the columns

correspondence

Catatonia made complex

Sir: Catatonia has been a poorly understood syndrome since psychodynamic theory struggled to explain its symptoms in the first half of the past century. The persistence of the nosologic confusion surrounding catatonia, malignant catatonia and neuroleptic malignant syndrome (NMS) is well illustrated by Carey *et al*'s confused and uncertain case study (*Psychiatric Bulletin*, February 2002, **26**, 68–70).

Did their patient have 'no history of catatonia' or did he suffer from 'persistent stereotypies, mannerisms . . . dyskinesia and . . . dystonia'? Both statements cannot be true! It is unsurprising that in such a patient, with a possible history of encephalitis, the administration of high dose, high potency neuroleptics precipitated the malignant syndrome. This is a well-recognised clinical scenario. The association of catatonia with general medical conditions was emphasised by Kahlbaum in 1874 and has been reviewed in detail more recently (Philbrick & Rummans, 1994; Clark & Rickards, 1999).

The important points to remember are:

(a) catatonia may be simple (motor symptoms only) or malignant (motor symptoms together with hyperthermia or autonomic instability)
(b) neuroleptic (and some other) medications may exacerbate simple catatonia and precipitate malignant catatonia, in which case it may be termed the NMS
(c) the most effective treatments for the catatonic syndrome are benzodiazepines or electroconvulsive therapy.

A fuller, clinically orientated review, including a suggested management plan, has been provided by Clark and Rickards (1999), while other authors have usefully considered the nosologic and dimensional status of the syndrome (for example, Mann *et al*, 1986; Singerman & Raheja, 1994; Fink, 1996). It is unfortunate that Carey *et al*'s discussion fails to aid understanding of a condition that is often iatrogenic and, as they point out, occasionally fatal.

CLARK, T. & RICKARDS, H. (1999) Catatonia 2: diagnosis, management and prognosis. *Hospital Medicine*, **60**(11), 812–814.

FINK, M. (1996) Neuroleptic malignant syndrome and catatonia: one syndrome or two? *Biological Psychiatry*, **39**, 1–4.

MANN, S. C., CAROFF, S. F., BLEIER, H. R., *et al* (1986) Lethal catatonia. *American Journal of Psychiatry*, **143**, 1374–1381.

PHILBRICK, K. L. & RUMMANS, T. A. (1994) Malignant catatonia. *Journal of Neuropsychiatry*, **6**(1), 1–13.

SINGERMAN, B. & RAHEJA, R. (1994) Malignant catatonia – a continuing reality. *Annals of Clinical Psychiatry*, **6**, 259–266.

Tom Clark Clinical Research Fellow in Psychiatry, University of Birmingham, Reaside Clinic, Birmingham B45 9BE

Authors' reply: It is agreed with your correspondent that certainty may often be preferred to confusion. We plead guilty to one nosological omission: the patient described had no history of classical catatonia (akinesis, mutism and waxy flexibility). Your correspondent's own cited review from 1999 (Clark & Rickards) admits there were no randomised controlled trials of treatment in catatonia. It is to be hoped that our article will have refreshed clinicians' awareness of this condition, as it is indeed often iatrogenic.

Stephen Carey Consultant Psychiatrist, Stratheden Hospital, Cupar KY15 5RR
David Hall Consultant Psychiatrist, Crichton Royal Hospital, Dumfries DG1 4TG

Missed-fit ECT audit

Sir: We read with interest the article by Davies and Wilson (*Psychiatric Bulletin*, June 2001, **25**, 215–216) on the rate of missed-fits during electroconvulsive therapy (ECT). We have recently completed a retrospective survey of the missed-fit rate in our hospital's ECT department. Of the 70 patients who received ECT between January and December 2001, case notes were obtained for 68. Eighty per cent of the patients were on antidepressants, 47% on antipsychotics, 19% on benzodiazepines and 3% on antiepileptic drugs, and no medication was recorded for one patient.

The total number of ECT treatments given was 481. Of these, only five resulted in missed-fits. These patients were not on benzodiazepines or antiepileptic drugs. The stimulus dose applied in all five cases was appropriate to the patients' age and gender. All of them went on to fit successfully later in the course. In addition, different junior doctors were involved in the administration of ECT on the above occasions.

The rate of missed-fits in our survey was very low, 1.04%, which is comparable with the rate reported by the authors (1.8%) in their third audit-year. Our ECT department is consultant-led, with theoretical teaching and clinical supervision, as well as random checks to ensure that correct procedures are followed. A stimulus-dosing protocol is strictly adhered to.

As a result of this survey, restimulation guidelines are being drafted and will be included in ECT dosing policy. It is also proposed that this survey will become an annual event in our department.

Mayura Deshpande Senior House Officer
Tegwedd Freer Consultant Psychiatrist, Wonford House Hospital, Dryden Road, Exeter EX2 5AF

Poetry and psychiatry

Sir: Holmes' carefully-reasoned evaluation of the relationship between poetry and psychotherapy (*Psychiatric Bulletin*, April 2002, **26**, 138–140) lends further support to the argument that the arts essentially complement our work in psychiatry and that a special interest group could be established by the College to promote this perspective, for the benefit of clinicians and patients alike.

