but for patients such as this (a subordinate judge) in whom memory disturbance can be incapacitating. It is just as safe and almost as simple.

I fully agree, however, that further inquiry is needed, and we are working on this.

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GLUCOSE TOLERANCE IN DEPRESSION

DEAR SIR,

What Dr. van Praag writes in his letter about "averages" in clinical investigations (*Journal*, September, 1968, p. 1195) is, I believe, of fundamental importance to all those actively engaged in psychiatric research.

It has long been my conviction that the study of sub-groups, as these are at times discerned in the collection of research information, merits the greatest possible care and detailed analysis. Yet the very existence of such sub-groups is often missed, either because of inappropriate statistics which "iron out" the meaningful clusters of data or (which has the same practical effect) because of the attitude of the research worker who analyses them.

I had the opportunity to participate in the discussion of this problem in a symposium during the last International Congress of Psychiatry in Madrid, and was delighted to see that at least the mathematicians are fully aware of the difficulties in medical research; they are making use of electronic devices to help in the extensive analysis of amassed research data, with the very aim of recognizing significant clusters. Welcome as this new development might be, it cannot, however, replace the inquiring eye of the clinician who has an intimate knowledge of his material. Dr. van Praag's letter is a typical proof of this.

My own experience is in line with Dr. van Praag's findings about a category of patients whose psychiatric disorder is probably correlated with disturbance of metabolism. Some of this research work done at the Bethlem Royal Hospital under W. Linford Rees was with puerperal depression, where the tendency in certain sub-groups to emerge was obvious in a number of metabolic parameters studied—including glucose (Jacobides, 1957); although the deviations from the norm were never deemed great, especially as they were gauged by the single methods of Glucose Tolerance Test and Insulin Sensitivity Test and not by the elaborate biochemical assessments of Dr. van Praag. It is hoped that the findings from puerperal psychotics will be published in some detail and that they will give support to the conclusion of Dr. van Praag, viz. that "averages can be deceptive in biological psychiatry". I can only add to this important epigram that averages can be *a menace* when they let meaningful information from a sub-category or even from a single patient be drowned and irrecoverably lost!

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TREATMENT OF PREMATURE EJACULATION

DEAR SIR,

In reply to the letter of Dr. Ahmed (*Journal*, September, 1968, p. 1197), I would like to make the following points: Dr. Ahmed reports that patients receiving a 1 per cent. solution of methohexitone sodium feel intense pain along the site of the vein. Having regularly used a 2·5 per cent. solution of methohexitone sodium, as recommended by Friedman (1966), I have never received any complaint of pain. It has been my experience that patients may complain of unpleasant giddiness during the induction period, but this can be avoided by the anaesthetist injecting the drug very slowly (Kraft, 1967).

The first patient's symptoms of enuresis, frequency of micturition and premature ejaculation, which Dr. Ahmed attributes entirely to anxiety, might also be interpreted in terms of passive male urethral eroticism (Fenichel, 1946). During his treatment, as the duration of erection increased, there was a parallel decrease in his frequency of micturition, which is of theoretical importance, as it provides a link between analytic and behaviour-orientated approaches to treatment in this field (Kraft, 1969).

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DEAR SIR,

In the letter on the above subject from Dr. Haroon Ahmed I was surprised to note his complaint that the administration of a 1 per cent. solution of methohexitone causes intense pain along the course of the injection site. I have been successfully using this technique for 18 months in the desensitization of phobias, and have no difficulty whatever from this cause.

A search through the literature reveals that this is the general experience. Coleman and Green (1960) state "some 50 per cent. of unpremedicated patients were aware of some sensation along the course of the injected vein. In a few instances this awareness would seem to indicate pain, but as this sensation is not recollected in the post-operative period nor associated with phlebitis it is of no significance." However, Barron and Dundee (1961) reporting on a series of over 600 administrations, state specifically that they received no complaints of pain on injection. This seems to have been the experience of the majority of workers with this drug. The fact that there are so few reports of injection pain would seem to be evidence that it is not generally a side-effect of consequence.

Rowlands (1968) recently reported that in his experience pain or discomfort with Brietal Sodium occurs very much less frequently when the drug is administered fairly quickly. He found that only 8 out of 852 patients (1 per cent.) complained of pain when the injection was given at a rate of 1 ml. every 2–2½ seconds. When the drug was administered slowly, it was found that 14 out of 285 patients (5 per cent.) complained of pain. These differences were subsequently significant ($p<0.01$).

The manufacturers of the drug have also stated that experience has indicated that reports of injection pain are much more likely to appear when the methohexitone solution is injected into the back of the hand rather than into the antecubital fossa. Presumably in a small vein the solution does not become diluted with blood quite so rapidly.

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DELUSIONS OF WITCHCRAFT: A CROSS-CULTURAL STUDY

DEAR SIR,

In their interesting study, Drs. Risso and Böker (*Journal*, August, 1968, p. 963) seem to have fallen into the same error that Kanner (1959) ascribed to Freud. In the second paragraph of their reported paper, in discussing the difficulties met by those facing a new culture, they write: "This gives rise to misunderstandings and difficulties in adaptation, which *may lead* to a psychiatric disorder" [italics not in original, as also in the following quotation]. In the next paragraph we have the jump, unproved, from the *posse* to the *esse*: "In all eleven patients psychodynamic interpretation *showed* that experience with foreign women *had caused* psychological problems. . . ."

Witchcraft studies, in addition to illustrating the mental mechanisms propounded by Freud from dream work and psychotic material, also contain clues on drugs which influence, directly or indirectly, states of mind. The recognition of and reference to drugs is noted, the authors speaking of: "substances . . . which can cause severe generalized toxic phenomena, so that a supposed love potion is merely a pseudonym for a dangerous poisonous drink." Yet in this and in a subsequent instance they focus on psychopathology exclusively: "the patients did not distinguish between a death potion and a love potion."

This distinction must have been difficult apart from the psychopathology of disturbed patients. When the standardization of drugs did not exist and the power of new potions could only be guessed at or tried by unethical biological assay, there must often have been real difficulties for the sorcerers and fatalities amongst their clients. The determination of whether a dosage of new philtre would produce love feelings or would rob an individual of all feelings must have been a problem.

The attitude of the doctor on the efficacy of drugs is widely recognized and is sometimes labelled "placebo effect". It may be that, apart from suggestion, some drugs are active in a particular state of mind. Professor Webster, in a lecture in Birmingham, gave his opinion that some of the despised abortifacients were indeed active because of the mental state of the clients. Ironically, when scientific trials are