on the problem of alcoholism in the USSR and on media reports of Soviet airforce personnel consuming aircraft de-icing fluid (N.B. *not* engine fluid). However, I did not and should not have intended to put my points in such terms as were published. I sincerely hope they will not have caused offence.

ROBIN JACOBY

The Bethlem Royal Hospital
Monks Orchard Road
Beckenham
Kent BR3 3BX

Distress caused by miscarriage

SIR: Milner (*Journal*, July 1989, **155**, 127) raises the issue of the amount of distress caused by miscarriage. Research shortly to be published in this *Journal* (Friedman & Gath, 1989) indicates high levels of distress in a group of women one month after miscarriage. In a series of 67 women, 48% PSE cases and two cases of self-harm not known to the medical profession were found. Another paper (Friedman, 1989) discusses the dissatisfaction of patients with their management and the problems of caring for this group of patients.

I agree with Dr Milner on the need for doctors and nurses to be more aware of this distressing condition, and that quite simple intervention may be effective in alleviating the considerable emotional turmoil caused.

TREVOR FRIEDMAN

Department of Psychiatry
University Hospital
Nottingham NG7 2UH

References

FRIEDMAN, T. & GATH, D. (1989) The psychiatric effects of spontaneous abortions. *British Journal of Psychiatry* (in press)

FRIEDMAN, T. (1989) General practitioners' management of miscarriage. *Journal of the Royal College of General Practitioners* (in press).

CPK levels and neuroleptic malignant syndrome

SIR: I was interested to read Maharajh's letter (*Journal*, June 1989, **154**, 885–886), as our District Biochemist, Mr G. Trevis, and I have recently started looking at the interpretation of CPK levels (including isoforms of MM isoenzymes) in the face of many variables. For example, elevated levels have been found in acute cerebral disorders, head injury, alcohol excess, muscle diseases, after oral neuroleptics, and in renal, cardiac, or thyroid dysfunction.

Some years ago there was considerable interest in elevated levels of CPK in patients with acute psychosis, and now more recently in raised CPK in neuroleptic malignant syndrome (NMS). I would suggest that a diagnosis of NMS should depend far more on clinical examination than finding a raised CPK. It has been suggested that the raised levels in acute psychotic patients may well be due to increased motor activity (Goode *et al*, 1979) or even intramuscular injections, but a study by Kumar (1984) looking at levels of CPK in schizophrenics and their first-degree relatives compared with normal controls found not only significantly raised CPK levels in the patient population but also in the first-degree relatives compared with normal subjects. The phenomenon of malignant hyperthermia has much in common with NMS, and again has been associated with increased CPK levels, and at one time it was thought that a raised level may predict a susceptibility to malignant hyperthermia, although this was subsequently refuted (Paasuke & Brownell, 1986).

Finally, I note that Dr Maharajh questions what the levels of CPK may be in black psychotic patients without NMS. Earlier work (Meltzer & Holy, 1974) has suggested that there are sex–race differences in serum CPK activity, levels being highest among black males and lowest among white females, and more recently a study by Gledhill *et al* (1988) confirmed that black males had higher CPK levels than white males.

SHEELAH JAMES

Barnsley Hall Hospital
Stourbridge Road
Bromsgrove B61 0EX

References

GLEDHILL, R. F., VAN DER MERWE, C. A., GREYLING, M. *et al* (1988) Race–gender differences in serum creatine kinase activity: a study among South Africans. *Journal of Neurology, Neurosurgery & Psychiatry*, **51**, 301–304

GOODE, D. J., MELTZER, H. Y., MORRETTI, R. *et al* (1979) The relationship between wrist monitored motor activity and serum CPK activity in psychiatric in-patients. *British Journal of Psychiatry*, **135**, 62–66.

KUMAR, A., UPADHYAYA, G. L. & TRIVEDI, J. K. (1984) Serum CPK levels in schizophrenics and their first degree relatives. *Indian Journal of Physiology and Pharmacology*, **28**, 128–132.

MELTZER, H. Y. & HOLY, P. A. (1974) Black–white differences in serum creatine phosphokinase (CPK) activity. *Clinica Chimica Acta*, **54**, 215–224.

PAASUKE, R. T. & BROWNELL, A. K. (1986) Serum creatine kinase level as a screening test for susceptibility to malignant hyperthermia. *Journal of the American Medical Association*, **255**, 769–771.

