population 710 000, with an estimated 2500 severely mentally handicapped persons, a number of them present a need for intensive nursing over varying periods, in addition to psychiatric problems associated with their handicaps. These people come to the mental handicap hospital and fall into four categories.

(a) *Rehabilitation* – people with learning difficulties from community residences who have sustained serious limb fractures and have not made progress in busy general hospital departments.
(b) *Therapy for particular problems* – for example, a large pressure sore and a rare skin disorder, Grover's disease.
(c) *Care of patients discharged* from general hospitals who are transferred for continuing care.
(d) *Terminal care patients* who need nursing with attention to general health, feeding, care of bladder, bowels, skin, control of pain and infection.

A team approach brings the knowledge and skills of various professions to help these patients:

(a) Medical cover – consultant psychiatrist, general medical practitioners.
(b) Nurses trained and experienced in handling mentally handicapped patients.
(c) Physiotherapy – suitable chairs, mobility aids.
(d) Nutrition – feeding, supplements, dietetic advice.
(e) Medication, dressings – advice from pharmacist.
(f) Control of infection.
(g) Support from visitors, League of Friends, chaplains.

Special equipment, for instance, alternating pressure air mattresses, is invaluable.

Conditions in need of the care above can rise suddenly, such as strokes and accidents or, more insidiously, physical and mental deterioration, immobility, heart and lung disease, dementia and cancer. In planning services, the needs of the patients described here are at risk of being overlooked. A local National Health Service-staffed facility can bring together economically the expertise and care necessary.

DOUGLAS A. SPENCER

Meanwood Park Hospital
Tongue Lane
Leeds LS6 4QB

Jaspers' psychopathology

SIR: It is laudable that P. J. Harrison (*Journal*, August 1991, **159**, 300–302) undertakes to encourage trainees to read Karl Jaspers' *General Psychopathology*. Many psychiatrists, and especially trainees, are reluctant to start reading this bulky and arguably 'difficult' volume. It is, however, important not to start reading this seminal book with the wrong expectations.

One needs to be aware that the historical impact of Jaspers' book is mainly due to its publication at a time when psychiatrists were at pains to prove that scientific methods were at hand which would give psychiatry a respectable position alongside other medical specialties. Jaspers proposed a methodological basis of psychopathology, and the emphasis of his book is thus an epistemological one. This explains the main difference from the usual psychiatric textbooks.

Jaspers is not integrating all philosophy and psychology into psychiatry but rather, special brands of them: the South West German school of Neokantianism (Max Weber in particular), Edmund Husserl's philosophy of the 'Logical Investigations', and the elementary and associative schools of psychology in the wake of Wilhelm Wundt. Like Wundt, he was convinced that the human psyche is best studied by starting to analyse its constituent parts. From Weber he took the concept of 'ideal types' in order to develop nosology. He transformed Husserl's phenomenological method into an idiosyncratic part of his psychopathological system concerned with the study of patients' subjective experiences.

Thus, Jaspers' view is shaped by the sources he drew from. His book is biased towards the epistemological view that natural science should be the mainstem of an approach to psychopathology, and that psychological phenomena can be described by a reductionist analysis of complex psychic reactions and experiences. Jaspers does not focus on the perspective of the observing subject but assumes an uninvolved, 'neutral' subject. This assumption of the primacy of the scientific perspective is, in our opinion, the main reason why Jaspers' book should be read not as a 'bible' but critically and 'against the grain' as one possible perspective on psychopathology. There are now clinically and epistemiologically different approaches (e.g. Conrad, 1952, 1958; Habermas, 1972; Devereux, 1978; Vygotsky, 1978) which draw on the methods of Gestalt analysis and concepts such as intersubjectivity, making allowance for the role of the subjective and participant observer. Comparing and contrasting them with Jaspers' work enables one to develop an in-depth

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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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MICHAEL LANGENBACH
ALAN S. LEE

Department of Psychiatry
University Hospital
Queen's Medical Centre
Nottingham NG7 2UH

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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S. M. BENBOW
A. MARRIOTT
G. DAWSON

York House
Manchester Royal Infirmary
Oxford Road
Manchester
M13 9BX

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

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