tive awareness (as in psycho-dynamic psychotherapy). Reading books alone will not suffice in learning to become a good practitioner here. Metaphorically speaking, what is called for is a degree of experiential 'immersion'. The difference between 'knowing about' from books and lectures on the one hand, and actual 'immersion' on the other, is rather akin to reading about Japan as opposed to going there and learning to speak Japanese! The latter approach creates a new experiential viewpoint together with a language (jargon) for talking about it. Having more than one point of view gives perspective. 'He who only knows England does not know England very well'! Trainee psychotherapists are thought how to listen attentively, observe, analyse and reflect more so than 'doing'. We are essentially the same as those whom we wish to help. Thus it is useful to also look at ourselves in terms of our defences and so forth.

The experiential aspect of teaching psychodynamic psychotherapy is incorporated into the tripod approach to becoming a practitioner namely: 1) Formal study (reading and lectures), 2) Personal therapy (individual and/or group) and 3) Supervision of practice. Other schools of psychotherapy are increasingly adopting this tripod approach. The more complementary perspectives we learn the better. Therefore, it is advisable for clinical psychologists and social workers, working in psychiatric hospitals to learn the language and constructs of psychiatry. Likewise, trainee psychiatrists would do well to continue to learn how to view the world through psychological and sociological 'lenses'. Thus I hope that psychiatric trainees in Ireland, under pressure with an ever-expanding curriculum, do not lose sight of the value of training in the dynamic psychotherapies.

**Michael DelMonte, PhD,**
*Senior Clinical Psychologist,*
*St Patrick's Hospital,*
*Dublin 8,*
*Ireland.*

**References**
1. Trigwell PJ, Curran S, Milton J, Rowe C. Training in psychodynamic psychotherapy: The psychiatric trainee's perspective. Trish Journal of Psychol Medicine 1995; 12 (2): 57-9.
2. Clare AW. Commentary on "Training in Psychodynamic Psychotherapy: The psychiatric trainee's perspective". Ir J Pychol Med 1995; 12(2): 59-60.
3. Leibenluft E, Tasman A, Green SA. Less time to do more: psychotherapy on the short-term in-patient unit. American Psychiatric Press: Washington, DC, 1993.
4. Winter DA. Personal conduct psychology in clinical practice. Routledge, London, 1992.
5. Bergin C, Garfield S. The handbook of pychotherapy research. Wiley: London, 1944.
6. DelMonte MM. Silence and emptiness in the service of healing. Br J Pychotherapy 1995; 11(3): 368-78.
7. Neelman J, Persaud R. Why do psychiatrists neglect religion ? Br J MedPsychol 1995; 68 ()2): 169-78.

## Commentary on 'Training in Psychodynamic psychotherapy: the psychiatric trainees perspective'

*Sir* – I would like the opportunity to reply to Prof Clare's comments. He has made some strong criticisms of myself as a psychotherapy tutor and in addition I was not given the opportunity of seeing his criticisms before publication.

I suspect that Prof Clare's somewhat aggressive commentary is intended to promote correspondence on the topic of psychotherapy training for junior psychiatrists and I fully support this aim. However, despite his strong re-statement of the trainees' comments about their dissatisfactions with psychotherapy teaching, he has missed the point that this trainer and trainees have at least a good enough understanding and working relationship to write an article together expressing different views. It arose out of a supervision group in which th three trainees were given the opportunity to talk about the difficulties of learning psychotherapy. Does a dogmatist commonly facilitate this sort of discussion?

Prof Clare did not notice the trainees' comment that they have gone on to incorporate their psychotherapy training in their general psychiatric practice. Their experience of psychotherapy teaching was in many respects helpful, despite it's shortcomings. Their dissatisfactions were taken on board by their tutors and they went back and revisited ideas that they initially felt antagonistic towards.

Is Prof Clare suggesting that multidisciplinary training is to be discouraged? There are difficulties in multidisciplinary teaching, but the outcome is usually that in the long run trainees say they have learned a lot about the perspectives of different disciplines and this benefits their working relationships.

