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Carbamazepine and ECT

SIR: With the increasing use of carbamazepine in patients with psychiatric disorders, it is necessary to remember that this drug is also an effective anticonvulsant. Its use in patients undergoing electroconvulsive therapy may result in giving an anaesthetic (along with the risks that this involves) unnecessarily, since one may fail to induce a seizure. We have recently observed a patient who was being given both carbamazepine and ECT, in whom ECT failed to induce a fit on two separate occasions before the paradoxical combination of therapies was noticed. After stopping the carbamazepine the patient had a normal response to ECT.

Case report: The patient was a 45-year-old West Indian female with a 22-year history of recurrent episodes of depression. In 1985 she had a longer refractory period of depression, and was given ECT for the first time. She had a normal response with all nine administrations of 4 s bilateral ECT, and made a good recovery. In 1987 she again presented with depression, and over the ensuing 2 weeks became worse and also tended towards unpredictable violent outbursts. She was already taking amitryptiline and chlorpromazine, and at this point carbamazepine (200 mg t.d.s.) was added. Five days later she began a course of ECT, but on the first administration a bilaterally applied current for 4 s failed to produce a fit despite two attempts. Four days later, at the second administration, two consecutive bilateral applications of current for 5 s again failed to produce a fit. The carbamazepine was stopped, and after a further 7 days a third administration of ECT now produced a modified seizure. Three more successful ECT treatments were then administered over the next 2 weeks. The anaesthetic technique used for this patient was identical in 1985 and 1987. In order to rule out the possibility of a clinically unobserved fit having occurred due to excessive muscle relaxant, the patient was questioned 12 h after the second anaesthetic about events immediately prior to and following the episode. She had good recall of these events, showing no evidence of amnesia.

There has only been one previous report of ECT being given along with carbamazepine (Cantor, 1986), and in this case the ECT induced seizures as usual. However, on the strength of the aforementioned case we would suggest that clinicians are cautious in using this combination of therapies, since there is no evidence that it is efficacious in humans, and it may even be hazardous for the patient.

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Dressing Disorder

SIR: Going through psychopathology handbooks, we realise how little attention is paid to dressing disorder, or to the relationship between man and his clothes. Psychoanalytical texts have devoted more space, in relation to abnormal sexual behaviours such as transvestism. Nevertheless, one's own appearance, figure, and clothes are communications of psychopathological value, as Frankenburg & Yurgelun (1984) suggested when they put forward the existence of a 'dressing disorder' which, in spite of its frequency and seriousness, is not included in our current nosology. It consists of an imperious and irresistible necessity to buying clothes and ornaments in order to dress fashionably or to imitate the style of famous people, even though they might be expensive, uncomfortable or unsightly. Recently, we have attended two women showing similar behaviour.

Case reports: (i) ADL, aged 33, had previously suffered from three depressive episodes of moderate intensity, and she consulted about a similar one, which lasted several months, precipitated by a psychosocial stress. In contrast to the prevailing symptoms – sadness, anhedonia, little self-esteem, irritability, anorexia, and tiredness – throughout her depressive episodes she showed an imperious need to dress herself in a smart and expensive way, buying too many clothes and ornaments and trying to smarten herself up in an exaggerated way, quite unlike her usual tastes. This behaviour always disappeared once her depressive episodes were solved, and she returned to a casual and simple way of dressing.

(ii) BOG, aged 21, had suffered a serious post-traumatic stress disorder after being attacked with a knife by her boyfriend, her life being in danger. Later on, after she had partly recovered, a typically bulimic pattern (DSM–III) arose, which was put down to the beginning of a new and stressful job. This pattern, when she consulted us, was accompanied by an unavoidable need of going shopping and buying clothes and ornaments in great amounts (for instance, dozens of trousers or shirts), offering as a justification the desire to dress fashionably, to find herself slimmer and to diminish her anxiety and low self-esteem associated with

bulimia. Most of her savings were spent on unnecessary clothes, and the pattern only improved when the bulimic symptoms decreased after psychopharmacological and behavioural therapy.

These two patients show similar syndromes within different pathologies, similar to those described by Frankenburg & Yurgelun (1984). In their opinion, there is a specific 'dressing syndrome' which mostly affects women from their adolescence onwards, frequently overlapping with eating disorders and wasting excessive amounts of time, energy, and money in trying to be fashionably dressed, look thinner or anticipate a future loss of weight. Similar antecedents might be found in their mothers. The course of the disorder could be chronic or episodic, with relapses worsened by journeys, free time, etc. Its prevalence is unknown but presumably high. Logically, education in a consumer society would predispose to the disorder, puberty, new relationships or higher studies acting as precipitating factors. Features such as the lack of friends or confidants, as well as the need to please others, would make the problem chronic. According to Frankenburg & Yurgelun treatment is difficult, and it is no use trying to control the availability of money or credit cards which would only postpone the problem. Consequently, the prognosis is regarded as rather poor.

This type of disorder could be frequent but almost unnoticed, not only because of the lack of a nosological description, but also because it overlaps with other disorders, as happened with our patients. It would be interesting to develop studies to clarify the issue from the psychopathological and epidemiological point of view, as well as from the aetiopathogenic and therapeutic side. We also need to take into account the considerable amount of influence that women receive from the mass media, fashion industries, and aesthetic environments, in search of an ideal of femininity defined more by its aesthetic perfection than by the adaptation to one's own psychophysical identity. In people whose psychological structures are immature or who have inadequate defense mechanisms, these circumstances might lead to the appearance of compulsive behaviour and superficial and pathologically idealised relationships with the environment or with the opposite sex.

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A HUNDRED YEARS AGO

Medical Witnesses in Lunacy Trials

To the Editors of *The Lancet*

Sirs, Medical men are placed frequently in a difficult position when being examined as experts in lunacy cases. This is much increased by the difference in opinion which exists among judges as to what may be given by them in evidence, and allowed to be admissible. This was made most evident in two cases which occurred during last week. I was present on *subpoena* as witness in the Ramsgate shooting case tried at Maidstone before Mr Justice Mathew. In this case the question of ability to plead was primarily raised. The medical men examined were asked whether in their opinion he was of unsound mind. When being arraigned for his trial, and on their giving the answer in the affirmative, the jury so found. Immediately the case was over, I went down to Leeds to give evidence in another trial of a similar description. On my arrival, I found that Mr Justice Day had ruled exactly opposite to what I had heard Mr Justice Mathew rule at Maidstone. I give the shorthand writer's notes. Mr Waddy, counsel for the prisoner, asked Dr Clifford Allbutt, who was retained as well as myself in the case, "Was he, in your opinion, sane or insane when examined this morning?" To which Mr Justice Day remarked: "Experts are not to be asked questions which the jury are sworn to try. You may ask matters of fact as to what he saw or heard, but you must not ask him whether he is sane or not. I am not laying down this point with respect to this particular question of insanity, but I lay it down as a rule by which I shall always be guided in all cases when scientific or expert witnesses are called to give evidence." I think the time has come when medical men should know what they may say in cases where the pleas of insanity has been raised, and not, when they arrive on the scene, find they are prohibited from expressing their legitimate opinion for fear of interfering with the prerogative of the British jury, who are stated to be the proper persons to decide the vexed and complicated question, and not the medical expert. The importance of the subject is my excuse for troubling you with this communication.

I am, Sirs, faithfully yours,
L. FORBES WINSLOW, D.C.L. Oxon
Wimpole-street, W., Feb. 22nd, 1888

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The Lancet, 25 February 1888, 396.

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