

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'

(*Psychiatric Bulletin*, August 1991, 15, 490–492). The gist of his article is that psychotherapy is morally reprehensible because it subjects the patient or client (or whatever you want to call the individual in therapy) to a series of “edifying conversations”, not because the therapist truly cares but simply because it is his job and he has a financial stake in the whole proceedings.

Firstly, psychotherapy is not about edifying conversations, it is about increasing autonomy (Holmes & Lindley, 1989), allowing people who have previously been inhibited by neurotic mechanisms to experience life to the full and to increase their freedom of action. Often topics discussed in psychotherapy sessions may be far from edifying and concern the darkest and most dangerous parts of the self, the essence of the enterprise being to allow the patient to come to terms with these elements in his character and to use them to enhance his life in his own way. A teacher, perhaps, may have edifying conversations with his pupils, presumably because he knows best. However, although the psychotherapist may guide, he is in turn guided by his patient, the process being reciprocal (Casement, 1989).

Secondly, although the author is surely right that no psychotherapist can care about their patients in the sense that they care about themselves, does this necessarily mean that all feelings of warmth or empathy are phoney? It is commonplace to feel partisan on behalf of one's patients and to become upset when things happen to infringe their rights or wellbeing. This happens in all branches of medicine. Is it desirable that the therapist should care as much about his patient in a personal sense as he does about himself? Psychotherapists listen, they reflect, they judge the timing and nature of interpretations. In short, they practise a skill which is as much a discipline as any other branch of medicine. It is not their role to offer friendship.

Psychiatrists are not compelled to take on therapy cases for financial reasons. Most people practising in the field do so because they have a special interest in this fascinating area and are not there simply because it means “more bucks”, to quote Mel Brooks. In any case, why is paying psychotherapists morally worse than paying any other type of practitioner?

Finally, Dr Charlton makes the common error of equating psychotherapy with psychoanalysis. He does not seem to acknowledge the existence of briefer psychodynamic therapies which are eminently suitable for use in the National Health Service. Would he really want to deprive patients of these treatments on the ground that they are immoral?

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References

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 HOLMES, J. & LINDLEY, R. (1989) *The Values of Psychotherapy*. Oxford University Press.

DEAR SIRS

Dr Charlton published an interesting and thought-provoking article (*Psychiatric Bulletin*, August 1991, 15, 490–492). His depth of feeling for the subject matter was clearly visible. Unfortunately much of his discussion was based on misconceptions, which even a non-convert to psychotherapy could correct. For example: psychotherapists do very little talking and instructing but spend most of their time listening; counselling and psychotherapy, which he lumps together, are very different types of treatment; there is no evidence to show that in the great majority of cases psychotherapy is damaging (Andrews & Harvey, 1981); you can still get psychotherapy in the NHS so technically you do not have to pay for it (psychoanalysis is different).

Unfortunately his views on psychoanalysis are also misconceived. Because patients have to pay for analysis, they are obviously choosing this form of treatment, and presumably have a good idea of what is involved. Dependence (something that Mr Charlton has concerns about) is in fact one of the fundamental aims, so that regressions can occur and be worked through. Other forms of therapy do not produce a dependent relationship. The patient is autonomous, encouraged to remain so, and able to terminate therapy at any stage.

He raises the issue of medical paternalism, a concept that most of us will recognise. Doctors are constantly encouraging patients towards autonomy, but many of them do not seem to want this. This is why the family doctor is still such an important figure. Perhaps we should be addressing Dr Charlton's point from a different angle, and ask why society today needs to keep casting doctors in such a paternal role.

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Reference

- ANDREWS, G. & HARVEY, R. (1981) Does psychotherapy benefit neurotic patients? *Archives of General Psychiatry*, 38, 1203.

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Dr Charlton (*Psychiatric Bulletin*, August 1991, 15, 490–492) rightly identified the immorality of psychodynamic psychotherapy in its phoney professional neutrality, its busy-bodying interference in the domain of private data and its undermining of