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Depersonalisation and Self-Perception

SIR: I found Mellor's discussion (*Journal*, July 1988, **153, Suppl. 2,** 15–19) of the phenomenological philosophy of depersonalisation both interesting and disturbing. Having pointed out how some great men, such as Schilder and Schneider, may fail to agree on certain fundamental aspects of interpretation, he goes on to offer a "tentative proposal that two forms of depersonalisation exist", a malignant, dysphoric variety, and a benign, possibly protective type. Surely this proposal fails to take the reactions of the subject into account? I have seen patients who have been given morphine react differently, with euphoria or with dysphoria, depending on a number of circumstances, not the least of which was the presence or absence of pain respectively. This reaction is also modified by the duration of exposure to opiates (O'Shea & Falvey, 1988).

If a subject experiences dizziness as a result of a brain tumour or because of beta-blocking drugs, is the experience qualitatively different of necessity? Again, surely, one factor determining those other-than-lost emotional reactions (Schneider, 1959) is the patient's interpretation of the significance of the phenomenon? My own viewpoint, be the setting delusional or otherwise, is that of Mayer-Gross (1935) and some more recent observers (for example Cohen, 1988): i.e. that the experience is probably a physiological event, complicated by factors such as genetics, personality, biochemistry, structural change, environmental circumstances, and so on. Philosophy and psychoanalysis fail to provide uniform explanations simply because of this complexity.

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Lithium-Induced Carpal Tunnel Syndrome

SIR: With reference to the article by Deahl (*Journal*, August 1988, **153,** 250–251), we should like to point out that this is not the first report of lithium-induced carpal tunnel syndrome, as stated. We reported just such a case in these very correspondence columns two years ago (*Journal*, September 1986, **149,** 386–387).

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The Truth About ECT

SIR: At the end of their interesting review on the use of electricity in the treatment of mental illness, Drs Beveridge & Renvoize (*Journal*, August 1988, **153,** 157–162) bring in the practice of ECT. Strictly this is irrelevant to their subject and simply serves yet again to perpetuate misunderstanding of the nature of ECT. ECT is in no sense electrical *treatment* or electrotherapy, but only the use of an electrical stimulus instead of a pharmacological one (subcutaneous insulin, intravenous metrazol, or inhaled flurothyl) to set off an epileptiform disturbance in the brain; it is this disturbance which is therapeutic. We do not talk of the motor car as an electro-automobile because it has spark plugs, or of electro-central heating because an electric pump shifts the hot water. We do not pit the mysterious force of electricity against (mysterious) mental illnesses, as a hostile lay public may believe, nor (with muscle relaxants) should there be any convulsion (unpleasant word). So electroconvulsive therapy as a name has all the wrong associations and helps to perpetuate the bad image of the treatment. A more accurate name would be relaxant ictal therapy (RIT), which would be better for public relations. As for shock treatment, it does not mean, as some suppose, electric shock treatment like the painful tingling from a shocking coil or worse from the mains, nor surgical shock, nor emotional or physical shock (as given to the mentally ill in the past with the whip, the ducking stool, or the release of snakes in the dark). The word shock was introduced by Sakel to express the fairly fast action and non-specific nature of the effects of insulin therapy, and got carried over into pharmacological treatment.

Many authors writing briefly about the origins of ECT link it as Drs Beveridge and Renvoize do with the history of electrobiology, or with old practices of fright and torture. But the roots of its discovery are

quite different. The 19th and early 20th century psychiatrist was faced with two common conditions which caused a great deal of work – general paresis (GPI) and epilepsy – stimulating clinical observation and research. It was noted that: (a) some psychotics improved when they had a fever; (b) some psychotics improved after a spontaneous epileptic fit; and (c) at post-mortem, epileptic brains and schizophrenic brains differed greatly, suggesting some antagonism between the schizophrenic and the epileptic process. The first point led Wagner-Jauregg, a Viennese contemporary of Freud, on a long search for artificial fever therapy; in 1917 he found that malarial infection would cure GPI, and he received a Nobel prize in 1927. The second and third led Meduna in Budapest in 1935 to induce fits with metrazol, with therapeutic success. But his method was unpleasant for patients and difficult to control. Cerletti had been studying experimental epilepsy in dogs using an electrical stimulus; with Bini, he adapted the stimulus for man and so produced a painless and easily controllable variant of Meduna's treatment. ECT is part of the history of epileptic studies, and its understanding and that of epilepsy march together.

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Is Castration Too "Barbarous" for Rapists?

SIR: I fear that Salzman (*Journal*, August 1988, **153**, 270) is suffering from the illusion that motivation for recurrent sexual offending and rape is purely sexual. Often the apparently sexually motivated acts, which he attributes to "psychosexual malignancy", are in fact expressions of a deeper, more complex and less obvious psychopathology. Indeed, such pathology may still be expressed as serious aggression after libido has been artificially reduced.

Furthermore, even individuals whose main problem is deemed to be hypersexuality, and perhaps therefore those he believes most likely to respond to surgical castration, are probably those least likely to agree to such treatment. Indeed, individuals who might agree to voluntary sacrificial surgical castration to justify their liberation from detention may be those least helped by it and most in need of rather wider and more subtle treatments.

However, when libidinal suppression is required, the currently available, equally dependable, but reversible 'chemical castration' using hormonal implants already has an accepted role as an adjunct to the overall treatment of certain sexual offenders. Indeed, there is carefully controlled provision for such treatment under Section 57 of the Mental Health Act 1983.

Surely the use of presently available treatments rather than radical, but not magical, surgical castration will result in the continuation of a more considered overall approach to our patients and also less iatrogenic psychological morbidity in those whose ongoing mental stability is, after all, critical to both their success and the safety of others beyond conditions of detention.

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Females and Caring

SIR: I read with interest the recent review article by Morris (*Journal*, August 1988, **153**, 147–156) concerning factors affecting the emotional wellbeing of the caregivers of dementia sufferers. The different approach and strategies that men have to caring is described by Zarit *et al* (1986).

However, the evidence at present reveals that females receive less statutory help than males when caring for an elderly relative. A study of carers found that 4% of mothers, 20% of wives and 24% of daughters received home help support, while 95% of caring sons and 68% of husbands received this service (Equal Opportunities Commission, 1982). It could be said that these figures simply reflect the fact that men are more willing to organise and accept help, but my concern is that they are a reflection of society's basic assumption that women can cope with caring whatever the burden. Do we as professionals become more aware of the burdens of caring when the carer is male?

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Delusional Depression in Nineteenth Century Scotland

SIR: It is encouraging to find two serious studies of the history of psychiatry in the August edition of the British Journal of Psychiatry. It is surely a sign of the present health of psychiatry as a specialty that it is