consultants. Usually senior registrars obtain management experience by attending special courses, as at the King's Fund or University of Keele, and by being members of local medical committees. We wish to report our experience in extending this form of training by arranging (RR) and receiving (DB) a special 'management module' in general management during a senior registrar placement.

Medway Management Training Programme for Senior Registrars in Psychiatry

The training programme started with DB attending the well-established three day course at Keele University. This provided useful lectures and discussions on subjects like the relationship between the consultant psychiatrist and the multi-disciplinary team, the clinician as leader, the new NHS, medical audit.

The subsequent six months practical training involved DB spending one session a week with a wide range of local managers, the whole programme being co-ordinated by RR. The attachments involved one, two or three sessions with each 'trainer manager', to include tutorials and attendance (with observer status) at high level management meetings like the District Health Authority Unit Management Board, District Commissioning Advisory Group and Directorate meetings. Tutorial-type discussions took place with the Director of Finance, Contracts Director and Director of Human Resources. The role of information technology in management was outlined by a physician and a surgeon, currently working in resource management. Detailed learning about mental health services, shadowing the Clinical Director and attending the Directorate and Service Review Meetings, provided insight about organisation and service delivery aspects of mental health services.

Such a programme provided management training from a number of helpful perspectives. The theoretical knowledge acquired on a course can be 'tested out' in discussion with local managers, and after the committee meetings with senior clinicians. Observation, from the relatively unthreatening position of senior registrar, of the ways in which managers make and carry out decisions, will facilitate better understanding and help the aspiring consultant to join the ranks of managers in future. Following participation in such a programme even those who do not wish to be involved in management should find it easier to know how to put forward their own proposals to managers.

Our experience suggests that:

(a) provision should be made in each Region/District for training senior registrars in management
(b) such a training should involve a theoretical course as well as practical "hands on experience" through observation and tutorials. The duration should be at least 6 months with a half day session each week
(c) involvement of local managers in the programme is more effective as the trainee can understand the local issues from a different perspective.

Dominic Beer

Greenwich District Hospital
London SE10 9HE

Rama Rao

Medway Hospital
Gillingham, Kent ME7 5NY

Somatic correlates in mental retardation

Dear Sirs

In the study of mental retardation, 'somatic correlates', the physical features typically characteristic of disorders associated with mental retardation, have traditionally attracted great importance. Textbooks on mental deficiency and clinicians of yesteryear emphasised the minutiae of different syndromes. This preoccupation with detail earned such quips as "syndromitis" and "syndromatosis" and as "like a zoo" for doctors' demonstrations of patients.

In long-stay hospitals captive populations have been accessible for research into their various abnormalities. Anatomical anomalies of developmental origin appear to be more frequent and more marked among mentally retarded people. These physical features can be classified as primary, a *sine qua non*, and pathognomonic of a condition, as secondary, not essential but distinctive and supporting a diagnosis, and as tertiary, incidental to the diagnosis.

In the 125 years since Dr John Langdon Haydon Down described "Down's Syndrome" in 1866, numerous conditions with mental retardation have been recognised on a basis of a constellation of observable physical characteristics. Where a biochemical or chromosomal defect has been the first identification of a disorder, it has been necessary to re-examine series of patients to discover any distinguishing physical features. Anatomical abnormalities can alert the practitioner to a need for further investigations.

In the move to concentrate on "The Psychiatry of Mental Handicap" the status and relevance of somatic correlates are open to question. A number of reasons can be offered why specialists in mental retardation should not "de-skill" themselves by abandoning the somatic dimension. Mentally retarded patients who have had no previous assessment by a specialist are still not infrequently referred to the service. The cause of mental retardation in patients may have significant implications for their families and relatives. The recognition of somatic

https://doi.org/10.1192/pb.16.4.236 Published online by Cambridge University Press

abnormalities which suggest dysmorphogenesis may justify obtaining the advice of a clinical geneticist. In 50% of people with mental retardation the cause is uncertain and dysmorphic features could become increasingly relevant as clinical genetics develops and advances.

