disorientation and hallucinations.

To reconfirm that this was a case of sensitivity to clarithromycin – a rechallenge would be necessary but also dangerous and risky to both the patient and medical staff and would be an academic exercise.

A young patient with late stage acquired immune defiency syndrome (AIDS) had acute psychosis shortly after taking clarithromycin. In both cases the psychosis was resolved on withdrawal but recurred on rechallenge.

A 77 year old man developed mania six days into treatment with clarithromycin for a soft tissue infection. His mania resolved on withdrawal.

A 56 year old man with chronic renal insuffiency and underlying aluminium intoxication maintained on peritoneal dialysis developed visual hallucinations. They developed 24 hours after starting clarithromycin for chest infection and resolved completely three days after withdrawal. There is no clear evidence that neuro-psychiatric complication of clarithromycin develop more readily in uremic patients but several factors may predispose towards these adverse effects such as reduce drug clearance, altered plasma protein binding, different penetration of drug across the blood brain barrier or on increased propensity for drug interaction.

A 53 year old man taking long term fluoxetine and nitrazepam developed a frank psychosis one to three days after starting to take clarithromycin for a chest infection. His symptoms resolved on withdrawal of all three drugs and did not recur with erythromycin or fluoxetine and nitrazepam were restarted in the absence of antibiotics. The symptoms may have been due to a direct effect of clarithromycin or else inhibition of hepatic cytochrome P450 metabolism leading to fluoxetine toxicity. There are also two incidents reported of patients who were being treated with clarithromycin for a helicobacter pylori infection.

The UK pharmaceutical company Vigilance Group CSM, has 17 reports since 1991 of paranoid delusional psychosis. There are speculations that these reactions maybe under reported. To date the Irish Medicines Board has three reported cases of a similar kind.

## Conclusion

A 19 year old girl reacted to clarithromycin and developed an acute psychotic reaction. She responded to risperidone and now resumes a normal life. The family were worried that their daughter was admitted to a general hospital as a normal girl and was discharged with a psychotic illness five days later.

It frightens the family to think that their child could react in this way to antibiotics and whether a similar reaction could develop with other antibiotics or if clarithromycin was re-prescribed.

The other fear the patient has is of a recurrence of the psychosis and medically ones wonders whether she is now prone to further psychotic episodes or not.

Declaration of Interest: None

**References**

1. Meylers 14th edition; Macrolides, chapter 26: 874, 881
2. Merck Manual,17th edition: 1113-1115

# Letters to the Editor

Ir J Psych Med 2005; 22(2): 73-76

# Psychology and psychiatry training

Re: *The absence of dedicated information on dissociative disorders in clinical psychology and psychiatry training programs in Ireland.*

We are aware that neither in the training of clinical psychologists or of psychiatrists in Ireland is time given to the contemporary empirical and clinical understanding of dissociative symptoms and dissociative disorders. As clinicians and researchers who have on our caseloads a number of individuals who have been exposed to severe traumatic events throughout their lives and display dissociative symptoms or have a dissociative disorder, we would advocate that dedicated time (eg. a lecture or lecture series) should be given to dissociation and the dissociative disorders in the clinical psychology and psychiatry training curricula. In light of the contemporary scientific understanding of psychiatric illnesses, we believe the omission of relevant empirically-informed knowledge on dissociation and the dissociative disorders represents a potential gap in the training of clinical psychologists and psychiatrists in Ireland.

Over the past 25 years, the scientific study of dissociative disorders has increased substantially. For example, large series studies ($n > 50$) of individuals with dissociative identity disorder (DID) have been published from Australia, Belgium, Canada, Germany, The Netherlands, Turkey, and the USA, to name a few.[1-4] In addition, studies on the clinical phenomenology of dissociative disorders have been published by clinicians and researchers from England, Japan, India, Italy, New Zealand, and Puerto Rico, among others.[5-7] Studies have begun to address dissociative disorders in Ireland, and clinicians' attitudes towards them. In a survey of Northern Irish psychiatrists and psychologists, Dorahy and Lewis[8] found that the existence of DID was generally accepted, though more so by psychologists. However, most clinicians were sceptical that recent cases in the literature represented an accurate diagnosis, indicating that iatrogenesis and misdiagnosis were the likely explanations for increases in DID prevalence. These explanations are consistent with viewpoints in the British[9] and Irish[10] literatures, but are inconsistent with empirical data. Only a very small number of Northern Irish clinicians ($n = 9$ of 86 respondees) had diagnosed, or been involved in the treatment of, DID. A follow-on study using clinical vignettes indicated that most Northern Irish psychiatrists and clinical psychologists failed to detect DID even in a case where discriminating and characteristic symptoms and features of the disorder were overt.[11]

Arguably, this may be a consequence of unfamiliarity with



https://doi.org/10.1017/S0790966700009009 Published online by Cambridge University Press

the contemporary phenomenology and empirical understanding of this and other dissociative conditions. The failure to detect dissociative disorders represents an important clinical issue for mental health care in Northern Ireland, and by extension the Republic of Ireland, as a recent study has found that dissociative disorders, including DID, are not uncommon in complex psychiatric patients in the Province.[12] Partly because of the failure to accurately detect dissociative disorders, and as a consequence engage in effective treatments, individuals with these conditions often have large case files, multiple inpatient hospital admissions, and represent a considerable burden on mental health resources. Treatment strategies for dissociative disorders are relatively distinct from many other psychiatric conditions, and usually involve a phase-oriented psychotherapy approach, similar to the treatment for complex PTSD. Thus the accurate detection of these conditions is the first step to effective treatment.

