British Journal of Psychiatry (1991), **159**, 156–166

Correspondence

Editor: Ian Pullen

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Prescribing practices

SIR: The following letter was written by my father John Dunne, Emeritus Professor of Psychiatry at University College, Dublin, shortly before his death at the age of 92, on 1 January 1991. Having qualified in 1922, he lived through many changes in psychiatry, such as the discovery of electroconvulsive therapy (ECT), antidepressants, and neuroleptics. However, in recent years he became concerned about certain prescribing practices; his views are stated below.

SIR: There is reason for concern about the prescribing of neuroleptics by some colleagues, who, firstly, are using very large doses, e.g. chlorpromazine 800 mg to 1000 mg, haloperidol 70 mg and over, etc., daily, and who, secondly, prescribe a number of neuroleptics, three, occasionally four, simultaneously, often in similar large dosage. This practice is most likely to occur if the patient's behaviour is difficult to manage, particularly in the setting of an acute in-patient unit.

Such practice is likely to get neuroleptics a bad name with the public at large, resulting as it does, in greater incidence of side-effects, which could lead to litigation by injured parties seeking compensation, and this, in turn, would make many individual psychiatrists reluctant to use them in adequate dosage. The discrediting of neuroleptics would also increase patients' resistance to taking them.

This would be a major disaster for psychiatry; I write as one still in active practice, who has been practising for over 65 years, and who recalls the treatment of psychotic patients before the introduction of neuroleptics.

It is my opinion that the prescribing patterns described are, firstly, due to pressure to get patients out of hospital in short periods of time, or to keep patients out of hospital, and secondly, due to failure to ensure that adequate numbers of trained nursing staff are available at all times, sufficient numbers being essential to nurse confidence. When nursing staff are confident that they can cope effectively with all behaviour, and that they themselves, and their patients, are safe, they can then promote the other aspects of a therapeutic environment; respect for, understanding of, and sensitivity towards each patient, accompanied by constructive communication and activity, thereby promoting recovery, and making untoward incidents unlikely. This has been my experience, and it is supported by extensive literature, dating from at least the 18th century to the present.

Pharmacology now makes a major contribution to psychiatric treatment, how major perhaps only individuals such as I fully appreciate, but this does not obviate the need for human therapeutic process. Attempts to replace human means of treatment by excessive reliance on pharmacology, for whatever reason, is not just a poorer form of treatment, it is likely to lead to the discrediting of very valuable drug therapies, with serious consequences for many who would benefit from them.

JOHN DUNNE

I believe that the views expressed in his letter are of great importance to current psychiatric practice.

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Outcome for elderly depressives

SIR: The paper by Burvill *et al* (*Journal*, January 1991, **158**, 64–71) is a further helpful addition to the debate over what outcome can be expected nowadays for elderly depressives referred for specialist psychiatric treatment. Regarding the work which I carried out with David Jolley in 1986, there is one misquotation. It concerns the sex ratio of our sample, to which reference is made twice; the correct ratio is male:female = 1:4 (and not the other way round, as stated by Drs Burvill *et al*).

Having corrected this, and taking into account arguments from our original paper, the suggestion by Drs Burvill *et al* that our patients were not likely to be representative of those usually presenting to psychogeriatric services seems an unlikely explanation for