its equivalent, before declaring the patient a non-responder.

The important review of Quitkin *et al* (1984) addresses the question regarding the length of treatment and its relation to treatment resistance. He suggests that there is a paucity of treatment trials extending beyond four weeks, although some literature suggests that treatment extended to six weeks may improve response, particularly in those patients without melancholia. He strongly argues for the extension of treatment trials to at least six weeks. It has not been established whether one tricyclic is more effective than another. If a patient cannot tolerate an 'adequate' dose of a tertiary amine, a trial of a secondary amine may be indicated. A monoamine oxidase inhibitor (MAOI) may be indicated subsequently, if one has not already been employed at a dose corresponding to 90 mg of phenelzine or 60 mg of tranylcypromine. Alternative therapy such as fluoxetine, psychostimulants, lithium or thyroid augmentation, as well as combination regimens, may be considered when first line treatments have failed.

Until the problem of classification is resolved, we suggest that investigators report diagnostic criteria applied and the parameters of pharmacological treatment employed, including duration of treatment, dose of drugs, concomitant medications, and blood level data when available. Perhaps a better way of defining treatment resistance might be lack of response to 300 mg of a tertiary amine or a secondary amine such as nortriptyline at a blood level of 100 ng/ml, 90 mg of phenelzine, or 60 mg of tranylcypromine with platelet MAOI inhibition of 80% for a minimum of six weeks. These criteria may help to define treatment resistance. While this may not always be data based, it would allow for a certain amount of standardisation across sites.

Finally, it is well established that comorbidity on both axes I and II effect outcome. A new and more inclusive taxonomy should be multidimensional and allow for the characterisation of depressive subtypes, comorbid anxiety and psychotic disorders, character disorders and patterns of substance use, as well as definitive pharmacological parameters to guide treatment.

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GEORGE M. SIMPSON
JULIE B. KESSEL
Eastern Pennsylvania Psychiatric Institute
3200 Henry Avenue
Philadelphia
Pennsylvania 19129

Psychiatry and post-traumatic stress disorder

SIR: Kohen's letter on the "Psychological sequelae of torture" (*Journal*, February 1991, **158**, 287) and her reference to Turner & Gorst-Unsworth (*Journal*, October 1990, **157**, 475–480) underlines the reluctance of the body of British (and Australian) psychiatrists to grasp the nettle of the significance to psychiatry of the concepts embodied in the diagnosis of post-traumatic stress disorder (PTSD). Her concise but dramatic picture of the consequences of the widespread use of torture in Turkey – without mention of PTSD – illustrates the wide-ranging pathology in both the persecuted and the persecutors, and intergenerational effects. If one extends this view of torture to terrorism and violence generally, the social, as well as psychiatric, consequences of the sort of events associated with a PTSD become monstrous (Burges Watson, 1990).

The scanty involvement of British psychiatrists at the Second European Conference on Traumatic Stress held at Leeuwenhorst in The Netherlands in September 1990, compared with the large number of psychologists, is a cause for concern. Perhaps after side-stepping the psychological consequences of trauma for nearly 100 years, psychiatry finds it difficult to reassess its position. There is abundant evidence that violence breeds violence and, as Bowlby (1984) said "It has been extremely unfashionable to attribute psychopathology to real life experience". Perhaps even more telling is Guntrip's (1971) comment "An aggressive society becomes self perpetuating, a nearly insoluble problem".

Dr Kohen is not alone in seeing a connection between unbridled violence, terror and human degradation and a wide variety of presenting psychopathological states (Veterans' Administration, 1985; Ulman & Brothers, 1988), although the relationship and the extent of the relationship remains to be determined. Is psychiatry going to leave the responsibility of investigating this primarily in the hands of psychologists?

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I. P. BURGES WATSON

308 Murray Street
Hobart 7000
Tasmania

Access to Health Records Act, 1990

SIR: I feel it is important to draw colleagues attention to the likely effects of this Act.

From 1 November 1991, patients will have a statutory right of access to their health records. From 1987, this has applied to computer health records (Data Protection Act Subject Access Modification (Health) Order, 1987), but the new legislation relates also to manually written health records.

The only information which may not be revealed is that which the record holder believes likely to cause serious harm to the physical or mental health of the patient or any other person. The record holder must not reveal information related to or provided by an individual, other than the patient, who could be identified by that information, unless that person consents. (This restriction does not apply if a person so identified is a health professional who has cared for the patient.)

This is important for child psychiatrists because:

(a) The application can be made by a child (under the age of 16) if the holder is convinced the child is capable of understanding the application. It could also be made by a parent (or person having parental responsibility) but only with the child's consent (if capable). If the child is incapable of understanding, but access is in its best interest, it can be given.
(b) Confidentiality – any information given by a child in the expectation that it would be kept confidential cannot be revealed.
(c) The Act is unclear about situations where the parent's and the child's interests do not coincide, i.e. where there is suspicion or certainty of child abuse.

It is important for all psychiatrists because the record holder is the person who decides whether or not to reveal information, on the grounds that it is or is not likely to cause serious harm to the physical or mental health of the patient or any other persons. If the record is held by a health service body the 'appropriate health professional' must be consulted. If the holder of the record is the General Practitioner (GP), he or she can give access but need not consult with the specialist. Hence, any psychiatrist writing to a GP and conveying information which he or she feels might be damaging to the patient to know might be well advised to state this in the letter. The decision about potential harm, however, rests with the record holder – the GP. It is important for there to be liaison between psychiatrists and GPs before extracts from psychiatric records are released.

The record holder may reveal information given by a health professional without the consent of that person. If the information relates to, or is provided by, another individual, not a health professional, it may not be revealed without the individual's consent. This will mainly apply to two groups – patient's relatives, and other non-health professionals such as social workers or teachers.

It is not essential to produce all the records (any potentially harmful information may be kept in a separate section) but the records must be kept in a way that will facilitate access if requested. Should we be copying the Social Services system of a main file which is open, and a smaller confidential section containing potentially harmful, confidential and third party information?

The BMA's advice is to avoid expressing views about the patient's behaviour or temperament. This is extremely difficult for psychiatrists to follow. Correct factual information which can be verified by the patient would be valuable, as would be a clear and agreed treatment plan. Case notes may in the future evolve without a description, or reflective musing, and with an inhibited kind of formulation, differential diagnosis, and prognosis. This will have an adverse effect on patient care.

A. M. GAITONDE
Surrey Child and Family Consultation Service
Health Centre
10 Gresham Road
Oxted, Surrey RH8 0BQ

Chloroquine-induced mania

SIR: Attention has been drawn in these pages to malaria presenting as depression (Arun Prakash & Stein, *Journal*, April 1990, **156**, 594–595). With increasing distant foreign travel, clinicians should be aware of the psychiatric complications not only of the disease but also the drugs used in prevention and treatment. A toxic confusional state with psychosis has been reported as a rare adverse effect of chloroquine (Brookes 1966; Rockwell, 1968; Good &