

### Depressive Disorder in Primary Care

SIR: Blacker & Clare (*Journal*, June 1987, **150**, 737–751) state that “only a proportion, probably less than 10%, of depressed patients in primary care are referred to psychiatric services”.

A large proportion of the psychiatric literature is devoted to research into biological aspects of depressive illness and to clinical trials of antidepressants. Fifteen to twenty years ago, patients with moderate to severe depression were often directly referred to a psychiatrist before antidepressant treatment had been prescribed. During that time, and under those conditions, much pioneering work was carried out into the biochemistry of depressive illness. The situation today is somewhat different: patients are often referred to specialist research units, often within the university setting, only after a general practitioner has failed to obtain an adequate response with one or more antidepressants for periods of one to two months. Since Katona *et al* (1986) have pointed out that previous antidepressant treatment can affect biological variates for up to three weeks after withdrawal from the drug, researchers are investigating not the biological characteristics of depressive illness but the biological legacy of previous antidepressant treatments. In addition, they are also looking at a highly selected group of patients who are often half-way through their self-limiting episode.

The majority, if not all, of new antidepressant drug trials are carried out under the supervision of a psychiatrist in either an in or out-patient setting. Conclusions are therefore drawn from a population of patients who may have psychotic features or suicidal ideation and, as described above, are by definition often relatively treatment-resistant. While this traditional testing ground provides a stringent test of a new antidepressant, I feel that putative antidepressants should be tested in the general practice arena where one finds the full spectrum of depressive disorders.

I concede that such trials would be difficult to carry out. Indeed, my own preliminary survey has indicated a marked disinclination of general practitioners to test new drugs. The possibility of destroying the doctor/family relationship at the first sign of an adverse reaction was the most common reason.

It should be emphasised, as Blacker & Clare have done, that the situation may be somewhat different in the USA where one may bypass the general practitioner and contact a mental health professional directly. For this reason, biological and clinical trial data obtained in the USA in the last ten years or so may be more relevant than that obtained in the UK.

Perhaps closer collaboration between psychiatrists and general practitioners and their respective Royal Colleges could once again ensure that pioneering research is carried out in the UK.

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### Khat-induced Paranoid Psychosis

SIR: As my article of 1945 was perhaps the first on the subject of khat-induced psychosis (Carothers, 1945), and since the course of the illness in the two cases there described differed markedly in one respect from that described by Dhadphale & Arap Mengech (*Journal*, June 1987, **150**, 876), I would like to add a comment to this discussion. The latter writers saw no relapses in any of their 15 patients, whereas one of my patients suffered two relapses requiring readmission within a year, and the other had three such relapses within 13 months. In explanation of this discrepancy, I can only surmise that by the time of the later article some supervision after discharge was maintained in Kenya: a supervision which was not available there in 1945.

However this may be, it seemed to me then (and does so still) that, since the great majority of khat chewers suffer no obvious ill-effects, these florid psychoses occur in people who are mentally vulnerable and who do require some organised support when discharged from hospital.

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### HIV and Informed Consent

SIR: I read Davies's letter (*Journal*, June 1987, **150**, 881–882) with interest. As the natural history of human immunodeficiency virus (HIV) infection unfolds, so the neuropsychiatric complications are recognised with increasing frequency. Psychosis may

accompany HIV infection (Thomas *et al*, 1985; Rundell *et al*, 1986; Jones *et al*, 1987) or may be the first presentation of the acquired immunodeficiency syndrome (AIDS) (Thomas & Szabadi, in press). Indeed, HIV dementia may be the first and only manifestation of HIV infection (Navia & Price, 1987).

In psychotic patients who come from high-risk groups (promiscuous homosexuals, bisexuals, drug addicts, prostitutes, and haemophiliacs), HIV infection must be considered in the differential diagnosis. A clinical dilemma is posed when such individuals are unable to give informed consent to HIV testing (or understand the pre-test counselling, etc.) by virtue of their disturbed mental state.

Venepuncture without consent on an informal patient is a battery and a form of trespass on that person. Should those psychotic individuals who are unable to give consent or are irrationally refusing (as a result of their mental disorder) be detained under Section 2 of the 1983 Mental Health Act for the purpose of assessment and further investigation of their mental illness?

I have had personal experience of two psychotic patients who were HIV positive; it was necessary to detain both under the Mental Health Act, as one had tried to throw himself in front of passing vehicles and the other had threatened to cut his mother's throat. It is envisaged, however, that there will be some psychotic individuals (from high-risk groups) who are not thought to be a risk to themselves or others but who are unable to give informed consent. In these individuals it would seem inappropriate to recommend detention under the Mental Health Act for performing a blood test. In such cases, would a doctor be ethically justified in removing some blood from a co-operative patient for HIV screening without obtaining informed consent?

The advantage of knowing HIV status is apparent. Treatments for HIV infection are available, but as yet are only palliative. The infected individuals can be identified and appropriate precautions taken, if not already being practised. A negative test should lead to further investigation of the aetiology of the psychosis.

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#### Behavioural Psychotherapy in General Practice (Marks, *Journal*, May 1987, 150, 593-597) – A Response

SIR: It is widely believed (by several people, in fact) that psychiatry is a highly specialised business. This notion is based upon quite false assumptions that I need hardly trouble you with here. Literally hundreds (possibly thousands) of Girl Guides, St John's Ambulancemen, swimming bath attendants and the like have found it quite easy to acquire what at first sight appear to be complex skills without any time-wasting basic science training.

In fact, you can take it from me that psychiatry is beset by unnecessary and restrictive mystique, whereas within days (possibly hours) all that needs to be known about the subject can be imparted to thousands (if not millions) of quite ordinary people with little knowledge of anything particular already in place, so to speak.

We have recently shown, for example, that the therapeutic silence in group therapy is a skill mastered easily by cohorts of bus drivers although, admittedly, they may have been a tactiturn bunch to begin with. Our classes in writing benzodiazepine prescriptions, too, have clearly demonstrated that, within just a few minutes, most cloakroom attendants have grasped a skill hitherto thought to require years of training.

It is true, of course, that we have had a bit more difficulty in training a group of unemployed geography supply teachers to recognise schizophrenic thought disorder, but this may well have been due to some confusion on our part about this strange condition.

The evidence for what I'm saying comes from my own long experience, you understand. But you can take it from me and my staff that there is really nothing to it and we could within weeks (or possibly days, in an emergency) turn out thousands (possibly millions) of perfectly well-qualified psychiatrists busily and successfully treating just about anything you care to mention.

Frankly, I can't see what all the fuss is about.

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