symptoms, some have a few of the 'textbook' risk factors for completed suicide but almost all are in emotional distress. If one adopts Dr Flanigan's 'screening' rationale one is indeed left with making arbitrary judgements on this group.

Surely Dr Flanigan is wrong and the 'ethical guidelines' for dealing with this group are clear. They are people who are suffering and as psychiatrist, physician and fellow human one should aim to alleviate their distress in whatever ways are possible. Before we can attempt this we need to sense why the patient felt driven to parasuicide. A warm empathic approach in a quiet room off the main ward and ensuring that the patient has fully recovered from the effects of alcohol or sedative drugs are essential to any worthwhile assessment. A system for understanding emotional disturbance and suicidal behaviour, such as that outlined by Beck[1] not only enhances the assessment but may also help the patient to feel understood. Such an approach allows for therapeutic intervention during the assessment.

The assessment of parasuicide is an opportunity for intervention in a group of patients at risk of further self-harm and completed suicide, many of whom may never be able to articulate or cope with their distress in any other way. The defensive 'screening' approach may help the trainee to sleep easier and keep the demand for beds down but it will do little to alter such patient's maladaptive reactions to emotional stress.

A desire to understand the individual attempters actions is not only humane, it will help us unravel the aetiology of suicidal and parasuicidal behaviour. This is an area, as any psychiatric textbook chapter on suicide will show, where our knowledge is grossly deficient.

P. M. McLaren

St Thomas' Hospital
London SE1

Reference

[1] Beck, A. *et al* (1979) Specific techniques for the suicidal patient. In *Cognitive Therapy of Depression*. New York: The Guildford Press.

Training in psychotherapy

Dear Sirs

Professor Marks (*Bulletin*, June 1988) has made several very pertinent suggestions for improving the quality and balance of higher psychotherapy training. I would like to single out two of his suggestions for further comment. Firstly, he proposes a greater emphasis on and familiarity with the empirical basis of psychotherapy; for example a thorough knowledge of the indications for the various forms of psychotherapy and the routine application of outcome measures to the trainee's clinical practice. This suggestion is vital for the long term health of psychotherapy as a sub speciality. Only through first hand knowledge of such issues will the trainee acquire a critical appreciation of the strengths and weaknesses of his speciality and of his own clinical practice. This awareness could provide a powerful stimulus to the development of clinically relevant research ideas and a commitment to evaluation. The paucity of relevant good quality UK based psychotherapy research is painfully apparent in the journals and at conferences such as those of the Society for Psychotherapy Research and attests to the vital need for developments such as Professor Marks suggests.

How can this training requirement be best met? Probably very few training centres can provide the broad academic and clinical input required. There is consequently an obvious role for the College to fulfil, possibly by mounting specialised research methodology workshops in psychotherapy, similar in style to the successful workshops for general psychiatry training already in existence. Here experts on psychotherapy research could sharpen up the trainee's awareness of the indications for the various therapies, give indications of the key areas currently requiring research in psychotherapy, and the various levels at which trainees could contribute to this research. In addition advice could be given on how to apply measures to the trainee's clinical work and which measures best to apply. The College might like to consider at this point establishing a co-ordinated national research programme in psychotherapy as this would have numerous benefits, including reducing the likelihood of a great deal of redundancy and irrelevancy in terms of the research individual trainees might undertake.

The second recommendation Professor Marks makes is that trainees should be able to apply and supervise *most* of the methods of psychotherapy. There are good clinical grounds for supporting this recommendation and ensuring that the psychotherapist is able to respond flexibly within and between patients in terms of the therapeutic approaches he is able to apply. Individual trainers, however, are unlikely to be able to satisfy these eclectic needs and the College will therefore probably have to consider establishing rotational schemes which might need to be sub-regional rather than district-based if they were to meet the expanded needs for training.

