methodology can be identified and improved. Measures of the clinical significance of change, for example, can be employed as well as measures of symptom severity.

I believe that the particular needs of individual patients are likely to be best served by systematic and critical enquiry across a broad range of research methods and treatment approaches. Morstyn (1993), by contrast, argues that the psychological processes in some forms of psychotherapy are simply too complex and individual in character to be represented by numerical variables, thus ruling out research methods that employ statistical analysis. These are deep philosophical waters but in accepting Morstyn's argument Cheng & Baxter risk granting some methods of treatment an immunity from public scrutiny. How would they seek to answer common sense questions regarding such matters as the likelihood of symptom remission following treatment? The myth that poses the greatest threat to research in this field is the one that elevates some forms of psychotherapy to a special and mysterious status.

MORSTYN, R. (1993) Some fallacies of statistical inferences about psychotherapy. *Australian and New Zealand Journal of Psychiatry*, **27**, 101–107.

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The points raised by Cheng & Baxter equate closely with our experiences as the analytical psychotherapists undertaking the clinical work with the AP group in this trial.

In particular once the trial was underway, it quickly became evident that few of the patients would have been offered analytical psychotherapy in our usual clinical practice, and in retrospect it was an error not to have included a measure of anticipated suitability for this type of treatment in our initial assessment.

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A HUNDRED YEARS AGO

General paralysis

The old proverb – It is the pace that kills – finds nowhere a more striking illustration than in this disease which, under the hurry, anxiety, and excitement of modern life, is becoming more and more common. For some unexplained reason the affection is more common in this country than in many others, and is, comparatively speaking, infrequent in Scotland. This has been explained by Northern patriots as another illustration of the harmlessness of whisky as compared with beer, a fallacious argument, for the onset of general paralysis may have been preceded by no excesses, and, given other factors, may occur in total abstainers. But while much with regard to the etiology remains obscure, one factor is almost always to be traced, namely, hard work under conditions of excitement and responsibility.

Among the educated classes it is men, and occasionally women, in the prime of life, whose careers are arrested at the point when success is almost in their grasp. Among skilled artisans too, it is often the industrious earnest man who is singled out – the man who is always anxious about the quality of his work, and will work all night, if allowed, to finish his task. And there are many, though not so large a number as is usually imagined, in whom previous excess appears to have caused the onset of symptoms; but in many cases this conclusion is due to a confusion between cause and effect, since in most cases of general paralysis a certain amount of moral perversion is symptomatic of the early stage of the disease. The disease is practically confined to the first half of adult life, and those who have stood the strain until they are 50 need have little fear of being attacked by this terrible complaint.

The name of the disease gives little guidance to the symptoms met with, and many different clinical groups are classed under the same head. One feature, unhappily, is common to them all – the progressive character of the paralysis and the absence of any hope of recovery, medicine being powerless at present to do more than delay the inevitable result. In all forms, also, when the disease is once established, there is gradual steady failure of the physical and mental powers of the patient, until finally the paralysis becomes complete, and death closes the scene.