Perception of psychiatry by the media and by patients

DEAR SIRS

I read with interest Dr Peter Haddad's article in the *Bulletin* (Haddad, 1991) about the portrayal of psychiatrists in films, and I would like to comment on his conclusions, because I think they have an important bearing on the education of psychiatrists.

Dr Haddad gives some vivid sketches of the terrifying figures depicted as evil psychiatrists, and points out the power that such images can have in the minds of anyone – especially, of course, mentally disturbed people, whose perception of the psychiatrist facing them may be greatly influenced. "However, the fact remains that Dr Evil is a gross misrepresentation of the average psychiatrist", he adds.

He goes on to express regret that "this stereotype may prejudice public opinion", and might make patients "more likely to incorporate psychiatric staff into their persecutory delusions; the negative effects on treatment are obvious."

It seems to me that these remarks reflect an idea about the psychotic individual which, put simply, is that he or she has irrational beliefs about the psychiatrist (and/or the nursing staff) and has to be shown that they are false. "You are wrong about me," a psychiatrist might say. "I intend you no harm, and your suspicions are a proof that you are out of touch with reality. But take these drugs which I offer you, and you will come to perceive me and others as we really are – not at all the sinister figures you accuse us of being".

I know very well, from many years work in psychiatry, that such an idea would frequently be the basis of a response to a psychotic patient. But would not today's registrars be encouraged to consider other possibilities? In particular, far from regretting as negative the possibility that a patient might "incorporate psychiatric staff into their persecutory delusions", might this not form the basis for an attempt to understand the meaning of the patient's delusions, accepting the relationship he/she imposes as a means to doing so? I don't of course mean pretending to agree with the patient – (something I have seen attempted in desperation) but being prepared to treat what the patient says as meaningful, and even perhaps, in some way, true.

Perhaps this is asking a lot; it means spending much more time with psychotic patients, and it involves the psychiatrist (or nurse) in very stressful situations. I might well have dismissed the idea of writing this letter had it not been for rather an odd coincidence. In the same issue of the *Bulletin*, Pourgourides & Oyebode (1991) write about the psychopathology of the double, as presented in a novel, whose central character is a man named Suguro. He is accused of very serious misdeeds, which he sincerely denies, attributing them to an elusive shadowy double who "is everything that (the real) Suguro is not, and the achievements of a lifetime are threatened by the reports of unacceptable behaviour ascribed to this 'double'." Needless to say, his 'double' represents the disowned parts of himself which he must come to accept, enduring a great deal of pain in the process.

It is interesting to put those two communications together. Is *any* psychiatrist (let alone "an average' one) completely devoid of the enjoyment of power? In our profession, power over people's minds and bodies is available, and has sometimes been dreadfully abused. If we never provide opportunities for trainees to experience themselves as the embodiment of imagined persecutors, there can be at least two regrettable consequences. The first is that the patient may never discover who "really were" the accuser and accused, and have to accept that he was simply mistaken – or wrong – or mad; hoping that the drugs he is given will seal off a part of his mind. The second is that the psychiatrist may never recognise his double in the patient's delusions.

To make another parallel, it is as though the problem raised for psychiatrists by representations of "Dr Evil" could be solved by suppressing the films and videos etc. I am suggesting rather that we make them the object of serious study, whether on a screen or in the consulting room.

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DEAR SIRS

It was with interest that we read Dr Haddad's article on the media's perception of psychiatry and psychiatrists (*Psychiatric Bulletin*, 1991, **15**, 652–653). It would appear that the stigma surrounding mental health problems is still a potent force despite the increasing emphasis on community care.

In this connection we have looked at psychiatric out-patient attendances at a local district general hospital (DGH) and a nearby psychiatric hospital in Swansea. We identified all new referrals, from 1 February to 31 August 1991, made to four consultants in adult psychiatry who hold clinics at both the local DGH and their base at Cefn Coed Hospital (CCH). We had compared the rates of non-attendance for new cases at these clinics and in doing so have assumed that there should be no difference.

