tryptophan shortens REM latency (6) which is the opposite of the effect on REM latency observed in our diamorphine addicts. If, as in rats and mice, morphine tolerance and dependence in humans is accompanied by an increased rate of brain serotonin synthesis our observations suggest that this excess serotonin is only partially available for normal cerebral synaptic activity. Methadone has similar effects on brain serotonin (7).

We postulated that our findings support the hypothesis of Collier (8) that physical dependence and tolerance to morphine and related substances are mediated via a blocking action of the receptor mechanism for serotonin at brain synapses. If this be correct it would account for the paradoxical findings of Chernik *et al.*, for as PCPA reduced the available serotonin the parallel reduction in methadone intake described in their report would progressively remove the blockage of serotonin receptors, so that the nett effects could well be the maintenance of equilibrium in the serotonin actually available for synaptic transmission. This would be reflected in the relative stability of the EEG sleep pattern. It would be interesting to know whether the patient's clinical condition also remained stable.

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CAPACITY TO MANAGE AFFAIRS

Dear Sir,

When medically assessing either a person's testamentary capacity or his ability to manage possessions, it has been customary to do so in relation to the nature of the actual affairs to be handed down or managed. For example, questions such as 'has the patient a reasonable knowledge of his estate' and 'has he the capacity to appreciate who might be entitled to his bounty' can be asked in both instances. Inquiry couched in these terms, however, seems to overlook that affairs themselves can sometimes become too complex for normal people.

Complexity of affairs increases beyond the capacity of some normal people to manage them properly, when such increases do not depend on the skill and effort of the person concerned, e.g. from a chance large win in a lottery or a sizeable unexpected legacy. When this happens to someone who is already mentally ill, but whose capacity to manage has not until then required questioning, medical assessment needs special care. Any pre-morbid (and thus still normal) relative inability should be discounted, only incapacity due to ill health being relevant.

Thus a healthy only child of low normal intelligence, perseverance or emotional control, may become mentally ill but continue to live with and be informally supervised by wealthy parents until inheriting (without restriction) on their deaths. Although implicit in medical assessment, it then helps to keep issues clear if specific reference to illness is made in the questions asked, e.g. 'has the patient's knowledge of his estate been significantly influenced *by mental disorder*' and 'has review of possible beneficiaries suffered *because of mental illness*'?

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A COLLUSION WITH SANITY: A CLINICAL EXTRACT

Dear Sir,

It is an observable fact—which has become exaggerated, unfortunately, into a fashion and a political expedient—that certain kinds of unusual experience and behaviour are conveniently labelled 'mad' in order to legalize the removal of a person from his

usual social setting. However, there has been much less detailed recording of another kind of social action in psychiatry which, for a variety of reasons, ignores the madness of a person so that he or she can be *discharged* from the institutional setting. Recently, such an instance has nearly occurred in the ward of the hospital in which I work.

A married lady from a Mediteranean country was admitted to the hospital because of an intense jealousy of her husband, believing that he was keeping another woman in the house. The patient, however, proved very difficult for the staff to manage (including the Secretary), because of her demanding, manipulative and rude behaviour which included a constant edgy note to her voice. There was a vicious circle set up, since irritable staff reaction tended to reinforce her difficult behaviour. She also caused disturbances outside the hospital, as when she lit all the candles in a nearby Catholic church. As the weeks passed, discussion of the situation became more and more centred around these features of her mental state, until a point was reached when a discharge date was fixed. The woman insisted most vehemently that she would not leave hospital until, in effect, her husband was brought to heel. The staff had decided that the woman had intractable personality problems, that she was making no good use of the hospital, and that it was time to return home to face her marital problems. The question of forcible removal by the police was mentioned. The difficulty of distinguishing the degree of truth in cases of marital jealousy was agreed generally.

However, on the afternoon of discharge, we finally managed to obtain the presence of the husband in the nurses' office, who, with the help of an interpreter, clarified a number of issues. The upshot of that meeting was that the patient now remains in hospital until more information is obtained about many important aspects of her history, and until the effect is seen of larger doses of phenothiazines.

The following staff discussion led to an examination of the factors which gave rise to such an obviously anomalous situation. All the staff were experienced and well versed in psychotherapeutic principles. The ward itself was sympathetically orientated to the group and therapeutic community approach. What then had happened?