I am sure Prof Clare does not think that the seminar format for teaching, which is designed to encourage discussion, is a bad idea. One of the reasons given by the trainees, for finding this difficult, was that it was unfamiliar. Doctors are used to being taught 'facts' both from their medical undergraduate teaching and later at postgraduate level. This does make it harder to adapt to a subject which is concerned with the history of ideas, concepts and with models of the mind. This context needs to be given consideration by psychotherapy trainers and teachers so that the different way of thinking entailed is clearly indicated. Moreover, the differences between factual knowledge, theories that relate to an understanding of human nature and opinion need to be distinguished. How to apply these theories usefully in thinking about patients in a psychiatric setting should be a central concern to teachers.

I was surprised that Prof Clare misunderstood my suggestion that trainees should look critically at research into psychotherapy practice and at the scientific literature (for instance, that related to memory storage and retrieval, and to the importance of attachment in relation to child development and to adult life). As well as ideas of psychoanalysis, this is also important to the study of psychotherapy. However, my comments were abbreviated in the interests of producing a brief article and I see my meaning was not clear.

'Negative reactions' are not always the same as 'negative attitudes'. Negative reactions in my book refer to doubts, disappointments and anxieties which need to be addressed but which are also important aspects of learning. Negative attitudes include the wish to denigrate and dismiss without any thoughtfulness. I did not think this was the case with this group of trainees. The trainees' fear that their objections are going to be analysed and in a critical fashion is another area that needs to be faced by psychotherapy trainers.

Perhaps my reply will be interpreted by some readers as a fundamentalist defending his corner. The anti-psychotherapy dogmatists may think so. It is not intended as such, but rather as an attempt to put an important question about how psychotherapy should be taught to trainee psychiatrists back into the arena of sensible debate. It seems to me that Prof Clare and I may well be on the same side. Some understanding of psychoanalytic ideas is essential for the educated and thoughtful psychiatrist. In addition, teaching about the range of psychotherapy approaches (psychodynamic, cognitive behavioural, systemic) how and when to apply them is also essential even if the psychiatric trainee does not intend to develop a special interest in this area. There are a number of reasons why it is difficult to teach psychotherapy successfully and helpfully in the context of a general psychiatric training and these need to be addressed thoughtfully and constructively.

**Dr Celly E Rowe, MRCP, MRCPsych,**
*Consultant Psychotherapist,*
*Leeds Community and Mental Health Services,*
*Psychotherapy Department,*
*40 Clarendon Road,*
*Leeds LS2 9PJ,*
*England.*

## The Tukes of York

*Sir* – In Prof Breathnach's enlightening article on the Tukes of York, he refers to my great great grandfather, Dr John Eustace (1791-1871), a Dublin friend and physician who knew Daniel Tuke and modelled his hospital, Hampstead, on the moral treatments at the Retreat York. However, John Eustace became

