Correspondence

Stigma of psychiatric in-patient care

Sir: In their descriptive study of attitudes to illness in 30 first-admission psychiatric and medical in-patients, McCarthy *et al* (*Psychiatric Bulletin*, 1995, **19**, 349–351) found, not surprisingly, that psychiatric patients were more likely to regard admission as unnecessary and to hide their diagnosis from relatives, friends and workmates. A simple audit of flowers and Get Well cards received on the two wards would probably point in the same direction. Certainly, medical and nursing staff do not complain of hay-fever symptoms on psychiatric wards!

What is surprising about the results is that 10% of the medical patients questioned did not agree that their admission had been necessary. Does this suggest that a lack of insight into illness is not an exclusive preserve of psychiatry or should these medical patients have had a mental state examination?

YVONNE HA
The Maudsley Hospital, Denmark Hill, London SE5 8AZ

To be or not to be discharged: an ethical dilemma

Sir: I sympathise with my colleagues (*Psychiatric Bulletin*, **19**, 199–202) describing their plight in such a lucid and heart-felt way. We have all experienced, in clinical work at one time or another, such patients who 'refuse to get better' and sabotage any attempts made by professionals to help them. Staff find this type of patient difficult to cope with, especially if they have been violent and disruptive, and it is demoralising to contemplate that one's efforts are met with almost unmitigated failure. The case in point is a particularly damaged individual with a debilitating mental illness, poor impulse control, drug and alcohol problems, possible learning disabilities and there is substantial evidence of lack of adequate parenting and personality development.

Although the risks of the patient becoming uncontainable and engaging in dangerous behaviour if (and when) discharged can not be underestimated, it seems that there may still be things that can be done to alleviate some of the pressures imposed by looking after such an 'unrewarding' patient. I wonder whether his needs have been thoroughly assessed, including his intelligence (how limited is limited?). We are told about a behavioural programme that was instigated but perhaps staff support and a more dynamic understanding of the issues involved (expectations, hospital as container, aggressive impulses and emotional vulnerability) might make more sense of the problem that Kotak *et al* are confronted with.

In my opinion 'discharge refuser' is another unfortunate term for people who present with extremely complicated problems and special needs and which (term) obscures the underlying nature of the presenting symptoms and does not allow a deeper understanding of these patients.

A. HASSIOTIS
Learning Disabilities Service, St Charles Hospital, Exmoor Street, London W10 6DZ

Sir: We agree with Dr Hassiotis that to cope effectively with the constant frustrations and challenges posed by our patient good staff support is essential and that psychodynamic understanding is helpful in elucidating the complex issues involved.

Our patient had psychometry which revealed that his cognitive functioning is in the borderline learning disability range. However, having referred him to Learning Disability Services many months ago, it is still uncertain whether they have anything to offer to this man in terms of his long-term management.

Having said this we feel that Dr Hassiotis has misunderstood our main point: as outlined in the paper there are many different reasons why patients refuse discharge. Clearly, there is a danger that to label someone a 'discharge refuser' and to take this as justification for discharging them abruptly may be 'acting out' on the part of staff, who feel unable to tolerate their feelings of helplessness, anger and irritation with a very difficult clinical problem. However, there are also patients whose psychopathology gets hugely intensified in an institutional setting and these are usually individuals with anxiety-provoking 'complicated problems and special needs' like our patient. Our main point is that the current political climate of multiple enquiries into the 'failures' of community care makes

https://doi.org/10.1192/pb.20.1.52-b Published online by Cambridge University Press

it almost impossible to take any therapeutic risk with cases like this.

A. KOTAK, F. NOORE, K. MUTHIAH,
F. RAFFIQUE & U. SCHMIDT
Paterson Centre for Mental Health,
20 South Wharf Road, London. W2 1PD

Antidepressants in epilepsy

Sir: While I welcome advice given in the *Bulletin* with regard to therapeutics, I am in a quandary over the conclusions reached by Duncan and Taylor in response to their question "Which is the safest antidepressant to use in epilepsy?" (*Psychiatric Bulletin*, 1995, **19**, 355–356). They conclude that (MAOIs aside) the agents of first choice should be an SSRI (apart from fluvoxamine) or trazodone.

The specific problem that their conclusions raise is that of viloxazine, an antidepressant not considered in the article, but recommended as "the antidepressant of choice in treating depression in epileptic patients" by Stuart Montgomery (1990, pp 47–48). That the 'guru of SSRIs' should single out a different class of drug for a special indication would make me feel that the authors should have at least mentioned viloxazine and their reasons for not endorsing Montgomery's view.

I would be interested in their retrospective opinion.

MONTGOMERY, S. A. (1990) *Anxiety and Depression.* Petersfield: Wrightson.

MATTHEW JELLEY
Hillview Lodge, Royal United Hospital,
Bath BA1 3NG

Sir: Dr Jelley refers to Stuart Montgomery's assertion that "the only antidepressant which does not seem to be associated with increased convulsions is viloxazine and it should therefore be regarded as the antidepressant of choice". Our experience of prescribing patterns in of a number of psychiatric institutions leads us to believe that viloxazine is only very rarely used (possibly because it frequently causes headache and nausea). Thus, we feel few prescribers would have experience of using viloxazine and data on its clinical use are, we believe rather limited. This last point is perhaps exemplified by the fact that the Committee on Safety of Medicines have only received 169 reports of adverse effects due to viloxazine in 22 years. Interestingly, the CSM have received five reports of convulsions (CSM; personal communication).

We did consider including viloxazine in our article but eventually did not because of its very limited use and because we could find few data to confirm its relatively low propensity to cause seizures.

DENISE DUNCAN and DAVID TAYLOR
Maudsley Hospital, Denmark Hill,
London SE5 8AZ

The dilemma of psychiatrists in training

Sir: Psychiatrists in training are often tormented by divided loyalties. As a junior trainee, the pressure to pass the examinations as early as possible overrides academic commitments and commitments to develop patient care skills. In effect, examinations have become a hindrance to academic pursuits, let alone basic professional commitments of those doctors who choose to become psychiatrists. The College offers a research option instead of the essay paper of the examinations. Considering the stipulations attached to this option, it does not seem that the College expects many candidates to attempt it. Once the membership is obtained, the new member immediately joins the rat race to get into a higher training post but with little guidance. By the time this state is achieved many of those psychiatrists in the higher training grades metamorphose into a 'burnt out' state or one of 'self actualisation'. Another hindrance to further achievements in academic or patient care skills is that once in a higher training grade, one is expected to be an authority on all aspects of psychiatry. This view is supported by the observation that those who excel in academic or clinical work do not necessarily do well in the examinations and vice versa. We would suggest that the examination system should relinquish its current fixations and mature out to incorporate assessment of more useful skills than those required to pass the examinations. It will be better if we initiate this rather than someone else imposing it on us.

P. DE VRIES
Fulbourn Hospital, Cambridge CB1 5EF
O. THACHIL
Worcester Royal Infirmary, Worcester WR5 1JG,
M. J. SORE
West Suffolk Hospital, Bury St. Edmunds
IP33 2QZ
A. JOSEPH
Manchester Royal Infirmary, Manchester M13 9WL
A. MICHAEL
S3, Addenbrooke's Hospital, Cambridge CB2 2QQ

https://doi.org/10.1192/pb.20.1.52-b Published online by Cambridge University Press