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## Informing patients about the side-effects of antipsychotic medication

Sir: The study by Smith & Henderson (*Psychiatric Bulletin*, May 2000, **24**, 172–174) highlights the selectivity of information given to patients by doctors about antipsychotic medication. However, the information gathered is in effect about doctors' attitudes, about those side-effects on which they thought it worth volunteering information, and much remains to be understood about actual practice and patients' response. Psychiatrists tend not to be aware of which side-effects of antipsychotic medication are most likely to cause distress to patients (Day *et al*, 1998). In the last few years there has been a major shift in prescribing practice from conventional antipsychotics to atypicals. Atypicals have a very different profile of side-effects and we need to know how troublesome their particular side-effects (weight gain and sedation) are to patients.

Studies have shown little positive evidence that informing patients with schizophrenia about side-effects improves adherence (MacPherson *et al*, 1996; Chaplin & Kent, 1998). One can certainly imagine that patients will feel happier in their awareness of side-effects when they can also be told of coping strategies, for example, "this medicine can cause weight gain but we will monitor your weight and ask the dietician to advise you about what to eat".

We are currently studying in-patients' knowledge of the side-effects of antipsychotic medication, their sources of information and their desire for more information. We are asking doctors which side-effects they have discussed with their patients and are auditing case notes for details of the information offered. Our preliminary results show that the level of knowledge and understanding about side-effects is low, many patients suffer physical problems but are unsure whether these are caused by their antipsychotic medication and most patients say they do not wish for more information. When asked, one in three patients said their side-effects were so bad they wanted to stop their medication.

CHAPLIN, R. & KENT, A. (1998) Informing patients about tardive dyskinesia. Controlled trial of patient education. *British Journal of Psychiatry*, **172**, 78–81.

DAY, J. C., KINDERMAN, P. & BENTALL, R. (1998) A comparison of patients' and prescribers' beliefs about neuroleptic side-effects, prevalence, distress and causation. *Acta Psychiatrica Scandinavica*, **97**, 93–97.

MACPHERSON, R., JERROM, B. & HUGHES, A. (1996) A controlled study of education about drug treatment in schizophrenia. *British Journal of Psychiatry*, **168**, 709–717.

***Camilla Haw** Consultant Psychiatrist, **Jean Stubbs** Head of Pharmacy, St Andrew's Hospital, Billing Road, Northampton NN1 5DG

## Shell-shock

Sir: We read with interest Howorth's (*Psychiatric Bulletin*, June 2000, **24**, 225–227) paper on the treatment of shell-shock and, while agreeing with much of what he wrote, question the accuracy of several points. In general, he implies that psychological knowledge grew in a smooth progression from insights gained in the First World War to the present day. In fact, our research has shown that these new ideas were largely abandoned in the interwar period and had to be resurrected when war threatened in 1939 (Jones & Wessely, 2000). Both Myers and McDougall were so disillusioned by their experiences that the former moved to the field of industrial psychology and the latter emigrated to the USA. So upset was Myers by the rejection of his ideas by the military authorities that he refused to give evidence to the Southborough Committee on shell-shock because, as he wrote in 1940, "the recall of my past five years' work proved too painful for me". Millais Culpin, Professor of Medical Industrial Psychology at the London School of Hygiene, observed that few doctors with any regard for their reputation would mention an interest in psychoanalysis during the 1920s "without the verbal equivalent of spitting three times over the left shoulder, and even to speak about the revival of war memories carried the risk of being accused of advocating free fornication for everyone" (Culpin, 1952).

While post-traumatic stress disorder (PTSD) and shell-shock undoubtedly have some elements in common, both disorders have been influenced by cultural forces, so that it may not be true to say that one is a precursor of the other. Shell-shock is a reflection of the medical ideas of the early 20th century and its very name encapsulates the terrifying qualities of trench warfare. PTSD, first identified in the 1960s, was originally termed 'post-Vietnam syndrome' and it expresses many of the conflicts of that war. In our detailed examination of the medical records of shell-shock cases, we have found that the majority of servicemen did not exhibit delayed symptoms (even though their applications for a war pension may not have been made until the early 1920s). Clinicians of the time commented how symptoms could readily become chronic unless they were treated swiftly by the methods of abreaction that Howorth describes. Finally, the notion that all soldiers, even those that were well led and highly trained, could break down in action was not accepted by the military authorities until the Second World War. The *Southborough Report* (War Office Committee of Enquiry into 'Shell-Shock', 1922) concluded in 1922 that regular units with high morale were virtually immune from such disorders as shell-shock.

