if the discovery of such a link were to remain as a conclusion in itself.

The real question to be addressed is whether such a change in referral rate represents an increase in work done with patients and their families. If general hospitals were a virgin soil for such work then there would be grounds for thinking this to be so, but this is not the case. Social work departments have been developing liaison work for the past 90 years, and many of the problems encountered by liaison psychiatrists are familiar to us.

Despite the reluctance of some medical and surgical specialists to refer patients, it has been possible for the social worker to offer not only a practical service where appropriate but a skilled therapeutic service to patients suffering from mild affective and neurotic disorders, and preventive work with patients at high risk of such disorders.

For example, at St Charles Hospital, London, the Social Work Department offers counselling to surgical patients and patients with life-threatening medical conditions such as cancer, to all women seeking terminations of pregnancy, and to elderly patients and their relatives. They had also developed a system of assessment of patients admitted following deliberate self-harm in advance of the 1984 DHSS recommendations and in consultation with the psychiatrists at Springfield Hospital.

Because of the social worker's perspective it is often possible to offer a systematic approach which includes and takes account of family and network processes. It is frequently a failure to attend to these that leads to slow discharge or high re-admission rates. It would be unfortunate if an increase in the level of liaison psychiatry with a medical psychiatric model were to undermine this work.

Although much of this is written up in the social work journals it is likely that these are read even less frequently by doctors than the medical journals are read by social workers. Perhaps more collaboration and research is needed in this area.

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A Patient with Resistant Schizophrenia

SIR: We read with interest, but some surprise, the recent report by Roberts *et al* (*Journal*, December 1986, **149**, 789–793). The case highlights many of the difficulties of managing schizophrenia resistant to treatment. However, we were puzzled because the authors presented this as "clearly an unusual case". The tenor of the paper suggested that one is unlikely to find other such patients.

Watt *et al* (1983), in a prospective study, followed 121 patients presenting to the mental health service of a discrete geographical area for five years: 50% failed to become symptom-free in that time, and for over 40% each acute exacerbation of the disorder resulted in progressively less recovery. Among patients with a first episode of schizophrenia referred from nine medical centres in London and its surrounds 17 (nearly 7%) never left hospital throughout the first 20 months of follow-up. (Macmillan *et al*, 1986). On the Denis Hill (Secure) Unit, another ward at the Bethlem & Maudsley Joint Hospital, there are currently 16 out of a total of 27 patients with psychotic illnesses, mostly schizophrenic in type. Five of these have been floridly ill with positive symptoms, probably unremittingly so, for a time approaching that described by Roberts *et al* and have been continuously in hospital with well documented, vigorous treatment with the full range of medication appropriate to psychosis. Some have had ECT too. Another patient who first presented with psychosis and was first admitted only 18 months ago has similarly failed to show any significant reduction of his psychotic features. The other secure units in the South East Thames Region could report a similar situation and the Special Hospitals, in particular Broadmoor and Park Lane, could report many such patients. Even the open forensic unit at the Maudsley Hospital usually has one or two such patients.

How can it be that psychiatrists working together in the same institution can have such different experiences? We would speculate along the following lines. First, psychiatry is becoming increasingly compartmentalised, and with the very considerable clinical demands made on all of us there is insufficient time to explore the interesting byways of other people's wards and practice. Secondly, forensic psychiatric units have been encouraged by general psychiatrists to take aggressive patients off their hands and do so. In our experience treatment resistant schizophrenic patients are frequently aggressive. Thirdly, the policy of dismantling NHS asylums has forced a number of treatment resistant schizophrenic patients into non-medical settings, such as prisons, doss houses, and the streets.

One comment on the treatment resistance itself may be pertinent. Most schizophrenic patients who do not respond to medication (in the sense that their hallucinations and delusions do not go away) do, in fact, derive some benefits from medication, either in terms of sedation, in mood improvement, or in improvement of other neurotic symptoms. Furthermore, our current work shows that although our

treatment-resistant psychotic patients almost invariably have unusual cognitive patterns on neuropsychological testing, most can be helped a great deal by the provision of a stress-free milieu (advocated by Murray), together with the careful provision of suitable occupations and recreations. Above all, they need appropriate supportive psychotherapy.

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SIR: I was astonished to read the Maudsley Grand Rounds case report (Roberts *et al*, *Journal*, December 1986, **149**, 789–793). Where is the data to support the view that all "acute symptoms of schizophrenia can be controlled pharmacologically"? Existing data suggests that a substantial proportion of cases show unremitting psychotic symptoms. The landmark Camberwell study of Brown *et al* (1972) included 29 patients who left hospital with persistent symptoms in the 101 consecutive admissions who were discharged to family households. The five patients who remained in hospital probably suffered persistent symptoms. Thus, it seems reasonable to conclude that at that time excellent treatment at the Maudsley Hospital was unable to induce a remission in one-third of cases.

Despite considerable recent advances in our understanding of the pharmacology of schizophrenia there is little evidence to suggest major advances in the efficacy of drug treatment. However, there have been developments in psychological interventions that appear to add to the efficacy achieved by drugs alone. These include a broad range of behavioural psychotherapy interventions (Hagen, 1975; Paul & Lentz, 1977; Falloon, 1985). Before advocating the low stress social environments offered by the long-stay asylum I would recommend pharmacologists to seek the assistance of a skilled behavioural psychotherapist in the comprehensive management of schizophrenia.

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Psychological Disorders in Obstetrics and Gynaecology

SIR: In her review of *Psychological Disorders in Obstetrics and Gynaecology*, Jequier (*Journal*, December 1986, **149**, 807) applauds the comprehensive coverage assembled by the editor of the book, R. G. Priest.

About one-fifth of all pregnancies end in spontaneous abortion or miscarriage, although estimates range from 10 to 43% (Miller *et al*, 1980; Llewellyn-Jones, 1982). This is comparable in frequency of occurrence to that of induced abortion, which Olley (1985) puts at about three in ten. Yet a complete chapter is given to the latter and the bare mention of the former is in a brief coverage of psychogenic factors in repeated abortion.

It is now being recognised in some of the literature (Raphael, 1984) that spontaneous abortion frequently has profound psychological effects and that these reactions are often missed or mishandled, partly because the event is dismissed as 'routine'. What a pity, then, that this "splendid contribution to the literature" has failed, like the reviewer, to give recognition to such a common and distressing, but often ignored, problem in obstetrics and gynaecology.

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