due to their leading lives relatively independent of males) had been similar to those of the lesbians. In any case, until marital status has been controlled as well as other factors, the results of my research, although interesting, may prove little. It is my hope to write a much more comprehensive paper based on a much larger number of subjects, which will be considerably more definitive concerning the lesbian personality than was possible in the present study.

JUNE H. HOPKINS.

*North Riding College of Education,*
*Filey Road,*
*Scarborough.*

## PATIENTS' PERCEPTION OF HIDDEN FIGURES

DEAR SIR,

May I refer Messrs. Crookes and Hutt, whose articles entitled 'Perception of Hidden Figures by Neurotic and Schizophrenic Patients' appeared in the March issue of the *Journal* (p. 335), to the work I have done in this field (1, 2)? I too found significant differences between the performances by schizophrenic and neurotic patients on the Gottschaldt figures. When the effect of intelligence on these performances was partialled out, however, the differences disappeared (1). Moreover, a factor-analytic study which was undertaken later confirmed that the (untimed) Gottschaldt Figures Test is an almost pure measure of general intelligence (2).

D. ROMNEY.

*Sunnybrook Hospital,*
*2075 Bayview Avenue,*
*Toronto 12, Ontario, Canada.*

(1) ROMNEY, D. M. (1967). *Aspects of Cognitive Dysfunction in Nuclear Schizophrenics and their Parents and Siblings.* Unpublished Ph.D. thesis, University of Newcastle Library.
(2) —— (1969). 'The validity of certain tests of over-inclusion'. *Brit. J. Psychiat.*, 115, 591–2.

## PSYCHOTHERAPY WITH FAILURES OF PSYCHOANALYSIS

DEAR SIR,

The paper by M. Schmideberg (116: February, 1970, pp. 195–200) clarifies the question we should be asking when we embark on psychoanalysis or other long-term psychotherapeutic endeavours. The patients in such situations are chronic, or will become so during the course of prolonged therapy, and are suffering from some degree of defect or disability. It follows that the medical model for the rehabilitation of the chronic patient may thereby be applicable, and such principles as the development of motivation, the assisting of the patient in acquiring new skills in work or living, and the structuring of a program of graduated steps in the return to full functioning are to be considered in the treatment. The chronic patient, be he tubercular or neurasthenic, has much the same problem in finding his way back to full community participation.

If we accept this view that chronicity is one of the essential features of the patient commonly seen in long-term psychotherapy, we must then ask what is the contribution of psychotherapy to the rehabilitation of the chronic psychiatric patient? Rehabilitation is invariably a complex process involving many modalities, and a total program that will vary from phase to phase with the patient's progress through his rehabilitation. It follows, then, that psychotherapy as a total approach to the chronic patient cannot but be inadequate. The psychotherapist who sits in a room alone with the chronic patient and engages in a verbal exchange is of little assistance to the patient who needs practice in developing new life skills. The psychotherapist's consultation room is hardly an all-purpose laboratory for dealing with daily life problems. Furthermore, the passive-appearing psychotherapist is a particularly poor role model to the patient in his search for new and useful identifications. To the psychotherapy patient, the psychotherapist is the least active of workers. He appears to do nothing and to relate to no one. He does not appear to 'work'.

I would submit that when we have identified a chronic patient in need of psychiatric rehabilitation, such a program should *never* be limited to psychotherapy, and psychotherapy should always be combined with other rehabilitative techniques. For the chronic patient coming from the middle and upper social classes, the practice in verbal techniques afforded by psychotherapy is not usually the necessary element in his rehabilitation. Rather, participation in meaningful vocational and social situations is much more essential. In contrast, patients drawn from the lower classes may be defective in the verbal skills required and impartable from psychotherapy. Hence, we might conclude that psychotherapy is of more critical importance and potential value in relation to chronic patients drawn from the lower classes than to those from the upper and middle classes. This, of course, is in marked contrast to the practices and preferences of the psychotherapist as a practising professional.

