Recovery: beyond mere survival

Sir: David Whitwell (Psychiatric Bulletin, October 1999, 23, 621–622) argues that ‘recovery’ is a myth, promulgated by over-optimistic therapists of all persuasions. If ‘recovery’ means getting back to exactly how you were before (as he argues), then no doubt he is right, at least for many people with significant mental health difficulties. But the mental health world needs optimism — not over-optimism, that a person can rebuild a satisfying, hopeful life and contribute to society despite the continued presence of mental health problems. Indeed, this is precisely how recovery is defined in the now extensive American literature: there is no way back to life before problems started, but there is a way forward (Deegan, 1988; Anthony, 1993; Young & Ensing, 1999).

The experience of physical disability shows just how powerful this type of ‘recovery’ can be, even in the face of the most extreme impairment. After Jean-Dominique Bauby’s massive stroke he could only move one eyelid, his sole means of communication. There is no doubt that he would have agreed with Whitwell’s interviewee who said that ‘I will never be the same person again’. However, he was able to find some meaning and purpose, however, limited, in his highly restricted new life in ‘writing’ what the Financial Times described as, “one of the great books of the century” (Bauby, 1997).

As Patricia Deegan (1988) puts it:

“Recovery does not refer to an end-product or result. It does not mean that my friend (with quadriplegia) and I were ‘cured’. In fact, our recovery is marked by an ever-deepening acceptance of our limitations. But now, rather than being an occasion for despair, we find that our personal limitations are the ground from which spring our own unique possibilities.”

Whitwell’s interviewees at times seemed to be equivocal about whether they had, in fact, ‘recovered’ — an ambivalence from which Whitwell concluded that they did not think they had recovered. Here there seems to be some confusion between recovery as an ongoing process and ‘being recovered’ as an end-point. Deegan (1988) makes precisely this point when she argues that recovery does not mean ‘cure’, it is not an end-point — ‘recovered’ — but a continuing journey: “… an ongoing process. It is a way of life. It is an attitude and a way of approaching the day’s challenges” (Deegan, 1992).

The challenge for service providers is how to reduce the barriers which impede the re-building of a person’s life. How to help people to gain more opportunities: for work, income, friends and social networks. Whitwell also illustrates the importance of helping people to appreciate the “strength they have derived from the damage they have sustained and overcome”.

People ‘disabled’ by mental health problems can do more than just ‘survive’. If the Disability Rights Commission, coming into force in April 2000, succeeds in breaking down some of the barriers of discrimination faced by mental health service users; and if professionals follow the National Service Framework recommendation to support users in gaining social inclusion — then chances for recovery could increase. Not cure, but new meaning.

References


*Liz Sayce, Disability Rights Task Force Member and Director of Lambeth, Southwark and Lewisham Health Action Zone, 7 Lower Marsh, London SE1 7NT, Rachel Perkins, Consultant Clinical Psychologist and Clinical Director of Rehabilitation and Continuing Care Services at South-West London and St George’s NHS Trust, London.

Sir: I read with interest Dr Whitwell’s comments about the myth of recovery from mental illness (Psychiatric Bulletin, October 1999, 23, 621–622). The topic, particularly resonated with me as the institution where I work is being featured in a television series entitled ‘The Talking Cure’ (my italics). I would agree with Dr Whitwell’s premise that we live in an age where expectations are high and there is a pressure on psychiatrists to provide ‘solutions’ or ‘cures’ through whatever treatment they offer be it psychotherapy, pharmacotherapy or some combination of the two.

It seems to me that the current emphasis on clinical governance and evidence-based medicine as well as the need for randomised-controlled trials to prove that our treatments are effective is part of this culture. While I would not argue against the value of quality assurance and evidence-based medicine, perhaps a more realistic appraisal, in broader terms, of the likely outcome of our treatment is needed.

The most up to date antipsychotics do not ‘cure’ schizophrenia in the same way that psychodynamic psychotherapy does not cure people with borderline personality disorders. In child psychiatry there is a pressure for clinicians to provide a cure for conditions such as Attention-Deficit Hyperactivity Disorder (ADHD), with medication such as methylphenidate. ADHD is increasingly regarded as a ‘thing’ that can be ‘cured’ whereas it is actually more of a conceptual tool which may help us to address a complicated area of child psychiatry. Of course, we often do offer valuable therapeutic interventions, otherwise what would be the point of us-existing, but let us be realistic about what we can achieve. In this way too, patients may feel more empowered to find their own ways of alleviating their difficulties without relying excessively on clinicians.

