that judges can "agree in rating psychoanalytical aspects of interpersonal relatedness, and that such judgements have clinical relevance".

Quality of object relations is defined as a person's enduring tendency to establish certain types of relationships that range along an overall dimension from primitive to mature. In a semi-structured interview, the patient's life-long pattern of relationships is explored in reference to criteria that characterise five levels of object relations. An overlap with Hobson *et al*'s interview and Personal Relatedness Profile (PRP) is suggested. Of the 30 items from the PRP, we judge 22 to have clear parallels with the QOR criteria.

Hobson *et al* report satisfactory reliabilities for most items of the PRP. The QOR scale has been refined through its use in five clinical trial studies of time-limited dynamic therapy, with progressive improvements in inter-judge reliability. In a current comparative trial of short-term group therapy, two reliability studies have each returned intraclass correlation (ICC(2,2)) values of 0.81.

Hobson *et al* also report that the PRP successfully discriminated between patient groups defined by diagnoses of borderline personality and dysthymic disorder. In our work, we have examined subgroups defined by low and high QOR scores. Low-QOR patients tend to show more pathology on pre-therapy measures of outcome, notably those indices addressing interpersonal functioning. Quality of object relations has been found to be a direct predictor of the therapeutic alliance (Piper *et al*, 1991) and outcome in brief individual therapy (Piper *et al*, 1998), and of remaining and benefiting in a day treatment programme (Piper *et al*, 1996). Quality of object relations also appears to be a moderator of the impact of transference-focused technique in brief individual therapy. In short, QOR has provided important indications regarding the selection of patients for psychodynamic therapy and for the use of particular techniques with particular patients.

We encourage Hobson *et al* and others to continue the development of theoretically relevant measures of psychoanalytic constructs and examination of their clinical utility.

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'Patient *v.* client'

Sir: A patient is someone I attend to, treat and work with. Webster's (1987) *Dictionary* defines patient as "One that suffers, endures or is victimized". The word is derived from the Latin *pati* (to suffer). It saddens me to see some colleagues referring to patients as 'clients'. Webster's defines client as "A person who engages the professional advice or services of another". It is derived from the Latin *clinare* (to lean). Prostitutes and lawyers may have clients. Psychiatrists have patients.

Clinical social workers prefer to use 'client' (Lieberman, 1987), as do psychologists. Occupational therapists lean towards the use of 'client' and psychiatric nurses use both. Social workers brought 'client' from the field of social welfare, where its use attempted to avoid imposing a sick role. Its use in the field of psychotherapy was geared towards avoiding the medical model. Its use by nurses and occupational therapists seems curious. It is inaccurate to claim that a 'client' *engages* their professional services.

Words have meanings and significance. The use of 'client' reflects an assumed equality in the relationship. However, the inherent inequality between psychiatrists and patients is recognised in the ethical and legislative restrictions placed on relationships between psychiatrist and patient. Sharrott & Yerxa (1985) quoted Pellegrino, "There is . . . a special dimension of anguish in illness. That is why healing cannot be classified as a commodity, or a service on a par with going to a mechanic . . . to a lawyer . . .".

Use of 'client' to describe a patient ignores the ethical and moral bond between psychiatrist and patient, one which is based on non-maleficence and beneficence while still respecting patient autonomy.

I urge all mental health professionals to abandon the cold, inappropriate 'client' to describe the individuals who entrust us with their care.

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Schizophrenia and diabetes mellitus

Sir: It is reported that patients treated with clozapine are more often classified as having type 2 diabetes mellitus or impaired glucose tolerance compared with patients in a control group (Hagg *et al*, 1998). Clozapine increases the risk of diabetes if there is a history of pre-existing diabetes, a family history of diabetes or if the patient is Black. Such patients may need close blood sugar monitoring during initiation of clozapine treatment (Popli *et al*, 1997).

We report the case of a 30-year-old Black male, diagnosed with schizophrenia 10 years ago. He has no history of pre-existing diabetes or a family history of diabetes. He was detained in a medium secure unit. Resistant to traditional depot antipsychotic medication, he was commenced on clozapine. The dose was gradually increased to 325 mg daily. After three months, he developed a sore throat, felt lethargic and unwell. His speech became slurred and he was thirsty. Blood sugar was 19 mmol/l. Clozapine was stopped and he was admitted to casualty in a hyperglycaemic ketoacidotic state. He made a good recovery and his diabetes resolved completely. Clozapine was discontinued.

