population would be "living at the very margin of human existence."

The gulf between south and north is so great and so unbridgable that almost inevitably one feels a sense of personal helplessness. For this reason, I shall end with a reference to Professor Ralph Dahrendorf's inaugural Arnold Goodman charity lecture, delivered in November last year. After concluding that economic growth in the future will at best be precarious, intermittent, and patchy, he argued that governments of all complexions, whether Thatcher or Mitterand, will be forced to reduce expenditure and draw back from commitments undertaken in easier times. He goes on to argue that, in the interests of freedom and justice, the voluntary sector will have to grow. He encourages us in the United Kingdom with the information that the amount of money

each person gives is 10 times that of any other country in Europe, but humbles us by telling us that giving in the United States of America is 10 times ours. Our giving, both corporate and individual, has to increase and a proportion of that giving should always be for the Third World.

I thank Unicef for permission to cite data from their report, *The State of the World's Children 1984*, published by Oxford University Press.

Reference

- ¹ Unicef. *The state of the world's children 1984*. Oxford: Oxford University Press, 1983.

Personal Paper

From chlorpromazine to NMR scans

JOHN CRAMMER

Just 30 years ago I began learning psychiatry at the Maudsley Hospital, London, in the year when chlorpromazine (Largactil) came into clinical use and opened the psychotropic age. It was not until I had finished my registrarship that the new antidepressant drugs—tricyclics, such as imipramine, amitriptyline, desipramine, and nortriptyline, and monoamine oxidase inhibitors, such as phenelzine—came out, with a burst of new clinical, pharmacological, and biochemical knowledge. This was a revolution in the treatment of psychological illness and of mental patients, and there has been nothing quite like it, nothing so dramatic, in the quarter of a century since I became a consultant. Thirty years ago we had only barbiturates as tranquillisers and electroconvulsive therapy for depression; there was morphine-hyoscine compound injection for the severely disturbed, leucotomy for chronic illness, and dynamic psychotherapy for some neurotic patients. The new drugs have all but eliminated these old treatments and have brought psychiatry into the general practitioner's surgery.

A few months ago I saw a young man from the north, who had suffered from depression for over two years. It was an effort for him to continue at work, where he thought that he was making mistakes. He avoided people, and he sat at home without interest in anything, crying at times. He had seen two general practitioners, a National Health Service psychiatrist, and a private psychiatrist, without great improvement. His sister wrote from America saying "try the Maudsley" and so he came. We get quite a few patients like this from all over the country, through relatives and friends, when local treatment seems to have failed. Some prove difficult or impossible to help. He, luckily, was easy. I gave him nortriptyline in adjusted doses and in four weeks he

was strikingly better, as confirmed by a spontaneous letter from his mother.

I like nortriptylin, and imipramine which is sedative as well as antidepressant but not too strongly so as amitriptyline sometimes is, because they are both drugs with 25 years of clinical experience and extensive scientific research behind them, and they are in my experience quite likely to work. But that means always adjusting the doses to the individual, sometimes up as high as side effects will allow, less often downwards. I give one or the other drug this full trial of different dosages over several weeks, and if it fails move to a drug of a completely different class—a monoamine oxidase inhibitor, again with a trial of rising dosage. That is, like many people, I follow a system.

The young man's doctors back home had given him mianserin and Tranxene (clorazepic acid), separately and together, Lentizol (amitriptyline), alone or with the others, lithium carbonate, trazodone, and back to mianserin. They had been prescribed in static timid doses, seemingly randomly without system, and with a preference for the relatively new and unexplored. Mianserin has been in general use for only six years or so, trazodone for half that time. It is sad that so many practitioners do not know how to use antidepressants properly. Among psychiatrists at least there is sometimes a belief that if you think carefully about what you are prescribing you will not think about the patient, that chemotherapy drives out psychotherapy. The effective treatment of depression needs both. You have to control at least some of the symptoms—if only insomnia and agitation—but you also have to make yourself credible to the patient, and you may have to treat his social setting in some way.

Need to be approachable

I have always begun by allowing a full hour for my interview with a new patient, even during the 11 years that I was a full time NHS consultant, first in Birmingham and then in Bucking-

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hamshire. One or two patients have commented with amazement and wondering satisfaction that no one has ever listened to them for so long before. A few have imagined that they must be getting private practice service by mistake. I play up a little my act of being senior yet approachable, busy with untidy desk, yet relaxed, knowledgeable, confident, sincere. I always ask how the illness affects the patient's work, enjoyment of hobbies, and human relationships, and how my proposed treatment will fit in to the routine of his daily life. These expressions of concern also help in the clinical assessment because I draw a big distinction between the disabilities produced by an illness and the unhappiness or unpleasant feelings experienced during it: it is the disabilities that I am aiming to eliminate.

With each new patient I bear in mind and ask appropriately about the attitude of others to him or her, because someone else—relative, lawyer, social worker—may have pressured him with no desire of his own for treatment into coming to me, perhaps for a misconceived reason at that. In dealing with the problem that the patient presents I have to satisfy these others in the background as well as the person I am interviewing, and their attitudes may be prepotent.

"Have you ever known a case like mine before?" "Will I go mad?" "Will I have this for ever?" Most patients have such fears, though only some voice them, and therefore such questions must be brought into the open and answered. This means offering a suitable brief statement of the nature of the illness and how the treatment is expected to work. The human mind hungers for explanations, but these should be kept close to the facts of the individual case, admitting areas of ignorance or uncertainty but putting the positive encouraging side as well, and

eschewing so far as possible the mythologies of neurotransmitters or ego psychology.

