situation. I should point out, however, that even at that time there was considerable worry among those working there as to whether these efforts would be enabled to continue and I can only hope that they have done so as I have not been able to visit the hospital again since that time. We were also very pleased to see some of the hostels on the Greek mainland to which patients from Leros had been transferred but were nevertheless worried as there seemed to be some reluctance on the part of the authorities to continue with this encouraging development. We were also saddened to find that, although the official recommendation from the EC was that the old hospital should be closed and gradually phased out, several new buildings were being erected on the site.

There was one further point which was raised in the letter to you; that the embargo on new admissions to Leros was in fact introduced by the Greek government in 1981 prior to our first visit in 1983. The point I was making, however, was that I personally have no doubt that the maintenance of that embargo was largely due to the influence coming from the EC intervention. Indeed, to my knowledge there has been some slippage in this regard and a small number of new patients have in fact been admitted to Leros from surrounding areas.

I hope these remarks go some way to clear up the confusion and inaccuracies in my interview which were due to the time at which this was carried out, with the inevitable delay between then and its publication.

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(*In future the dates of interviews will be added. – eds.*)

'Family therapy in the training of general psychiatrists'

DEAR SIRS

I read with interest the article by Drs Wilkinson & van Boxel on family therapy experience in the training if general psychiatrists (*Psychiatric Bulletin*, 1992, **16**, 790–781). I agree with all they say about the importance of such experience for trainees and the specific skills which can thus be acquired.

There is also a role for systemic family therapy in adult psychiatry as a treatment modality (Bloch *et al*, 1991; Macdonald, 1992). In our own brief therapy clinic we see unselected adult referrals from general practitioners and others. The team has been established for four years and offers strategic and solution-focused therapy. Contact with us is usually brief, 12 sessions being the maximum but four the average. Clients or referring agents report satisfaction after one year in two-thirds of our cases. Junior medical staff have commented on the value of experience in this style of working. A detailed follow-up study is in progress and will be reported in due course.

This appears to be a cost effective way of providing treatment for a wide variety of disorders as well as introducing staff to the techniques of family assessment referred to by Drs Wilkinson & van Boxel.

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Cognitive therapy in literature

DEAR SIRS

In 'Cognitive therapy and Winnie-the-Pooh' (*Psychiatric Bulletin*, 1992, **16**, 758) Dr Hosty draws attention to principles of cognitive therapy in *Winnie-the-Pooh*. The work of other artists and writers also contained some of these principles, long before the development of cognitive therapy.

In *Nicholas Nickleby*, the "genius of despair and suicide" uses cognitive techniques to prevent the Baron von Schwillenhausen from committing suicide. Dickens concludes: "And my advice to all men is, that if ever they become hipped and melancholy from similar causes (as very many men do), they look at both sides of the question, applying a magnifying glass to the best one . . .).

In a letter to his brother, Theo, Vincent van Gogh writes, "My head is sometimes heavy and often it burns and my thoughts are confused, – I don't see how I shall ever get that difficult and extensive study into it – to get used to and to persevere in simple regular study after all those emotional years is not always easy. And yet I go on; if we are tired isn't it then because we have already walked a long way, and if it is true that man has his battle to fight on earth, is not then the feeling of weariness and the burning of the head a sign that we have been struggling? When we are working at a difficult task and strive after a good thing we fight a righteous battle, the direct reward of which is that we are kept from much evil."

As Freud did not discover the unconscious, Aaron Beck did not discover the principles of cognitive therapy. His great achievement was rather to recognise their importance, offer a comprehensive list of cognitive errors or faulty assumptions and describe in detail therapeutic interventions to challenge and

correct such assumptions. These therapeutic methods could be learnt by other therapists, and evaluated scientifically in follow-up studies.

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Mental health legislation and the practice of psychiatry

DEAR SIRS

The letter from Dr McNicholas (*Psychiatric Bulletin*, 1992, **16**, 568–569) makes compelling reading. Her focus appears to be on the cost factors as primary predictors of treatment within the mental health arena, and indeed in some cases this is certainly the case. However, one factor which she failed to mention is the influence of mental health legislation upon the practice of psychiatry. Although not working in the United States, I can speak from a Canadian perspective. The changes that are occurring in mental health legislation here are primarily directed towards the rights of the individual. This is an excellent premise in many areas as it allows greater patient autonomy and a sense of involvement in the treatment process. However, psychotic patients may have very little insight into their disabilities, and they are in danger of avoiding the treatment they sorely need. This most vulnerable and disadvantaged section of the psychiatric population may actually be harmed by their own autonomy in such an instance, and it behoves physicians to advocate on behalf of such patients in an attempt to assure their right to treatment.

Dr McNicholas is correct in her suggestion that all patients should have appropriate care irrespective of cost. We must also attempt to insure that mental legislation is directed toward those most in need.

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Psychiatry of mental handicap – its future

DEAR SIRS

Psychiatrists who work predominantly in mental handicap services are concerned about the development of services for those of their patients who also develop mental and emotional illness. The minority with joint contractual arrangements with general psychiatry and child psychiatric services may not feel anxious about this issue, but the majority of psychiatrists working in mental handicap do not seem to have a clear role or function in the new services. With the reorganisation of the NHS, particularly with the emergence of independent trusts of hospitals and community services, the confusion will, I am sure, turn into chaos.

Already in some areas, in order to get more 'business and finance", general psychiatric colleagues are willing to provide services for mentally handicapped patients with mental illness. If money can be saved by these means, such practices may be encouraged and the integration of psychiatric mental handicap services with general psychiatric services, child psychiatric services, etc, will accelerate.

The principles of normalisation could be manipulated to support such 'integration'. Local authority social services, who have the major responsibility for the provision of services for mentally handicapped people, may also use such cost-saving tactics. Conflict between psychiatric subspecialties arising from the change of policy by trusts will be detrimental to both specialist and general provision for mentally handicapped people and their families.

Does the psychiatry of mental handicap as a distinct subspecialty have a future? Will there be a gradual merger with general psychiatry and other subspecialties? This would certainly adversely affect the training and educational needs of the psychiatrists and ultimately the service for this vulnerable section of society. However, if there is going to be integration of specialised services within the core of general psychiatric services or other specialised services, then there is an urgent need to clarify the role, function and division of the expertise, that is, specialists, psychiatrists, specialist nurses, etc, within these emerging and developing integrated services.

The Royal College of Psychiatrists, particularly the mental handicap, general psychiatry, community psychiatry and child psychiatry sections, should urgently look at this issue and provide guidelines to the profession as well as service providers, and the government.

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MRI on adolescents presenting with schizophrenia

DEAR SIRS

It can now be considered standard practice to undertake brain scanning of adolescents presenting with schizophrenia. Magnetic Resonance Imaging (MRI) offers the best available resolution and the least invasive method.

The chances of a brain scan producing results of immediate clinical relevance to the management of an individual patient are not high. However, we can expect quantitative differences between the brains of adolescents with schizophrenia and those of control