and transference encouraged, or a supportive approach in which interpretations are rare, defences bolstered, and a more reality-based therapist-patient relationship established; this will vary also within an individual patient over time. It is appropriate on occasion for judicious, hopefully mutatative dynamic work to be done with patients whom one has largely supported; likewise, it may be appropriate as a phase in therapy to relax exploratory work in favour of support in those patients to whom one is offering dynamic psychotherapy. Beyond that the bias may change from episode to episode – a patient may be supported on an occasion of crisis, only to be re-referred a few years later for more definitive work.

By defining dynamic and supportive psychotherapies too rigidly I believe we diminish their potential. While not decrying the merits of brief focused psychotherapy, there is always a danger of writing the script of treatment in advance, which is surely counter to the 'dynamic' of dynamic psychotherapy. By sticking too rigidly to the limited goals of supportive psychotherapy we may deny our patients opportunities for growth. We are greatly indebted to Dr Crown, however, for once again emphasising that we must continue to think about what we are doing, why and how we are doing it, and how often, in psychotherapy.

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SIR: I first express my gratitude to Dr Crown for his stimulating paper. The article was (almost certainly) a response to an all-too-vague and inadequately documented phenomenon. In comparing dynamic and supportive psychotherapies, he dealt very briefly with comparisons concerning goals or desirable outcomes, and I believe that this area contains essential differences worth noting. Dynamic therapy is concerned with change – often very basic change of life strategy. Supportive therapy does not pursue such fundamental goals.

In a situation of transient difficulty, where the patient needs to survive a crisis (divorce, bereavement, physical disease, etc.) without mental breakdown, or where mental breakdown has occurred, and supportive therapy aims to minimise the likelihood of recurrence, change of values, defences, or behaviour may be quite undesirable, and support frequently aims to bolster familiar coping mechanisms.

Where a presented problem involves long-standing focal or general inadequacy of life-strategy, change may be the principal goal of therapy, and its achievement may require the dismantling of familiar coping mechanisms, construed neurotic or maladaptive. Dynamic psychotherapy requires the abandonment of safe havens behind neurotic defences, for the more challenging and dangerous pattern of less defensive relating, with the reality of regression and risk of breakdown.

I believe, with Dr Crown, P. Sifneos and others, that dynamic psychotherapy carries the likelihood of worsening adaptation before improvement occurs, based on more adaptive life strategies emerging.

Dr Crown concludes that supportive is not psychotherapy and vice versa. He does not concede here, although the abstract of his 1986 talk did concede, that supportive therapy may be therapeutic. Within a definition of psychotherapy which includes substantial personal change as an essential ingredient, I believe his latest analysis to be accurate. However, in the interests of a catholic and tolerant definition of psychotherapy, I would be much happier to accentuate the therapeutic construction of supportive therapy. Many psychotherapists provide support for numbers of their patients, and many other professionals view their supportive endeavours as therapeutic. Applying a medical model of therapy and examining 'fit', there are clearly 'curative' and 'palliative' categories of intervention, each deemed 'therapeutic'. Some psychotherapists would possibly argue that palliation is not part of their remit; I believe that to be an untenable posture.

It has to be conceded that dynamic and supportive therapies differ. Radical and conservative managements always do, but each can justifiably claim to be therapeutic. If it were conceded that supportive therapy be therapeutic but not psychotherapy, the question would need to be addressed; if not the psyche, then what *is* being treated?

I can supply no satisfactory solution to this dilemma and accordingly I cast my vote in favour of accepting supportive psychotherapy as a kind of psychotherapy, albeit conservative and limited in its goals.

This view would not concede the status 'psychotherapist' to practitioners of supportive therapy not engaged in, trained in, and committed to radical curative forms of psychotherapeutic endeavour. While this debate (who is a psychotherapist?) is probably nearing, if not conclusion, at least significant progress, it would be a pity for the established forms of radical psychotherapy to regard as a challenge, or with any trepidation, any pretensions to status which may be claimed for supportive psychotherapy on behalf of its many non-psychotherapist practitioners.