Essentially, I would agree with Dr Whitwell that the desire for complete or absolute cure is a primitive one. Sometimes after a session with a particular family or child I wonder what help I have offered them. It may well be that they
have found their contact with psychiatric services useful, but I find that I need to let go of the desire to solve all their problems or offer them a way of escaping all their difficulties. This is how it is with mental illness generally. I believe we need to be more realistic about what we can offer our patients in terms of ‘recovery’ while at the same time always working with them to alleviate their difficulties in the hope that things will improve.

Jon Goldin, Specialist Registrar Child and Adolescent Psychiatry, The Twickel and Portman NHS Trust, 120 Belvoir Lane, London N8 3BA

Community Treatment Orders

Sir: Two recent articles (Psychiatric Bulletin, November 1999, 23, 644–646 and Psychiatric Bulletin, November 1999, 23, 647–648) continue the debate surrounding the proposed introduction of Community Treatment Orders (CTOs). Having experience in the use of CTOs in Victoria, Australia it is our contention that a CTO does not confer any advantage to the patient in comparison with a comprehensive community care. Indeed, we observed that their use frequently served to alienate patients from mental health services.

In reviewing CTO usage McVor (1998) highlights the paucity of research in this area despite their widespread implementation in Australia and New Zealand and suggests the need for controlled trials in order to justify their continued use. Burns poses the question, ‘is there a group of patients who are poorly served by the present legislation who are currently repeatedly subject to compulsory admission and whose welfare would be better served by a CTO?’. In our endeavour to practise evidence-based psychiatry surely the question must be, ‘Can a patient be subject to a CTO in the absence of proven efficacy?’.

Andrew Al-Adwani, Locum Consultant Psychiatrist, Department of Psychiatry, Swithland General Hospital, Cliff Gardens, Swithland, North Lincolnshire DN15 7BH


My concern is that occasionally a patient who stops his or her antipsychotic medication, against advice, remains well for some years at least.

I know of no way to predict this. Thus, some people may be forced indefinitely to take medication they do not need.

Robert J. Doig, Consultant Psychiatrist, St Ann’s Hospital, St Ann’s Road, London N15 3TH

Mobile telecommunications and agoraphobia – a modern treatment advance?

Sir: I wish to report how the advent of new technologies may be influencing the ways in which patients manage their own symptoms.

It recently came to my attention that a husband and wife had devised a method by which they had been able to extend the period of time in which a profoundly agoraphobic patient was able to be independent of their spouse, both inside and outside the home. By both parties of the marriage having a mobile telephone in their possession it allowed, in this case the husband affected with a considerable degree of agoraphobia, to spend considerable periods of time on his own without developing a severe degree of anxiety and fearfulness, with accompanying panic symptoms and an urge to either return home or seek the company of his wife. There is, therefore, an increased degree of security knowing that help is at hand if symptoms recur. An example of this is that he is now able to spend long periods of time fishing, away from the home, an activity he found intolerably stressful previously, as he became acutely concerned if he was not able to return home immediately, or did not have access to a means of transport to do so. Therefore, his anticipatory anxiety has been alleviated by the knowledge that he can contact his wife at any time, leading to a larger social repertoire. He developed a much better sense of control over his circumstances and has broken the cycle of dread of being alone in public places.

While there are obviously dangers of dependency occurring because of this, I do feel it allows the patient to have more autonomy.

I am unaware of any other reports of mobile telecommunications being used in this way and it provides a good example of how new technologies may have serendipitous spin-offs for psychiatric patients.

John W. Coates, Consultant Psychiatrist, Mental Health Services, Rotherham General Hospital, Moorgate Road, Rotherham, South Yorkshire S60 2UD

Reference


*Feargal Leonard, Specialist Registrar in Old Age Psychiatry, Priority House, Heritage Lane, Maidstone, Kent ME16 9PH, Michael Ventress, Senior House Officer in Forensic Psychiatry, Trevor Gibbons Unit, Maidstone

Sir: I think Professor Burns (Psychiatric Bulletin, November 1999, 23, 647–648) is quite right to point out that most psychiatrists can think of ‘a handful’ of patients who would truly benefit from a Community Treatment Order (CTO). The criticism though that Moncrieff & Smyth are posing the wrong question (Psychiatric Bulletin, November 1999, 23, 644–646) “How can psychiatry control antisocial behaviour?” is slightly unfair. The genesis of the currently proposed reforms can be traced back to Frank Dobson’s widely publicised comments on the Michael Stone case, that community care had failed because psychiatrists had not been using their power to treat people in the community. Of course psychiatry possessed no such power at the time of Mr Dobson’s ill-informed comments, but Mr Dobson never retracted this statement and the government has gone on to propose CTOs. College caveats aside, it is, therefore, correct to view the CTO as the Government’s attempt to hold psychiatrists accountable for the behaviour of dangerous people who have had contact with psychiatric services.

