Correspondence

Consultant jobs in mental handicap

DEAR SIRS

If there are any psychiatric trainees considering a career in mental handicap who have been depressed and disheartened by Dr Nwulu's article on the subject (*Bulletin*, July 1988, **12**, 279-281), I would like to point out that his experience and opinion is by no means representative of the majority of the profession. While not denying that there are problems with consultant posts in some areas of the country, these are in the minority, and the Mental Handicap Section of the College has been active in providing guidelines to ensure that consultant posts in the speciality are of good quality.

As with any other speciality, the amount of satisfaction you get from the job depends a great deal on how much effort you are prepared to put into it. The 'centres of excellence' that Dr Nwulu mentions have only become so because of the hard work and enthusiasm of the consultants involved. Involvement in management is essential if one is to get the kind of service in which one wishes to work, and the time and energy spent on research and teaching is more than compensated for by the intellectual stimulation which it provides.

Neither is it true that all academic units are divorced from the realities of life in the rest of the service. In the Stoke Park Group we have a University Department which is involved in the teaching of medical students, psychiatric trainees, and other professionals, and is actively involved in many research projects concerning the aetiology, amelioration and hopefully, prevention of mental handicap. But we also run an 800 bedded hospital group in which *all* patients are regularly discussed by a multidisciplinary team and are subject to short and long-term goal planning, as well as providing a comprehensive service to a catchment area of 200,000 population, including long-term support to families with a mentally handicapped member. With the development of more community-based care, we are planning for the new role of the (much reduced) hospital – that of providing specialised units for those people who will not realistically be able to be cared for in the community e.g. the psychiatrically ill, behaviourally disturbed, ageing etc., as well as an increased demand for short-term assessment and treatment, and respite care for those with special needs.

Services for the mentally handicapped are in the midst of enormous upheaval at present and the consultant is the one person with both the knowledge and training to know what services are required, and the power to obtain them. The next few years may well be challenging but they certainly will not be boring.

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DEAR SIRS

I would like to commend Dr Nwulu on his excellent article 'Consultant Jobs in Mental Handicap: Dead End Posts' which appeared in the July *Bulletin* (12, 279–281). Dr Nwulu suggested measures to rectify this situation but the question of who should do this arises – DHSS or Royal College of Psychiatrists? I would have thought that both have a responsibility to do so and would suggest that a joint committee should consider this and implement the necessary changes as soon as possible.

Although dissatisfaction among psychiatrists in mental handicap is quite widespread, no measures to improve the situation have been taken. I am afraid that inactivity will not solve this situation and urgent measures are required.

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Psychotherapy training

DEAR SIRS

Professor Marks' recent letter regarding psychotherapy training raises several important issues. A consultant psychotherapist in the National Health Service should, as he indicates, have a broad knowledge of all the various types of psychotherapy, whatever his own personal preferences, and be able to assess patients and assign them to whichever type seems most appropriate at that moment. I am sure he is right too in urging more rigorous attention to determining success of outcome in all types of psychotherapy, in spite of the difficulties this poses. Objective measurements of success are notoriously

difficult in long-term dynamic therapy, initial goals often changing in the course of therapy, and symptoms which were originally troublesome becoming better tolerated, even if still present. There is also the problem of patients vanishing after a course of psychotherapy before enough time has elapsed to make it clear whether or not significant changes have been maintained over time. This makes it difficult to evaluate success or failure of therapy with any accuracy and must be remedied if we are to make the best use of our limited resources.

There is, indeed, a lack of training in helping with psycho-sexual problems. The availability and the type of training seems very haphazardly spread throughout the country, according to the whereabouts of consultants with an interest in this field and the time to run clinics and supervise juniors. At present, I am one of the first two doctors to be taking the course run by the Marriage Guidance Council (Relate) on sexual dysfunction which offers a thorough training in behavioural methods of treatment. Perhaps this or other courses might be available to a larger number of psychotherapy trainees in the future.

On the question of personal therapy, it may depend on what sort of psychotherapy the trainee intends to practise as to whether personal therapy is considered essential or not. I have known one or two excellent dynamic therapists who have had no therapy themselves, but, particularly in this field, it is all too easy to over-identify with patients or to fail to understand how one's own prejudices and ideas affect them if one has had no experience of personal therapy. My own view is that I could not have begun to understand what my patients go through both in and between sessions had I not undergone the experience myself. Norman Macaskill[1] in his review of the literature on personal therapy for therapists concludes that there is *no* evidence that personal therapy for the therapist has a positive effect on outcome of therapy with patients, although there is evidence to suggest that the emotional health of the therapist is of importance in outcome. More research, he concludes, is essential in this area.

Another issue involved in training future psychotherapy consultants is the supervision of supervision, when the trainee first starts supervising other junior staff, individually or in groups. Supervision is a skilled activity which needs to be learnt and therefore itself should be supervised by more experienced staff; this, I believe, is not standard practice at present.

The last point deserving of attention is that raised by Clifford Yorke.[2] He believes that psychotherapy consultants should not just be available to assess, treat and supervise but should be "teaching psychoanalysis as a theory of mind (as opposed to a method of treatment)". Training in this small but pervasive subspeciality should involve developing the ability to communicate clearly with others about what one is doing and educate them when necessary in the underlying theoretical basis of one's work, rather than preserving the mystique which has sometimes been attached to the practice of psychotherapy.

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References

[1] MACASKILL, N. (1988) Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychotherapy*, **4**, 219–226.

[2] YORKE, C. (1988) A defect in training. *British Journal of Psychiatry*, **152**, 159–163.

Use of benzodiazepines

DEAR SIRS

Recently the West Glamorgan Division of Psychiatry has reviewed two papers about the use of benzodiazepines, one prepared by the CSM[1] and the other by colleagues in North Essex.[2] Both are commendable to non-specialists but not to psychiatrists. In neither is there the suggestion that this group of drugs has an important and continuing role in psychiatric practice. The CSM paper is very inflexible:

Uses

As anxiolytics

1. Benzodiazepines are indicated for the short-term relief (2–4 weeks only) of anxiety that is severe, disabling or subjecting the individual to unacceptable distress occurring alone or in association with insomnia or short term psychosomatic, organic or psychotic illness.
2. The use of benzodiazepines to treat short-term mild anxiety is inappropriate and unsuitable.

As a psychiatrist who deals mainly with the elderly, but with over 20 years experience of using virtually one benzodiazepine – Chlordiazepoxide – I find publications of this nature an inhibiting and constraining influence on good psychiatric practice.

Chlordiazepozide is a very good drug with virtually no side effects. It is also helpful to know that in a dose of 10mgs it has little effect on psychomotor performance. A double-blind field trial with police drivers in Basle showed that it had no significant impairment of driving performance.[3]

In my experience, the risk of dependence has not been a problem but this aspect of the benzodiazepines must be taken into account in conjunction with the fact that very many patients have benefitted from taking them. Currently, I am concerned about patients who are suffering from the distressing symptoms of anxiety because of ineffective treatment by