Jacobides), when they attended the Maudsley Hospital (they would have been excluded from the control group if this diagnosis had been made), and it should be remembered that only one of the 8 children was rated as "autistic" on his behaviour at that time. The diagnosis of an organic brain disorder on the basis of behaviour alone is generally an unreliable and unsatisfactory procedure, but it does appear that "autism" is frequently associated with organic brain dysfunction. "Autism" was also associated with language deficits. All but one of the 8 children had been impaired in their language development *before* they became autistic. Only one remained without speech at follow-up, but two others had speech so limited as to be of little or no communicative value.

Professor Jacobides is correct in his assumption that many of the cases were seen by him during the time he worked at the Maudsley Hospital, and our behavioural ratings were based in part on his careful records, for which we are grateful.

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TABLE I

Presence of "Brain Damage" in Control Children

Strong likelihood 24:	1 Cerebral lipoidosis
	2 Tuberculous meningitis followed by transient hemiparesis (and, in one case, the onset of epilepsy)
	1 Hemiparesis from birth
	1 Mongol
	7 Epilepsy + Focal abnormality on EEG
	2 Epilepsy + abnormalities on neurological examination
	9 Uncomplicated epilepsy
	1 Spike focus on EEG, marked clumsiness, change in development following meningitis in infancy
Probable 5:	2 Gross generalized EEG abnormality
	1 Spike focus on EEG
	1 Gross motor incoordination
	1 Facial asymmetry, left extensor plantar response
Possible 9:	4 Marked clumsiness
	3 Uncertain abnormalities on neurological examination
	1 Generalized abnormality EEG
	1 Premature birth, convulsion in infancy
No evidence of brain damage: 25	

PSYCHIATRIC SERVICES FOR THE DEAF

DEAR SIR,

In his review of the book *Comprehensive Mental Health Services for the Deaf* by John D. Rainer, M.D. and Kenneth Z. Altshuler, M.D., Dr. Minski rightly stresses the need for the development of psychiatric services for the deaf in this country.

However, his statement that "an important aspect of psychiatric treatment is lacking not only in this country but probably throughout the world" gives the impression that there are no provisions here for the deaf with mental illness whatsoever.

Psychiatric services for the deaf have been developing within the Manchester Regional Hospital Board since 1964 when we undertook a survey of the deaf population of two mental hospitals (1). For the past two years out-patient clinics for deaf patients have been held in the Department of Audiology and Education of the Deaf at Manchester University, and requests for assessment of deaf patients have been received from all over the country. At this hospital deaf patients have been admitted for assessment and treatment and a Unit for deaf patients is to be opened in the immediate future, with nursing and other ancillary personnel trained in manual communication methods and conversant with the psychological and psychiatric implications of deafness.

I fully endorse his view that this book should be read not only by all psychiatrists but also by the Ministry of Health and Regional Hospital Boards.

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REFERENCE

1. DENMARK, J. C. (1966). "Mental illness and early profound deafness." *Brit. J. Med. Psychol.*, **39**, 117.

THE BODY IMAGE OF THE AVIATOR

DEAR SIR,

We were very interested to see the paper by Tucker, Reinhardt and Clarke (*Journal*, February, 1968, p. 233). One of us (A.S.) is currently using the same conceptual approach in the study of motor vehicle drivers. We agree with the authors that the question of the degree of control the operator achieves over his vehicle is vital in determining the changes which take place in his body image. It follows from this that once the operator has left the vehicle his body image will return to its previous boundary, although some time may elapse before it is fully restored. It seems to us essential, therefore, that any tests which are