of the average day of a normal and rational human being attempting to protect his or her civil liberties. These are practical problems faced by the average person.

With the advent of the Human Rights Act 1998 civil liberties have come to the forefront. It is an Act that cannot be ignored. Indeed, with increasing litigation, authorities have by nature become defensive. Part of the method of making life impossible for complainants is to increase the bureaucracy.

The number of letters, phone calls, etc. reported by Lester *et al* (2004) may be part of 'normal' human behaviour and reaction to bureaucracy. In a democratic country, we all have a right to protect our civil liberties. Often litigants lack knowledge, have no idea of procedures, and are misled by authorities who have a vested interest in protecting themselves. To label this behaviour as an 'abnormality' or something that requires psychiatric intervention is ludicrous. Indeed, I note the Royal College of Psychiatrists runs a very successful anti-stigma campaign to stamp out discrimination against those with mental illness. The diagnosis of querulous paranoia runs the risk of misuse by those who wish to use psychiatry as a manner of silencing criticism. The behaviour exhibited in the study is indeed a normal reaction to the circumstances faced. 'Normal' of course depends on many variables such as response time of the complaint officers, failure to address questions, replies to phone calls, etc. These factors have not been addressed.

It stands to reason that psychiatrists are not judges. Indeed, the merits of the complaint will be subjectively assessed by each psychiatrist based on his or her prejudices. This is hardly independent.

Querulous paranoia is a diagnosis best left within the darkened past of psychiatry – perhaps pre-war Russia where Stalin often used 'madness' to silence his critics. Genetically, we are all 'different' by nature and react in various ways to injustices. It is essential to maintain the civil right to seek a remedy without interference from psychiatry. Interference from psychiatry will only increase the stigma associated with it for so many years.

It is often the case that different personas, atypical to the perceived norm, are subjected to psychiatric analysis. There is a minority of serial complainants but the difference is to ascertain whether their complaints have merits or not. A psychiatrist cannot assess this fairly. Without an independent legal assessment, any person who attempts to fight or campaign for their civil liberties runs the risk of being labelled with a psychiatric illness. Their credibility will often be substantially affected. This, indeed, may be a rather convenient way of silencing uncomfortable critics of negligent authorities. This was not what psychiatry was meant for and neither should it risk going down that route, given the good work done by the College's anti-stigma campaign on raising awareness of discrimination in mental health.

Lester, G., Wilson, B., Griffin, L., *et al* (2004) Unusually persistent complainants. *British Journal of Psychiatry*, **184**, 352–356.

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Author's reply: Judging from Dr Pal's letter we failed totally to communicate adequately the purpose, the methodology or the conclusions of our paper on unusually persistent complainants. Dr Pal's letter comes, therefore, as a welcome opportunity to clarify our views.

We scrupulously avoided the term querulous paranoia. The unusually persistent complainants and their controls were selected by professionals working within the ombudsmen's offices, many of whom are legally trained. We are studying not courts and bureaucracies, but organisations whose mission is to assist complainants find a satisfactory resolution to their grievances. The organisational responses to the complaint, far from being ignored, were examined as the most likely precipitant of unusual persistence.

Dr Pal's passionate defence of civil liberties and attack on 'misleading' bureaucracies set on 'silencing criticism' seems misplaced as a criticism of a paper aimed at understanding and assisting those currently damaged by engagement within systems of complaints resolutions. Dr Pal clearly has a generous view of 'normal reactions', which incorporates behaviours involving a total fixation on a grievance to the point where individuals consume all their time, resources and energies in a futile pursuit that lays waste their own, and their families', lives. Dr Pal also presumably encompasses within the notion of normal overt and covert threats against complaints officers and their families.

Having our approach compared to Stalin, even a Stalin who Dr Pal seems to believe improved his behaviour post-war, might be considered intemperate, directed as it is at the authors of a paper which attempted to broaden the sympathies and concerns of mental health professionals for a distressed and disturbed group within our communities.

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GHB and date rape

I read with interest the important editorial by Rodgers *et al* (2004) on γ-hydroxybutyrate (GHB, liquid ecstasy) and the new threat it poses to young adults. It is worth adding the growing threat of the use of GHB as a 'date/acquaintance rape' drug; GHB is cited in this regard along with psychoactive substances such as flunitrazepam and ketamine (Smith, 1999).

GHB is a typical 'date rape' agent (O'Connell *et al*, 2000) as it is relatively easy to obtain, and it causes a rapid relaxing and disinhibitory effect. Moreover, since it is colourless and odour-free, it is easily added to the potential victim's drink without arousing any suspicion. These characteristics make it easy and less risky to perpetrate the crime. Additionally, GHB frequently causes the victim to be regarded as unreliable in the eyes of law-enforcement authorities because of changes in consciousness, perception, and anterograde amnesia, and at times hallucinations during and following the act.

Since GHB is difficult to identify in the urine as it is quickly eliminated from the body, it is rarely collected as evidence of the crime. This drug is not routinely checked for in urine toxicology screening kits and is therefore likely to be missed at the emergency room. Doctors and other professionals working with sexual assault victims should be aware of the possibility of GHB intoxication, more often than not, of an unknowing victim.

