

she did not have any neurological deficit. Investigations including EEG and CT scan of the head did not reveal any abnormality.

Some believe that impaired visual acuity and a disorder of brain function are both required for CBS to develop but it is also known to develop in individuals with normal vision (Podoll *et al*, 1989). There is no consensus on whether pathology in the visual system is necessary, possible or incompatible with the diagnosis of CBS (Hecaen & Albert, 1975).

In this patient, complex, isolated, persistent and recurrent visual hallucinations were hypnogogic in nature. Lesions of diencephalon and also diffuse lesions of cortex can produce hypnogogic hallucinations which are predominantly or solely visual, and the aetiology of CBS may lie in structural or functional abnormalities of this region.

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PODOLL, K., OSTERHEIDER, M. & NOTH, J. (1989) Das Charles-Bonnet-Syndrom. *Fortschritte Der Neurologie-Psychiatrie*, **57**, 43–60.

TEUNISSE, R. J., CRUYSSBERG, J. R. M., VERBEEK, A., *et al* (1995) The Charles Bonnet Syndrome: A large prospective study in the Netherlands. *British Journal of Psychiatry*, **166**, 254–257.

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SIR: We commend Teunisse *et al* (*BJP*, February 1995, **166**, 254–257) for the first ever major case finding study using fixed criteria and a control group. However the authors' assertion that in other prevalence studies on complex visual hallucinations in visually impaired patients, the concept of Charles Bonnet syndrome (CBS) was not used is somewhat unjustified.

There is considerable confusion with the use of the term CBS by both psychiatrists and ophthalmologists. Originally defined as visual hallucinations in elderly patients without evidence of ophthalmological impairment, the term has been modified over the years to include visual hallucinatory phenomena of a pleasant or neutral nature in conjunction with a clear state of consciousness (Damas-Mora *et al*, 1982). Within this modification is the fact that it is often associated with ocular disease. There seems to be no consensus however, about the relationship between eye pathology, brain lesions and CBS. At least two definitions exist (Damas-Mora *et al*, 1982; Gold & Rabins, 1989). The authors criteria in the study are almost identical to the criteria proposed by Gold & Rabins.

Two recent prevalence studies not mentioned by the authors are worthy of mention. Norton-Willson & Munir (1987), in a retrospective study of 434 consecutive patients referred for consultation to a psychogeriatric unit over a period of 3.5 years, reported eight cases of visual perceptual disorders resembling CBS. Brown & Murphy (1992) studied 100 consecutive patients with macular choroidal neo-vascularisation in a cross-sectional fashion and reported 12 subjects with formed hallucinations (Charles Bonnet syndrome). These authors have not defined or used any criteria for CBS preferring instead to use the term visual perceptual disorders or formed visual hallucinations.

We suggest that if systematic research into this interesting phenomenon should meaningfully progress, some consensus on the criteria for CBS should be arrived at, or else we risk having to give up the use of this eponym which has so far stood the test of time.

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The cultural context of hallucinations

SIR: Al-Issa (1995) is right to emphasise the importance of the cultural context of hallucinations. But his discussion of the origins of hallucinations in terms of cultural attitudes appears incomplete.

Al-Issa distinguishes "rational" cultures, which make a rigid distinction between reality and fantasy, from the "less rational" cultures which have a more flexible distinction. In his view, a rigid distinction promotes negative attitudes towards hallucinations and makes people less introspective, less familiar with the workings of their own imagination, and so less aware of imaginings such as hallucinations.

Al-Issa then suggests that the unfamiliarity with one's inner world that is, in his view, promoted by rational cultures, may increase the experience of unintended imagery. He follows other authors in suggesting that this may result in the development of hallucinations. He therefore appears to be suggesting that unfamiliarity with one's own imagination can both *increase* hallucinations (via unintended imagery) and *decrease* hallucinations (through lack of awareness).

A central difficulty in Al-Issa's thought-provoking essay is his failure to distinguish between hallucinations of different origin that occur, even within one culture. (Many "less rational" cultures themselves distinguish culturally sanctioned hallucinations as different from those arising from mental illness). Flexible boundaries between reality and fantasy may, as Al-Issa suggests, facilitate culturally sanctioned hallucinations. These are regarded in a positive light by both the subject and his society. In contrast, lack of familiarity with one's own imagery has been associated almost entirely with the hallucinations of patients with schizophrenia and depression (Heilbrun, 1980; Heilbrun *et al.*, 1983). Similarly, unintended verbal imagery has been postulated as underlying the development of schizophrenic hallucinations (Hoffman, 1986). These hallucinations are often regarded in a negative light by both the subject and society, even in many "less rational" cultures.

The cultural context of an hallucination can be of great importance to the hallucinator. But this does not mean that the cultural context is relevant to the development of all hallucinations.

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- HEILBRUN, A. B. (1980) Impaired recognition of self-expressed thought in patients with auditory hallucinations. *Journal of Abnormal Psychology*, **89**, 728–736.
- , BLUM, N. & HAAS, M. (1983) Cognitive vulnerability to auditory hallucination. *British Journal of Psychiatry*, **143**, 294–299.
- HOFFMAN, R. E. (1986) Verbal hallucinations and language production processes in schizophrenia. *The Behavioural and Brain Sciences*, **9**, 503–548.

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Mental health tribunals

SIR: We would like to respond to the editorial by Wood (1995).

The Mental Health Act 1983 (Department of Health, 1983) is in need of review. Tribunals are dissatisfied with their limited powers (Roberts,

1991), RMOs find the procedure untherapeutic (Wessely & Blumenthal, 1994), and the current methods of ensuring patients' civil liberties are unsatisfactory (Webster & Dean, 1989; Bradley *et al.*, 1995). There is still considerable criticism of the changes brought about by the 1983 Act. Peay (1989) concludes that tribunals invariably endorse recommendations of the RMO, and that changes are only a procedural safeguard. Wood (1995) suggests that Section 2 orders be lengthened if patients are known to have suffered previous breakdowns, to reduce the pressure on already hard pressed tribunal offices and RMOs; that tribunals help the Home Secretary to collate a series of reports on restricted patients to participate further in the decision making process as to their discharge; and finally, that tribunals have a broader range of options than simply to discharge or not.

Lengthening Section 2 orders without strengthening the rights of patients to a tribunal, for instance with an automatic review of the circumstances of their detention, would augment current concerns that patients are being detained without satisfactory protection of their civil liberties. Wood (1993) has previously proposed an alternative procedure of "emergency review" by the Medical Member of the tribunal only, but this is unlikely to satisfy the conditions of the European Court of Human Rights which requires that detained patients should have right of access to a body which is both judicial and has the characteristics of a court.

The role of the managers' hearing appears to duplicate the role of the mental health tribunal. Hearings tend to be less formal, are conducted by managers who are "lay people", and discharges are less likely. Rather than shadowing the mental health review tribunals managers could, with appropriate selection, training and remuneration, develop their role to perform this initial automatic review which Wood proposes. They would presumably be less likely to discharge patients given the acuteness of patients' symptoms, however, their additional role would come closer to satisfying the first part of the objectives of the Mental Health Act legislation: "to safeguard against improper detention and protracted detention". This would give all patients detained under an assessment order the right for early and automatic review of their detention, without clogging up the tribunal system, nor necessarily requiring detailed written reports from RMOs which are difficult to produce in the short time currently permitted for Section 2 tribunals.

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