

multiple objects, displayed dangerous behaviour related to the delusion, and probably suffered from a personality disorder.

This would suggest that dangerousness (related in male homosexual erotomania, like male heterosexual erotomania, is associated with multiple delusional objects and unrelated dangerous behaviour. Whether these factors are predictive of similar behaviour in female erotomania remains to be seen. In the female homosexual erotomania case quoted (Urbach *et al*, 1992), there were several delusional objects (possibly up to five) and the individual engaged in both related and unrelated dangerous behaviour.

DOUST, J. W. L. & CHRISTIE, K. (1978) The pathology of love: some clinical variants of de Clerambault's syndrome. *Social Science and Medicine*, **12**, 99–106.

PETERSON, G. A. & DAVIS, D. L. (1985) A case of homosexual erotomania. *Journal of Clinical Psychiatry*, **46**, 448–449.

URBACH, J. R., KHALILY, C. & MITCHELL, P. P. (1992) Erotomania in an adolescent: clinical and theoretical considerations. *Journal of Adolescence*, **15**, 231–240.

ROBIN P. D. MENZIES

Regional Psychiatric Centre (Prairies)

P.O. Box 9243

Saskatoon

Canada S7K 3X5

#### Outdated ECT machines

SIR: Arnott & Wilkinson (*BJP*, April 1993, **162**, 572–573) found that mean seizure duration and the proportion of seizures lasting longer than 25 seconds increased when they upgraded their Ectron Duopulse Series 3 ECT (E3) machine to an Ectron Series 5 model (E5). They attributed the increase in successful seizures to the “higher electrical output” of the E5 machine. We encountered similar differences in patients treated in an ECT clinic equipped with a (modified) Series 2 Ectron Duopulse (E2) – an earlier version of the E3, identical in terms of stimulus parameters and power output – and one equipped with an E5. We could not confidently attribute the differences to the machine owing to a variety of unmatched variables, for example the clinics catered for different populations (over 65 and under 65 respectively).

Arnott & Wilkinson did not state whether their machine was the basic (unmodified, E3u) or modified (E3m) version, and at what setting on the respective machines patients were stimulated. An E3m may, at certain settings, deliver a greater total electrical charge than the E5. The maximum output of the E5 is 400 mQ at 200 ohms, compared to 350 mQ for an E2/E3m at the ‘ECT2’ setting over 6

seconds. The difference in power output between the E5 and E2/E3m (14%) is, therefore, not great, but they do differ markedly with respect to stimulus intensity. The E5 delivers its maximum power in 3.25 seconds, whereas the E2/E3 does so in 6 seconds. Thus it is only in terms of stimulus intensity that the E5 is ‘more powerful’ than the E2/E3m.

No-one knows which variable – total electrical charge (mQ), or stimulus intensity (mQ/s) – is more important (Special Committee on ECT, 1993). A useful, much needed and relatively easy audit research project would be to compare two groups of matched subjects allocated to receive treatment by means of an E5 machine (set at 300 mQ) or an E3m machine (set at ECT2; stimulus duration 5 seconds).

SPECIAL COMMITTEE ON ECT OF THE ROYAL COLLEGE OF PSYCHIATRISTS (1989) *The Practical Administration of ECT*. London: Royal College of Psychiatrists.

HAKHEEM KAZEEM

Windsor Day Hospital

Liverpool

#### Cognitive function and fall-related fractures

SIR: Jaborian *et al* (*BJP*, July 1994, **165**, 122) provide evidence of strong correlation between poor scores on a battery of tests and prior fall-related fractures in the elderly. They conclude that “low scoring in psychometric tests is a major risk factor for falls”.

Correlation is not causation, but a causal link may be the reverse of that suggested, with fat embolism from the fractures impairing cognitive performance.

J. D. WILSON

52 Jensen Road

Lincoln LN4 2QU

#### Creativity and psychopathology

SIR: Post's impressive survey of 291 famous men (*BJP*, July 1994, **165**, 22–34) supports a link between high levels of psychopathology and creativity, especially in artists and writers. The psychotic diagnosis for the painter Edvard Munch would further strengthen such a link.

