Correspondence

Putting the emphasis on physical treatments

DEAR SIRS

I read the 'Point of View' by Dr Paul Bridges (*Journal*, June 1983, **142,** 626) with pleasure and some relief. I had become aware of a loss of self-confidence on my part in the use of physical treatments. I had decided that this was due to a subtle undermining of my therapeutic confidence by the considerable agitation concerning physical treatment in psychiatry, which had had its effect despite resistance on my part. I had been heard to say that depressed patients did not seem to recover so quickly or so completely as they used to, and amongst other explanations for this I began to assume that this was because GPs were being more successful at treating the straightforward depressed person, and were referring the more complex issues to the psychiatrists. However, I could not be entirely satisfied with this explanation because those patients I saw still seemed to be treated with quite low doses of antidepressants, and there were no fewer referrals overall, though they were being spread about amongst the clinical psychologists and community psychiatric nurses in our team. At our multiprofessional case discussions there has been increased resistance to the use of physical treatments and ever increasing attempts to formulate the patient's problems in social, psychological and dynamic terms. I suspect therefore that the decisions to increase the dosage of antidepressants or to prescribe, or to continue a course of ECT, have been postponed or even avoided with the failure to recover, or delayed recovery of the patient. I have therefore been advising myself, my trainees, and the GPs I work with, to use antidepressants and other medication appropriately and with confidence. Paul Bridges' article is therefore for me very timely.

While being subtly undermined, I have been nevertheless at the same time struggling to get across to trainees, and anyone who will listen, just those attitudes to depression that Paul Bridges stresses. The analogy I use is of a man run over by a bus and the resultant broken leg. It may be tempting to shoot the bus driver, it may be appropriate to counsel the victim about how to avoid such accidents, particularly if such a thing has happened to him before, and it may be appropriate to look at the road, the crossing, the traffic density and the like to try to prevent a similar occurrence. The immediate management, however, is to repair his broken leg, and it is the medical procedure that is central, and the other processes that are adjunctive, not the reverse.

Psychiatrists must treat their patients medically with vigour when it is indicated. The person who introduced the word 'endogenous' into the psychiatric vocabulary has a lot to answer for, since it results in just the sort of thinking that Dr Bridges describes. I have been rather dismayed to find, during the great deal of interviewing I do nowadays, that applicants for senior registrar posts for example, are more interested in psychotherapy and various related fashionable therapies like 'psychodrama', than the medical aspects of their patients' conditions. I do not agree with the view expressed at the Cambridge Meeting last year, that psychiatry has lost its sense of direction because insufficient attention has been paid to psychotherapies. This may have been the case, but I believe if anything, that the opposite is now true, and the medically qualified psychiatrist, as opposed to the psychologist, social case worker and psychotherapeutically-oriented CPN, has got to think very carefully about his/her own future role. Paul Bridges has made an important contribution to this debate.

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The College and South Africa

DEAR SIRS

I wish to comment on the report of the Special (Political Abuse of Psychiatry) Committee (***Bulletin,*** June 1983, **7,** 115).

1. The WHO report on political abuses of psychiatry was not given serious consideration by the committee because the WHO team did not visit South Africa. A visit by WHO was prevented by the sudden introduction of new mental health legislation by the South African government which made an independent investigation impossible.
2. The WHO document summarizes the evidence in connection with legislation to detain ordinary pass law offenders in 'rehabilitation' centres for medical 'treatment'. The Special Committee report does not comment on it.
3. The report refers to a far from comprehensive investigation by the American Psychiatric Association. The APA Committee were taken on a guided tour by Smith, Mitchell & Co under the watchful eye of the Department of Health, the very agencies who were under investigation. Their request to investigate public mental health facilities was expressly forbidden by Dr Henning, Chief Psychiatrist for the Department of Health. '... We were not allowed to interview staff and patients, examine records, or use our survey instruments to evaluate public facilities. We were thus *prevented from investigating a crucial link in the mental health service system'* (emphasis added) (*American Journal of Psychiatry,* 1979, **136,** 1499). Potential informants were possibly prevented from giving crucial evidence because of the draconian strictures of the Mental Health Amendment Act of 1976, and independent interpreters were seldom available to

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help the investigators with interviews.