The psychiatrist who is afraid of getting 'wet' (or appearing to be) is perhaps afraid of the uncertainty that all difficult endeavours, including scientific explorations, may reveal. The purpose of a special interest group in the arts would be to share versions of such uncertainty that psychiatric science may be less aware of and would hopefully serve to reduce the polarisation of psychiatric approach to the experience of mental illness, which Holmes has described.

Iain McClure Consultant Child and Adolescent Psychiatrist, Acorn Centre, Vale of Leven Hospital, Alexandria, Dunbartonshire G83 0UA

https://doi.org/10.1192/pb.26.7.275-b Published online by Cambridge University Press

columns

Can deception be therapeutic?

Sir: In their letter, Gralton and Sandford (*Psychiatric Bulletin*, March 2002, **26**, 114) admit withholding information from their patient, suggesting, however, that she 'was not told a lie'.

It was impressed upon many like me in our school-days that to tell less than the truth is to tell a lie. If we, as a profession, reject this version of the matter, might we not reasonably be accused of attempting to deceive ourselves?

Public confidence is paramount, so to defend deception under any circumstances is a risky business. Why take chances?

Larry Culliford Consultant Psychiatrist, South Downs Health NHS Trust, Brighton BN1 3RJ

Abreaction

Sir: The efficacy of barbiturate-facilitated abreaction in the investigation and treatment of mental disorders has been well documented since 1930, when Bleckwenn carried out his pioneer work. Dysken *et al* (1979), reviewing the North American literature, cited 52 studies in which the procedure was found to be useful, and there have been no reports of permanent harm. If this valuable technique were to disappear from the therapeutic armamentarium, as suggested by the results of the Wilson survey (*Psychiatric Bulletin*, February 2002, **26**, 58–60), it would be a most unfortunate development.

An explanation for the disuse of abreaction may be found in the nature of the procedure as it is usually performed. Psychiatrists are unskilled in parenteral administration and lack confidence in their ability to cope with respiratory depression or laryngospasm. These hazards are eliminated if the necessary drugs are given by mouth.

We have found that the oral administration of up to 300 mg of amobarbital with 80 mg of methylphenidate produces an abreactive state in which the patient can talk freely about sensitive issues and release the corresponding emotions. Addition of the stimulant to the barbiturate combats somnolence and promotes a smooth flow of speech. Employing this method we have enjoyed a number of successes in the treatment of post-traumatic stress disorder.

We believe that abreaction is a unique therapeutic instrument that should be preserved and used more widely than at present.

BLECKWENN, W. J. (1930) Narcosis as therapy in neuropsychiatric conditions. *JAMA*, **95**, 1168–1171.

DYSKEN, M. W., CHANG, S. S., CASPER, R. C., *et al* (1979) Barbiturate-facilitated interviewing. *Biological Psychiatry*, **14**, 421–432.

R. Denson Psychiatrist, Lakehead Psychiatric Hospital, PO Box 2930, Station P, 580 Algoma Street North, Thunder Bay ON P7B 5G4, Canada

the college

Neurosurgery for Mental Disorder
Report of a Working Group of the Royal College of Psychiatrists' Research Committee

Council Report CR89
£7.50. 82 pp.

There have been a number of developments in the area of neurosurgery for mental disorder (NMD) in recent years, including marked changes in clinical delivery. This report was produced following extensive collection of evidence from a wide range of individuals and bodies, and a comprehensive review of published data on neurosurgery up to the end of 1999. The working group adopted the following definition of NMD:

> 'A surgical procedure for the destruction of brain tissue for the purposes of alleviating specific mental disorders carried out by a stereotactic or other method capable of making an accurate placement of the lesion.'

The report discusses the future of NMD services, and concludes that steps should be taken to conserve the current resources within established centres in the UK. It suggests that this could be achieved through the establishment of an independent national advisory committee, which would monitor all aspects of NMD practice. A central task of the national advisory committee would be the establishment of a multi-centre prospective audit, through the deployment of standardised process and outcome measures. It could also be responsible for the development of nationally agreed assessment and treatment protocols, liaising with other international centres and researchers, and publishing an annual report on NMD activity in the UK.

obituaries

Christine Helen Wilson

Formerly Consultant Psychiatrist
Shrewsbury Child Clinic,
Shropshire

Christine Helen Wilson, known as Helen, was born in Lincolnshire. She was a vigorous schoolgirl; she cycled regularly and played tennis, netball and hockey. Her medical studies in Newcastle coincided with the onset of severe aggressive rheumatoid arthritis. Helen endeavoured to carry on as usual and played down her disability despite its devastating effect and several surgical interventions. She graduated MBBS (Durham) in 1966.

She trained in psychiatry in Newcastle and gained the DPM in 1970 and her MRCPsych in 1972.

Helen joined the West Midlands Training Scheme in Child and Adolescent Psychiatry as a senior registrar in 1972, being based in Shrewsbury and Birmingham. In 1977 Helen took up a consultant child psychiatrist post in Shropshire where, despite her severe disability, she established good relations with patients and their families, and was highly regarded by colleagues at all levels.

After retirement in 1996 she was able to conserve her energy and had several quiet but happy years with her family and

https://doi.org/10.1192/pb.26.7.275-b Published online by Cambridge University Press