medication. For example, the 1994 VIDAL (the French equivalent of the British National Formulary) gives an advisory maximum daily dose of the oral antipsychotic fluphenazine of 800 mg, and an average daily dose of 25–300 mg, compared to a 20 mg maximum daily dose in the BNF (a 4000% difference). Further research into the relative merits of these divergent treatment approaches is clearly needed.

THOMPSON, C. (1994) The use of high-dose antipsychotic medication. *British Journal of Psychiatry*, **164**, 448–459.
VAN OS, J., GALDOS, P., LEWIS, G., *et al* (1993) Schizophrenia sans frontières: concepts of schizophrenia among French and British psychiatrists. *British Medical Journal*, **307**, 489–492.

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Lithium in steroid-induced depression

SIR: In their report of two cases of successful lithium treatment of mood disorders associated with corticosteroid treatment, Terao *et al* (*BJP*, January 1994, **164**, 109–111) conclude that the effectiveness of lithium in these cases is a manifestation of its activity as a serotonergic antidepressant. This interpretation is tenable, but another interpretation must also be considered.

Mixed mood disturbances (referred to as agitated depression, dysphoric mania, or mixed manic-depressive states) can closely resemble other depressive states (McElroy *et al*, 1992). If these two patients were suffering from mixed mood disturbances, then their positive responses to lithium would be seen as responses to a mood-stabiliser. Note that each of these patients had anxiety and irritability as prominent symptoms.

The authors' interpretation would predict a positive response in these cases to serotonergic antidepressants. Although specific serotonergic drugs have not been systematically studied in these patients, reports on responses to older non-specific antidepressants (each of which has some serotonergic activity) have been very negative (Hall *et al*, 1978). Authors who had previously reported positive results of lithium treatment for steroid-induced mood disturbances had noted the high incidence of manic and mixed manic-depressive states in these patients as a reason for trying lithium (Siegal, 1978; Falk *et al*, 1979).

By the same token, an interpretation based on mood stabilisation would predict a positive response to other mood stabilisers, such as carbamazepine or valproate. Consider the following case. A 41-year-old female was being treated for Crohn's Disease of long duration with prednisone in doses as high as 60 mg per day. All other treatments had failed. She found that irritability, racing thoughts, emotional lability and dysphoria appeared whenever high-dose prednisone was used. I rejected lithium because it irritates the gastrointestinal tract. Carbamazepine, in a dose of 800 mg per day, brought about complete cessation of her mood disturbance even at the highest prednisone doses.

Steroids are frequently used in high doses. More research on the treatment of steroid-induced mood disturbances would be very useful.

FALK, W.E., MAHNKE, M.W. & POSKANZER, D.C. (1979) Lithium prophylaxis of corticotrophin-induced psychosis. *Journal of the American Medical Association*, **241**, 1011–1012.
HALL, R.C.W., POPKIN, M.K. & KIRKPATRICK, B. (1978) Tricyclic exacerbation of steroid psychosis. *Journal of Nervous and Mental Disease*, **166**, 738–742.
MCELROY, S.L., KECK, P.E., POPE, H.G., *et al* (1992) Clinical and research implications of the diagnosis of dysphoric or mixed mania or hypomania. *American Journal of Psychiatry*, **149**, 1633–1644.
SIEGAL, F.P. (1978) Lithium for steroid-induced psychosis. *New England Journal of Medicine*, **299**, 155–156.

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Language and psychiatry

SIR: While welcoming Thomas & Fraser's review of recent developments in linguistics (*BJP*, November 1994, **165**, 585–592), I am surprised that no mention of any psychoanalytic works was made, as psychoanalysis is above all a textual analysis. The French psychoanalyst Jacques Lacan said that "psychoanalysis has only one medium: the patient's speech", thus rehabilitating speech and language as the basis of Freudian analysis (Lacan, 1953).

