our patients are becoming alienated from us, because they feel we do not speak the same language. I also agree that the increasing concentration on biological explanations emphasises individualism, as opposed to a broader perspective encompassing social and personal dimensions, and that as a result of the positive developments in neuropsychiatry and psychopharmacology we may focus increasingly on narrow medical interventions. However, I suspect the majority of psychiatrists would acknowledge that the social framework within which they are working is also changing the focus of their practice, and thereby the educational environment for postgraduate trainees.

I work in a psychiatric day hospital, where we have managed to protect a multidimensional approach to patient care. Even in this relatively protected setting, however, we have to defend ourselves against the increasing pressure to treat patients in as short a time as possible. We are expected, appropriately, to justify our interventions, and the easiest measure of improvement is a change in the patient's mental state. My colleagues in the acute service are faced with an ever-increasing demand with ever-decreasing resources, and they find it difficult, if not impossible, to pay attention to their patients' needs in a way that does justice to the complexity of their situations. In these circumstances the only way to survive with one's integrity intact is to focus on an increasingly narrow model of psychiatry, in which doctors deal with the medical problem, and leave everything else to their colleagues from other disciplines. For some psychiatrists this fits in with their personal view, but in my experience the majority find such a limited approach frustrating and unsatisfying. There is a serious danger that a new generation of psychiatrists who have been trained in this environment will lose sight of the intellectually more rewarding, and clinically more effective, broad perspective of mental illness.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Authors' reply: The responses to our editorial (Thomas *et al*, 1996) demonstrate the inherent problems of psychiatry. No one doubts the profession's commitment in wanting to do its best to help patients, but, as Greenberg points out, the practice of psychiatry is time-consuming. We work under pressures of time, which force us to practise in ways that do not provide us with the opportunity to listen carefully to what our patients really have to say to us. Under these circumstances the use of biological models and disease entities which have no established scientific validity (Boyle, 1990) becomes attractive. This means that we interpret our patients' experiences in terms of mental state phenomena, without really listening to what they have to say. This leads to dissatisfaction and disenchantment for the psychiatrist as well as the patient, because psychiatry is a speciality which attracts those who are fascinated by the necessity to juggle with the complex and unresolvable. This, ultimately, is a resource issue, one which needs to be located firmly within political discourse, because governments are elected on the basis of policies which determine economic priorities in the country as a whole. As a profession we must engage in political discourse if we are to change this situation.

Our starting point was the disaffection of service users with psychiatry, and this basic premise remains unchanged by resource issues. What point is there in increasing the availability of psychiatrists if they continue to practise in the same way? Our argument has major implications for the training of psychiatrists. Kraemer & Roberts observe that child psychiatrists have always recognised the importance of the interaction between biology, psychology and sociology in understanding individual development, and this suggests that all psychiatric trainees should be exposed to child psychiatry. But there is more to it than that. Collaboration between the profession and other organisations, including user groups such as the Manic Depression Fellowship, is important and valuable. This welcome development must be extended to other areas, particularly the involvement of service users in the training of psychiatrists. There is a growing number of service users who are involved in training, and some are starting to make contributions to the education of psychiatrists. We regard this as vital if we are to balance the 'technology' which increasingly dominates academic teaching.

There remains, however, an insoluble conflict between all specialist languages (whether neuroscientific, psychological or social) and that of our patients' experiences. The two are locked in a dialectic; oppositional discourses which express a tension with which psychiatrists must engage. If we fail to do this, and we lose our ability for self-reflection, our patients will become even more alienated, and the disillusionment of our profession will increase.

Boyle, M. (1990) *Schizophrenia: A Scientific Delusion*. London: Routledge.

Thomas, P., Romme, M. & Hamelijnck, J. (1996) Psychiatry and the politics of the underclass. *British Journal of Psychiatry*, **169**, 401–404.

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Ethology and self-injury

Sir: The article by Jones & Daniels (1996) is a welcome addition to the ethological conceptualisation of suicidal behaviour. In the model proposed by Jones & Daniels there remains the need to link the "feelings of frustration, threat, abandonment or arousal" with the subsequent behaviour. The concept of "conservation withdrawal"; Engel (1962) appears to provide this link. Engel (1962) noted that conservation withdrawal "may lead to behaviour to h[elp] cling, ingratiate, reward, force or seduce external object so as to prevent or replace [the] loss and ensure continued supply. With the failure of such changes or mechanisms to provide the solution, the affect is felt wit[h] increasing intensity . . . the drive aspect is s[o] preservative, but in a primitive 'last ditch' sense. It is essentially a conserving and includes a heightening of the barriers to reduce incoming stimu[li] reduction of activity to save ene[rgy] 'holding action' until the arrival supplies, help in the form of a s[uc]h object".

While such a formulation c[an] criticised as lacking specificity t[o] behaviour, it is consistent with th[e] invariably reported wish to escape who take drug overdoses. Furthe[r] those who cut themselves it is c[om]mon reports of the cutting bringing reality (Simpson, 1976; see [also]

The application of this clinical and theoretical adva[n]tages clinical point of view an[d] suicidal acts as examples o[f] withdrawal, as relatively un[re]solved responses to stress with the wish an intolerable situation, allows a no[n]

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