varicella zoster immunoglobulin will prevent or attenuate infection. Both the 1990 and 1992 editions of the Department of Health's handbook *Immunisation Against Infectious Diseases* recommend that such prophylaxis should be given to patients taking high doses of corticosteroids (2 mg/kg/day) with proved susceptibility to varicella if contact with chickenpox occurs.⁶ Although this handbook is distributed to all medical practitioners, many may be unaware of these particular recommendations.

Alternatively, prophylactic oral acyclovir may be considered. A recent placebo controlled trial showed that acyclovir was effective in preventing clinical chickenpox in healthy children exposed to varicella. Treated children developed subclinical or mild infections.¹⁴

In addition, in view of a recent shortage in the supply of varicella zoster immunoglobulin, an attenuated varicella vaccine could be used. This is effective in preventing infection in healthy children, provided that it is given within 72 hours of contact.¹⁵ Although of no benefit as prophylaxis after exposure in children with leukaemia because of the need to stop all immunosuppressive treatment for seven days before it can be given this vaccine has been used successfully in seronegative children taking steroids to prevent infection in hospitals.¹⁶ It is still an unlicensed preparation, however, and is only available on a named patient basis.

AMENDMENT OF STEROID CARD

A similar case was widely publicised recently in the national press.¹⁷ Although some benefit may result from drawing attention to cases such as ours through the medical press, we believe that the steroid card given to all patients being treated with high doses of corticosteroids or other immunosuppressive drugs should be amended. This card was designed in the 1950s and might now be revised to include details of the patient's history of varicella, or the results of serological studies in patients who claim not to have had varicella. The card should also emphasise the

importance of seronegative patients' reporting contact with varicella zoster or measles as soon as possible.

Amending the steroid card, however, should be seen as just one approach to patient awareness in this area. Supplementary advice should also be available in the form of a patient information leaflet. Indeed, as a result of our case, such a leaflet is being proposed for our trust.

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Controversies in Management

Psychotherapy—a luxury the NHS cannot afford?

More expensive not to treat

Jeremy Holmes

This is the eighth in a series of articles examining some of the difficult decisions that arise in medicine

Psychotherapy is "the systematic use of a relationship between therapist and patient—as opposed to physical or social methods—to produce changes in cognition, feelings and behaviour."¹ Psychotherapy, or perhaps more usefully "the psychotherapies," is a generic term covering a spectrum of treatments that can be grouped under four main headings: analytic therapy, cognitive behavioural therapy, systemic (or family) therapy, and creative therapies such as psychodrama and art therapy. Each of these can be brief or long term and delivered to individuals, couples, or families and groups. I shall consider the case for the psychotherapies under three main headings: empirical, economic, and ethical.

Controversy about the empirical evidence for the value of psychotherapy continues, although the debate has moved on considerably since Eysenck's ill fated attempt to discredit it in the 1950s. Meta-analysis has provided overwhelming evidence for the usefulness

of psychotherapy, which produces "effect sizes" of around 0.8-1.0.² This means that the average patient having psychotherapy does better than 85% of control subjects. This kind of outcome is comparable with that found with antidepressant drugs, and far better than those found in some medical trials. For example, in a study of aspirin in the prevention of heart attacks the effect size was 0.32, and trials were discontinued on the basis of this figure, because it was thought unethical to withhold such an effective treatment from control subjects.³

The debate has now moved on from considering psychotherapy's overall effectiveness to questions such as which forms of therapy are suitable for which conditions, what "dose" is likely to produce greatest benefit, and what are the active ingredients and non-specific factors of different psychotherapy treatments? Some of the most robust recent research findings can

be summarised as follows. Where emotions run high in the families of schizophrenics, family intervention prevents relapse and readmission to hospital⁴; patients suffering from depression who discontinue antidepressant drugs relapse on average within five months while those who receive cognitive behavioural or analytic psychotherapy stay well for more than two years⁵; psychological treatments for anxiety are an effective alternative to drug therapy and result in lower relapse rates once treatments are stopped⁶; women with chronic refractory irritable bowel syndrome improved physically and psychologically after a course of brief analytically oriented psychotherapy compared with those who were offered supportive "chats," and this improvement was maintained for at least one year⁷; in patients with borderline personality disorder, a year of twice weekly individual analytic therapy produced an effect size of around 1.0 on most measures of improvement.⁸ These studies suggest that in the central areas of psychiatric morbidity psychotherapy can help improve health.

