Correspondence

Self-damage in patients with Klinefelter's Syndrome

DEAR SIRS

It was interesting to read the letter from Professor Priest and his colleagues (*Bulletin*, July 1984, **8**, 140). I have encountered a young man, aged 33, of dull, normal intelligence, who has been diagnosed as Klinefelter's Syndrome. He is a single, obese man, with sparsely distributed body hair, marked gynaecomastia, and under-developed genitals. He has a long history of self-mutilation which includes cutting himself with razor blades and glass, swallowing glass pieces, safety pins and stones, and at times re-opening operation scars. He has undergone multiple laparotomies and shows extensive skin scarring in both arms and abdomen. He has also taken repeated overdoses, and been admitted to various psychiatric hospitals all over the country. Though uncommon, the combination of Klinefelter's Syndrome and self-mutilation does seem to exist.

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DEAR SIRS

We should like to report a similar case to those reported by Professor Priest and his colleagues (*Bulletin*, July 1984, **8**, 140).

The patient is a 32-year-old, married man with documented Klinefelter's Syndrome. He is sterile and presently impotent. He has a sociopathic personality disorder. He has a normal EEG and his IQ is in the dull range of 75–80. He, too, has exhibited transient psychotic features. He has few characteristics of Money's[1] stereotype Klinefelter. He more resembles the picture described by Wakeling[2] with delayed maturation; poor scholastic achievement, marked neurotic traits in childhood, a diagnosis of personality disorder and behaviour which is erratic, impulsive and aggressive.

He has shown a vast array of behaviour problems. These include court appearances and a prison sentence for alcohol related offences and violence and orthopaedic treatment for fractions sustained in fights. He has made multiple appearances in Casualty with self-inflicted lacerations and overdoses, however, none of these have ever been life threatening. At a peak he made six such appearances over a three-week period. He has also been violent towards his wife, hospital staff and occasioned damage to hospital property. Also well documented is a high rate of drug and alcohol abuse in self-mutilators;[3,4] he abuses both drugs and alcohol.

A further interesting, though difficult, problem he presents is periodic urinary retention of obscure origin, often combined with nocturnal enuresis. This has led to further appearances at Casualty with demands for catheterization. This problem has been extensively, though fruitlessly, investigated both urologically and neurologically. All psychological approaches to this problem have been defeated by the patient who will, whilst insisting he requires help, systematically destroy 'bell and pads' or sabotage any other programmes. One could speculate that his recurrent demands for catheterization, which is both painful and invasive, constitute a variant of self-mutilation.

His retention is not presently a problem. Attempts at in-patient assessment have without exception ended with violence, suicidal threats or self-discharge. He is currently out of contact with the local psychiatric services.

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The importance of clear directives in community care

DEAR SIRS

The June issue of the *Bulletin* contained a letter and statement from the National Schizophrenia Fellowship urging more forward planning in the provision of adequate community services to cope with the proposed discharge of many psychiatric patients back into the community. The same issue also contained Sidney Brandon's review of *The Mind Manifesto: A Common Concern*, in which he expressed concern about interdisciplinary conflicts, rivalries and self-interests displayed in connection with proposed community services.

After four years working as a community psychiatrist in Edinburgh, I am left in no doubt that we, the psychiatric profession must seriously rethink our own current strategies about delivery of service and our training procedures if we are to take into account the trend towards community care. Inevitably we will have to work more closely, not only with community psychiatric nurses and community-based psychologists, but also with primary care teams, with local authority social workers, and with voluntary workers and the private sector if, as psychiatrists, we are to continue to maintain any role in the joint care of the emotionally and behaviourally disturbed in the community.

I believe we must urgently formulate methods of assisting the transition from our present clinical practice, i.e. hospi-

talized, centralized and medicalized, to allow a gradual transfer to a more social and community orientated multidisciplinary approach for psychiatric treatment. One possible option would be to designate a proportion of existing psychiatrists interested in a community-orientated approach to act as front-runners for a limited period of time to facilitate the necessary changes towards community care, working in close partnership with area health planners and policy makers much as community medicine specialists do in their field.

