



# the columns

## correspondence

### Is ECT patient-centred?

At times the balance between understanding patients' experiences of ill health and the biological models of disease processes can be difficult to achieve. Most healthcare professionals recognise the importance of both the scientific theories of disease and abnormal functioning, but also of ethical issues and the subjective experience of illness. Evidence-based medicine highlights the importance of taking into account three elements: the evidence, patient particulars and patient preference (Haynes, 2002). To ignore any one of these aspects would lead to an approach to care which cannot be patient-centred.

Professor Cawley suggested that 'psychiatry is more than a science' (Cawley, 1993), containing an 'undefined something extra' in addition to its scientific knowledge and practice. Psychiatry's concern with the uniqueness of each individual, empathy and communication with patients is 'inevitable and ever-present'.

This is especially important for patients undergoing electroconvulsive therapy (ECT), who not only face the stigma of the treatment but also the potential disempowerment of such a technique, particularly in those cases where it is carried out against the wishes of the patient. The study carried out by Kershaw *et al* (2007) was potentially able to address this issue, but unfortunately the researchers did not report whether the patients were being treated voluntarily, nor their attitudes towards ECT before receiving treatment.

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Smith & White (2007) showed it was feasible to complete HCR–20 (Historical Clinical Risk – 20-Item Scale) ratings on most patients within 48 hours of admission to their general psychiatric wards but did not demonstrate that this approach was likely to be valid or useful.

First, HCR–20 was specifically developed for forensic patients. Furthermore, the reliability of the results in some items can be poor even for trained raters (Douglas *et al*, 2003) and worse for untrained ones.

The drive behind risk assessment is to identify patients who represent a significant risk of serious violence. However, the risk of a patient with schizophrenia being convicted of serious violence is 0.2% per annum (Wallace *et al*, 1998) and Monahan (1981) has emphasised that 'if the base rate [of violence] . . . is low then even a relatively accurate predictive test risks misclassifying many non-violent people.'

Risk assessment should be reliable, valid and result in a risk management plan, and therefore it requires careful enquiry. It is wasteful and unhelpful to assess every patient admitted. Detailed assessment should be for those *a priori* representing increased risk. Professionals should screen patients for previous violence and only then carry out detailed risk assessments on those who have a history of violent behaviour and those who for other reasons give concern, for instance because of violent fantasies or threats. To assist them, professionals need to know the most important predictors of violence, in order of importance: psychopathy, previous violence, and comorbid substance misuse.

The HCR–20 is an appropriate tool for forensic patients, but the MacArthur Classification of Violence Risk (COVR) is more valid for general psychiatry. This is available with a software programme with cut-off points for high and low risk, though these need to be treated with caution in the UK population.

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MONAHAN, J. (1981) The Clinical Prediction of Violent Behavior. National Institute of Mental Health.

MONAHAN, J., STEADMAN, H. J., APPELBAUM, P. S., *et al*. MacArthur Classification of Violence Risk (COVR) (<http://www3.parinc.com/products/product.aspx?Productid=COVR>).

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### Polydipsia in psychiatric patients

Chronic subdural haematoma is notorious for leading to mistakes in diagnosis (Lishman, 1978). Before the advent of computerised tomography, only a fourteenth of cases in mental hospital patients was diagnosed in life (Cole, 1978). We report a case presenting with polydipsia.

An elderly man with chronic psychosis was admitted to a medical ward with a 2-week history of polydipsia and agitation. Liaison psychiatrists transferred him to an acute psychiatry ward as a case of psychogenic polydipsia. He was found to be manic with euphoria and flight of ideas. Occasionally he also complained of headaches, had dyspraxia and became incontinent. This prompted an MRI (magnetic resonance imaging) brain scan showing bilateral chronic subdural haematomas with modest mass effect. Conservative management was tried at first. However, a fresh bleed with onset of hemiparesis led to emergency evacuation with full recovery and resolution of polydipsia.

Psychogenic polydipsia is a common occurrence amongst psychiatric inpatients (Dundas *et al*, 2007). As the underlying pathophysiology of this syndrome is unclear, comprehensive evaluation of such cases is warranted.