von Münchhausen (1720–1797, Bodenwerder, Germany), called the lying baron (Lügenbaron), whose name has been given to this syndrome. The Baron himself would smile at reading his name 'Munchausen' in the English literature, mutilated as it is (the meaning being 'house of the monk'). But I think he deserves nevertheless a correct citing of his name, he who during his lifetime was not a decided fan of truth.

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Community Treatment Orders

SIR: I wish to echo Dr Hardman's recommendation (*Journal*, May 1993, **162,** 710) that scrutiny of the Victorian Community Treatment Order (CTO) system be made in order that its applicability in England be clarified. I agree that the CTO is not used a great deal – the service in which I work has a catchment population of 210 000 and geographically covers 20% of the State, but has only 31 such Orders at the time of writing. It is the experience of most of our community psychiatric nurses that the CTO is indeed useful as a 'persuader' where depot neuroleptics are concerned, and this service has also found it useful in the placement of longer stay, institutionalised individuals into a community residential programme.

The actual practical usefulness of the CTO when its role as a persuader is insufficient – that is, when a person is, for example, still refusing his/her medication – is a more difficult issue. The main legal redress offered in these circumstances is revokation or return to hospital as an involuntary patient.

While there is nothing in the law to prevent an injection being given by force in a patient's own home, the practical reality is that most nurses are reluctant to do this, given its potential personal risk and the chances of significant damage to the therapeutic relationship. In practice, then, the CTO is revoked for a period of time long enough to remove the patient to hospital, to give the injection, and to return the patient home. While this is cumbersome in terms of paperwork, it does at least assure us that adequate treatment will be delivered, and is practically a far better arrangement than the English Guardianship Order, which can direct a patient to attend for treatment but places no onus on the patient to take it.

The CTO is, of course, no substitute for adequate patient and carer education and appropriate compliance training. Rather, it is an augmentation to other more clinically-based concepts of care in the community, as, indeed, is any aspect of the Mental Health Act. In support of Professor Lamb's (*Journal*, May 1993, **162,** 587–592) assertion that "the chronically mentally ill ... need asylum and sanctuary in the community", a CTO is likely to ensure they have treatment as well.

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Mania and Down's syndrome

SIR: Drs Cooper & Collacott (*Journal*, June 1993, **162,** 739–743) are incorrect in stating "There have been no reported cases of mania in women with Down's syndrome". Haeger (*Journal*, July 1990, **157,** 153) reported a case of recurrent mania in a 46-year-old woman; her first episode occurring at the age of 32 years. Table 1 requires amending to include this case.

If the case reported by Haeger is incorporated with those reviewed by the above authors, there have then been eight reported cases of mania in people with Down's syndrome, seven male and one female, the mean age of first manic episode is corrected to 33.4 years, and the length of follow-up from first episode to time of report becomes 1–14 years.

Subsequent amendments of symptom frequency (Table 2) include an increase by a factor of one of elated mood, pressure of speech, sleeplessness, sexual inhibition, physical aggression, and possibly grandiose ideas. Long-term prophylaxis was addressed using maintenance promazine.

The author recommends that all review articles state their source of reference information, thereby allowing an assessment of the accuracy of the data collection to be made and prevention of subsequent publication of inaccurate information.

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Low serum cholesterol and serotonin receptor subtypes

SIR: We read with interest the article by Hawton *et al* about low serum cholesterol and suicide (*Journal*, June 1993, **162,** 818–825). One of the main concerns of the authors is the lack of available *in vivo* data about the effects of low serum cholesterol on serotonin receptor subtypes which are especially involved

in aggressive, violent, and suicidal behaviour. We would like to point out a preliminary study which investigated the effects of cholesterol-reducing agents on the serotonin-related behaviour *in vivo* (Dursun, 1992).

Rather high doses of cholesterol-lowering agents, gemfibrozil and cholestyramine, both significantly blocked the inhibitory action of a serotonin-1A receptor agonist ligand on the serotonin-2 receptor-mediated-behavioural response (head-shakes), while gemfibrozil significantly potentiated this behavioural response and cholestyramine showed a trend towards potentiation of the same behaviour in rodents (significantly low plasma cholesterol levels compared with control animals have been confirmed by biochemical studies after behavioural studies) (Dursun, 1992). These preliminary results show that cholesterol-lowering agents can indeed alter both serotonin-2 receptor-mediated behaviour and a serotonin-1A/serotonin-2 receptor interaction *in vivo*. Therefore, alterations of the functional state of the serotonin receptor subtypes and their interactions by the cholesterol-lowering agents may be implicated in understanding the involvement of serotonin in the relationship between low serum cholesterol and suicidal behaviour. However, further preclinical and clinical research is needed to understand the mechanisms of this relationship.

DURSUN, S. M. (1992) *An Investigation into the Pharmacology of Tics and Tic-like Movements*, PhD Thesis. Birmingham: Aston University.

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Concepts of illness and disease

SIR: Is there any stronger a *prima facie* case for linking the abuse of psychiatry for political reasons in the former USSR with difficulties about the concept of mental illness than there is for, say, linking the abuse of surgery for financial reasons in capitalist countries with difficulties with the concept of physical illness? A simpler, and perhaps less self-deprecatory, view is that the particular susceptibility of psychiatry to totalitarian abuse is merely a consequence of the practical, rather than conceptual, opportunity provided by the need to treat psychiatric patients on occasion without their voluntary consent.

In their article (*Journal*, June 1993, **162,** 801–810), Fulford *et al* build on the notion (Fulford, 1989) that there is a distinction to be made between biological-scientific and social-evaluative concepts with a claim that "disease really is an evaluative concept". We are therefore asked to allow priority to the latter paradigm of a binary 'is-ought' dichotomy between process and praxis.

An alternative model, tripartite rather than binary, could be based on Popper's three 'worlds' (e.g. Popper & Eccles, 1977). Popper's 'world 1', or physical world, was distinguished from the world of subjective experiences (world 2), and from what he called "the products of the human mind" (world 3).

Adapting this model, medicine can be conceived as being continuously involved in three interactive realms. The first, or objective realm, is concerned with disease as dysfunction, with medicine functioning as an essentially scientific enterprise. In the second, or subjective realm, illness is perceived as distress, with medicine responding as an empathic art. In the third, or social realm, sickness becomes an enacted role, with medicine engaged as a social or political activity. For medicine to be practised appropriately, it is necessary to identify honestly which realm, or realms, are being inhabited at which times, and to be able to move accurately and flexibly between them.

It seems uncontentious that there will be political implications if social evaluative judgements (realm 3) are rationalised as scientific ones (realm 1), and that this applies equally to physical illness. No doubt this is often done with benevolent intent, as, for instance, when invalidity status is granted to unemployed miners with relatively mild chronic obstructive airways disease. However, if psychological medicine has a special vulnerability, apart from legal questions of consent and competence, this could be found in the particularly disgusting and disturbing nature of its subjective realm (realm 2). Thus, psychiatrists may be especially liable to use scientific concepts defensively, not in order to deny that ethical judgements are being made in the interests of social expediency, but principally to protect themselves from states of aesthetic 'disease'.

FULFORD, K. W. M. (1989) *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press.
POPPER, K. R & ECCLES, J. C. (1977) *The Self and Its Brain*. London: Routledge and Kegan Paul.

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Neurological complications of anorexia nervosa

SIR: The recent review of the medical complications of anorexia nervosa by Sharp & Freeman (*Journal*, April 1993, **162,** 452–462) made compelling reading. One factor that did not receive attention, however,