from the past' (American Psychiatric Association, 1994: pp. 428, 766). Dr Burges Watson infers from this that the flashback is a new term for an old phenomenon; what in the past would have been described as a vivid memory of conflict is today called a flashback. The objection to this hypothesis is that we discovered both phenomena in medical records from the First and Second World Wars. We were careful to adopt a rigorous definition of flashback (which included the sense of reliving the traumatic episode) to distinguish it from eidetic memories.

In answer to Dr Hambidge, we were unable to include veterans of the Falklands War because ministerial permission was not granted to study recent war pension files of service personnel still living, and because the Medical Assessment Programme is limited to veterans of the Persian Gulf War. As regards the collection of data, three research assistants recorded symptoms on a standardised form by copying verbatim from medical notes. These were then reviewed in detail by the lead investigator, who re-examined the files to ensure accuracy and consistency of interpretation. War pension files with missing information were excluded from the study. In general, the case notes were comprehensive, often detailing a serviceman's history from enlistment until death. As these are a continuous series of records, there is no reason to suppose that deficiencies in reporting were confined to modern assessors rather than being spread randomly throughout the archive.

Declaration of interest

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Human rights and mental health

I agree with Bindman *et al* (2003) that, to date, the jurisprudence of the European Court of Human Rights has not set a 'high standard' for modern mental health services. This is apparent not only in areas of the process of detention and its lawfulness, but also in areas of treatment standards and material standards of the facilities in which people are detained. I would also echo their sentiment that the wording of article 5(1)e of the European Convention on Human Rights is at best unfortunate and at worst deeply stigmatising. That said, I believe that the doctrine of the 'living instrument' (*Tyrer v. United Kingdom*, 1978; Reed & Murdoch, 2002) in Strasbourg jurisprudence is of fundamental importance in interpretation of the Convention and may yet lead to improved protection of the human rights of both patients with mental illnesses and people with learning disabilities.

With respect to patients who are *de facto* detained, the case of *Rierra Blume v. Spain* (1999) may improve rights protection. Here, the European Court of Human Rights ruled that the complainants, who had been escorted by the police to receive, among other things, psychiatric treatment, had been *de facto* detained and that their detention was unlawful. However, many patients for various reasons, especially non-protesting patients as in the Bournewood case (*R v. Bournewood Community and Mental Health NHS Trust*, 1998), will not take cases to the courts, and the protection of their rights may depend on relatives or voluntary organisations acting on their behalf.

Legal protection with regard to the autonomy of patients with mental illnesses and people with learning disabilities may improve by a back-door means, arising from the debate over privacy protection and article 8 rights ('right to respect for private and family life'). However, rights can be secured in court only if challenges are brought, and many people with mental illnesses or learning disabilities may not have the awareness or the means to bring such challenges. The importance of ways other than legislation for highlighting and securing rights, such as the Royal College of Psychiatrists' anti-stigma campaign 'Changing Minds', education campaigns about mental illness and the work of numerous voluntary agencies, cannot be underestimated in promoting equal rights and opportunities for these population groups.

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Slavery and psychiatry

Raj Persaud (2003) begins his review of Thomas Szasz's book *Liberation by Oppression: A Comparative Study of Slavery and Psychiatry* by asserting that something false is true: 'Thomas Szasz became famous for being at the vanguard of the anti-psychiatry movement'. First, Szasz has never been part of the anti-psychiatry movement, much less at the vanguard of it. Second, there is as much truth in Persaud's assertion as there is in asserting that the Nazis were simply practising medicine. Szasz has made it absolutely clear for over 50 years now that he supports psychiatry between consenting adults, that is, he supports contractual psychiatry. Third, Dr Persaud then asserts that Szasz is an 'ally rather than an enemy of the National Health Service general adult psychiatrist'.

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This is another fiction masquerading as fact. Szasz is not an ally of National Health Service psychiatrists, none of whom, to my knowledge, has denounced or renounced the practice of psychiatric slavery. Moreover, Szasz is a classical liberal, not a socialist. The two cardinal principles of the classical liberal credo are the affirmation of the right to bodily and mental self-ownership and the prohibition against initiating violence.

