Al-Issa then suggests that the unfamiliarity with one's inner world that is, in his view, promoted by rational cultures, may increase the experience of unintended imagery. He follows other authors in suggesting that this may result in the development of hallucinations. He therefore appears to be suggesting that unfamiliarity with one's own imagination can both *increase* hallucinations (via unintended imagery) and *decrease* hallucinations (through lack of awareness).

A central difficulty in Al-Issa's thought-provoking essay is his failure to distinguish between hallucinations of different origin that occur, even within one culture. (Many "less rational" cultures themselves distinguish culturally sanctioned hallucinations as different from those arising from mental illness). Flexible boundaries between reality and fantasy may, as Al-Issa suggests, facilitate culturally sanctioned hallucinations. These are regarded in a positive light by both the subject and his society. In contrast, lack of familiarity with one's own imagery has been associated almost entirely with the hallucinations of patients with schizophrenia and depression (Heilbrun, 1980; Heilbrun *et al*, 1983). Similarly, unintended verbal imagery has been postulated as underlying the development of schizophrenic hallucinations (Hoffman, 1986). These hallucinations are often regarded in a negative light by both the subject and society, even in many "less rational" cultures.

The cultural context of an hallucination can be of great importance to the hallucinator. But this does not mean that the cultural context is relevant to the development of all hallucinations.

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Hoffman, R. E. (1986) Verbal hallucinations and language production processes in schizophrenia. *The Behavioural and Brain Sciences*, **9**, 503–548.

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Mental health tribunals

Sir: We would like to respond to the editorial by Wood (1995).

The Mental Health Act 1983 (Department of Health, 1983) is in need of review. Tribunals are dissatisfied with their limited powers (Roberts, 1991), RMOs find the procedure untherapeutic (Wessely & Blumenthal, 1994), and the current methods of ensuring patients' civil liberties are unsatisfactory (Webster & Dean, 1989; Bradley *et al*, 1995). There is still considerable criticism of the changes brought about by the 1983 Act. Peay (1989) concludes that tribunals invariably endorse recommendations of the RMO, and that changes are only a procedural safeguard. Wood (1995) suggests that Section 2 orders be lengthened if patients are known to have suffered previous breakdowns, to reduce the pressure on already hard pressed tribunal offices and RMOs; that tribunals help the Home Secretary to collate a series of reports on restricted patients to participate further in the decision making process as to their discharge; and finally, that tribunals have a broader range of options than simply to discharge or not.

Lengthening Section 2 orders without strengthening the rights of patients to a tribunal, for instance with an automatic review of the circumstances of their detention, would augment current concerns that patients are being detained without satisfactory protection of their civil liberties. Wood (1993) has previously proposed an alternative procedure of "emergency review" by the Medical Member of the tribunal only, but this is unlikely to satisfy the conditions of the European Court of Human Rights which requires that detained patients should have right of access to a body which is both judicial and has the characteristics of a court.

The role of the managers' hearing appears to duplicate the role of the mental health tribunal. Hearings tend to be less formal, are conducted by managers who are "lay people", and discharges are less likely. Rather than shadowing the mental health review tribunals managers could, with appropriate selection, training and remuneration, develop their role to perform this initial automatic review which Wood proposes. They would presumably be less likely to discharge patients given the acuteness of patients' symptoms, however, their additional role would come closer to satisfying the first part of the objectives of the Mental Health Act legislation: "to safeguard against improper detention and protracted detention". This would give all patients detained under an assessment order the right for early and automatic review of their detention, without clogging up the tribunal system, nor necessarily requiring detailed written reports from RMOs which are difficult to produce in the short time currently permitted for Section 2 tribunals.

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Roberts, J. (1991) Problems of review and discharge: is tribunal necessary? *Journal of the Royal Society of Health, June*, 111–113.
Wessely, S. & Blumenthal, S. (1994) Patterns of delay in mental health review tribunals. London: HMSO.
Webster, L. & Dean, C. (1989) The working of the 1983 Mental Health Act: the experience of patients, relatives, psychiatrists, general practitioners and social workers involved in compulsory admission. *Psychiatric Bulletin*, **13**, 477–479.
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ECT seizure threshold

Sir: Tobiansky & Lloyd (1995) may be correct that they have described an idiosyncratic effect of fluoxetine on seizure threshold, but their case report did not contain sufficient information to assess the validity of their suggestion.

