

Showalter and Shorter, who suggest that 'Victorian faints, swoons and convulsions' are now rare and have largely disappeared from clinical practice. Any clinician currently working in the borderland between neurology and psychiatry would dispute this observation. Indeed, in October 2003 the first international conference on psychogenic movement disorders was held in the USA (Trimble and I attended), and it is clear that these disorders are becoming so common (1 in 30 of consecutive referrals to a movement disorder clinic) that even neurologists are taking note and wanting help. Trimble's elegant riposte to the social historians is that 'hysteria has never risen from the ashes: the fires have been burning brightly all along'. He goes on to criticise the diagnostic categories of both the ICD and DSM as being arbitrary (we all agree with that) and argues that, in a medicolegal setting, their use can be not only misleading but also mischievous.

Chapters on the clinical presentations and assessment are sound and well written, but I found most useful the chapters dealing with the legal context and issues of causation and compensation. Trimble outlines the shortcomings of Lord Woolf's reforms and the role of the single joint expert (SJE), who is unlikely to satisfy the needs of both parties in complex psychiatric cases. There are up-to-date accounts of compensation as well as the problems of legally aided claims. Issues of foreseeability and rules for secondary claimants/victims are described, with

helpful case vignettes, and Trimble introduces the term 'lexigenic' to emphasise the legal equivalent of iatrogenic illness. Chapters about mechanisms and causation include descriptions of recent imaging studies on hysteria and malingering.

This is a valuable text for psychiatrists involved in medicolegal work, especially those asked to provide reports on patients with unexplained gait disturbances, whiplash neck injuries and symptoms that are not matched by organic findings. The Department for Work and Pensions informs us that 70% of patients on long-term disability benefits have symptoms that are essentially medically unexplained: Trimble's book explains how to assess these patients when they are involved in a legal claim and how to prepare a coherent report for the court.

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Self-Made Madness: Rethinking Illness and Criminal Responsibility

By Edward W. Mitchell. Aldershot: Ashgate Publishers. 2003. 272 pp. £50 (hb). ISBN 0 75462 332 7

To what extent could we hold people with mental illness responsible for their own disturbed states of mind? And what would this mean for those individuals with mental

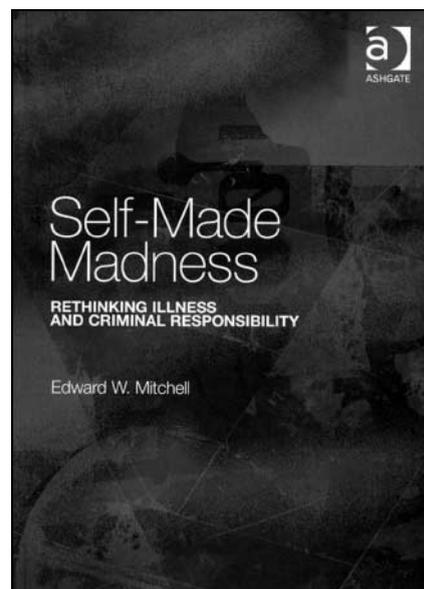
illness who are charged with criminal offences? These questions are explored by Edward W. Mitchell in an erudite and complex analysis of what he terms 'meta-responsibility'. He offers both a conceptual analysis, and an empirical investigation of how mock jurors would judge a defendant who had committed a violent offence while non-compliant with prescribed psychotropic medication.

Mitchell found that his mock jurors gave intriguing answers to questions of meta-responsibility. Although some took the view that the defendant was criminally responsible because of the causal link between non-compliance and relapse, they also took the view that he could not be responsible *because* he had relapsed. There was also a suggestion that it was the decision to come off medication that should be judged for culpability, and not the offence itself.

The issues Mitchell raises are of profound importance for both psychiatrists and mental health service users. Current Department of Health policy emphasises the importance of involving patients in the management of their condition; of treating the patient as their own 'expert'. However, when it comes to mental health, government policy seems to assume that service users cannot be trusted to manage their own condition, and are uniformly incapacitous in terms of responsibility for criminal offences. Numerous homicide inquiries have criticised professionals who have tried to share clinical decision with their patients and allowed the patients some control over their medication.

As clinicians, we know that mental illness does not necessarily abolish the capacity to form meaningful and competent intentions. There must therefore be some pressure on those with mental illness who have acted violently to explain why their disorder should be both an explanation, and exculpation, for their behaviour. From my own clinical experience, these questions are as troubling for patients who have been violent when psychotic as they are for the rest of us.

The more expert and autonomous the patient seeks to be, the more responsibility they must take for their actions. In ethical terms, not to respect autonomy when present is both to act disrespectfully and to act unjustly. However, this approach is a radical challenge to the traditional belief that those with mental illnesses should not be held responsible for their behaviours.