These rather serious misrepresentations aside, Persaud ignores the core ideas in Szasz's book. Institutional psychiatry is an extension of law: institutional psychiatrists are agents of the state, not of their patients. Doctors who practise contractual medicine are agents of their patients, not of the state. The importance of this difference cannot be overemphasised.

People labelled by institutional psychiatrists as mentally ill are concurrently defined by the courts as less than human, in much the same way 'Negroes' in America were once defined as three-fifths persons. This is how Black people were, and people with mental illnesses are, deprived of liberty and justice by the state. Labelling of anyone as less than human is legal fiction, something false that is asserted as true, that the courts will not allow to be disproved. Just as defining Negroes as three-fifths persons served to maintain the institution of slavery, defining people as mentally ill serves to maintain the institution of psychiatry.

A person has a right to refuse treatment for cancer. A person does not have a right to refuse treatment for mental illness. If institutional psychiatrists are deprived of their power by the state to deprive mentally ill persons of their liberty, that is, if the state did not allow psychiatrists to enslave their patients in the name of liberating them, institutional psychiatry would go the way of slavery, as well it should.

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Treatment of common mental disorders in general practice: are current guidelines useless?

The paper by Croudace *et al* (2003) confirms the pattern set by previous studies (Upton *et al*, 1999; King *et al*, 2002) in showing little or no effect of educational and treatment initiatives on primary care physicians' practice of psychiatry. The authors provide various explanations for the negative outcome; one of these – 'failures in the content of the guidelines themselves in terms of their evidence base or relevance' – deserves greater prominence. Although psychiatry can claim some credit for advances in the diagnoses and treatment of more-severe disorders seen in secondary care, our interventions for the common mental disorders in primary care are much less securely founded.

The guidelines do not take proper account of the well-established fact that approximately two out of five patients presenting with common mental illnesses in general practice (even when considered ill enough to merit psychiatric input) improve rapidly within a few weeks. These probably merit the often forgotten diagnosis of adjustment disorder (Casey *et al*, 2001). Thirty per cent pursue a slower course of recovery and a further 30%, mostly with mixed anxiety and depressive disorder, have a worse outcome with frequent relapses (Tyrer *et al*, 2003), although in the short term a variety of interventions can be effective.

The methodology of Croudace *et al*'s study is to be commended and the results show that even when guidelines lead to greater specificity in identifying illness, this is not accompanied by better outcomes. Pressured general practitioners in the past used to take the approach that if a patient with mental health symptoms presented for treatment, the doctor could listen sympathetically and, unless there was significant risk, would ask them to come back in 4 weeks' time. If the patient returned, he or she might have a more serious problem necessitating formal treatment. Such an approach may have a greater evidence base than any of our guidelines. It nicely separates those with adjustment disorders from the rest, prevents inappropriate therapies that might lead to iatrogenic problems like dependence, and is an excellent predictor of improvement many years later (Seivewright *et al*, 1998). If we were able to help general practitioners at the time of presentation to diagnose which patients needed intervention and which did not, we might be doing a better service than any of the current guidelines that litter general practice surgeries in this and many other countries.

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Note

This letter was submitted before the appointment of P.T. as Editor of the *Journal*.

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Management of borderline personality disorder

Verheul *et al*'s article (2003) states that dialectical behaviour therapy is an efficacious treatment for high-risk behaviours in patients with borderline personality disorder and suggests that this occurs via four core features (Linehan, 1993): routine monitoring; modification of high-risk behaviours; encouragement of patients to consult therapists before carrying out these behaviours; and prevention of therapist burnout.

We propose a management strategy for these patients delivered via a systemic approach that incorporates these principles and is especially relevant for services without the capacity to provide the skills base or intensity required for effective dialectical behaviour therapy. Such an approach has been developed by our service and is currently the principal method of

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