therapies. Moreover rotational training schemes require that trainees are pitched into a new job every six months which certainly discourages application to any therapy which is likely to require more than an hour or so a week for a few weeks. A further problem with psychological treatments is the fact that many anxiety states, mild depressive states, and obsessional disorders respond rather well to antidepressant drugs and a trainee may be discouraged from persistence with a psychological approach if all along he suspects that the patient may show much greater benefit from such prescription.

Cognitive behavioural treatments, although relatively brief in comparison with psychodynamic approaches, do require further abbreviation if they are to be widely applied to the prevalent problem of anxiety. I realised this fact when, as a trainee myself, I worked in a neurosis treatment unit. It became apparent that the huge problem could only be effectively tackled if self-help methods were developed.

It has been my major effort, both as clinician and trainee of junior psychiatrists, to develop such an approach and the method of Anxiety Control Training has been described in detail in my text, *Clinical Neurosis* (1991). It is a technique which requires only two hours of therapist time per patient (six to eight weekly 15-minute sessions) and it is readily taught to others. My experience over many years of practice has been that trainees rapidly acquire competence after brief instruction and from the very first year of entry into training have the satisfaction of applying a brief psychological treatment which, if selection is correct, may be rapidly effective. Long-term follow-up study of the outcome of ACT has been delayed by the problem of securing research assistance for the requisite period but this has now been completed and the study submitted for publication. We have shown that patients continue to improve with regular practice of the technique following the brief intervention by the therapist. This information provides the basis for an optimistic statement by the trainee who, on departure for the next post on rotation, may not see the patient again.

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Reference

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Psychiatrists as managers

DEAR SIRS

Dr Stern's suggestion that psychiatrists who become involved with management do so because of "poor therapeutic skills" (Psychological treatments by psychiatrists? *Psychiatric Bulletin,* May 1991, **15,** 296) is a surprising generalisation, especially given Dr Stern's commitment to cognitive therapy!

Effective management depends not only on a sound grasp of the new NHS business ethic, but also on the ability to understand individual and group dynamics and the capacity to work effectively with teams. These skills are the bread and butter of good psychiatric practice, hence good psychiatrists are often good managers.

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DEAR SIRS

The letter from Dr Power-Smith in response to my previous letter in the *Bulletin* somewhat misses the point. I do not mean to imply that psychiatrists do not often make good managers, but rather to emphasise that our training in therapeutic skills ought to keep up with current developments. Unless this happens, psychiatrists would not be well equipped to carry out psychological treatments.

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Cost-benefit analyses of psychotherapeutic treatments

DEAR SIRS

Uncontrolled studies of group-analytic therapy, inpatient psychodynamic psychotherapy and behaviour therapy have demonstrated a post-treatment reduction in health service usage and improvements in measures of economic productivity. Studies of clinical psychology attachments to general practice have demonstrated similar findings.

Unfortunately there have been only two controlled studies of note in this country. A study of behaviour therapy for phobias and sexual problems (Ginsberg *et al*, 1984) confirmed the earlier uncontrolled findings from the same unit, although attrition rates were high despite a follow-up period of only one year. A more naturalistic controlled study of a clinical psychology attachment to general practice (Earll & Kincey, 1982) found no economic benefit, contradicting the uncontrolled work.

Work from the United States suggests that psychotherapy is broadly cost-effective, leading to lower utilisation of other health services, particularly for hospitalised patients in older age groups. But much of these data come from insurance company records and therefore have limitations. Firstly, the health insurance system works to limit the number of