in schizophrenic births as Hare and Price's presentation might seem to suggest.

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FLUPENTHIXOL (FLUANXOL)

DEAR SIR,

In 1969, in this *Journal* (Vol. 115, pp. 1399–1402), Reiter reported on his uncontrolled impression of this drug in the treatment of affective illness. He considered that it was liable to cause only minimal side effects and that it had an antidepressant action which was very quickly apparent. I have tested these assumptions in 59 patients from May to December, 1970. Fifty-three of the patients have diagnoses of an affective disorder, and in 12 of them the illness was regarded as an endogenous pattern of depression. I have also given the drug to many more patients since these initial 59. I found a worthwhile sustained improvement in 24 of the 53 patients. I should emphasize that all these patients had relatively chronic illnesses and had had previous treatment with tricyclic antidepressants and in some instances MAOIs and ECT as well.

Side effects were minimal, as Reiter claims, the main ones being occasional constipation and mild drowsiness. My results are so similar to those of Reiter that it would not be worth while to describe them further in any detail. I came to the same conclusions as he did and regard flupenthixol as a most interesting and potentially useful antidepressant. In a series not selected for chronicity I would anticipate a better response rate than here, and I venture to predict that controlled trials, when undertaken, will show it to be an active drug. The main difficulty in organizing a controlled trial for this substance is that it acts so quickly that it is unsuitable to make a direct comparison of it with drugs which require a month to work.

I wish to thank Dr. W. T. Simpson of Lundbeck Research for supplies of flupenthixol.

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CHLORIMIPRAMINE IN THE TREATMENT OF SEVERE DEPRESSION

DEAR SIR,

In your issue for August 1970, (Vol. 117, p. 211) Collins reports few side effects in the treatment of depression by intravenous chlorimipramine, given by drip infusion. I wish to comment on a hitherto unreported side effect in connection with this relatively new anti-depressant.

Case. Female, age 52 in depressive phase of manic-depressive psychosis. She responded well to intravenous drip infusion of chlorimipramine and was discharged after five days. Whilst returning home by taxi, her whole body began to shake so on arrival home she immediately called her general practitioner. He came within minutes and found her almost completely paralysed, while there was intense coarse shaking of all her limbs. He contacted me and I suggested she be given benzhexol 5 mg. orally. After 15 minutes the paralysis and shaking had disappeared. She completed her recovery on oral chlorimipramine and benzhexol.

Since this time I have seen several patients who while receiving oral chlorimipramine have reported uneasiness and shaking of the hands. These side effects have been alleviated by benzhexol. These symptoms and their alleviation suggest an extra-

pyramidal reaction, which may need to be countered by antiparkinsonian drugs.

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PSYCHOTHERAPY WITH FAILURES OF PSYCHOANALYSIS

Dear Sir,

I should like to comment on two patients who were recently referred to me, having received psychoanalysis with no improvement.

Case 1

Male aged 50, single, suffered from an obsessional neurosis, in particular agoraphobia, over 20 years. He had had five years of psychoanalysis with no improvement, and was sent to me by an analyst because his condition was worsening and he was no longer suitable for analysis.

I attempted to treat him by behaviour therapy, and tried to persuade him that a new approach to his treatment could be helpful. I was impressed by his continued reference to his previous therapist, whom he regarded as a supreme being. He continually stated that only analysis could help him, despite his worsening condition. After four visits he informed me that he could not accept behaviour therapy, because he *knew* it would not help him.

Case 2

Female aged 44, divorced. A new immigrant with adaptation problems complicated by an aggressive dependent personality. She had ten years of continuous psychotherapy with two well-known analysts with no improvement, before she decided to emigrate (running away from her therapist)? I treated her with encouragement and supportive therapy, purposively avoiding analytic explanations. She rebelled against this and discontinued treatment after two months. Two months later she contacted me, requesting further advice; she appeared self-sufficient and well on the way to integration in a new 'society' but still spoke of her analysts with considerable awe.

These cases illustrate some of the points made by Dr. Schmideberg (1) and some of the difficulties psycho-analysis creates for patients. Analysts are generally very vague in their criteria for the selection of patients. Moreover, the process of treatment appears to 'brainwash' the patients, and thus make other methods of treatment unacceptable. The first case, an obsessional neurotic, is an extreme example—a person totally unsuited for psychoanalysis who was unfortunately unable to accept a course of treatment that could help, if not cure his disablement. The second patient seemed to fit some of the main criteria for psychoanalysis (intelligent patient with personality problems) but did not improve; and later although she responded to a simpler and shorter form of treatment she continued to find non-analytic reasoning difficult to accept. This case also illustrates that 'failed' cases of psychoanalysis can be helped by other forms of psychotherapy.

I have always found it difficult to discover what are the criteria of successfully treated cases of psychotherapy. Here again, analysts are vague in their answers. I personally find that many psychoanalytic concepts of thought formation are useful in the understanding of patients, but consider rigid adherence to one particular method of treatment is destructive. This is also true in other spheres of medicine.

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THE MAUDSLEY HOSPITAL CLINICAL SENSORIUM TEST

Dear Sir,

We have recently undertaken a revision and adaptation to American conditions of the battery of questions described under the headings of clinical sensorium test (Part I), clinical questionary, and memory questionary, used in the Institute of Psychiatry at the Maudsley Hospital for assessment of mental function in elderly patients (Ball *et al.*, 1967; Shapiro *et al.*, 1956). We have not yet undertaken tests of validity and reliability, and before proceeding with these we should be grateful for the comments of any persons likely to be interested in using such a test. Copies may be obtained by writing to Mr. Bruce Boltuch at the Geriatric-Psychiatric Unit, Building #12, Bergen Pines County Hospital, Paramus, N.J. 07652.

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David Peter Birkett.

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