In-patient psychotherapy

SIR: We were interested to read Norton & Hinshelwood's (1996) account of the clinical need for in-patient psychotherapy units. However, we do not believe that in-patient psychotherapy units are the only, or indeed the best treatment for these patients. In-patient units are expensive to run, make heavy demands on staff round the clock, and remove patients from their normal environment and support networks.

We run a therapeutic community as a day service, which is open for five days a week and caters for a similar patient population at a district level. Like the Henderson, the programme is one of milieu therapy with intensive group psychotherapy. There is no individual treatment. Like the Cassel, the analytic principles of "a culture of enquiry" and staffing and supervision to prevent splitting and other destructive defensive procedures are paramount.

The advantages of having day patient treatment are financial, administrative and clinical. Treatment costs are approximately half of in-patient facilities, and the complexities of staffing the unit are much less. A considerable clinical advantage is the on-call system for out of hours run by the patients themselves, which is seen as an important part of the therapeutic process itself. For many patients it is also important that their previous social functioning continues during their admission, and this is particularly important for those who are parents.

NORTON, K. & HINSHELWOOD, R. D. (1996) Severe personality disorder. Treatment issues and selection for in-patient psychotherapy. *British Journal of Psychiatry*, **168**, 723–731.

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Antipsychotic drug-induced dysphoria

SIR: Gray *et al* (1996) cite four flaws in King *et al*'s (1995) report which in their view invalidate their conclusions. We wish to report observations made in a further healthy volunteer study which are relevant to their concerns.

In a study designed to assess the cognitive and psychomotor effects of haloperidol, 15 male volunteers aged 18–26 years were given single doses of haloperidol 2, 4 and 6 mg, lorazepam 2.5 mg and placebo at weekly intervals in a double-blind, repeated measures design. When given 6 mg of haloperidol, 12 volunteers experienced adverse effects, variously described by them as restlessness, irritability or tension. Three volunteers described the effects as 'severe' or 'very severe', six as 'moderate' and three as 'mild'. In most of these cases the effects began between 3 and 5 hours after drug administration, but two subjects developed symptoms at 6 and 8 hours respectively. Symptoms were treated with procyclidine 5 mg in nine volunteers, which gave relief to the symptoms. Two volunteers who did not receive procyclidine had persistent symptoms resulting in insomnia that night, and lasting more than 24 hours.

At the 4 mg dose of haloperidol, nine volunteers experienced similar adverse effects, two rating the effects as 'severe' or 'very severe', one as 'moderate' and six as 'mild'. Once again, two volunteers experienced late onset of symptoms at 6–8 hours but most described the onset of symptoms at 3–4 hours. One volunteer described mild restlessness three hours after receiving the 2 mg dose. Thus, dysphoria occurred in 80% of subjects receiving 6 mg of haloperidol, 60% receiving 4 mg of haloperidol and 6% receiving 2 mg of haloperidol. Dysphoria occurred in the absence of objective signs of akathisia. In most cases the onset of symptoms coincided with the theoretical time of peak plasma levels, but in a significant minority of cases the effects are delayed. These studies were not designed specifically to examine adverse effects of antipsychotic drugs, and we agree with Gray *et al* that the area of antipsychotic drug-induced dysphoria requires further rigorous investigation.

GRAY, R., BROWN, C., HOOGHAMER, R., *et al* (1996) Antipsychotic drug-induced dysphoria. *British Journal of Psychiatry*, **168**, 655–656.

KING, D. J., BURKE, M. & LUCAS, R. A. (1995) Antipsychotic drug-induced dysphoria. *British Journal of Psychiatry*, **167**, 480–482.

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Inappropriate secretion of antidiuretic hormone and SSRIs

SIR: We have observed hyponatraemia in an elderly depressive patient treated with the SSRI citalopram. The SIADH syndrome has been described