JANSSEN Organon

Risperdal (risperidone)
(Always refer to the data sheet before prescribing) **USES:** The treatment of acute and chronic schizophrenia, and other psychotic conditions, in which positive and/or negative symptoms are prominent. Risperdal also alleviates affective symptoms associated with schizophrenia. **DOSAGE:** Adults: All patients, whether acute or chronic, should start with 1mg b.d. This should be increased to 2mg b.d. on the second day and 3mg b.d. on the third day. From then on the dosage can be maintained unchanged, or further individualized if needed. The usual optimal dosage is 2 to 4mg b.d. Doses above 5mg b.d. generally have not been shown to provide additional efficacy over lower doses and may increase the risk of extrapyramidal symptoms. Since the safety of doses above 8mg b.d. has not been evaluated, doses above this level should not be used. A benzodiazepine may be added to Risperdal when additional sedation is required. Elderly, renal and liver disease: A starting dose of 0.5mg b.d. is recommended. This can be individually adjusted with 0.5mg b.d. increments to 1 to 2mg b.d. Use with caution in these patients. Children: Experience is lacking in children aged less than 15 years. **CONTRAINDICATIONS, WARNINGS ETC:** Contraindications: Known hypersensitivity to Risperdal. Precautions: Orthostatic hypotension can occur (alpha-blocking effect). Use with caution in patients with known cardiovascular disease (e.g. heart failure, myocardial infarction, conduction abnormalities, dehydration, hypovolaemia, or cerebrovascular disease). Consider dose reduction if hypotension occurs. There is a risk that tardive dyskinesia may occur. If signs and symptoms of tardive dyskinesia appear, the discontinuation of all antipsychotic drugs should be considered. Caution should be exercised when treating patients with Parkinson's disease or epilepsy. The Neuroleptic Malignant Syndrome, characterised by hyperthermia, muscle rigidity, autonomic instability, altered consciousness and elevated CPK levels has been reported to occur with classical neuroleptics. Consequently, the possible occurence of this syndrome cannot be ruled out for Risperdal. In the event, all antipsychotic drugs, including Risperdal, should be discontinued. Patients should be advised of the potential for weight gain. Risperdal may interfere with activities requiring mental alertness. Patients should be advised not to drive or operate machinery until their individual susceptibility is known. Pregnancy and lactation: Use during pregnancy only if the benefits outweigh the risks. Women receiving Risperdal should not breast feed. Interactions: Use with caution in combination with other centrally acting drugs. Risperdal may antagonize the effect of levodopa and other dopamine agonists. Side effects: Risperdal is generally well tolerated and in many instances it has been difficult to differentiate adverse events from symptoms of the underlying disease. Common adverse events include: insomnia, agitation, anxiety, headache. Less common adverse events include: somnolence, fatigue, dizziness, impaired concentration, constipation, dyspepsia, nausea, abdominal pain, blurred vision, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, rhinitis, rash. The incidence and severity of extrapyramidal symptoms are significantly less than with haloperidol. However, the following may occur: tremor, rigidity, hypersalivation, bradykinesia, akathisia, acute dystonia. If acute, these symptoms are usually mild and reversible upon dose reduction and/or administration of antiparkinson medication. Occasionally, orthostatic dizziness, orthostatic hypotension and reflex tachycardia have been observed, particularly with higher initial doses. An increase in plasma prolactin concentration can occur which may be associated with galactorrhoea and disturbances of the menstrual cycle. Rare cases of water intoxication with hyponatraemia have been reported. Overdosage: Experience is limited. Reported signs and symptoms include drowsiness and sedation, tachycardia and hypotension and extrapyramidal symptoms. Establish and maintain a clear airway, and ensure adequate oxygenation and ventilation. Gastric lavage and activated charcoal plus a laxative should be considered. Commence cardiovascular monitoring immediately, including continuous electrocardiographic monitoring to detect possible arrhythmias. There is no specific antidote, so institute appropriate supportive measures. Treat hypotension and circulatory collapse with appropriate measures. In case of severe extrapyramidal symptoms, give anticholinergic medication. Continue close medical supervision and monitoring until the patient recovers. **PHARMACEUTICAL PRECAUTIONS:** Store between 15°C and 30°C, in a dry place and protected from light. **PRESCRIPTION MEDICINE. PRESENTATIONS, PACK SIZES, PRODUCT AUTHORISATION NUMBERS AND COSTS:** White, oblong tablets containing 1mg risperidone in packs of 20. PA545/31/1 £14.35. Pale orange, oblong tablets containing 2mg risperidone in packs of 60. PA545/31/2 £84.85. Yellow, oblong tablets containing 3mg risperidone in packs of 60. PA545/31/3 £124.77. Green, oblong tablets containing 4mg risperidone in packs of 60. PA545/31/4 £164.69. Starter packs containing 6 Risperdal 1mg tablets are also available £4.43. **REFERENCES:** 1. Peuskens J et al. B J Psych, 1995, **166,** 712-726. 2. Lindstrom E et al. Clin Therapeutics, 1995 [N111879]. Date of preparation June 1995. Code No: 0097822. **PA HOLDER:** Janssen Pharmaceutical Ltd., Little Island, Co. Cork, Ireland. TM denotes Trademark. Additional information is available on request from: Janssen-Cilag Ltd., Saunderton, High Wycombe, Bucks HP14 4HJ.

