appreciation of many of the basic problems of psychiatry. This is now the major benefit to be gained from reading Jaspers as a trainee.

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Systemic family therapy

SIR: We were pleased to read Bloch *et al*'s account of the use of systemic family therapy in adult psychiatry (*Journal*, September 1991, **159**, 357–364) and would agree with many of their comments about our limited knowledge of the role of family therapy in adult clinical work.

We are members of a multi-disciplinary group of staff who have been using family therapy within an Old Age Psychiatry service for a similar time. The development of our clinic has been described elsewhere by team members (Marriott & Pickles, 1987; Benbow, 1988) and we have recently been reviewing our own experience in working with later life families. We have found that the clinic can be helpful with complex and relatively longstanding problems in late life. We have also been experimenting with a team consensus rating, similar to that used by Bloch and co-workers, although we have reservations about using a team rating as an outcome indicator. It is good to hear about others struggling with the same problems.

Our family therapy clinic is, however, not part of a psychotherapy service, but is relatively unusual in that it is integrated within a comprehensive psychogeriatric service. This has problems and advantages (Benbow *et al*, 1990). We feel that later life is a stage of adulthood when the role of the family is both very important and often neglected. Those who work with the elderly physically and/or mentally ill cannot avoid family problems, but may not often address them. We are aware of an upsurge of interest in this area over recent years.

The issue of cost-effectiveness is a difficult one. Although working in a formal clinic setting in a team is undoubtedly staff-intensive, we feel that experience in family work has spin-offs throughout the elderly service and affects the work of team and non-team members in many spheres. This is difficult (if not impossible) to quantify, but may be an important and little-recognised advantage of staff gaining experience in family therapy. As confidence grows, team members see families outside the clinic, alone or with non-team colleagues. Individuals may 'internalise' the team, enabling team members working alone to utilise interventions and strategies which at one time would not have been available in their repertoires. Work patterns with other agencies are also affected, as well as work with individuals and families outside the clinic.

In Old Age Psychiatry, family therapy adds a new dimension: we feel that we are not what we were!

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Polycythaemia and psychotic depression

SIR: Murray & Hodgson (*Journal*, June 1991, **158**, 842–844) have described the first case of polycythaemia rubra vera complicated by psychotic depression. We describe here a second case of psychotic depression associated with polycythaemia rubra vera.

Case report. A, a 69-year-old woman with no family or personal history of psychiatric disorders, was found to have polycythaemia rubra vera (RBC 9.9 million/mm^3; WBC 16 000/mm^3; platelets 1.4 million/mm^3; splenomegaly) when she was 49, in 1971, during investigations for an acute myocardial infarction. During the following seven years she had another myocardial infarction, frequent transient