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CORRESPONDENCE

Correspondents are asked to be brief

Behaviour Disorders and Public Safety

SIR,—In an otherwise admirable leading article on "Behaviour Disorders and Public Safety" (8 July, p. 70) you lend credence to the myth that psychopaths lack a capacity to experience guilt and are therefore to be considered amoral rather than immoral. Of course it all depends on what you mean by psychopath. But my experience in both general and forensic psychiatric practice is that a large majority of people whose behaviour and personality trait would lead them to be so labelled can in fact experience guilt and are not amoral. Indeed, they may have experienced guilt so keenly at one time that psychopathy is their defence against it and other distressing emotions like it.

While it may be true that some individuals of this type are so deviant and have been so for such a long time that ordinary psychotherapeutic measures cannot reach them, my impression is that many so-called psychopaths (character disorder or sociopath may be preferable terms) are in fact treatable. But the therapist needs to get behind the "acting-out" defence mechanisms in order that feelings of inferiority, unlovableness, depression, and guilt may stand revealed and be utilized therapeutically. Often I feel that the psychopath is but a neurotic in disguise.

Group therapy and therapeutic community practices have proved particularly advantageous in treatment. Such methods go a long way to circumvent the authority conflicts which characterize the treatment of this class of patient and at the same time provide opportunities for confrontation and necessary control. These methods also avoid the one-to-one encounter with what often proves to be a manipulative and frustrating patient; this situation goes beyond the skill and patience of most of us. But even if the psychopath defeats all our efforts—and this happens with other kinds of patient too—I think it unhelpful to project our own feelings of anger, impotence, and guilt, label the patient accordingly, and thus seek to absolve ourselves from further responsibility.—I am, etc.,

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Herpes Simplex and Temporal Lobe Epilepsy

SIR,—Dr. Constance A. C. Ross (8 July, p. 112) suggests that unrecognized herpes simplex virus infection of the brain may be a cause of temporal lobe epilepsy. We have been investigating this possibility for some while, but as yet we have insufficient data to draw definite conclusions. She also reported that of 20 people with proved herpes simplex encephalitis seen in Glasgow between 1962-71 only one was younger than 10 years old, and she surmized that an acute presentation of this form of encephalitis is uncommon in young children. One might draw the same conclusion from the Oxford series of approximately 20 cases; none was younger than 11 years old. However, to do so would probably be incorrect.

Of 31 patients with encephalitis attributed to herpes simplex virus and reported to the Epidemiological Research Laboratory of the Public Health Laboratory Service during 1971 (8 January, p. 121) ten were younger than 10 years old, and indeed nine of them were younger than 2 years old. In eight of them the diagnosis was based on a more than four-fold rise in serum antibody titre; the other two were diagnosed on the basis of virus isolation from the brain at necropsy. They all presented as an acute illness usually accompanied by seizures. The severity can be judged from the fact that three died, five were left severely brain damaged (four of them with persistent epilepsy), one was moderately disabled, and only one was regarded as having fully recovered. In view of current discussions about the efficacy of various treatments for herpes simplex encephalitis, it is noteworthy that the child who recovered (who incidentally had virus isolated from the lumber C.S.F.) was the only one not treated with steroids during the acute phase.

One must conclude that herpes simplex virus can produce a fulminating encephalitis with severe sequelae in young children. Whether there are milder cases in whom the diagnosis is missed but who subsequently develop temporal lobe epilepsy remains an open question.—We are, etc.,

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Haemoglobinometry in New Units

SIR,—Your leading article (15 July, p. 129) rightly cautions against the premature acceptance of mmol/l. as the unit for haemoglobin concentration. But the change must come eventually, and to defer it by advocating as an interim solution the adoption of g/l. will only cause additional confusion. As you point out, the real choice is between expressing the concentration in terms of the molecular weight of the single haem monomer containing one atom of iron or the tetramer containing 4 atoms. From the point of view of clinical respiratory physiology there is no doubt but that we should adopt the former. The advantage of having the haemoglobin concentration and the oxygen capacity of blood in equivalent units and sharing the same normal value of 9 mmol $l.^{-1}$ is surely overwhelming.—I am, etc.,

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