(5) Follow-up: out-patient appointment arranged.

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Benzodiazepines and ECT

DEAR SIRS

While it is accepted that benzodiazepines have anticonvulsant activity, most psychiatrists would not prescribe them and administer ECT at the same time in the belief that seizure is the necessary requirement for the patient to get better, the reality of the interactions seem to be more complicated than that.

Firstly, it is known that there are depressed patients who seem to have adequate seizures during ECT treatment, but still remain equally depressed. Secondly, there are patients who are on small doses of benzodiazepines, get ECT, have seizures and improve. Thirdly, there are patients who are in the process of withdrawal from benzodiazepines and develop depression as a result (Lader *et al*, 1981) that seems to be difficult to treat with antidepressants and most likely ECT too. During withdrawal, patients experience among many other symptoms those of depression, and major convulsions or temporal lobe seizures sometimes occur on abrupt withdrawal (Ashton, 1986). As these symptoms can occur together I would suggest that for several weeks following the withdrawal of benzodiazepines patients would show altered responses to ECT and antidepressants. My concern is that clinicians might misunderstand this to indicate that in future ECT should not be given on the grounds that: "s/he does not respond to ECT". It would be interesting to hear from other psychiatrists if they have found altered response to ECT as a result of benzodiazepine withdrawal.

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The double negatives and the Mental Health Review Tribunal

DEAR SIRS

We would like to express through your correspondence columns some difficulties we have experienced in conveying the reports of the Mental Health Review Tribunal to our patients who had appealed against their detention under the Mental Health Act 1983. Here are two examples of the Tribunal's decision on two patients detained under Section 2 (extracted from form 7);

(1) "The Tribunal is *not satisfied that . . . . is not now* suffering from mental disorder of a nature and degree which warrants his/her detention in a hospital for assessment. The Tribunal is *not satisfied that it is not necessary in the* interests of the patient's health and safety that she should be detained. . . ."

(2) "They are *not satisfied that he/she is not suffering from* mental disorder. . . . They are also *not satisfied that his/her* detention as aforesaid is *not justified in the interests of* his/her own health. . . ."

In both cases the Tribunal accepted the medical and social worker's opinion and since the Tribunal had no objection to the reasons for their decision being "fully disclosed" to the patient they were conveyed to the patients and in both cases the patients insisted on seeing the reports for themselves. After reading the report both patients refused to believe that they had lost their appeal and had great difficulty in interpreting the double negatives. One patient's appeal against her subsequent detention under Section 3 was, we believe, related to her inability to understand the Tribunal's report on her initial appeal against Section 2.

Until the 17th century the use of double or multiple negatives was permitted in educated English as a form of emphasis (*International English Usage*, Croom Helm): "Nor go neither; but you'll lie like dogs, and yet say nothing neither" (Shakespeare, *The Tempest*, Act 3, Scene 2). This form is now only used in dialects, e.g. "He didn't say nothing".

The use of double negatives is still legitimate in educated English when they combine to express a positive (*Longman Guide to English Usage*). In the example "a not unhappy choice" or "not infrequently" the word "not" negates the negative word to produce a "weak positive". While in "You cannot not admire her pluck" and "None of us have no friends" a "strong positive" effect is produced. The above two examples from the Tribunal reports are similar to the later examples of "strong positive" and yet they caused consternation and confusion in our patients.

The capacity to understand such linguistic points will depend, of course, upon the level of sophistication that the patient possesses. Only a few patients are highly literate and though the disorder of mood and thinking can cause problems in understanding the written word, we believe that our patients were stymied by the style of the language used. There is no denying(!) the fact that the use of multiple negatives makes the sentence difficult to understand even for normal people, and the less said the better for terms like 'aforesaid', 'heretofore' and 'notwithstanding'.

One only has to read some of the legal reports and the small print of insurance policies to appreciate that. It may not be a mere coincidence that the chairman of the Tribunal is a lawyer. So, was the style the result of a 'deliberate and artful vagueness' or 'artless vagueness'? The factors which 'shape' the lawyer's language are amusingly discussed by David Lavine in a book entitled *The State of the Language* (eds L. Michaels and C. Ricks, 1979, University of California Press) and in our case we believe the problem is 'linguistic rather than legal'.

Would it not be considerably easier for everyone concerned if these reports are pitched at the lowest common denominator? The Plain English Campaign calls it 'reader friendly' style.

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Overseas doctors

DEAR SIRS

In response to Professor Sims' letter in the *Psychiatric Bulletin,* (November 1989, **13,** 637–638) we would like to make the following comments. We are very pleased to note that since our article was submitted the Overseas Desk has expanded their guidelines for the Overseas Doctors Scheme.

Of course *Achieving a Balance* has not yet been implemented but there are many "visiting registrars" as described by *Achieving a Balance* already working in psychiatry and other disciplines (*BMJ,* 26 August 1989, **299,** 531). Undoubtedly there will be many more.

The World Health Organization conference on Postgraduate Psychiatric Training, as reported by Holden, saw the training requirements of overseas trainees as ... "Rather than 'hands on' clinical experience ... the skills of administration, research, innovation and teaching" (*Psychiatric Bulletin,* October 1989, **13,** 558–560). These skills are not routinely acquired at Registrar and Senior House Officer levels in the UK.

Given the complexity and heterogeneity of the needs of overseas doctors we remain concerned as to how the approval teams will assess and determine how these needs are met.

Finally, overseas doctors who are indebted to UK institutions which enable them to leave temporarily difficult working conditions are unlikely to criticise these institutions.

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Community initiated research

DEAR SIRS

Drs Maharajh, Clarke & Hutchinson (*Psychiatric Bulletin,* October 1989, **13,** 575) imply that another of Dr Littlewood's papers (1985) falls foul of the same criticisms that I made (*Psychiatric Bulletin,* March 1989, **13,** 148) of his paper in the *Psychiatric Bulletin* on the subjects of "community initiated research" and cannabis psychosis (*Psychiatric Bulletin,* **12,** 486–488). My impression from their letter is that the earlier paper (on research conducted in Trinidad in 1979–1981) has not at all "aroused similar feelings" among them as did the more recent paper arouse in me. Nor may the same criticisms be made of the two (very different) papers.

My "feelings" about Dr Littlewood's paper in the *Bulletin* were that the initiator(s) of a research project, if they have contributed significantly to the genesis of the endeavour, should take at least some (perhaps equal?) responsibility for the resulting publication of findings and conclusions, along with the person(s) who actually implemented the study. I felt that this comment was highly pertinent since Dr Littlewood's theme had been as much that of "community initiation" of research as that of cannabis psychosis itself.

In contrast, the feelings of Dr Maharajh and his colleagues, in response to Dr Littlewood's earlier paper, appear to include a sense of grievance that their culture, society and history have been misrepresented and that incorrect deductions or conclusions have been made on the basis of the data. No such allegations were made by me concerning the paper in the *Psychiatric Bulletin,* nor are their comments pertinent to the content of that paper, and they have not presented any evidence to support their claims in respect of the Trinidad paper. Furthermore, no claim was made (to my knowledge) that the Trinidad study was "community initiated". Why then should any more "credit or discredit" be given to the subjects of this research than to the subjects of, say, any clinical drug trial?

It seems to me quite inappropriate that Dr Maharajh and his colleagues should use your columns to make unsubstantiated claims that Dr Littlewood's research in Trinidad was unethical or "inaccurate". Indeed it is they who have "misinterpreted" my comments on Dr Littlewood's paper in the *Psychiatric Bulletin* if they imagine that I was making criticisms that were in any way similar to theirs.

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