to develop flexible arrangements for availability of nursing staff. This, with its attendant problems in terms of forming a cohesive staff group, is the only way to avoid the dangers of on the one hand generally excessive levels and on the other occasional dangerous inadequacies.

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Community Treatment Orders

A Discussion Document of the Royal College of Psychiatrists

DEAR SIRS

It would appear that after an excellent description of the need for a compulsory Treatment Order in the Community, this document under paragraph 6, Procedures to Follow if Patients continue to Refuse Treatment, in the end concludes that compulsory treatment can only be given voluntarily; thus the order, with the back-up threat of rehospitalisation, becomes no more than blackmail to comply. This, however, seems to be because of poor use of words "... most patients will then agree to treatment. However, some will not and it is not proposed that the patient should be actually given medication compulsorily outside the hospital setting ... in the case of refusal ... admission to hospital is appropriate".

The issue in this paragraph would have been clearer if, instead of "not agree", the document had used "resist". What it is clearly trying to avoid is the inculcation of the use of what used to be called "a show of force" in the community: hence the suggestion that the patient, under such circumstances, be returned to hospital, where, presumably, the treatment would be forced if necessary.

This paragraph should then make it clearer that the Compulsory Treatment Order in the Community advocated in the rest of the document does mean compulsion and should be insisted on to the point at which resistance could only be met by force: at this point alone would readmission to hospital be considered.

As luck would have it, in my experience the schizophrenics who most need the compulsory treatment to avoid self-defeating relapse in the community not only refuse it if they possess the power, even against their own good estate, but, once they know compulsion exists and can lead to sanctions, comply readily, even to the point of regular visits to hospital for their depot injections.

I hope, then, the College will make clearer its position by strengthening the wording of paragraph 6 along the lines I have suggested.

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Judge Schreber's nervous illness

DEAR SIRS

In 1986 Dr Stanley[1] re-examined Judge Schreber's nervous illness in the *Bulletin*. His study was based on the English translation[2] of Schreber's autobiography, undoubtedly the most famous ever published. This is partly due to Freud using it as a starting point for his theory of paranoid psychosis. In addition though, as Baumeyer[3] wrote, "...the excellent presentation of his psychosis, the admirable objectivity of the description, and the even artistic imagination of his delusion make (it) ...a classical book which after 50 years (A. B.: and even after 85 years) has lost nothing of its attraction".

Stanley[1] ends his article by stating that the translators "...tried to discover the eventual outcome (of Schreber's illness) but were only able to establish that Schreber died in 1911 (and that) there is no mention of a post-mortem examination which Schreber said would provide 'stringent proof' that he suffered from a physical disease of the nervous system".

To provide that proof without a post-mortem is what Stanley[1] tries to accomplish. By an analysis of Schreber's writings, and by interpreting it against the background of relevant literature, the author suggests Schreber might have suffered from temporal lobe epilepsy and damages to other parts of his brain caused by encephalitis lethargica.

Having published the first autobiography of an African psychotic patient under the subtitle *A Schreber Case from Cameroon*,[4] I had come across more recently published literature on Judge Schreber's case and I feel Stanley's interesting article requires a supplementation.

Macalpine & Hunter[2] mention briefly a first paper by Baumeyer[5] in which he reports on "a further psychotic breakdown in 1907 which lasted to his death in 1911" but they had not been able to verify it. In the year of MacAlpine & Hunter's publication Baumeyer[3] reported in a second, detailed paper how he found Schreber's original case notes of the Mental Hospital Leipzig-Dösen where Schreber was treated as an in-patient from 27 November 1907 until his death on 14 April 1911. The case notes reprinted in the paper include excerpts, some very extensive or even copies, of the case notes of 11 previous periods of Schreber's hospitalisation. Most relevant in the present context is the fact that the case notes also include, as Baumeyer[3] states, "...a very detailed post-mortem protocol" of which the summary (pathologisch-anatomische Diagnose) is reprinted as follows (translation into English of German terms by A. B.): 'Pleuritis exsudativa chronica. Pyothorax sinister. Atrophy of the left lung. Atelektasis of the left upper pulmonary lobe. Pericarditis fibrinosa acuta—Myode-generatio.—Sclerosis of the coronary arteries. Multiple haemorrhages into the pons cerebri".