CULPIN, M. (1952) *A criticism of modern trends in the treatment of psychoneuroses*, pp. 71–73. Medical Press.

JONES, E. & WESSELY, S. (2000) The impact of total war on the practice of British psychiatry. In *The Shadows of Total War: Europe, East Asia and the United States 1919–1939* (eds R. Chickering & D. S. Mattern) Cambridge: Cambridge University Press.

MYERS, C. S. (1940) *Shell-Shock in France 1914–1918, Based on a War Diary kept by C. S. Myers*. Cambridge: Cambridge University Press.

WAR OFFICE COMMITTEE OF ENQUIRY INTO 'SHELL-SHOCK' (1922) *Southborough Report*. London: HMSO.

***Edgar Jones** Senior Research Fellow, **Simon Wessely** Professor of Epidemiology and Liaison Psychiatry, GKT School of Medicine, Department of Psychological Medicine, 103 Denmark Hill, London SE5 8AZ

## Flexible training in psychiatry

Sir: I am writing on behalf of the Executive of the Woman in Psychiatry Special Interest Group, where I hold the brief for flexible training. We were very interested to read the recent articles on flexible training. As a general comment, we think it is encouraging that more information is becoming available on part-time training in psychiatry. Findings are overall encouraging: the Dean *et al* (*Psychiatric Bulletin*, November 1999, **23**, 613–615) study found that flexible trainees were satisfied with the quality of their training in spite of some drawbacks mentioned, including perceived lack of status, some inequality in training opportunities and a lack of part-time consultant posts at the end of training. Herzberg & Goldberg (*Psychiatric Bulletin*, November 1999, **23**, 616–619) found that the quality of flexible trainees compares favourably with that of full-time trainees.

There is general agreement that there is an increased demand for flexible training and working which needs to be addressed. Job-sharing both at training and consultant levels has been suggested as an alternative. In connection with this, we would like to make two specific points arising from Garrard's (*Psychiatric Bulletin*, November 1999, **23**, 610–612) paper. The first point relates to the author's own experience of setting up her own job-share in an approved senior house officer post. Regarding the negotiation of her contract she says "We agreed to share our on-call duties, study and annual leave, *pro rata* and return to full-time training if the other left". We believe this is not a good arrangement, as it does not protect the trainee's basic requirement to work part-time. Further, we suggest that study leave ideally should not be shared *pro rata*, as both partners are expected to gain continuing professional development points on an equal basis to full-time trainees.



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We believe that protective arrangements should be negotiated for a consultant job-share, to secure the part-time position if the job-share partner leaves. In that case, it should be up to the employing trust to advertise the vacant part-time position. In fact it may be better altogether for separate part-time training contracts to be issued in all cases. If flexible training and working is to be seen as a valid and solid option, it has to be respected as such. Although job-shares may be convenient for financial or managerial reasons, they should not be binding for the incumbents to revert to full-time occupation.

The second point relates to the comment "Additional funding from the postgraduate dean's budget was arranged by our medical staffing department for us to overlap in one session per week". This is a welcome development. We are pleased to report that the Flexible Training Office Thames Region has taken the initiative to make this 'overlapping' session available for all job-share schemes. It has been pointed out that there may be financial implications, such as increased administrative costs, for trusts to employ two people. We would argue that the possible additional cost should be balanced against the possibility of recruiting and retaining well-trained doctors into the speciality.

**Alicia Etchegoyen** Consultant Child and Family Psychiatrist, Chelsea and Westminster Hospital, 869 Fulham Road, London SW10 9NH

## Social networks in 'community care'

Sir: Leff *et al*'s finding (*Psychiatric Bulletin*, May 2000, **24**, 165–168) that the majority of the 'TAPS' cohort lead impoverished social lives contrasts with the original vision of community care. Their reference to the nature of severe psychiatric illness seems to imply that this is responsible. Many seriously ill former long-stay patients have shown unexpected potential for social and personal relationships in coping with a relocation that would have taxed any demographically similar population, irrespective of mental illness. Most also faced a policy of confining them to small, dispersed groups (Heginbotham, 1985) on the assumption that this would automatically spawn social networks in 'the community' and with an unpleasant implication that relationships among themselves were second best that has not been entirely avoided by TAPS.