Andrew Al-Adwani, Locum Consultant Psychiatrist, Department of Psychiatry, Swithland General Hospital, Cliff Gardens, Swithland, North Lincolnshire DN15 7BH


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Robert J. Doig, Consultant Psychiatrist, St Ann’s Hospital, St Ann’s Road, London N15 3TH

A minister for adolescence?

Sir: We were encouraged to read Parkin’s (Psychiatric Bulletin, October 1999, 23, 587–589) review of the difficulties surrounding the admission and treatment of 16- and 17-year-olds under the Mental Health Act 1983. As a newly formed Community Adolescent Mental Health Team we have been grappling with the current legal confusion surrounding the status of adolescents on a daily basis. The concept of Gillick competence developed from a case regarding the rights of those under 16 to seek confidential contraceptive advice and, as such, it made sense – but it is now being extended into areas where it is increasingly nonsensical and legally untested, for example, should the parents of a cannabis-using 16-year-old be told about the drug use?

The confusion over adolescents’ legal status appears to hinge on one issue: are rights acquired on reaching a certain age or a certain competence? The answer at the moment is ‘it depends’. It depends on whether the issue in question is consent to sex or treatment, whether the patient is male or female, homosexual or heterosexual and consenting or refusing. Adolescents’ legal rights should surely be either gained at a certain age, or based on their individual competence, but not the current mixture.

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Women’s groups were rightly heartened by the Labour Government’s decision that all future legislation would be scrutinised for its effects on women’s issues. A similar approach to adolescents seems overdue. Even the recently published National Service Framework for Mental Health (Department of Health, 1999) refers to ‘working age adults’. Does that include 16- and 17-year-olds?

Reference


*Joe McDonald, Consultant Psychiatrist in Adolescent Mental Health, Anthony Ross, Community Nurse (Adolescent Mental Health), Elizabeth Taylor, Community Nurse (Adolescent Mental Health), Allan Brownrigg, Social Worker (Adolescent Mental Health), Barnes Unit, Adolescent Mental Health Team, Durham Road, Sunderland S73 4AF

obituaries

Walter E. Barton

Formerly Professor Emeritus of Dartmouth Medical School, Lebanon, New Hampshire, USA

Walter Barton was born 29 July 1906 in Oak Park, Illinois, the oldest son of Alfred J. and Bertha (Kalish) Bartusich. He received his MD from the University of Illinois. He spent his internship at the West Suburban Hospital in Oak Park, Illinois and then moved to the Worcester State Hospital in Massachusetts for his residency in psychiatry. He stayed on to gain hospital administration training and because he had met Elsa, then superintendent of nurses, his future wife. In June 1938 he attended the National Hospital, Queen Square, London, England for further neurological training.

His academic career included faculty teaching appointments at Smith College School of Social Work and at the Medical Schools of Tufts, George Washington, Georgetown, and Boston University, where he was Clinical Professor of Psychiatry. He also served as Chairman of the Massachusetts Psychiatric Faculty, Inc. When he ‘retired’ in 1974 he joined the Faculty of Dartmouth Medical School and was actively teaching there until his death.

Walter Barton was president of several major psychiatric organisations in the USA. He was honoured by being elected a Life Fellow by the American Psychiatric Association, the American Medical Association, and the American College of Physicians, as well as elected an Honorary Fellow of the Royal College of Psychiatrists of England and of the Australian and New Zealand College of Psychiatrists. He received a number of prestigious awards including the Salmon Medal for Achievement in Psychiatry by the New York Academy of Medicine in December 1974 and in 1975 he received the Distinguished Service Award of the American Psychiatric Association. In 1975 he was awarded an Honorary Doctor of Science by the University of Illinois Medical School, and in 1983 the American Psychiatric Association awarded him their first Administrative Psychiatry Award for outstanding contributions in the field.

During his career in the 1930s he was in the Massachusetts National Guard and saw active service in the Second World War in the Philippines, for which he was awarded the Legion of Honour.

In the 1950s and 1960s he was appointed the Superintendent of Boston State Hospital in Massachusetts which he transformed into a leading service, teaching and research centre. There, through the Barton Mental Health Center he conducted one of the first community demonstration programmes out of which grew the Community Mental Health Movement.

