left alone." He states that his consultant neurologist was of no more use to him than the milkman. These statements do not accord with my own experience of this dreaded disease.

In May 1973 my patient, a healthy father of three, developed pain in his knee. This was soon followed by localised muscular fasciculation and the dread diagnosis of motor neurone disease. I did not tell my patient and he proceeded bravely until he needed the help of a wheelchair. I told his wife the diagnosis and she was adamant that her husband must not be told.

In 1974 came the exciting news that Professor Albert Cook¹ had successfully arrested the progress of motor neurone disease by electrical stimulation of the spinal cord. He had re-established central transmission and three patients had shown significant improvement in voluntary muscular performance. His work followed the original discovery of Illis that regeneration in the central nervous system could occur at the synaptic junction.^{2,3}

My patient was enthusiastic and Professor Cook offered to treat his motor neurone disease by electrical stimulation if I could get him to New York. Our local Lions Club and their Brooklyn counterparts sponsored his visit. Massive press publicity evoked a tremendous response. My patient was flown in his wheelchair to Long Island College Hospital, where two electronic dorsal column stimulators were inserted into his spinal cord. He met patients who had received similar treatment. A newsletter listed every patient in the United States who had received the same electronic stimulation. Some of those with amyotrophic lateral sclerosis reported improvement in their motor function. My patient returned to this country full of hope. I lectured with him at various medical meetings, where he was happy to tell his audiences of his operation and to demonstrate the intricacies of his electronic stimulator. He continued to report and discuss progress with other patients in the United States. Unfortunately the condition progressed, but he never lost hope. He was sure that he would ultimately win. He died suddenly in September 1976 but the day before his death had a wonderful time visiting friends with his family.

Following his death Professor Illis established a similar unit to provide electrical stimulation for progressive lesions of the spinal cord. My patient died a happy man and his family hopes that his experiences will help in the future management of motor neurone disease.

KENNETH T FARN

Atherstone, Warwicks CV9 2PE

¹ Cook AW. *Lancet* 1974;ii:230-1.

² Illis LS. *Lancet* 1973;i:1035-7.

³ Cook AW. *Lancet* 1973;i:1442-3.

ECT: balancing risks and benefits

SIR,—Professor D A Pond (9 February, p 403) suggests possible circumstances in which unmodified electric convulsion therapy (that is, ECT without concomitant anaesthesia and muscle relaxation) might still be used. He fails to convince us, however, that such an anachronistic approach to the treatment of disturbed patients has any place whatsoever in contemporary British psychiatric practice.

We believe that it is essential that a clear statement is made on this matter both for the peace of mind of our patients and their relatives

and for the good name and reputation of British psychiatry. We believe that further use of unmodified ECT would be indefensible and that it should be removed from consideration as a treatment approach in any circumstances. We see no need to modify the detailed guidelines on ECT issued by the Royal College of Psychiatrists in 1977, guidelines which nowhere mention the unmodified form of treatment.

PAUL BEBBINGTON
D H BENNETT
J L T BIRLEY
ANTHONY W CLARE
J CUTTING

Maudsley Hospital and
Institute of Psychiatry,
London SE5

Bethlem Royal Hospital,
Beckenham, Kent

R KUMAR
A H MANN
PAUL MULLEN
MARIAN RON
PAUL WILLIAMS

Residential homes for the elderly: arrangements for health care

SIR,—The DHSS circular on residential homes for the elderly¹ was not circulated to appropriate consultants or family doctors in the Health Service. In some respects the advice is good, but it does contain suggestions with which the medical profession would take issue.

