includes the difference between the two outcomes (which includes in-patient compulsion from readmissions in both groups). There is no evidence that recruitment and selection were biased in any way and again we fail to understand on what Drs Owen and Curtis base this criticism. We adhered to the highest research standards throughout and the study has been extensively and rigorously peer reviewed.

Dr Mustafa in his letter advances no scientific critique of our work but does articulate the common response of many clinicians – 'I have seen it work'. We have sympathy with this – we both entered this study expecting to find improved outcomes from CTOs. However, they do not deliver them and we were as disappointed as Dr Mustafa. Psychiatry has a long history of clinicians clinging to ineffective treatments convinced that they work. This is not surprising given the variation in outcomes in psychiatry and the fluctuating natural history of psychoses. Naturalistic observational studies do not prove otherwise – they have produced contradictory results, some for, some against.[2] That is why we need rigorous randomised controlled trials. OCTET is such a rigorous trial and its findings, however unpalatable to some, are robust. It is also worth remembering that the only two other trials found the same.[3] A profession that aspires to evidence-based practice should take these results seriously.

1 Curtis D. OCTET does not demonstrate a lack of effectiveness for community treatment orders. *Psychiatr Bull* 2014; **38**: 36–9.

2 Maughan D, Molodynski A, Rugkåsa J, Burns T. Community Treatment Orders: a systematic review of clinical outcomes. *Soc Psychiatry Psychiatr Epidemiol* 2014; **49**: 651–63.

3 Rugkåsa J, Dawson J. Community treatment orders: current evidence and the implications. *Br J Psychiatry* 2013; **203**: 406–8.

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doi: 10.1192/pb.38.4.197a

Insulin coma therapy

Anyone working in an insulin unit in the 1950s would not recognise Dr Pimm's account of the results of their treatment,[1] or details of what it involved. The patients received daily and increasing doses of insulin, rising to many hundreds of units, for a 6-week period. The depth of the resulting hypoglycaemic coma was determined by the patient demonstrating a Babinski response over a period of 15 min. They were then revived by ingesting glucose.

I worked in the insulin unit at Newcastle General Hospital from 1956 to 1959, when I was senior registrar to Sir Martin Roth. Insulin treatment was reserved for people experiencing their first attack of schizophrenia, and from memory I would say half made a complete remission and another 25% improved. Nobody thought that we were effecting a cure, but remissions lasted about 2 years. One woman relapsed 9 years after her treatment. Of course there were dangers, but in those days the alternative was incarceration in a locked ward in a Victorian asylum, with little hope of rehabilitation or discharge.

Martin Roth was an intellectual giant, but also a man who was perspicacious and compassionate, and who would not have contemplated using such a treatment if he did not think it effective. The depth of the coma seemed to me to be critical in terms of remission. A few patients did not regain consciousness when given glucose, but usually 'came out of it' after some hours, although there was the occasional death. Very occasionally, a patient who was clearly psychotic who had an 'irreversible coma' on recovery was greatly mentally improved. These days, people find this difficult to believe, but I witnessed it on one occasion. I find it inconceivable that a multitude of psychiatrists, working in Europe and North America over 25 years, would not have noticed that the treatment they were giving was having no effect, when it clearly was, if only for a limited period. The real question was not whether insulin worked but how did insulin work.

I have no wish to minimise the success of Dr Bourne's crusade, but what made insulin units redundant was the realisation that the new antipsychotic drugs actually worked, and at last, we had an effective, cheap and long-lasting method of managing a seemingly incurable disease. This was generally accepted by 1960.

1 Pimm J. Dr Bourne's identity – credit where credit's due. *Psychiatr Bull* 2014; **38**: 83–5.

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doi: 10.1192/pb.38.4.198

Hope and hopelessness in carers of a relative with schizophrenia

In her editorial, Rebecca McGuire-Snieckus warns clinicians against promoting optimism in their clients, since this can lead to unmet expectations and negative reactions when such expectations are not realised.[1] In his commentary on the editorial, Femi Oyebode criticises Martin Seligman for exaggerating the importance of happiness at all costs as a goal of existence, and quotes Aristotle as stating that it is the mark of a courageous man to face things that are terrible to a human being.[2] I wish to illustrate this in the context of family carers of relatives with schizophrenia. In particular, I focus on the overinvolved carer who is unable to relinquish her/his hopes and expectations for the affected relative. They are readily recognised by habitually referring to their relative in the past tense, for example, 'she was such a beautiful girl' or 'he was such a good student'. This form of speech reveals the fact that the carer is living in the past and has not come to terms with the reality of their relative's illness. This is particularly hard on the patient, who then feels driven to attempt to satisfy the carer's need for their success, and fails again and again. The remedy is to offer the carer grief work to mourn their losses and to accept the reality of their relative's disability and release both parties from this impasse, enabling them to develop a more realistic view. The patient will also benefit from grief work, administered separately from the carer.

1 McGuire-Snieckus R. Hope, optimism and delusion. *Psychiatr Bull* 2014; **38**: 49–51.

2 Oyebode F. Should psychology be 'positive'? Letting the philosophers speak. Commentary on . . . Hope, optimism and delusion. *Psychiatr Bull* 2014; **38**: 52–3.

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doi: 10.1192/pb.38.4.198a