From Boston he moved to Washington, DC and from 1963–1974 became the Medical Director of the American Psychiatric Association with great success. In the 1960s he helped to fashion the Veterans Administration’s Physical Medicine Rehabilitation Program and led scientific exchanges to Japan, Scotland, Mexico, Scandinavia and the former USSR. His work has been published extensively, including 12 books and over 180 articles.

Walter Barton died on 26 January 1999, aged 92. He is survived by two children, grandchildren and great-grandchildren.

Gail M. Barton

Matthew Radzan

Formerly Honorary Consultant, Bexley Hospital Kent

Dr Matthew Radzan (Hugh) died aged 85 on 1 May 1999 from a myocardial infarction at this home in Bexley Kent. Hugh was born on the 5 January 1914 in Bethnal Green and lived in the London area most of his life. His father, an immigrant from Russia, settled in East London and followed his profession of jeweller and watchmaker. Hugh attended Raine's School, Stepney.

He obtained his MB BS (Lon) in 1939 from King's College, London, followed by a DPM in 1940. In 1971 he was elected FRCPsych. In the Second World War he served with the Royal Army Medical Corps in the Middle East from 1939 to 1945 achieving the rank of Major (specialist psychiatrist).

His first civilian psychiatric appointment was to Hollingby Hospital, Sussex and in 1948 he was appointed to Bexley Hospital, Kent. I met him in 1949 under happy circumstances and our association continued for a further 50 years until his recent death.

In those days Bexley Hospital, with over 2000 beds, served a large area of south-east London, to which was added an adjacent piece of Kent. The medical Superintendent then was Dr L. C. Cook whose Deputy was Dr Comerford. They were both distinctive characters and complemented each other in a way that led to a smooth running hospital. Many changes were taking place both in the
treatment and management of patients with an increase in staff at all levels. When Dr Comerford died, Hugh took his place as Deputy, and when Dr Cook retired in 1958, Hugh became Medical Superintendent. He enjoyed his new position, but due to his sometimes brutal frankness and his exacting disposition he became, on occasion a controversial figure.

Many clinical psychiatrists at this time had become dissatisfied with the existing management structure and there was much discussion about the possibility of changing the way mental hospitals were administered. There was a proposal that a Medical Advisory Committee be set up to advise the Hospital Management Committee. A transition of this nature did begin to take place about 1960 and it affected the position of the Medical Superintendent. Hugh was not pleased, but accepted the change, uttering gloomy prognostications about the future of clinical freedom. No doubt, in later years, he did have the satisfaction of being able to say “I told you so”. He continued to pursue the goals he had set himself and was responsible for planning and organising the opening of Castlewood Day Hospital and re-instate, an industrial unit for patients. Both these projects are alive and active to this day.

He decided to exercise the option to retire from his post at Bexley Hospital in 1968 and then held various locum posts as well as jobs with local authorities with the emphasis on children’s care. He was also appointed for two consecutive terms of three years each to be a member of the Mental Health Review Tribunal, South-East Metropolitan Region, expiring October 1975. This work satisfied him immensely. Above all, he loved to have family and friends around him and would discuss and give advice on all manner of things. He was, in fact, very knowledgeable on many matters besides medicine.

He enjoyed good health and was able to follow his hobbies and pursuits fully until about 1982 when health problems arose. But with considerable ingenuity and resourcefulness he overcame most of his difficulties and was still able to enjoy motoring, watching car racing and holiday travel. It was only in the last year or two of his life that he became more house-bound. He leaves a wife, two daughters, a son, nine grandchildren and six great-grandchildren.

Harbans Capoor

Major General Ishrat Husain
Formerly Consultant Psychiatrist, Karachi, Pakistan

Major General Ishrat Husain was born on 25 December 1928 in Gwalior, India and graduated in medicine from the King Edward Medical College, Punjab University in 1951. He entered the Armed Forces of Pakistan in 1952 and in 1957 specialised in Psychiatry.

He gained the DPM (Lon) in 1965 and became a Founder Member of the Royal College of Psychiatrists in 1971 and was elected to the Fellowship in 1984.

He was a major force in developing psychiatry in Pakistan and an eminent and leading psychiatrist in the Pakistan Armed Forces. The Pakistan Armed Forces recognised him as a true veteran by awarding him the Sitara-e-Imtiaz (Military) in 1978 and Hila-e-Imtiaz (the highest award for meritorious services) in 1984. He was the Commandant, Armed Forces Medical College Rawalpindi, Pakistan from 1982–1986. As Commandant he arranged the first regional meeting outside the UK of the Royal College of Psychiatrists in Rawalpindi. He was also the Adviser in Psychiatry to the Armed Forces of Pakistan.

