

of workshops and nine half-days of case discussion may be sufficient to introduce participants to a limited range of treatment approaches appropriate to out-patient neurotics; but it cannot begin to provide the range of theoretical knowledge and of practical experience required in potential trainers. A clinical supervisor is expected to be a person of considerable expertise, with a grasp of his field built up over a period of time. The proposed course implies a serious dilution in the standards of training offered within the NHS, particularly given the extent to which the theories and methods, the entire conceptual basis, of behaviour therapy are at variance with those of the rest of psychiatry.

There is room for concern over the content, as well as the form, of the course. Professor Marks' contributions to research on the anxiety-related disorders are deservedly known and respected internationally; but there is much more to behavioural practice than exposure treatment and response prevention. The whole range of procedures developed from the principles of operant learning are excluded from what has come to be known as behavioural psychotherapy; so that young psychiatrists will be brought up knowing nothing of what can be done in the way of rehabilitation of chronic patients, of the management of behaviour disorders in children and adults, or of the treatment of the life-style problems associated particularly with alcoholism and drug addiction. The broad-spectrum behavioural treatment programme, based on a full functional analysis of the patient in his environment, will cease to exist for the next generation of psychiatrists. It is ironical that this should be the outcome of a course designed to increase knowledge, particularly when the relevance of such formulations is increasingly being recognized in areas of general medicine. The proposed course cannot be seen as offering anything more than acquaintance with a limited range of techniques applicable over a limited range of patients; it will do nothing to help psychiatrists develop a proper understanding of the potential scope of behavioural methods.

One way round the problems is to accept that there is not in fact a shortage of trainers. Most clinical psychologists would be only too happy to pass on some of their skills to their psychiatric colleagues. The resources are already there; it only requires a willingness to accept that much knowledge relevant to psychiatry has been developed outside that discipline and can best be taught by practitioners of other disciplines. Collaboration in this area can only benefit all parties concerned, not least the patient. At the same time it would mean that psychiatrists who cannot make monthly trips to London would have an opportunity to learn as much, perhaps even more, as those based in the south-east of England.

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### ***Appeal for identical twins with alcoholism or schizophrenia***

DEAR SIR,

Recent research has suggested that a proportion of alcoholics and also schizophrenics may have evidence of minor brain dysfunction. The Genetics Section at the Institute of Psychiatry are currently investigating these possibilities by examining identical twins discordant for either alcoholism or schizophrenia. This involves our carrying out various cognitive tests and computerized axial tomography on identical twins with either of these disorders, and on their unaffected co-twins.

So far we have tested ten pairs of whom one is an alcoholic and eight pairs of whom one is schizophrenic. Our results are very promising; unfortunately identical twins constitute only one in every 200 of the general population, and so such twins with either alcoholism or schizophrenia are few and far between. I would be very grateful if readers of the *Bulletin* would let me know of any identical twins with alcoholism or schizophrenia who would be willing to spend 2-3 hours at the Institute of Psychiatry to complete some psychological tests and have a CAT scan (both non-invasive and painless procedures!) We would be happy to pay travel expenses from anywhere in the United Kingdom to London for both the affected subjects and their co-twins.

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### ***One psychiatric hospital?***

DEAR SIR,

British psychiatric hospitals have traditionally been divided into General Psychiatric and Mental Handicap Hospitals. This division arose at a time when knowledge about mental disorder was primitive. Within the last thirty years or so a marked development has taken place in regard to knowledge about the aetiology and treatment of the mentally ill. The divided practice of psychiatry goes on, however, and in my view is detrimental to the patient's interest.

For example, if a mentally handicapped patient develops a schizophrenia-like illness, a problem immediately arises. Most mental handicap hospitals have no treatment facility like ECT, and nurses are not trained to deal with mentally ill patients. I feel the time has come to desegregate psychiatric hospitals in order to create a hospital for mental disorder where the entire range of psychiatric problems can be dealt with.

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