The circular which mandates inquiries after homicide is evidence of a widespread social assumption that any history of any mental illness throws responsibility into doubt. The beneficent ideal of medicine assumes that we take care of patients because they cannot take care of themselves; it is only recently that the assumed incapacity of psychiatric patients has come to be questioned.

Mitchell ends his book with an entertaining fantasy that Dr Jekyll is put on trial for taking a substance that allows Mr Hyde to emerge. His argument deserves attention. Although not always an easy read, his book is thought provoking and I recommend it.

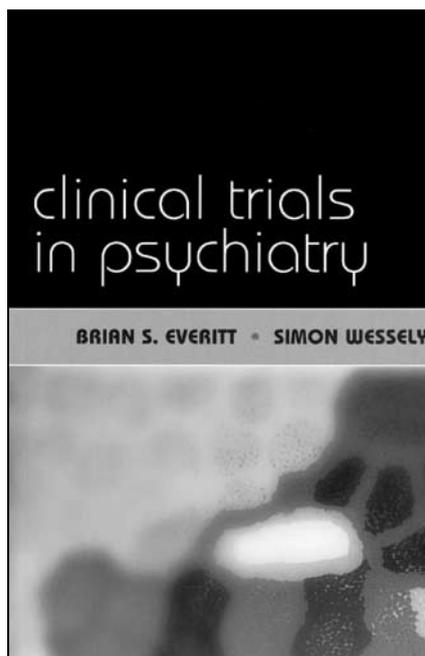
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Clinical Trials in Psychiatry

By Brian S. Everitt & Simon Wessely
Oxford: Oxford University Press. 2004.
189 pp. £27.50 (pb). ISBN 0 19 852642 3

Everitt & Wessely are to be congratulated on producing an excellent guide to help overcome the snags in clinical trial research. Clearly written and in an engaging style, the book is likely to become a classic textbook on clinical trials, and not just in psychiatry. The authors' enthusiasm and grasp of clinical trial research make for a gripping and insightful read.

The first chapter deals with the bleak history of non-evidence-based treatment of mental illness. The 'slow march from dogmatic, even mystical, certainty to proper scientific uncertainty' is painfully described. Exorcism, bleeding, vomiting, purging, spinning on a pivot, removal of teeth and tonsils all came into fashion, were taken up and then dropped. Chapter 2, describing the slow move from expert opinion to the development of the clinical trial, is liberally interspersed with illuminating case histories and quotations: 'the plural of anecdote is not evidence'. Chapters 3 and 4 cover the design and special problems of trials in psychiatry. As shown by the typical Cochrane review, previous trials have generally been of poor methodological quality, too small and have used the wrong outcome measures. Everitt & Wessely note the overemphasis on symptoms and recommend patient-rated



functional outcome measures. For maximum relevance, trials should be pragmatic, and set as close to real-life clinical practice as possible. Chapters on statistical analysis and systematic reviews are aimed also at non-statisticians and avoid being over-technical. The final chapter covers the arguments for, and against, clinical trials in an objective and balanced way. Appendices on practical issues are informative and well-referenced.

The book is well set out, with a summary at the end of each chapter. It is excellently researched with many recent references. It should be essential reading for anyone involved in clinical trials in psychiatry, whether a researcher or a user of research evidence. I would also recommend it to a much wider readership – it is one of the very best books that has been written on clinical trials.

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Mental Health Global Policies and Human Rights

Edited by Peter Morrall and Mike Hazelton.
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The title of this book turns out to be a bit of a misnomer. Its main focus is on the

policies and progress of different countries in integrating comprehensive mental health services. Much less space in the book is devoted to human rights; there is no comparative analysis of the countries or any account of the policies of those agencies with a global remit, such as the World Health Organization and other United Nations agencies, or international organisations such as the World Federation for Mental Health, the World Psychiatric Association or Amnesty International; nor an overview of the influence of dictatorships, democratisation or public health renewal on the evolution of mental health services within countries.

Most of the chapters provide straightforward descriptions of the history of the evolution of services, their current situation and future aspirations and, as such, are of considerable interest in their own right. The UK chapter is somewhat disappointing, being a cursory and parochial antipsychiatry, anti-government polemic which thereby misses a golden opportunity to make a constructive dispassionate analysis of the levers and barriers to progress in the UK.

Fortunately the other chapters are generally very informative, clearly written, and helpful to readers from other parts of the world. For example, the Australian chapter contains an important analysis of the development of mental health consumerism, and the need to ensure it does not undermine the other important contributions to mental health policy, including a

