peutic approaches was thus hypothesised. With the influx of 'newer' treatment modes, the enthusiasm had shifted away from psychotherapeutic to pharmacotherapeutic modes which were more 'mathematical' and 'objective'.

Since these modes were simpler and shorter, and their efficacy more measurable, clinicians started casting a doubt upon the usefulness of psychotherapy, not to mention its possible deleterious effects. The success of neuroleptics was, however, not the only reason for pessimism in psychodynamically orientated theories and therapies. The outcome studies in the field of psychotherapy only reinforced the fears of its demise (Stanton *et al*, 1984; Gunderson *et al*, 1984) and cautioned its readers about the inherent difficulties of undertaking research in this immensely popular research area in the early part of this century.

In the past, probably, research in this field has been overinclusive. Trying to explore and analyse every aspect of patients' psychopathology which was volunteered or exposed was neither cost effective nor productive. In contrast to psychotherapeutic research, pharmacotherapeutic research currently enjoys substantial grants since it somehow succeeds in halting the disease process, the management being shorter, simpler and target orientated. It is more acceptable although it is symptom orientated and lacks a definite aetiological hypothesis (the aetiology is suggested only because the drug works). Psychodynamic exploration and psychotherapeutic management, although seen with scepticism, happen to be assessment procedures which are actually based on a solid and stable aetiological hypothesis, and thus enjoy a distinct advantage over biological research. Abandoning such a potential area when the answers are still not available in biological psychiatry may be a serious omission.

It is encouraging to see the newer psychotherapeutic procedures becoming short term, target orientated and cost effective. If psychotherapy is to survive as a potentially useful management procedure in the future, such amendments are necessary.

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Child psychiatry in the 20th century (England & Wales)

SIR: The paper by Wardle (*Journal*, July 1991, **159**, 53–58) misleadingly refers, in its title, to the development of services for child and adolescent psychiatry in Britain. The paper, in fact, refers to the development of these services in England and Wales; Scotland is ignored. There is no mention, in Table 6, of the Kilbrandon Report of 1964 and the subsequent Social Work (Scotland) Act of 1968 which led to the setting up of Children's Hearings. Similarly, this table ignores the report *Crossing the Boundaries: New Directions in the Mental Health Services for Children and Young People in Scotland* published in 1983. Perhaps the College could ensure in future that papers purporting to describe national developments should do just that: the alternative, as displayed in Dr Wardle's paper, is at best unsatisfactory and at worst offensive.

HMSO (1983) *Crossing the Boundaries: New Directions in the Mental Health Services for Children and Young People in Scotland*. Edinburgh: HMSO.

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Evaluation of motor disorder in mentally handicapped people

SIR: We welcome Jones' discussion (*Journal*, September 1991, **159**, 441) of the evaluation of motor disorder in mentally handicapped people (MHP) and the DISCUS (Sprague *et al*, 1989).

There are numerous difficulties in any form of assessment of dyskinesia in severely and profoundly mentally handicapped people, the level of cooperation being only one of them. Others include: stress and anxieties caused by the examination, and exacerbated by the problems in verbal and non-verbal communication; the inability on the examiner's part to assess the individual's wishes and consent; the limited information of the mental state; and especially, mood on the day of rating.

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Dyskinesia can be an outcome of the original attack to the central nervous system as well as a tardive response to neuroleptic medication. This is difficult to differentiate in mentally handicapped people who have been on medication. No single scale could be sufficient to assess and differentiate all forms of motor disorders in MHP comprehensively because of the wide range and variety of the disorders.

It is the synthesis of different reliable and validated scales for movement disorders, Parkinsonism, and akathisia, together with checklists of different clinical and neurological observations, assessment of social dysfunction and disabilities and their statistical analysis, which will bring a better understanding to the varieties, and extent, of motor disorders in this population.

SPRAGUE, R. L., KALACHNIK, J. E. & SHAW, K. M. (1989) Psychometric properties of the Dyskinesia Identification System: Condensed User Scale (DISCUS). *Mental Retardation*, **27**, 141–148.

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Safety of 5-HT reuptake inhibitors

SIR: David Healy (*Journal*, June 1991, **158**, 737–742) waxes lyrical on serotonin reuptake inhibitors. He asserts (without producing any data) that they are far safer than earlier tricyclics and MAOIs. He goes on to advocate their widespread prescribing in general practice. According to the Committee on Safety of Medicine there were 774 reports of adverse effects associated with fluoxetine including 13 fatalities up to July 1990 (further details are available from the author). It is the 5-HT reuptake inhibitor, zimeldine, which has by far the highest ratio of adverse drug reactions per prescription of any antidepressant (Pinder, 1988).

No doubt the current generation of 5-HT reuptake inhibitors will be shown to be of value in clinical psychiatry, but there is no rational basis for Dr Healy's encomium at the present time.

PINDER, R. M. (1988) The risks and benefits of antidepressant drugs. *Human Psychopharmacology*, **3**, 73–86.

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Post-partum psychoses and breast feeding in developing countries

SIR: Post-partum psychosis has been considered as an absolute contraindication to breast feeding (Behrman *et al*, 1987). This position essentially stems from a simplistic perception of the problem, which has not changed over the last few decades despite an increase in our understanding of the condition. In India, with its high fertility rate, the magnitude of the problem, despite the low incidence of the condition (1–2 per 1000 deliveries; Inwood, 1989), is high. Infants born to such mothers, if not allowed breast feeding, would be subject to the high mortality and morbidity of artificially fed babies (Kumar *et al*, 1981; Unni & Richard, 1988).

Since there are marked variations in symptoms, differences in duration of the disorder and incapacitation of the mother, and various problems for the child, such a simplistic approach to management in general, and breast feeding in particular, needs to be re-evaluated. With the reduction in emphasis on the timing of onset and the increased emphasis on the clinical presentation in recent years, many classifications recognise the heterogeneity of the conditions previously classified as post-partum psychosis. The emphasis on the syndrome approach to psychiatric diagnoses and the symptomatic nature of therapy have increased the need to sub-categorise the presentation and individualise care.

In our experience, phenothiazines, butyrophenones, tricyclic antidepressants and carbamazepine have been employed in normal adult doses with no serious complications arising in the child. The majority of serious side-effects described are theoretical, and considering the problems with artificial feeding, and the social and economic disruption, in relation to the efficacy of these drugs in treatment, their employment in therapy is of considerable practical importance, especially in reducing the duration of illness. Antipsychotics would be necessary in treating patients with psychotic features and agitation, while antidepressants should be employed for depressive syndromes. With the exception of lithium, which is excreted in breast milk in amounts sufficient to harm the child, other antidepressants and antipsychotic medication given to the mother are tolerated well by the infant. In cases where medication for prophylaxis of affective disorders would be necessary, carbamazepine would be preferred to lithium since breast feeding can be continued (Mortola, 1989).

Thus, the contraindication to breast feeding would, in actual terms, be the risk of infanticide and of harm to the neonate rather than the diagnosis *per se* or the drugs used (excluding lithium). While these

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