with adults. I am sure this is no less relevant dealing with children and adolescents. The danger lies in the risk that aspects of the therapist's own internal world may intrude into the therapeutic relationship. It is seldom possible for residential workers to have a personal analysis, but the restriction of verbal and non-verbal interventions and communications to those of the Rogerian type reduces the extent to which counter-transference phenomena influence the transactions.

While some of the need for extensive training is reduced and technical problems are less pressing, the Rogerian technique is a difficult one to master. A tape recording of any session shows how often one fails to make a non-directive reflection of feeling communication. With children and adolescents in residential care there is a need to meet the very real demand for directive interactions. I have not been able to resolve this conflict. While his technique is a valuable one, Rogers' theory of personality on which the technique is based is less useful and in no way supplants classical analytical concepts. This type of technique used by lay therapists with appropriate support is one way in which the huge demand for psychotherapy can be met.

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THE TERM 'PSYCHOSIS' AND GLOSSARIES OF MENTAL DISORDERS

DEAR SIR,

It is not surprising that Dr. McCormick (*Journal*, June 1975, **126**, p. 593) has difficulty with the definition of the term 'Psychosis'. Many people think that this is a useful term until they begin to ask their colleagues; they then discover that almost everybody has a slightly different shade of meaning from his neighbour, and it soon becomes evident that it is impossible to produce a definition which is generally acceptable.

In his comments, Dr. McCormick does not do justice to the 1968 glossary, in that by shortening an apparent quotation he has over-simplified it. The full quotation from the Introduction to the 1968 *British Glossary of Mental Disorders* reads as follows (I have italicized the words left out by Dr. McCormick):

> 'No precise definition of "Psychosis" has been proposed in this Glossary. No such definition is required *for the effective use of the classification.' To many psychiatrists* the so-called psychoses have this in common, that they are largely due or are supposed to be due to an organic process.

The 1968 introduction was in no way suggesting that the term 'Psychosis' can be satisfactorily defined, but simply that for the use of that particular classification it was not necessary to make such an attempt. The Introduction goes on to say: 'On the other hand not all mental disorders ascribed to brain lesions are described as psychotic. There are, for instance, personality disorders due to brain lesions which do not fall into any of the so-called "psychotic" categories.' This point is a good example of the complications which would arise if attempts were to be made to assign a simple meaning to a term with a long and difficult history.

There is a rational and simple solution to the problems set by words such as 'psychosis', which is simply not to use it as a technical term in diagnostic classifications. The term does, of course, have its uses as a general indicator of such qualities as severity, abnormality and disability, and those who wish to retain it in their own frame of reference should be requested to say what they mean by it whenever it appears.

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REGIONAL ADOLESCENT UNIT

DEAR SIR,

Many in adolescent psychiatry will agree with Dr. Framrose that there is a need for an increased number of specialized units for young people with whom existing units cannot cope (1). While not disagreeing, I believe this point of view needs qualification.

It is not uncommon for such adolescents to be identified as a group and special units of one sort or another proposed to 'contain' them, even though these children may have little more in common than the fact that the local adolescent unit is unable or unwilling to admit them. When they are not accepted for admission there is understandable frustration and resentment on the part of those who have made the referral, particularly when alternative offers of help which may be made are unacceptable (2, 3, 4). After all, the person making the referral may feel, reasonably enough, that everything short of admission has been adequately tried. This may be one reason why residential units came first in adolescent psychiatry, other services being a more recent development and still relatively rare (2), in contrast to the history of services for younger children.

As Dr. Framrose points out, what evidence there is suggests that psychiatrists are fairly successful in identifying (as neurotic or psychotic) those adolescents they are able to help by admission to their units. At Long Grove we are finding that the most urgent and pressing requests for admission tend to be on behalf of those boys and girls whom, like Dr. Framrose, we feel that admission to the unit will least help. The majority of these requests come from social workers (5). That this sort of referral is showing a slight decline within a rising total referral rate could indicate some degree of acceptance of alternative help we offer; but a more significant factor, probably, is the feeling that 'it's not worth trying to get anyone in *there*'.

I think there is a danger of 'placement' being seen as something of a panacea for impulsive, aggressive, unhappy young people who won't do as they're told. I am sure there is indeed a need for more residential accommodation for this group, but plans for such provision should be within the context of developing adolescent *services*, within which adolescent *units* would play a significant but perhaps quantitatively minor part. I do not think we yet know what different sorts of residential regime these children need, nor the part psychiatry should play in their management; but I think it can be predicted with reasonable certainty that special units set up in isolation from a comprehensive and flexible service will very rapidly fill up, acquire waiting lists and in their turn become selective.

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