

Correspondence

Letters for publication in the Correspondence columns should be addressed to:

The Editor, *British Journal of Psychiatry*, 17 Belgrave Square, London SW1X 8PG

INFORMATION PROCESSING MEASURES AND THE OBJECT CLASSIFICATION TEST

DEAR SIR,

In a recent article (Hemsley, 1976) I reported a lack of significant relationships between measures derived from a choice reaction time task and the number of non-A responses produced on Payne's object classification test (Payne, 1962) within a group of acute schizophrenics. It was there suggested that scores on the latter are influenced by 'responsiveness' and that this would tend to blur any such relationships. A subsequent analysis is consistent with this interpretation. Instead of employing the total of non-A responses as the score on Payne's test, the ratio of non-A to total responses was calculated; this method was used by Phillips *et al* (1965). A correlational analysis indicates significant correlations between this measure and two of those derived from the choice reaction time task, response decision time (Rd) ($r = +0.446$, $P < 0.05$), and susceptibility to distraction (D) ($r = +0.473$, $P < 0.05$). The findings are therefore consistent with the suggestion that scores on the object classification test reflect both information processing deficits, as originally put forward by Payne *et al* (1959), and 'responsiveness', the latter being reduced in chronic patients. It is of interest that although the total of non-A responses of chronic schizophrenics tend to fall within the normal range, the ratio of non-A to total responses exceeds all other psychiatric groups except acute schizophrenics (Payne, 1971).

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PROPRANOLOL PSYCHOSIS

DEAR SIR,

We should like to report re-emergence of paranoid delusions and auditory hallucinations in two patients treated with propranolol for hypertension. One of these also showed features of hypomania.

Previously reported side effects of propranolol include visual hallucinations, insomnia and nightmares (1, 2) and confusion (3). In addition, schizophrenics on high doses became ataxic (4).

Case 1

An East European of 65 with no psychiatric history was admitted with accelerated hypertension (BP 265/160) and given methyl DOPA, bendrofluazide, and increasing doses of propranolol over seven days reaching 320 mg thrice daily. The blood pressure failed to respond until minoxidil (a vasodilator) was added, reducing the pressure to 130/90 by day 9. The patient was alert and well.

On the eleventh day he became confused and agitated. He was clumsy and ataxic, had difficulty understanding instructions and was disorientated. The next day he became terrified, insisted with certainty that the hospital was full of Russians about to abduct or kill him, begged his wife to fetch the police and eventually tried to run away, assaulting a doctor who delayed him. Propranolol was discontinued, but for three days he remained psychotic. He described hearing Russian voices speaking to him from the television, and once saw ten Russian soldiers in uniform walk into the ward and surround his bed. (They fled when he shouted for help.)

He was given chlorpromazine 100-200 mg thrice daily, and that day became euphoric. He spoke under pressure, became jovial and expansive, punned, and described hearing beautiful music. The next day he showed complete recovery: he could remember some of his experiences, with insight and much embarrassment. His wife explained that fear of

abduction by Russian soldiers was quite common among this group of immigrants and might in fact be realistic.

Management of his blood pressure was continued, replacing propranolol by atenolol, a beta-blocker which penetrates the blood-brain barrier poorly.

He remains well one year later, without further incident.

Case 2

A violinist aged 50 was admitted with accelerated hypertension (230/145) and was given minoxidil, frusemide and propranolol (up to 320 mg thrice daily). After two days on propranolol he became psychotic. He believed the patients were planning to shoot him and the nurses, and heard a group of patients loudly singing a song designed to warn him of his fate. (The ward was in fact quiet at this time.) Logical arguments were of no avail. He spoke under pressure in great agitation and attempted to escape from the ward. At that time he was alert but disorientated.

Propranolol was replaced by atenolol and the symptoms all remitted during the succeeding week, without specific treatment. The patient had no previous psychiatric history and has remained well.

Inspection of blood pressure charts showed that psychosis was not associated with hypotension in either patient, occurring during stable or rising pressure phases. The patients recovered despite continuance of the other drugs used. Propranolol is known to accumulate in the brain in concentrations up to ten times the plasma level (5), and it seems to have been the sole cause of paranoid delusions and hallucinations in these patients.

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RATIONING OUT-PATIENTS

DEAR SIR,

I was greatly interested by Dr Robin's article

(*Journal*, August 1976, p 138) 'Rationing Out-Patients', in which he finds that an eleven week increase in waiting time produced a 10 per cent decrease in new referrals seen, and this with no apparent detriment to his clients. When I worked in the field of child psychiatry I too experienced this very general problem of an ever-increasing number of new referrals. The clinic team employed a variety of devices—none wholly successful—to keep this waiting period down to around six weeks. It is ironic to realize that if Dr Robin's thesis is correct our efforts were worse than useless.

Perhaps my experience of some years ago may be helpful, in that it both goes some way to substantiate Dr Robin's theories and also underlines some possible snags. At that time I had been set to work in a child psychiatric clinic which had accumulated a long waiting-list. On it were about sixty children who, on average, had been waiting around fifteen months. However, when we made personal inquiry, we found that only some fifteen parents still wanted treatment. Our waiting-list had shrunk to a quarter of its original size. But despite this bonus we had our problems.

Most important, these children, though presenting with a mixed bag of symptoms, proved extremely difficult to treat. Time, of course, had eliminated all the children who would have made a quick spontaneous recovery—as also families 'poorly motivated'. But it seemed to us that time had also sieved out most of the children for whom it could be hoped that psychotherapy could tip the balance in favour of mental health. It is a possibility that some children would have been more readily treatable in the early days of their disorder but with time had become 'fixed' in their patterns of maladjustment. And though the parents of these remaining children had shown dogged persistence in waiting for psychiatric help, they were not very regular in attendance once this help was offered.

Another difficulty, not unexpected, was the anger with which many parents greeted our long-delayed offer of help. Some parents declared that their child was no better but that they had become used to its disturbance. Some, we felt, even when the child was genuinely improved, would have been most reluctant to seek our help again.

The example I cite is, admittedly, an extreme one. All the same, before we become too complacent about long waiting-lists (let alone contrive them) we should remember that the object of psychiatry is not simply to assess patients but, as far as possible, to cure them. We must thus be reasonably sure that a long wait will not result just in more treatment sessions for fewer patients—and possibly a poorer therapeutic result. It would also be interesting to