in psychotherapy of the analytically orientated type. They are encouraged to conceptualize and formulate their patients' problems in the broadest sense; treating them as members of a family group and considering relevant cultural factors. Although by no means abandoning the medical model, this is set in the much broader context of the whole person and his interaction with his fellow men.

As a medical student I found myself increasingly disenchanted with the dry narrow 'scientific' view of man. I was forced to the inescapable conclusion that human suffering cannot be reduced to a series of biochemical formulae, and unlike many I failed to find patients who derived much benefit from medication, but found many whose suffering was in fact worsened by misguided therapeutic zeal. It was for this reason that I chose psychiatry in the hope that here, at least, I could improve the quality of people's lives. It is therefore with growing disillusionment that I watch British psychiatry's love affair with medicine. If only the mountain had moved to Mohammed things might have been so different.

Looking at Britain from a distance one is immediately struck by the quality of British contributors to the field of human understanding, who have made so little impact on British psychiatry, while transforming attitudes across the Atlantic. Melanie Klein, Anna Freud, John Bowlby, Michael Balint, Donald Winnicott, Harry Guntripp, Ronald Fairbairn, Wilfred Bion, Henry Ezriel . . . the list is endless. Surely we should take pride in this psychological heritage and attempt to build on it.

I, for one, willingly respond to Professor Jones' challenge. But will I be given the opportunity; or forced to look elsewhere, where pastures are greener and more receptive? Who will be the loser?

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MEASUREMENT IN PSYCHOTHERAPY

DEAR SIR,

Any constructive comment on the vexed question of how to measure outcome in psychotherapy is welcome. The suggestion by Adams (*Journal*, June 1978, **132**, 595–97) that Post-Test Only Control Group Design is adequate to identify statistically significant differences in morbidity between groups exposed to different treatment schedules is statistically attractive, but it surely allows room for dangerous misinterpretation. For any significant difference in severity between groups at least two rather different explanations must be considered. One is that treatment has helped each group to different extents, the other is that treatment has harmed each group to different extents. Clearly several possible permutations exist.

The author considers that a pre-treatment measure is of secondary importance in answering the outcome question. I suggest that unless such a measure is included we cannot decide whether a treatment has been 'more therapeutic' than another or merely 'less damaging'.

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IS PARENTHOOD TEACHABLE?

DEAR SIR,

The recent Government paper 'Violence to Children' (1), presented to Parliament in March 1978, raises some controversial issues. I would like to comment on one of them concerning 'Education for Parenthood' (Para 11–18).

The report encourages the spending of more money on 'education for parenthood', since the Health Education Council has had its resources recently increased by £1 million. The report recommends that 'the Government should ensure that education for parenthood is available for boys and girls of all levels of intellectual ability'. This raises the important issue of whether parenthood is teachable. Can we in fact educate severely disturbed and violent people so that they become good parents? I do not think that we can.

Paulson and Blake (2) have cautioned against viewing battering parents as a function of educational disadvantage, and Steele and Pollock (3) regard educational factors as irrelevant and place more emphasis on the maladjustment resulting from violent childhood experiences. Kempe (4) found that all social classes were represented in his sample of battering parents, and it is the experience of many clinicians that highly qualified and well-educated people are not immune to violence; they may have all the knowledge of child care but they may be unable to apply what they know in real life.

There is no convincing study to show that violent parents lack the knowledge of proper parenthood, but most of the studies do show that they lack the ability to practise it.

People learn to be good parents by following the example of their own parents, and not by reading

books or attending courses. Because violent parents have themselves experienced parental violence and hostility (5) they lack the basic requirements for good parenthood; namely a stable and mature personality, reasonable ability to control their impulses and above all a good parenthood model to follow. These requirements are non-teachable, and I do not know of any course, however intensive it may be, or any book, however well-written, which can teach these qualities.

It seems that there is very little that can be achieved by 'education for parenthood.' It may help the basically good parents to be better parents, but it may make severely disturbed parents feel more inadequate, and more guilty, and so they may become more violent towards their children.

I wonder whether the £1 million available would be better spent on the education of the professional people working in this field rather than on the too ambitious and unrealistic task of trying to educate severely disturbed and violent parents into becoming loving, caring and kind parents.

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CONTINUOUS APOMORPHINE INFUSION IN ACUTE DYSTONIC REACTIONS TO NEUROLEPTICS

DEAR SIR,

Acute dystonic ('neurodysleptic') reactions (ADR) are a not infrequent side-effect of neuroleptic drugs. In hypersensitive subjects they may occur even after a single dose. Anticholinergic drugs (e.g. orphenadrine, procyclidine, diphenhydramine, diazepam, barbiturates and thiocolchicoside) are commonly used to correct these adverse reactions. The beneficial effect of apomorphine given intramuscularly is also known (1). However, administered in this way, apomorphine has a brief duration of activity (less than one hour): therefore, repeated injections are frequently necessary, and an adequate control of the efficacious dose without side-effects (mainly vomiting) is difficult.

Our previous experience indicates the advantages of intravenous administration of apomorphine: in this way the control of the emetic effects of this drug is far more easy even in individuals not protected by neuroleptics (2).

We administered apomorphine HCl in saline by continuous intravenous infusion in 8 subjects (6 females, 2 males, 13 to 35 years old) affected by ADR. ADR were due to metoclopramide (3) in 3 cases, chloropromazine plus trifluperidol in 2 cases, trifluperidol, haloperidol and fluphenazine each in 1 case. Efficacious doses in controlling ADR ranged from a minimum of 18 μg/min (0.4 μg/kg/min) for 3 hours (total: 3.2 mg) in a female patient who developed ADR after 20 mg metoclopramide *per os*, till a maximum mean dose of 70 μg/min (1.7 μg/kg/min) for 12 hours (total 50 mg) in a female who developed ADR after treatment with trifluperidol 2 mg/day plus orphenadrine 80 mg/day parenterally for 3 days (in this case up to 250 μg/min of apomorphine were administered initially for 30 consecutive minutes, without side-effects). The mean dose in the 8 patients was 35 μg/min for 260 minutes (mean total: 8 4 mg).

This way of treatment promptly and fully controlled ADR in all cases. No significant changes in blood pressure and heart rate were noted even during 250 μg/min of apomorphine in the above said patient, nor nausea or vomiting occurred, the only side-effect being a slight degree of sleepiness.

We think this may represent a new simple and safe way to treat acute dystonic reactions to neuroleptics.

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