Examples of bad practice are to be found everywhere, including the UK and Italy. To claim that the majority of the Italian psychiatric services offer a poor service on the basis of a two-weeks visit, with a reference list which indicates that basic material has not been read, can hardly provide a basis for a sound judgement.

c. *Relevance to Britain*

As late as 1979, Prof. Jones wrote: "But we have plenty of evidence that such institutions [i.e. psychiatric hospitals] can be damaging" (in Meacher, p. 3). Yet in the present article the authors can outline only negative outcomes to the disappearance of such settings.

In my view the Italian experience has demonstrated more than once that: 1. It is possible to gradually de-structure and dismantle the psychiatric hospital with the partnership of patients and staff. 2. Community mental health centres can offer a good psychiatric service without a hospital, provided non-medical asylum facilities are available. 3. It highlighted the conditions for successful as opposed to unsuccessful outcomes, including the desirability and possibility of a nearly full redeployment of the staff group.

I fully endorse the point made by the authors that a psychiatric system cannot be changed by the law alone. The nearest example is provided by Britain, where officially we opted in 1959 for a fully fledged community care policy. Not even *one* psychiatric hospital has closed down since then, despite the considerable reduction in numbers of in patients (Fowler, 1982).

For a real, non-cosmetic, change of the psychiatric system there is a need for a changed professional and political attitude, a fact which the Italians, for one, have understood perfectly.

It is the very lack of a real change in Britain which attracts to the Italian experience professional and lay people here who are unhappy with the stalemate of our psychiatric system, without necessarily wishing to imitate the Italian format.

If Jones and Poletti assume that an "antediluvian, imperialist" approach which stresses the impossibility of comparing "backward" Italy to "enlightened" Britain will convince anyone in 1985, they may be in for a rude surprise from the natives and other inhabitants of the British Isles.

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What Price Psychotherapy?

DEAR SIR,

Shepherd (*Journal*, May 1985, **146**, 555–556) rebuts the suggestion that he 'latched on' to the paper by Prioleau *et al* (1983) on the grounds that writers in two other medical journals did the same. But consensus, whether orchestrated or not, does not constitute evidence. An impartial observer would surely find it surprising that, out of the rash of meta-analytic papers, this particular one has been singled out for attention, based as it is on 32 papers describing patients and therapies almost wholly untypical of NHS practice. For example, psychiatrists were involved in only three of the studies, nearly half of the therapists were undergraduate or postgraduate students and the patients were schoolchildren in 13 cases and university students in nine.

One's suspicion that it was the conclusions of the study rather than its merits that gained it such notoriety is heightened by the account given of it in a fourth article, an editorial written by Prof. Shepherd's registrar in a journal he himself edits (Wilkinson, 1984). In language not usually associated with professional or scientific discourse, this article calls for the 'protection of unhappy and at times desperate people' from 'unscrupulous practitioners of psychotherapy' and describes the growth in the number of consultant psychotherapists (to a figure still well below College recommendations) as a 'disturbing piece of information'.

Shepherd depicts the debate about psychotherapy in terms of two extreme vocal groups with a large silent majority. This is the picture which his style of argument, and also that of Eysenck (*Journal*, 1985, **146**, 556–557) (which has indeed remained unchanged for 30 years) would tend to perpetuate. Fortunately, in both the UK and the USA, there is a large and growing body of vocal practitioners and researchers who have long tired of polemics and

who are busy integrating and improving the practice of psychotherapy and its evaluation. They find the question 'Is psychotherapy effective?' inappropriate rather than unimportant, just as a similar question applied to psychiatry, teaching, parenting or any other complex human activity would be judged unproductive by any sophisticated investigator.

As for Sam Weller, his comments hardly support Prof. Shepherd's argument, for the alphabet, however painfully achieved, was of immense benefit to the Victorian charity boy, even though research had not demonstrated the uses and effects of literacy. The uses and effects of psychotherapy are in the realm of value and meaning as well as of symptoms and behaviours and their measureement is never going to be easy. This is not to say that it should not be attempted, but any suggestion that only those effects that are easily measurable are real or important would be philistine in the extreme. We need more, and more subtle research, but we do not need to mount a 'vigorous initiative' by one section of the College on another, however much Prof. Shepherd might hanker after the role of Grand Inquisitor.

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Fear of AIDS

DEAR SIR,

The title of the article "A Pseudo AIDS' Syndrome following from Fear of AIDS" (Miller *et al*) (*Journal*, May 1985, **146**, 550–551) is not substantiated by the content of the article itself. They say "We report two cases showing psychiatric symptoms associated with a fear of Acquired Immune Deficiency Syndrome", but only in the second case of perhaps very understandable anxiety arising from a possible contact with an AIDS carrier could the (I feel unnecessary) invention of "Pseudo AIDS Syndrome" be stated to be *following* from a fear of AIDS. The other case they report is a classical description of a depressive illness.

Surely we need no further confusion in our already confusing and loose nosology. Do we call a depressive illness characterised in part by either hypochondrical, over-valued or frankly delusional ideas of cancer (even if the patient has been recently in contact with a cancer victim), a "Pseudo-Cancer Syndrome". No, I think not.

They say "The above cases highlight two manifestations of fears of AIDS resulting in significant impairment". What they actually describe, however, are two manifestations of psychiatric disturbance characterised *in part* by a fear of AIDS resulting in significant impairment but, contrary to the title of the article, they do not convincingly describe "The psychiatric symptoms resulting *from* a fear of AIDS" which they wish to refer to as "Pseudo AIDS".

Both these patients were at high risk of contracting AIDS, and further I fear that the invention of a "Pseudo AIDS' Syndrome", set against the backcloth of the difficulty of diagnosing AIDS itself in the early stages might prejudice the diagnosis of AIDS where it actually exists.

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Parasuicide in Adolescents

DEAR SIR,

Doctor Donald J. Brooksbank's recommendation (*Journal*, May 1985, **146**, 459–463) of "A short stay in hospital" for adolescents who have attempted suicide is not entirely borne out by the data cited.

In the first place these data suggest that, in the common case, where there is no identifiable psychiatric disorder, the immediate aftermath of the suicide attempt is a spell of safety. The overall suicide risk is greater than for the general population and most of this risk extends over the subsequent year. This suggests that, if the purpose of the hospitalisation is protective custody to prevent a second attempt, then the length suggested is almost exactly the wrong one.

In the second place much of the evaluation suggested is non-medical and even (by Dr. Brooksbank's statements) non-psychiatric. This being so, it might be equally well carried out in an out-patient clinic or (perhaps even better) by means of visits to the patient's home.

In the third place there is evidence that these young people are characterised by anti-social and manipulative behavior. A short term hospitalisation after a suicide attempt tends to be in the permissive atmosphere of an open ward of a general hospital. Such patients may be difficult to handle in such an