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Editor: Greg Wilkinson

A Case of Resistant Schizophrenia

SIR: It is gratifying that our colleagues at the Joint Hospital (Roberts *et al, Journal,* December 1986, **149,** 789–793) have discovered neuroleptic-resistant schizophrenia. However, had they visited any of the large psychiatric hospitals, which they seem to prefer to call asylums, they would be likely to find a number of patients with this disorder.

Notwithstanding the failure of electroconvulsive therapy in this patient, I would suggest that lithium should be tried. Sometimes 'continuously floridly psychotic behaviour' has a masked affective component, as Crammer suggests in the paper.

We have reported the case of a 27-year-old married lady who required high doses of depot neuroleptics to control episodes of schizophrenia (as diagnosed at that time) associated with very disturbed behaviour and to maintain prophylaxis (Barnes & Bridges, 1980). Her severe symptoms were improved, but certainly not controlled, by the use of ECT. However, there was a good response to lithium, although, ultimately, she was found to be most settled on haloperidol (20 mg t.d.s.) and carbamazepine (400 mg t.d.s.) with procyclidine. Her compliance on this medication is good, and it has kept her out of hospital so far for the past four years. I should add that she was transferred originally to my care at Bexley Hospital from the Bethlem Royal Hospital, where it was considered that she was doing too much damage to both the staff and the fabric and hence "asylum" was needed.

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Anorexia Nervosa and Dysmorphophobia

SIR: I should like to comment upon Sturmey & Slade's paper (*Journal,* December 1986, **149,** 780–782). Anorexia nervosa and dysmorphophobia are functional disorders which usually occur in young individuals and are characterised by disturbances of the body image. In the former condition subjects characteristically perceive themselves as fatter than they are, as with the reported patient who "considered herself to be generally too 'broad'", whereas in dysmorphophobia, subjects typically complain about one particular aspect of their appearance, such as the nose, chin, mouth, breasts, or penis (Morselli, 1886; Hay, 1970; Thomas, 1984).

In anorexia nervosa and in the reported patient weight loss occurs, and consequently observed appearance cannot be considered normal. In dysmorphophobia there is a subjective feeling of ugliness or physical defect which the patient feels is noticeable to others, although appearance is within normal limits (Morselli, 1886).

I think that it is incorrect to consider that their patient exhibits dysmorphophobia, as the disturbance in body image was not localised, abnormality of body size was present, and there was a primary diagnosis of anorexia nervosa from which the dissatisfaction with appearance developed.

Making these distinctions is important if one wishes to identify and study a homogenous group of dysmorphophobics where an over-valued idea concerning appearance, in the absence of underlying classifiable psychiatric disease, is the principal abnormality.

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SIR: The report on anorexia nervosa and dysmorphophobia (Sturmey & Slade, *Journal,* December 1986, **149,** 780–782) demonstrates how easy it is to further complicate psychiatric nosology.

Certainly the history suggests that the patient warrants a diagnosis of anorexia nervosa; many of the classical features are present, including a disturbed body image. Dysmorphophobia, however, is confused yet again by an initial emphasis on physical

appearance and then referring to it as a social phobia. Here the term is superfluous, because the feature of disturbed body image is a diagnostic criterion of anorexia nervosa. If the authors used this method of 'overlapping nosology', then why didn't they call the report "A study of anorexia nervosa, dysmorphophobia, social phobia, anxiety neurosis, obsessive-compulsive neurosis, and personality disorder, etc."?

It would be interesting to follow up this patient for a time. If her brother has another "schizophrenic attack" (*sic*) and she follows suit then we can label her "schizophrenic" and start all over again!

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Munchausen's Syndrome and Drug Dependence

SIR: London & Ghaffari (*Journal*, November 1986, **149**, 651–654) report on the failure of treatment in a patient with Munchausen's syndrome approached primarily as a problem of dependence on drugs. The demand for pethidine injections is as much a hallmark of this syndrome as is the assertion that the patient is allergic to contrast dyes. The authors state that their patient was in the Royal Army Medical Corps. This is a common assertion (O'Shea *et al.* 1982, 1984). It is rarely true in my experience.

The strongest theory to date of the origins of Munchausen's syndrome suggests that it is a trait learned in childhood: a 'Munchausen mother' induces fictitious diseases in her child; the child later assists the mother in fabricating such illnesses; the young adult goes out into the world seeking mothering with the only language he knows that will procure it – i.e. illness behaviour. Doctors respond with admission, investigations, and treatments, and reject when they find out that the patient has lied (Meadow, 1985; O'Shea, 1984). Most workers now accept that Munchausen patients fall somewhere within the spectrum of psychopathy, and in those cases of Munchausen's syndrome which appear to begin in adult life, scrutiny will nearly always reveal underlying psychopathy.

London & Ghaffari describe the family diseases of their patient in detail, and yet feel that the RAMC was responsible for his being "introduced" to a medical environment. Incidentally, even proxy cases may lie about their nursing experiences (Meadow, 1985).

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Autocastration and Biblical Delusions in Schizophrenia

SIR: I read with interest the paper by Waugh (*Journal*, November 1986, **149**, 656–659). I remember being called one Sunday to a surgical ward at the Queen Elizabeth Hospital, Woodville, South Australia, as the duty psychiatrist. The patient I was called to see had, the previous day, removed his own penis and genitalia, and also his tongue, with a scalpel. He had also attempted to perforate his ear drums, and there were superficial lacerations to his upper eyelids. It became clear later that he had also considered cutting off his right hand. He was about 30 years old, Chinese-Malaysian, and a medical practitioner.

I saw the patient twice on succeeding days, and he was able to communicate lucidly by means of pencil and paper. Like Waugh's patient, his thought content conveyed a sense of relief at having totally removed his genitals and also his tongue. His reasoning was that he could no longer do evil or speak it. He did not refer to Matthew 19:12, or any other biblical verse specifically, but he clearly felt that he had done what he had in order to atone for masturbation, lustful thoughts, and the use of obscene language. He felt that he had made his peace with the Almighty.

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SIR: I would like to suggest a name for the syndrome described by Waugh. 'Klingsor's syndrome' seems to be the obvious choice. Klingsor was a character in Wagner's *Parsifal* who unmanned himself in a vain effort to gain entry to the brotherhood of Grail Knights. The suggested title thus incorporates both the element of autocastration and the religious motive described by Waugh.

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