His influence in education was enormous, eventually becoming Dean of the Faculty of Medicine at the Quaid-e-Azam University, Islamabad and Chairman of the Board of Studies for the MHSc (Medical Administration) in 1985. He took an active part in teaching psychiatry to medical students, junior doctors and postgraduate students. He was an inspiration and a role model to a number of his students who are now practising as consultants in psychiatry. Some of the key appointments he held were Chief Instructor in Psychiatry at Armed Forces Medical College, Professor in Psychiatry and Honorary Consultant at Aga Khan University.

His key research was into the psychological factors in military aviation and the use of psychotherapy. He was involved in the rehabilitation and psychological well-being of prisoners of war in 1971 on their return to Pakistan. He was instrumental in ensuring that the prisoners of war were allowed to continue their armed forces careers and, in addition, he conducted a study of their psychological and mental state.

In recent years he had been involved in developing Pakistan Institute of Learning and Living, an institution created with the object of promoting the state of mental well being with special emphasis on people with low income. This work reflects Ishrat Husain’s qualities as a person and his passionate, enthusiastic approach. He was a deeply religious person who found great solace and wisdom in all religions.

On a personal level, he was noted for his gentle demeanour and his soft-spoken manner. He was a guide, a mentor and a great physical and emotional support to his children and grandchildren.

I. B. Chaudhry

book reviews

A Beautiful Mind: The Life of John Nash

The story of John Nash offers interest and encouragement to patients, relatives and psychiatrists. He is a highly respected mathe-
outer space. His recollection of this period is of mental exhaustion with an increas-
ingly powerful understanding of a secret world unknown to others.

Twelve years ensued with involuntary admissions to psychiatric hospitals. Guilt, the need for penitence and dread became more prominent; voices argued within his head. Insulin coma and tranquillisers were given. Drug treatment conferred major benefits, renewing creativity, but the discon-
tinued medication for a reason not usually proffered to psychiatrists. ‘If I take the drugs I stop hearing voices.’ Eventually he was accepted home by his wife and allowed to attend Princeton informally.

During his 40s and 50s Nash and others noticed a gradual weakening of his psychosis. He still experiences abnormal thoughts and voices, though with minimal intensity. He now recognises their unnatu-
ralness and rejects them, or wards them off by avoiding reflection on subjects, such as politics, that have provided a focus for psychotic beliefs.

What trick of genes or environment cruelly ensured that a son of Nash devel-
oped schizophrenia when 13 years younger than his father had been? Or determined that an illegitimate son, who spent his early years in a succession of foster homes, escaped the illness? More

hopeful is the reminder that schizophrenia can substantially and spontaneously improve, even while untreated. Also reas-
uring is the success of medication, while it was taken, in dispelling both positive and negative symptoms and restoring
talent. Credit should be given to his wife and to Princeton. Their tolerance and understanding are patently the opposite of strong expressions of emotion.

The biographer portrays mathemati-
cians as usually remote or odd, citing examples that include the mental illnesses of Newton and Gödel. Yet her case is not proven; indeed she describes several practical and well balanced colleagues of Nash. With this minor reservation I recommend her sensitive account for professional and lay readers alike.

Spencer Madden, Emeritus Consultant Psychia-
trist, Countess of Chester Hospital, Chester CH2 1UL

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**Practice Guideline for the Treatment of Patients with Delirium. Also includes Treating Delirium: A Quick Reference for Psychiatrists**


This is the tenth in a series of practice guidelines published by the American Psychiatric Association and has been

produced by consensus forming among experts in the field of delirium. I think the guidelines are excellent, providing a useable and welcome review of the management of delirium, as well as showing the direction developments in the management of this condition are likely to take. They are well written, as well as up to date with the latest trends in our understanding of the outcome of delirium.

