current polarity has prompted us to review our original data on normal subjects (Sheffield and Mowbray, 1968), to see if any of our subjects showed a consistently opposite reaction to the others in the trial. In our study, scores on the 'Clyde Mood Scale' (the closest parameter to that measured by Nias and Shapiro), showed an apparent effect of the current which was not statistically significant. However, on analysing individual scores in our data there was no individual who reacted consistently in an opposite direction to the general trend for each item.

Another interesting point is that we also encountered the same difficulties regarding the itching under one electrode which made double blind conditions of the trial a little more difficult to control. Surprisingly in our case it was consistently the positive electrode applied to the forehead and not the negative electrode as described by Nias and Shapiro.

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HALOPERIDOL IN THE TREATMENT OF STUTTER

DEAR SIR,

Recent trials of haloperidol in the treatment of stutter (Refs 1, 2, 3) have evoked widespread interest and as expected have been followed by cautionary tales. Faced with a stutterer demanding to be put on the 'new' treatment, what should the therapist do in the light of current knowledge?

The position at present seems to be this—these three trials were all controlled studies, but samples were small. The results seem to bear a direct relationship to the mean dosage employed for each trial and for how long it was given (see Table overleaf).

In our own study (1) the dosage was increased in weekly steps to a final dose of 4·5 mg. daily at the beginning of the third week. This dose was maintained for six weeks. The first assessment, however, was made at the end of the fourth week, after patients had taken the maximum dose for two weeks. (The significant results obtained at four weeks were maintained at eight weeks but had not improved further). Three-year follow-up of this two-month study showed stutterers to have maintained some improvement—in one dimension of three measured the improvement was significant.

Swift, Swift and Arellano in their three-week study reached a peak dose of 3·5 mg. daily, which was only maintained for one week before the assessment of progress was made. Results showed significant improvement in 6 out of 7 patients with stutter, all of whom relapsed within two weeks of discontinuing the trial.

Quinn and Peachey in their three-week study gave a mean dose of 2·5 mg. daily but do not say whether this was given throughout the three-week trial period. Four out of 18 patients were substantially improved and 6 others improved in lesser degrees, but none of their results reached statistical significance.

Although these studies were not strictly comparable, the following comments can be made:

1. The effective dose of haloperidol in the treatment of stutter in most cases seems to be 3·5 mg. daily.

2. The maximum effect seems to be reached after two weeks on the effective dose. Maintenance dose, however, may be lower.

3. Individual response to the drug is variable. It is probably prudent to build up to the more effective dose by weekly increments.

4. The incidence of side effects is high and calls for weekly supervision of patients during the first 4 or 5 weeks.

5. Clinical impression suggests treatment should be continued at least two months—our three-year follow-up of patients whose stutter had been treated successfully with haloperidol for two months (though not cured) showed that the improvement had been maintained, although in only one dimension of three measured did this reach statistical significance.

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Comparison of three trials of haloperidol in the treatment of stutter

Trial	No. involved		Daily dose regime			Total duration of trial	Improvement	Follow-up after cessation of treatment	Results of follow-up
	Control group	Test group	Week 1 (mg.)	Week 2 (mg.)	Week 3 (mg.)				
1. Wells and Malcolm	24	12	1.5	2.25	4.5	2 mths	10 out of 12 significant improvements after 4 weeks	3 years	Improvement significant in 1 out of 3 dimensions measured, 'improved' other 2 measures
2. Swift, Swift and Arellano	11	8	1.5	2.5	3.5	3 weeks	6 out of 7 significant improvement (1 withdrawn)	2 weeks	Relapse 2 weeks after treatment stopped
3. Quinn and Peachey	10	18	2.5 (mean)	2.5 (mean)	2.5 (mean)	3 weeks	4 out of 18 'substantially improved'. 6 'improved'. *Not* statistically significant	—	—

READING LIST IN PSYCHIATRY

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