Correspondence

The Approval Exercise—constipated chaos?

DEAR SIRS

Dr Launer (*Bulletin*, April 1984, **8**, 74–5) brings serious charges to bear against the Approval Exercise, claiming that it is 'bringing units all over the country to their knees'; 'leading to real suffering among patients'; 'morally wrong'; and 'undermining patients' rights to care and treatment'. He attributes this to widespread anal fixation among those responsible, leading to progressive costiveness (metaphorically speaking, I presume).

The evidence which I have collected from many parts of the country runs counter to this view. Most have found the Exercise to be an excellent aperient—perhaps resulting in a little painful colic at times, but usually constructively productive.

I believe the Exercise to be an important instrument of College educational policy. There are good grounds for concluding that it has promoted an improvement of educational standards throughout Great Britain and Ireland and this, in the long run, must bear fruit in terms of better clinical practice. I would like to pay tribute to the large number of members who have taken part in visits, to the Panel Conveners who carry a heavy burden, and to the Dean, who is responsible for the Exercise to the Court.

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Getting rid of 'Section' jargon

DEAR SIRS

Professor Gunn's letter about 'Section jargon' (*Bulletin*, April 1984, **8**, 74) is most timely, but the headings could be even more coherent. I would suggest the following for the sections most relevant to general psychiatrists: S 2—assessment order (civil); S 3—treatment order (civil); S 4—emergency order; S 5—detention order; S 35—assessment remand; S 36—treatment remand; S 37—treatment order (judicial); S 41—restriction order; S 57—irreversible treatment certificate; S 58—hazardous treatment certificate; S 78—assessment order (judicial); S 136—police order.

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Job stress and burnout

DEAR SIRS

We found Dr Morrice's article on job stress and burnout (*Bulletin*, March 1984, **8**, 45–6) very interesting. However, we wondered if the questionnaire employed by Dr Morrice really measured what it was intended to measure. In particular, we were concerned over the possibility that general practitioners and hospital doctors would use a less exact definition of 'clinical depression' than psychiatrists.

To explore these misgivings, we repeated part of the Morrice experiment with one addition to the questionnaire: the psychiatrist was asked to explain why he answered 'yes' or 'no' to question (e)—see Table I.

TABLE I

Responses from psychiatrists (Aberdeen—Eb; Eastern Health Board—EHB) expressed as percentages of each group

Question	Eb (n = 11)	EHB (n = 22)
(a) Lack of work enjoyment	9	91
(b) Periods of exhaustion	54	68
(c) Work stressful	63	55
(d) Enduring boredom	27	41
(e) Depression	0	14

Seventy-eight questionnaires were sent by post to consultant psychiatrists, psychiatrist grade practitioners, and senior registrars in the Irish Eastern Health Board area. The names were obtained from the comprehensive mailing list of the *Irish Journal of Psychotherapy*. Twenty-two (28 per cent) completed questionnaires were returned—21 were from consultants, one came from a senior registrar.

When these results are compared with those of Morrice, psychiatrists emerge as the group most lacking in work enjoyment and as the group reporting the highest incidence of 'clinical depression' (Table I). Since this is a reversal of the original findings, and despite the different geographical setting and the lack of controls, doubt is cast on whether Morrice's questionnaire measured what was intended.

In answer to the question 'Please explain the basis for your answer to question (e)' (i.e. 'Would you say this has amounted to clinical depression?'), the expected explanations were received: psychiatrists will not use such a term unless they perceive certain symptoms (e.g. sleep disturbances, loss of interest, or reduced vegetative functions) which would have to last for at least a number of weeks. By contrast, one may gather that non-psychiatrists employ the term in the same way as we would use terms like 'unhappy' or 'bored'.

The 'Remarks' section was filled in by most respondents. Many of the entries were remarkably candid and personal. The greatest stressors were perceived as 'lack of an understanding colleague to confide in'; 'lack of sabbatical and educational breaks'; 'the obstructionism of administrators';

https://doi.org/10.1192/pb.8.7.139-b Published online by Cambridge University Press

and 'psychotherapy'. Personal tragedies were also blamed for difficulties in maintaining interest in one's work by a significant minority. Several coping strategies were reported as being helpful, especially: 'turning off' after work, maintaining outside interests, research, and 'devaluation' of perceived opponents. Most respondents felt that the questionnaire was not detailed enough to tap the essence of burnout. Two respondents questioned its validity as an entity. In contrast to Morrice, we were struck by the openness and honesty of the respondents, many of whom signed their questionnaires. We are indeed grateful to them.

In conclusion, whilst we do not feel that Dr Morrice's questionnaire measured a specific syndrome, we do believe that we tapped, if not lanced, a boil.

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'Clomipramine Challenge Test'

DEAR SIRS

I should like to take up Dr Holmshaw's invitation to comment on his 'Clomipramine Challenge Test' (*Bulletin*, April 1984, **8**, 76).

I am extremely concerned that Dr Holmshaw should feel it is appropriate for a psychiatrist deliberately to induce 'florid schizophrenic psychosis' in susceptible people by neuropharmacological methods.

In addition, I wonder whether I might assume that Dr Holmshaw follows usual medical practice by informing his patients of the desired effects of the drugs he gives them, and also of any likely side-effects.

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Self-damage in patients with Klinefelter's Syndrome

DEAR SIRS

Two of us (Prof R. G. Priest and Dr G. G. Wallis) found out by chance that we had a patient each who both showed striking features in common. They both have been diagnosed as Klinefelter's syndrome and XXY constitution has been confirmed on chromosomal assay. They are both persistent self-mutilators of an extreme degree, and show extensive scarring from skin cuts. Both have been diagnosed as having gross personality disorder. They are single, with scanty facial hair and atrophic testes. One is 25 years old and the other is 33.

There are also differences. The younger one has diffuse slow waves in the EEG, and the older one has had psychotic features. The younger one is quite intelligent, and the older one has an intelligence in the dull-normal range intelligence. Both have taken overdoses, but the younger has swallowed razor blades, and abused alcohol and other drugs.

Although self-cutting is well known to occur in patients of definitely subnormal intelligence, it is not so common in adults in the normal intellectual range. In the patients described here it seems to be more related to their abnormal personalities.[1,2]

We are wondering if other psychiatrists have encountered this combination of Klinefelter's syndrome and persistent self-mutilation. If so, through the courtesy of your columns we should like to invite them to write to us so that we may build up a picture of the resulting syndrome, if such an entity exists.

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REFERENCES

[1]PRIEST, R. G. (1979) Aggression and suicide. In *Aetiology and Management of Affective Disorders* (ed. A. M. Jukes). Horsham: Ciba.

[2]——— & WOOLFSON, G. (1978) *Minski's Handbook of Psychiatry*. London: Heinemann.

A 'College recommended' textbook of psychiatry?

DEAR SIRS

During our preparations for the second part of the examination for membership of the College, my friends and I noted the large number of books we had to refer to, in order to gather what information we felt would meet the requirements of the examination. Even then, depending on our sources, we held different views on important issues.

I suggest that the College considers appointing a special Task Force to produce a Standard Textbook of Psychiatry, in two volumes. Volume I would cover the theoretical requirements for the MRCPsych Preliminary Test, and Volume II would do the same for the Membership Examination.

The general idea is that the two volumes of the Standard Textbook of Psychiatry would represent views generally agreed by the College on the essential theoretical material of psychological medicine. As such, they will serve not only to facilitate the training of psychiatrists, but also (much more importantly) help to bring into coordination what the College sees as psychiatry.

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