Seizure threshold fluctuates with time and was not itself measured in their report, but inferred from seizure length. The relationship between seizure threshold and seizure duration is complex and non-linear (Enns, 1993). Seizure length is affected by several factors in addition to concomitant psychotropic drug treatment, chiefly the dose of induction agent, itself a seizure-shortening drug (Miller *et al*, 1985), and other aspects of anaesthetic technique (Collins & Scott, 1995). Only if all these factors were standard would it be appropriate to suggest a putative seizure-lengthening effect of fluoxetine.

Collins, I. & Scott, A. I. F. (1995) Anaesthetic technique in the practice of ECT (Letter). *British Journal of Psychiatry*, **166**, 118–119.
Enns, M. W. (1993) Seizure duration and seizure threshold. *Convulsive Therapy*, **9**, 130–131.
Miller, A. L., *et al* (1985) Factors affecting amnesia, seizure duration, and efficacy in ECT. *American Journal of Psychiatry*, **142**, 692–696.
Tobiansky, R. I. & Lloyd, G. G. (1995) ECT seizure threshold and fluoxetine (Letter). *British Journal of Psychiatry*, **166**, 263.

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The Chinese classification of mental disorders

Sir: Cooper provided a useful overview of the DSM–IV and ICD–10 (Cooper, 1995) but it is worth noting that China, which makes up some one-fifth of the world's population, has its own classification, called the Chinese Classification of Mental Disorders (CCMD). Its latest version, called the CCMD–2–R (2nd edition, revised), is published in January 1995 (Chinese Medical Association and Nanjing Medical University, 1995).

The CCMD–2–R is the result of several revisions, drafting, consultations, and field tests. It classifies mental disorders into 10 broad groups based on both aetiology and symptomatology. Much like the quick reference to the DSM–IV, it is published in Chinese in the form of a handbook of 238 pages. Costing only 6 *yuan* (about US $0.7) per copy, it contains operationalised diagnostic criteria for nearly all listed categories, and "crosswalks" to ICD–9 as well as ICD–10 codes for the same/similar conditions.

In devising the CCMD–2–R, Chinese psychiatrists have attempted to conform with international classification on the one hand, and to maintain a nosology with Chinese cultural characteristics on the other. Some Chinese psychiatrists feel that the CCMD–2–R is redundant because the ICD–10 (which is available in Chinese) is a comprehensive system that will not only serve them well, but also facilitate both inter-speciality and international exchange. But it appears that most Chinese psychiatrists believe that the CCMD–2–R has distinct advantages, such as brevity, the inclusion of culture-distinctive categories (e.g. *koro* (unipolar mania), *shenjing shuairuo*, and *qigong* (induced mental disorder), and the exclusion of diagnostic entities felt not to be suitable for use in China (e.g. pathological gambling, excessive sexual drive, and somatoform disorders) or without sufficient empirical basis (e.g. schizotypal disorder). The terms "neurosis" and "hysterical psychosis" continue to be used. Future revision of the CCMD–2–R is to be expected.

Sartorious noted that "a classification is a way of seeing the world at a point in time" (WHO 1992, vii). From this perspective, the CCMD–2–R is a useful avenue for understanding the Chinese mind as well as the contemporary Chinese social world. It may also provide valuable contrasts with the ICD–10 and DSM–IV as we move towards a truly international classification of mental disorders.

Cooper, J. (1995) On the publication of the *Diagnostic and Statistical Manual of Mental Disorders*: Fourth Edition (DSM–IV). *British Journal of Psychiatry*, **166**, 4–8.
Chinese Medical Association and Nanjing Medical University (1995) *Chinese Classification of Mental Disorders*, second edition, revised (CCMD–2–R). Dong Nan University Press.

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