Costs of psychotherapy

Attempts to estimate the annual costs of neurotic disorder in the United Kingdom suggest figures of £600m in direct medical costs, and a staggering £5.6bn in lost production—one third of the total cost of the NHS. If psychotherapy can be shown to diminish only a small fraction of this it will have proved its economic worth. Numerous studies have shown reduced offset costs—reduced use of medical services, drug bills, and social security payments—after psychotherapy.⁹ Two highly intensive inpatient psychotherapy units—the Henderson and Cassel Hospitals in London—have shown reduced use of health and social services by patients in the three years after discharge, saving sums far greater than the relatively expensive cost of a six month stay in the units.¹⁰

Not treating is unethical

Results such as these suggest an ethical dimension to the psychotherapy debate. Medical dilemmas inevitably imply questions of value. In the short term it may save money not to use expensive facilities and to make do without the luxury of effective psychotherapy—to

muddle through with a mixture of drug therapy, intermittent support, and a blind eye turned to much human misery. But is such short termism ethical given the evidence which suggests that good treatment produces lasting benefit which, from a medium or long term perspective, would save both money and unhappiness?

A wise therapist looks behind a question to the anxiety that underlies it. The NHS is in a crisis that seems to be based on underfunding—and certainly more money for health is much needed. But is it also a crisis of values, in which the personal aspect of medicine increasingly competes with rather than complements medical technology? Patient dissatisfaction and staff stress both have their roots in this conflict. Psychotherapy is concerned not just with removing distress, important though that is, but with the search for self esteem and a sense of meaning that underlies good health and has much to contribute to the managerial quest for quality and good morale.¹ Psychotherapy epitomises the values of the doctor-patient relationship, of healing as opposed to treating, that patients and doctors alike find so elusive in modern medical culture. To see psychotherapy as a luxury is to compound the heartlessness of a medicine whose values are already endangered. A vision of psychotherapy as both a necessary and ordinary part of medical practice offers hope in the bewildering world in which the NHS now finds itself.

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Unevaluated or inefficient approaches are hard to justify

Isaac Marks

The limited resources available for health make it important that money is spent in the best interests of patients. If money is spent on inefficient treatments there is less available for good care, so routine methods should have had their value proved in randomised controlled trials. This ideal is hard to attain. Randomised controlled trials cost time and money and only a minority of medical treatments have been evaluated in this way. To draw firm conclusions several randomised controlled trials in varying circumstances are usually needed and, for chronic conditions, follow up is essential to show that gains last. Finally, treatments which work in randomised controlled trials must be shown to be helpful in audit of routine care.

Given our imperfect knowledge, which are efficient psychotherapies and which not? Which have been well evaluated, for which problems in which circumstances, at what cost, and who can deliver them? Such questions can be answered firmly for some clinical problems, with less confidence for others, and hardly

at all for many. Most successful psychotherapies are brief (five to 15 sessions) and focused.

Anxiety disorders

Randomised controlled trials have shown exposure therapy to be the best treatment for phobic and obsessive-compulsive disorders.¹ It is at least twice as effective as alprazolam or relaxation.² It is effective given by nurse therapists and as self exposure under the patient's control and can be guided by phone. Exposure therapy was as successful when instructed by a manual or by a computer as by a clinician.³ Benefits exceeded costs in a randomised controlled trial. About six to 10 sessions with a doctor are sufficient for most patients, though more are needed for severe problems.

The evidence is fairly favourable for other anxiety disorders such as post-traumatic stress disorder,⁴ generalised anxiety disorder,⁵ and panic disorder without agoraphobia. Though brief behavioural or