the columns

correspondence

Merit in past practices

Sir: I read with great interest the elegant contribution of Henry Rollin on 'Psychiatry at 2000' (*Psychiatric Bulletin*, January 2000, **24**, 11–15).

He gives the impression that the decimation of the old mental hospitals was the direct result of Enoch Powell's policy of promoting community care, whereas the process had started in the 1950s by Joshua Carses 'Worthing Experiment', and had been enthusiastically espoused by many clinicians. The Victorian asylums had been built to house patients with serious disturbances, difficult to envisage in this neuroleptic age, and the appearance of effective antipsychotic medication made the sort of therapeutic milieu they offered both inappropriate and unnecessary. Enoch's vision has failed, not from lack of judgement, but from underfunding.

Dr Rollin writes of the enthusiasm for the physical treatments of the 1950s, which he thinks were illusory and regards his use of them 'with more shame than pride'. In taking this view, I think he does himself less than justice. I came into psychiatry in 1954, and although chlorpromazine was reported on, nobody believed that there could be a drug that controlled schizophrenia; it was much as if today it was claimed that there was a medicine that could cure mental impairment. The wards were full of violent, suicidal and deeply disturbed people. The majority were overwhelmed by hallucinatory experiences and their behaviour unpredictable, in spite of the gallons of paraldehyde that were dispensed. The relief afforded to 'involutional melancholics' by electroconvulsive therapy (ECT) was dramatic, and the treatment worked like magic on people suffering from catatonia. Although, the remission produced in schizophrenia by ECT usually lasted only a matter of months. However, it could last as long as a year, and permitted some patients to live outside hospital. But the real point is that uncontrolled schizophrenia causes its victim immense suffering, tormented as he or she is by false perceptions, and anything which could relieve the condition was not, in my view, illusory.

In the past all of us made mistakes, but it might be worth considering if some of the old discarded practices did not have some merit.

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Obtaining a part-time consultant post

Sir: Caswell & Lowe (*Psychiatric Bulletin*, February 2000, **24**, 64–65) discussed whether part-time training will lead to a part-time consultant post. They concluded that there is little current availability of such posts in their surveyed area which resulted in fully trained psychiatrists considering working in non-career grade posts. With such a recruitment problem in psychiatry this seems a great waste.

Part-time trainees wishing to work part-time as consultants need to take the matter into their own hands and publicise themselves to the trusts in which they would like to work. This strategy has recently worked successfully for me in gaining a part-time consultant post.

The high number of consultant vacancies in psychiatry means that those managing the services need to think imaginatively about using people trained to consultant level in a flexible way. But they need to know that they exist, so that jobs can be changed to suit the needs of the prospective candidate. Job-sharing is often proposed, but does not seem to be a good solution for unfilled consultant posts. There are many problems in job-sharing partnerships – both for the job-share partners and their employing trusts.

Part-time trainees in psychiatry are consistently shown in surveys to be highly motivated and qualified people who need urgently to be included in workforce planning.

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'Haltlose' type personality disorder (ICD–10 F60.8)

Sir: There is indeed no English equivalent word to describe 'haltlose' personalities (Cullivan, 1998). The word indicates a drifting, aimless and irresponsible lifestyle: a translation might be 'lacking a hold' (on life or onto the self).

This personality has, in English-speaking countries, been described as "the unstable psychopath" (Slater & Roth, 1979). Schneider (1992) used the descriptor "*Willenlose Psychopathen*", indicating the absence of intent or rather a 'lack of will'. People with chronic alcohol dependency have been said, not uncommonly, to have haltlose personality disorder.

Those with haltlose personality disorder have features of frontal lobe syndrome, sociopathic and histrionic personality traits.

(a) He or she lacks concentration and persistence and lives in the present only. His or her immediate affects, moods and interests rule completely; he or she has no interest in the future, and no hold in the past: in this sense he or she is quite at mercy of the environment. He or she is certainly easily persuaded, and is often led astray by the surrounding persons, sometimes criminals.

(b) He or she mixes well with sociopaths as he or she also has an inability to learn from experience, and no sincere sense of remorse for his or her actions.

(c) In common with the histrionic personality he or she has a number of endearing qualities: charming with an apparent emotional warmth, but also an enhanced suggestibility and a superficiality of affect. He or she is usually overoptimistic and pleasant to be with. This makes him or her quite a likeable character, the 'lovable rogue' which we sometimes see in our substance misuse clinic.

References

CULLIVAN, R. (1998) Definition of 'haltlose'. *Psychiatric Bulletin*, **22**, 58–59.

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