Psychiatrists who have more than enough work to do are well aware that the large majority of mentally handicapped people, as with the general population, happily do not need their attention, but a small minority do. Their interests are best served by a broad eclectic approach which can offer mentally handicapped people a range of residential options to meet their needs through, for example, the parental home, fostering, staffed and unstaffed flats and houses, group homes, hostels and hospital, of occupational options such as training centres, special care units, sheltered workshops and continuing education centres, and advice from a range of specialists, psychiatrists, psychologists, nurses, physiotherapists and dietitians.

Community orientated services for mental handicap are the avowed objective in future NHS planning, which if fulfilled will see the dissolution of large mental handicap hospitals by the end of the century. Now mentally handicapped people can look forward to the promised land of community care. Mental handicap should be striving to reach beyond the obsolete prejudices of yesterday.

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Medical aspects of fitness to drive

DEAR SIRS

I wonder if the College is aware of the facts of the document which is published by the 'Medical Commission on Accident Prevention' which is supported by the Royal College of Psychiatrists.

I had a man aged 46 in my out-patient clinic with depression whose Heavy Goods Vehicle Licence had been removed from him because he was on medication for his depression. Because he had lost the HGV licence he was sacked by the bus company for whom he had worked for 13 years. His Union finally advised him that he could not fight this dismissal but he should go for a pension. Working with the Senior Medical Adviser to the Transport Executive I discovered that he was not eligible for a pension unless he was going to be continuously ill for the rest of his life.

Because this man has had a depressive illness, which is now under treatment, he is now unemployable, although in the normal course of events one would expect him to recover quite easily. The worry of all this and the financial strain have upset him even more which is making his depression harder to treat, naturally.

It seems to me quite wrong that somebody should lose their job for ever because of a treatable psychiatric condition. Would it be possible for some recommendations to be made for patients like this, that they are only temporarily prevented from driving and their HGV held in abeyance until they have recovered.

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'Psychoanalysis—Science or Nonscience?'

DEAR SIRS

I am delighted that my article 'Psychoanalysis: Science or Nonscience?'[1] has stimulated such lively debate in the correspondence columns of the *Bulletin* and the *British Journal of Psychiatry*. My critics Thompson, Wright and Anderson unanimously assert that nonscience is not the same as nonsense, and confirm that Popper in fact did not imply this; my point was that some colleagues use their own notions of what constitutes science (often drawn from Popper) to dismiss any body of knowledge that does not conform thereto, designating it as not worth considering, and therefore as nonsense.

My intention was to widen the debate as to what constitutes knowledge, and therefore science, and to encourage new formulations. I was disappointed that the above-mentioned gentlemen appeared not to have read further than my critique of Popper, which did not form the main bulk of the article. Nevertheless, I would like to comment on some of their points.

I agree with Wright when he says that falsifiability and testability 'are the same in the sense in which they are used by Popper'; my point is that they are not of necessity the same—a theory can be tested by showing it to be true or false. An example of testing by verification (which Thompson requests) is the prediction of future events by a theory, such as the prediction of the existence of planets which were later discovered. Even when theories are falsified they are not rejected but remain true and are used at different levels of explanation (Wright uses my example of classical versus relativity theory). This is why transcendental realist theory with its emphasis on different levels of explanation is a more interesting and practically useful model.

My basic point is that there is nothing magical about falsifiability as a criterion of scientificity. It seems a neat and useful tool at face value, but on deeper examination it is subject to the same logical problems as verifiability: both require an external or *a priori* criterion which is separate from the theory to be tested. To use a Popperian example: the conjecture that 'all swans are white' can only be refuted if one has some prior knowledge, namely that 'swan-ness' is not the same as 'whiteness'; otherwise the existence of a black creature that looks like a swan could not refute the conjecture. Indeed Popper's theory has been called 'a version of inductivism' (Harre),[2] retaining as it does one of the inductivist principles, namely the principle of accumulation; that science is the accumulation of well-attested facts (attested by the use of falsifiability criteria). Harre further says that experimental evidence alone is insufficient to confirm or refute a theory; other rational procedures of decision are necessary; science is a complex activity and cannot be described as simplistically as Popper does.

Psychoanalysis constitutes a body of theory which seeks to explain intrapsychic phenomena; the theory of resistance to therapy is not an 'ad hoc theory' (Wright) but is part of the general theory, which operates at different levels of

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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REFERENCES

[1]MATHERS, Carola B. (1986) Psychoanalysis: science or nonscience? *Bulletin of the Royal College of Psychiatrists*, **10**, 103–104.

[2]HARRE, R. (1972) *The Philosophies of Science*. Oxford University Press.

(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).