BRITISH MEDICAL JOURNAL

LONDON SATURDAY 8 OCTOBER 1966

Pointers

Adrenal Cortex: In Part I of his Lumleian Lecture Dr. C. L. Cope discusses hypo- and hypercortical function, and the assessment of cortisol secretion rate as a basis for therapeutic intervention (p. 847).

Proliferative Glomerulonephritis: Dr. R. H. R. White and his colleagues report some improvement in nephrotic patients treated, because they were steroid-resistant, with immunosuppressant agents (p. 853). Leader at p. 842.

Diazepam (Valium) in Tetanus: Professor R. G. Hendrickse and Dr. P. M. Sherman, at Ibadan, find this drug of particular value in reducing tonic muscle spasm, but it produced no significant improvement in mortality rate (p. 860). Dr. D. Femi-Pearse reports similar experience in Lagos (p. 862).

Anticoagulants in Congestive Heart Failure: Dr. J. G. Domenet and colleagues found the protection these gave in the first 10 days of treatment was counterbalanced by increased tendency to thromboembolic episodes during the same period (p. 866). Equipment for self-administration of heparin (p. 883).

Pygopagus Conjoined Twins: Dr. J. M. Gupta describes a case where one twin survived separation (p. 868).

Leprosy in England: Case report of patient resistant to dapsone therapy (p. 872).

Public Health: C.M.O.'s report for 1965 records rises in lung cancer and infectious syphilis (p. 846).

Renal Disease: Dr. J. S. Cameron discusses dialysis and renal transplantation in the second part of his Growing Points article (p. 873).

Medical Schools: Dr. N. Malleson discusses the ideal plan for a decentralized clinical school and estimates costs (p. 879).

Cystic Fibrosis: Inheritance and serum factor discussed at international conference (p. 882).

New Charing Cross Hospital: Phase I to start in August 1967 (p. 884).

Pertinax: Without Prejudice (p. 885).

Arthritis: Dr. P. H. N. Wood writes on relationship of erosive to rheumatoid arthritis (p. 887).

Christmas Gifts Fund: Sir Zachary Cope appeals on behalf of R.M.B.F. (p. 892).

Practice Hazards: Medical Protection Society's report (p. 897).

G.M.S. Committee: Debates pay freeze and area health boards (*Supplement*, p. 143).

Hospital Staff Charter: Views of Hospital Junior Staffs Group Council (*Supplement*, p. 146).

Dispensing Doctors: Guide to methods of payment (*Supplement*, p. 149). See also G.M.S. Committee **(p. 143).**

Questions about Psychotherapy

Psychotherapy has been defined as the treatment of disease by psychological methods.[1] Though this seems a clear enough definition it begs several questions. It does not distinguish between physical and mental disease. This is in keeping with the assumption that psychological factors play some part in many physical illnesses. But are neuroses and personality disorders, the most common conditions calling for psychotherapy, diseases? K. Schneider asserted that only disorders with an organic aetiology can be regarded as diseases proper.[2] The so-called functional psychoses—the schizophrenias and the manic-depressive disorders—can be included among the diseases on the working hypothesis that they are caused by some physical processes still unknown. No such working hypothesis is generally accepted for the neuroses and personality disorders, which are not diseases in the accepted sense but abnormal reactions or deviations of the personality. And what are psychological methods? Clearly hypnosis and psycho-analysis, and methods derived from it, fall into this category. Counselling based on more than common-sense knowledge of human motivations would also qualify. The position of behaviour therapy based on learning theory is debatable. If the emphasis is laid on the conditioning mechanisms it may be regarded as a kind of neurophysiological treatment.

There is, then, no clearly defined and agreed concept of psychotherapy. Since psychological factors have a role in any treatment, even in surgery, all therapies may be said to have a psychotherapeutic component. Modern psychiatric teaching aims at making the student aware of this. Then aren't all doctors psychotherapists, or, as psychotherapy is supposed to be one of the psychiatrist's main skills, aren't all doctors psychiatrists? There is no surer way of putting psychiatrists' backs up than by asking this question, which implies that psychotherapy is no more than an attitude of mind in the approach to the patient—indeed much the same as the bedside manners of old. Those who practise psychotherapy insist that it is a skill which has to be learned like other skills, and that it needs wide knowledge of normal and abnormal behaviour. Every psychiatrist and a few general practitioners spend part of their working time doing psychotherapy of one kind or other—that is, they try to modify the conditions of some of their patients by the use of verbal communication, though not many of these doctors will have had systematic instruction in psychotherapy. Psychotherapy is time-consuming and therefore costly, and its efficacy has not been proved by tests like those used to assess physical treatments. However, if the disorders treated by psychotherapy are not diseases in the conventional sense, is it right that it should be evaluated in the same way as the treatments of physical diseases? There is a great deal about psychotherapy that is obscure, uncertain, and controversial.

An inquiry[3] carried out in Scotland by R. M. Mowbray and G. C. Timbury was aimed at clarifying some questions about psychotherapy.

Questionaries were sent to 184 psychiatrists. The first question asked what they understood by psychotherapy. Most thought this term to be appropriate only when there was a deliberate attempt to treat the patient by psychological means, but only 55% believed that the main aim of psychotherapy was the removal of symptoms. Brief psychotherapy was regarded as less effective than prolonged treatment by 59% and 63% rated skills acquired in psychiatric practice as more important that the personal characteristics of the therapists. The forms of psychotherapy used by the psychiatrists included psycho-analysis, explanation, reassurance, suggestion, and abreaction. Less than one-third of the group used desensitization and aversion therapy. Most were strongly influenced by the psycho-analytical approach, but only a small number of patients had been treated with psycho-analysis. There was little opposition to combining psychotherapy with drug treatment.

