therapist, although Luborsky *et al* assume without checking that inexperienced therapists were worse. Also, no benefit of longer over shorter treatment. Altogether, an impressive series of negatives.

Anyway, the majority of studies included in these analyses defined success as based on the therapist's own judgement. Apparently psychotherapists are excused not only from placebo controlled studies, but also from double-blinding! When Harty & Horvitz (1976) compared therapists, patients and research judge's ratings of the benefit of psychotherapy, the therapists always rate their outcomes as more successful than either the patient or the outside observer (this applied particularly strongly to psychoanalysis where judges gave only a 20% success rate after a median of 540 treatment sessions!)

The definition of psychotherapy as doctors listening to patients is one which is specific to certain dynamic psychotherapies. Nevertheless, I had always supposed that the dynamic therapist did indeed speak from time to time: using words of greatly enhanced impact due to being so sparingly employed. But this definition does not begin to cover the scope of techniques included in the meta-analytical studies, nor the even larger range of counselling and psychotherapies which are actually practiced under those names. High-minded comments outlining the "aims" of dynamic psychotherapy are all very pleasant, but so what? Everybody (excepting a few evil geniuses) "aims" to help unhappy folk, enhance their autonomy and all the rest of it. The whole point at issue is whether or not psychotherapy actually delivers what it promises.

Nietzsche attempted (among many other things) the *unmasking* of, for example, Christianity; saying that the *actual* effect of a doctrine may be exactly contrary to its self-advertised "aims". My argument with psychotherapy is analogous. In the first place I have tried to demonstrate that the "unmasked" effect of psychotherapy is often morally bad rather than good; in the second place (and given that psychotherapy may be unavoidable) that there is no justification for professionalising the activity.

If psychotherapists "do not claim ..." to be experts, then what is their justification, why do they exist at all? In any case, whatever their "claims", objective evidence of *therapeutic* expertise is lacking; expertise at *theory* is another matter altogether. It is not sufficient for professionals to wring their hands modestly and emphasise how difficult their job is; when the very points at issue are the value and effectiveness of what they are doing.

The psychotherapist's status and/or livelihood should not depend on attracting and maintaining a set of clients to practice upon. A network of amateurs and part-timers doing psychotherapy as a sideline would effectively fill any gaps left by family, friends and aquaintances: who are and should remain the first-line helpers when life gets tough.

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References

HARTY, M. & HORVITZ, L. (1976) Therapeutic outcomes as rated by patients, therapists, and judges. *Archives of General Psychiatry*, **33**, 957–961.

LUBORSKY, L., SINGER, B. & LUBORSKY, L. (1975) Comparative studies of psychotherapies. *Archives of General Psychiatry*, **32**, 995–1008.

SMITH, M. L. & GLASS, G. V. (1977) Meta-analysis of psychotherapy outcome studies. *American Psychologist*, **32**, 752–760.

DEAR SIRS

I must confess, after going through the whole-hearted correspondence (*Psychiatric Bulletin*, 1991, **15**, 770–774 in response to Bruce Charlton's article on 'The Moral Case against Psychotherapy' (Psychiatric Bulletin, **15**, 490–492), I had to go back to the article once again to see why and what in that article, which was only a "personal view", invited such a response from the respondents who presumably practise psychiatry. Some even questioned Dr Charlton's right to put down a personal view and the editorial's acceptance for its publication.

Charlton's article, on the other hand, was a timely stimulus for introspection and raised very important issues regarding training, practice and future of psychotherapy specially for the changing 'new look' NHS.

Whereas the respondents were quick to appreciate that Bruce Charlton failed to differentially analyse types of psychotherapy and lumped all of them together under an umbrella term "psychotherapy", amusingly they too did not fare better on that count. Thanks to half a century of interest by professionals from diverse specialities starting with Freud's psychoanalysis at the beginning of this century, the theoretical orientation and practice of psychotherapy has changed dramatically (Arya, 1991). Moreover, in the last 40 years psychopharmacology has threatened its survival which has necessitated emergence of many new and diverse forms of psychotherapies. Fortunately or unfortunately, neither of the two disciplines (psychopharmacology and psychotherapy) could convincingly prove to be based on a definite aetiological hypothesis. The clash of interests has to continue and only articles of critique (like Charlton's) can make us practise with awareness of this deficiency in our limited repertoire of knowledge about what we recognise as psychiatric ailments.