Another consideration in the development of a program for the rehabilitation of the chronic psychiatric patient pertains to the use of the paraprofessional. This type of mental health technician or indigenous

non-professional is appearing with increasing frequency in American mental health programs. While the use of non-professionals is hardly a discovery for most countries around the world, this kind of commonsense utilization of a hard-headed member of the patient's own neighbourhood or background class is a dramatic addition to American psychiatry. The paraprofessional or mental health technician works along with the professional in the various clinic or hospital settings and provides many of the specific direct supports that Schmideberg has mentioned as being helpful in guiding her patients back to more complete daily functioning. The paraprofessional is able to offer direct suggestion and advice, participate with the patient in problem-solving, and offer direct encouragement to him. Indeed, in the very area in which the psychotherapist is weak as a role model, the paraprofessional is strong. The paraprofessional is seen as an active participant who gets out of the office and into the real life situation along with the patient. The paraprofessional may be seen by the patient as an activist and an advocate in contrast to the office-bound psychotherapist who is passive and inhumanely non-judgmental, as Schmideberg has pointed out.

LEON D. HANKOFF.

*40 Montana Place,*
*Brooklyn, New York 11234,*
*U.S.A.*

## THE SEEBOHM REPORT

DEAR SIR,

Miss Tanner's distress at the negative reception given to the Seebohm Report by the R.M.P.A. is understandable, in a way praiseworthy, but undeniably naïve (*Journal*, April, 1970, p. 457). Did she really expect the R.M.P.A. would acquiesce in a proposal which involved abjuration of some of its power? As a social scientist she might have been expected to know that social institutions are all resistant to change, and that psychiatry, now that it is accepted as one of component medical institutions in general, is no exception. The dominant ideology of all such institutions is always conservative (small 'c' of course), and the point is neatly demonstrated by Dr. Pilkington's last sentence in his reply—'It is to be hoped that in any future deliberations the psychiatric social workers will reconsider their position not merely by attempting to envisage a new Social Services Department but rather by studying the manner in which comprehensive and integrated psychiatric services ought to be developed in the future.' The linguistic nuances of the sequence 'merely', 'new', 'rather' carry the implication that the existing psychiatric establishment organization is basically the optimum one.

Resistance to change in social institutions is almost a universal phenomenon—witness the distrust of all forms of revisionism in political science (tragically in Czechoslovakia) as well as applied social science (tiresomely in Western democracies); for that matter, Freud was intransigently hostile to the changes in psychoanalysis proposed by Jung and Adler. Actually the protest letter by Finn, in the same issue of the *Journal*, at Beccle's derogatory review of Goffman's *Asylums* is probably occasioned by the operation of the same forces and mechanisms. The perception of the need for change, especially if it be radical change, is experienced by some and not others. The perception may or may not depend on superior wisdom; but factors other than 'wisdom' are likely to be involved. One could perhaps hazard a guess at the age ranges and status ranges of the authors concerned. The longer one has been socialized by an institution, the more the institutional hierarchy gives one a *persona* and a set of roles, the more one becomes uncritically the creature of the institution—which is exactly one of the major ideas that Goffman is advancing, surely.

Miss Tanner had better look elsewhere for advocacy of change. The emergence of some non-institutionalized charismatic leader is a more likely source, some one with campaigning fire and a vision, not too hampered by doubts or misgivings. This has usually been history's way. Perhaps Des Wilson could be recruited from Shelter? Changes in establishment policy are only ever won by sustained and repeated assault from without, and the reformer's lot may well be thankless, to put it mildly. It might be some encouragement to reformers to remember the case of Chadwick, who was disliked, discredited and largely destroyed for his attempts to reorganize aspects of human welfare. In July 1854 *The Times* jeered after his defeat 'We prefer to take our chance of cholera and the rest than be bullied into health . . . The truth is Mr. Chadwick has very great powers, but it is not so easy to say what they can be applied to. Perhaps a retiring pensiph with nothing to do will be a less exceptionable mode of rewarding this gentleman than what is called an active sphere' (1). Chadwick was thereafter sent to Victorian England's equivalent of Siberia, yet by 1889 events had vindicated him; he was rehabilitated, knighted, honoured in various ways and *The Times* attitude towards him is now unrecognizable. His obituary there in 1890 reads '. . . Figures and undeniable facts were the talismans with which he accomplished achievements which to the comtemporaries of his early manhood would have seemed miraculous. He may