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.

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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 inpatient 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.

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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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interest in human suffering appropriate to the specialty; it may also reflect the turmoil of psychiatrists in training. Whether this is a cause or a result of choosing a psychiatric career remains unclear. It would be interesting to compare these findings with trainees elsewhere or in other fields.

We are grateful to all those replying to the survey and hope that non-responders may be tempted to move on from literature they felt unable to admit to.

PAUL HARRISON
ALEXANDRA DAY

Littlemore Hospital, Oxford

Sir Charles Symonds

DEAR SIRS

I much enjoyed Sidney Crown's Proustian jaunt down Memory Lane (*Bulletin*, July 1988, **12**, 263–266) which, despite his protestations, is 'history', and most important history at that.

However, I think he has been a little unfair to Sir Charles Symonds. I had the privilege of working under Sir Charles for well nigh three years at RAF Central Medical Establishment, London, where he enjoyed the exalted rank of Air Vice Marshal. Initially, I agree, he did present as a cold intellectual; but this was a facade. He was in fact a shy man, the more one got to know him the more one was able to penetrate the facade and discover the very human being who lay beneath.

He was ever-loyal to his protégés, and up to the time of his death he would write to me in his own hand commenting about a paper or a letter I had published in the medical press.

HENRY R. ROLLIN

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Information leaflets for patients

DEAR SIRS

I am writing to you on behalf of the Medication Working Party of Camberwell Health Authority's Mental Health Care Group. We are planning to research and develop information leaflets, (which are to be given to patients), on their psychotropic medication. We would like to hear from other groups of researchers involved in this field or those who are interested in this kind of development.

JANET CARRICK

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Code of Practice and compulsory admissions

DEAR SIRS

I wish to contribute to the debate on management of severe psychiatric disturbance under the 1983 Mental Health Act.

My colleagues and I continue to encounter ASWs who induce patients to acquiesce to informal admission. The ASW can do this with confidence if the necessary two doctors have already completed, or state their readiness to complete, recommendations for compulsory admission. When admission takes place in this way, ward staff experience considerable difficulty in establishing rapport with an informal, but reluctant, patient. In my experience, reassessment with a view to compulsory detention usually takes place at a later date, sometimes with an unnecessary crisis requiring the use of emergency holding powers and always with detriment to staff-patient relationships.

Both the 1985 Mental Health Act Commission Draft Code of Practice and the 1987 DHSS Code proscribed the use of coercion to induce a patient to acquiesce to informal admission by threats of compulsory admission if he does not comply (section 1.15.4 and paragraph 30 respectively). The DHSS Code went further; paragraph 28 observed that "although the patient may indicate willingness to be admitted informally, in a very few cases compulsory admission may still need to be considered under certain circumstances".

Both Codes invited a response. In response to the MHAC Code, the BMA supported the advice against coercion. The BMA also made the following suggestion about when the ASW does not wish to make an application despite medical recommendations (section 1.17.7): "The duty of the ASW to inform the nearest relative in writing when she/he does not agree to a compulsory admission should be extended to informing the doctor who made the initial request in writing."[1] This suggestion was not taken up in the DHSS Code.

In response to the DHSS Code, the College reiterated the BMA's suggestion, recommending that paragraph 41, should read, "the ASW should also provide his reasons **in writing** to the other professionals involved, discuss alternative courses of action and consider what continuing social work help may be needed by the patient and the family. **The social worker should make clear the relative's own rights to make an application.**"[2,3] (Bold print used in the original College response to indicate additions.)

The College also accepted paragraph 30 unaltered and recommended that paragraph 28 include an explanation of what should be regarded as "certain circumstances". One of the circumstances the College suggested covered the contingency of coercion.

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