appearance of both conditions, as the authors point out, may well be delayed.

On a different tack, and starting another hare, the recent interest in the association of pernicious anaemia and primary hypothyroidism¹¹ is perhaps pertinent, despite the rare association of this thyroid disorder with diabetes in Joslin's series. With the similarities in the pathological progress of Hashimoto's disease and pernicious anaemia¹² one cannot resist the temptation to recall the initial "insulinitis" of the juvenile-onset diabetic,¹³ with his known progression to islet atrophy.—I am, etc.,

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Infective Hepatitis and Marrow Aplasia

SIR,—Since Dr. C. S. Pitcher and Dr. E. M. Spence have drawn attention to the rare association of infective hepatitis and marrow aplasia (January 19, p. 171), I should like to record briefly a further case.

On March 29, 1962, a girl aged 8½ years was admitted with marked jaundice of three weeks' duration, her illness starting with nausea, vomiting, and anorexia. The liver was moderately enlarged, bile pigment was present in the urine and absent from the stools. The following results were obtained from investigations done soon after admission. Serum: Total proteins 6.8 g./100 ml., Kunkel's test negative, thymol turbidity 1 unit, bilirubin 29.6 mg./100 ml., van den Bergh positive, alkaline phosphatase 35 units/100 ml., S.G.O.T. 590 units/100 ml., S.G.P.T. >700 units/100 ml. Blood: Hb 99%, macrocytosis, target cells, no L.E. cells, W.B.C. 6,400/c.mm. (polymorphs 52%, lymphocytes 43%, eosinophils 2%, monocytes 3%). Prothrombin concentration 47%. Prednisolone was given for 38 days, and during this time jaundice and liver enlargement lessened, although the former persisted for approximately 11 weeks from the onset.

On August 21 she returned with spontaneous bruising of two weeks' duration. At this time the blood prothrombin concentration was 100%, Hb 45%, W.B.C. 3,000/c.mm. (polymorphs 24%, lymphocytes 72%, eosinophils 1%, monocytes 3%), platelet count 8,000/c.mm. Bone marrow (iliac crest): generalized hypoplasia of all cellular elements; the erythroblasts were mostly late normoblasts, and the majority of granulocytes were myelocytes. Inquiry was made into the possibility that marrow hypoplasia was the result of drug toxicity or of contact with domestic poisons, with negative results. Treatment included further prednisolone, testosterone propionate, and transfusions of platelet-rich blood and of foetal marrow.

Until her death from extreme gastro-intestinal bleeding five months after the onset of marrow aplasia, the patient suffered repeated bleeding from several sites, and treatment, apart from blood transfusions, had no discernible effect.—I am, etc.,

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This Island Now

SIR,—I read with very considerable interest Professor G. M. Carstairs's "Reith Lectures" (*The Listener*, November–December, 1962), and also the summary of these lectures and your leading article thereon (January 19, p. 141).

I think Professor Carstairs has put us completely in his debt by his many fascinating observations on sociological trends in this country. If there is a weakness in his presentation, it is, I think, entirely due to his almost pure-Freudian psychological approach. (I think your leader has also this implicit criticism.)

Freudian psychological theory may satisfy some people as an "interpretation," but if so they must face the fact (acknowledged by Professor Carstairs) that it is deterministic in its philosophy, and that therefore it is, in this writer's opinion, almost barren as a guide to treatment ("... psycho-analysis has undermined our confidence in the reality of free will."—Fifth Reith Lecture). It is, I fear, of no great help to discover that a pessimistic patient was bottle-fed in his infancy (Second Reith Lecture). We cannot put the clock back and breast-feed him. Nor again, I fear, is it much help to be told that "much of the delinquency shown by working-class youths can be viewed as protest behaviour" ... about the "good things in life which they would like to have, but which are still beyond their reach." (Third Reith Lecture.) Professor Carstairs points out that the prison population has increased threefold since 1938 (Fifth Reith Lecture). But there is no comparison between the material things our adolescents can enjoy now and what were available to them in the thirties.

This exclusive reliance on Freudian theory has, in my opinion, been a disastrous development for British psychiatry. To give one simple example: Professor Carstairs nowhere mentions the enormous rôle of the sentiments (first enunciated by McDougall^{1 2 3}) in the formation of character and therefore in all the subsequent choices of life. All except feeble-minded delinquents know perfectly well that stealing is wrong and that they will be punished if caught. But very few of them have built up (largely due to parental neglect, ignorance, or lack of effort) any "sentiments" about stealing. They do not associate stealing with anything mean or vicious or shameful, and hence they are liable to repeat the offence at the first opportunity, but with perhaps greater cunning. The non-Freudian child psychiatrist has here a definite aim. He knows that if he has to succeed, he must by some means build up sentiments at, say, the age of 16 that should largely have been formed at the age of 6. This can be difficult, but is often enough surprisingly easy. Nor is it even impossible with hardened criminals. And sentiments, unlike beliefs, as McDougall has pointed out, are part of the enduring superstructure of the mind, and will therefore affect conduct throughout life. Nor does Professor Carstairs make any reference, in his many controversial statements on sex, to the disharmony of the sentiments which much of this conduct ("sex