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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