Paradoxical intervention

SIR: Macdonald's letter (*Journal*, June 1989, **154**, 883) has prompted me to read the case report of use of paradoxical intervention in a ritualist woman

https://doi.org/10.1192/bjp.155.4.567a Published online by Cambridge University Press

by Adshead *et al* (*Journal*, December 1988, **153**, 821–823) and put pen to paper. While paradoxical strategies are useful and effective in the treatment of many problems from thumbsucking to schizophrenia (Seltzer, 1986), either as an adjunct to other treatments or on its own, unscrupulous or erroneous application may lead to disastrous consequences for the patient, the therapist, and their therapeutic relationship. Adshead *et al* would see themselves as lucky at just feeling uncomfortable to "maintain a firm sceptical stance" and to face the disruption of therapeutic relationship if they knew that some physicians in ancient China (as early as 280 BC) even got killed for treating (successfully!) their emperors with paradoxical strategies (Wang, 1986).

As a non-specific method, paradoxical strategies can be applied to any number of neurotic and psychotic conditions irrespective of the aetiological basis. It acts through three main mechanisms: (a) breaking the vicious cycle of symptom-formation by reducing the performance anxiety, e.g. in the treatment of insomnia and sexual dysfunction; (b) eliminating resistance against therapeutic changes by putting the patient into a therapeutic double-bind no-lose situation so that the patient is held responsible for the control of symptom and the change, e.g. paradox used in hypnosis (Ericksonian) and paradoxical psychotherapy; (c) providing a new frame of reference to look at the pathological context, distancing the patient from the symptom by the use of humour, ridicule, sarcasm, and absurdity. Paradoxical intervention is appealing to the person's integrity and depends on the therapist's accurate and intuitive understanding of the psychopathology and assessment of the patient's resources. One of the prerequisites of paradoxical intervention is the intense relationship between the therapist and the patient rather than the content of the intervention (Seltzer, 1986).

Dr Adshead *et al*'s case report serves well to demonstrate what can go wrong with the use of paradoxical intervention. Instead of putting the patient into a therapeutic double-bind, no-lose situation, Dr Adshead has trapped her into a pathogenic double-bind, damned-if-you-do-it-and-damned-if-you-do-not position by the anti-exposure treatment of "Do not practice exposure". She was doomed either to comply with the psychiatrist's words and refrain from practising exposure, which was effective in the beginning, and probably stay on with her symptoms for another 10 years, or to disrupt the therapeutic alliance and mobilise other resourses to help herself. Luckily this woman had enough integrity to seek help from the nurse therapist (angel-delegate) and another psychiatrist and finally gained improvement. As for the psychiatrists (the devil-delegate in this case), maybe they can escape from their self-inflicted no-win predicament by changing their anti-exposure treatment to "Do not practice exposure if you don't really want to change". Whatever the patient's choice or outcome turns out to be, the psychiatrists will not be confronted with hostility and ungratefulness from the patient.

Another comment on the case report is that despite the prominent depressive features and the possibility of an underlying affective illness giving rise to the obsessive/compulsive symptoms, and despite the interesting coincidence of a relapse of symptoms at the time of returning home on discharge or weekend leave, with the couple refusing marital therapy and denying any relationship problem while frequent arguments could be seen when the husband was involved in the treatment scheme, the authors were ascribing the failure of treatment to the patient's non-compliance instead of looking into other psychosocial factors relevant to the perpetuation of the symptoms.

Finally, the main therapeutic techniques responsible for the favourable outcome in this case seem to be the exposure and response prevention (or maybe the 'support' by the other psychiatrist?) instead of the paradoxical intervention. Giving unjustified credit to the paradoxical intervention may be doing more harm than good to our understanding and mastery of this psychotherapeutic technique. Cautious evaluation and clear rationale may be the best guiding principles for the application of this effective and flexible armament in psychotherapy.

FAN, T. W.

South Kwai Chung Psychiatric Centre
South Kwai Chung Polyclinic
Kwai Chung, N.T.
Hong Kong

References

SELTZER, L. F. (1986) *Paradoxical Strategies in Psychotherapy*. New York: John Wiley & Sons.

WANG, M. Q. (1986) *Psychotherapy in Traditional Chinese Medicine* (in Chinese). Szechwan: Chung King.

Psychiatric despotism?

SIR: Returning from Hungary, that most oriental and Asiatic of European countries (in every locality there is a thoroughfare named in honour of Attila), I find two Hungarians, Imre Karacs in the *Sunday Times* and Thomas Szasz in the *Journal* (June 1989, **154**, 864–869), using the terms "Asiatic despotism" and "oriental despotism" respectively, to describe that of which they do not approve.

https://doi.org/10.1192/bjp.155.4.567a Published online by Cambridge University Press