would prolong the duration of the treatment indefinitely." The research in the last decade highlights the beneficial effects of psychotherapy in the elderly population. There have been successful reports of nearly all modes of psychotherapy, including individual, group, marital and drama, family, and behavioural therapy.

We are only too aware of the changes that an ageing person has to make in trying to adapt to the altered dynamics of his or her life. Adjustments have to be made to family life when one child after the other leaves home and becomes independent. Marital relationships acquire new dimensions when they cannot use children to mask the problems which might be present in the relationship. Ageing may also give rise to anxieties about the loss or diminuation of sexual potency, or reproductive capacity. The psychological implications of retirement, loss of professional identity and work role, are evident. This may lead not only to lower income and a lower standard of living, but also to low self-image. One cannot ignore the anxieties and fears of becoming ill and dependent on others and the dread of losing mental and physical capacities. Finally, the ageing person may be haunted by the inevitability of death and increasing loneliness as close friends and relatives die, resulting in severe disruption to the psychological balance of this group of people.

Sorenson (1986) writes that the ageing process presents a challenge to the narcissism of the individual due to physical, social, and psychological changes and losses. There is a danger that mental health professionals may add to narcissistic trauma by underestimating elderly patients' potential for change. He emphasises further that the elderly are as susceptible to change as younger patients, and that one discovers during therapy that the aged patients are struggling, just as the younger ones are, with attempting to regain control in their lives and recover a sense of dignity for themselves. Psychotherapy can help them meet the formidable challenge that the ageing process presents to the sense of self.

I feel that the elderly population has been underserved by British psychotherapists. It is high time that we open our doors for this population, who are no less complicated than the younger population popularly accepted for psychotherapy. I feel that a combination of prejudice against the elderly by society and the psychotherapist, poor training in the field of geriatric psychotherapy, limited financial resources, mobility and transportation problems, and finally personal resistance, has been responsible for such a low interest in the field.

Finally, in the words of Vander (1983), "Psychotherapy with the elderly requires a concentration of one's own attitude towards the elderly, a knowledge of the various conceptual issues underlying work with the elderly, and careful planning of goals and interventions based on clients' needs. Using these tools the psychotherapist can experience satisfactions equal to or greater than those gained from the work with younger clients".

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Quinine Psychosis

SIR: With reference to Jerram's report (*Journal*, June 1988, **152**, 864) of a case of quinine-induced psychosis, I report another case with a relationship between quinine and psychosis.

Case report: A 69-year-old lady was admitted with a four-day history of over-activity, talking excessively, insomnia, and grandiose delusions. She was elated, showed flight of ideas, and had no perceptual or cognitive impairments. There were no antecedent medical illnesses, social precipitants, or any new medication. She had had a mastectomy two years previously for carcinoma of the breast, and was taking tamoxifen (20 mg b.d.). She had been taking quinine sulphate (300 mg nocte) for one year, for night cramps, in addition to pilocarpine eye drops for glaucoma. These were continued on admission. Physical examination was normal. Full blood count, ESR, B12 and folate levels, ECG, liver and renal function tests were normal. X-ray chest and isotope brain scan were also normal, ruling out metastases. TSH levels were 7.4 mu/l; she was clinically euthyroid. A diagnosis of manic depressive psychosis, currently manic was made. She was put on chlorpromazine (400–600 mg/d) for about three weeks. Her agitation was controlled, but she continued to exhibit psychotic features such as taking off her clothes, posturing, and incoherence of speech. In view of her poor response to chlorpromazine and the fact that psychotic reactions to chlorquine are known, her quinine was stopped. She returned to her normal self in 48 hours and developed a sudden intolerance to chlorpromazine – drowsiness, oedema feet and postural hypotension. Chlorpromazine was tapered off over ten days and these symptoms cleared up too. An EEG done at this stage showed

bitemporal generalised theta and delta components in runs lasting up to 30 seconds. When seen at home two weeks later she was symptom-free, and had no night cramps. Further clinical and EEG follow-up is planned.

In this case, quinine had been taken in a standard dose for over a year, in contrast to Jerram's report, where the patient took a homeopathic quinine preparation. Quinine and chloroquine are older antimalarial drugs and share a similar mode of action (Goodman *et al*, 1985). Whereas psychotic reactions to chloroquine are known (Dukes, 1984), a literature search failed to reveal any other reports of psychoses with quinine. Jerram mentions reports on psychosis with quinidine, an optical isomer of quinine; but it is known that isomeric forms of the same drug can have different properties. I endorse Jerram's view that quinine should be added to the list of drugs which can induce psychoses.

I must stress here the importance of critically reviewing a patient's current medication. It is also important that this is conveyed to the general practitioner. It is often seen, especially in the elderly, that after a dosage regimen is rationalised during hospital stay, the patient, on discharge, ends up with all the previous medications.

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Psychosurgery for Bipolar Affective Disorder

SIR: Two recent publications in the *Journal* (Lovett & Shaw, 1987; Poynton *et al*, 1988) reported on a combined total of 18 patients treated for resistant bipolar affective illness with psychosurgery. In the last 15 years, we have similarly treated 11 patients with bipolar illness at the Neuropsychiatric Institute, Sydney.

Nine patients were female, the mean age at the time of surgery was 45.5 years, and they had been ill for an average of 13.8 years. All patients underwent a bilateral orbitomedial procedure, nine by stereotaxy and the two earliest ones by open operation. The mean follow-up period was 5.0 years (range 1–9 years).

Using the global outcome criteria described by Goktepe *et al* (1975), six patients showed good improvement (grade II) at 3–6 months after surgery, two were slightly but significantly better (grade III), and three were largely unchanged. At the time of last contact, five had maintained grade II improvement, one was grade III, and four were unchanged (grade IV). One patient was lost to long-term follow-up.

When the effect on mania is considered, of the five patients who had had multiple manic and depressive episodes over many years requiring frequent admissions prior to surgery, three had only minor swings afterward and were well-controlled on medication while two were unchanged. One patient with a rapidly-cycling illness had an attenuation of the intensity of her illness, but still needed regular psychiatric treatment with occasional admissions. One patient had three episodes of mania in the three years prior to surgery, and only one episode in the following four years. The four remaining patients had too few hypomanic episodes before psychosurgery for us to comment on any antimanic effect. When improvement occurred in the patients with multiple episodes, it was evident for both mania and depression.

Our experience, therefore, supports the conclusion of Poynton *et al* (1988) that although some patients may show good improvement, the overall results for bipolar illness are less favourable than for unipolar illness. Manic swings do seem to be modified, and in our cases the anti-manic effect was as great as the anti-depressive one, but no greater, unlike the effect in cases reported by Lovett & Shaw (1987) and Poynton *et al* (1988). We have not observed hypomanic swings following psychosurgery on unipolar patients.

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