I do not think we can possibly achieve the sort of co-ordinated services that will be required to cope with psychiatric problems in the community without a great deal of preparatory ground work and good will from the psychiatric profession. Apart from our specialist function, we probably have a part to play in establishing good working relationships with the many agencies involved and in the setting up of interdisciplinary liaison meetings. However, in the course of such community work, assumptions about the doctor always having authority over other workers may need to be questioned. The whole balance of responsibility, accountability and priorities may well be very different within the community team as opposed to a hospital based team.

I believe such changes cannot be produced by paper directives alone, and that very positive action and energy will have to be extended to effect this new approach to psychiatric management. Hence, it is my belief that we should designate community psychiatric specialists, even if temporarily, to help facilitate and discriminate positively towards the concept of community care. Psychiatrists currently working in the traditional model usually have neither the time, energy nor motivation to leave their busy work roles and establish new footings in the community. If community care is to work, it must not be left to develop by chance or by fault.

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Part-time posts in psychiatry

DEAR SIRS

I was interested to read R. Toms' article about part-time training in psychiatry (*Bulletin*, June 1984, **8**, 104–106). I trained part-time, starting in 1974 when both my children were at school, and I share with her many of the difficulties that she experienced; waiting endlessly for job approval and finance, grappling with an unfamiliar exam format and coping with the problems of being tied to a geographical base. I started in the local psychiatric hospital and after four years was seconded to the academic centre 40 miles away for one year. Once I passed the Membership and gained a senior registrar appointment the Joint Committee on Higher Psychiatric Training requirements were that I should spend all my time at the academic centre, thus adding three hours' travelling time to each working day. I had found a limited year's secondment manageable, but the prospect of four or more years as a senior registrar making this journey filled me with dismay. However, I persisted and, in order to hurry along the time that I might consider myself qualified enough to apply for a consultant post, did some locum part-time consultant work in my own area.

After about a year of this routine my husband's job moved south, and we decided it was easier for me to apply for a consultant post than renegotiate with a new Regional Health Authority about continuing part-time senior registrar training. We had also decided that I would not move house again so could undertake the long-term commitment which I felt was necessary to a consultant post. Fortunately for all of us, jobs became available in areas convenient to the family, and I applied and was appointed to my present post. At each interview (I attended two) my training was fully discussed by the College representative on the interviewing board. The rest of the interview probably followed much the same format as for other candidates, except that my commitment to psychiatry was questioned.

I felt that the rigours of part-time training were such that only the very committed would survive them! I think it is for this reason that I write, to warn other candidates who move from part-time to full-time jobs that this may be what they face. Perhaps, if I had continued to work in my own area where I was known, there would have been no question about my commitment and it may only be that I moved into a new Health Authority that this occurred. However, it is quite common for consultants to divide their time between establishments—private or NHS practice; clinical and academic work—they are effectively working part-time in various areas and I find it difficult to understand why women who choose to divide their time between work and home cannot be regarded in the same way. In a society that is moving towards a shorter working week there may be much that the medical profession can learn from part-timers.

On reflection, two aspects of my part-time training stand out. Firstly, the difficulties associated with being tied to a geographical base, the limitation of opportunities, amount of time spent travelling and the sense of isolation; and secondly, the enormous amount of support and encouragement I received throughout from a small group of local and regional administrators and colleagues from senior house officer to professor, but particularly other part-timers.

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Must psychoanalysis be scientific?

DEAR SIRS

Dr King's thoughtful article, 'Must Psychoanalysis be Scientific?' (*Bulletin*, August 1984, **8**, 152–54), arrived at the rather tentative conclusion that psychoanalysis, and similar attempts to understand the mind, should not be rejected because they are unscientific. Nobody is likely to dispute this as a proposition standing on its own, but perhaps one should go on to consider the next question: in what way should systems of thought like