Considering the high standard of brain pathology in the mental hospitals of that period it is justified to assume the post-mortem would have discovered any relics of brain disease if they had existed, especially signs of chronic, subacute, or previous encephalitis of any type.

Taking into account further that Dr Baumeyer, whom I

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knew well personally and professionally, was an experienced neuropsychiatrist besides being a psychoanalyst, he certainly would have reprinted also the post-mortem protocol *in toto* or in parts if there had been any indication of brain pathology further to the signs mentioned in the re-printed summary.

Baumeyer has written four articles on the subject. The first paper,[5] the one quoted briefly by Macalpine & Hunter,[2] seems to have been a preliminary note. The essential paper[3] referred to above was, probably abridged, translated into English.[6] The last one[7] gives additional information on Schreber's life provided by his adopted daughter still alive in 1970, emphasising Schreber's "unimpaired vitality" ("ungebrochene Vitalität") during the time from 1902 when he was discharged from hospital, until 1907 when he was readmitted for the last and final in-patient period. The two papers in German[3,7] are also included in the first[8] of two reprints[8,9] of Schreber's book. Both volumes list further publications, apparently all referring to psychoanalytical or sociological contexts, and none to a discussion of a possible organic cause of his psychosis.

By going carefully through the whole material available, I did not find "stringent proof" either of Stanley's[1] hypothesis or of Schreber's own assumption of a physical disease of the nervous system which consequently must still be considered as delusional and part of an endogenous psychosis.

I hope Dr Stanley and the readers of his fascinating paper will be interested in the additional information presented. It is a pity that studies like Dr Stanley's have become rare. Nowadays, work of this type seems to require the leisure of retirement, enjoyed also by the writer of this letter.

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DEAR SIRS

I am grateful to Dr Boroffka for his comments and the news that there was in fact a post-mortem examination. The multiple haemorrhagic lesions in the pons are an interesting finding. Were there any histological reports on the CNS?

Schreber certainly had many hypochondriacal delusions; for example at one time he believed that Professor Flechsig's soul was within his abdomen—"a fairly bulky ball or bundle, which I can best compare with a corresponding volume of wadding or cobweb".[1] (He finally let it escape through his mouth). I am, however, confident that many of his somatic symptoms were due to physical disease of the nervous system, as he claimed in his Memoirs. He gave delusional 'explanations' for these symptoms, usually attributing them to the action of rays, or to miracles.

Dr Boroffka mentions the testimony of Schreber's adopted daughter that he was in good health in the interval between the two illnesses. Freud[2] quotes Schreber's own account: "After the recovery from my first illness I spent eight years with my wife; years, on the whole, of great happiness, rich in outward honours, and only clouded from time to time by the oft-repeated disappointment of our hope that we might be blessed with children."

Freud expressed some doubt about his theory that this catastrophic illness was due to 'an upsurge of unconscious homosexuality' when he wrote: "It remains for the future to decide whether there is more delusion in my theory than I should like to admit, or whether there is more truth in Schreber's delusion than other people are as yet prepared to believe".

Encephalitis lethargica would explain all his somatic symptoms (some very unusual, and in combination virtually unique to this disease), and it could certainly account for the severe psychosis. Long periods of remission were a recognised feature.

In the College discussion which followed a paper on encephalitis lethargica by Goodall[3] Sir Hubert Bond said: "It must be patent to all present that Dr Goodall is dealing in his paper with a malady which accounted, in its end products, for at least 50% of mental hospital patients."

Judge Schreber died six years before the disease appeared in *epidemic* form in 1917. One wonders whether his claim that he suffered from a physical disease of the nervous system[1] would have been so readily dismissed if he had developed his illness during an epidemic.

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