tion of such internalised anger in his essay *Mourning and Melancholia* (1925) fits this piece well. Walter, in the book of that name by David Cook (Penguin, 1980), is a boy with mental handicap. Shakespeare's plays contain characters with psychological or psychiatric issues: Macbeth's guilt, Lear's madness. Hamlet's introspection and perhaps depression are some better known examples. Further discussion of madness in the theatre can be found in Davis (1992).

A list such as this can be no more than idiosyncratic, but might provide an introduction to those wishing to explore the field of madness in literature. Other suggestions from readers would be welcomed.

DAVIS, D. R. (1992) *Scenes of Madness – A Psychiatrist at the Theatre*. London: Routledge.

FREUD, S. (1925) Mourning and melancholia. In *Collected Works*, Vol 14, pp. 239–258. London: Hogarth Press.

ROBERT M. COHEN

Gordon Hospital
Bloomburg Street
London SW1V 2RH

'Taking Liberties'

SIR: I am prompted to write this letter after watching the recent BBC2 documentary, *Taking Liberties* (7 May, 1992). The programme argued a case for death on psychiatric wards being associated with violent and difficult behaviour and poor quality of care. This association with death may be so, but at best the evidence is tenuous (Shah, 1992).

It was a pity that the programme did not concentrate on the more general issue of the established relationship between violent and difficult behaviour, attempted suicides and suicides on psychiatric wards, and staffing levels, agency nursing staff, staff attitudes, under-involvement of medical staff and overcrowding (James *et al*, 1990; Shah *et al*, 1991). Intervention at these levels offers opportunity for primary and secondary prevention, which may ultimately not only reduce behaviour disturbance but improve staff and patient morale and quality of care.

The programme appeared to portray that large Victorian hospitals are the mainstay of treatment. This is no longer the case with the closure of large hospitals and implementation of the community-care policies. However, it has been shown that levels of violence may be increasing in newer psychiatric units in district general hospitals (James *et al*, 1990). Thus, we should concentrate on all types of psychiatric units.

JAMES, D. V., FINEBERG, N. A., SHAH, A. K., *et al* (1990) An increase in violence on an acute psychiatric ward: a study of associated factors. *British Journal of Psychiatry*, **156**, 846–852.

SHAH, A. K. (1992) Violence, death and associated factors on a mental handicap ward. *Journal of Intellectual Deficiency Research* (in press).

—, JAMES, D. V. & FINEBERG, N. A. (1991) Violence among psychiatric in-patients. *Acta Psychiatrica Scandinavica*, **84**, 304–309.

AJIT SHAH

Section of Epidemiology and General Practice
Institute of Psychiatry
De Crespigny Park
Denmark Hill
London SE5 8AF

Neuroleptic-induced dislocation of the jaw

SIR: We wish to report a case of neuroleptic-induced orofacial dystonia complicated by dislocation of the jaw, to remind clinicians of this uncommon yet serious occurrence.

Case report. A previously well, unmarried, 21-year-old waiter, of Greek origin, was admitted to hospital with recent onset of bizarre behaviour, elevated mood and formal thought disorder. Over the following four weeks his psychosis was treated with haloperidol to a maximum dose of 30 mg daily and adjunctive use of clonazepam, initially at a dose of 2 mg b.d. Throughout this time he experienced intermittent orofacial dystonia, cogwheel rigidity and festinant gait which responded to benztropine, 2 mg per day. The anticholinergic medication was withdrawn over a period of two weeks and he was discharged on haloperidol, 7.5 mg at night.

He was readmitted a week later with recurrent symptoms associated with medication non-compliance and cannabis abuse. He received haloperidol, 20 mg in divided doses, and clonazepam, 2 mg during the initial 12 hours but became more agitated and disturbed and received haloperidol, 20 mg, and clonazepam, 2 mg, in the subsequent six-hour period. He developed an orofacial dystonic reaction 18 hours after reintroduction of haloperidol. Benztropine, 2 mg intramuscularly, was administered six-hourly without effect. He was noted to have facial asymmetry, difficulty swallowing, salivary drooling and was unable to close his mouth. A dislocated jaw was suspected clinically and an anterior dislocation of the right temporomandibular joint was confirmed radiologically. There was no evidence to suggest traumatic dislocation. Haloperidol was discontinued and his jaw was successfully relocated under sedation. This was followed by a diminution of his agitation without evidence of orofacial dystonia.

His psychosis gradually responded to thiothixene, a high potency antipsychotic agent from a different pharmacological class, without recurrence of dystonia. A diagnosis of schizophreniform disorder was reached and he was discharged to his family home five weeks later.

Dystonic reactions develop in up to 2.5% of patients treated with antipsychotic agents within 48 hours of their commencement (Rupniak, 1986). The majority are either self-limiting or resolve with anticholinergic drug administration and are not