Such impoverishment should not be accepted for de-institutionalised patients, even at this late stage, and services for other groups, including assertive outreach and home care, also need fully to incorporate social network considerations if they are not to lead to similar disappointments. The TAPS review will hopefully stimulate debate; and I would suggest an approach based on the promotion of a network of varied relationships across a range of activities and settings (Abrahamson, 1997).

ABRAHAMSON, D. (1997) Social networks and their development in the Community. In *Communication and the Mentally Ill Patient* (eds J. France & N. Muir). London: Jessica Kingsley.

HEGINBOTHAM, C. (1985) *Good Practice in Housing for People with Long-Term Mental Illnesses*. London: Good Practices in Mental Health.

**David Abrahamson** Consultant Psychiatrist, Community Mental Health Rehabilitation Team, 313 Shrewsbury Road, London E7 8QU

## Chlordiazepoxide dosage for alcohol withdrawal

Sir: I would like to comment on the data of Naik *et al* (*Psychiatric Bulletin*, June 2000, **24**, 214–215). The initial mean daily dose of chlordiazepoxide equivalents used by general practitioners and specialist alcohol services – namely 45.8 mg and 98.1 mg – approximates to 12 mg four times daily (q.d.s.) and 25 mg q.d.s. respectively. The former is very low, the latter low in more severe dependence.

An inadequate initial daily prescription of chlordiazepoxide can have two adverse consequences:

(a) the emergence of aversive (e.g. agitation and/or withdrawal hallucinations) and/or dangerous (e.g. withdrawal seizures) complications;
(b) an inability of the patient to cope with the withdrawal symptoms, resulting in the resumption of drinking.

Moderate to severely dependent individuals (as judged by the Severity of Alcohol Dependence Questionnaire, Stockwell *et al*, 1979) may require in the order of 40 mg of chlordiazepoxide q.d.s. and one or two extra 'as required doses of 40 mg' for comfortable withdrawal in the first one to two days. Patients and their carers can be given the advice to reduce the amount of chlordiazepoxide if it causes excessive sedation or ataxia. Experience suggests that the as-required medication is needed by most patients at least in the first night when withdrawal symptoms are worse.

Initial undermedication is an iatrogenic cause of non-adherence and needs to be emphasised in the training of those undertaking alcohol detoxification. Furthermore, clinicians managing a patient defaulting after the first day of detoxification should establish (by assertively seeking the patient) whether their initial daily prescription was too low.

STOCKWELL, T., MURPHY, D. & HODGSON, T. (1979) The severity of alcohol dependence questionnaire: its use reliability and validity. *British Journal of Addiction*, **78**, 145–155.

**Roger Howells** Consultant Psychiatrist, Maudsley Hospital, Denmark Hill, London SE5 8AZ; e-mail: roger.howells@slam-tr.nhs.uk

## Multi-professional training in psychiatry

Sir: I read with interest Bamforth *et al*'s proposal for more multi-professional learning for psychiatry trainees (*Psychiatric Bulletin*, February 2000, **24**, 72–73).

I am a psychiatry trainee from the UK currently working in Melbourne on a Crisis Assessment and Treatment Team. Apart from the consultant and registrar, the other members of the 10-person team come from non-medical backgrounds such as nursing, social work, occupational therapy and clinical psychology. Many have over 15 years' experience of working in mental health and as a result our daily discussions of patient management make use of a broad range of expertise. I have found this experience very instructive, particularly as the hierarchy of decision-making which prevails in the UK is largely unrecognised. Furthermore, non-medically trained clinicians often bring to discussions of management their experience of having worked in the past as patient advocates and case managers.

Medical schools have begun to recognise the value of multi-agency involvement in teaching (Lennox & Peterson, 1998). I agree with the suggestion that psychiatry trainees would benefit if experienced nurses, occupational therapists, social workers and psychologists were given a more formal role in teaching.

LENNOX, L. & PETERSON, S. (1998) Development and evaluation of a community-based, multi-agency course for medical students: descriptive study. *British Medical Journal*, **316**, 595–599.

**Daniel J. Smith** Registrar in Psychiatry, North West Crisis Assessment and Treatment Team, 200 Sydney Road, Brunswick, Melbourne 3056, Victoria, Australia; e-mail: daniel.smith@nwhcn.org.au

## Homicide inquiries

Sir: Not many would disagree with Szmukler's article (*Psychiatric Bulletin*, January 2000, **24**, 6–10) but I have to take issue with his interpretation of the inquiries regarding "the patient as an automaton". One of the concepts he elaborates in support of his argument that patients have feelings and a mind of



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