Correspondence

Less severe mental illness

Sir: Increasingly, the term 'severe mental illness' is being used as a euphemism for schizophrenia and manic depressive disorder. Unsurprisingly, it has given rise to the notion of 'less severe mental illness'. This phrase tends to act as an umbrella for illnesses as diverse as depression, anxiety–phobic disorders, eating disorders, obsessional states and personality disorders.

We would like to distance ourselves from the phrase 'less severe mental illness', not least because it is not! In terms of life-disruption, personal and family distress and the general impact on society, neurotic and personality disorders can be just as severe as schizophrenia. Indeed, in terms of response to treatment, it's hard to understand how the term 'less severe' can even be considered.

We fear that the use of the term is patronising to the distress of our patients, may unduly influence the research-funding bodies and, most hurtful of all, impact on the attitude of colleagues towards those of us who work particularly with these patient groups.

We would suggest that the term be dropped and that psychiatrists, as doctors, use internationally-established diagnoses.

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Integration of psychiatry and psychotherapy

Sir: The editorial 'Integration of Psychiatry and Psychotherapy' (*Psychiatric Bulletin*, August 1996, **19**, 465–466) has remained on top of my desk for several reasons. Not only because it was a lucid and, as expected, interesting read (vintage Jeremy Holmes) but also because it perhaps did not really have the last word on this important subject, nor identify completely the 'landmarks' which led to the *Guidelines for Psychotherapy Training as Part of General Professional Psychiatric Training* being implemented. Certainly the first landmark was indeed like a newly erected cairn which guided the way on unexplored paths (the first woman and also the first psychotherapist as President), and the second landmark (the College Guidelines) has undoubtedly already influenced for good the basic training of general psychiatrists, as any member of the Central Approval Panel or Court of Electors would recognise.

As Dean, I am well placed to note the innovative ideas that have emerged as a result of these requirements of the Court of Electors being made a mandatory requirement on training schemes. These have included the apointment of psychotherapists, the sessional commitment of cognitive–behavioural therapists, the orientation of a psychotherapy department towards the training needs of senior house officers (SHOs), and the appropriate involvement of general psychiatrists with interest and expertise in psychotherapy.

However, writing as a former Chairman of the General Psychiatry Section, is there a part of the story missing? My local enquiries which I undertook for a paper at the Joint Meeting of the General Psychiatry Section and the Psychotherapy Section showed clearly that *prior* to the foundation of the College, the Royal Medico-Psychological Association had recommended such training for general psychiatrists and over subsequent years Council had in general supported these recommendations, but not made them mandatory.

Jeremy Holmes is no doubt correct in saying that there were several reasons for this reluctance, although not all psychiatrists are trained at the Institute and some, like myself, were influenced greatly by Desmond Pond's leadership at 'the London' where in the late sixties the 'splitting' between British psychiatry and psychoanalysis was fortunately less apparent. Certainly the debate in those days as to whether psychotherapy could be carried out at all unless a personal analysis had been experienced seems curiously archaic from a present standpoint. No doubt there was, and is, an unnecessary splitting still enshrined in Holmes' question: "Is it really possible to combine psychiatry and psychoanalysis when their 'feel' is so very different?"

Nevertheless for most general and community psychiatrists is this not an outdated critique? Most psychiatrists are using psychotherapy skills – Cinderella (supportive therapy) did get to the ball and counselling skills, as well as cognitive and brief dynamic therapy, are now familiar training requirements.

However, why *did* the College (both Council and Court of Electors) change its mind and make basic psychotherapy training mandatory? Not, I think, because they were occupied with issues of 'status', or a wish to resolve half-forgotten battles from the past, but because most psychiatrists working with multi-professional teams regarded this as a *sine qua non* for good practice, and for maintaining professional self-esteem.

Certainly the somewhat precocious influence of the General Psychiatry Section, which endorsed multi-model psychiatry, was undoubtedly a major explanation as to why these formerly controversial issues caused such little dissent (or debate) when the *Guidelines for Psychotherapy Training as Part of General Professional Training* (Royal College of Psychiatrists, 1993) were proposed; although influential academics correctly endeavoured to see that the psychotherapy recommendations were realistic and achievable. To that extent the most difficult decisions for the Court of Electors are yet to come, i.e. when training programmes are being revisited in two to three years time and the psychotherapy training requirements for SHOs reviewed, how will the Court respond to requirements that have not been *fully* implemented?

No doubt consultant psychotherapists and the Psychotherapy Section were appropriate advocates for these changes but the challenge for these specialist psychotherapists is equally great. Will they indeed direct their energies to the training of psychiatrists in their first years of training, and provide a menu of clinically relevant supervision sessions across the broad range of psychotherapeutic treatment?

I indeed hope, using the Holmes' metaphor, to remain a 'footsoldier' of psychiatry and certainly there is plenty of room in the trenches for a psychotherapist familiar with the rigours of trench warface including the ability to adopt strategies to meet unexpected demands.

The *Guidelines* were of course written by a general psychiatrist (James Watson), a psychotherapist (Sandra Grant), and that notable hybrid now from North Devon whose pungent writings have as usual sparked off this less eloquent, but hopefully relevant, historical response.

ROYAL COLLEGE OF PSYCHIATRISTS (1993) *Guidelines for Psychotherapy Training as Part of General Professional Training* (CR 27). London: RCPsych.

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Warning signs at a discharge meeting

Sir: The patient was subject to Section 117, Level 3 Care Programme Approach and the Supervision Register. There had been full agreement on the care plan until we came to warning signs. The patient agreed that 'stopping medication' was a warning sign. That was why he was in hospital now. 'Suicidal thoughts' were also a warning sign. He was well aware that he might kill himself one day and did not object to being on the Supervision Register.

However, he strongly disagreed with 'social withdrawal', included because he had been admitted to hospital in a catatonic state. He felt he had the right to silence like anyone else and became suspicious and upset having previously been very positive about the care plan. It was agreed that social withdrawal would have to be accompanied by self neglect to qualify as a warning sign. The sheaf of relevant forms were amended and he was asked to sign them.

He wanted to know whether signing the forms meant he was making a future commitment or just a current one. Would it make a difference to him if he did not sign? We reassured him it would make no difference to his care, and he should only sign if he agreed.

Trust had evaporated, and he now decided he wanted to appeal against his inclusion on the Supervision Register. He was on the Supervision Register because he had made several serious suicide attempts in the past which always occurred without warning, when he had no psychotic symptoms and was taking medication. Only when he was well did he fully realise how much his illness had frustrated his progress through life.

The meeting, witnessed by a baffled nearest relative, was unavoidably stressful and protracted. Later I was recalled to the ward to fill in the Early Notification of Discharge Form for the general practitioner which I had forgotten. Only that night did I remember that I had also forgotten to sign the most important form of all. It was presumably designed in 1983 because it was the size of a postcard and merely required the name of the patient, the date and my signature to discharge him from Section 3.

With the advent of the Supervised Discharge Order which adds another 20 pages of documentation to the discharge procedure, I wonder whether it is the profusion of paperwork that is the warning sign for our profession – the gradual change from doctor to discredited public official continues.

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Plasma levels of tricyclics and related antidepressants

Sir: I was interested in reading the opinion by Taylor & Duncan (*Psychiatric Bulletin*, September 1995, **19**, 548–550) that "...tricyclic serum levels