Post lists three artists – Van Gogh, Modigliani and Rossetti – as suffering from a psychotic disorder, all of them organic in nature. My reading of the biographies of Munch is that he suffered from persecutory delusions and auditory hallucinations. Heller (1984) describes Munch's flight from Germany in a vain attempt to avoid his delusional

pursuers, and Stenersen (1972) describes how the artist used to assault complete strangers in response to the derogatory comments that he attributed to them.

The biographies are less clear about whether such symptoms can be totally attributed to Munch's undoubted misuse of alcohol, but whatever their cause the case of Edvard Munch helps to illustrate how great artistic achievement may result from both personal suffering and abnormal experience.

HELLER, R. (1984) *Munch: His Life and Work* (pp. 195–198). London: John Murray.

STENERSEN, R. (1972) *E. Munch: Close-up of a Genius* (p. 30). Oslo: Gyldendal Norsk Forlag.

PHILIP STOKES

*Yarmouth Regional Hospital*  
*Nova Scotia*  
*Canada*

#### Lack of care in Rwanda

SIR: Rene Stockman's description (*BJP*, August 1994, 165, 145–148) of psychiatric services in Rwanda is now tragically dated. I have recently returned from a mission to Rwanda on behalf of Physicians for Human Rights (UK). Many people will have seen the BBC report of our second visit to the hospital at Ndera near Kigali. We found only 22 surviving patients, most of whom appeared to be suffering from a recrudescence of psychotic symptoms. The last member of staff had left four days before our visit and the patients had received no medication for over a week.

Evidence of the ferocity of the attack on the hospital abounded. Grenade damage to floors and roofs was extensive and automatic fire had raked the building. Unburied human remains littered the ground to the rear of the hospital. Among the most shocking findings was the condition of three allegedly violent, psychotic patients who had been incarcerated by the refugees who had taken over most of the building. Confined to tiny cells, their chances of survival seemed slim.

The scale of psychological disturbance among the survivors of the recent genocide compounds the tragedy. We carried out a survey of psychiatric morbidity, in the towns of Rwamagana and Gahini in east central Rwanda. This area was chosen as being one of the most settled in the country. The massacres only occurred for two to three weeks before the RPF over-ran former government forces.

The instrument used was the 20-question neurotic subscale of the WHO Self Report Questionnaire (Hardinge *et al*, 1980). Preliminary scrutiny of the responses suggests a 'caseness' rate of over 90%.

We deliberately excluded the psychotic subscale, since the first question in particular ("Do you feel that people are trying to harm you?") seemed so wholly inappropriate to the circumstances. Indeed the scale of the disaster that has befallen Rwanda almost defies quantification.

It is to be hoped that in the rush to meet the immediate and pressing physical needs of the people of Rwanda, some 70% of whom are either refugees or internally displaced, their equally urgent psychological needs are not ignored. In particular, appropriate models for the treatment of severely traumatised children, and training in their application, will be needed if the cycle of violence which has beset this country for so long is to be broken.

HARDINGE, T. W., DE ARANGO, M. V., BALTAZAR, J., *et al* (1980) Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychological Medicine*, 10, 231–241.

ANDREW CARNEY

*Harperbury Hospital*  
*Harper Lane*  
*Radlett, Herts*

#### Cognitive therapy in panic disorder

SIR: The study by Clark *et al* (*BJP*, June 1994, 164, 759–769) poses problems concerning its claims for cognitive therapy in panic disorder.

1. The patients had relatively mild panic disorder. Apart from having no marked agoraphobia, they had only about 2.7 panics a week, compared to over four a week in larger multinational studies (Cross-National Study, 1992; Marks *et al*, 1993). The study gives no work or social disability measure.

The authors write of "the need for a psychological treatment for the less phobic panic disorder patients whose attacks were thought unlikely to be completely eliminated by situational exposure alone". Exposure is such a psychological treatment, and eliminated 96% of panics in severe panic/agoraphobia (see below). As it works best in less severe cases (Basoglu *et al*, 1994a), exposure would have been suitable for the 81% of Clark *et al*'s cases who had agoraphobic avoidance and for some of the remaining 19% who had situational panics.

2. The study's 'control' group was simply on a waiting list, which did not control for the non-specific factor of attendance and rating over 10 sessions – omission of such a placebo control is crucial. In the studies cited above placebo had a major anti-panic effect (but not an anti-phobia effect). Six months post-entry, although panic