terned" (not guilty for reasons of insanity). Treatment possibilities inside the prison are very limited.

The residential Belgian psychiatric care is well organized, but the lack of medium security forensic units in psychiatric hospitals is a limitative factor.

The University Forensic Center of the University Hospital of Antwerp provides an exhaustive out-patient treatment program for sexual abusers. Data on the first 150 consecutive paraphiliac patients will be presented. We will focus on:

- inclusion/exclusion criteria for the treatment program
- the six steps of the cognitive-behavioural relapse prevention treatment program
- the role of coercion in the treatment
- the problem of the liability of therapists with this group of high-risk patients.

SEXUAL OFFENDERS: TREATMENT, PUNISHMENT OR BOTH?

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Sexual psychopath laws have a long history in the United States. Although details have varied over time and place, their intention is to detain those sex offenders who are assessed as being particularly dangerous for indefinite periods. In order to avoid this being prescribed as a cruel and unusual punishment, a treatment component is invariably attached to the indefinite detention. Poor assessment techniques, uncertainty in predicting sexual dangerousness, idiosyncratic and inconsistent treatment, and lack of resources have meant that clinical issues and empirical scrutiny have tended to be submerged beneath political and legal debate about the way society deals with men who sexually offend.

Although sexual psychopath laws per se do not exist in Europe, mental health legislation is sometimes used as a way to achieve a similar end. In addition, in the UK there is currently a debate about whether sexual offenders should be treated differently from men who offend in other ways. This paper will look at research that has taken place regarding the American legislation, and will discuss their meaning for European countries.

THE SLIDING SCALE: TREATMENT OF SEX OFFENDERS IN THE NETHERLANDS

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In Holland sex offenders are more likely to be assessed for a psychiatric diagnosis than other offenders because of their higher possibility of a psychiatric illness or a personality disorder, and therefor a diminished responsibility for their crime. The other reason is their high rate of recidivism, even after years of treatment, so all is tried to prevent relapses.

Being well diagnosed after having committed a crime sex offenders have a lot of legal possibilities to shorten their detention by doing ambulatory, dayclinical or clinical treatment. Partly their detention is left behind as a rod behind the door: to appear again when the conditional treatment is not followed. Partly the detention has been changed in TBS (terbeschikkingstelling): obligatory and controlled treatment in special clinics and hospitals, and in severe cases detention and treatment in one of the seven TBS maximum security hospitals.

So far a network has been established from ambulatory psychotherapy for incest perpetrators to long stay provisions for chronicle re-offending paedophiles or rapists. In fact these legal categories do not say anything about the treatment as psychiatric diagnoses and index crimes are not specific among one another. Important parameters for a certain kind of treatment are the presence of obsessional and compulsive symptoms, concordance of sexual and aggressive acts, perversive phantasies over a longer period, lack of empathy, motivation for treatment, symptoms of a extrovert or introvert personality disorder, and lessened ego-strength. These criteria will be worked out as indications for certain kinds of forensic treatment as the Dutch penal law provides the control.

S58. Membrane phospholipids in schizophrenia and other psychiatric disorders

Chairmen: I Glen, M Keshavan

MEMBRANES AND PSYCHIATRIC DISORDERS

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Phospholipids are essential for the structure of neuronal membranes and for normal development and functioning of the nervous system. There is growing evidence that one of the essential fatty acids in membrane phospholipids, arachidonic acid (AA), and its metabolites modulate neurotransmitter receptors and second-messenger systems. Evidence is accumulating that phospholipid metabolism in both brain and red blood cells may be disturbed in schizophrenia. In particular, in patients with negative symptoms, levels in the phospholipids of the essential fatty acids, AA and docosahexaenoic acid (DHA), in red blood cell membranes are severely abnormal. Cytosolic phospholipase A2, the enzyme that releases AA from membranes, shows increased activity in acute schizophrenia, and is downregulated by classical antipsychotic drugs. P-31 nuclear magnetic resonance spectroscopy of the brains of untreated patients shows increased levels of phosphodiesterase which are associated with increased lipid membrane breakdown. The membrane hypothesis of schizophrenia may represent a new and fruitful paradigm for research.

A GENETIC ABNORMALITY IN SCHIZOPHRENIA RELATED TO PHOSPHOLIPASE A2

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Direct and indirect measurements of PLA_2 activity demonstrate an increase in medication-free patients with schizophrenia compared to healthy controls. In addition, P^{31} NMR measurements of CNS phospholipid metabolism *in vivo* provide evidence consistent with increased CNS $cPLA_2$ activity in individuals with schizophrenia, including those who are neuroleptic naive.

Two studies were undertaken to determine a possible genetic basis for alterations in phospholipid synthesis and activity in schizophrenia. Initial results demonstrated an association in 65 schizophrenics compared with a matched normal control population. A follow up haplotype relative risk study of 44 triads (mother, father, affected offspring), confirmed the results seen in the association study. Results suggest that a genetic variant near the promotor region of the gene for cytosolic phospholipase A_2 ($cPLA_2$), the rate limiting enzyme

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in the synthesis of prostaglandins from arachidonic acid (AA), is associated with schizophrenia.