The circular proposes that residential homes should no longer have a family doctor who is paid a retaining fee to give general medical advice. The idea that elderly residents should have their own doctors is laudable, though it can cause problems when there are 40 residents with 20 different doctors. A more important issue is the apparent intention to reduce the amount of nursing in these homes despite the general tendency for them to be asked to admit an increasing number of physically and mentally frail people, as the fitter individuals are more happily and appropriately accommodated in warden flatlets or bungalows. Nurses who become residential care officers, however deinstitutionalised we hope they are, will still rightly enjoy carrying out small nursing duties for the residents in the homes who have become their friends. Indeed, such nursing duties may have been a factor in their decision to apply for the post in the first instance. They are in a unique position to draw the doctors' attention to the atypical symptoms of serious illnesses in the elderly. As residents become increasingly frail other residents and the staff will be happy for them to remain so long as simple nursing procedures, such as the dressing of ulcers, giving injections, and introducing catheters, can be carried out satisfactorily. The district nursing service is overstretched and has difficulty in providing the frequency and continuity of care that is so important in the elderly, and those in the community will be given priority in times of shortage. The BMA has proposed that every home should employ one trained nurse who is responsible for the nursing care of the residents.²

It has frequently been argued that domiciliary physiotherapy is a waste of skilled physiotherapists' time. This view has now been challenged by Partridge and Warren.³ In the case of the residential home this argument cannot be sustained as at least one session a week could be fully occupied with individual referrals. A physiotherapy service is important in maintaining the residents' mobility but is still

more important in ensuring that the elderly with acute chest infections in the winter are treated adequately. The suggestion of transporting these people to a physiotherapy outpatient department for this purpose is unrealistic, uneconomical, impractical, and medically dangerous.

I hope that the DHSS will consult the members of the medical and nursing professions who work in residential homes and who have reservations about the wisdom of some of the suggestions made in this circular. If the policy is not reversed many happy residents will have to be hospitalised unnecessarily, to their personal detriment and that of the NHS and social services.

J ANDREWS
Consultant physician to
geriatric service, Hounslow
Health District

West Middlesex Hospital,
Isleworth, Middx TW7 6AF

¹ Department of Health and Social Security and Welsh Office. *Residential homes for the elderly: arrangements for health care. A memorandum of guidance.* London: DHSS, June 1977.

² General Medical Services Committee. *Report of the General Medical Services Committee to the annual conference of representatives of local medical committees, 1976.* London: British Medical Association, 1978.

³ Partridge CJ, Warren MD. *Physiotherapy in the community.* Canterbury: Health Services Research Unit, University of Kent at Canterbury, 1977.

Psychoanalysis, psychotherapy, and health services

SIR,—Dr B Barnett letter (26 January, p 249) appears to be criticising psychiatry, and possibly psychiatrists in general, for a number of failings. He introduces his argument in a general comment about Professor M Shepherd's Personal Paper (15 December, p 1557). It appears that we are to believe that psychiatry is in some way responsible for the continued health hazards of smoking and early teenage pregnancies, and is mysteriously mixed up with the development of social services and the influence of sociology on medical practice in general. It would have been helpful to learn what Dr Barnett feels should be done in order to combat these various problems connected with health. How can psychiatry be on the one hand so powerful that we could assume that it *could* combat these problems which have defeated everybody else, and yet so weak as to be useless?

Dr H A C Mason's letter in the same issue (p 248) is a personal contribution of much interest; I must admit to some bias here since Dr Mason taught me for several years. The two approaches highlight a problem. One offers evidence and personal contribution, the other appears to be a general expression of some feeling or another which, if I am not allowed to use any psychological theory to explain it, must remain obscure in origin.

I have found psychotherapy and the psychoanalytical theories extremely valuable in understanding psychiatric syndromes. I have found in selected patients that psychotherapy works where other treatments which I also use have failed. I do not know what this means and am inclined to an empirical view about all treatment in psychiatry at the present state of knowledge. From my experiences of working in a peripheral psychotherapy clinic entirely within the National Health Service in Plymouth I have found patients referred from many sources who have both had all the usual range of

treatments and have benefited greatly by psychotherapy. That, of course, is not to say that all psychiatric patients should automatically receive psychotherapy; it may well be that psychotherapy is suitable for some people as a treatment method, or it may be that psychotherapy is suitable for certain psychiatric conditions or stages in their evolution or devolution. Nevertheless, unless research continues and evidence continues to be collected either for or against the argument in a scientific way we shall never know the answer. My colleagues and I in Plymouth are preparing a paper concerning our experiences in our psychotherapy clinic, which I hope will be ready for submission soon.