Of 194 cases due to be seen at the DGH, 63 (32%) did not attend; of 279 cases due to be seen at CCH,

132 (47%) did not attend. This was a highly significant difference ($P < 0.01$) and suggests that there is a great deal of reluctance for people to become associated with psychiatric hospitals.

The drive towards community-based care in the form of community health teams we would hope to be an important factor in eliminating this stigma by making the services more accessible and less intimidating for the people who may require their help.

In addition, patient access to medical records may have an important part to play in de-stigmatising psychiatry. Psychiatrists could take this opportunity to improve doctor/patient communication and show that psychiatry is not the secretive and sinister profession it is often portrayed to be.

T. N. Evans
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Observation of the suicidal in-patient

Dear Sirs

There is substantial psychiatric literature concerning the assessment of suicidal risk. There is little empirical assessment of observation of the suicidal in-patient. It has been suggested that a code of practice might be formulated (Morgan, 1988). We felt it might be helpful to construct a picture of day-to-day clinical practice on a nation-wide basis.

A postal questionnaire concerning this subject received a disappointing response rate (55%) which precludes meaningful statistical analysis. We feel, however, that the findings merit some discussion. The vast majority of units who responded had a written policy concerning observation. Two-thirds utilised constant surveillance of the patient. In the majority of units the level of observation was a multidisciplinary decision. In four, nursing staff alone made this decision.

A clear majority of respondents felt that a controlled trial of observation would be unethical. We would suggest that this probably reflects a high degree of confidence in this regime.

Our experience is that patients find this practice intrusive and often resent it. Conversely, relatives appear grateful for it. We do wonder, however, given the loss of privacy involved, whether there is a case for its being included as a treatment requiring informed consent or a second opinion from a psychiatrist approved under Part IV of the Mental Health Act 1983.

The final issue concerns the prison system. Despite calls for prison reform, there have so far been no moves to implement this regime for the suicidal patient within the prison system. The obvious difficulty here is the resource implications for overstretched prison hospitals. Given that the option is a form of seclusion ("unfurnished accomodation") we would suggest that this issue should be urgently addressed.

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Air freshener perfumes

Dear Sirs

Over the last 12 years, I have collected 51 cases who appear to be adversely affected by the presence of so-called 'fresh' perfumes in their environment. They present with symptoms of tiredness, nausea, headache and mild derealisation. A minor subgroup suffer irritation of the nose, chest or eyes and three of the cases were severely disturbed emotionally, with tearfulness and inability to cope. One young man was contemplating suicide. Signs of fine tremor, intention tremor, nystagmus and an unsteady Rombergs test were present in most (Lawson, 1985). In all cases, symptoms resolved completely when they cleared sources of 'fresh' odourants from their environment. None of the cases went on to develop anxiety or depression needing treatment in its own right.

'Fresh' perfumes, like traditional perfumes, are a mixture of many different odourants, but a greater proportion of the constituents are synthetic in the case of the 'fresh' variety. There is also the possibility that a new agent – the 'Malodour Counteractant' – discovered by A. Schleppink in 1968 and developed by Monsanto, has a specific mode of action in blocking the exchange of protons, which is a leading feature of unpleasant odourants (Schleppink, 1981).

It is thought that fresheners act by stimulating the olfactory nerve so strongly that unwanted odours are not perceived. The theoretical consequences of strong stimulation of the olfactory nerve are interesting. There is no doubt that the major input is to the rhinencephalon, now termed the limbic lobe, and thought to mediate emotion. There are also connections between the olfactory nerve and the hypothalamus and the caudate nucleus. There is therefore some theoretical basis for the observed effect on emotions and on muscle tone. Further corroboration of the likelihood of perfumes affecting mood comes from the work of Dodd, who has used perfumes to induce beneficial mood changes (Dodd & Van Toller, 1983).