of couple therapy, whether analytically or behaviourally based, focused on the couple's interaction and mutual projections are totally different from the psychodynamics of one to one examination of an individual's personal anxieties.

Nigel Mather and colleagues' paper attempted only to assess how far achievement of this brief technique is possible by seminar training with leaders who are not psychoanalysts.[3] It is good to know that the multidisciplinary British Association of Sexual and Marital Therapists has now begun to offer training and is using the seminar method. I look forward to its assessment of results.

PRUDENCE TUNNADINE
Scientific director

Institute of Psychosexual Medicine,
London W1M 9DE

1 Duddle M. Training in psychosexual medicine. *BMJ* 1994;**308**: 1440. (28 May.)
2 Skrine RL, ed. Psychosexual training and the doctor-patient relationship. Carlisle: Montana Press, 1987.
3 Mathers N, Bramley M, Draper K, Spread S, Tobert A. Assessment of training in psychosexual medicine. *BMJ* 1994; **308**:969-72. (9 April.)

Should relatives watch resuscitation?

A haunting experience in Nepal

EDITOR,—I wish to contribute my experience to the debate concerning whether relatives should be allowed to witness resuscitation.[1,2] While I was a medical student doing my elective in Nepal a large earthquake occurred there. In the first 24 hours afterwards the hospital, staffed by three doctors and three medical students, was overwhelmed by 500 casualties. On the same day a 35 year old woman attempted suicide by ingesting organophosphorus weedkiller. Her husband had left her for her younger sister, and she was thus homeless with four children. Debate ensued: in view of the hospital being overrun by earthquake victims should she be treated? The potential consequences of her death to her children, however, led to her being admitted to a makeshift intensive care unit. Her children slept on a bench on the veranda outside.

In the absence of a bleep system a cardiac arrest occurring in the unit was signalled by the wail of an old air raid siren. The women arrested and was resuscitated several times before dying. Unfortunately, the siren also acted as a signal to the children. Each time we performed cardiac massage and defibrillation on the woman we were aware of four forlorn faces pressed up against the window. What did they think we were doing to their mother? How could we stop attempts at resuscitation when to admit defeat would bring such miserable consequences to our audience? I am still haunted by the experience. I suspect the children are too.

SIMON BRITTEN
Surgical senior house officer

Royal United Hospital,
Bath BA1 3NG

1 Adams S, Whitlock M, Higgs R, Bloomfield P, Baskett PJF. Should relatives be allowed to watch resuscitation? *BMJ* 1994;**308**:1687-9. (25 June.)
2 Correspondence. Should relatives watch resuscitation? *BMJ* 1994;**309**:406-7. (6 August.)

Opportunity is appreciated

EDITOR,—I am surprised that the article and subsequent correspondence discussing whether relatives should watch resuscitation have paid such little attention to the feelings of the resuscitation team.[1,2] Most doctors would admit that resuscitation is stressful. People cope with anxiety in several ways, but most medical staff seem to try to do this by using a mixture of humour and detachment from the patient. Both of these are difficult to use in the presence of a relative. Doctors and nurses often feel less confident, guilty, and sad after a failed attempt at resuscitation. The presence of a relative, who is usually emotionally distraught, puts the patient into context as someone's father, husband, or child and negates this coping strategy.

I have worked in an accident and emergency department where relatives were invited to watch resuscitation while accompanied by a senior member of the nursing staff. I and other team members found it harder to cope when relatives were present at resuscitations. This was recognised in the department, and measures were taken for staff to recharge their emotional batteries and have time to offer support to each other. Relatives often expressed how much they had appreciated the opportunity to witness the resuscitation. I believe that allowing relatives to witness resuscitation is beneficial and should become more widespread, as should recognition of the staff's need for coping strategies in this stressful situation.

JANET DAY
Trainee general practitioner

Clitheroe Health Centre,
Clitheroe

1 Adams S, Whitlock M, Baskett PJF, Bloomfield P, Higgs R. Should relatives be allowed to watch resuscitation? *BMJ* 1994;**308**:1687-9. (25 June.)
2 Should relatives watch resuscitation? [Letters.] *BMJ* 1994;**309**: 406-7. (6 August.)

We have no regrets

EDITOR,—R J Schilling's letter suggesting that relatives should be prevented from watching resuscitations seems to us to represent two of the worst foundations for medical practice: arrogance and anecdote.[1] Beliefs that patients and relatives should be present only at the convenience of the doctors and that the doctor knows best are sadly outdated. The use of one anecdotal experience to guide clinical practice is also unacceptable.

