columns

difficult and using interpreters is often the only solution. Asking questions of a sexual nature requires tact. A patient is unlikely to reveal problems of a sensitive nature to an interpreter, for fear of embarrassment, especially if they are from the same cultural background. Sex has always been a taboo subject in this community and it is difficult to find literal translations of terms used when taking a sexual history, without having to resort to colloquial slang. The accuracy of histories could be doubted.

With psychiatric illness already associated with stigma in south-east Asian communities, patients are unlikely to freely admit to sexual dysfunction as well, in a community in which male virility and fertility among males and females is seen as culturally desirable. Asian women are unlikely to want to discuss such sensitive issues with a male or agree to intimate examinations. Understanding of psychiatric illness can be limited, and sexual dysfunction may not be recognised as a symptom of illness or side-effect of medication.

Questioning patients about sexual dysfunction is a sensitive issue, especially when the patient is from another culture. As clinicians we must be aware of the need to ask about such symptoms.

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doi: 10.1192/pb.31.5.233b

Opportunity for sub-specialty recruitment

The importance that undergraduate experience of psychiatry has in shaping the career choices of medical students is highlighted by Eagles *et al* (*Psychiatric Bulletin*, February 2007, **31**, 70–72). However, although some form of psychiatric experience is included in all medical school curricula the psychiatric sub-specialties often miss out, with possible consequences for recruitment.

It is important to address this, and one of the best ways of doing so is through the provision of special study modules. These are clinical attachments chosen by the student that usually last 3 weeks and may be in clinical environments to which the student is not routinely exposed. These modules should have a strong clinical focus and give the student the opportunity to see what the clinician actually does from day to day. The General Medical Council states that 25–33% of the medical school curriculum should now be delivered in this way (General Medical Council, 2003). This gives scope for many of the psychiatric sub-specialties to be included as possible options.

The observation that exposure to clinical psychiatry tends to promote positive attitudes suggests that this would be a good way of boosting sub-specialty recruitment. Special study modules present clinicians in psychiatric sub-specialties with a great chance to convey their enthusiasm and educate medical students in their areas of work. We should seize the chance and contact the special study module coordinators of the local medical schools to put our specialties forward.

GENERAL MEDICAL COUNCIL (2003) *Tomorrow's Doctors. Recommendations on Undergraduate Medical Education.* General Medical Council.

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doi: 10.1192/pb.31.5.234

Therapeutic use of soap operas

Dr Breen describes the therapeutic use of soap operas in a boy with autistic-spectrum disorders (*Psychiatric Bulletin*, February 2007, **31**, 67–69). The use of soap operas is already widespread in old age psychiatry as a tool for informal assessment of cognition. Personally, I cannot bear their blend of stereotypical characters, exaggerated emotions and simplistic conflict, yet feel duty bound to monitor plot lines as a matter of professional obligation. Now it seems our colleagues in child and adolescent psychiatry may become similarly compelled to watch these grinding pantomimes in the name of enhancing the social intelligence of their flock. Is now the time to call for such activities to be formally incorporated into our job plans?

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doi: 10.1192/pb.31.5.234a

Blood glucose monitoring in a regional secure unit

Dr Tarrant (*Psychiatric Bulletin*, August 2006, **30**, 286–288) reaffirms the shortfalls in blood glucose monitoring in psychiatric practice, and we have confirmed this in two audits at a regional secure unit. The first (conducted in 2003) found that 30% of the in-patient sample on antipsychotic medication (an indicator of potential risk of hyperglycaemia) had random blood glucose measurement, and only one patient (who was diabetic) had regular blood glucose monitoring and measurement of glycosylated haemoglobin (HbAlc). The second audit (conducted in 2006) found that 58% of patients had their blood glucose measured at baseline, and half or less had appropriate monitoring.

These audits suggest that monitoring of blood glucose was unsatisfactory and recommendations (e.g. robust review of physical healthcare at care programmed approach meetings) to improve standards have subsequently been put into place. However, what is not known is the impact that the poor monitoring had on patient morbidity. One might predict that early detection and treatment of hyperglycaemia would prevent secondary problems such as coronary, renal and vascular complications in this patient population. It is therefore imperative that monitoring of blood glucose and other indicators of metabolic risk, such as HbA1c, lipid profiles and hormone levels (e.g. thyroid function tests), is undertaken whatever the setting (primary or secondary care and prisons) for all people on antipsychotic medication. It is also important that adherence to local/national protocols is audited regularly.

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doi: 10.1192/pb.31.5.234b

We are all nidotherapists

We disagree with Tyrer *et al*'s comparison of 'standard and nidotherapy perspectives of the environment for those with mental illness' (*Psychiatric Bulletin*, January 2007, **31**, 1–3). The views attributed to 'standard' perspective (which we assume refers to usual clinical practice) do not represent the practice or belief of any clinician we know. The authors' suggestion (for standard perspective) that the 'environment is of secondary importance in psychiatric practice' sharply contrasts with the bio-psychosocial approach which is drummed into trainees from their first day in psychiatry. Similarly, we are not aware of any clinician who believes that 'once people with mental illness get better their original environmental problems resolve'. On the contrary, all clinicians we know identify with the perspectives attributed to nidotherapy even if limited resources constrain their implementation.

Although it is helpful to highlight the importance of the environment in the management of people with mental illness, giving this a fancy name sounds like 'rebranding old wine in new bottles'. What we need are the resources to continue to improve all aspects of the lives of people with mental illness.

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doi: 10.1192/pb.31.5.234c