# "Thank you for giving us back our bass player."

## SELF-SUPPORTING

Risperdal offers schizophrenic patients an early opportunity of recovery and return to an active, independent lifestyle.

## SELF-ASSURED

Risperdal has the desired benefits of a first line therapy. It is effective in both positive and negative symptoms, and benefits patients in acute and chronic stages of schizophrenia. And with a low risk of extrapyramidal side-effects compared with a conventional neuroleptic[1], Risperdal may also help patient compliance.

## SELF-FULFILMENT

Risperdal has 1.4 million patient months experience to its credit[2], thus helping many patients to return to a normal life.

**Risperdal™**
**RISPERIDONE**

**The benefits are self-evident**

https://doi.org/10.1017/S0790966700014610 Published online by Cambridge University Press

Medical Superintendent in Bloomfield Hospital in 1813 during his undergraduate medical education at Edinburgh University and held that position for two years. He then completed his studies at Trinity College Dublin. It was then that he founded Hampstead, a house near the grounds of the legendary castle where Sir Richard Steele, the essayist resided. The Eustace family to this day, five generations later, still carry on the hospital practice which has grown extensively since the year it was funded in 1825. At no time later did any family member work in Bloomfield, nor was it part of Hampstead Hospital.

**Dr Denis Eustace, LRCPI, MRCPsych,**
*Consultant Psychiatrist,*
*Hampstead,*
*Glasnevin,*
*Dublin 9,*
*Ireland.*

## Suicide and abortion

*Sir* – Fahy and Kelleher, in recent letters debated whether it was possible, in individual cases, to predict whether a woman denied an abortion is at higher risk for suicide. After a US Supreme Court decision in 1973 (Roe v Wade), abortion was legalised in the the US. This permits us to examine the changes in the suicide rate from the 10 year period prior to Roe v Wade (1963-1972) to the 10 year period after the decision (1974-1983).

The suicide rate of men in the US increased significantly from the first period to the second period (from 16.3S to 18.91 per 100,000 per year, t18 = 10.82, two-tailed p<0.001), whereas the suicide rate for men did not change significantly (6.18 and 6.13, t18 = 0.23). Looking at the suicide rate for women by age (see Table 1), the suicide rate for those aged 15-24 increased from 1963-1972 to 1974-1983, that for women 25-34 did not change while that for women aged 35 and older decreased. Looking at the simple regression coefficients of suicide rate on year, for women aged 15 to 65, the suicide rate was increasing from 1963 to 1972. In contrast, the suicide rate for women of all ages from 1974 to 1983 was decreasing, with the greater speeds of decrease found for women aged 45-55 and 35-45. Thus, prior to Roe v Wade, the female suicide was rising in the US, whereas after Roe v Wade the female suicide rate was declining.

Of course, many other social factors may have affected the suicide rates of men and women in America during the period studied (1963-1983), but the data are consistent with the hypothesis that liberalising the abortion laws was associated with a decrease in the suicide rates of women, and in particular women aged 35-54.

**David Lester, PhD,**
*Executive Director*
*Center for the Study of Suicide*
*RR41, 5 Stonegate Court*
*Blackwood, New Jersey 08012, US*

**References**
1. Fahy TJ, Kelleher MJ. The prediction of suicide and the law on abortion. Ir J Psychol Med 1995; 12: 39-40.

## Clozapine for the treatment of levodopa and dyskinesia in Parkinson's disease

*Sir* – We were interested in the correspondence concerning clozapine for the treatment of levodopa-induced psychosis and dyskinesia in Parkinson's disease[1,2] and would like to add the following two points.