There was no doubt that emotional difficulties had blocked the objective appreciation of the patient's condition. Generally speaking, staff tolerance was at a low ebb, owing to parochial medico-political difficulties, nursing administrative problems, and an increasingly severe nursing shortage on the ward. Frustrations rose relentlessly, long-standing patient groups had to be wound up and community meetings left sparsely attended by the staff. In addition, during the period of our particular patient's admission and initial assessment there was a changeover of part-time locum consultants. The present part-time locum consultant found the woman very demanding, being accosted in the corridors and during his out-patient sessions. In effect, he had almost abdicated responsibility for her general management to the ward staff, accepting uncritically all their comments about her condition and her prognosis.

One Sister said that she kept reminding other staff about various points that had to be followed up, and became more and more frustrated because 'nothing was moving'. This led her to become angry 'with everybody'. The ward social worker commented that 'somehow' she had found herself repeatedly putting Mrs. X's name at the bottom of the list for further exploration of her social history, and had 'inadvertently' forgotten to write up her interview with the husband. The local authority social worker had visited rarely, and the previous worker who had been in regular contact with the patient during a previous admission frankly did not want a further relationship, giving as one good administrative reason that he had moved to a different area.

The ward doctor admitted to neglecting her. He was very overworked, her 'English was so poor', and 'anyway, the ward social worker was soon to be seeing the husband with an interpreter'. It is noteworthy that the native tongue of the doctor was not English either (as indeed was the case with many other members of staff). The occupational therapist was also being increasingly overburdened with extra work and often found herself, she said, 'having to go to a meeting' when the patient asked for the umpteenth time to 'come and feed the sewing machine right now!'

However, another nurse stated, to the incredulity of other members of staff, that he actually enjoyed his relationship with her, but perhaps this was because he was stationed in the ward for only a few months. A further young nurse said she had few problems with the patient, as she was able to listen to her for considerable periods. This girl was of a notably placid temperament.

Possibly the most interesting comments came from the male out-patient Charge Nurse, who knew the patient on the previous admission when he was the Charge Nurse of the ward she was in (a different ward from the present one.) The out-patient department is situated at the end of a long L-shaped corridor, and the consultant had a separate discussion with this Charge Nurse.

'She doesn't bother me here. I just let her talk or knit. She's certainly very psychotic, like seeing the

Madonna and St. George hovering about her bedside and saying that she sees one of the doctors here every night on TV.' He felt that she had 'soul'. At the out-patient department she 'took on herself' certain privileges which were acquiesced in, while, on the other hand, she undertook small dressmaking alterations for his family, which she enjoyed. On being asked whether he felt that he should be communicating any of this information to the ward staff or whether they should be making enquiries of him, he replied that he did not feel it his place to inform the staff, as the out-patients was a separate department and the ward staff might feel that he was 'interfering'. The staff's surmise was that he might be able to establish a better relationship with the patient as he would not be having 'too much contact with Mrs. X, and that probably he felt he was doing the staff a favour by keeping her out of the way!'

Undoubtedly, in the relatively calm atmosphere of the out-patient department and with a circumscribed relationship, the psychotic experience of the patient had emerged more clearly. Apart from personality differences, the actual ward nursing staff were subject to constant interruptions from telephones, other patients, etc. However, a factor in maintaining the relationship between the out-patient Charge Nurse and the patient may have been the sense of mutual obligation engendered by the privileges and small personal work undertaken by the patient.

Looking back on this whole episode, so far, it would not seem unreasonable to conclude that in a stressful setting people with socially unacceptable experiences or behaviour may be extruded from their social setting. This may be engineered by labelling the individual 'mentally ill' and requesting admission to an institution. This article describes an alternative way of dealing with such a situation by labelling the individual 'sane' and attempting discharge from the same kind of institution.

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A COMPILATION OF PAPERS FOR THE USE OF POST-GRADUATE STUDENTS OF PSYCHIATRY

DEAR SIR,

The Clinical Tutors' Sub-Committee, through the courtesy of John Wyeth and Brother, has prepared a third printing of the compilation of selected papers in psychiatry for post-graduate students, the previous two printings being exhausted. A limited number are available; those wanting copies should write to John Wyeth and Brother Ltd., Huntercombe Lane South, Taplow, Maidenhead, Berks. The third printing has two additional papers: 'Trial of Maintenance Therapy in Schizophrenia', by J. P. Leff and J. K. Wing (*Brit. med. J.*, 1972, *iii*, 599–604); 'Prophylactic Lithium in Affective Disorders', by A. Coppen *et al.* (*Lancet*, 1971, *ii*, 275–9).

Extra copies of these two papers can be had by sending an SAE (3p, 11½ in. × 9 in.) to the address below.

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