had been said when he was stuporose. He became again a
brother. After a night's sleep with a hypnotic, his memory
nothing of the last two days and did not recognize his
began to talk, move and eat. He claimed to remember
during his brother's visit became akinetic and mute.
was unexpectedly irritable with the nursing staff and
years previously, and had decided against the responsi
Physically he was improving. After 48 hours with no
continued well, put on weight and went home smiling. There
killed himself by cutting his shunt.
pam. He demanded attention for his tremor, but remained
Dramatic tremor in his leg. The latter could be abolished
had been no further news from his sister when he returned
stupor was made, and amylobarbitone given through his
urine spontaneously for thirty-six hours. Breathing was
increasing to 120 when his wife was mentioned. Without
evidence of an organic cause, and no earlier depressive
symptomatology, a provisional diagnosis of hysterical
stupor was made, and amylarbarkitone given through his
nasogastric tube. He was incontinent of a large quantity of
urine, asked if he was in heaven, and then fell asleep. When
he woke up he appeared to be his former cheerful self,
eating, speaking and moving normally, and with a memory
'like a dream' for the period of inaccessibility. He con
continued well, put on weight and went home smiling. There
had been no further news from his sister when he returned
a month later with a mild infection at the shunt site, and a
had been said when he was stuporose. He became again a
popular Joker in the ward, appeared to accept that he
could not live with his brother, and progressed well. On
the morning he was due for discharge, he had a cardiac
arrest and died.
Both men had recently started haemodialysis, a
situation of helpless dependency frequently asso-
ciated with depression, anxiety and suicidal ideation,
especially in those over 35 (Kaplan De-Nour, 1979).
Possibly their chronically raised blood urea made
them more vulnerable to a hysterical reaction of this
type. The lesson to be learned from the first case in
particular is not to underestimate a patient's capacity
for prolonged dissociation from feelings of despair.
Symptomatic recovery may be a snare, and hysterical
stupor a rehearsal for death.

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**THE NURSE'S CLINICAL ROLE**

Dear Sir,

The development of a nurse therapist training
scheme described by Dr Bird, Professor Marks and
Mr Lindley (Journal, October 1979, 135, 321—9) has
a significance extending far beyond behavioural
psychotherapy and clinical psychiatry and it is
important that it receives the widest possible debate.
Professor Marks' impressive pioneering work clearly
supports an expansion of the clinical role of the nurse
and, by implication, forces other professions to define
their particular area of competence more clearly.
The two groups most affected by the advent of the
nurse therapist in behavioural psychotherapy are
obviously clinical psychologists and psychiatrists.
Some of the implications for psychologists are men-
tioned in the paper and no doubt will be discussed by
members of that profession. As for psychiatrists, a
reappraisal of our sphere of special skills is long over-
due; it is a misuse of training if psychiatrists are

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undertaking tasks which can be performed just as competently by other professionals whose training is shorter and less costly. The content of psychiatric training ought to be assessed with this in mind. We need to determine what other aspects of psychiatric practice can be carried out by non-medical professionals and which tasks require a medical degree. The results would almost certainly lead to a diminished role for psychiatrists but the specialty might be healthier and more viable as a result.

If the nurse’s responsibilities are to expand, some lessons can be learned from the United States where the career role of nurse clinician is well established. One area which is of particular significance for psychiatry concerns the detection and management of emotional complications in the physically ill, a facet of what has come to be known as liaison psychiatry. The liaison nurse clinician undertakes special training, leading to a master’s degree, after a basic nursing course and the scope of nursing in this field has recently been described (Biodeau and O’Connor, 1978; Beraducci et al, 1979). Such an expansion of the nurse’s sphere of influence offers the prospect of improved psychological care for the physically ill. Indeed, if the psychological needs of patients in general hospital wards are to be met it might be more realistic to establish a career structure for liaison nurse clinicians rather than to expect an increase in the numbers of psychiatrists available for liaison work. However, if this is done the particular contributions of nurses and psychiatrists will have to be defined, within certain limits, so that unnecessary overlap is avoided.

This is another area where the specially-trained nurse could extend the traditional boundaries of nursing responsibility. The establishment of a career structure for the liaison nurse should be given serious consideration by nursing and medical authorities in the United Kingdom.

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References


DEAR SIR,

Professor Marks and his colleagues are to be congratulated upon their most recent paper (Journal, October 1979, 135, 321–9) on nurse therapists in psychiatry, and also upon the careful planning and evaluation evident in this project. They make a number of important points. It may seem churlish then to express irritation at their implicit but persistent suggestion that the nurse’s clinical role is extendable only in the direction of behaviour therapy. I have written elsewhere of this matter and of my different experience at the Ross Day Hospital (Morrice, 1974, etc.). Here let me make but two points.

(1) To insist, as the authors do, that the expanded role and greater autonomy of the nurse are ‘new’ and ‘unusual’ is to deny the practice over many years of well-known therapeutic communities like Henderson Hospital, the Cassel, Dingleton, and Fort Logan. In such settings the multidisciplinary team has demonstrated its basic purpose in enabling paramedical staff to broaden their clinical roles and responsibilities in an atmosphere which seeks to encourage new learning for all. So it happens that the performance of the nurse in therapy with groups, couples, and families is seen to match that of more prestigious professionals.

(2) Fostering a nursing elite, trained and confined to behaviour therapy (with all its undoubted advantages), may lead to neglect of the urgent need for many more nurses to be trained, led, and supervised in a broad psychodynamic treatment approach. My belief is that, if even a small percentage of nurses, in and out of hospital, were to make more conscious and skilful use of the opportunities presented in their day-by-day relationships with patients, a transformation would occur in many situations that are still too often bleak, inactive, and merely custodial.

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References


THE VALIDITY OF NATIONAL SUICIDE RATES

DEAR SIR,

Douglas (1967) argued that official suicide rates were inaccurate since different coroners and medical examiners have different criteria for categorising deaths. In support of this, Brooke (1974) presented