When I began psychiatry psychoanalytic psychotherapies had already had a 30 year run. Although analysts did not like to say so straight forwardly, and preserved a secret service mystique about their actual techniques, it was evident that dynamic psychotherapy had little or nothing to offer most psychiatric patients. It seemed, and still seems, to me, that the intensive analytical approach while strong on explanation is weak in therapeutic power. It does not relieve disability so much as try to change the patient's evaluation of that disability; it is re-educative in the long term, sometimes with a moral quasireligious flavour. It is a specialised form of befriending. But it leaves out of account the individual's surrounding world of others, relatives and community, who also have to be satisfied by any treatment.

Psychoanalysis is not to be equated with all psychotherapy for it is only one limited variety of the relationship between doctors and patients. Growth in understanding of methods and uses of psychotherapies has been slow in the past 30 years, but behaviour therapy and cognitive therapy have emerged. A great deal remains unexplored, however, in making conscious and deliberate the actions of doctors with patients. On the other hand, totally new knowledge of brain function is growing apace through in vivo methods such as computed tomography and nuclear magnetic resonance scans and the use of drug probes. Clinical knowledge is also deepening, particularly of the links between psychological disturbances and physical illnesses—for example, endocrine disorder, cerebral trauma, nutritional disturbance. All this may result in a completely new view of diagnosis in psychiatry before the next 30 years have passed.

A patient suspects that some types of small cigar give him diarrhoea. Is it possible to develop an allergy to tobacco (or any additives) with gastrointestinal symptoms?

It is unlikely that any ingredient of the smoke of small cigars would cause diarrhoea either because of allergenicity or through some other mechanism. It is not clear whether nicotine itself stimulates or inhibits gut motility,^{1,2} and recently there has been a flurry of interest in the fact that ulcerative colitis occurs more commonly in non-smokers than smokers.³ If the patient's suspicions are correct and if the mechanism is similar to that for food intolerance the demonstration of a raised rectal prostaglandin E2 concentration specifically following the smoking of a small cigar would help to clinch the matter.⁴—FRANCIS J C ROE, independent consultant in toxicology and cancer research, London.

¹ Schnedorf JG, Ivy AC. The effect of tobacco smoking on the alimentary tract. An experimental study of man and animals. *JAMA* 1939;122:898-904.

² Hug CC, Bass P. Effects of nicotine on gastrointestinal contractile activity. *University of Michigan Medical Center Journal* 1970;36:246.

³ Harries AD, Baird A, Rhodes J. Non-smoking: a feature of ulcerative colitis. *Br Med J* 1982;284:706.

⁴ Jones VA, McLaughlan P, Shorthouse M, Workman E, Hunter JO. Food intolerance: a major factor in the pathogenesis of irritable bowel syndrome. *Lancet* 1982;ii:115-7.

What is the physiology of tiredness?

There is no comprehensive definition of tiredness or fatigue. Tiredness as sleepiness results in an unusually short latency in falling asleep for the time of day, and is one of the difficulties encountered by shift workers. Other patients describe loss of energy when also admitting to sustained feelings of anxiety, tension, and depression, or describe a feeling of having been overburdened and unappreciated during endless months or years of heavy pressure while out at work, looking after children in the home, or caring for elderly relatives. There is no known chemical basis for any of these feelings, though a drug such as amitriptyline must presumably correct chemical mechanisms when relieving the loss of energy found in depression. I am assuming that the questioner does not primarily have in mind the tiredness experienced by those suffering from such conditions as untreated diabetes mellitus, pulmonary tuberculosis, or anaemia. The questioner gives the impression that he conceives of "neurotic illness" as either present or absent, but we all have neurotic characteristics in our

make up, and we are only normal if we sometimes feel tired from the sustained pressures, anxieties, or boredom of our lives. Perhaps the doctor must be willing to listen to his patients and also gently educate them not to think that there should either be elixirs of life or sleeping drugs for all those who feel weary. It might be better to encourage new interests and activities, for variety adds spice to life.—IAN OSWALD, professor, psychiatry department, Edinburgh.

Is there any danger to watch and clock repairers from the inhalation or ingestion of radioactive materials, particularly thorium, used in watch-making?

Up to the 1960s the common luminising agent for clocks, watches, and instrument dials was radium 226 or a mixture of this with mesothorium (radium 228). These nuclides emit gamma radiation, which requires heavy shielding to provide adequate attenuation. In the early days of the use of such compounds safety precautions were inadequate, and many dial painters died from the inhalation of radioactive gas and from ingestion by sucking brushes. Since the 1930s, safety standards have improved with a realisation of the hazard. In the 1960s these nuclides were replaced by much lower activity nuclides, such as tritium and promethium 147 produced in atomic reactors. Being beta rather than gamma emitters the normal watch casing was an effective shield, reducing body dose rates to some 500 times less than a watch luminised with radium 226.¹ For watch, clock, and instrument repairers, the risk will be low since the risk of inhalation or ingestion does not arise, as it has always been the practice to put a sealing coat on the luminising compound during manufacture. The number of cases when an instrument or watch luminised with radium 226 is worked on will probably be small anyway and the newer nuclides pose little risk. All components with a luminising paint content should be disposed of carefully and not allowed to accumulate. Reluminising, if carried out, should be done with the usual care devoted to the use of radionuclides and in accordance with the appropriate legislation.²—F LUNAU, senior occupational hygienist, London.

¹ International Labour Office. *Encyclopaedia of occupational health and safety*. 3rd ed. Geneva: International Labour Office, 1983.

² Ministry of Labour. *The ionising radiations (unsealed radioactive substances) regulations 1968*. London: HMSO, 1968. (SI 1968/780.)