We were both present at the unsuccessful resuscitation of our 7 month old son last year. It was a traumatic experience that will haunt our memories for a long time, but we have no regrets about having been there. Attempts to usher us away while our child was dying seem incomprehensible, and we can understand the favourable response of parents and relatives allowed to watch resuscitations. We could not have surrendered or abandoned our child at such a critical time to a group of anonymous doctors. We believe that few parents would want, or should be forced, to do so.

New ideas will always take some adjusting to, but there is little excuse for denying relatives the choice of being present at resuscitations. Doctors may have to control their attempts at black humour, but our own professional experiences during resuscitations suggest that this would be no bad thing.

JOHN WRIGHT
Registrar in public health medicine

North Yorkshire Health Authority,
York YO3 4XF

HELEN FORD
Senior registrar in neurology

St James's University Hospital,
Leeds LS9 7TF

1 Schilling RJ. Should relatives watch resuscitation? *BMJ* 1994; **309**:406. (6 August.)

Hearing voices

EDITOR,—As the editors of *Accepting Voices*, the book reviewed by Raymond Cochrane,[1] we believe that the sentences that he quotes are so taken out of context as to be misleading. For example, he quotes, "It is unfortunate that hearing voices is designated as auditory hallucinations because that presumes the existence of pathology." This might sound strange, since half of the patients diagnosed as having schizophrenia suffer from auditory hallucinations, until one realises that only a third of people who hear voices have a mental illness. Tien and Eaton *et al* have shown that 2% to 4% of the population have these experiences.[2,3] In separate epidemiological studies they have shown that the phenomenon is related to a psychiatric illness in only one third of people who experience it. Hearing voices is too often taken to indicate schizophrenia.[4]

Cochrane quotes another sentence out of context: "[Romme] advises voice hearers to cope with their voices by accepting 'the presence of an influence lying outside [themselves], but grasp fully that it is not more powerful than [themselves].' " This also sounds strange in isolation. Cochrane himself refers to the fact that "the most widely used method is to treat the patient with neuroleptics, but some patients have drug resistant hallucinations which require other treatments." It is in patients requiring alternative treatment that we have explored the efficacy of other methods. We have found that advising some of these people that the voice is outside themselves is helpful. Many people tend to believe that what the voices say is the truth, but they can be helped to have a dialogue in which that is not thought to be so. This often reduces anxiety, allows them to realise that the content may be nonsense, and helps them to gain control.

When a medical approach fails, as it does in 60% of cases of auditory hallucinations, ways of learning to cope with the hallucinations remain, and these are central to the ideas we were presenting. English academic research workers—for example, Bentall *et al*[5]—are also exploring alternative treatments.

M ROMME
Professor of social psychiatry

S ESCHER
Science journalist

Medical School,
University Limburg,
PO Box 616,
6200 MD Maastricht,
The Netherlands

1 Cochrane R. Hearing voices [book review]. *BMJ* 1994;**308**:1649. (18 June.)
2 Tien AY. Distributions of hallucinations in the population. *Soc Psychiatry Psychiatr Epidemiol* 1991;**26**:287-92.
3 Eaton WW, Romanoski A, Anthony JC, Nestadt G. Screening for psychosis in the general population with a self-report interview. *J Nerv Ment Dis* 1991;**179**:689-93.
4 Kluft RP. First rank symptoms as a diagnostic cue to multiple personality disorder. *Am J Psychiatry* 1987;**144**:293-8.
5 Bentall RP, Haddock G, Slade PD. Cognitive behaviour therapy for persistent auditory hallucinations: from theory to therapy. *Behaviour Therapy* 1994;**25**:51-66.

Child resistant containers

EDITOR,—In her letter about accidental ingestion of methadone by children Michelle Jacobs raised the question of the use of child resistant containers for liquid medicines.[1] Child resistant containers have been used for solid dose medicines for several years, and the Royal Pharmaceutical Society of Great Britain has been trying for some time to extend the use of such containers to liquid medicines.[2]

There has been considerable difficulty in producing a child resistant container—that is, bottle and cap—that can be used for liquid medicines without the cap sticking as a result of the sugar in many of the medicines. Despite the potential difficulties, in 1991 the society advised its members to dispense methadone, as a special case, in child resistant containers.

A new shape for the neck of standard medicine bottles has now been approved by the British Standards Institution, and bottles and caps are being produced to meet these new requirements.