forensic services, most of these units function in isolation and are unaware of similarities and differences of practice. The recent articles (Zigmond, 1995; Dix, 1995) highlight the most relevant issues.

We propose to have a one day meeting of senior PIC staff to discuss important issues raised by Zigmond (e.g. high dose medication, standards of care, criteria for admission) and any other relevant issues.

We would be happy if those interested should write to us including a brief description of their unit.

DIX, R. (1995) A nurse-led psychiatric intensive care unit. *Psychiatric Bulletin*, **19**, 285–287.
ZIGMOND, A. (1995) Special Care wards: Are they special? *Psychiatric Bulletin*, **19**, 310–312.

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Management training at senior registrar level

Sir: The Collegiate Trainees Committee Report on management training in psychiatry (*Psychiatric Bulletin*, April 1995, **19**, 264–266) states that there has been much discussion about management training at senior registrar level. Unfortunately this increasingly important aspect of higher professional training remains underdeveloped. In an attempt to plug this gap the Senior Registrars' Forum (supported by Lundbeck) has expanded to provide regional one-day workshops in addition to established residential workshops. The one-day workshops aim to cover a variety of management topics according to local needs. Recent workshops have covered government strategy, information technology, delegation and leadership skills.

For further information about the Senior Registrars' Forum, forthcoming events and future workshops, please contact the Senior Registrars' Forum, c/o Sunningdale House, Caldecotte Lake Business Park, Caldecotte, Milton Keynes MK7 8LF.

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An ethical dilemma in child psychiatry

Sir: Reading the case description (*Psychiatric Bulletin*, February 1995, **19**, 84–86) of an eight-year-old, otherwise normal girl without prior psychiatric or psychologic disturbance, who developed a syndrome of negativism, mutism, incontinence, muscle weakness, with failure to feed following two 'viral' infections compels our consideration of a systemic basis for her condition. We consider it likely that this patient suffered from a post-viral encephalitis with resultant syndrome of catatonia. The prolonged and persistent course of disability may have been encouraged by the failure to consider proper interventions for such a disorder.

On a descriptive level, the prominence of motor signs suggests that the syndrome may meet the definition of catatonia, usually defined by abnormal motor movements accompanying a mental disorder (Taylor, 1990). Stupor, negativism, mutism, rigidity, and posturing are frequently identified signs. A variety dominated by excitement is recognised. Most reviewers see catatonia as a functional state which seems not to result from structural brain changes. For decades, catatonia has been considered only as a subtype of schizophrenia, as the DSM–III and DSM–III–R classifications compelled the classification of patients manifesting the motor signs of catatonia into the single class of "schizophrenia, catatonic type [295.20]". Such a classifaction also prompted treatment with neuroleptic drugs.

For almost three decades, however, authors have described catatonia in patients with affective disorders, especially mania, secondary to systemic disorders, especially lupus erythematosus, infections, and following various neurotoxic agents. Re-consideration of the characteristics and treatment response of patients with the neuroleptic malignant syndrome argues that this syndrome is better considered a type of catatonia rather than a consequence of dopaminergic inhibition (White & Robins, 1991).

Catatonia is best described as the prominence of at least two motor abnormalities in patients with mental disorder (Taylor, 1990). While detailed treatment studies are lacking, case material argues that the administration of benzodiazepine drugs is the first treatment (Fricchione *et al*, 1983), and in patients who fail such intervention or who develop the

malignant or fulminant varieties of catatonia, the use of electroconvulsive treatment is warranted, and at times, lifesaving. Indeed, the association of catatonia with schizophrenia and the automatic administration of neuroleptic drugs is not only rarely helpful but is associated with worsening of the syndrome (Fricchione *et al*, 1983).

This child may have been improperly classified; if so, the prolonged illness and poor outcome may have been avoided by a consideration of this diagnosis and its treatment early in the course.

A full list of references is available from the authros on request.

FRICCHIONE, G. L., CASSEM, N. H., HOOBERMAN, D., *et al* (1983) Intravenous lorazepam in neuroleptic induced catatonia. *C Clin Psychopharmacol* **3**, 338–342.

TAYLOR, M. A. (1990) Catatonia. A review of the behavioral neurologic syndrome. *Neuropsychiat. Neuropsychol. & Behav. Neurol.* **3**, 48–72.

WHITE, D. A. C. & ROBINS, A. H. (1991) Catatonia: Harbinger of the neuroleptic malignant syndrome. *Br J Psychiatry* 158, **419–421.**

MAX FINK and DONALD F. KLEIN, *State University of New York at Stony Brook, PO Box 459, St James, New York 11780, USA*

Sir: In their letter, Fink & Klein make the interesting diagnostic suggestion that the case we described in our article suffered post-viral encephalitis with residual catatonia. As the case details were only intended to provide sufficient information to illustrate a number of ethical dilemmas, some of the data less relevant to these issues were omitted. Let me provide them now.

First, the child was thoroughly investigated in a neuro-surgical unit before admission to us, and re-assessed by our own neurological department while under my care. No evidence of neurological impairment was detected. Second, the child showed no evidence of specific catatonic features at any time. She had the non-specific feature of double incontinence, but no waxy flexibility or any of the characteristic peculiarities of voluntary movement.

Fink and Klein's therapeutic suggestions are more surprising. This girl recovered from her marked pervasive refusal within three months without medication. Dedicated nursing care was sufficient to achieve this result. Her residual symptoms consisted of extreme anger with her parents and an eating disorder. Benzodiazepines did not seem indicated. The symptoms she showed would surely not have warranted electro-convulsive therapy in an adult, let alone an eight-year-old child.

In our article, we did not provide a DSM–IV diagnosis, and perhaps we should have done, although in my experience, as in that of Leo Kanner, the disorders shown by many children who come to psychiatric attention suggest the children have not read the classification books (Kanner, 1969). I think the least inappropriate diagnosis would have been Conversion Disorder, with Dissociative Disorder as the main differential. As noted in the article however, we preferred to use the 'local' diagnosis of Pervasive Refusal Syndrome (Lask *et al*, 1991) because it is accurately descriptive and carries no unjustifiable aetiological or psychodynamic assumptions.

KANNER, L. (1969) The children haven't read those books: reflections on differential diagnosis. *Acta Paedopsychiatrica*, **36**, 2–11.

LASK, B. BRITTEN, C. KROLL, L., *et al* (1991) Children with pervasive refusal. *Archives of Diseases of Childhood*, **66**, 866–869.

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The pitfalls of audit for the psychiatric trainee

Sir: Despite being encouraged to spend time on audit, I found this activity to be fraught with difficulties. My experience stems from conducting an audit of patient satisfaction on an acute adult psychiatric ward. Following my first survey, quality standards were agreed on and recommendations for change were made. The survey was repeated one year later, by which time I was working in another district.

The response to the first survey was encouraging, with 50 questionnaires being completed within four months (74% of all patients discharged). But the following year it took five months to get 39 questionnaires completed (41% of all patients discharged) and, half way through the second survey, it became apparent that the majority of patients were being discharged without being given a questionnaire. I resorted to posting questionnaires to the home address of recently discharged patients, rather than abandoning the audit completely. The poor response to the second survey and necessary