4. It is rather disingenuous of the Special Committee to rely on the observations of Dr Sidney Bloch while on a holiday in South Africa. Doubts about Dr Bloch's visit have been expressed previously, not least by South African psychiatrists (*Bulletin*, March 1982, **6**, 44–45); if the Special Committee wishes to base its conclusions on this 'investigation', we should know more about the circumstances of the visit.
5. The Special Committee's report fudges the issue of the psychological impact of apartheid. The arbitrary division of certain issues as purely social/political or medical/psychiatric is by itself a political gesture and the Special Committee shows its bias in failing to recognize it as such. If the Committee or the College are to pursue this position to its logical conclusion then they should find it impossible to consider many of the issues relevant to social and epidemiological psychiatry, such as unemployment, migration, alcoholism, etc. The report pleads for more research in this area. I provided the Committee with at least 20 papers from both within and outside South Africa, all of which clearly demonstrated the cost of apartheid in terms of psychological suffering, illness and human lives.
6. The report, while admitting that deliberate racial discrimination is at the heart of psychiatric practice in South Africa, comes to the disturbing conclusion that this issue lies outside the Committee's remit. This illogical position that if governmental policies are behind the unethical and unacceptable nature of the health care system then such policies and practices are beyond criticism stems from the Committee's rather rigid and arbitrary definition of what constitutes political abuse of psychiatry. In 1978, when the Council of the College endorsed a recommendation to set up a special committee, its brief, although never made explicit, was to investigate reports of abuses of psychiatry for political ends wherever they occurred. The definition of what constituted such abuses was a *post hoc* one and arrived at by the Committee's exclusive preoccupation at that time, namely Soviet abuses.
7. The report does not take into consideration recent allegations from South Africa that political detainees are being transferred to psychiatric hospitals following police torture and that in most cases psychiatrists allow such individuals to be transferred back to police custody after compulsory 'treatment'.
8. The Committee did not at any time set up a full inquiry into this matter by calling for evidence from interested parties, meeting individuals who had first-hand experience of South African psychiatry, or even considering all the documentary evidence available to it.

The College has in the past shown commendable concern and a genuine commitment to dealing with various allegations of unethical practice in the field of mental health, especially from Eastern Europe. After the publication of the report on South Africa, however, it must be a matter of serious doubt if such a commitment shows sufficient breadth and impartiality to allow the College to consider abuses of psychiatric standards and practices irrespective of where they occur and what political ideology lies behind them.

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Consultant psychiatrists in mental handicap

DEAR SIRS

The contrast between the concern expressed by Dr Singh (*Bulletin*, June 1983, **7**, 110) for the future of the psychiatrist specializing in mental handicap and Professor Bicknell's optimism about the effects of recent trends (*Bulletin*, September 1983, **7**, 168) should not go without comment.

The number of unfilled consultant posts in this field rose by 400 per cent between 1972 and 1980 (*Bulletin*, February 1982, **6**, 20) and there were 41 posts vacant (25 per cent of the total) in England and Wales in September 1982 (*British Medical Journal*, **286**, 651). Of these, 50 per cent were not being advertised, half of them being occupied by locums with varying qualifications. A personal survey in March 1983 revealed that the posts without substantive occupants had risen to 49 in England alone; it is now suggested that specialist consultant services in this field be abolished altogether in some Districts.

The uneven distribution of consultant effort in the UK is shown in the College document 'Mental Handicap Services—The Future' (*Bulletin*, July 1983, **7**, 134). Those Regions that have concentrated on less radical changes appear to have done better on the whole.

It does not seem, therefore, that the more drastic movements generated and sustained by the many enquiries and campaigns of the past 10 to 15 years in this field have been favourable to recruitment from within psychiatry, at least not in England and Wales. Others, notably social workers and community nurses, may feel that they have more to offer in, for example, reducing stress to abnormal life styles and in giving family support, and it is significant that the new mental handicap nursing syllabus makes little reference to the need for any psychiatric skills.

It would, I suggest, be of the most practical help if the increasing number of consultants with academic links in mental handicap could get together and produce an agreed syllabus for postgraduate training of psychiatrists in this field, and also give articulate guidance on the reform of undergraduate exposure. Otherwise, in accord with Farber's Law, we shall all continue going down the same road in different directions!

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