The guidelines discuss and outline the causes, investigation and management of delirium from the medical, psychiatric and environmental perspective. They are backed up by a quality review of the evidence base in the literature. The guide-

lines cover almost all the key areas of importance in delirium and give advice on the choice of therapeutic agents and other interventions. My only disappoint-
ment is that they do not really mention the differentiation of delirium from dementia, which is an important problem in the management of both conditions (Macdonald & Trelor, 1996). Topics even included a discussion of electroconvulsive therapy and delirium (only possibly indi-
cated in the neuroleptic malignant syndrome). In addition, as is so often the case the guidelines highlight some of the differences between US and European psychiatry. Here is discussion of the use of restraints; interestingly, they are consid-
ered particularly safe for elderly people because of the lack of drug interactions, but it is admitted that fractures are a special risk in this group. More impor-
tantly, even though a solid evidence base for newer drugs is awaited, the guidelines show that we are now moving towards the use of phystostigmine and other choli-

nesterase inhibitors in the acute manage-

ment of delirium. In many ways the management of delirium has always been one of passively containing the problem until it either goes away or progresses to dementia. Now, we can see the begin-

nings of the active management of delirium with, hopefully, improved outcomes as a result.

I think this work is the best review I have seen of delirium and would recom-

mend it for all libraries that postgraduate psychiatrists and physicians use. It would be a very useful standard resource for old age psychiatrists as well. As ever, we will need to help our medical colleagues find out more about delirium, and this book may well be helpful in this respect.

Finally, there is a useful Patient and Family Guide for Delirium included. I know of many families who would like to have such a document while they watch their relatives struggle through a delirious process.

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**Reference**


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**Clinical Research in Psychiatry: A Practical Guide**

Edited by Stephen Curran & Chris-
topher Williams. Oxford: Butter-

Less than a third of specialist registrars make full use of the research time allo-
cated to them during the four years of their higher training, and this book could have been dedicated to the other two-

thirds who do not. A sentiment of ‘no excuse we really do’ weaves its way persuasively through the text. Each

contributor works hard to promote the benefits and personal rewards of research on the one hand, while tackling head-on those commonly encountered obstacles which can transform the most enthu-

siastic, even euphoric researcher gripped with inspiration to answer a question which really interests them, into a frustrated and weary one disillusioned by the inevitable problems and pitfalls which will befall even the most carefully conceived projects.

Practical, task-focused and concise chapters describe many of the separate components of a research project from its conception to conclusion, including designing and undertaking a literature search, planning and writing a study protocol, identifying collaborators, assembling a project team, obtaining grants and disseminating results. The reader will understand that these authors are just as familiar with the challenges of research work as they are with its plea-

sures. One message comes across loud and clear: challenges are there, and will
be overcome. One early chapter reviews a survey of specialist registrars' attitudes to research opportunities during their training, and the obstacles they face. Lack of time, appropriate support and their need for supervision are already widely recognised, but here the authors reveal less well appreciated and more ominous sounding syndromes, including "the canteen culture" of the "anti-research milieu", profound attacks of procrastination and acute unpredictable episodes of deep-seated vacillation. A later chapter, entitled 'Maintaining momentum', revisits each of these potential obstacles one by one, inviting the readers to identify those barriers most relevant to their own progress, helping them to devise specific plans to overcome them. Presentation is another strong point of this publication, with emphasis placed on the use of summary boxes in the text to direct the reader's attention to the salient issues raised in each of the chapters.

In taking this practical, problem-focused approach less space is devoted to more technical questions, such as study design or sample selection. The coverage of such issues relevant to quantitative studies is therefore not exhaustive, while those for qualitative designs is almost non-existent, and is mainly limited to highlighting the various differences between these two approaches. For instance, there are three chapters dealing with aspects of the analysis of quantitave data, but virtually no mention is made of the range of methods appropriate to the analysis of qualitative material. This seems to be a lost opportunity when a pluralist approach combining both methods is now promoted by many investigators, as well as those who commission their work. If support for research generally is hard to come by, that for qualitative approaches in particular is even thinner on the ground. A similarly practical approach in this area would have been a bonus.

This is a useful book, and contains much wisdom for anyone interested in the 'how to do it' of research work. The text seems to roll along with a momentum of its own, and is pervaded with a sense of the editors' enthusiasm. It is refreshingly down to earth and accessible, and the covers of many of its copies will quickly become dog-eared and tatty around the edges because its owners have so often had reason to dip into it and draw on the useful lessons learnt, and shared here, by others.

**Sarah Marriott, Consultant Psychiatrist, Paterson Centre for Mental Health, 20 South Wharf Road, London W2 1PD**

**The Marriage of Heaven and Hell**


If you are from the upper social classes and becoming manic, your illness is manifest in slightly more flamboyant ways; in 1908 Virginia Woolf and friends took part in the now famous Dreadnought Hoax. A telegram was sent to HMS Dreadnought, the flagship of the British home fleet then anchored at Weymouth, advising the Admiral of a visit by the Emperor of Abyssinia and four of his entourage. The group (Woolf et al) all disguised by dark greasepaint and wearing flowing robes, were met by a guard of honour at the station and escorted round the ship by the captain. Woolf's brother played the interpreter and used what one sailor called a 'rum lingo'. Virginia remained silent, which is perhaps why they escaped detection. They got back safely and all would have been well, had not one of the party informed the press, whereupon a storm broke over their heads.