Charlton's article raised some very important questions. Is the training of juniors in psychotherapy

sufficient for them to practise psychotherapy? Should it be encouraged? Should a 'talk with doctor' be given the status of psychotherapy? In a broader sense – Who should be the best person for an individual in crisis? Does it have to be a medically trained psychiatrist? Do we need to redefine the boundaries and specify which type of patients go for which type of psychotherapy? (earlier suggested by Ludwig & Othmer (1977). Does it become doctor's business to get involved in the intricacies of an individual's life and further have we still not learnt that psychotherapy is aimed at cure and not at making perfect human beings?

I tend to differ with those who decided to challenge the credentials of Bruce Charlton for having given this stimulating piece for self-inspection. I can only congratulate the editorial board for accepting it.

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References

ARYA, D. K. (1991) Future of psychotherapy. *British Journal of Psychiatry*, **159**, 883–884.

LUDWIG, A. M. & OTHMER, E. (1977) The medical basis of psychiatry. *American Journal of Psychiatry*, **134**, 1087.

Attention Deficit Hyperactivity Disorder

DEAR SIRS

I would like to make contact with any child psychiatrists involved in the pharmacological treatment of the Attention Deficit Hyperactivity Disorder. I would also like to hear about their experience in the use of ADHD rating scales in diagnosis and in monitoring the progress of treatment.

I think there may be a minority of British child psychiatrists recognising either the reality or the frequency of occurrence of ADHD. For my part, some companionship and sharing of clinical experience would be greatly appreciated.

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Clozapine autonomy v. paternalism

DEAR SIRS

I read with interest the recent number of articles on the practical usage of clozapine (*Psychiatric Bulletin*, 1991, **15**, 223–224; *Psychiatric Bulletin*, 1991, **15**, 645–646 (correspondence). In this country it is being used primarily in treatment resistant schizophrenia. Concerns over the risk of agranulocytosis has meant that regular blood sampling is imperative to the point that the company will not dispense the drug to individual patients without first securing blood samples. By definition then, treatment with clozapine includes initial weekly blood sampling.

It has been suggested that this situation is analogous to the use of lithium-carbonate (*Psychiatric Bulletin*, 1991, **15**, 645, correspondence). However, in patients known to respond well to lithium, but unwilling to submit to blood testing, it can be considered appropriate to continue to prescribe it, albeit with close supervision for signs of toxicity. This constitutes an important difference from treating with clozapine.

The current situation with clozapine also brings into the question of practice of compulsory treatment orders under part IV of the Mental Health Act 1983 (part X of the Mental Health (Scotland) Act 1984). By definition, those people being treated with clozapine are intractable schizophrenics who, through the nature of their illness, are quite likely to be unfit to give formal consent. Under the terms of the Mental Health Act, a drug may then be given without the patient's consent. Clearly, however, the act does not enable the responsible medical officer to secure blood samples without consent. In legal terms, the latter action is tantamount to assault. However, given that clozapine has the potential to improve some patients' intractable symptomatology dramatically, the situation can invoke a strong paternalism in the medical practitioner, perhaps with concomitant disregard for the autonomy of the individual.

In the light of increasing concerns over the safety of medicines in recent years, it is more than likely that similar treatments which involve regular blood monitoring will continue to come onto the market in the future. Surely some form of national guide-lines should be forthcoming involving both legal and medical professions. The central issues appear to be two-fold.

(a) Is it medically and legally justifiable to perform venepuncture on a patient taking clozapine without that patient's consent?

(b) If it is not, what is the risk/benefit analysis of commencing clozapine in a patient whom one knows will not consent willingly to regular venepuncture?

These topics seem worthy of urgent debate

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Obtaining consent for treatment with clozapine

DEAR SIRS

The problems of obtaining consent for treatment with clozapine, which includes, of necessity, frequent and