This is another fiction masquerading as fact. Szasz is not an ally of National Health Service psychiatrists, none of whom, to my knowledge, has denounced or renounced the practice of psychiatric slavery. Moreover, Szasz is a classical liberal, not a socialist. The two cardinal principles of the classical liberal credo are the affirmation of the right to bodily and mental self-ownership and the prohibition against initiating violence.

These rather serious misrepresentations aside, Persaud ignores the core ideas in Szasz's book. Institutional psychiatry is an extension of law: institutional psychiatrists are agents of the state, not of their patients. Doctors who practise contractual medicine are agents of their patients, not of the state. The importance of this difference cannot be overemphasised.

People labelled by institutional psychiatrists as mentally ill are concurrently defined by the courts as less than human, in much the same way 'Negroes' in America were once defined as three-fifths persons. This is how Black people were, and people with mental illnesses are, deprived of liberty and justice by the state. Labelling of anyone as less than human is legal fiction, something false that is asserted as true, that the courts will not allow to be disproved. Just as defining Negroes as three-fifths persons served to maintain the institution of slavery, defining people as mentally ill serves to maintain the institution of psychiatry.

A person has a right to refuse treatment for cancer. A person does not have a right to refuse treatment for mental illness. If institutional psychiatrists are deprived of their power by the state to deprive mentally ill persons of their liberty, that is, if the state did not allow psychiatrists to enslave their patients in the name of liberating them, institutional psychiatry would go the way of slavery, as well it should.

Persaud, R. (2003) Book review: *Liberation by Oppression* (T. Szasz). *British Journal of Psychiatry*, **182**, 273.

J. A. Schaler Department of Justice, Law and Society, School of Public Affairs, American University, Ward Circle Building, 4400 Mass. Ave., NW, Washington, DC 20016–8043, USA

Treatment of common mental disorders in general practice: are current guidelines useless?

The paper by Croudace *et al* (2003) confirms the pattern set by previous studies (Upton *et al*, 1999; King *et al*, 2002) in showing little or no effect of educational and treatment initiatives on primary care physicians' practice of psychiatry. The authors provide various explanations for the negative outcome; one of these – 'failures in the content of the guidelines themselves in terms of their evidence base or relevance' – deserves greater prominence. Although psychiatry can claim some credit for advances in the diagnoses and treatment of more-severe disorders seen in secondary care, our interventions for the common mental disorders in primary care are much less securely founded.

The guidelines do not take proper account of the well-established fact that approximately two out of five patients presenting with common mental illnesses in general practice (even when considered ill enough to merit psychiatric input) improve rapidly within a few weeks. These probably merit the often forgotten diagnosis of adjustment disorder (Casey *et al*, 2001). Thirty per cent pursue a slower course of recovery and a further 30%, mostly with mixed anxiety and depressive disorder, have a worse outcome with frequent relapses (Tyrer *et al*, 2003), although in the short term a variety of interventions can be effective.

The methodology of Croudace *et al*'s study is to be commended and the results show that even when guidelines lead to greater specificity in identifying illness, this is not accompanied by better outcomes. Pressured general practitioners in the past used to take the approach that if a patient with mental health symptoms presented for treatment, the doctor could listen sympathetically and, unless there was significant risk, would ask them to come back in 4 weeks' time. If the patient returned, he or she might have a more serious problem necessitating formal treatment. Such an approach may have a greater evidence base than any of our guidelines. It nicely separates those with adjustment disorders from the rest, prevents inappropriate therapies that might lead to iatrogenic problems like dependence, and is an excellent predictor of improvement many years later (Seivewright *et al*, 1998). If we were able to help general practitioners at the time of presentation to diagnose which patients needed intervention and which did not, we might be doing a better service than any of the current guidelines that litter general practice surgeries in this and many other countries.

Casey, P., Dowrick, C. & Wilkinson, G. (2001) Adjustment disorders: fault line in the psychiatric glossary. *British Journal of Psychiatry*, **179**, 479–481.

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Note

This letter was submitted before the appointment of P.T. as Editor of the *Journal*.

P. Tyrer, M. King MRC Collaborative Group for the Evaluation of Complex Mental Health Interventions in Primary and Secondary Care, Imperial College and Royal Free Campus of Royal Free and University College Medical School, Rowland Hill Street, London NW3 2PF, UK

J. Fluxman General Practitioner, Harrow Road Medical Centre, London, UK

Management of borderline personality disorder

Verheul *et al*'s article (2003) states that dialectical behaviour therapy is an efficacious treatment for high-risk behaviours in patients with borderline personality disorder and suggests that this occurs via four core features (Linehan, 1993): routine monitoring; modification of high-risk behaviours; encouragement of patients to consult therapists before carrying out these behaviours; and prevention of therapist burnout.

We propose a management strategy for these patients delivered via a systemic approach that incorporates these principles and is especially relevant for services without the capacity to provide the skills base or intensity required for effective dialectical behaviour therapy. Such an approach has been developed by our service and is currently the principal method of

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