SCHIZOPHRENIC SYMPTOMS AND DIETARY INTAKE OF N-3 FATTY ACIDS

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There is evidence that certain n3 and n6 essential fatty acids (EFAs) are depleted in cell membranes from red blood cells (RBC) and brains of patients suffering from schizophrenia. If these findings are of primary significance then the possibility is raised of modifying schizophrenic symptomatology by dietary supplementation with fatty acids. We have carried out detailed analysis of dietary fatty acid intake of 20 schizophrenic patients. It was found that a greater intake of n3 fatty acids and particularly eicosapentenoic (EPA) in the normal diet, was associated with less severe schizophrenic symptoms and particularly less positive symptoms, as well as less tardive dyskinesia (TD). Furthermore, supplementation of the diet for 6 weeks with 10 g/day of concentrated fish oil (MaxEPA) resulted in significant amelioration of both schizophrenic symptoms and TD.

THE RELATIONSHIP BETWEEN PLASMA FATTY ACID CONCENTRATIONS AND MOVEMENT DISORDERS

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It has been postulated that dyskinesia may be attributable to the schizophrenic disease process rather than to its treatment. This is in line with the hypothesis that a putative organic vulnerability may cause dyskinesia to emerge even without exposure to neuroleptics. In the present general population survey of dyskinetic phenomena, no 'a priori' assumption was made of their cause.

Spontaneous and tardive dyskinesias were studied in a random population sample of 446 men, aged 59 years. Dyskinesia (AIMSscore of ≥ 2 in any body part) was seen in 15.1% (n = 74). Dyskinetic men had higher cigarette consumption, more psychiatric morbidity and they were more often exposed to neuroleptics. *Dyskinesia was associated with several abnormalities in Essential Fatty Acid (EFA) concentrations in plasma, but the most consistent finding was low arachidonic acid (AA) levels* in phospholipids, triglycerides and cholesterol esters. In a logistic regression model, cigarette consumption ($p < 0.02$), exposure to neuroleptics ($p < 0.01$), and low AA levels in the phospholipid fraction ($p < 0.0001$) were independently associated with dyskinesia. Further analyses of our data indicated that impaired conversion of linoleic acid (LA) to AA is a problem in dyskinesia.

Conclusion: Dyskinesia is associated with EFA abnormalities. These abnormalities are present also in individuals who have not been exposed to neuroleptics and who have no psychiatric disorder. The results are compatible with the free radical hypothesis of dyskinesia, but they also indicate that impaired conversion of LA to AA contributes to the low EFA levels seen in dyskinetic men.

S59. Psychiatry and the media

Chairman: A Clare

'MINDERS' — A TV YEAR WITH A CMHT

Tom Burns. *St. George's Hospital Medical Lung, London*

Minders was a series of six programmes broadcast at prime time on BBC2 during May and June 1995 to an estimated audience of just under 2,000,000. Most of the programmes were for half an hour although two were extended. Most episodes focused on the experience of an individual patient centering on their contact with the mental health team. The programmes were ground-breaking in the way in which they obtained access to acute mental health crises, including police involvement in compulsory admissions and even the filming of an appeal tribunal against detention.

The reasons for agreeing to take part and the details of agreements between managers, staff and patients will be outlined. The mechanics and ethics of obtaining informed consent were complex. There were a whole series of complications which could not have been foreseen (e.g. dependency on the TV crew, family involvement and rights, differing staff responses and involvement of other patients).

Response to the series varied very much between different groups. It was also sharply divided between that to the first programme 'Whose Mind is it anyway? John's story' and the other five. 'Whose mind is it anyway?' charted the compulsory admission and care of a young black patient suffering from schizophrenia in such a way that most viewers were left confused about why he was admitted in the first place and outraged at the perceived effects of his treatment. As staff we felt betrayed and grossly misrepresented. The issues which led to this state of affairs has many lessons for those considering co-operating with the media.

Overall, however, we felt that the programmes gave a sympathetic and honest portrayal of the untidy reality of suffering from a mental illness. This may act as an antidote to the oversimplified sound- bite approach so common in this field. Hopefully it will help generate a more realistic debate about the problems inherent in modern mental health care. It has undoubtedly removed some of the barriers to further such programmes which hopefully will build upon its achievements and not repeat its failures.

THE PSYCHIATRIST AS MEDIA INTERVIEWER — FINDING THE LIMITS

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The growing participation of professional psychiatrists within radio and television raises a number of important ethical questions concerning the limits of enquiry and the exploitation of subjects interviewed. Concerns regarding the abuse of psychiatric power and the devaluation of the image of psychiatry and psychiatrists are considered in this paper as are the similarities and differences between the roles and responsibilities of professional journalists and professional psychiatrists participating in the media. Questions considered include: Are psychiatrists justified in acting as interviewers in the public media? Is a degree of unacceptable manipulation involved in such interviews? How are appropriate limits set to both the content and the method of such interviews? In the light of this experience, the author, himself a psychiatrist who has participated within the British and Irish media for more than twenty years, puts forward certain guidelines which should govern the behaviour of psychiatrists