rence of sporadic cases in the general population of North-West London for two months before and for at least two years after the outbreak in the hospital. A considerable proportion of these patients were extravert types of stable personality with no history of previous illness of any kind. A further outbreak of 370 cases of the disease seen by Dr. Betty Scott in Finchley between 1964 and the summer of 1966 was described in the *British Medical Journal* (1970, **i**, 170).

The totally irreconcilable line of cleavage from the opinions expressed by Drs. McEvedy and Beard lies in the fact that all the physicians of the Royal Free Hospital who had care of cases in 1955 were in no doubt that the symptoms were organically determined and could not possibly be regarded as 'pure' hysteria. Final and complete refutation of the McEvedy and Beard hypothesis was advanced by Dr. David C. Poskanzer (*B.M.J.* 1970, **ii**, 420), who reminded us that in an outbreak in New York he and his colleagues (Albrecht, R. M., Oliver, V. L., and Poskanzer, D. C. (1964) *Journal of the American Medical Association*, **187**, 904) demonstrated a considerable increase in creatinuria and an increase in the creatine/creatinine ratio, suggesting an abnormality of muscle; on recovery this disappeared. He makes the very intriguing suggestion that 'instead of ascribing benign myalgic encephalomyelitis to mass hysteria or psychoneurosis' Drs. McEvedy and Beard might 'consider the possibility that all psychoneurosis is a residual deficit from epidemic or sporadic cases of benign myalgic encephalomyelitis'. I trust that all fair-minded psychiatrists would agree that this view should be accorded serious consideration before consigning these unfortunate patients with their functional prolongation and tendency to relapse to the implied stigma of 'pure hysteria'.

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VIOLENCE AMONG ATTENDERS AT A LONDON DRUG CLINIC

Dear Sir,

Gordon (1973) finds that clinic attenders have more violent-crime convictions after first drug use than before. However, the *per year* rate for violence convictions before and after drug use is about the same—and larceny lower! Even with liberal assumptions (e.g. that the pre-drug period should exclude only ages 13 and younger) the data corrected for time fail to show a statistically significant increase.

Moreover, the post-drug conviction rate is almost certainly enlarged because the sample patients are subject to a very high rate of police surveillance. And even if offences did increase following drug use, non-drug events could be responsible. In fact a non-opiate sample having the same early conviction records might well have much higher rates of later convictions than the clinic sample.

Gordon elaborates only slightly on the actual behaviours that constitute 'indictable offences of violence'. His examples of 'more serious' crimes of violence include six items—among them, dangerous driving and malicious damage.

He states, 'There is little to suggest that the findings would be specific to this clinic . . .'. However, the proportion of people without criminal convictions in Gordon's sample is less than half of the corresponding proportion for people approaching all of London's drug clinics the following year.

Finally, it should be made explicit that the results seem in no way attributable to clinic treatment itself, as most of the 'post-drug' period precedes clinic attendance.

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References

Gordon, A. M. (1973). *British Journal of Psychiatry*, **122**, 205.

BEHAVIOUR THERAPY IN MENTAL DISORDERS

Dear Sir,

Our booklet, *Behaviour Therapy in Mental Disorders*, was reviewed in your *Journal* in February this year (**122**, 229), and we were not surprised that such a parochial publication should have been criticised in the way it was.

Nevertheless it seems unfortunate that the reviewer should pick out one case of marital disharmony which was in fact successfully treated. It seems to us that it is more important for the patient that his problems are solved than that they should be pedantically classified to satisfy the doctor's rigid requirements.

General practitioners are not inclined to read psychiatric books, even paperbacks, and anything that makes them aware of progress in the available treatments must be of some use.

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