It is fashionable now for mentally retarded people to have "individual programme plans", IPPs. A complementary medical "individual physical (or somatic) profile" could be proposed as an essential part of the holistic appraisal of these people.

DOUGLAS A. SPENCER

Meanwood Park Hospital
Leeds LS6 4QB

The moral case against psychotherapy

DEAR SIRS

Dr Charlton's paper (*Psychiatric Bulletin*, 1991, **15**, 490–492) was an interesting account of his opinions regarding psychotherapy. However, it was a confused and confusing article. Confused because he has a fundamentally incorrect understanding of the basic principles of psychotherapeutic treatments. Confusing because in applying his arguments, he fails to make the distinction between the various forms of psychotherapy. Presumably his criticisms were levelled at dynamic psychotherapy and it is to this area that the following comments are addressed.

Perhaps a better definition than the one given would be: psychotherapy is what happens when a doctor listens to a patient. It is not meant to be "edifying conversation". Although dependent on the interaction of two people, the passage of intimate, personal details is from patient to doctor. As such, the psychotherapeutic relationship is unique, allowing for the amplification of transference phenomenon which occur. The process of effecting change in the individual (one of the main aims of dynamic psychotherapy) can be painful, disquieting and anxiety-provoking for the patient, and he needs to work hard both within and between sessions to do it successfully. This experience can be far from edifying.

Dr Charlton sees it as a surrender of autonomy. This is a false conclusion. A further aim of dynamic psychotherapy is the enhancement of autonomy. The patient is not given the answers to his problems, it is a means whereby he can clarify the causation and current status of his difficulties in order to find a solution for himself. It is the person himself who chooses to medicalise his problems. Such is his right if his autonomy is to be respected.

Psychotherapists do not claim to be experts at talking to people about their lives. Neither are they trained to practise their jobs professionally and efficiently. Their reasons for choosing this particular job is beyond the scope of this discussion.

No-one is claiming that psychotherapy is the universal panacea for all emotional problems – to do so would be as foolish as claiming it to be morally depraved. However with careful selection of patients, it has been shown to be an effective treatment (Luborsky *et al*, 1975; Smith & Glass, 1977).

Finally, psychotherapy is a difficult and demanding occupation. Perhaps a more appropriate warning to its adherents would be that contained in the words of Nietzsche: "He who fights with monsters should look to it that he himself does not become a monster. And when you gaze long into an abyss the abyss also gazes into you" (Nietzsche, 1972).

T. N. EVANS
A. IWANCZYK
H. M. JONES

Cefn Coed Hospital
Cockett, Swansea
West Glamorgan SA8 3HR

References

LUBORSKY, L., SINGER, B. & LUBORSKY, L. (1975) Comparative studies of psychotherapies. *Archives of General Psychiatry*, **31**, 995–1008.

NIETZSCHE, F. (1972) *Beyond Good and Evil*. Penguin.

SMITH, M. L. & GLASS, G. V. (1977) Meta-analysis of psychotherapy outcome studies. *American Psychologist*, **32**, 752–760.

DEAR SIRS

I am accused both of creating confusion and myself being confused. This might be a more compelling argument if the field of psychotherapy possessed anything approaching clarity or precision: it does not. There are no "basic principles of psychotherapeutic treatments", but almost as many principles as there are therapists (presumably because these "principles" are based upon pure theory with no means of discriminating between them except by what takes your personal fancy). It therefore becomes a pointless exercise to "make the distinction between the various forms of psychotherapy".

For proof we need look no further than the meta-analyses of Smith & Glass (1977) and Luborsky *et al* (1975) which Evans *et al* cite with approval. I personally consider such meta-analytical techniques to be highly dubious – or at least very prone to mislead – but nevertheless let us consider their conclusions. First of all, they report that psychotherapy is better than no treatment: in other words they have rediscovered the *placebo* effect. But secondly they report "negligible differences in the effects produced by ten different therapy types" (Smith & Glass) and "insignificant differences between therapy types in proportions of patients who improved" (Luborsky *et al*). Also, Smith & Glass showed no differences in outcome according to the length of "training" of the

https://doi.org/10.1192/pb.16.4.236 Published online by Cambridge University Press