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Mephedrone as a cognitive enhancer and its kinship to khat

The report on the adverse effects of mephedrone in patients presenting to an acute service in Scotland echoed many of our own findings in attendees of a service aimed at the early detection of psychotic illness based in inner-city London.¹

In a small sample, we found that 8% of patients ($n=5$) seeking help for concerns about their mental health were using mephedrone. They reported using the drug for recreational reasons (during activities such as clubbing) and simply out of curiosity. Four out of the five patients stated that they also used mephedrone as a cognitive and performance enhancer to aid them in their studying and to help them stay awake while at university or college. They explained that it was a cheap and accessible alternative to other stimulants: one dose of 200 mg costs £2–3.

As mephedrone has now been classified as an illicit substance, it is possible that similar (currently unclassified) chemical compounds will become more widely used as cognitive enhancers in the student population. Both acute secondary and primary care mental health services should be aware of the adverse effects of this group of stimulants.

It is interesting to note that mephedrone is a semi-synthetic form of cathinone, the drug found in the East African herb khat. The chewing of khat has a long history and the drug continues to be used legally within several immigrant populations in Britain. Understanding the adverse effects of mephedrone has allowed us to appreciate the adverse consequences of khat misuse – a problem that has provoked substantial debate previously.²

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If not now, when . . . ?

The contrast between the cover of the August issue of *The Psychiatrist* and the content of the related article¹ could hardly have been greater. On the outside: shocking depiction of a winged Freud in drag – women's bathing costume, high heels –

flanked by the sphinx. Inside: announcement of change of job title from 'consultant psychotherapist' to 'consultant medical psychotherapist', buttressed by bland reassurance that 'the working role of most medical psychotherapists has become more like that of other consultant psychiatrists' and that warfare between different therapeutic modalities has ceased, and predictable pleas for greater recognition and investment in medical psychotherapy.

Sadly, it's the cover that gets it right. Medical psychotherapy is a chimera trying awkwardly to reconcile two currently incompatible sets of values – medical instrumentalism and psychotherapeutic humanism. A change of name will do nothing to resolve medical psychotherapy's abiding dilemma: how to stay true to psychotherapeutic values without isolationism or, claiming a spot in the mainstream, undermining its case for a separate identity.

I would like to see medical psychotherapy accepting the full irony and challenge of its chimeral status: a 'hopeful monster',² ensuring on the one hand that psychiatry does not become increasingly confined to pharmacology and forensics, and on the other that psychotherapists keep sight of their prime task – contributing to the effective treatment of psychological illness.

But nature abhors a chimera. Cash-strapped chief executives are unlikely to fall in with medical psychotherapy's vague promises when they can get NICE-approved therapies delivered by bureaucracy-savvy clinical psychologists and nurse specialists at half the price.

Which brings us back to Mace & Healy's seemingly proud statement that medical psychotherapy is unique among the CCT-bearing specialties in being 'not descriptive of the types of patients seen'. But therein lies its great weakness. Despite today's name-change, the rose will smell as un compelling until the Faculty of Medical Psychotherapy becomes the Faculty of Personality Disorders and Complex Cases. Then at last the unique skills of the medical psychotherapist really will be seen as indispensable, and Mace & Healy's legacy come to fruition. Yesterday's hopeful monster may yet become tomorrow's role-model: the psychotherapeutically sensitive psychiatrist.

- 1 Mace C, Healy K. Medical psychotherapy: a speciality for now. *Psychiatrist* 2011; **35**: 301–4.
- 2 Gould SJ. *The Structure of Evolutionary Theory*. Harvard University Press, 2002.

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Psychological therapies for bipolar disorder: addressing some misunderstandings

We would like to reply to the letter published in your journal by Gupta & Brown,¹ concerning a recent British Psychological Society report on understanding bipolar disorder.² As authors of that report, we were pleased that it has generated debate. In the main, responses from psychiatric and other clinical colleagues have been overwhelmingly positive: MDF The Bipolar Organisation referred to the report as 'ground-breaking'³ and Stephen Fry's tweet on the report led to 2000 downloads in one day.