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correspondence

Recovery as a medical myth

Sir: I would like to comment on the responses to my paper (*Psychiatric Bulletin*, October 1999, **23**, 621–622). Prior (*Psychiatric Bulletin*, January 2000, **24**, 30) states that I was using a medical concept of recovery; I agree. However, I did not define recovery, and it was the patients who thought that they had not recovered. I think that this concept of recovery is part of a medical model in which people suffer from clearly defined episodes of illness, from which they can hope to make an equally clearly defined recovery, provided they get the right treatment.

Psychiatry has tended to operate with these oversimplified concepts. My conclusion is that recovery from mental illness is part of a medical view of things, and as such is largely a myth. It is an unexamined idea that people believe, but which does not reflect reality. It also seems that this unhelpful myth is shared by our patients. One reason for the hold that this myth has is that it fits quite well with the situations that we face in acute psychiatry. It justifies interventions that may be urgent and difficult. It is in the longer term that the model fails.

Hope and optimism are essential in mental health services, as Sayce and Perkins comment (*Psychiatric Bulletin*, February 2000, **23**, 74). That is why the medical concept of recovery – by which so many are likely to be disappointed – is an unhelpful myth. They mention a different process of recovery – which is slow, and very personal: a rebuilding of a life, which may take a life time.

We are only now beginning to understand this process and how to help people with it. It is an exciting and growing field. What is clear is that medical treatments by themselves do not achieve this. Too often in the past the traditional medical focus on diagnosis, medication and coercion have been seen by service users as standing in the way of personal recovery. There is a problem concerning words here. Recovery is a very positive and uplifting word. It has been linked into a limited medical model where it does not fit. 'Personal recovery' may be a better term as it stresses the individual, and gets away from the idea that this is something that we can do to people.

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Managers' hearings: dialectic and maternalism

Sir: In his editorial, 'Managers' hearings: dialectic and maternalism' (*Psychiatric Bulletin*, October 2000, **24**, 361–362), Kennedy appears to equate maternalism with a strategy of weakly avoiding confrontation.

I feel obliged to challenge this stereotype, not on behalf of strong authoritarian female parents, who are more than able to come to their own defence, but on behalf of Milne's quoted maternal archetype (Milne, 1928), Kanga, who cannot.

In order to deal with Tigger, "a young person of impulsive and energetic temperament who does not know what he wants but has strong opinions about his dislikes", Kanga does not, as is suggested by Kennedy, avoid confrontation. Rather, Milne's maternal archetype encourages her charge to explore the therapeutic possibilities of her food cupboard. In the context of a long-term relationship, Tigger has a role in planning his own breakfast. Kanga asserts her own view by insisting that when she "thought he wanted strengthening, he had a spoonful or two of Roosbreakfast after meals as medicine".

Kanga does not, like Kennedy's avoidant maternalistic psychiatrist, conceal the fact that she has her own opinions as to what is best for Tiggers.

In using the terms paternalism and maternalism Kennedy is confounding the real issue. Both stereotypical 'authoritarian psychiatry' and stereotypical 'avoidant psychiatry' are unhelpful attempts to sidestep the reality that, mentally ill or not, our patients have minds of their own. It cannot be left up to psychiatrists to decide in which contexts our opinions should prevail.

MILNE, A. A. (1928) *The House at Pooh Corner*. London: Methuen.

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Use of the cuff method in electroconvulsive therapy – a response

Sir: The study by Jan Wise *et al* (*Psychiatric Bulletin*, August 2000, **24**, 301) is interesting. The authors have found no significant difference in seizure duration between the cuffed and uncuffed limbs and suggest that the use of the cuff method to 'observe' absent seizure cease, as it merely delays addressing the real cause of 'absent' seizures. The following issues also need to be considered in this respect:

(a) A tonic–clonic seizure that is not witnessed may be owing to inattention, absence of seizure activity or excessive muscle relaxation (Fink, 1983). Electroencephalogram (EEG) monitoring is helpful in detecting the occurrence of a cerebral seizure, while the 'cuff' method is useful where excessive muscle relaxation may obscure an overt motor seizure. Thus, the two seizure monitoring methods address different (although related) aspects of the electroconvulsive therapy (ECT) session.
(b) The absence of any significant difference between the cuffed and the uncuffed limbs is perhaps more indicative of the absence of excessive muscle relaxation (so as to obscure a visible seizure) during ECT rather than the 'ineffectiveness' of the cuff method itself – as is suggested by the authors.
(c) The cuff method does not necessarily delay addressing the real cause of 'absent' seizures because it oft-times helps to rule out excessive relaxation as a cause for an apparently absent seizure.

Therefore, both EEG and the cuff method have a role in monitoring seizures in ECT sessions, especially so because there are no recommended dosages of succinylcholine for purpose of administering ECT.

Perhaps, an assessment of the difference in seizure intensity across limbs and the mean dosage of relaxant used would have been informative regarding the degree of modification achieved during ECT.

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FINK, M. (1983) Missed seizures and the bilateral–unilateral electroconvulsive therapy controversy. *American Journal of Psychiatry*, **140**, 1198–1199.