This anecdote comes from Peter Dally's biography of Virginia Woolf, with particular reference to her manic-depressive illness and the desperate attempts by her husband, Leonard, to cope with it. A retired consultant psychiatrist from the Westminster Hospital, Dally has painstakingly researched the inner dynamics of the dazzling Bloomsbury group. The gripping story that emerges is that some of the 20th century's brightest minds seemed curiously incapable of applying their intellects to the basic challenges of the emotional difficulties in their own lives.

Earlier in her life, Lytton Strachey, widely known to be a confirmed homosexual, proposed to Virginia and she accepted, to his shock and dismay, but they both managed to extricate themselves from the quagmire. Leonard and Virginia's own married sex life seems to have been deeply unsatisfactory from an early stage, yet they appeared to have done little to use their vast educational resources to inform themselves about possible solutions. Despite Leonard taking over the publishing of the International Psycho-Analytical Library, he made almost no attempts to obtain any kind of ongoing therapeutic help for Virginia's manic depression. She read Freud 'compulsively' for a while, yet also seemed unable to attempt any psychological understanding of her moods. No doctor specialising in neurology or psychiatry was ever engaged for help by the Woolfs for any prolonged period.

Dally prefers impassionate reporting of the facts rather than a polemic, but what emerges is a group of gifted individuals reduced to rather immature avoidance whenever in danger of confronting their own difficulties. There are some interesting clues here for the clinical psychiatrist of why sometimes the most intellectual patients are oddly the most difficult to treat.

Indeed, this eventually proved Virginia's undoing as Leonard took her to see a kind of family doctor inexperienced in mental illness, living miles away, for an inadequate consultation the day before her suicide. The ultimate tragedy of untreated manic depression is poignantly apparent in her suicide note — the deep loss to all of us when creativity and genius cannot be protected from the ravages of mental illness, or perhaps darkly inevitable insight. Her final lines ever include "... I am certain I am going mad again ... I am always hearing voices, and I know I shan't get over it now."

**Raj Persaud, Consultant Psychiatrist, Maudsley Hospital, De Crespigny Park, Denmark Hill, London SE5 8AF**

**miscellany**

**Treatment decisions in young people — new information sheets by FOCUS**

Involving children and adolescents in decisions about their medical treatment has been an area of considerable debate and contention for some time. This issue has been front-page news, especially when controversial court decisions are made to overrule children's and/or parents' decisions about the medical treatment they wish to receive or decline. This is, however, an everyday issue for practitioners who care for children. For this reason, FOCUS, the child and adolescent mental health project at the Royal College of Psychiatrists' Research Unit has produced a set of three information sheets that give an overview of some of the key issues in this complex area.

Sheet number 1: The Legal Framework covers issues such as consent, refusal and competence (to decide) in relation to Acts
of Parliament and court rulings that have set legal precedents.

Sheet number 2: Practice Guidelines gives guidance and advice to clinicians working with children where issues of consent from the child, parent(s) or guardian are an essential part of the treatment plan. Case studies are used to illustrate the complexity of these situations, for example, the treatment of a child with anorexia nervosa who is refusing to eat.

Sheet number 3: Frequently Asked Questions and References lists common questions about children and their involvement in treatment decisions in terms of consent, refusal and competence. Full references are listed together with a ‘further reading’ section.

The sheets are aimed at all practitioners who look after children as well as parents and key interest and welfare groups. For further information, please contact Carol Jowett, FOCUS Project Manager, College Research Unit (telephone: 020 7235 2351 ext 256).

Clinical Excellence 2000 – promoting quality in mental health and learning disabilities is the title of the Royal College of Psychiatrists Research Unit’s fifth multi-professional conference focusing on quality and effectiveness issues in mental health services. The conference will take place at Merton College, Oxford, on 5–7 April 2000. This conference focuses on achieving excellence in mental health and learning disability services from a practical perspective. Initial presentations will set the scene for creating quality in mental health services in the ‘New NHS’ and parallel sessions will focus on current developments in mental health services to promote excellence, changing the culture of mental health services to facilitate and nurture quality improvements and real examples of projects that have made a difference. The event aims to provide an opportunity for people working in mental health and learning disability services to share best practice and innovative ideas at both strategic and practice levels and uses a parallel session format to help delegates select a range of sessions that they will find most useful. Further information: Sam Coombs, Communications Officer, College Research Unit (Telephone: 020 7235 2351 ext 234).

