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Correspondence

Accident Neurosis and the Law

DEAR SIR,

I was interested to read Tarsh and Royston's 'Follow-up Study of Accident Neurosis' (*Journal,* January 1985, **146,** 18–25), although this study does seem to provoke almost as many questions as it answers. Reference is made by the authors to the wrath which claimants reserve for the "whole medical and legal merry-go-round". I am not competent to comment on the specialist medical aspects but some of the apparent complaints about lawyers and the legal system do need to be examined more closely.

Medical examinations are never "for the benefit of lawyers"; they are all ultimately for the benefit of the claimant, since clearly no lawyer in his right mind, whichever side he is on, could possibly advise settlement of a case until he has expert medical advice as to the extent of the injuries suffered.

Some clients do of course come to resent their own lawyers and sometimes with justification, particularly if a lawyer has accepted a type of case of which he has had no experience and with which he is not competent to deal. There are however many reasons why clients seek to change solicitors, one of which is unjustified dissatisfaction with entirely accurate and proper legal advice that the claim is not as strong or as large as had been hoped. It is also interesting that two out of the three types of complaint specified, namely that the claimants were never told what was happening or why and that their professional advisers were not even interested, are very similar to complaints frequently made by litigious patients about their doctors; and while it is of course true that the legal process is a slow one and that lawyers are responsible for some of the delays, ironically one of the most common reasons given by plaintiffs' solicitors for their failure to pursue a case swiftly is delay by the medical experts in providing reports and opinions.

More use could be made of interim payments, although only "in cases where the outcome is not clear" when it is not liability (including the question of causation) which is in doubt but purely the extent of the injury. Section 6 of the Administration of Justice Act 1982 does in fact provide for the award of provisional damages for personal injuries in certain circumstances, but this Section is not yet in force and in any event it will probably be of little help in the present context.

It is not disputed that the legal process is often slow and cumbersome and that delays by lawyers can increase the distress of claimants. My quarrel with the study is that it seems to place more blame for accident neurosis on lawyers and the legal system than the results of the research would appear to justify. The authors assert that "if potential patients knew where they stood early, and in particular, if they knew that no one was liable for damages, then it seems likely that much neurosis might not arise" and they go on to suggest that "the overall system needs to be accelerated and better explained in all medical, legal and social aspects so that claimant dissatisfaction should not be the obstacle to improvement that it appears to be today". However, nowhere in the study is there any real evidence to support these views and if anything they appear to be inconsistent with the authors' previous reference to the "lack of improvement after compensation".

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Psychotherapy and Psychiatric Need

DEAR SIR,

In the midst of the psychotherapeutic jihad between the faithful and the heretics, it was a distinct pleasure to read Richman and Barry's paper (*Journal,* February 1985, **146,** 164–168) pointing out the growing tendency for less handicapped psychiatric patients to receive more services with consequent detriment to more severely handicapped individuals.

In an age when medical and paramedical mental health professionals willingly undertake to talk people out of everything from cancer to unemployment and when the growth of untested, quasi-scientific "therapies" with no rational basis and an inbuilt reluctance to submit to close scrutiny begins to resemble, in several ways, that of a colony of salmonella, it is high time that we take a good look at ourselves and decide where our main responsibilities lie.

I heartily agree that "a substantial proportion of psychiatrists should return to the problems for which they are best equipped to deal". If we do not stick to what we know best, and if we continue to spread ourselves ever wider across the whole range

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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.

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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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