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Changes to the MRCPsych examination

Sir: The ability to elicit a history and to examine the mental state are essential clinical skills, but ones that are difficult to test. Direct observation would appear to be the most appropriate way of assessing such skills. However, Dale (*Psychiatric Bulletin*, October 2000, **24**, 395) is concerned about the validity of the objective structured clinical examination (OSCE) in the revised MRCPsych examination (Katona *et al*, *Psychiatric Bulletin*, July 2000, **24**, 276–278).

Currently both parts of the examination include the assessment of a single unobserved long case. This has doubtful reliability and provides an insufficient variety of clinical situations. In contrast, the OSCE is designed to test the candidates' competence in a range of clinical and practical skills.

At St George's Hospital the incorporation of an OSCE into undergraduate assessment has been a valuable learning experience for the examiners. It has indicated deficits in clinical teaching. In particular, we have reflected on how little observation of assessment by the students takes place during their psychiatry attachments.

It is pessimistic to suggest that the OSCE will delay the development of postgraduate clinical skills. Instead, the exam will emphasise their importance. Candidates preparing for the exam would be well advised to request that their education supervisors observe them carrying out patient assessments.

The OSCE will improve assessment in the MRCPsych examination and may provide the impetus to improve clinical teaching in the 'real world'.

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Corrigendum

'The future (or not) of the medical member. An aspect of the 1983 mental health review'. On page 9 of the paper by Graham Rooth (*Psychiatric Bulletin*, **25**, January 2001, 8–9), in the author's details, the e-mail address should read:

roothfg@cs.com

the college

2001: A Mind Odyssey briefing

It is a real delight to discover that our College has a soul, and that it wants our help putting it on show.

There were about 20 people representing various divisions, faculties and special interest groups (SIGs) at the 90 minute briefing, which was enthusiastically introduced by the President, John Cox. 2001: A Mind Odyssey is a celebration of the arts, psychiatry and the mind, which aims to inspire those involved in mental health services – both professionals and service users – to explore creativity and the emotionally healthy aspects of people's lives, and thereby to facilitate people in expressing themselves. The idea is to help raise awareness of the therapeutic benefits of artistic expression.

2001: A Mind Odyssey will be launched at the Annual Meeting in London, 9–13 July 2001 and will finish at the Annual Meeting in Cardiff, 24–28 June 2002.

At the briefing Deborah Hart (Head of External Relations, tel: 020 7235 2351, ext. 127; e-mail: dhart@rcpsych.ac.uk) spoke briefly on 'where we are now', outlining a dozen events already planned for next year's Annual Meeting: art therapy workshops; film study sessions; a reception at the National Portrait Gallery; an Indian dance troupe; a children's art exhibition; classical music concert; and theatrical events among them. Other exciting events are also planned throughout the year and for the sign-off in Cardiff in 2002.

Next, Alexi Wedderburn (Events Organiser, tel: 020 7235 2351 ext. 149; e-mail: awedderburn@rcpsych.ac.uk), newly employed part-time by the College, told us 'what you can do', encouraging individual College members as well as SIGs, faculties, etc. to organise events in our localities, with or by amateur and professional groups, taking advantage of our Regional Arts Boards/Councils and local resources such as art galleries, art centres, libraries and our own trusts and hospitals. There were plenty of suggestions and further advice from her, and then about fund-raising from the next speaker, Chris Beynon (Fundraiser, tel: 020 7235 2351, ext. 149), all of which was repeated in the text of an extensive and helpful 'briefing pack' handed out – extra copies available from Deborah or Alexi.

David Hart, currently poet in residence at South Birmingham Mental Health Care Trust, gave a presentation on his work in the 'older adults' department. Dr Akmal Makhdum from the College's Eastern Division and the psycho-pharmacology SIG then spoke about enterprising local, divisional and national initiatives, mainly coupled also with the College's 'Changing Minds' campaign against stigma, already running or planned, for example, involving 30 local schools and even some local restaurants.

There was a lot of discussion and finally, we were told, the rest is up to us, but that the College would answer every question and provide all the support needed. Once Alexi has approved your idea you will be able to use the 2001: A Mind Odyssey logo. Even if you only have a vague idea about a possible project, why not contact her and discuss it?

Larry Culliford

Election of president

Notice to Fellows and Members: Fellows and Members are reminded of their rights under the bye-laws and regulations, as follows:

Bye-law XI

The President shall be elected annually from amongst the Fellows.

Regulation XI

(1) As soon as may be practicable after the first day of June in any year the Council shall hold a nomination meeting and shall at such meeting nominate not less than one candidate and not more than three candidates.

(2) Between the first day of June in any year and the date that is 4 clear weeks after the nomination meeting of the Council, written nominations accompanied in each case by the nominee's written consent to stand for election, may be lodged with the Registrar, provided that each such nomination is supported in writing by not less than 12 Members of the College who are not members of the Council.

(3) An election by ballot shall be held in accordance with the provisions of the regulations.

The nominating meeting of the Council will be held on 6 February 2001 and the last date for receiving nominations under (2) above will therefore be 6 March 2001.

Professor John Cox is in his second year of office as President and is therefore eligible for re-election.

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