that this is a factor in the safety of the treatment. If anybody would care to write to me to give me information on their experiences, I would be extremely grateful.

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Mental Health Review Tribunals

DEAR SIRS

We had four Mental Health Review Tribunals here this week. All were compulsory referrals; three of the four patients refused to appear before the Tribunal. Is that a record?

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