Furthermore, an adequate training in family therapy, marital therapy, behaviour therapy and the treatment of sexual dysfunction, if it were to be contained within the current four year time limitation, would necessarily impinge on the time currently

given to training in individual and dynamic psychotherapy. Serious consideration would therefore need to be given to ways of reducing the amount of time devoted to training in these approaches without sacrificing the quality of such training. One suggestion might be to abandon the requirement for some form of personal analytic experience, as no evidence exists to suggest this experience has a clinically significant impact.[1]

If training in the psychotherapies were to evolve along the lines suggested, training would more clearly be research-based and related to client need. There would then be some prospect that psychotherapy would be seen to be clinically relevant and empirically-grounded — vital attributes if it is to survive and grow in an age of medical audit, limited financial resources and competing service priorities.

N. D. MACASKILL

Whiteley Wood Clinic, Sheffield

Reference

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

Positive aspect of benzodiazepines

DEAR SIRS

Peter Tyrer's warnings about the possible repercussions of benzodiazepine prescription (*Bulletin*, **12**, 190) and the statement from the Committee on Safety of Medicines (p205, same issue) is undoubtedly timely and relevant. However there is a risk that papers such as this, which focus primarily on the adverse aspects of benzodiazepine treatment, may lead to a biased image of this class of drugs being presented to the lay public, particularly by the general media which is not governed by any ethic of scientific objectivity and which is usually responsible for interpreting medical and scientific information for general consumption.

The problems of addiction and cognitive impairment are a major concern in a general practice and psychiatric out-patient setting where anxiety states, insomnia, dysthymia and other 'minor' problems are dealt with. Clinicians in psychiatric hospital in-patient wards deal with a very different patient type suffering from major psychoses, organic brain syndromes and retardation. It would be unfortunate if the emphasis on the problems inherent in the use of these drugs in usually high-functioning individuals were to be generalised to the more severely ill. The public is seldom, if ever, exposed to articles dealing with the positive aspects of the benzodiazepines such as their adjuvant role in the treatment of schizophrenia,[1] manic-depression[2], and epilepsy[3] to name but a few of the many conditions where maligned drugs like lorazepam, alprazolam and diazepam are used. The concept of psycho-social addiction in a patient with late-stage Huntington's Chorea is invalid yet patients and relatives alike become unduly concerned when informed that an 'addictive' benzodiazepine is being prescribed. To prevent this inappropriate type of generalisation it would be advisable to include appropriate qualifying statements in medico-legal articles and position statements, particularly those that may be studied by lawyers. Failure to give the benzodiazepines some deserved 'good press' could be an error of omission that the medical profession may later regret.

TIMOTHY J. HOLDEN

University of Alberta
Alberta, Canada

References

[1]WOLKOWITZ, O. M. *et al* (1986) Combination alprazolam-neuroleptic treatment of the positive and negative symptoms of schizophrenia. *American Journal of Psychiatry*, **143**, 85–87.

[2]MODELL, J. G. *et al* (1985) In-patient clinical trial for the management of manic-agitation. *Journal of Clinical Psycopharmacology* **5**(2), 109–113.

[3]MOFFETT, A & SCOTT, D. F. (1983) Stress and epilepsy: the value of a benzodiazepine — lorazepam. *Journal of Neurology, Neurosurgery and Psychiatry*, **47**, 165–167.

What do trainee psychiatrists actually read?

DEAR SIRS

Previous correspondence in the *Bulletin* has included lists of recommended reading for psychiatrists in training. We carried out a survey of trainees on the Oxford rotation (senior house officers to senior registrars) to see how the books actually read compared to the suggested lists. The questionnaire asked them to quote the six novels which had influenced them most in some way, and which might be of interest to other trainees. Fifty questionnaires were sent and 32 returned.

The top authors were Kafka and Plath, followed by Greene, Hardy, Hesse, Orwell, Steinbeck and Tolstoy, with Dickens, Sartre and Solzhenitsyn trailing behind. The most popular novel was *The Bell Jar* (Plath), followed by *The Trial* (Kafka), *War and Peace* (Tolstoy), *The Ordeal of Gilbert Penfold* (Waugh), *Nausea* (Sartre), *Gormenghast* (Peake), *Cancer Ward* (Solzhenitsyn) and *The White Hotel* (Thomas).

The predominance of works and writers concerned with alienation, sexuality and suicide indicates an

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