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TRIAL OF 'PIRACETAM' IN CHRONIC SCHIZOPHRENIA

DEAR SIR,

A double-blind cross-over trial of Piracetam (2 = pyrrolidone acetamide) *v* placebo has recently been completed on sixteen male and eleven female chronic schizophrenic in-patients aged 20 to 65 years, most of whom were severely disabled despite medication and sustained efforts at rehabilitation. The trial was stimulated by work suggesting that Piracetam improves interhemispheric transfer of visual information across the corpus callosum (Buresova and Bures, 1976) and reports of impairment of transfer of information across the corpus callosum in chronic schizophrenia (Rosenthal and Bigelow, 1972; Beaumont and Dimond, 1973). The drug has been used in a variety of psychiatric conditions on the continent, especially in chronic organic states where memory is impaired (Abuzzahab *et al*, 1973; Dencker and Lindberg, 1977). The dosage was 1,600 mg of Piracetam three times a day for four weeks, in addition to the long-term psychotropic medication the patients were already receiving. Assessment of response was by Wing's Symptom and Behaviour Rating Scales.

The drug failed to produce any significant change in either symptoms or behaviour in this group of patients. There was no apparent effect on blood chemistry, nor were any side-effects detected. A detailed report is available on request.

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SPECIALIST NURSES

DEAR SIR,

It was with dismay and concern that I read Professor Goldberg's frivolous review of *Nursing in Behavioural Psychotherapy: An Advanced Clinical Role for Nurses* (*Journal*, September 1977 **131**, p 320). It is unfortunate that so eminent a professor should treat an important development as a joke. Not only is it reactionary and prejudiced but it does not attempt to make a constructive critical appraisal of well researched work in which nurses and patients are so closely involved. The attitude adopted by Professor Goldberg takes no cognisance of a successful attempt to help sick people more quickly than might otherwise be the case. This extension of the nurse's role is but one of a series of advances being made by nurses in the clinical field and should be treated with the courtesy it deserves.

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DEAR SIR,

It is a pity that Professor Goldberg should utilize his obviously fertile imagination to do gross injustice to what is an important development for nurses, as well as a potentially important therapeutic advance for psychiatric treatment in this country.

Psychiatric nurse therapists do not wish to 'fly the aeroplane' but merely to ease the burden of the pilot by providing specialist intervention for patients who might, through lack of time or other resources, go

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untreated. We do not claim to replace the therapeutic team but to strengthen it.

Those who give serious consideration to this important book will find much of interest and many ideas which, I hope, will become very widespread in British psychiatry, namely, goal definition, targeting of problem areas, therapeutic investment versus benefits achieved, and objective measurement at all stages throughout treatment.

In the unlikely event that the reviewer finds his own aeroplane hijacked by a lorry driver, I am sure he will be able to pursue a rewarding career in the literary field. I have no such pretensions. I would just like to be able to provide a demonstrably worthwhile service to the adult neurotic population.

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DEAR SIR,

I am sorry that Miss Skellern should think my review was a joke, and I realize it will only make matters worse when I say that it was deadly serious. In the short space allowed me for my review I wished to make two points in as vivid a way as possible: first, to question what the basic educational requirements should be for a practitioner of behavioural therapy, and second to ask what the relationship should be between the nurse therapist and other professionals—notably clinical psychologists and doctors.

Although Miss Skellern may call me reactionary, it seems to me to be reasonable that practitioners of behavioural therapy should have qualifications in psychology, just as psychiatrists should have qualifications in medicine and airline pilots should know a little about general physics and engineering. At a time when our society is producing many graduates in psychology, it seems a pity that some of these could not be offered the sort of specialist training Dr Marks has described.

Mr Brown assures me that nurse therapists do not wish to 'fly the aeroplane', but this point is far from clear, since the course claims to provide an independent role for nurse therapists and the relationship of the nurse therapists to other members of the therapeutic team is left critically unclear. If the nurse therapists are to work alongside established clinical psychologists and under their general supervision let this be clearly stated: it has not been stated so far. Mr Brown goes on to say that nurse therapists will have an effect on British psychiatry: but again, the relationship between a nurse therapist and a psychiatrist is not made clear. If nurse therapists are to work on their own in the community, or if they are to work in a primary care setting, let it be made clear who is to pay them and to whom they are responsible. Mr Brown adds the image of the hijacker to my simile: I would only say that until these issues are resolved, it is the nurse therapist who will seem to others to have hi-jacked the aeroplane.

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WHAT'S IN A NAME? ATTEMPTED SUICIDE

DEAR SIR,

Psychiatrists, aware of the growth in the number of patients who take overdoses of drugs, usually accept the view put forward by Stengel (1964) that those who kill themselves and those who do not succeed in killing themselves represent two different but overlapping populations. Those who survive the overdose and other methods of potential self-destruction provide many problems; a minor one is how to name the act carried out by such individuals.

There have been a number of suggestions concerning nomenclature. *Attempted suicide* is applicable only to a small percentage; undoubtedly there are a few who intended to kill themselves and fortuitous discovery has prevented death. For these, the term is appropriate. For the majority it is recognized that the intention to die is not in the forefront of the individual's motives. A number of alternative terms have been suggested for this behaviour. *Parasuicide* (Kreitman *et al*, 1969) is commonly used but it retains the connotation of a partial suicide—suicide related behaviour. *Pseudocide* (Lennard Jones and Asher, 1959) self-evidently and '*Self-poisoning*' (Kessel, 1965) have developed pejorative meanings with the implication of 'merely' an overdose and not an act of someone in distress. Ramon and his colleagues (1975) have drawn attention to the differing attitudes of nurses and doctors towards such individuals.

There is need to coin a new term which can be precisely defined without the disadvantages associated with the present names. I would like to propose the name *Propetia* which I introduced at the Annual Congress of the International Association of Suicide Prevention in 1975. The word derives from the Greek προπετεία meaning rashness, headlong haste and containing the idea of falling into something or rushing into it in a reckless manner without previous assessment of the risks. It is thus different from the

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