LIBET, B. (1993) The neural time factor in conscious and unconscious events. In *Experimental and theoretical studies of consciousness*. (Ciba Foundation Symposium 174), 123–146. Chichester: Wiley.

S. SPENCE

MRC Cyclotron Unit
Hammersmith Hospital
London W12 0HS

SIR: Prins' article was well argued and enlightening. Throughout he did rather limit his discussion by focusing upon those rare and baffling cases which seem to defy rational explanation. This has the effect of making evil, or rather evil acts, seem to require a supernatural explanation. Of some relevance here are two studies from the psychology literature which displayed how easily evil acts could be evoked from ordinary people using straightforward, albeit ingenious, experimental preparations.

Most of Milgram's (1974) subjects were easily persuaded to give near-fatal electric shocks (as they believed) to another person. Although the subjects were not happy about this they nonetheless proceeded to administer the shocks despite the screams and shouts of the 'victim'.

In Zimbardo's simulation of a prison environment the investigators were at pains to use normal healthy volunteers (Haney *et al*, 1973). The experiment had to be halted after six days as the people assigned the role of prison warders had become bullying, cruel and coercive. In this case the 'warders' appeared to be enjoying their opportunity to exercise power over a group who they knew to be wholly innocent. These two somewhat neglected studies illustrate starkly the propensity for evil behaviour from the man or woman in the street given the appropriate circumstances. Since the way in which we construe evil is as suitable a topic for psychological, and indeed psychiatric, enquiry as is the nature of evil itself, I believe they are useful reminders that evil acts are not just something that other people in deviant groups do.

HANEY, C., BANKS, C. & ZIMBARDO, P. G. (1973) Interpersonal dynamics in a simulated prison. *International Journal of Criminology & Penology*, **1**, 69–97.

MILGRAM, S. (1974) *Obedience to Authority*. New York: Harper & Row.

P. WHITBY

St Woolos Hospital
Newport
Gwent NP9 4SZ

AUTHOR'S REPLY: I do not find myself in fundamental disagreement with any of the correspondents, but perhaps a few observations will help to promote further thought and debate.

My former colleague Allen Bartholomew takes me to task for not referring to personality disorder (and in particular to psychopathy). In fact, on p. 299 of my editorial, I do make passing reference to these conditions in connection with the ambivalence of mental health professionals to work with this group of individuals. Bartholomew's comments on the legal position of psychopathic disorder in the State of Victoria are timely in view of the Reed Committee's recent report on the subject in the UK (Dept. of Health and Home Office, 1994).

This theme is developed further by Childs in his Scottish contribution. In this, he suggests a wider remit for psychiatrists in the courts, notably in relation to matters of mental illness. However, I am not sure to what extent mental health professionals 'South of the Border' would wish to espouse the adoption of the flexibility of the Scottish Childrens' Hearing System in relation to adult cases. Despite this, it has always seemed to me that, as he says, 'Scottish common sense and moderation' in their legal system have much to commend them. (It is worth noting that some of our own innovations have been based upon their sensible practices – for example, our adoption of the notion of Diminished Responsibility in our 1957 Homicide Act.)

Cooklin emphasises the manner in which the Bulger case has tended to demonise children and has placed an undue and unhelpful emphasis upon juvenile misdemeanours, raising the emotional temperature in our discussion of them. She suggests that we underestimate the *immaturity* of children (currently the tendency is to do the reverse) most notably in determining their age for criminal responsibility.

Spence thoughtfully suggests that the harder face of neuroscience may make a substantial contribution to psychiatry's concerns with responsibility. However, a recent contribution by Buchanan (1994) would suggest caution in espousing uncritically too strong a claim in this area. Finally, Paul Whitby reminds us not to rely too heavily upon notorious *causes célèbres* and to make too many extrapolations from them. More importantly perhaps, he alerts us to the capacity of 'ordinary' men and women to perpetrate evil (violent) acts. I address this important phenomenon in some detail in Chapter 7 of the revised edition of *Offenders, Deviants or Patients* (to be published by Routledge in Spring, 1995). All the correspondents indicate the need for a wide-ranging inter-disciplinary debate of this important topic. Perhaps the College should

https://doi.org/10.1017/S0007125000143442 Published online by Cambridge University Press

facilitate a more in-depth discussion than the modest contributions of Geoffrey Jones and myself have permitted.

BUCHANAN, A. (1994) Brain, mind and behaviour revisited. *The Journal of Forensic Psychiatry*, **5**, 232–236.

