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Milieu and Mutilation – A Case for 'Special' Treatment?

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Special hospitals are principally concerned with the treatment of patients of dangerous, violent or criminal propensities referred from the courts and prisons. However, patients can be transferred from local NHS hospitals. The case of one such patient illustrates the potential benefits of such a transfer, even for patients who are not of immediate danger to others.
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The provision of special hospitals is required by the Secretary of State for Social Services under section 4 of the National Health Service Act 1977. There are three such hospitals in England and Wales – Broadmoor, Rampton, and Moss Side and Park Lane (now one hospital). They provide the same range of therapeutic services as ordinary psychiatric hospitals, but are intended for the treatment of detained patients who, in the opinion of the Secretary of State, require such treatment under conditions of special security because of their dangerous, violent, or criminal propensities.

The majority of patients admitted to special hospitals come from the courts (via a hospital order under section 37 of the Mental Health Act 1983) or on transfer from prison (under sections 47 or 48 of the Mental Health Act), usually after the commission of a serious offence (e.g. murder or manslaughter). Approximately 20% of patients are transferred from National Health Service (NHS) hospitals under section 3 of the Mental Health Act 1983 (civil patients). Many of these patients will not have been convicted of a criminal offence but will have been transferred because of persistently dangerous and unmanageable behaviour in a local hospital.

The following case highlights the difficulties such civil patients can present before transfer to a special hospital; the patient was unusual in that his primary difficulties lay in self-destructive behaviour rather than dangerousness towards others.

Case report

J was born following a full-term breech delivery. No abnormalities were noted in early development. At school he was noted to be slow at reading, and although he made friends he was teased and bullied as a young teenager. He left school at 15 with no qualifications or ambition.

His leisure activities were mainly solitary in nature (e.g. stamp and coin collecting). He occasionally drank, did not smoke, and experimented with LSD twice in his early teens. After leaving school he worked as a trainee chef for almost two years. Further employment was interrupted by illness.

The patient's father, in his late 60s, is a retired county council clerk. He was a lay preacher with fundamentalist

Christian views. When J was 16, his father was admitted for depression, was treated successfully with electroconvulsive therapy (ECT), and made a complete and uneventful recovery.

J's mother, in her early 70s, is a semi-invalid with chronic neurotic depression compounded by angina pectoris. She took to her bed following the death of her younger son, aged four, who died after inhaling a peanut. The patient's only other brother, in his early 30s, has been in hospital continuously for several years with a schizoaffective illness.

The patient has always enjoyed good physical health.

When J was 16 he was admitted to the local psychiatric hospital after an overdose precipitated by the departure of a girlfriend. Treatment lasted seven months and a tentative diagnosis of schizophrenia was made. Some months later he was readmitted complaining of voices telling him to harm himself. Shortly after discharge he took an overdose of chlorpromazine. Two further compulsory admissions followed; he was noted to be depressed, threatening suicide, and behaving oddly.

From the date of this last admission he remained an in-patient in the local hospital, although occasionally allowed home leave, usually at weekends. He was noted to have florid schizophrenic symptoms, auditory hallucinations (voices telling him to cut himself), and passivity feelings (a force which made him break windows). He suffered bouts of depression with early morning waking and suicidal thoughts. His behaviour became increasingly disturbed, and he began breaking windows and mutilating himself with the broken glass, saying, "I can't get glass out of my mind". At times he heard "the devil's voice".

After a weekend of home leave he took a further overdose. He was referred to a special hospital because he was presenting such management difficulties. He was not accepted for admission on the grounds that he did not present a danger to others; it was suggested that he be placed in a regional secure unit (RSU). He was, therefore, assessed by a consultant from the local RSU, who commented that because the patient was suffering from a chronic psychotic illness he would not be suitable, because the unit placed emphasis on time-limited treatment. Short relief admissions, however, were offered when the new unit was due to open.

The patient's self-destructive behaviour escalated. For example, he jumped off a motorway bridge, and fractured both ankles and suffered a crushed lumbar vertebra. He bit, twisted and pulled at the middle two fingers of his right hand necessitating their eventual amputation. Finally, he set fire to himself, sustaining second-degree burns to his chest and legs.

He was again referred for admission to a special hospital. The consultant noted that the patient did not constitute a risk to others and, therefore, was not suitable for admission. Some months later J became increasingly aggressive towards nursing staff when they attempted to restrain him from breaking windows and hurting himself. He then stated that a voice was telling him to murder a particular female member of staff. He was once again referred for admission to a special hospital. He was accepted on the grounds that he now constituted a grave and immediate danger to others.

