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