I believe an emerging profession of 'psychotherapist' will have no difficulty identifying practitioners of radical intervention, with acceptable

training and commitment. The spectre of a dilute, meaningless grouping practising everything from psychoanalysis to dianetics must surely be dismissed ere long.

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Screening for HIV

SIR: I am astonished that an academic psychiatrist such as Dr Goodwin (*Journal*, March 1988, **152**, 426–427) should find difficulty in accepting the need to determine the HIV status of a patient in which HIV encephalopathy forms part of the differential diagnosis.

The psychiatric syndromes accompanying HIV encephalopathy remain undefined, and it is only with reports such as that of Thomas & Szabardi (*Journal*, November 1988, **151**, 693–695), backed up with post-mortem studies, that an adequate nosology of the condition can be developed. Our predecessors did not quibble over the justification for determining whether infection with treponema pallidum was present in their patients, and I can see no reason why the position should be any different for HIV. Dr Goodwin appears to assert that, because an effective treatment is, as yet, unavailable for AIDS, we should refrain from studying the syndromes that HIV may cause (how can they be studied if the HIV status is unknown?). The consequences of such a position extended to non-AIDS psychiatric disorder would be, quite simply, stagnation.

Dr Goodwin's dismissal of the nursing management issue is, in my opinion, trite. HIV infection poses quite specific problems where behavioural disturbance occurs. Nurses on acute admission wards are able to receive immunisation against hepatitis B and I believe this should be *de rigueur*. No such immunisation exists against HIV. The conventional wisdom that HIV transmission is limited to sexual intercourse and the injection of large quantities of body fluids is gradually giving way to a realisation that quite minor insults can lead to seroconversion (a review of this is in preparation) and that needlestick accidents and blood spillage may represent very real hazards to staff. When a patient becomes acutely disturbed, there is a natural reaction to respond to the problem immediately; in the case of HIV positive patients who not infrequently spit and spray blood when disturbed, intervention by staff without adequate protection may well result in infection with the virus. To place staff at needless risk of contracting a lethal condition because of the dubious niceties accorded to HIV infection (as opposed to any other transmissible agent) is quite unacceptable.

It is my view that patients who are to be admitted to a psychiatric unit, when behavioural disturbance may be likely, should be routinely screened for HIV carrier status. In the case of informal patients, where consent for screening is not forthcoming, consideration should be given as to the appropriateness of admission. In the case of those detained under the Mental Health Act, I am sure that 'assessment' may be taken to include dangerousness from HIV carriage as well as other parameters.

I am still unable to fathom why there is so much furor about HIV. A raised mean corpuscular volume may label a patient as an alcoholic (in the absence of B_{12} and folate deficiency) – should we have to obtain specific consent for a full blood count? Why is AIDS accorded this unprecedented protection from investigation?

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Therapeutic Factors in In-patient Psychotherapy Groups

SIR: It was encouraging to see a report of a British study on therapeutic factors within in-patient psychotherapy groups (Kapur *et al*, *Journal*, February 1988, **152**, 229–233): published research in this area tends to originate largely in the US.

In order to obtain their in-patient sample, Dr Kapur *et al* collected data from 3 groups operating in 3 separate units. Even then the sample is quite small ($n=22$). This raises the question of how widely group psychotherapy is available to in-patients in contemporary acute admission units. Our own findings suggest that such groups are only available to a very low percentage of in-patients (Mushet & Whalan, 1987).

The study also raises the question of how much psychotherapeutic work can be done with in-patients. Dr Kapur *et al* report that the group therapy offered followed Yalom's (1983) interactional framework. It is not clear from the data, however, that patients were able to respond to this focus, as the value of factors such as altruism and cohesiveness is mainly stressed in the results. Our research findings suggest that such morale-boosting factors are very important to in-patients but that, when an interactional framework is used, patients place particular