Professor R. N. Mohan, Consultant in Old Age Psychiatry and Clinical Tutor for the Northern Birmingham Mental Health NHS Trust is the organiser of three two-day courses. Mental health law update for specialist registrars, being held on 7–8 March 2000 and Mental health law update for consultant psychiatrists, being held on 6–7 April 2000, will focus on key issues related to the Mental Health Act and Mental Health Law. Management course for specialist registrars in psychiatry, which will take place on 4–5 May 2000, will cover NHS structures and functions, terms and conditions of service, time management and negotiating skills. Further information about all the courses, which will be held at the Birmingham Medical Institute:

Mrs Denis Makepeace (Telephone: 0121 685 6574).

The Centre for Evidence-Based Mental Health at the University of Oxford’s Department of Psychiatry would like to announce the Fourth Workshop on Evidence-Based Psychiatry, which will take place at Merton College, Oxford, on 5–7 April 2000. This workshop will equip participants with the basic skills necessary to apply the principles of evidence-based medicine in psychiatry. The strategies covered will include searching for, and critically appraising evidence and using research findings in everyday clinical practice. The workshop will use a problem-based approach, involving both small group work and lectures, and will demonstrate how evidence-based medicine can help in making clinical decisions concerning diagnosis, treatment, prognosis and harm. There will also be plenty of opportunities for informal discussion. Applications can be made via Internet forms at: http://www.psychiatry.ox.ac.uk/cbhm/merton2000. Further information: Pat Gresham, Centre for Evidence-Based Mental Health, University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX (Telephone: 01865 226476; Fax: 01865 793101; Email: pat.gresham@psch.ox.ac.uk).

The Politics of Recent Mental Health Policy is the title of a critical psychiatry day conference which will take place in central London on 7 April 2000. Some of the topics to be addressed include: community care without compulsion; incapacity and mental illness as a basis for psychiatric legislation; and compulsory community treatment: implications for patient rights and civil liberties. The conference will look into the history of mental health legislation in the 20th century and give the results of a recent survey of psychiatrists’ opinions about community treatment orders and detention of people with personality disorder. There will also be workshops in the afternoon on advocacy, advance directives and challenging assumptions about drug treatment. Further information: Dr Joanna Moncrieff, Charing Cross Department of Psychiatry (Telephone: 0181 846 7336; E-mail: joannamoncrieff@compuserve.com) or Dr Jonathan Bindman, Institute of Psychiatry (E-mail: j.bindman@iop.kcl.ac.uk).

The Belmont Postgraduate Psychiatric Centre would like to announce The 55th Residential Revision Course for the MRCPSych Examinations, which will take place at the University of Surrey, Guildford on 5–13 April 2000 (Part I) and 13–20 April 2000 (Part II). Further details: Mrs E. C. Denning, Belmont Postgraduate Psychiatric Centre, ChilTERN Wing, Sutton Hospital, Sutton, Surrey SM2 5NF (Telephone: 020 8296 4177).

The Association of Therapeutic Communities are the sponsors of Experiential Residential Workshop, an event which will be held in Kent on 5–7 May 2000. The course focuses on the use of intensive psychosocial treatment for borderline personality disorder and other clinical conditions and is designed for those who work in, or are interested in working in therapeutic communities. Further information: The Association of Therapeutic Communities, 13–15 Pine Street, London EC1R 0JH (Telephone/ fax: 020 8950 9557; E-mail: post@therapeuticcommunities.org).

The University of Manchester, Department of Psychiatry are the organisers of The 8th Manchester Course in Liaison Psychiatry, a week-long course which will take place on 5–9 June 2000. The course is most suitable for newly appointed consultants and specialist registrars. Emphasis is placed upon small group teaching and workshops. Clinical issues covered include somatisation, psychological reactions to physical illness and medico-legal aspects of liaison psychiatry. Other issues to be covered are managerial and administrative issues, research and audit. Further information: Mrs Una Dean, Secretary to Dr E. Guthrie, University Department of Psychiatry, Rawnsley Building, Manchester Royal Infirmary, Manchester M13 9W (Telephone: 0161 276 5383, Fax: 0161 273 2135; E-mail: Una.Dean@man.ac.uk).