

FEIGNED PSYCHOSIS

DEAR SIR,

I read with interest the excellent paper on the above subject by Dr Hay (*Journal*, July 1983, 143, 8–10). In it we learn that the simulation of schizophrenia in most of his southern Manchester cases is a prodromal phase of the psychosis itself occurring on the basis of a markedly abnormal personality. This should alert the physician to be wary of the malingering diagnosis in such a context and the moral condemnation of the patient that could easily go with it.

It would be a mistake in my opinion, however, to overgeneralize these findings to the world at large. While practising as a psychiatrist in Singapore during the 1950's I had occasion to review the literature up till that time and to describe two instances of feigned psychosis (Burton-Bradley, 1959). Quite apart from these it soon became clear that such cases were by no means uncommon and their appearance a daily event. Nor did they occur in extremely deviant premorbid personalities, and their subsequent histories were without mishap. None developed schizophrenia. There was no evidence of any sort to indicate that they were in any respect other than normal people. It is true that no formal follow-up studies were done but it was clear that in the conditions prevailing any ensuing psychosis would surely have surfaced.

The administrative structure at that time was exceptional. There was but one psychiatrist for the whole island, one mental health facility only, in the form of a mental hospital and one avenue alone through which all psychiatric patients were channelled and assessed. The local conditions were such that the disparity of availability of food, quality of accommodation and congested living conditions was the opposite to that existing in most of the larger industrialised countries. All these patients came from grossly overcrowded quarters, and the hospital seemed a highly desirable place to be, the stigma of insanity notwithstanding. They sought commitment earnestly and the possibility of long confinement did not deter them.

The patient was usually a male or female adult between the ages of fifteen and fifty years. Prior to interview, he sought information concerning the symptoms and signs of schizophrenia from those knowledgeable mental hospital attendants who were ready to oblige dishonestly for a fee. He presented the data so obtained to the psychiatrist often with great skill in the form of a more than usually good imitation of psychotic illness and in some instances the pretended visual hallucinations, delusions and other bizarre symptomatology closely resembled the real thing. In short, apart from the general features of

simulation as such, these cases were specially characterised by:

- (1) A dramatic onset of claimed psychosis associated with a marked desire to enter a mental hospital.
- (2) A background setting of disparity between hospital and home favouring the former in terms of food, shelter and overcrowding.
- (3) A high degree of sophistication in insane lore.

BURTON G. BURTON-BRADLEY

*Faculty of Medicine,
University of Papua New Guinea
Papua New Guinea*

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FOLIE IMPOSÉE IN A KENYAN COUPLE

DEAR SIR,

John, 31 and his wife Jane, 23 were referred because both of them had been shouting obscene words to their next door neighbours, locked themselves inside their house most of the time, and refused to open to callers. Whereas they believed they were quite alright, they complained bitterly about their neighbours whom they accused of trying to sabotage their marriage and jobs, and kill them. John went further and insisted that the neighbours had tried to kill them by rays transmitted through the fence and also by colourless and odourless gas. These same neighbours had enlisted the help of a very powerful witch doctor who lived 300 miles away and had the supernatural power to inflict harm even from that distance. He admitted to threatening auditory hallucinations in the third person.

John had first become ill 12 years previously. He had become increasingly isolated, suspicious of other people (including his relatives) and had deteriorated in his school performance. He was admitted to a mental hospital and discharged within 4 weeks on a long term prescription of chlorpromazine. He subsequently obtained a clerical job and moved to his own house 3 years ago in preparation for marriage one year later. On moving to his own house he stopped taking his drugs. One of John's younger brothers suffered from schizophrenia. His mother and his maternal uncle suffered from psychiatric illness and were both on long term treatment.

Jane, who was seen separately, had the same complaints about the neighbour as her husband with the exception that she did not feel the effects of rays coming from the neighbours. On further enquiry she

had no other psychopathology in addition to her delusions. According to the relatives who escorted them, Jane had been quite well until she married John and had gradually taken on some of John's odd behaviour. There was no history of mental illness in Jane's family background. Their relatives described their relationship as closed to outsiders and emotionally very close.

John alone was put on Modecate 50 mg monthly. His psychotic features, including his delusions, disappeared, and his social interaction improved. Jane was not put on any treatment, but her condition improved after that of her husband.

DAVID M. NDETEI

*Department of Psychiatry,
University of Nairobi,
P.O. Box 30588,
Nairobi, Kenya*

ECT SEIZURE DURATION AND ALLEVIATION OF DEPRESSION

DEAR SIR,

Katona and Berrios (*Journal*, April 1983, 142, 426) are correct in stating that ECT seizure duration is longer when measured by EEG criteria than by gross observation of tonic-clonic movements. However, these investigators are for two reasons probably incorrect in suggesting that inter-group differences in EEG seizure duration may account for the difference in anti-depressive efficacy found by Robin and de Tissera (*Journal*, October 1982, 141, 357–66) between low energy pulse and high energy sinusoidal stimulus waveforms.

Firstly, while Robin and de Tissera did measure seizure duration solely with the naked eye, it is probable that, had they measured seizure duration with EEG monitoring, any difference in seizure duration obtained with the two methods would have been randomly distributed among their three treatment groups. This is because patients were randomly assigned to the three ECT groups and because there is ample evidence in the ECT literature showing no difference in EEG seizure duration between ECT with low versus high energy stimulus waveforms (Cronholm and Ottosson, 1963; Weiner, 1980; Daniel *et al.*, 1982, 1983; Weiner *et al.*, 1983).

Secondly, no ECT study to date has demonstrated statistically a positive correlation between the anti-depressive efficacy of ECT and EEG seizure duration without confounding EEG seizure duration with treatment number, as did Maletzky (1978) and a recent investigation by Kramer (1983). In this regard, I do not

think that Maletzky's anecdote quoted by Katona and Berrios obviates the need to control for treatment number. In fact, a recent study (Weiner *et al.*, 1983) found that the anti-depressive efficacy of ECT was related neither to the mean nor total EEG seizure duration in patients receiving a comparable number of brief-pulse or sinusoidal treatments.

What appears to be important with respect to therapeutic efficacy is not the precise duration of seizure activity (Weiner *et al.*, 1983), but rather the administration of 5–8 adequately generalized tonic-clonic seizures (d'Elia *et al.*, 1983). In this regard, some types of low-energy brief-pulse waveforms (pulse-widths of 0.6 msec. or less), as used by Cronholm and Ottosson (1963) and Robin and de Tissera (1982), may produce inadequately generalized seizures, a hypothesis discussed elsewhere (*Journal*, May 1983, 142, 536–37) with respect to Robin and de Tissera's results.

WALTER F. DANIEL

*Medical Research Service,
Veterans Administration Medical Center,
508 Fulton Street,
Durham, North Carolina 27705, USA*

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