Psychiatric Bulletin (1993), **17**, 625–630

Correspondence

Situation comedy compliance

DEAR SIRS

It is widely accepted that the media tend to portray mentally ill people, psychiatry and psychiatric treatment in an almost exclusively negative way. Psychiatrists have been seen as "purveyors of grim and grisly treatments in large mental hospitals" (Ramsay, 1991) and, particularly through television and cinema, the media has the ability to adversely affect the attitudes of literally millions of people with a single piece of negative "information" (Footring, 1991). Consequent upon increasing awareness of the power of the media to inform, to advise, to mislead, to educate and to influence choice, sponsorship has fast become a cogent means of advertising and companies are falling over themselves in their desire to link their product to a well-known name. Murphy's Stout, Worthington Beer, Coca-Cola, and Legal & General are variously associated with detectives, rugby, films and the weather forecast. Should the Royal College of Psychiatrists also jump upon this bandwagon?

We have been responsible for the care of a 23-year-old man with a four year history of bipolar affective disorder. In the manic phase he has been a substantial management problem, so much so that at times he has required periods of "special care" in a secure ward. He settles quickly with drug treatment but unfortunately, despite many repeated attempts from both family and health care workers, he remains non-compliant upon discharge from hospital; hence his frequent relapses. This suddenly changed ten weeks ago.

On entering the consulting room for an out-patient review JS was smiling broadly, being cheerful but euthymic and reactive in mood. He declared that he was "fine", and claimed that it was due to his mood being "so well stabilised by that lithium carbonate stuff". His attitude had markedly altered in that he now felt lithium was "really good stuff – a hip drug", and so had been taking the prescribed dose for the preceding fortnight. This was a direct result of the mention of the drug on the BBC2 situation comedy *Red Dwarf*; the characters were discussing their mood swings when one suggested that lithium carbonate would be an appropriate mood stabiliser. Since seeing this programme, ten weeks ago, JS has remained keenly compliant, and very well indeed.

There is much evidence to show that patients remember only a percentage of what doctors tell them at interview (Wright, 1991). What is communicated is more likely to be understood by the patient, remembered, and influential upon their attitudes, if it is felt to be "on their wavelength", as in the above example.

If it has not done so already, perhaps the College could become active in a campaign to increase the favourable exposure of psychiatric treatments in popular television programmes; 'Victor Meldrew' and 'Lovejoy' might succeed where we mere mortals can only try but fail!

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Psychotherapy referrals

DEAR SIRS

I was interested in the recent paper on psychotherapy referrals by Maloney from Oxford (*Psychiatric Bulletin*, June 1993, **17**, 352–354). Regular audit over the past five years in the Exeter Psychotherapy Service has provided similar results, in the sense that GPs and consultant psychiatrists have a broadly equivalent rate of successful referral for psychotherapy. There was a tendency for referrals from non-medical members of community mental health teams to be less accurate, and we have therefore encouraged these workers to discuss referrals with the GP or relevant consultant.

A detailed examination of consultant referrals over a period of three years revealed a four-fold variation between consultants in the number of referrals made, with a "success" rate (judged by entry into therapy) ranging from 25–70% of referrals. There was no clear correlation between the number of patients referred and the success rate, but some suggestion that consultants who referred much more or less than average tended to have low "success" rates. Discussion of this variability at an audit meeting was inconclusive, but suggested that some consultants were over-optimistic in what the service

could achieve, and that some patients needed further discussion before referral was made.

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Mental Health Review Tribunals in practice

DEAR SIRS

It has been drawn to my attention that the references for my paper (*Psychiatric Bulletin*, June 1993, **17**, 331–336) contain two errors and an omission.

(a) There is a third edition of Richard Jones' *Mental Health Act Manual* published in 1991.
(b) The reference to the 'Mental Health Act *Manual*', DOH, should read 'Mental Health Act 1983, *Memorandum* on Parts I to VI, VIII and X', Department of Health. London: HMSO.
(c) *Mental Health: Tribunal Procedure* (1992) L. Gostin & P. Fennell, Longmans.

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DEAR SIRS

Gordon Langley has provided a valuable service to Tribunal members and non-members alike in his paper on 'Mental Health Review Tribunal practice' (*Psychiatric Bulletin*, June 1993, **17**, 331–336). In addition to the references he quotes, new Tribunal members are provided (among other material) with *A Guide For Members* produced by a small group of us in 1988. In addition, both new and experienced members will find Larry Gostin's and Phil Fennell's *Mental Health: Tribunal Procedure* (second ed, Longman, 1992) a most useful aid to practice. (See David Tidmarsh's review of it in the June issue of the *Journal*, p. 860).

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Clozapine withdrawal syndrome

DEAR SIRS

I was interested to read Palia & Clarke's description of a possible clozapine withdrawal syndrome (*Psychiatric Bulletin*, June 1993, **17**, 374–375). My own experience of treating 20 patients with this drug confirms that the inevitable rebound that one witnesses on stopping it suddenly is worsened by a confusional state which varies in severity from patient to patient. Because of my awareness of this, the last time I took a patient off the drug (for reasons other than a red alert), I weaned the patient off a dose of 375 mgs daily over three weeks (the latest Clozaril data sheet suggesting gradual reduction over one to two weeks). Despite this, the confusional state that accompanied the rebound psychosis was most marked, and led to the patient having to be nursed in pyjamas for one week. This patient had been taking clozapine for over two years, and I wonder whether the weaning off period should be extended to a month or more if the patient is well established on the drug (say a minimum of 18 weeks, which is the time that blood testing changes from weekly to fortnightly).

I look forward to reading or hearing of others' experience in this area.

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Hypnosis in psychiatry

DEAR SIRS

Dr Mathew on 'Hypnosis in Psychiatry' (*Psychiatric Bulletin*, April 1993, **17**, 202–204) concludes that "Hypnotherapy should be considered as a supportive and supplementary therapy and not as a substitute form of therapy to treat the untreatable." What exactly does he mean? A "substitute" for what? And, how can the "untreatable" be "treated"?

There are numerous examples of hypnosis as a treatment in its own right as distinct from being merely "supportive" or "supplementary", as in severe refractory irritable bowel syndrome (Whorwell *et al*, 1984, 1987) and infertility without any organic basis (Mackett, 1985). I recently treated two cases in which AID had been attempted unsuccessfully over a prolonged period. The patients were referred by a consultant in infertility. Both became pregnant within months.

I agree with the author that psychiatric patients should not consult those with no medical qualifications and no formal training in psychiatry. But why pick on the practice of hypnosis in this connection? For similar reasons, I have never been in favour of the direct referral of psychiatric problems to clinical psychologists.

Mathew concludes that hypnosis is valuable in liaison psychiatry where specialists have not discovered any organic abnormality. This may or may not be true, but diagnosis (and therefore therapy) should be based on positive grounds, not merely on