

This brief note has been prepared to advise psychiatrists of the existence of such a unit of learning and where possible to stimulate its use in the nurse training curriculum and promote such activities in their clinical practice.

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changed by lectures, confrontations or polemics. Mental illnesses and the problems they present will remain. A commitment to serious clinical work may give psychiatrists the opportunity to regain what has been lost.

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Psychiatry in decline

DEAR SIR

Dr Morrison has voiced the thoughts of many psychiatrists on the future of their specialty (*Bulletin*, January 1985, 9, 4-7). The public has never had a confidence in psychiatrists equal to that placed in other medical practitioners. However, they were prepared to put their trust in them. Over the past twenty years, as Dr Morrison points out, an unease and suspicion about psychiatrists and their practice has increasingly appeared. Can this change be attributed to the emergence within the population of 'damaging paranoid forces'? I believe that Dr Morrison identifies the real cause when he says that, 'it is the very nature of psychiatry that undermines our purpose.'

I have held the view for many years that the majority of our colleagues have refused to acknowledge the true nature of mental life and the disturbances which affect it. The wish that pathological mental events could be simply and easily influenced for good has triumphed over reality. Mental events have an inherent resistance to change as is evidenced in perseverative phenomena at the conceptual as well as the sensorimotor level and in the compulsion to repeat. As we have now learned, this inertia, which is so much a feature of mental pathology, cannot be speedily overcome by chemotherapy, by brief or sometimes prolonged psychotherapy, by behavioural methods or by social intervention.

The general public came to believe that psychiatrists possessed remarkable therapeutic powers. Psychiatrists were idealized. Great expectations were aroused. These expectations have not been met and a serious disillusionment with psychiatrists has set in. There is a turning to others who encourage these unrealistic expectations. It is disillusionment with psychiatrists, not paranoid anxieties, which has led to the present disenchantment on the part of the public.

Eleven years ago (*News and Notes*, September 1974, 11) I expressed the fear that great damage had been done to psychiatry because of the erosion of the clinical tradition caused by enthusiasm for natural science methodology and an uncritical advocacy of biochemical theories of mental illness. This damage has been increased by the down-grading of mental hospital practice and the promotion of district hospital and community psychiatry. A generation of psychiatrists has been deprived of the clinical knowledge which was second nature to those of earlier years. The resulting lack of confidence has been sensed by other professions and by the general public enhancing innate fears and doubts about the competence of psychiatrists. It is unrealistic to believe that these attitudes can be quickly halted or reversed. They will certainly not be

DEAR SIR

As Secretary and Finance Officer of the Mental Health Act Commission, I am puzzled by the reference in 'Psychiatry in Decline' (*Bulletin*, January 1985, 9, 4-7) to second opinion psychiatrists earning 'more than £600 a day'.

The Commission provides a second opinion service through some 100 appointed doctors (twenty-one Commissioner doctors and an outside panel of about eighty). During its first year the Commission arranged 2,200 second opinions. Each one costs £46.35 (the standard exceptional consultation fee) plus any incidental travel/subsistence expenses. With a policy of trying to arrange for a second opinion speedily (within two working days for ECT cases), doctors are not often asked to see more than one patient a day.

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Training in community psychiatry

DEAR SIR

I was interested to read Hugh Freeman's article (*Bulletin*, February 1985, 9, 29-32) on training in community psychiatry.

I would like to call attention to the paragraph about Dingleton which says that the 'philosophy practised there may be more acceptable to doctors preparing to work in the community' than to those training for hospital practice. Mention is also made of broadly based psychotherapy training there which is in contrast with most psychotherapy training.

I understand that the principle of democratization, as described at Henderson, has provided some inspiration for their approach. This is also true of my own training at John Conolly Hospital in Birmingham. Democratization seems to me to be about sharing responsibility. A shift of responsibility from the hierarchical structures of many mental hospitals to other workers and towards patients living independently in the community also seems central to community psychiatry.

Working therapeutically with all types of psychiatric patient requires extensive and effective support for the workers to deal with such phenomena as countertransference, apathy and the projections of severely damaged and regressed personalities.

Development of group skills in multidisciplinary settings may be seen as a partial solution to the problems of meeting this need. The personality growth which may result from a sharing of responsibility, if the group is working, I suggest is essential to good training in community psychiatry.

Resistance from the established order is to be expected and faced. It is not surprising that academic psychiatry and the