being less than optimal; and, to the extent that training fails to make nurses' attitudes more consistent with those of art therapists, nursing education is losing an opportunity for increasing co-operation between medical and para-medical staff.

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BRITISH PSYCHIATRY'S LOVE AFFAIR

Dear Sir,

I sympathize with Dr Macilwain's transatlantic letter (*Journal*, September 1978, **133,** 282) following the critique of British psychiatry by Professor Kathleen Jones (*Journal*, April 1978, **132,** 321–32), which describes psychiatry's 'love affair' with medicine at the expense of a wider conceptualization, including psychodynamic awareness. From greener pastures elsewhere, Dr Macilwain asks if he would be permitted to practise psychiatry as he would wish to over here. Since this concerns many psychiatrists in training, I feel it can be stated that there are several hopeful signs that the aims and attitudes of influential people here are changing for the better, as in the following examples.

One way of assessing the priorities of the DHSS in a time of economic stringency is to look at the number of new posts established in different specialities. Before 1975 there were no senior registrar posts in psychotherapy apart from four in London, but since then four new provincial posts have been created. At consultant level, data from the Medical Manpower Division of DHSS (in *Health Trends*, **9,** 45 and **10,** 61) indicates that between September 1976 and September 1977 consultant posts in psychotherapy rose from 18 to 32. This 78 per cent increase compares with a 1 per cent fall in mental handicap (although the number of posts in these specialities is much larger), while forensic psychiatry posts rose from 9 to 11 (22 per cent). The need to develop psychotherapy services in areas where they barely exist is being recognized, as shown by several new consultant posts such as the one I have been appointed to in Kent.

From its inception in 1971, the Royal College of Psychiatrists has adopted the policy that all trainees in general psychiatry should have some training in basic psychotherapeutic skills (*Journal*, **119,** 555–7). This aim is seriously limited by the lack in most areas of trained psychotherapists, but is increasingly being implemented according to local opportunities (*Journal*, **132,** 398–402 and *The Bulletin*, August 1978, 143–5), including Aberdeen where Dr Macilwain and I were colleagues and here in Cambridge where psychotherapy training is given a high priority. Psychotherapists themselves are increasingly responding to the challenge to demonstrate their ability to 'deliver the goods'. Careful and sophisticated research on the effective components of psychotherapy and its long-term effects, e.g. Malan's work on brief psychotherapy, is being matched by development into new areas, e.g. Brook's frontier work on the attachment of psychotherapists to general practice surgeries (Brook and Temperley, 1976). Dr Macilwain rightly emphasized the importance of attitudes of teachers in medical schools. In Cambridge, with the encouragement of senior medical staff, we have attempted to use regular discussion groups on the subject of all aspects of doctor-patient relationships, although serious difficulties have been encountered.

Lastly, in Sir Denis Hill's lecture on 'The Qualities of a Good Psychiatrist' (*Journal*, August 1978, **133,** 97–105) he freely acknowledges the essential place of psychotherapy and an awareness of psychodynamic factors. I was impressed with his description of clinical maturity which starts: 'personal and emotional maturity, which means freedom from personal neurotic nostalgia with one's own past'. The grass may well be greener in Canada or America, but the soil over here is more fertile than it may appear and needs good farmers to work in a challenging and rewarding field.

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DO CHRONIC SCHIZOPHRENICS IN HOSPITAL NEED MORE THAN ONE NEUROLEPTIC DRUG?

Dear Sir,

In psychiatric hospitals long-stay patients are commonly prescribed more than one type of neuroleptic preparation. Rationale for such practice is not clear. We wish to report here our experience in switching patients from multipharmacy to a single drug regime.

We assumed the clinical responsibility of a ward in which there were 30 female chronic schizophrenic patients. Their mean age was 60.3 ± 1.5 years and they had been in hospital for a mean period of 27 ± 2.3 years. Fifteen of these were receiving more than one type of neuroleptic preparation including

depot injections, and 10 patients were on a variety of other compounds including tricyclic antidepressants, anxiolytics and fenfluramine. Twelve patients were receiving antiparkinsonian drugs and 8 patients were receiving sedatives at night. The majority of the patients were receiving the drugs three times daily.

We decided to maintain all the patients on a single neuroleptic, haloperidol. This was prescribed in oral doses equivalent to their previous medication calculated on a basis reported by Howard (1976). All patients receiving antiparkinsonian drugs were switched to procyclidine. No other drug was allowed apart from nitrazepam at night which was given if required only. The drug administration was reduced to once daily in 1/3 of the patients and twice daily in the other 2/3.

Prior to the change of medication the patients' psychiatric morbidity was assessed on a Brief Psychiatric Rating Scale (BPRS). The ward sister, who had known the patients for many years, was asked to rate their behaviour on Wing's ward behaviour scale. Extrapyramidal side-effects were rated on a modified extrapyramidal rating scale (Okasha and Hirsch, unpublished). Each patient was asked to complete a standardized side-effects checklist, with the help of nursing staff if necessary. All the patients continued with the usual activities including occupational and industrial therapy.

Six months later all the clinical ratings were repeated.

The results are shown in the table (see pp. 224). There was no significant difference in the BPRS nor on the extrapyramidal symptoms (EPS). Two patients were withdrawn from the antiparkinsonian drug during the trial but this was added in 3 patients. The nurses' rating scores showed a significant decrease, as did the patients' complaints of side-effects.

Caution must always be used in interpreting the results of an open study. However, although the trial was initially viewed with some anxiety by the nursing staff, it was soon welcomed as it was found that patients could be maintained at the same level or better on a single medication given once or twice daily. It was felt that there was an increase in drug compliance by patients and also an increase in the amount of time the nurses could spend with the patients in other activities. Our experience supports the report (Dimitriou *et al*, 1977) of beneficial results of single dose regime. The 50 per cent decrease in side-effects reported in patients is highly significant. This indicates that limiting the treatment to one drug alone renders the therapeutic regime more acceptable to patients. We therefore believe that it is usually of little value to give patients more than one type of neuroleptic. Probably the most important variable is the dosage of the neuroleptic which should be carefully adjusted.

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SODIUM VALPROATE AND TARDIVE DYSKINESIA

Dear Sir,

Since A. C. Gibson (*Journal*, July 1978, **133**, 82) has been unable to replicate our encouraging findings concerning the efficacy of sodium valproate in the treatment of tardive dyskinesia, we would like to point out a few salient points in our experimental design:

1. A half of our subjects were over 65 years of age. This combined with the high dose of sodium valproate used by us led to relatively high blood levels of the drug.
2. The offending and 'high potency' neuroleptics were avoided and our patients were treated with 'low potency' neuroleptics, such as chlorpromazine, which are known to have effects on many other transmitter systems in addition to dopamine. At the pharmacokinetic level these drugs are known to increase blood levels of many other therapeutic agents by inhibiting their metabolism. When used in combination with 'high potency' neuroleptics sodium valproate seems to be ineffective in the treatment of tardive dyskinesia. We have recently documented that sodium valproate does not enhance the efficacy of pimozide in the treatment of tardive dyskinesia.

We think that differences in experimental design between Gibson's and our work explain the discrepant findings.

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