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

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inferior drugs, low-dosage phenothiazines and β-blockers. In the life history of a new drug there is a recognised cycle, its release with considerable hype and exaggerated expectation, the recognition of problems and disadvantages, and its eventual role is established, or it is withdrawn from use. From the tone of these two publications and remarks I have heard at psychiatric meetings, benzodiazepines are running the risk of being banned. Surely this must not happen. If we are concerned about our image and our efficacy in dealing with a whole range of psychiatric problems, the benzodiazepines must be retained as part of our armamentarium.

On reflection, the College statement on benzodiazepines and dependency[4] leaves one with an uneasy feeling. One does not get an impression that its authors and the participants at the special meeting on 10 June, 1987 were individuals who spend the major part of their time at the 'coal face' dealing with patients. This group seemed to consist mainly of psychiatrists with a major commitment to academic work or with a bias in their work towards undertaking trials with new drugs. It would seem to me that individuals with a major commitment to academic work or to the evaluation of new drugs are not well placed to form accurate or impartial views about the place of benzodiazepines in contemporary psychiatric practice.

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References

[1]COMMITTEE ON SAFETY OF MEDICINES (1988) Benzodiazepines, dependence and withdrawal symptoms. *Current Problems*, **No 21,** January 1988.

[2]RAMSTER, D., BARBER, A. J., DEB A. & FREE, K. (1987) Essex benzodiazepines policy. *The Pharmaceutical Journal*, **239,** 677.

[3]KIELHOLZ, P., GOLDBERG, L., OBERSTEG, J., POELDINGER, W., RAMSEYER, A. & SCHMIDT, P. (1967) Strassenverker, Tranquilizer und Alcohol. *Deutsche Medizinische Wochemschrift*, **92,** 1525–1531.

[4]ROYAL COLLEGE OF PSYCHIATRISTS (1988) Benzodiazepines and dependence: A College Statement. *Bulletin of the Royal College of Psychiatrists*, **12,** 107–109.

The mentally ill on remand in prison

DEAR SIRS

I am extremely concerned about the fate of the mentally ill on remand in prison. When I took over as senior registrar at the start of the year, I understood that my duties included assessment of people on remand in Brixton prison and that often this would lead to admission to hospital. This system seems to have broken down completely. Virtually all the prisoners end up in police custody.

Two recent referrals underlined this point. Both went to court *two days* after the referral and both went to police custody. Thus neither is available for assessment.

In the first six months of this year 10 out of 12 referrals went to police custody within 14 days of referral and were not seen. I was able to see one man only because the prison medical officer 'pretended' he was unfit to go to Court.

I would be interested to know whether others have similar experiences or any suggestions as to what we might do. If these occurrences are widespread, they can only lead to further delays within an already overburdened prison system. Meanwhile patients with mental illness who require hospital treatment are not receiving it.

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The proposed Community Treatment Order

DEAR SIRS

It is exasperating when all one's charm, wiles, stratagems and threats fail to persuade a symptom-controlled patient with chronic psychosis that his/her continued wellbeing depends on continuing treatment. Nevertheless, I am extremely grateful to Lucy Scott-Moncrieff for enumerating all the excellent clinical and practical arguments, as they concern the individual patient, for us. I was sorry also to read that she shared my fear that this development could give further encouragement to the development of an even more threadbare community-based service.

In view of the profession of the author, I would like also to have read her views on the legal implications of this proposal, which seem to me to arise from the basic step of taking away certain civil rights from an already highly under-privileged section of the community. Are there not also political issues? If a future Government decided that the Community Treatment Order was a useful form of control of political dissidents or even Stonehenge-loving hippies, would we come out of the affair any more nobly than our Russian colleagues?

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