handicap. Families struggle on and hospital admission is sought when a crisis occurs. An earlier and closer psychiatric appraisal can anticipate family breakdown and incidentally obtain much valuable information for epidemiological studies and for the provision of services.

There will continue to be a place for a consultant specializing in the psychiatry of mental handicap. His future role will be much less hospital-based and biassed and will involve a wider commitment in the community and in health care management.

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DEAR SIR,

I have not always been in agreement with Dr. Alex Shapiro (*Journal*, May 1975, **126**, p. 481), but in relation to the recent correspondence with Albert Kushlick I must confess that Shapiro talks with that sad sense that is based on experience, especially sad when a once viable hospital provision (albeit with its defects) is allowed to 'grind to a halt. Compared with him Kushlick and Blunden, *Journal*, May 1975, **126**, p. 487) sound like singers in an opera composed in cloud-cuckoo land (presumably sited near the Elephant & Castle).

In Scotland, fortunately for the 'patient' and the parents, the hospital service is still preserved and even strengthened. From what I hear on my infrequent visits to the 'affluent South' the hospital service is in a state of rack and ruin with nursing figures in some hospitals 30 per cent under establishment.

The problem really relates to two different Government polices: (1) to separate Social Work from Health; and (2) to run down mental handicap hospitals before any adequate provision exists in the community. My own catchment population is something around 625,000 but the community based residential accommodation is 18 places (males only).

I have come back to the idea once favoured I think by the N.S.M.H.C., namely a single service for the mentally handicapped, centrally funded and analogous to the excellent service that existed in Northern Ireland until our present 're-organization'.

I know there are arguments against this (see T. D. Hunter, 1973), but as the split between health and social services seems likely to last 5, 10 or even 15 years I think we should seriously reconsider this concept of a single service, centrally funded, which would be quite outside the N.H.S. and the Social Work Services. For one thing, I think an imaginative jump like this might alter the trend in nursing and medical staff recruitment and, more important, offer some prospect for improved services to 'patients' and parents not in the year 2000 but perhaps even before 1980.

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REFERENCE

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TECHNIQUES OF PSYCHOTHERAPY WITH CHILDREN

DEAR SIR,

A technique of psychotherapy suitable for once-a-week sessions in Health Service out-patient clinics was described by Dr. Haldane last month (*Journal*, May 1975, **126**, p. 469). The psychotherapeutic method discussed was based on the work of Carl Rogers in individual and group therapy with adults. The application of Rogerian techniques to work with children has been developed and described among others by Axilene (1947).

For the past two years I have been applying Rogerian techniques in several residential child care establishments, one of them being the Church of England Children's Society unit for children who have experienced fostering or adoption breakdowns and who need a therapeutic programme before they can be introduced to another placement. Individual and group sessions are carried out and residential and field social workers have been introduced to Rogerian techniques through the in-service training programme. So far evaluation of the results is based on subjective judgements. During the operation of the unit there have been no failures in subsequent placements and children who came into the unit with signs of acute disturbance have all made adequate or satisfactory adjustments in their eventual long-term placement.

It is unrealistic to expect that more than a tiny minority of the 5,000 children a year dealt with by the Society could receive psychotherapy in Child Guidance Clinics or Young Persons' Units, due to the desperate shortage of psychotherapeutic time within the Health Service. But I have found that field and residential social workers have been able to develop a Rogerian psychotherapeutic skill in a way which would never have been possible with conventional psychoanalytically based psychotherapy.

Dr. Haldane refers to the dangers of the latter technique used without adequate training in work

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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REFERENCE

AXILENE, V. (1947) *Play Therapy*. New York: Ballantine Books.

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.