Thus, eight years after originally being referred to a special hospital because of unmanageable behaviour, J was finally accepted for admission at the third request. During that period he had continuously been an in-patient in the local hospital, which had gone to great lengths to contain his self-mutilating behaviour. He had been nursed in his own room and treated with massive doses of both major and minor tranquillisers, including depot neuroleptics. He had received a variety of antidepressants – tricyclic, tetracyclic and monoamine oxidase inhibitors. He had received ECT on many occasions, including fortnightly maintenance ECT for one year. Other failed treatments included lithium carbonate, modified narcosis, abreaction, relaxation training, and behavioural therapy. Physical investigations, which included brain scan, electroencephalography (EEG), skull X-ray, chest X-ray, thyroid function tests, liver function tests, full blood count, erythrocyte sedimentation rate (ESR), serology for syphilis, urea and electrolytes, porphyrins and blood glucose, were all normal. Psychological assessment noted an intelligence quotient of 81 (WAIS).

On admission to the special hospital, at the age of 31, J was taking the following medication: chlorpromazine (200 mg q.i.d.), haloperidol (30 mg q.i.d.), benperidol (0.25 mg q.i.d.), flupenthixol (100 mg i.m. weekly), orphenadrin (50 mg q.i.d.), and imipramine (25 mg q.i.d.). Physical examination was normal other than revealing residual scarring. An EEG, chest X-ray, full blood count, ESR, serology for syphilis and electrocardiography were within normal limits.

The patient was placed on the admission ward. Within ten days he began to break windows and cut himself with glass, in response to voices. He was transferred to the intensive-care ward. This ward has higher staffing levels and patients remain under observation 24 hours a day. Each patient has his own room. There is a small occupational therapy unit on the ward. While on the ward, J attempted to strike nursing staff and he spent long periods in seclusion. He attempted to smash glass (which was unbreakable) at every opportunity. He developed a large frontal haematoma from banging his head. He attempted to emasculate himself and enucleate his eye. Prompt nursing intervention prevented injuries other than a laceration to his scrotum and grazing to his eye.

Six months after admission his behaviour began to settle sufficiently to allow graduated periods out of seclusion. Throughout this period medication was altered and modified, eventually leading to its total withdrawal. After nine months on the intensive-care ward he was returned to the admission ward to complete his initial assessment. The patient was of dull–normal intelligence, anxious, and inhibited in his dealings with others. After some months he befriended a fellow patient, once more took up stamp collecting, and began to enjoy basket making in the workshops.

He was eventually discharged 21 months after admission. Throughout his stay there was no evidence of psychosis and the diagnosis of schizophrenia could not be sustained.

When visited at home six months after discharge he was living with his parents, showed no evidence of psychosis, remained free of medication, and was seeking a job through the Manpower Services Commission. He had bought a camera, continued with his stamp collecting, was occasionally going

out for a drink and had re-established contact with an earlier girlfriend who had been an in-patient at the local psychiatric hospital. Three months earlier he had picked up a kitchen knife and put it to his throat. He did not inflict any injuries on himself. Other than this one episode, when reviewed five years later he had remained stable. He attributed his well-being to his stay at the special hospital, because of the 'discipline' he encountered there.

Discussion

This case illustrates a number of points. Firstly, many psychiatrists are under the mistaken impression that difficult and unmanageable patients in local hospitals are suitable for admission to a special hospital. This case clearly demonstrates that such patients can be refused admission to a special hospital. The guidelines in the *Memorandum to the Mental Health Act 1983* (Department of Health and Social Security, 1983) state that admission to a special hospital is not generally considered suitable for patients who require close observation to prevent self-injury unless this is associated with a propensity to violence towards others. This explains why J was twice refused admission. However, admission was agreed when J became overtly aggressive and dangerous towards nursing staff.

Secondly, J could well be representative of a group of underprivileged patients referred to by Snowden (1985) as "Those who are not dangerous enough to require the maximum security provided for by the Special Hospital but whose illness, because of its chronicity, will be unsuitable for longterm care in RSUs". These patients, sometimes referred to as 'difficult-to-place patients', often represent the chronically mentally disordered but minimally dangerous. They are not readily accepted by general psychiatrists and their plight must lead to further innovation if they are not to be inappropriately admitted to RSUs, special hospitals, or prison (Scannell, 1989).

Thirdly, such patients often receive many diagnostic labels before finally being considered psychopathic or personality disordered, their lack of response to treatment being considered an indication for such labelling (Gunn & Robertson, 1976). In this case J, initially thought to be chronically mentally ill did, indeed, turn out to have a personality disorder.

It is well recognised that personality-disordered patients, particularly those with a borderline disorder, can present with psychotic and psychotic-like symptoms (Gunderson & Zanarini, 1987). This may have been the form in which J's illness manifested itself, perhaps precipitated by a psychogenic reaction to the loss of his girlfriend.

