depressive psychosis' in this study may have been associated with a very heterogeneous group. In view of the importance of the study, I would ask Drs Lambourn and Gill to publish brief clinical descriptions of all their patients. It may then be possible to evaluate the general significance of their results. I do not accept that the data they have presented so far 'casts some doubt on current views of the effectiveness of ECT in general', although their results certainly cast doubt on the effectiveness of ECT in their sample.

A major problem in this kind of study is that the group of severely ill patients with particular clinical features, who would be expected to make a specific and dramatic response to ECT on the basis of clinical experience, cannot be easily included in a study with a placebo group, for ethical reasons. For all I know, none of the 32 patients in this study had the kind of syndrome which, I have found, urgently requires ECT. More information please!

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DRUG ABUSE IN MANDURAI

Dear Sir,

May we briefly report important findings on drug and alcohol abuse in this part of India? Apart from alcohol and tobacco, drugs are not thought to be abused to an alarming extent in India. The National Committee on Drug Addiction (N.C.D.A. 1971) concluded that much of the population was totally abstinent, a feature attributable to the cultural attitude. However, there have been fears that this position might change; some few alcoholics and hard drug addicts are known, although this remains very rare in women.

We have studied 178 (175 male) addicts and alcoholics in our department in the five years 1970–4. We included cannabis users smoking more than 0.5 g daily for several years.

Drugs involved were alcohol and/or cannabis in 146 (8 per cent), multiple drugs in 16 (9 per cent), barbiturates, amphetamines and opiates in 16 (11 per cent). The *incidence* of new cases appears to have doubled between 1970 and 1975. The study has indicated that addicts form a small percentage of those who seek psychiatric help (1.7 per cent), though this proportion is rising. Illiterates in India are generally averse to drugs, which in their view harm the body. Ayurveda, the Indian system of medicine, emphasizes the regulation of personal habits and nutrition, rather than medication, for positive health. These ancient concepts still prevail. Currently there has been a total prohibition of liquor consumption in some parts of India, and the ultimate aim of the Government is country-wide prohibition. The cultivation of cannabis has been banned, and within the next decade it will not be available from indigenous sources.

We intend to continue to study the situation as it changes in the next few years.

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Reference

N.C.D.A.: 'Drug Abuse in India' (1977) Report of the Committee appointed by the Government of India, Ministry of Health and Family Welfare, New Delhi.

ATTITUDES OF NURSING STAFF TOWARDS ART THERAPY

Dear Sir,

The efficacy of any form of therapy will be affected by the attitudes of nursing staff. We used a questionnaire to find out why psychiatric nurses valued art therapy, and how training affected their attitudes. Eighty-five nurses at a large psychiatric hospital were asked to indicate whether they agreed with each of 14 statements; of these nurses 48 were trained, and 37 untrained or in training. The hospital had organized a programme of art therapy for ten years entirely administered by trained personnel.

The nurses correctly perceived art therapy as an activity intended to encourage self-expression and relaxation, rather than the development of artistic skills. However, only 65 per cent considered art therapy to be a form of treatment, and many saw it merely as an ancillary service akin to occupational therapy. Many nurses recognized forms of treatment other than purely physical ones: in fact only 44 per cent agreed with the suggestion that 'physical treatments (tablets, ECT, etc) are on the whole more effective than any other kind of treatment'. Nevertheless, the benefits of art therapy were seen as largely social. A surprising finding was that there was no significant difference between the proportions of trained and untrained staff who agreed with any question.

The different attitudes of psychiatric nurses and art therapists must result in the therapeutic outcome

being less than optimal; and, to the extent that training fails to make nurses' attitudes more consistent with those of art therapists, nursing education is losing an opportunity for increasing co-operation between medical and para-medical staff.

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BRITISH PSYCHIATRY'S LOVE AFFAIR

Dear Sir,

I sympathize with Dr Macilwain's transatlantic letter (*Journal*, September 1978, **133,** 282) following the critique of British psychiatry by Professor Kathleen Jones (*Journal*, April 1978, **132,** 321–32), which describes psychiatry's 'love affair' with medicine at the expense of a wider conceptualization, including psychodynamic awareness. From greener pastures elsewhere, Dr Macilwain asks if he would be permitted to practise psychiatry as he would wish to over here. Since this concerns many psychiatrists in training, I feel it can be stated that there are several hopeful signs that the aims and attitudes of influential people here are changing for the better, as in the following examples.

One way of assessing the priorities of the DHSS in a time of economic stringency is to look at the number of new posts established in different specialities. Before 1975 there were no senior registrar posts in psychotherapy apart from four in London, but since then four new provincial posts have been created. At consultant level, data from the Medical Manpower Division of DHSS (in *Health Trends*, **9,** 45 and **10,** 61) indicates that between September 1976 and September 1977 consultant posts in psychotherapy rose from 18 to 32. This 78 per cent increase compares with a 1 per cent fall in mental handicap (although the number of posts in these specialities is much larger), while forensic psychiatry posts rose from 9 to 11 (22 per cent). The need to develop psychotherapy services in areas where they barely exist is being recognized, as shown by several new consultant posts such as the one I have been appointed to in Kent.

From its inception in 1971, the Royal College of Psychiatrists has adopted the policy that all trainees in general psychiatry should have some training in basic psychotherapeutic skills (*Journal*, **119,** 555–7). This aim is seriously limited by the lack in most areas of trained psychotherapists, but is increasingly being implemented according to local opportunities (*Journal*, **132,** 398–402 and *The Bulletin*, August 1978, 143–5), including Aberdeen where Dr Macilwain and I were colleagues and here in Cambridge where psychotherapy training is given a high priority. Psychotherapists themselves are increasingly responding to the challenge to demonstrate their ability to 'deliver the goods'. Careful and sophisticated research on the effective components of psychotherapy and its long-term effects, e.g. Malan's work on brief psychotherapy, is being matched by development into new areas, e.g. Brook's frontier work on the attachment of psychotherapists to general practice surgeries (Brook and Temperley, 1976). Dr Macilwain rightly emphasized the importance of attitudes of teachers in medical schools. In Cambridge, with the encouragement of senior medical staff, we have attempted to use regular discussion groups on the subject of all aspects of doctor-patient relationships, although serious difficulties have been encountered.

Lastly, in Sir Denis Hill's lecture on 'The Qualities of a Good Psychiatrist' (*Journal*, August 1978, **133,** 97–105) he freely acknowledges the essential place of psychotherapy and an awareness of psychodynamic factors. I was impressed with his description of clinical maturity which starts: 'personal and emotional maturity, which means freedom from personal neurotic nostalgia with one's own past'. The grass may well be greener in Canada or America, but the soil over here is more fertile than it may appear and needs good farmers to work in a challenging and rewarding field.

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DO CHRONIC SCHIZOPHRENICS IN HOSPITAL NEED MORE THAN ONE NEUROLEPTIC DRUG?

Dear Sir,

In psychiatric hospitals long-stay patients are commonly prescribed more than one type of neuroleptic preparation. Rationale for such practice is not clear. We wish to report here our experience in switching patients from multipharmacy to a single drug regime.

We assumed the clinical responsibility of a ward in which there were 30 female chronic schizophrenic patients. Their mean age was 60.3 ± 1.5 years and they had been in hospital for a mean period of 27 ± 2.3 years. Fifteen of these were receiving more than one type of neuroleptic preparation including