Firstly, there is concern over the use of clozapine because of the (albeit relatively rare) potentially fatal side effect of agranulocytosis. One of the other newer antipsychotic agents, risperidone, has been reported in the literature for the treatment of hallucinations in levodopa treated Parkinson's disease patients[3] and, in Lewy body disease.[4]

Secondly, we were concerned that Jalenques and Coudert[2] recommended that electroconvulsive therapy should be considered in the management of levodopa psychosis in Parkinson's disease. We are unsure on what this recommendation is based. There is literature suggesting that Parkinson's disease itself may benefit from electroconvulsive therapy,[5] although a carefully designed definitive trial is required to answer this question. The only report of electroconvulsive therapy to treat psychosis in Parkinson's disease,of which we are aware, takes the form of a brief clinical report[6], and we feel that further work should be undertaken before electroconvulsive therapy should be recommended for the treatment of levodopa psychosis.

**Dr Gwyneth Rees,**
*Registrar in Old Age Psychiatry,*
**Dr Peter Madeley,**
*Consultant in Old Age Psychiatry,*
*The Queen Elizabeth Psychiatric Hospital,*
*Mindelsohn Way,*
*Edgbaston,*
*Birmingham B15 2QZ,*
*England.*

**References**
1. Hughes TA, Mindham RHS, Ross HF. Clozapine for the treatment of levodopa - induced psychosis and dyskinesia in Parkinson's disease. Ir J Psychol Med 1995 12:39.
2. Jalenques I, Coudert A-J. Clozapine for the treatment of levodopa - induced psychosis and dyskinesia in Parkinson's disease. Irish Journal of Psychological Medicine. 19953.
Alessandra M, Bonifeti V, Giustini P . Risperidone for hallucinations in levodopa - treated Parkinson's disease patients. Lancet 1994 343. 1370 - 1371
4. Lee H, Cooney JM, Lawlor BA. The use of risperidone, an atypical neuroleptic, in Lewy body disease. International Journal of Geriatric Psychiatry. 1994 9: 415-417.
5. Madeley P, Biggins CA, Boyd JL, Midham RHS, Spokes EGS. Cell implantation in Parkinson's disease. British Medical Journal 1990 301:556.
6. Hurwitz TA, Calne DB, Waterman K. Treatment of dopaminomimetic psychosis in Parkinson's disease with electroconvulsive therapy. Can J Neurol Sci 1988 Feb; 15(1):32-4

## Calcium carbimide and gluten intolerance

*Sir* – Calcium carbimide acts by interference in the metabolic oxidation of alcohol. Its use is indicated as an adjunct in the treatment of Alcohol Dependence Syndrome.[1] If taken with alcohol, the patient experiences severe headache, nausea, facial flushing and general malaise.[2] We report the case of a female patient with a diagnosis of Alcohol Dependence Syndrome, in which the use of calcium carbimide in treatment was rendered ineffective by the coexistence of gluten intolerance.

*Case report:* AB is a 31 year old separated mother of two with a chronic history of Alcohol Dependence Syndrome. She was commenced on calcium carbimide medication under a regime of daily supervision by her community psychiatric nurse. However, she presented in a state of alcoholic intoxication on several occasions whilst she was known to be compliant with her medication. It transpired that KD also had a diagnosis of Coeliac disease which she had not previously revealed and was non-compliant with her gluten free diet.

Coeliac disease is characterised by an abnormal mucosa in the small intestine, induced by a component of the gluten protein of wheat. The disorder manifests itself by symptoms of malabsorption and the treatment is a gluten free diet.[3] Our patient had been non-compliant with her diet for several years. The reason calcium carbimide did not cause an adverse effect when alcohol was ingested was possibly because the medication was malabsorbed in association with gluten intolerance.

This case underlines the need for a medical history in all patients prior to prescribing calcium carbimide medication.

**Darina Sloan, MB, MCPsych.,**
**Margaret Hannon, MB**
**James O'Boyle, MB, FRCPsych, DPM, DCH**
*St Vincent's Hospital,*
*Fairview, Dublin 3,*
*Ireland.*

**References**
1. Data Sheet. Lederele Laboratories North Road, Finglas, Dublin 11.
2. Silverstone T, Turner P. Drug Treatment in Psychiatry. London: Routledge & Kegan Paul, 1978.
3. Macleod J. Davidson's Principles and Practice of Medicine (14th ed).