We appreciate that 'psychiatric folklore' has tended to deem dissociative disorders as rare, and with the absence of valid scientific data before the early 1980s this perception was in line with the empirical knowledge of that time. However, with the exception of dissociative fugue, which still appears to be rare, contemporary studies indicate that dissociative disorders are not uncommon in psychiatric settings. For example, prevalence rate studies from around the world have reported dissociative disorders in over 1% of the psychiatric in-patient population.[13-16]

In our opinion, the inclusion of phenomenological and treatment information on dissociation and dissociative disorders, in what we know is already a very full training curriculum for clinical psychologist and psychiatrists, is worthy of serious consideration.

***Christopher Alan Lewis**
Senior Lecturer in Psychology
School of Psychology
University of Ulster at Magee College
BT48 7JL, Northern Ireland

**Martin J Dorahy**
Clinical Psychologist
Trauma Resource Centre
North & West Belfast HSS Trust, School of Psychology
The Queen's University of Belfast, Northern Ireland

**Heather Mills**
SPR in Psychiatry
Craigavon Psychiatric Unit, Northern Ireland

**Bridget O'Rawe**
Staff Grade Psychiatrist
Mater Hospital, Belfast, Northern Ireland

**Michael C Paterson**
Chartered Clinical Psychologist

**Paul Miller**
Consultant Psychiatrist
TMR Health Professionals
Belfast, Northern Ireland

**Correspondence*

**References**
1. Boon S, Draijer N. Multiple personality disorder in the Netherlands: A clinical investigation of 71 patients. Am J Psychiatry 1993; 150: 489-494.
2. Middleton W, Butler J. Dissociative identity disorder: An Australian series. Aust N Z J Psychiatry 1998; 32: 794-804.
3. Putnam FW, Guroff JJ, Silberman, EK, Barban L, Post, RM. The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. J Clin Psychiatry 1986; 47: 285-293.
4. Ross CA, Norton GR, Wozney K. Multiple personality disorder: An analysis of 236 cases. Can J Psychiatry 1989; 34: 413-418.
5. Baker D, Hunter E, Lawrence E, Medford N, Patel M, Senior C, Sierra M, Lambert MV, Phillips ML, David AS. Depersonalisation disorder: Clinical features of 204 cases. Br J Psychiatry 2003; 182: 428-433.
6. Martinez-Taboas A. Multiple personality in Puerto Rico: Analysis of fifteen cases. Dissociation 1991; 4: 189-192.
7. Umesue M, Matsuo T, Iwata N, Tashiro N. Dissociative disorders in Japan: A pilot study with the Dissociative Experiences Scale and a semi-structured interview. Dissociation 1996; 9: 182-189.
8. Dorahy MJ, Lewis CA. Dissociative identity disorder in Northern Ireland: A survey of attitudes and experience among psychiatrists and clinical psychologists. J Nerv Ment Dis 2002; 190: 707-710.
9. Merskey H. The manufacture of personalities: The production of multiple personality disorder. Br J Psychiatry 1992; 160: 327-340.
10. Casey P. Multiple personality disorder. Primary Care Psychia 2001; 7: 7-11.
11. Dorahy MJ, Lewis CA, Mulholland C. The diagnosis of dissociative disorders by Northern Irish psychiatrists and clinical psychologists using case vignettes. Journal of Trauma and Dissociation 2005; in press.
12. Dorahy MJ, Mills H, Taggart C, O'Kane M, Mulholland C. Do dissociative disorders exist in Northern Ireland?: Blind psychiatric – structured interview assessments of 20 complex psychiatric patients. under review.
13. Friedl MC, Draijer N. Dissociative disorders in Dutch psychiatric inpatients. Am J Psychiatry 2000; 157: 1012-1031.
14. Gast U, Rodewald F, Nickel V, Emrich HM. Prevalence of dissociative disorders among psychiatric inpatients in a German university clinic. J Nerv Ment Dis 2001; 189: 249-257.
15. Modestin J, Ebner G, Junghan M, Erni T. Dissociative experiences and dissociative disorders in acute psychiatric inpatients. Compr Psychiatry 1996; 37: 355-361.
16. Rifkin A, Ghisalbert DO, Dimatou S, Jin C, Sethi M. Dissociative identity disorder in psychiatric inpatients. Am J Psychiatry 1998; 155: 844-845.

# ADHD

Re*: Attention Deficit Hyperactivity Disorder versus Childhood Bipolar Disorder.*

In the United States there has been a massive increase in the diagnosis of bipolar disorder in children in certain areas. This can be seen in the paper on the *Risk of Substance Use Disorders in Adolescents with bipolar disorder* by Wilens *et al.*[1] I started working in child psychiatry in 1974. Since that time I have seen two people with bipolar disorder in the age ranges described by this paper. I find the 'Boston' view of bipolar disorders does not gel with clinical reality. I guess the view of not gelling with clinical reality is easily dismissed. The overlap in symptoms of ADHD and bipolar disorder appears to be what has caused the problem. Would the same result have been found if it was done in New Orleans or London? I don't know what to make of bipolar populations selected as they were selected through newspaper advertisements, internet postings, etc. I would be much happier with a diagnosis of dysphoric conduct disorder than childhood bipolar disorder with conduct disorder. In addition mood stabilisers don't work well in these patients in my experience.

**Michael Fitzgerald,**
Henry Marsh Professor Child & Adolescent Psychiatry
Trinity College Dublin
Dublin
Ireland

**Reference**
1.Wilens T, Biederman J, Kwon A, Ditterline J, Forkner , Moore H, Swezev A, Synder L, Heinin A, Wozniak J, Farone S. Risk of Substance Use Disorders in Adolescents with Bipolar disorder. Journal of the American Academy of Child and Adolescent Psychiatry, 2004; 44(11): 1380 – 1386.



https://doi.org/10.1017/S0790966700009009 Published online by Cambridge University Press