A further intriguing and easily overlooked possibility may have been the occurrence of so-called 'behavioural toxicity' (Fingl & Woodbury, 1975). 'Behavioural toxicity' was first coined to describe some undesirable side-effects of psychotropic drugs. Steiner *et al* (1979) described nine young borderline schizophrenic patients who developed full-blown psychotic reactions after the introduction of antipsychotic medication. There was an immediate dramatic relief of symptoms when the medication was stopped. No extrapyramidal side-effects were noted. They postulated that psychodynamic factors came into play: "The behavioural toxicity in such cases is a flight into psychotic, chaotic disorganisation and panic behaviour". Van Putten & Marder (1987) have suggested that behavioural toxicity generally refers to the extrapyramidal side-effects of antipsychotic drugs and in particular to akathisia. "At times akathisia can be associated with dramatic exacerbations of psychosis. . . ." Their explanation for this also formulated a psychodynamic mechanism: "An occurrence that probably depends on the meaning and significance that a psychotic mind attaches to the experience of akathisia". In a review of a number of such cases, Van Putten & Marder (1987) added, "It is reasonable to conclude that akathisia in the extreme case can drive people to suicide and to homicide".

Thus the introduction of antipsychotic medication may have caused an exacerbation of J's condition, leading to the further prescription of medication resulting in a vicious circle of worsening psychosis followed by ever-increasing doses of medication. This is another possible explanation for the improvement in J's mental state when all medication was withdrawn. One advantage of a secure facility with its high staff: patient ratio is the ability to withdraw medication and observe the consequences of this without the concerns which such action can lead to in an open ward.

Finally, with regard to treatment, Whiteley (1970) may have been referring to this type of patient when he suggested that "more authoritarian and directive regimes with less responsibility given to the subject, may have to be established before any maturation or social learning can proceed", and Craft *et al* (1964) commented upon the more favourable outcome of patients treated by "a firm, paternalistic and sympathetic approach". Thomson (1986) has referred to 'structure' in milieu therapy, commenting, "Patients and staff need to know the area in which they have freedom but also the points beyond which they may not transgress and the penalty for transgression must be known. If they are learning new ways, they must, like children, learn the boundaries." Perhaps J was right that 'discipline' had helped him change.

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Koro-Like Symptoms in a Man Infected with the Human Immunodeficiency Virus

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A 32-year-old man presented with koro-like symptoms in association with a depressive illness and HIV infection.
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The psychiatric syndrome koro is characterised by a conviction that the penis is shrinking; this is usually accompanied by intense anxiety and fear of impending death. In its classic form the phenomenon is culture specific to South-Asian Chinese people, to whom it is known as *suk-yeong* (Yap, 1965*a*). In non-Chinese subjects, koro usually occurs in the context of another psychiatric disorder, and the symptom typically resolves once the underlying illness has been treated (Berrios & Morley, 1984).

This report describes koro-like symptoms in a 32-year-old man, in association with a depressive illness and infection with the human immunodeficiency virus (HIV).

Case report

A 32-year-old man was being seen regularly in a clinic for sexually transmitted diseases (STD), following seroconversion with HIV four years previously. He remained physically asymptomatic and there was no evidence of lymphadenopathy, infections, or neurological complications. His white-cell count, including T-helper cell count, was normal, as was a cranial computerised tomography scan. In the past he had twice contracted syphilis and had several gonorrhoea infections, and he was seropositive for hepatitis B.

For the five years preceding his psychiatric admission he had experienced self-limiting episodes of low mood, and had been receiving supportive counselling from a psychologist attached to the STD clinic. He had no other psychiatric history before this admission, which was initiated by his counsellor when he became severely depressed. At the time of admission the patient gave a two-month history of disturbed sleep with early morning wakening, decreased appetite, diurnal mood variation, absence from work, and suicidal ideas.

Before admission he had a good employment record. He lived alone, but had many friends and enjoyed a full social life. Family relationships had been strained since he disclosed his homosexuality as a teenager. His father had died ten years earlier, before reconciliation could occur. Since the age of 16 he had multiple male sexual partners, but had never formed a lasting relationship. Following the disclosure of his HIV status he abstained from sexual activity for one year, partly as a response to feelings of anxiety and guilt, as well as fears that he might transmit the virus to others. He gradually resumed sexual activity, but at a reduced intensity, until the year before admission, when he became inactive again owing to diminished libido.

His pre-morbid personality was thought to show features of sensitivity to criticism and rejection, need for approval, extreme concern with his physical appearance and health, combined with a wariness of forming confiding relationships.