His psychotic symptoms continued and his behaviour was highly disturbed, involving damaging furniture and being assultative. He was transferred to a special (high-security) hospital. Despite treatment with various traditional antipsychotic medications, he made no improvement for three years.

A trial of risperidone was discontinued when blood sugar levels were noted to be elevated. They remained elevated after withdrawal of risperidone. Control of his diabetes was achieved using an oral hypoglycaemic (glibenclamide). In the two years since traditional antipsychotic and oral hypoglycaemic medications have been prescribed together, he has continued to experience psychotic symptoms but has not acted violently. He was returned to the medium secure unit.

Increased irritability is a reported psychiatric aspect of diabetes (Surridge *et al*, 1984). We question whether his latent diabetes may have made him less able to control his behaviour in response to psychosis. Conventional antipsychotic medication only became effective in controlling his violent behaviour after his diabetes was stabilised. Could latent diabetes be an unrecognised cause of treatment resistance in schizophrenia?

Hagg, S., Joelsson, L. Mjorndal, T., *et al* (1998) Prevalence of diabetes and impaired glucose tolerance in patients treated with clozapine compared with patients treated with conventional depot neuroleptic medications. *Journal of Clinical Psychiatry*, **59**, 294–299.

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Mirtazepine causing hyperphagia

Sir: We report a case of hyperphagia occurring following the introduction of mirtazepine.

A 56-year-old married woman suffered from an episode of severe depression that had lasted for over two years. The illness had been precipitated by a range of family stresses and her condition was exacerbated by further personal trauma. A prominent feature of her depression was loss of appetite, which resulted in marked loss of weight. On a number of occasions she was at risk of developing electrolyte imbalance due to restricted fluid intake. Treatment with a range of antidepressants with and without lithium augmentation proved ineffective, and three courses of electroconvulsive therapy (ECT) produced only temporary improvement. She was started on mirtazepine and the fourth course of ECT. Six days following the start of mirtazepine her appetite showed a dramatic improvement. This became particularly clear when the dose was increased to 45 mg/day. Sixteen days after the start of treatment she started eating excessively large quantities of food as well as showing inappropriate eating behaviour, such as eating leftovers from other patients' plates, attempting to take food from wastepaper bins, attempting to pick up food from the floor, and taking food from other patients' dormitories. She was also bingeing on biscuits, chocolates, cake and crisps.

Her weight increased by 10 kg within a period of four weeks. Her eating behaviour started to settle over the next two weeks but her appetite remained excessive. The bingeing behaviour gradually declined and the inappropriate eating behaviour stopped completely.

The voracious appetite seemed more settled when she was reviewed a week later but she still showed occasional binge eating. Her mood showed progressive improvement over a period of four to six weeks for the first time in two years.

This case of hyperphagia lasted for two to three weeks in a patient recovering from a chronic depressive disorder. This coincided with the introduction of mirtazepine while also undergoing ECT. Mirtazepine is known to increase appetite and weight. According to the manufacturer's database, there has been one previous reported case of hyperphagia, in a 54-year-old woman two weeks after commencing the drug, and settling after its withdrawal. In the present case, the hyperphagia also started after about two weeks but was self-limiting despite continuing with mirtazepine at the same dose. It is of interest that, in this case, the marked reduction in appetite was a prominent feature of this patient's depressive illness and that the improvement in mood and appetite eventually occurred simultaneously. This raises the question of whether mirtazepine may have a special therapeutic role in severely depressed patients who also show severe reduction in their food intake.

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One hundred years ago

The Medico-Psychological Association of Britain and Ireland

The fifty-eighth annual meeting of this association will be held in London on July 27th and 28th, at the society's rooms, 11, Chandos-street, W., under the presidency of Dr. J. B. Spence. The presidential address will be delivered in the afternoon of the first day and will be followed by the conferring of medals and distribution of prizes presented by the association, after which a paper upon Christopathia and Bibliopathia, or the Psychopathy of so-called Christian Science, will be read by Dr. C. H. Hughes, President of the Faculty, and Professor of Neurology and Psychiatry of the Barnes Medical College, St. Louis, U.S.A. On Friday demonstrations and papers will be presented by (among others) Dr. F. W. Mott, F.R.S.,

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