Freud's command to his first patients (the hysterics for whom speech was so problematic) was to speak. It was through this speech that the unconscious text emerged. His example of the fort-da game (Freud, 1920) shows how the child uses language in order to cope with the mother's absence

and to symbolise her. The child throws a spinning reel away and exclaims "fort!" ("gone"); he pulls it towards him – it is "da" ("here"). Thus language is necessary because no relationship with another can be perfectly satisfying; there must always be some separation between mother and child, child and siblings, subject and other. Language also confers on us a history – another way in which it differentiates us from other primates. In analysis, for Lacan, "the subject assumes his own history" (Lacan, 1953). It is not the gaining of insight which is therapeutic in psychoanalysis (and Freud never said anything about insight), it is the very act of speaking, "the putting into words of the event ... [which] determined the lifting of the symptom" (Lacan, 1953).

It may be that this "talking cure" has implications at a neurochemical or neurostructural level. We know that the process of memory storage involves changes at these levels and it is reasonable to assume that the retrieval of memory and the remembering through speech in analysis results in similar changes. I do not wish to attempt to direct correlation between the praxis that is psychoanalytic discourse, and the science of neurobiology. Nevertheless it is interesting that Thomas & Fraser end their paper with a brief review of language therapy as a way of altering faulty discourse. It would appear that these therapies have some overlap with psychoanalysis.

FREUD, S. (1920) Beyond the pleasure principle. In *Standard Edition*, Vol. **18** (ed. & trans. J. Strachey), pp 224–226. London: Hogarth Press.

LACAN, J. (1953) Function and field of speech and language in psychoanalysis. In *Ecrits. A Selection* (trans. A. Sheridan). London: Tavistock Routledge.

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Psychiatrists and priests

SIR: Sims (*BJP*, October 1994, **165**, 441–446) asserts that "We need to balance the importance of the spiritual in the life of our patients with denying absolutely any sort of priestly role for ourselves as psychiatrists."

In the course of psychotherapy, we cannot avoid being put into a priestly role by some of our religious patients, any more than we can avoid being put into a parental role by patients who need to work through, or who attempt to act out, something about their relationship with their real or internal parents. In both cases we should interpret the transference processes to enable our patients to achieve more healthy and realistic relationships with these figures.

Most priests believe they have the authority to convey forgiveness to those who feel guilty. No psychiatrist does this in so many words, but in therapy a similar process often takes place. A depressive patient gradually realises that the behaviour for which he blames himself was only partially under his control and that he was driven to act as he did by his past experiences. Thus his guilt diminishes. Another patient may accept more responsibility for his behaviour and feel ashamed. Because the therapist does not condemn him, and may, to his surprise, still hold him in high esteem, he can internalise this experience and forgive himself. So, through his relationship with his therapist, his 'sin' is forgiven.

In the course of the work, the therapist conveys to his patient a sense that he is valuable, lovable in spite of what he is like at the moment, and worthy of all the care he needs, even if it is not practically possible to give so much. The response of some patients to this is like a religious experience. Then the therapist is functioning very much like a priest, even through neither party acknowledges the spiritual aspect of their activity. When such things happen in our work I think we should accept them humbly and with appropriate awe, rather than deny our priesthood as Sims seems to require us to do.

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Comparing treatments for generalised anxiety disorder

SIR: Durham *et al*'s comparison of cognitive therapy, analytic psychotherapy and anxiety management training as treatments for generalised anxiety disorder (*BJP*, September 1994, **165**, 315–323) made certain assumptions which would seriously question the validity of their results. These assumptions fall under the uniformity myths for psychotherapy research. First, the patient uniformity myth assumes that all patients who suffer from the disorder are expected to respond, irrespective of their underlying psychopathology, to any of the three treatments, in a similar fashion.

This patient sample had a significant bias towards the lower social classes. Forty-six per cent were also diagnosed as having an avoidant or dependent personality disorder, and 66% were taking psychotropic medication. These factors suggest