The most common indications for individual psychotherapy were anxiety neurosis and hysteria. Chronic neurotic conditions and character disorders were treated more frequently with group psychotherapy than by individual psychotherapy. The senior psychotherapists estimated their success rate as higher (66%) than their juniors (41%). Better social and educational adjustment was rated highest among the indicators of success. The majority of the replies were in favour of training by a system of supervision and apprenticeship, which is available in only very few centres.

Mowbray and Timbury believe that most of the arguments about the results of psychotherapy fail to recognize that it is effective in helping the patient in dealing with personal and social problems arising from his disorder. They conclude that psychotherapy cannot be compared with conventional medical treatments and that it is "a highly individual method of helping patients with their problems rather than of treating circumscribed illnesses." But some doctors are better at this work than others because they know more about patients and their problems and the disorders from which these arise. This knowledge can be taught.

The realization that neuroses and personality disorders, and possibly even some psychotic conditions, are not diseases in the conventional sense has sometimes led to doubts about whether they fall into the doctor's province. Such doubts indicate a mistaken view of the doctor's function. Most doctors spend only a small part of their time killing bacteria, removing growths, repairing physical damage, and removing symptoms, though their training made them expect that they would be doing these things most of the time. Possibly some of the dissatisfaction of doctors in general practice stems from the discrepancy between what they expected to be their function and the realities of their work. Most of the doctor's time is spent in making his patients feel better, irrespective of whether their "dis-eases" are directly or indirectly due to identifiable noxious agencies. Henry Sigerist[4] made this point clearly when he insisted that medicine is not so much a natural but a social science and that one of its main functions is to keep man adjusted to his environment as a useful member of society. In this view of the doctor's function there can be no doubt that psychotherapy belongs to the essence of medicine and that there is no need to be apologetic about it because it only helps the patient in coping with the problems arising from his disorders. More knowledge, experience, and skill are needed to do this well than to apply standardized treatments to curable diseases. This is why it is so important that a great deal of thought should be given to the methods, the teaching, and the evaluation of psychotherapy.

[1] *The Oxford English Dictionary*, 1933. Oxford University Press, London.
[2] Schneider, K., *Clinical Psychopathology*, 1959. Grune and Stratton, London.
[3] Mowbray, R. M., and Timbury, G. C., *Brit. J. Psychiatry*, 1966, **112**, 351.
[4] Sigerist, H. E., *History of Medicine*, vol. 1, 1951. Oxford University Press, New York.

Immunosuppressive Therapy in Persistent Glomerulonephritis

Cytotoxic drugs can benefit patients with the nephrotic syndrome. For instance, mechlorethamine (nitrogen-mustard) was used as long ago as 1949.[1] But they have drawbacks and dangers, so that when corticosteroids came in and were found to be helpful[2] the cytotoxic drugs tended to fall from favour. Now that considerable experience with corticosteroids[3 4] has been obtained the disadvantages of long-term therapy are apparent. In addition, many forms of glomerulonephritis seem to have an immunological basis.[5] Consequently, interest is renewed in the cytotoxic drugs, which are known to have an immunosuppressant effect.[6]

The newer preparations are safer and can be taken by mouth. The recent observations by Sir Macfarlane Burnet and his collaborators[7] that cyclophosphamide can retard the development of lethal glomerulonephritis in strains of mice with a high incidence of spontaneous disease provide an encouraging experimental background to clinical trials. At page 853 of the *B.M.J.* this week Drs. R. H. R. White and J. S. Cameron and Professor J. R. Trounce report the results of immunosuppressive therapy in thirteen children and five adults with the nephrotic syndrome. Fifteen had failed to respond to adequate steroid therapy and many were seriously ill. In addition to the nephrotic syndrome most of them had haematuria, hypertension, and renal insufficiency—signs which were also regarded as sinister by D. Cornfield and M. W. Schwartz.[3] In addition, seven patients had anaphylactoid purpura, which generally carries a grave prognosis in association with the nephrotic syndrome.[8] Renal biopsies showed proliferative glomerulonephritis in all patients, with severe changes in thirteen. The cytotoxic drugs given—azathioprine and cyclophosphamide—appeared to benefit 12 of the patients. Sustained improvement was commoner in the younger ones, and three with anaphylactoid nephritis apparently recovered completely. The function of the bone-marrow was depressed in most of the children who improved.

In the light of these and other findings[9] corticosteroids can no longer be considered the best treatment for all patients with nephritis, and therefore criteria for selecting those likely to benefit are needed. An initial trial of corticosteroids may be hazardous. White and his colleagues emphasize the dangers of these drugs in severe proliferative glomerulonephritis, ascribing the good results obtained in two of their patients at least partly to the early recognition of steroid resistance and the prompt change of treatment. It seems logical to give cytotoxic drugs early rather than late if, by suppressing immune responses, they can stop the development of permanent scarring.

Severe glomerular disease is easy to recognize in renal biopsy specimens. However, some of the patients of White and his colleagues had proliferative glomerulonephritis of