(*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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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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DEAR SIRS

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

personal integrity and self-responsibility. However, he elides from the lay psychotherapist, to the doctor therapist, and to the psychiatrist. The moral responsibility involved is not equal in these three cases.

Fools and their money are soon parted, so the "client" who pays for lay psychotherapy gets his money's worth. When, however, a patient submits to psychotherapy by a doctor he is entitled to believe that this treatment arises from a scientific methodology at least as sound as the other "miracles of modern medicine". To fail to point out that psychodynamics have no basis in science is to slip into quackery. The moral position of psychiatrists practising this regime is even more deplorable. They, above all, have a duty to evaluate the "treatments" of mental disease and disorder and they should be aware of alternatives available as well as the limitations of applied science in their specialty.

What of the morality of a Royal College which acknowledges that psychodynamic psychotherapy is not a mandatory subject for study, but includes substantial questioning on it in its professional examinations?

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DEAR SIRS

In his amusing polemic (*Psychiatric Bulletin*, August 1991, **15**, 490–492) Bruce Charlton purports to put the moral case against psychotherapy. What he has done is to come out shooting in all directions from the hip: at caring professions, at phoney experts, at health faddists, and others. He seems to view his main target, psychotherapy, as some sort of emotional First Aid and enlists as his ammunition a lot of half-digested ideas about empathy, caring for the whole person, and the nature of friendship.

Sharing with Charlton's background in the biological sciences (I was a preclinical lecturer in neurophysiology for 10 years before training in psychiatry), I share also some of what I assume are his doubts concerning the claims of psychotherapy. In particular, I am concerned about the lack of empirical validation for what can be, as Charlton notes, as interminable process (he explicitly excludes time limited forms such as behaviour therapy and cognitive therapy). However, the central issue for the empirical investigator is not that psychotherapy has failed the crude tests of the past, but rather how to devise a sufficiently subtle methodology to give a valid assessment of its current therapeutic claims. It is reasonable to suppose that use of a "therapy" which failed adequate tests would be morally wrong, and any continuing practitioners would be charlatans: but such a clear cut state of affairs regarding psychotherapy is unlikely in the near future.

From the biological point of view, verbal utterances provide a potent input to the central nervous system and elaborate structural and functional arrangements exist for their reception and cognitive processing (for a biological perspective see Evans, 1982). If we accept this as empirically validated (as well as commonsense) information, then the logical next step is to determine how talk can be put to therapeutic use.

Surprisingly, Charlton does not seem much concerned with empirical issues and prefers instead to dwell on an equation between friendship and what he calls "good psychotherapy". This is a confusion and simply cannot be sustained. Even if they wish to be involved, friends and relatives may be too close – too biased in Charlton's words – to be of any value in the painful process of psychological investigation as opposed to the much more friendly process of psychological support. This is not an attempt to degrade friendship, but to indicate its fundamental values and natural boundaries.

To put it bluntly, talk is strong medicine. As friends and relatives, we should all be able to provide support and nourishment, and even a little First Aid for emotional injuries sustained in the rough and tumble of everyday life. More radical surgery requires the surgeon's skills and not the well-intentioned – and self interested – probings of a friend. Of course, in psychotherapy as in surgery, the moral issues can be seen more clearly when illuminated by good empirical data.

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EVANS, E. F. (1982) Functional anatomy of the auditory system (chapter 14), and Functions of the Auditory system (chapter 15), In *The Senses* (eds., H. B. Barlow and J. D. Mollon) pp. 251–306 and 307–332. Cambridge: Cambridge University Press.

DEAR SIRS

I hope you will consider the publication of an article I have in mind to be entitled, I think, 'The Moral Case against Anatomy'.

I believe that I have all the requirements necessary to write on such a subject, namely:

1. I haven't learnt anything about it for years.
2. It is about as far removed as possible from the way in which I make my living.
3. I have never experienced it personally.
4. I have almost no idea how it is done.
5. I am rather unfamiliar with its aims and objects.
6. I can work up a fine old froth of indignation every time I think about it.