I feel that the tradition in British medicine of allowing treatments to evolve and to see the outcome in clinical practice has always stood the test of time. The theories later produced may or may not be accurate. We should be swayed by the evidence of effectiveness in the clinical setting rather than by opinions, no matter how carefully thought out, from our own heads. I cannot believe that colleagues in the general hospital and in general practice would continue to refer patients for psychotherapy were they to feel that patients did not benefit, nor do I believe that our patients are so stupid as to continue with a form of therapy which requires a high degree of concentration, hard work, and dedication if they did not derive some benefit from it.

From the practical point of view, until we have a Coulter counter, computed tomographic scanner, or multiple analyser to investigate feelings and emotions it seems likely that we shall have to keep listening to our patients. Psychiatrists will fail as we all do in medicine at times; some psychiatrists will let down their colleagues and patients. Some of those psychiatrists will practice psychotherapy. We are all prey to human failings but that is a different argument from that concerning the scientific or artistic merit of the methods we are trying to use. Perhaps we can learn the answers by studying our patients rather than the agenda of the next committee meeting? If the medical profession has lost respect and influence in the field of human behaviour we are unlikely to regain it by futile demarcation disputes with colleagues, but we may regain it through demonstrating our worth to our patients.

I suggest that more and not less investigation of the psychotherapeutic contribution is indicated and we should not be put off because that is a greater challenge than physical observation and experimentation.

W C HUGHES

Moorhaven Hospital,
Ivybridge, S Devon PL21 0EX

SIR,—I have just read Professor M Shepherd's paper "Psychoanalysis, psychotherapy, and health services" (15 December, p 1557). In the penultimate paragraph he refers to family therapy as "less specialised" than psychotherapy. This is not so. It is, however, an alternative, particularly when children or adolescents are involved.¹ Evidence for its efficacy is probably stronger than that for individual therapy² and there is great scope for it in child psychiatry and social work. I think that the experience and role of the health visitor is also an excellent basis from which to develop family therapy skills but, as

with psychiatrists and social workers, advanced training is essential if effective help is to be given. Just interviewing families is not family therapy.

SEBASTIAN KRAEMER

Department for Children and Parents,
Tavistock Clinic,
London NW3

¹ Bruggen P, Davies G. *Brit J Psychiat* 1977;**131**:433.
² Well R, Dezen A. *Family Process* 1978;**17**:251.

Services for the mentally handicapped

SIR,—Dr Neil Gordon questions the need for consultants in mental handicap (9 February, p 403). He rightly comments that many of the problems of these patients are social and educational and that increasing contributions are being made to their care from these other services. However, despite this my experience over the past 10 years has been that there is an increasing demand for my contribution as a consultant psychiatrist (mental handicap) for help with diagnosis, assessment, treatment, and prevention.

An analysis of a sample of 233 cases seen in outpatients showed an age range of 1 month to 70 years, 113 being 16 or under. One hundred and twenty-five were male. More than half the cases (120) were referred from medical sources—general practitioners and school medical officers, and 44 from consultants (20 from paediatricians, 18 from psychiatrists, three from neurologists, two from physicians, and one from an orthopaedic surgeon). Social workers referred 111 cases.

