referred patient. Factors independent of diagnosis can affect the time of admission, for example, distance from the hospital. In our study of observation levels of acute psychiatric admissions (Langenbach *et al*, 1992), we found that the number of admissions varied with the day of the week. Of the 88 admissions during the one month study period, there was a peak of 20 (23%) on Fridays and a trough of six (7%) on Sundays.

The proportion of referrals later admitted will be affected by the assessment procedure employed and the organisation of the psychiatric services. Tyrer *et al* (1989) described the significant reduction in psychiatric admission rates in Nottingham with the establishment of a comprehensive rehabilitation service in 1980, and the introduction of a sectorised service in 1981. It is important to remember the role of senior medical staff and domiciliary visits in the assessment procedure, as a way of reducing inappropriate admissions.

As psychiatry continues to become more community orientated and the number of in-patient beds is reduced, it becomes increasingly important to avoid inappropriate admissions. This is an area which deserves further study.

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Management of anxiety

DEAR SIRS

In their guidelines for the management of patients with generalised anxiety (*Psychiatric Bulletin*, 1992, **16**, 560–565), the members of the consensus conference exclude hypnosis from their list of recognised psychological therapies. This seems a strange omission.

Relaxation, which is included in the recognised list of therapies, occurs also in eye fixation and progressive muscle relaxation, a commonly used method of induction and deepening in clinical hypnosis.

This differs from the Jacobson method of relaxation (Jacobson, 1938) cited by the authors, not only in technique but also in the much greater variety of suggestions used to achieve a state of complete calm. Not uncommonly, patients who have experienced the two methods report a better and more satisfying quality of relaxation from hypnosis. The latter has the added advantage over the Jacobson method in the shorter time taken to achieve complete relaxation and the ease with which patients can be taught to relax using self-hypnosis.

I am not aware of any intensive scientific scrutiny to which the Jacobson or any other method of relaxation has been subjected, as the authors suggest. Perhaps hypnosis offers no more and no less a 'complementary' method of relaxation than others and ought to be included in any 'recognised' list of anxiolytic psychological therapies.

The authors go on to imply that provision of psychological therapies depends on the availability of trained clinical psychologists, nurse behaviour therapists, community psychiatric nurses, and counselling services. Why is the psychiatrist omitted from this list? Every psychiatrist ought to be proficient in and able to offer at least one form of psychotherapy to his patients. The alternative is psychiatry offering an assessment service and biological treatment only with the bulk of specialised psychotherapy provided by non-medical therapists.

Judging from surveys, the general public expects psychiatry to offer psychotherapy as a form of treatment – biological therapy on its own is not enough.

Perhaps this dichotomy is reflected in the differing terminology used to describe the consumer in this paper. The main body of the text on description and management of anxiety refers only to 'patients', a term traditionally used by doctors and psychiatrists. The details of psychological therapies, however, almost entirely refer to the consumer as a 'client'. This unfortunate term conveys none of the complexity, suffering and endurance of patients (Regius, 1988); a patient is always a client but a client not always a patient.

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Overseas trainees

DEAR SIRS,

I read with interest Dr Adeniran's article (*Psychiatric Bulletin*, 1992, **16**, 701–702) outlining his successful assimilation on the Overseas Doctors' Training Scheme, particularly after the recent correspondence highlighting problems for overseas trainees.