and to symbolise her. The child throws a spinning reel away and exclaims "fort!" ("gone"); he pulls it towards him – it is "da" ("here"). Thus language is necessary because no relationship with another can be perfectly satisfying; there must always be some separation between mother and child, child and siblings, subject and other. Language also confers on us a history – another way in which it differentiates us from other primates. In analysis, for Lacan, "the subject assumes his own history" (Lacan, 1953). It is not the gaining of insight which is therapeutic in psychoanalysis (and Freud never said anything about insight), it is the very act of speaking, "the putting into words of the event ... [which] determined the lifting of the symptom" (Lacan, 1953).

It may be that this "talking cure" has implications at a neurochemical or neurostructural level. We know that the process of memory storage involves changes at these levels and it is reasonable to assume that the retrieval of memory and the remembering through speech in analysis results in similar changes. I do not wish to attempt to direct correlation between the praxis that is psychoanalytic discourse, and the science of neurobiology. Nevertheless it is interesting that Thomas & Fraser end their paper with a brief review of language therapy as a way of altering faulty discourse. It would appear that these therapies have some overlap with psychoanalysis.

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LACAN, J. (1953) Function and field of speech and language in psychoanalysis. In *Ecrits. A Selection* (trans. A. Sheridan). London: Tavistock Routledge.

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Psychiatrists and priests

SIR: Sims (*BJP*, October 1994, **165**, 441–446) asserts that "We need to balance the importance of the spiritual in the life of our patients with denying absolutely any sort of priestly role for ourselves as psychiatrists."

In the course of psychotherapy, we cannot avoid being put into a priestly role by some of our religious patients, any more than we can avoid being put into a parental role by patients who need to work through, or who attempt to act out, something about their relationship with their real or internal parents. In both cases we should interpret the transference processes to enable our patients to achieve more healthy and realistic relationships with these figures.

Most priests believe they have the authority to convey forgiveness to those who feel guilty. No psychiatrist does this in so many words, but in therapy a similar process often takes place. A depressive patient gradually realises that the behaviour for which he blames himself was only partially under his control and that he was driven to act as he did by his past experiences. Thus his guilt diminishes. Another patient may accept more responsibility for his behaviour and feel ashamed. Because the therapist does not condemn him, and may, to his surprise, still hold him in high esteem, he can internalise this experience and forgive himself. So, through his relationship with his therapist, his 'sin' is forgiven.

In the course of the work, the therapist conveys to his patient a sense that he is valuable, lovable in spite of what he is like at the moment, and worthy of all the care he needs, even if it is not practically possible to give so much. The response of some patients to this is like a religious experience. Then the therapist is functioning very much like a priest, even through neither party acknowledges the spiritual aspect of their activity. When such things happen in our work I think we should accept them humbly and with appropriate awe, rather than deny our priesthood as Sims seems to require us to do.

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Comparing treatments for generalised anxiety disorder

SIR: Durham *et al*'s comparison of cognitive therapy, analytic psychotherapy and anxiety management training as treatments for generalised anxiety disorder (*BJP*, September 1994, **165**, 315–323) made certain assumptions which would seriously question the validity of their results. These assumptions fall under the uniformity myths for psychotherapy research. First, the patient uniformity myth assumes that all patients who suffer from the disorder are expected to respond, irrespective of their underlying psychopathology, to any of the three treatments, in a similar fashion.

This patient sample had a significant bias towards the lower social classes. Forty-six per cent were also diagnosed as having an avoidant or dependent personality disorder, and 66% were taking psychotropic medication. These factors suggest