By far the commonest reason for referral (134 cases) was behavioural abnormality: aggression in 23; sexual misbehaviour in 18; psychiatric symptoms in 27; tantrums and screaming in 18; disturbances of eating, sleeping, bowel, and bladder control in 29. Hyperactivity, destructiveness, wandering, and obstinacy also occurred frequently. Most had more than one abnormal behaviour and commonly another major problem; for example, of the 23 aggressive patients, 11 suffered from epilepsy. Court reports were written on 14 patients (eight cases of sexual offences, six of theft). Other reasons for referral included delayed development; epilepsy; genetic counselling, and help in the elucidation of causes of physical symptoms. Help was sought in deciding the most suitable placement for occupation or residence in 65 cases. Seventy-six patients were admitted to an assessment unit¹ for diagnosis and treatment. Eighteen of the children were admitted to long-term hospital care (six had been referred by paediatricians). Some of these have died or been discharged but 20 of the total group remain in long-term hospital care.

Most consultants in mental handicap would recognise this as similar to their own work load—and very dissimilar to that of a paediatrician or a child psychiatrist, although there are areas of overlap. It is also important to have access to special facilities. The residential assessment unit to which the patients were admitted is in a hospital for the mentally handicapped and has a multidisciplinary staff team. As well as my work in this unit I have under my care 400 long-stay hospital residents, many of whom require continual consultant psychiatric clinical care.² My work includes teaching medical postgraduates, nurses, social workers, and others; there are case conferences and staff meetings as well as the administrative duties, which include hospital and divisional meetings. I visit community establishments and am involved in forward planning.

My work in a child guidance clinic and close contact with child psychiatric colleagues suggests that the pattern of working does not cater adequately for the needs of many mentally handicapped and their families. Often

the only source of help is through the school. There are many child psychiatrists who have little interest in the organic deficits of their patients and there is as yet little evidence that they are widening their work load to include the mentally handicapped or that this will happen in the future. The biological, physiological, and psychiatric abnormalities in many of these patients require very special skills from their doctors.² Their medical care must be a collaborative exercise but we should widen the training of both psychiatrists and paediatricians to include more experience with them.

Our local rotating psychiatric registrars spend six months based at a long-stay hospital with a programme which includes regular weekly attendances at a paediatric assessment centre, outpatients, and visits to community facilities. Paediatricians in training might also devote some of their time to gaining experience in the medical care of the children who are in mental handicap hospitals as they are a particularly severely handicapped group.

I hope that the creation of the first chair in mental handicap at St George's Hospital, London, will provide further stimulus to psychiatrists and other specialists in this field, and to future developments.

R M WALTERS

Stoke Park Hospital,
Bristol BS16 1QU

¹ Wiley Y. *Apex* 1975;**3**:22-3, 26-7.

² James FE, Snaith RP, eds. *Psychiatric illness and mental handicap*. London: Gaskell Press, 1979.

SIR,—In general I agree with the views of Dr Neil Gordon (9 February, p 403) on services for the mentally handicapped. Those of us who have worked in mental handicap hospitals for a long time will realise from time to time how ineffective the service has become. This is mainly because of: (a) the absence of a clearcut definition of "mental handicap" and the aims of the service; (b) not knowing who should have the ultimate responsibility for this group of people—hospitals or social services; (c) the fact that the defects these people are suffering will last all their lives, so it has to be decided whether they are to benefit from a hospital service with drugs, etc, or by gradually improving their learning abilities with special education and social training in a residential school setting. One has to realise that "mental handicap" is not a disease; it is not even a syndrome—it is only a clinical "state of mind." Until we find some curative treatment for this state we can only try to ameliorate the severity of the symptoms and render them tolerable to the patient and society at large.

The present system of psychiatric treatment in National Health Service hospitals functions in a dichotomy of (a) mental illness and (b) mental handicap, but both are medically manned by psychiatrists and very often there is very little or no discourse between these two groups of medical people. The fact is that anyone with mental handicap is very likely to suffer emotional and behavioural disorders, and therefore an integrated service practising "comprehensive psychiatry" is essential for a service to be productive. I do not think paediatricians are of much help once the child has developed some emotional and behavioural disorder, and psychiatrists must equip themselves to cope with such cases. Too many cooks spoil the broth and so one, and only one, psychiatrist should deal with a