not yet available to explain the aetiology of this disorder.

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Abreaction before ECT

SIR: We would agree with the general point made by Sivakumar *et al* (*Journal*, September 1991, **159**, 444–445), who suggest that the drug-assisted interview (DAI) is a procedure deserving of more attention, but would make a number of observations.

Sivakumar *et al* refer to 'abreactive techniques' as having 'evaluative and therapeutic' potential. DAIs have their roots in both biological psychiatry (narcosis therapies for psychotic disorders (Bleckwenn, 1930)) and dynamic psychiatry (drug assisted 'talking cures', generally based on early cathartic models (Horsley, 1936)). Most therapeutic applications of DAIs are related to these latter psychodynamic approaches to treatment. As we have pointed out, however, the status of abreaction – the free expression or release of previously repressed emotion – within psychotherapy has been debated over many years (Patrick & Howells, 1990). Although results may be dramatic, it is argued that alone it is insufficient to produce lasting change, passing over real areas of difficulty (Bronner, 1955). We think it has been correctly suggested that psychotherapeutic practice involves establishing a relationship in which trust, talk and understanding help a person to accept difficult issues, for which the patient needs to be fully conscious and cooperative (Brown & Pedder, 1979). In addition, several studies confirm that, in the treatment of hysteria, DAIs produce no significantly better results than general psychiatric treatment, although in some instances there may be economy of time (Lambert & Rees, 1944). Thus we would argue that valid *therapeutic* indications are few.

We believe that the mixture of biological and dynamic approaches implied within the term 'abreactive techniques' merely perpetuates uncertainty concerning the underlying intentions and indications of the interview. The term, 'drug-assisted interview' avoids such confusion.

Is there then a place for drug-assisted *diagnostic* interviews in clinical practice? A cautious appraisal of the literature suggests that the DAI may be useful in accessing the inaccessible patient and in the evaluation of disorders with a potential organic aetiology (Dysken *et al*, 1979). In disorders such as stupor, DAIs are no substitute for rigorous examination and investigation (Rashkin & Frank, 1974). They may prove very useful however; such interviews often accentuate apparent cognitive impairment if the aetiology is organic (Weinstein *et al*, 1953), and may lead to dramatic improvement in functional disorders.

This rule may mislead. Not all patients with organic disease worsen under amylobarbitone, and certain organic disturbances caused by organic states, such as substance withdrawal and epilepsy, may be dramatically alleviated (Ward *et al*, 1978). In contrast, if insufficient drug is given, the lack of mental clearing may be falsely ascribed to the presence of organic pathology.

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Special medical and nursing care needs of people with severe learning difficulties

SIR: The large hospitals for mental handicap usually had an infirmary ward for seriously and terminally ill patients. 'Demedicalisation' and 'normalisation' philosophies have prompted the closure of such provision in the belief that mentally handicapped people should be nursed in their own residences or, if they need intensive care, in general hospitals.

In practice, general hospitals are unable to give long-term nursing to people with severe learning difficulties beyond investigation, assessment, diagnosis and treatment of their illnesses. In Leeds,

population 710 000, with an estimated 2500 severely mentally handicapped persons, a number of them present a need for intensive nursing over varying periods, in addition to psychiatric problems associated with their handicaps. These people come to the mental handicap hospital and fall into four categories.

(a) *Rehabilitation* – people with learning difficulties from community residences who have sustained serious limb fractures and have not made progress in busy general hospital departments.
(b) *Therapy for particular problems* – for example, a large pressure sore and a rare skin disorder, Grover's disease.
(c) *Care of patients discharged* from general hospitals who are transferred for continuing care.
(d) *Terminal care patients* who need nursing with attention to general health, feeding, care of bladder, bowels, skin, control of pain and infection.

A team approach brings the knowledge and skills of various professions to help these patients:

(a) Medical cover – consultant psychiatrist, general medical practitioners.
(b) Nurses trained and experienced in handling mentally handicapped patients.
(c) Physiotherapy – suitable chairs, mobility aids.
(d) Nutrition – feeding, supplements, dietetic advice.
(e) Medication, dressings – advice from pharmacist.
(f) Control of infection.
(g) Support from visitors, League of Friends, chaplains.

Special equipment, for instance, alternating pressure air mattresses, is invaluable.

Conditions in need of the care above can rise suddenly, such as strokes and accidents or, more insidiously, physical and mental deterioration, immobility, heart and lung disease, dementia and cancer. In planning services, the needs of the patients described here are at risk of being overlooked. A local National Health Service-staffed facility can bring together economically the expertise and care necessary.

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Jaspers' psychopathology

SIR: It is laudable that P. J. Harrison (*Journal*, August 1991, **159**, 300–302) undertakes to encourage trainees to read Karl Jaspers' *General Psychopathology*. Many psychiatrists, and especially trainees, are reluctant to start reading this bulky and arguably 'difficult' volume. It is, however, important not to start reading this seminal book with the wrong expectations.

One needs to be aware that the historical impact of Jaspers' book is mainly due to its publication at a time when psychiatrists were at pains to prove that scientific methods were at hand which would give psychiatry a respectable position alongside other medical specialties. Jaspers proposed a methodological basis of psychopathology, and the emphasis of his book is thus an epistemological one. This explains the main difference from the usual psychiatric textbooks.

Jaspers is not integrating all philosophy and psychology into psychiatry but rather, special brands of them: the South West German school of Neokantianism (Max Weber in particular), Edmund Husserl's philosophy of the 'Logical Investigations', and the elementary and associative schools of psychology in the wake of Wilhelm Wundt. Like Wundt, he was convinced that the human psyche is best studied by starting to analyse its constituent parts. From Weber he took the concept of 'ideal types' in order to develop nosology. He transformed Husserl's phenomenological method into an idiosyncratic part of his psychopathological system concerned with the study of patients' subjective experiences.

Thus, Jaspers' view is shaped by the sources he drew from. His book is biased towards the epistemological view that natural science should be the mainstem of an approach to psychopathology, and that psychological phenomena can be described by a reductionist analysis of complex psychic reactions and experiences. Jaspers does not focus on the perspective of the observing subject but assumes an uninvolved, 'neutral' subject. This assumption of the primacy of the scientific perspective is, in our opinion, the main reason why Jaspers' book should be read not as a 'bible' but critically and 'against the grain' as one possible perspective on psychopathology. There are now clinically and epistemiologically different approaches (e.g. Conrad, 1952, 1958; Habermas, 1972; Devereux, 1978; Vygotsky, 1978) which draw on the methods of Gestalt analysis and concepts such as intersubjectivity, making allowance for the role of the subjective and participant observer. Comparing and contrasting them with Jaspers' work enables one to develop an in-depth