*Brit. J. Psychiat.* (1966), 112, 1075–1076

# Correspondence

## SHORTENED TREATMENT IN A CHILD GUIDANCE CLINIC

DEAR SIR,

Dr. Marjorie K. Hare's account (*Journal*, June 1966, p. 613) of her shortened method of treatment in a child guidance clinic is timely in view of our meagre knowledge of the results of child psychiatric treatment. It does however seem to call for a few comments:

(1) Studies of the presence or absence of overt symptoms two years later—especially when often based simply on telephone conversations or parents' letters—must be of limited value. Most child psychiatrists are more concerned about the longer-term adjustment of the children they treat. It is interesting that in the same issue of the *Journal*, Pritchard and Graham report various associations between childhood disturbances and psychiatric conditions in adult life. This aspect of the results of treatment is surely more important than the symptomatology two years later, though admittedly it is much more difficult to investigate.

(2) Dr. Hare's cases seem to have been a mixed group of routine child guidance referrals, and it may be that only a few of them needed intensive treatment. Unfortunately, it is impossible to tell from the data she gives how many were cases of mild reactive disorders in children who were basically normal in their emotional development and adjustment. It may be, however, that these were in the majority and that the 21 failures included most of the children requiring more intensive therapy.

(3) Some of the patients found to be "recovered" at follow-up had been discharged early from treatment because they were ". . . . needing urgent treatment elsewhere, e.g. in hospital." The number of such patients is not stated, but one must presume that the improvement at follow-up resulted at least in part from the treatment given "elsewhere". Indeed, it appears that the author, in referring these patients elsewhere, recognized their need for something more comprehensive than the shortened treatment she advocates.

Despite these points Dr. Hare is clearly right in saying that the virtues of the traditional treatment methods used in child guidance clinics need to be demonstrated. But so also do the virtues of shortened treatment, and Dr. Hare's paper, while stimulating and challenging, fails to achieve this. There is also a certain inherent implausibility about the thesis that a child's mental health and emotional development can be radically altered by a few half-hour sessions during which both child and parent are seen. Possibly, the truth is that some—even many—cases require no more than brief superficial therapy, but this does not mean either that such therapy is adequate for all cases or that more intensive treatment is not more effective.

Dr. Hare's paper is useful in drawing attention both to the need for assessment of treatment results in the child guidance field and to the difficulties involved. I wonder, however, whether the problems are not too formidable for an individual effort of this sort and ought not to be tackled by means of a more comprehensive, controlled, long-term follow-up study such as an organization like the Medical Research Council or a university psychiatric department might be able to undertake.

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## AMPHETAMINE SUBSTANCES IN URINE

DEAR SIR,

Drs. Johnson and Milner (1) rightly point out the non-specificity of the methyl orange test for amphetamine substances. In a paper published last year (2), as the result of obtaining 76 false positive results and one false negative result out of 229 tests, I concluded (*a*) that the methyl orange test is non-specific for amphetamine substances in urine (*b*) that a YES/NO questionnaire appears to be the best method at present for the determination of the incidence of amphetamine addiction and psychosis and (*c*) that amitriptyline, thioridazine, chlorpromazine and promazine produce the highest urinary amine readings. Contrary to Johnson and Milner, I obtained normal urinary amine values with chlorthiadepoxide, which is in agreement with the findings of Koechlin *et al.* (3) and also with the M.A.O.I.'s. I should like to add that as a result of these findings,



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gas chromatography is now used in our unit for the determination of amphetamine substances in urine.

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## PSYCHOGENIC DYSPAREUNIA

Dear Sir,

Following the publication of my article on the treatment of psychogenic dyspareunia by reciprocal inhibition (*Journal*, March 1965, p. 280) a number of people wrote who were interested in the follow-up of these patients. The original group of four which included the two cases reported have now been followed up (by post) for over two years. There has been no relapse of the presenting illness. One patient recently delivered herself of a son. One patient has subsequently needed treatment for a depressive illness, which responded to medication. The cases now treated in the series number eleven. None have relapsed, though one or two patients were rejected on the grounds that there were obvious problems in the marriage of which dyspareunia was only the presenting symptom.

There would seem to be no reason on theoretical grounds to anticipate relapse once intercourse has been enjoyed to normal orgasm, since the effect of reinforcement would presumably be towards facilitating the act.

Although starting with a different theoretical framework, the late Dr. Joan Malleson treated a far larger number of cases than I have done by more or less similar means and with excellent results (1, 2). As I have continued to see further cases, I have been convinced that whatever theoretical psychological framework one bases one's psychiatry on, a large measure of the success is due to the relationship developed and persuasion used by the therapist, whether one looks upon this as an anxiety-reducing effect in the application of behaviour therapy techniques, or as part of a transference situation.

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