Most local medical committees would be delighted to allow prescriptions for these and other modified foods. Perhaps the referees would consider issuing another *Proplis*, but whatever they do will they please give their reasoning or, if they cannot, make way for others who can?—I am, etc.,

A. A. LEWIS

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Treating Incontinence Electrically

SIR,—Like Mr. C. D. Collins and Miss Eileen Montgomery (8 July, p. 112) I was astonished to note the omission in your recent leading article on "Treating Incontinence Electrically" (17 June, p. 670) of maximum perineal electrical stimulation as one of the methods of treatment. This technique,^{1,2} which I introduced, is not meant to be part of any long continued treatment. In the original publication it was suggested that the one treatment with maximum perineal electrical stimulation under general anaesthesia might restore the pelvic floor postural muscle tone to the maximum possible for that muscle. When the treatment was successful then this increased tone so affected the urethra that normal sphincter control was restored. The follow up of the original cases carried out by my colleague, P. F. Schofield, showed that 12 months after one treatment 30% of the cases of stress incontinence remained dry and 22% showed substantial improvement. As already pointed out (8 July, p. 113) cases of incontinence referred to interested urologists have usually had all sorts of previous treatments, including several operations.

The treatment may restore continence in any patient, in whom pelvic floor weakness is playing a part, whatever the cause. Occasionally I have had dramatic success in referred postprostatectomy cases, sometimes many years after the original operation. The method can also prove useful in cases of anal weakness often seen in elderly people. I believe that it is the first contraction which is the important one, and if the muscle can be made to respond to its maximum extent, as originally postulated, then the return of function is much greater than can be obtained by minimal intermittent electrical stimulation or voluntary pelvic floor muscle re-education.

Although no panacea for incontinence, the method should certainly be tried before any operation or any of the more complicated electrical techniques.—I am, etc.,

THOMAS MOORE

Manchester

¹ Moore, T., and Schofield, P. F., *British Medical Journal*, 1967, 3, 150.

² Moore, T., in *Proceedings 14th Congress International Society of Urology*, 2, p. 493. Paris, Doin, 1967.

Wetting and Soiling

SIR,—Dr. A. C. Woodmansey's emphasis (15 July, p. 161) on the importance of prophylaxis in the approach to nocturnal enuresis cannot be too warmly applauded. But, though I would second his proposal for guidance of the parents, even before the baby is born, as a family doctor undertaking child welfare clinics I feel that these provide the most practical milieu for an approach to the mother.

Of course the problem is many faceted. Some are born enuretics (unfortunates with diverticulae of the bladder, ectopic ureters, or bladder neck obstruction); some achieve enuresis ("onset" enuretics who become enuretic after separation from the mother); and some have enuresis thrust upon them by parents who wish their children to conform to their notion of "normality."

Enuresis is a reflex wrapped in a guilt complex. If the mother of the two- or three-year-old attending a welfare clinic can be brought to accept that children are not created equal and that there is no fixed milestone along the path to nocturnal continence much wringing of hands and ringing of bells (*pace* Sir Robert Walpole) can be prevented.—I am, etc.,

DAVID LIVINGSTONE

Embleton,
Northumberland

SIR,—Dr. A. C. Woodmansey (15 July, p. 161) describes nocturnal enuresis, urinary incontinence, and encopresis as though they were all facets of a similar emotional problem. Thus he writes, "Enuresis has long been considered a sign of emotional disturbance; and there is good evidence of its frequent association with various upsetting experiences. . . ." This may be true, but the fact that enuresis is often associated with soiling and stealing in disturbed children does not alter the fact that the vast majority of children who wet their beds are not disturbed emotionally nor do they come from unhappy homes.

Over the past 6 years I have seen an average of 30 enuretic patients each week at the enuretic clinics run by the London Borough of Croydon, and the one striking thing about these children is that they are a cross-section of the child population and include all social grades and types of families in roughly the same percentage as in the general public. They therefore include patients who are not just bed-wetters but are incontinent of urine and faeces. These are referred to the child guidance clinic. Some of the enuretic patients who come to the clinics have previously attended child guidance clinics, sometimes over a long period of time, and in many cases the parents of the child have been distressed at the diligent attempts by the psychologist to find evidence of parental disturbance.

There are two facts about enuresis on which all are agreed—the number of enuretic boys is twice the number of enuretic girls, and there is a familial tendency. Neither of these two facts lend credence to Dr. Woodmansey's theory. On one point he has my full agreement. The child with nocturnal enuresis wets the bed because he fears he will wet the bed. The buzzer works because if it is properly used the child knows he will wake when there is only a small patch of urine on the draw sheet instead of a soaking bed. The buzzer acts not by any method of conditioning but by supplying the confidence that is lacking in these children. It is therefore extremely important that the parents are prepared to co-operate and wake the child as soon as the buzzer rings, as in many cases, especially with younger children, the child does not otherwise wake until the buzzer has been ringing for some time and the bed is soaking wet. Those of us who have used these machines for any

length of time know that some children sleep through the loudest of bells.—I am, etc.,

MARGARET WHITE

Croydon,
Surrey

SIR,—Unlike many articles on enuresis and encopresis I found the article by Dr. A. C. Woodmansey (15 July, p. 161) extremely helpful and constructive. I share his concept of fear playing a major role in the manifestation of these distressing habit disorders, and I would have liked to have seen mention made of the justifiable use of medication such as imipramine and diazepam to help alleviate fear not only in the child but also in the parents rather than rely exclusively on what Dr. Woodmansey describes as "psychotherapeutic skill to overcome their anxious doubts."—I am, etc.,

L. SONENSCHER

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Future of Mental Health Services

SIR,—We are grateful to Drs. Jan T. Leyberg and Marion E. Mackey for their letter (13 May, p. 409) and appreciate from it that our letter (4 March, p. 624) may require some clarification. Nevertheless, our criticism stands. That the present policies for the development of the psychiatric service produce a better basis for the less severely ill than the old remote mental hospital is not in question. What they do not provide are adequate facilities for the chronically inadequate, the incurable, and patients with character disorders. In spite of all the modern advances in treatment there are a minority of acute patients and also some long-stay patients who remain disturbed and impulsive in spite of all efforts. We believe that these patients might well represent a real difficulty, and indeed danger, in a general hospital unit.

We agree that in the foreseeable future there will still be a need for active, progressive mental hospitals. If this is recognized by the Department of Health obviously training and recruitment will continue satisfactorily, provided there is a high degree of staff integration between the general hospital unit and the mental hospital. Our gloomy views concerning training and recruitment were based on the assumption that the Department will have its way and the vast majority of existing mental hospitals will be closed.

While the psychiatric beds are being reduced the prison beds are increasing. No one ever made an inadequate person adequate by placing him in an inadequate situation, and this is in fact merely another way of creating institutional neurosis. Equally, many patients live in the community in squalid conditions—witness the Embankment and Waterloo Station and the slum hovels where many discharged schizophrenics eke out a miserable life. The scope for the therapeutic community in the general hospital is limited, as is its capacity for dealing with severe mental illness.

We believe the following general principles apply. (1) The whole range of psychiatric services requires a full development and that this is best done when the general hospital and the psychiatric hospital stand side by side on the same campus sharing those departments in which they have a mutual interest. (2) Where psychiatric units are created they must be large