the columns

correspondence

Recovery as a medical myth

Sir: I would like to comment on the responses to my paper (*Psychiatric Bulletin*, October 1999, **23**, 621–622). Prior (*Psychiatric Bulletin*, January 2000, **24**, 30) states that I was using a medical concept of recovery; I agree. However, I did not define recovery, and it was the patients who thought that they had not recovered. I think that this concept of recovery is part of a medical model in which people suffer from clearly defined episodes of illness, from which they can hope to make an equally clearly defined recovery, provided they get the right treatment.

Psychiatry has tended to operate with these oversimplified concepts. My conclusion is that recovery from mental illness is part of a medical view of things, and as such is largely a myth. It is an unexamined idea that people believe, but which does not reflect reality. It also seems that this unhelpful myth is shared by our patients. One reason for the hold that this myth has is that it fits quite well with the situations that we face in acute psychiatry. It justifies interventions that may be urgent and difficult. It is in the longer term that the model fails.

Hope and optimism are essential in mental health services, as Sayce and Perkins comment (*Psychiatric Bulletin*, February 2000, **23**, 74). That is why the medical concept of recovery – by which so many are likely to be disappointed – is an unhelpful myth. They mention a different process of recovery – which is slow, and very personal: a rebuilding of a life, which may take a life time.

We are only now beginning to understand this process and how to help people with it. It is an exciting and growing field. What is clear is that medical treatments by themselves do not achieve this. Too often in the past the traditional medical focus on diagnosis, medication and coercion have been seen by service users as standing in the way of personal recovery. There is a problem concerning words here. Recovery is a very positive and uplifting word. It has been linked into a limited medical model where it does not fit. 'Personal recovery' may be a better term as it stresses the individual, and gets away from the idea that this is something that we can do to people.

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Managers' hearings: dialectic and maternalism

Sir: In his editorial, 'Managers' hearings: dialectic and maternalism' (*Psychiatric Bulletin*, October 2000, **24**, 361–362), Kennedy appears to equate maternalism with a strategy of weakly avoiding confrontation.

I feel obliged to challenge this stereotype, not on behalf of strong authoritarian female parents, who are more than able to come to their own defence, but on behalf of Milne's quoted maternal archetype (Milne, 1928), Kanga, who cannot.

In order to deal with Tigger, "a young person of impulsive and energetic temperament who does not know what he wants but has strong opinions about his dislikes", Kanga does not, as is suggested by Kennedy, avoid confrontation. Rather, Milne's maternal archetype encourages her charge to explore the therapeutic possibilities of her food cupboard. In the context of a long-term relationship, Tigger has a role in planning his own breakfast. Kanga asserts her own view by insisting that when she "thought he wanted strengthening, he had a spoonful or two of Roosbreakfast after meals as medicine".

Kanga does not, like Kennedy's avoidant maternalistic psychiatrist, conceal the fact that she has her own opinions as to what is best for Tiggers.

In using the terms paternalism and maternalism Kennedy is confounding the real issue. Both stereotypical 'authoritarian psychiatry' and stereotypical 'avoidant psychiatry' are unhelpful attempts to sidestep the reality that, mentally ill or not, our patients have minds of their own. It cannot be left up to psychiatrists to decide in which contexts our opinions should prevail.

MILNE, A. A. (1928) *The House at Pooh Corner*. London: Methuen.

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Use of the cuff method in electroconvulsive therapy – a response

Sir: The study by Jan Wise *et al* (*Psychiatric Bulletin*, August 2000, **24**, 301) is interesting. The authors have found no significant difference in seizure duration between the cuffed and uncuffed limbs and suggest that the use of the cuff method to 'observe' absent seizure cease, as it merely delays addressing the real cause of 'absent' seizures. The following issues also need to be considered in this respect:

(a) A tonic–clonic seizure that is not witnessed may be owing to inattention, absence of seizure activity or excessive muscle relaxation (Fink, 1983). Electroencephalogram (EEG) monitoring is helpful in detecting the occurrence of a cerebral seizure, while the 'cuff' method is useful where excessive muscle relaxation may obscure an overt motor seizure. Thus, the two seizure monitoring methods address different (although related) aspects of the electroconvulsive therapy (ECT) session.

(b) The absence of any significant difference between the cuffed and the uncuffed limbs is perhaps more indicative of the absence of excessive muscle relaxation (so as to obscure a visible seizure) during ECT rather than the 'ineffectiveness' of the cuff method itself – as is suggested by the authors.

(c) The cuff method does not necessarily delay addressing the real cause of 'absent' seizures because it oft-times helps to rule out excessive relaxation as a cause for an apparently absent seizure.

Therefore, both EEG and the cuff method have a role in monitoring seizures in ECT sessions, especially so because there are no recommended dosages of succinylcholine for purpose of administering ECT.

Perhaps, an assessment of the difference in seizure intensity across limbs and the mean dosage of relaxant used would have been informative regarding the degree of modification achieved during ECT.

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