

them for him/herself in eternal action in society, solves them for others (e.g. Erikson, 1958). Not only do we have to recognise the biological fact as such but simultaneously look at the local (and our) procedures which construct it as a biological fact.

The whole issue seems an interesting instance of current sociological concerns with the 'structuring' versus the 'structured', and one which reflexive developments in post-modernist theory have opened up again. It may well be that psychiatry will have some place in the debate, as predicted by the British psychiatrist W. H. R. Rivers in 1920.

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'Compulsive' water drinking in psychosis . . .

SIR: Crammer (*Journal*, July 1991, 159, 83–89) outlines possible aetiological factors in polydipsia and water intoxication in psychotic patients. The association with psychotic symptoms suggests a common mechanism for both polydipsia and positive symptoms.

An alternative explanation in some cases could be that patients use water as 'self-medication'. As Crammer says, the majority of polydipsic patients experience no 'compulsion' to drink, but actively wish to do so. For example, Crammer suggests that drinking water may be anxiolytic, and would assuage a neuroleptic-induced dry mouth. Patients have also been described who enjoy the effects of intoxication (Cooney, 1989). (Indeed, the black market trade in anticholinergics, in some psychiatric hospitals, suggests a demand for cheap intoxicants!) A further possibility is that some of these patients have learned the trick of drinking to prevent subvocalisation, thus suppressing their auditory hallucinations (Forrer, 1960; Falloon & Talbot, 1981).

This suggests that we should not simply aim to contain or to control polydipsia. If there is reason to suppose that a patient's polydipsia might be intended as 'medication', we should consider interventions

that could substitute for the patient's own attempts at treatment.

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. . . and mentally handicapped people

SIR: Bremner & Regan's article (*Journal*, February 1991, 158, 244–250) on the prevalence of polydipsia in the mentally handicapped was an important addition to the literature. It has been our clinical experience that this very serious problem is relatively common in this population.

Drs Bremner & Regan conclude their article by suggesting that polydipsia be viewed as learned behaviour dependent upon a number of environmental factors. They emphasise the need to develop more effective interventions. We would like to call readers' attention to recent behavioural treatment interventions. McNally *et al* (1988) used a simple behaviour modification procedure to eliminate polydipsia in an autistic woman with severe mental retardation and a history of water intoxication. The intervention involved positive reinforcement of behavioural alternatives to drinking water and a mild punishment contingency. The procedure was effectively implemented by direct care staff with only basic behaviour-modification training. Polydipsia was eliminated in approximately six months, and gains were maintained after her discharge to a group home where she continued to reside polydipsia-free 18 months after placement (McNally & Calamari, 1989). More recently, Bowen *et al* (1990) have reported successful application of behavioural procedures to the treatment of polydipsia in a schizophrenic patient.

Although controlled studies are needed to evaluate further the efficacy of behavioural interventions for polydipsia, case reports encourage the use of these procedures either alone or as an adjunct to medical interventions.

BOWEN, L., GLYNN, S. M., MARSHALL, Jr, B. D., *et al* (1990) Successful behavioural treatment of polydipsia in a schizophrenic patient. *Journal of Behaviour Therapy and Experimental Psychiatry*, 21, 53–61.