DEPARTMENT OF HEALTH AND HOME OFFICE (1994) *Report of the Department of Health and Home Office Working Group on Psychopathic Disorder*. London.

H. PRINS

1 Home Close Road
Houghton on the Hill
Leicester LE7 9GT

OGS or tardive dystonia?

SIR: Tan *et al* (*BJP*, September 1994, **165**, 381–383) suggest that the delayed onset oculogyric spasm (OGS) observed in their study may be a form of tardive dystonia although there was no associated tardive dyskinesia. This appears unconvincing.

Burke & Kang (1988) note that the dystonic movements of acute and tardive dystonia are 'indistinguishable, with the exception that oculogyric crisis occurs in acute dystonia but not tardive dystonia'. Very few cases of OGS which may be regarded as a form of tardive dystonia have indeed been reported (Fitzgerald & Jankovic, 1989); in these, having developed after prolonged exposure to neuroleptics, and associated with other tardive movement disorders, the chronic and disabling OGS did not respond readily to anticholinergic agents, and persisted for months to years after neuroleptics were stopped.

Another rare form of delayed onset OGS has been described (Sachdev & Tang, 1992; Thornton & McKenna, 1994). The abrupt appearance of OGS along with other dystonic movements was accompanied by psychotic symptoms, catatonic phenomena and autonomic disturbances, reminiscent of post-encephalitic crises. This 'complex' acute dystonic reaction responded to intravenous procyclidine, but an oral anticholinergic agent was ineffective; and recurrences tended to persist for months after the termination of neuroleptic or switching to clozapine.

The OGS attacks observed in Tan *et al*'s study were of acute onset, and in all 34 cases promptly reversible with the use of oral benzhexol or intramuscular promethazine. There was no associated tardive dyskinesia. They showed no features suggestive of a form of tardive dystonia or the complex variant of acute dystonic reaction. They were no different from the usual form of acute dystonic reaction, apart from their late occurrence; all the 34 patients had received neuroleptics for more than five months.

Although acute dystonic reactions usually occur soon after a neuroleptic is started, they may develop in the course of therapy following sudden increases in dosage (Lees, 1985). Some patients who are receiving depot neuroleptics have recurrent acute dystonia a few hours after each injection. It is noted that eight of the 16 patients with recurrent OGS in Tan *et al*'s study were on fluphenazine decanoate, a depot neuroleptic prone to induce acute dystonia. Other possible causes include the use of neuroleptic as required (p.r.n.) on top of maintenance medication for mental deterioration or disturbing behaviour; and poor drug compliance – the patient restarting treatment after a period of self-prescribed abstinence.

The delayed onset of OGS Tan *et al* observed may well be related to these 'simple' causes, which were not excluded in their study.

BURKE, R. E. & KANG, U. J. (1988) Tardive dystonia: clinical aspects and treatment. In *Facial Dyskinesia. Advances in Neurology*, Vol. 49 (eds J. Jankovic & E. Tolosa), pp. 199–210. New York: Raven Press.

FITZGERALD, P. M. & JANKOVIC, J. (1989) Tardive oculogyric crises. *Neurology*, **39**, 1434–1437.

LEES, A. J. (1985) The drug-induced dyskinesias. In *Tics and Related Disorders*. pp. 172–234. Edinburgh: Churchill Livingstone.

SACHDEV, P. & TANG, W. M. (1992) Psychotic symptoms preceding ocular deviation in a patient with tardive oculogyric crises. *Australian and New Zealand Journal of Psychiatry*, **26**, 666–670.

THORNTON, A. & MCKENNA, P. J. (1994) Acute dystonic reactions complicated by psychotic phenomena. *British Journal of Psychiatry*, **164**, 115–118.

W. Y. LEE

Tokanui Hospital
Private Bag, Te Awamutu
New Zealand

Huntington's disease in the Oxford region

SIR: Shiwach (*BJP*, September 1994, **165**, 414–415 (letter)) criticises the estimate of the prevalence of Huntington's chorea in the Oxford Health Region given by Watt & Seller (1993) on the grounds that it did not include patients recorded by the Oxford Record Linkage Study, but not referred to the Oxford Department of Medical Genetics; and it used for the population of the Oxford Health Region a prevalence in 2.52 million instead of the figure of 2.437 million used by Shiwach.

Patients recorded by the Oxford Record Linkage Study must have been diagnosed as Huntington's chorea and hospitalised in an Oxford regional hospital. Patients in a regional hospital sometimes

https://doi.org/10.1017/S0007125000143442 Published online by Cambridge University Press