effects on the general psychiatric services. It has removed from general psychiatrists any motivation to direct interest towards a specialty so remote as child psychiatry, and with it adolescent psychiatry, creating an ever increasing gap between the two. Yet they have much in common—syndromes, dosage of medication and treatment methods using the verbal mode of communication, as opposed to play therapy used with children.

In practice, adolescent psychiatrists need the adult services; often for the continuation of treatment, sometimes for the sharing of in-patient facilities and expertise. Similarly, general psychiatrists need the adolescent services. There is a two-way relatedness between the two as opposed to a simple undirectional relationship between child and adolescent psychiatry. Having trained and talked with many general psychiatrists, I have no doubt that the adult services will be richly influenced by their understanding of adolescence. It seems as if an artificial barrier has been imposed between the two; as if the child has come between the adolescent and the adult.

Were adolescent psychiatry to be placed where it rightfully belongs—as a specialty in its own right—then formal recognition will be given to links that are realistically appropriate; early adolescence with child psychiatry and mid and late adolescence with adult psychiatry; the need for appropriate training in adolescence will be recognized, and much that is wrong with the existing confused and confusing adolescent service will begin to change.*

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* Psychiatrists working predominatly with adolescents in the London Region's (the Front-Liners) have formed a Group in order to discuss and understand matters pertaining to their work in adolescence. We have had three meetings, and hope to continue our discussions in the future. Anybody wishing to get in touch with us should contact one of the joint conveners: Dr J. E. Thomas, Consultant Psychiatrist, Tavistock Clinic, 120 Belsize Lane, London, NW3 5BA; or Dr K. S. Perinpanayagam, Consultant Psychiatrist, Brookside Young People's Unit, 107a Barley Lane, Goodmayes, Ilford, Essex, IG3 8XJ. The views expressed in this letter are those of the author and not necessarily those of the Group that has been formed.

The psychiatrist's role in treating patients with chronic pain

DEAR SIRS

Dr Stephen Tyrer's gloomy view of the psychiatrist's role in treating patients in chronic pain (*Bulletin*, July 1985, **9**, 135–136) may be explained by the following: it is inappropriate for patients with unexplained chronic pains to be treated in 'pain clinics' directed by anaesthetists, such clinics tend to create 'pain patients' who are prescribed a number of different treatments by the various specialists associated with the clinic. Better results are obtained when the patients are treated either by a psychiatrist or psychologist working in the clinic to which the patient presents.[1,2] I have been closely associated for six years with a Department of Oral and Maxillo-Facial Surgery and have had considerable success in managing patients with chronic facial pain with a combination of brief psychotherapy and tricyclic antidepressant therapy. We have also shown that tricyclic antidepressants have analgesic properties independent of any antidepressant effect.[2]

Furthermore, Dr Tyrer recommends the use of questionnaires such as the General Health Questionnaire and Anxiety and Depression inventories which may not be relevant to the study of patients with unexplained pain, as these case finding instruments and symptom rating scales do not adequately reflect the clinical picture shown by patients with chronic unexplained pain.[3] Psychiatric illness amounting to caseness may not always be detected in these patients, despite evidence of emotional problems such as an increased incidence of events.[2] Thus the limited role for the psychiatrist defined by Dr Tyrer is probably the result of the combination of inappropriate diagnostic criteria being used in inappropriate settings.

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Pre-registration house officer posts in psychiatry

DEAR SIRS

I read with interest the letter by Professor C. P. Seager (*Bulletin*, July 1985, **9**, 141–142), and congratulate him on the innovative attempt to improve early postgraduate training. It would seem an excellent means to offer experience in psychiatry which otherwise might not be gained, and no doubt it will attract a number of able candidates into our profession.

However, I would argue that four months each in medicine and surgery is wholly inadequate to gain skills necessary to last an entire professional life time. As a junior psychiatrist one has virtually sole responsibility for the physical well being of psychiatric in-patients, and the high incidence of either concurrent or causative organic disorder in patients presenting with psychiatric problems is well recognized.

Even after six months medicine and surgery, I myself feel poorly equipped—and judging by the fact that two out of four of Professor Seager's graduates intending to enter psychiatry have sought further medical experience, they also seem to feel on uncertain ground.

Further experience would remedy the lack of knowledge, but for many it is all too easy to be swept on in the post-registration single specialty stream; or worse, simply to remain blissfully unaware of one's ignorance.

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