psychological difficulties within their own cultural framework improves, it is very difficult to expect a dramatic change in the existing system. In fact any such efforts will be quite futile.

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Examination techniques

Sir: We share the concerns of Dr Donnelly in his description of the problems that junior psychiatrists often have in passing the MRCPsych clinical examinations (*Psychiatric Bulletin*, May 1995, **19**, 302–304). We believe that very good candidates sometimes fail more because of poor examination technique than a lack of knowledge or clinical skills. On the MCQ papers it is possible to score 74% of answers correctly yet because of 'negative marking' a net mark of only 48% may be achieved if every other response is wrong.

Other aspects of the exams illustrate the same point; having good levels of knowledge and clinical skills may not be enough to pass. The ability to present essays, SAQs, PMPs and the clinical case in an organised and professional manner is not one that comes naturally to everyone. These are skills that need to be practised and developed.

It is our experience, in teaching candidates in Yorkshire, that specific teaching of examination technique is sometimes overlooked by candidates and trainers alike. Within the setting of the Leeds Examination Techniques Course (which is run twice yearly) candidates are offered clear teaching in case presentation, and practise in each area of the written exam (Williams *et al*, 1995). The purpose of the course is not to teach facts about psychiatry (it is the responsibility of each candidate to learn these), but to encourage each candidate to present what they do know effectively. The skills required in the exam are also the skills of a good psychiatrist; to effectively gather, organise and integrate information in order to decide on appropriate treatment approaches.

Learning factual knowledge and clinical skills alone, although important, is not enough. We would encourage all trainees and trainers to be aware that candidates need to practise specific exam techniques as well, so that they can communicate these skills effectively.

WILLIAMS, C. J., TRIGWELL, P. & YEOMANS, J. D. I. (1995) *Pass the MRCPsych Parts I and II (All the techniques you need)*. London: Baillière Tindall/WB Saunders.

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Mental Health Task Force Support Group

Sir: Reading the briefing on the Mental Health Task Force Support Group by Wattis & Thompson (*Psychiatric Bulletin*, April 1995, **19**, 250–251), we are unsure as to how they have advanced the "cause of services for people with mental illness". One has the impression that there had been much consultation with 'user groups' and the publication of many documents – but to what effect, other than guidelines suggested elsewhere? Mention was made of the newsletter *Grass Roots*, supposedly circulated to notify people of the work of the Task Force, but it was unknown in the psychiatric hospital where we work.

The Task Force was set up to "help ensure the substantial completion of the transfer of services away from large old-style hospitals to a balanced range of comprehensive locally-based services" (Jenkins, 1994). However we suspect that this was a government quango set up to provide little more than a public relations exercise. We would be interested to hear of any tangible benefits of the Mental Health Task Force others have observed.

JENKINS, R. (1994) The Health of the Nation. recent government policy and legislation. *Psychiatric Bulletin*, **18**, 324–327.

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Interaction between staff of psychiatric intensive care units

Sir: There is very little formal interaction between staff of psychiatric intensive care units (PICU), e.g. at College level. Unlike

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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.

M. DOMINIC BEER, CAROL PATON and STEPHEN PEREIRA, *Specialist Mental Health Directorate, Bracton and Stansfield Clinics, Bexley Hospital, Old Bexley Lane, Bexley, Kent DA5 2BW*

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