O'Connell, T., Kaye, I. & Plosay, J. J. (2000) Gamma-hydroxybutyrate (GHB): a newer drug of abuse. *American Family Physician*, **62**, 2478–82, 2483.

Rodgers, J., Ashton, C. H., Gilvarry, E., *et al* (2004) Liquid ecstasy: a new kid on the dance floor. *British Journal of Psychiatry*, **184**, 104–106.

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Smith, K. M. (1999) Drugs used in acquaintance rape. *Journal of the American Pharmaceutical Association*, **39**, 519–525.

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Creative debate misses the point

The debate rages between Schlesinger (2004) and Wills (2004) over the evidence for a link between mental illness and creativity, but I believe that their focus is wrong.

Most studies to date have either focused on anecdotal (biographical) evidence or have been methodologically flawed retrospective cohort studies, and all would rate low on the hierarchy of evidence. Whatever the outcome of Schlesinger's and Wills' arguments, the question will remain unanswered until better controlled, masked, prospective and replicable randomised studies are carried out.

What is not in question is that mental illness is at least as prevalent in the creative community as in the general population and there are even examples of how some artists, including Dali and Munch, have used their mental illness to feed into the creative process (Saloman, 1996; Rothenberg, 2001). Given the hefty side-effect profiles of most psychiatric treatments, surely the emphasis should be on how best to treat such exceptional patients – indeed all patients – in a way that minimises their symptoms without rendering them incapable of practising their trade. That is, after all (at the risk of sounding naïve), what we are here for.

Rothenberg, A. (2001) Bipolar illness, creativity, and treatment. *Psychiatric Quarterly*, **72**, 131–147.

Saloman, M. (1996) Raphaelesque Head Exploding, Salvador Dali. *Neurosurgery*, **38**, 225.

Schlesinger, J. (2004) Heroic, not disordered; creativity and mental illness revisited (letter). *British Journal of Psychiatry*, **184**, 363–364.

Wills, G. (2004) Creativity and mental health (letter). *British Journal of Psychiatry*, **184**, 184–185.

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Comedians: fun and dysfunctionality

The astonishing levels of drug- and alcohol-related morbidity in the history of jazz and popular music is well described by Wills (2003). After reading his paper I reflected on another group of my heroes, comedians, about whom popular biographies also abound. As I thought of a list of comedy greats, the well-published problems of many – indeed, almost all – of them was striking. Here follows an unresearched short list of some of my favourite great comedians, who manifest a range of neuroses, affective disorders, psychoses and substance problems: Caroline Aherne, Woody Allen, Lenny Bruce, Graham Chapman, John Cleese, Peter Cook, Tommy Cooper, Tony Hancock, Spike Milligan, Dudley Moore, Richard Pryor, Victoria Wood.

The thought of a 2-minute after-dinner speech, let alone three shows per night at the Glasgow Empire, illustrates how unusual any group of comedians must be. There may be a need for somewhat hypomanic thinking to improvise comedy. There is possibly some mileage in the 'bullied at school' manic defence explanation for becoming a clown. Such factors suggest the possible preselection of high-risk people to enter the comedy field. Once selected, the factors suggested by Plant (1981) to explain why some occupations have a high risk of drinking, and by extension drug use, all seem applicable: availability; social pressure to use; separation from normal social or sexual relationships; freedom from supervision; very high or very low income; collusion by colleagues; and strains, stresses and hazards.

The popular 'myth' that, beneath the motley, clowns are distressed, may account for some over-reporting of comedians' problems, but perhaps some truisms are just that.

Plant, M. A. (1981) Risk factors in employment. In *Alcohol Problems in Employment* (eds B. D. Hore & M. A. Plant). London: Croom Helm.

Wills, G. I. (2003) Forty lives in the bebop business: mental health in a group of eminent jazz musicians. *British Journal of Psychiatry*, **183**, 255–259.

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One hundred years ago

The mental state in myxoedema. By H. Wolseley-Lewis, MD Brux., FRCS Eng., Senior Assistant Medical Officer at Banstead Asylum

HAVING recently had some cases of myxoedema under my care I have had an opportunity of making the following analysis of their mental state. These patients are commonly sent to asylums as cases of dementia or melancholia. They present, however, few of the characteristics of either condition. Their memory for remote events is generally good and their impairment of memory for recent ones is slight and confined to a period coincident with the duration of their disorder. Their apprehension is fair, their coherence of thought is good, their reasoning power is sound, and their consciousness is clear. What depression they exhibit arises rather from a consciousness of their condition than from any more fundamental affection of the emotions . . . I submit then that the changes in the mental condition of those suffering from myxoedema are almost confined to the sphere of action. It seems necessary to suppose that either some toxin in the plasma surrounding the motor cells inhibits the chemical processes which originate a motor impulse or that the absence of some substance from the blood interferes with the discharge. This toxin is neutralised or this essential substance is supplied by the administration of thyroid extract; the patients get well and keep so

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