of human dysphoria, we risk getting to the point where we are minimally effective in everything but are in fact no better than quacks with delusions of omnipotence. Indeed, that is already the opinion that many people hold of psychiatrists.

The present controversy about psychotherapy seems to me a great deal of talk about new methods of treating sprain whilst ignoring the fractures. As long as there is insufficient manpower and resources to deal adequately with the diseased and the disabled, it would seem that the distressed and dissatisfied warrant a lower priority, rather than the reverse which seems to apply at present. Apart from anything else, these latter groups of people are more in a position to deal with their problems themselves and are less likely to cause serious problems for themselves and/or the community if untreated. Of course, this makes them more gratifying and generally less risky to treat, and in some countries the ability to pay for psychotherapy automatically selects a certain class of patient.

This is not actually an attack upon psychotherapy or its advocates; there is a psychotherapeutic element in any activity that a physician undertakes, but formalised psychotherapy, though clearly indicated in some proportion of cases, appears to be so widely applied these days that inevitably it will come to be seen as a minimally effective and maximally expensive activity. Of course, the more one selects for suitability, the more one returns to the previously mentioned paradox of giving most treatment to the patients who need it the least.

I would therefore suggest that, when the last psychotic patient is reasonably free of distressing and troublesome symptomatology, has reasonable personal hygiene and appearance, and has adequate diet, occupation and living conditions, then psychiatrists can concentrate on psychotherapy to the exclusion of all else, since there will be nothing else left to do.

Finally, I take issue with Bloch and Lambert (*Journal*, January 1985, **146**, 96–98) when they suggest that "is psychotherapy effective?" is a "rather pointless question". Many of the references they cite as indicating that psychotherapy exerts some positive effect would be laughed out of the journal club if they related to other areas of psychiatric endeavour: for example the paper by Andrews and Harvey covers studies with totally untreated controls and 54% of the studies were not of traditional psychotherapy patients but included psychotics, handicapped and normal persons. They state that "whether this (the extent of the treated groups' superiority) is clinically important is difficult to determine". Strupp and Hadley's paper does not directly address the issue of effectiveness of psychotherapy and only concerns 15 patients anyway, and the paper by Strupp relates to only two cases.

From what is becoming an increasingly scientific branch of medicine, it would seem that the question is far from pointless and far from being settled. In my own experience, effective psychotherapy is delivered by those with common sense, compassion, charisma and natural talent. Studying the work of individuals with these qualities would show that psychotherapy can be extremely effective when delivered by the right person: the paradox here is that such an individual is likely to be equally drawn to the plight of the psychotic patient, and as a result he or she will be equally likely to be found in the back wards of the mental hospitals.

I can't help feeling that if people stuck to what they were good at, then the balance of services and the effectiveness of psychotherapy would cease to be problems.

MICHAEL HUNT
Swift Current Mental Health Clinic,
350 Cheadle Street West,
Swift Current, Saskatchewan,
Canada S9H 4G3

Combined Psychotherapy and Pharmacotherapy for Depression – the Compliance Variable

DEAR SIR,

Over the past five years a number of clinical trials of psychotherapy and pharmacotherapy, alone and in combination, have been carried out on depressed patients (Di Masico *et al*, 1979; Weissman, 1979; Rounsaville *et al*, 1981). A consensus would seem to have emerged, at least in the American studies, that there is no negative interaction in combining these two forms of treatment of ambulatory depressives. Moreover, positive and additive effects of the combined treatment appear to have been demonstrated.

I wish to suggest a possibility, which does not appear to have been considered by the investigators performing these trials, that the additive effect of psychotherapy on pharmacotherapy may simply be an artefact resulting from the former causing increased compliance with the latter.

Almost all of these studies have been done on outpatients. The compliance of such groups with medication is known to be notoriously low. One could speculate that compliance with the older generation of tricyclic antidepressants, as used in these trials, would be particularly poor owing to the patients' immediate experience of side effects and the time lag before any benefit would be apparent.

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It is commonplace experience in clinical practice that one of the most powerful determinants of medication compliance is the quality of the therapeutic alliance in the doctor/patient relationship. Patients in these trials who, in addition to medication, received psychotherapy very likely developed a stronger therapeutic alliance than those who did not.

It is not my purpose to attempt to argue that psychotherapy has no beneficial role in depression. Indeed, everyday clinical experience attests to its value and moreover, the abovementioned trials demonstrated an independent beneficial effect of psychotherapy alone. My point is simply that, unless serum levels of antidepressants are measured, the mechanism for the additive benefit of combined therapy must remain in doubt, as variations in compliance are very likely exerting a major influence. To date, no similar trials utilising serum antidepressant levels to monitor compliance have been published.

J. T. CONDON

Flinders Medical Centre,
Bedford Park,
South Australia 5042

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Psychiatry in Jeopardy?

DEAR SIR,

It seems to us that Professor Rawnsley's article 'Psychiatry in Jeopardy' (*Journal,* December 1984, **145,** 573–578) represents a developing and worrying consensus amongst psychiatrists which needs to be challenged both as to fact and to the superstructure it is made to carry.

The evidence that psychiatry is, in fact, in jeopardy is thin. The anti-psychiatry movement has abated, Laing and Szasz now have little in common and are proponents of different, fairly conventional psychotherapies. The Scientology Church is a shrill but small voice and we need feel no more jeopardised than the haematologists do by Jehovah's Witnesses. The 1983 Act is frankly little different from the 1959 legislation, and the criteria for Section 2 seem less restrictive than the old Section 25. Certainly gynaecologists seem to operate under at least equal legal restraint.

Professor Rawnsley's underlying cause, a deep seated ambivalence to mental illness, also needs close examination. Is not fear of mental illness more common amongst those less acquainted with it? On the whole, society seems to be moving towards a stress model of mental illness, sympathetic concern rather than fear. A considerable proportion of our patients are extensively supported in the community by a tier of semi-professional helpers; clergymen, Samaritans and the like. Having found such a universal defence of psychiatry, Rawnsley uses it rather indiscriminately. The mental hospital scandals, although perhaps explicable are certainly not defensible in terms of selective public attention. We are also puzzled by the rather odd incident recounted from his time in field research. He seems to recount a story of a man who had been in hospital for some time, presumably significantly disabled, who was discharged not only without consulting his support network but without even informing them. He would have witnessed a similar response if the patient were returning from a geriatric ward.

Running through the whole article we perceive a theme which is becoming more and more commonly expressed as an overall model of psychiatry within the profession. This model amounts to a paradigmatic shift from the traditional consensus of a multidisciplinary multifactoral approach to one which claims specifically medical factors as paramount and thus grants doctors hegemony. There is a common though false way of stating this argument that disguises it as a development of the multifactoral approach, by stating that as medical factors can be important only a doctor can have an overall view.

This new theme needs to be challenged not simply because it is false but because it is having a damaging effect on clinical practice. It can be discerned in the increasing interest in physical tests, the broadening use of lithium salts and a move towards DGH units. The social and personal implications of a diagnosis – treatment model – alterations to personal responsibility, changes of interpersonal conduct – are introduced incidentally.

In short we believe psychiatry is damaging its own practice in mounting a defence which won't work to a threat which doesn't exist.

STEVE GREEN

Royal Hospital, Weston-super-Mare,
Avon BS23 4NF

CHRIS SAGE

Barrow Hospital, Bristol

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