

## Correspondence

### *Everyday life in a drug trial*

DEAR SIRS

For a number of months we have been working as a team running a drug trial centre for treatment of patients suffering from Alzheimer's disease.

Our team comprises a psychiatric research registrar and a psychologist. While the psychiatric trainee deals with physical (including neurological) examination and appraisal of cognitive functions, the psychologist carries out formal psychometric tests.

Both psychiatrist and psychologist deal with organisation and administration of the trial, with the result that patients and their families rarely deal with anyone else in the hospital.

Each patient is regularly reassessed and, during the initial phases of the trial, this happens on a weekly basis. This involves travelling and often time off work for the caregivers. We enjoy a good level of cooperation. Maybe by making a virtue out of necessity, the personal effort and inconvenience in the attempt to help their loved ones becomes bearable, especially as the families are in a 'last straw' situation, albeit one that all too often fails to restore any degree of realistic hope.

Given the regular and informal nature of the consultations, we find that families become almost dependent on the contact with the research team. As they begin to relax, they also begin to ask questions that are virtually impossible to answer: "How long does he/she have?", "When will we see an improvement?"

We have learnt to share our uncertainties with them while we give as clear and as honest an explanation as possible as to the nature of the illness, its physical and social implications and what research has shown to be the average prognosis. Distressed relatives need to be given time to tell us their feelings, their sense of bereavement, their hopelessness. We are sometimes the only people they will confide their despair to without feeling the need to pretend otherwise, as we are not involved in the home situation. Relatives welcome realistic information and practical advice more than any form of futile encouragement.

Given the amount of time spent with these patients, a greater awareness of the emotional and cognitive features linked with a global dementing process has come about. Particularly striking is the level of insight to be found in many cases. Deep emotional understanding of the setting, our motives and their predicament can be surprising, especially in some cases where the scores on the Mini Mental State Examination test border on untestability. We do not

take for granted any more that dementia and loss of insight go hand in hand. This has helped us develop a more understanding and regardful attitude towards patients. Explanations are therefore given to both patients and relatives alike.

One difficulty we come across is having to compensate for the frequent speech problems, such as dysphasic errors, paraphrasias and occasionally the almost complete loss of any fluency in verbal expression. By giving the patient more time to answer, by encouraging him/her to relax and by modifying the way in which we ourselves speak, more effective communication is achieved. Indeed we adapt our speech to that of our patients, by slowing it down, scanning words clearly, using fewer words per sentence and maintaining eye contact. We also greatly reduce the use of symbolic and abstract concepts. The impression is that of a more concrete, semantically and logically immature, quasi developmentally younger form of language. The patients' speech seems to be linked with their failing cognition and level of preserved intelligence, rather than with the emotional substratum of their personal and interpersonal reactions. While our language becomes apt to the communication with a young child, behavioural, gestural and facial cues alert us to the fact that the emotional rapport is with a middle aged or elderly man or woman struck by and aware of his or her illness.

Being involved in a drug trial has been interesting and formative in our training experience. We were aware that we might be seen as promoting the administration of a drug "to cure the incurable" by some of our clients, and it was our duty to give our work an utterly realistic outlook. Most importantly, we have learnt that at no point should or could the administration of the trial medication come before the consideration of the patients and their rights. Even in this day and age, a proper drug trial audit must be clearly weighed on ethical grounds.

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### *The moral case against psychotherapy*

DEAR SIRS

I would like to reply to Dr Charlton's stimulating article 'The Moral Case Against Psychotherapy'