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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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INTERACTION BETWEEN DEPRESSED PATIENTS AND THEIR SPOUSES

DEAR SIR,

I would like to reply to the criticisms of Dr. John Kellet (*Journal*, May 1975, **126**, p. 488), who suggests that we have failed to demonstrate that depressed behaviour varies with the social environment. He has misunderstood certain principles in our procedure and argument.

Firstly, the sessions between patient and spouse, and between patient and stranger, occurred on the same day, though the interaction with the stranger was always the second recording. One might argue from this that there was a measure of habituation to the experimental situation by the second recording, but our results demonstrated a greater change than could be accounted for in this way.

The experimental situation with the stranger was designed to be a non-threatening social situation for the patient. The stranger was a responsive pleasant individual of the opposite sex. It evoked a formal social responsiveness in the patient, demonstrated by a marked reduction in levels of negative expressiveness (tension and anxiety), an increase in positive expressiveness (greater agreement and supportiveness) and, non-verbally, an increase in communicative (object-focused) hand movements and in imitative behaviour such as body congruence. This formal interaction cannot be directly compared with the later recording with their spouses at recovery, where one is viewing the interaction of a couple who derive mutual emotional support from each other. Our interest was to compare the patients' changed behaviour in the two socially different situations: (a) with the spouse; (b) with the stranger, and also to demonstrate a difference over time for their relationship with their spouses.

Our findings support our hypothesis that depressive behaviour is dependent on its social context.

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FACT AND FICTION IN THE CARE OF THE MENTALLY HANDICAPPED

DEAR SIR,

This title of recent correspondence in *The British Journal of Psychiatry* appropriately reflects the present dichotomy of approach to the services for the mentally handicapped. On the factual level are the day to day problems in the management of this group of people which parents, family doctors, teachers, nurses and consultants face and which have to be resolved on a practical and pragmatic basis by those personally involved doing the best they can with limited resources. On the fictional plane is much of the theorizing about what is thought to happen, according to the idealistic clap-trap of writers safely insulated from the mundane questions of daily routine care.

Last year informal meetings of representatives from the National Society for Mentally Handicapped Children as the 'consumer interest', the social workers and Local Authority and Health Services staff, which included consultants in paediatrics and mental handicap, were held in this hospital to discuss how to better services for the families with retarded children. In Leeds, with a population of about 700,000, it is estimated that 700 to 1,000 families are in need of special help because of their mentally handicapped children.

After much discussion, the consensus was reached by a largely non-medical group that only a doctor had the depth and breadth of experience to co-ordinate the multi-disciplinary team. The result has been the recasting of the job description of a consultant post in mental handicap to embrace work with children and families on a wider community basis, to forge links with the paediatric assessment unit and to emphasize a co-ordinating role. The post has been advertised and an appointment made.

It is apparent that at the present time many mentally handicapped children living at home or in hostels and attending special schools in the community are not receiving adequate psychiatric assessment and follow-up by a specialist in mental

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handicap. Families struggle on and hospital admission is sought when a crisis occurs. An earlier and closer psychiatric appraisal can anticipate family breakdown and incidentally obtain much valuable information for epidemiological studies and for the provision of services.

There will continue to be a place for a consultant specializing in the psychiatry of mental handicap. His future role will be much less hospital-based and biassed and will involve a wider commitment in the community and in health care management.

D. A. Spencer.

Physician Superintendent,
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Leeds.

Dear Sir,

I have not always been in agreement with Dr. Alex Shapiro (*Journal*, May 1975, **126**, p. 481), but in relation to the recent correspondence with Albert Kushlick I must confess that Shapiro talks with that sad sense that is based on experience, especially sad when a once viable hospital provision (albeit with its defects) is allowed to 'grind to a halt. Compared with him Kushlick and Blunden, *Journal*, May 1975, **126**, p. 487) sound like singers in an opera composed in cloud-cuckoo land (presumably sited near the Elephant & Castle).

In Scotland, fortunately for the 'patient' and the parents, the hospital service is still preserved and even strengthened. From what I hear on my infrequent visits to the 'affluent South' the hospital service is in a state of rack and ruin with nursing figures in some hospitals 30 per cent under establishment.

The problem really relates to two different Government polices: (1) to separate Social Work from Health; and (2) to run down mental handicap hospitals before any adequate provision exists in the community. My own catchment population is something around 625,000 but the community based residential accommodation is 18 places (males only).

I have come back to the idea once favoured I think by the N.S.M.H.C., namely a single service for the mentally handicapped, centrally funded and analogous to the excellent service that existed in Northern Ireland until our present 're-organization'.

I know there are arguments against this (see T. D. Hunter, 1973), but as the split between health and social services seems likely to last 5, 10 or even 15 years I think we should seriously reconsider this concept of a single service, centrally funded, which would be quite outside the N.H.S. and the Social Work Services. For one thing, I think an imaginative jump like this might alter the trend in nursing and medical staff recruitment and, more important, offer some prospect for improved services to 'patients' and parents not in the year 2000 but perhaps even before 1980.

Alistair Forrest.

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Reference

Hunter, T. D. (1973) Changing patterns of organization and management. In *New Perspectives in Mental Handicap* (eds. A. Forrest, B. Ritson and A. Zealley). Edinburgh: Churchill Livingstone.

TECHNIQUES OF PSYCHOTHERAPY WITH CHILDREN

Dear Sir,

A technique of psychotherapy suitable for once-a-week sessions in Health Service out-patient clinics was described by Dr. Haldane last month (*Journal*, May 1975, **126**, p. 469). The psychotherapeutic method discussed was based on the work of Carl Rogers in individual and group therapy with adults. The application of Rogerian techniques to work with children has been developed and described among others by Axilene (1947).

For the past two years I have been applying Rogerian techniques in several residential child care establishments, one of them being the Church of England Children's Society unit for children who have experienced fostering or adoption breakdowns and who need a therapeutic programme before they can be introduced to another placement. Individual and group sessions are carried out and residential and field social workers have been introduced to Rogerian techniques through the in-service training programme. So far evaluation of the results is based on subjective judgements. During the operation of the unit there have been no failures in subsequent placements and children who came into the unit with signs of acute disturbance have all made adequate or satisfactory adjustments in their eventual long-term placement.

It is unrealistic to expect that more than a tiny minority of the 5,000 children a year dealt with by the Society could receive psychotherapy in Child Guidance Clinics or Young Persons' Units, due to the desperate shortage of psychotherapeutic time within the Health Service. But I have found that field and residential social workers have been able to develop a Rogerian psychotherapeutic skill in a way which would never have been possible with conventional psychoanalytically based psychotherapy.

Dr. Haldane refers to the dangers of the latter technique used without adequate training in work

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