the abdomen. The problem, as your leading article points out, is to get junior staff to be sensitive to the need for pain relief and to practise what many of us have preached for so long.

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¹ Dudley, H A F (editor), *Hamilton Bailey's Emergency Surgery*, 10th edn. Bristol, John Wright, 1977.

SIR,—In your leading article (3 November, p 1093) "Analgesia and the acute abdomen" you state that the urgent relief of pain is unlikely to do harm by delaying diagnosis. You praise a more leisurely approach towards diagnosis, and suggest that young surgeons may find diagnosis easier in a sedated patient. Undoubtedly your approach is more humane for the majority of patients; but what a disservice you have done for a minority, who may develop gangrenous or perforated bowel with the attendant considerable morbidity which can occur with delay. Prevention by anticipation and prompt action is the best management. Early diagnosis in just these cases is often not easy and there are some patients, albeit perhaps few, in whom this will be more difficult following analgesia. In the majority of patients with severe abdominal pain a surgeon of reasonable ability will be able to arrive at a quick diagnosis and the problem of giving analgesia will not arise.

You are right, however, in drawing our attention to the delay in seeing the surgeon, and I would suggest that emphasis should be placed on solving this administrative problem rather than advocating analgesics inappropriately. I submit that many of the explanations given for these delays are tenuous. Attitudes and the sense of priority for such patients must change, but the responsibility rests with those at the top.

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Policies on self-poisoning

SIR,—Your leading article "Policies on self-poisoning" (3 November, p 1091) rightly points out that junior doctors are now better trained in psychiatric matters than they were at the time of the Hill Report.¹

So, again, you are right to suggest that physicians should decide in individual instances whether "a psychiatric opinion" is necessary. This does not alter the intention that in every instance a psychiatric evaluation (involving history and mental examination) is necessary, but recognises that such an evaluation falls within the abilities of every doctor.

I am quite sure that it is possible to train other professional workers to conduct part of such evaluation, either on their own or as part of a team; but it would be wrong for doctors to relinquish their proper responsibility for deciding diagnosis and the need for treatment.

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¹ Ministry of Health, Scottish Home and Health Department, *Hospital Treatment of Acute Poisoning*. Report of the Joint Subcommittee of the Standing Medical Advisory Committees. London, HMSO, 1968. (Hill Report.)

Physical indicators of emotional abuse in children

SIR,—Emotional abuse of children is a relatively recent concept about which very little is known, as most of the time and effort of research workers and clinicians has been taken up by the more pressing problem of physical abuse.¹

Emotional abuse is, however, a more serious problem as it could be more damaging than physical abuse and is certainly far more difficult to detect, prevent, or treat. It is not a single condition, but a whole range of maltreatment which is closely entangled with physical abuse. It describes an abusive environment rather than an abused child. That is why there is no one recognisable or constantly identifiable clinical picture which is diagnostic of emotional abuse.² There are, nevertheless, some attempts to describe behavioural syndromes which abused children repeatedly show. One of the earliest attempts is that of Ounsted,³ who described what he called "frozen watchfulness." MacCarthy said that the emotionally deprived infant or young child is "floppy, apathetic and may show frozen watchfulness."⁴ A recent attempt was made by me. I described a sign which I repeatedly noticed in older children who are emotionally abused by their parents.^{1 5} I called this sign "maintaining a cowering attitude in the presence of adults." A child in a cowering attitude backs away from adults and looks at them carefully and secretly, with his left arm half raised and ready to move in order to protect his face from unexpected physical or verbal assault.⁶

As I am currently interested in the recognition of physical indicators of emotional abuse in children, I would be very grateful for comments from your readers on this sign. I am particularly interested in whether other clinicians noticed this sign in this group of children and how often they have seen it.

I would also be very interested to know of any other physical indicators which other clinicians may have noticed in their daily dealing with this group of unfortunate children.

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¹ Guirguis, W R, in *Second International Congress on Child Abuse and Neglect* (abstracts). Oxford, Pergamon Press, 1978.

² Kolvin, I, in *Child Abuse: A Study Text*. Milton Keynes, Open University Press, 1978.

³ Ounsted, C, in *Psychiatric Aspects of Medical Practice*. London, Staples Press, 1972.

⁴ MacCarthy, D, in *Second International Congress on Child Abuse and Neglect* (abstracts). Oxford, Pergamon Press, 1978.

⁵ Guirguis, W R, in *Proceedings of the International Conference on the Child Under Stress*, Monte Carlo, 1978 (unpublished).

⁶ Guirguis, W R, *Psychiatric Symptomatology*. London, SK and F Publications, Origen Communications, 1979.

Affective disorders in alcoholic women

SIR,—There has been a tendency in the United Kingdom to neglect the link between affective states, drinking alcohol, and patients with alcohol addiction or drinking problems. A survey of 100 consecutive female patients in Manchester referred with drinking problems found that 36 were suffering from severe depressive symptoms at the time of initial interview requiring psychotropic medication. Twelve of the 36 had a history of previous depressive illnesses requiring professional

advice. In the vast majority of the 36 patients the referral letter drew attention to the drinking problem and ignored the depressive episodes. Twelve of the patients had experienced a recent bereavement and 23 were living alone.

It would seem that in women there is a common link with depressive states and alcoholism—a view supported by studies in the USA—and treatment of both the depressive state and the alcoholism is necessary. This can sometimes cause difficulties as some psychological methods of treatment of alcoholics are opposed to the use of psychotropic drugs. In my view, however, this view has to be resisted and treatment both to improve the drinking problem or alcohol addiction and to relieve the depression has to be carried out. It is also important to note that with the increasing emphasis on the diagnosis and counselling of alcoholics and problem drinkers in the community by voluntary trained counsellors, as has been advocated in various reports, it will be essential that such lay counsellors have the support of professional staff who will enable them to deal satisfactorily with recognition and treatment of such patients.

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Planning for the old and very old

SIR,—Your leading article on this topic (20 October, p 952) concludes, "... with clarity of thought and uniformity of application of well-defined principles substantial improvements are possible without any greater expenditure of resources." While improvements are certainly possible, I would suggest that most of your proposals will be neither inexpensive nor indeed helpful.

Firstly, many of the recommendations significantly increase spending: extra training and staffing in residential homes could well cost £10m a year and hostels for mentally disordered old people will have to be funded somehow. Further, there will be few savings from transferring residents from homes to sheltered housing. It has been known since Wager's work¹ that, where necessary domiciliary services are provided, the total costs of sheltered housing are usually no less than for homes.

Secondly, uniformity (in such matters as the admission criteria you mention) is neither possible nor desirable. It is impossible because of the significant differences between areas in the number and quality of long-stay places for the elderly, whether they are in homes or in hospitals. It is undesirable because, leaving aside differences between homes in their abilities to cope with the frail elderly, new approaches to the management of long-stay places are vital. With uniform admission criteria we should not have the innovations that have emerged such as forms of short stay and liaison arrangements with geriatric and psychiatric hospitals.²

This is an argument not for anarchy but for a careful assessment of the services for the old in each individual locality. Such assessments could lead to appropriate agreements about operational practices (including admission and discharge procedures) in the short term, and for the longer term could lead to priorities for expanding services, whether