encephalomyelitis (CFS/ME) is used as an 'umbrella term' because of the 'need for patients and clinicians to agree a satisfactory term as a means of communication' but the concept of neurasthenia is not used. The report's authors state that CFS is 'widely used among clinicians' and seem to consider it to be a disorder more physical than psychiatric. Equally, CFS/ME is not included in DSM–IV (American Psychiatric Association, 1994) or ICD–10. On the other hand, neurasthenia as defined in the ICD–10 is a psychiatric disorder whose main feature is 'persistent and distressing complaints of increased fatigue after mental effort, or persistent and distressing complaints of bodily weakness and exhaustion after minimal effort'. This fatigue could be associated with muscular aches, dizziness, tension headaches, sleep disturbances, irritability, dyspepsia and inability to relax. Neurasthenia includes 'fatigue syndrome' but excludes 'post viral fatigue syndrome'. Using ICD–10 criteria in the general population, Hickie *et al* (2002) found that 1.5% of the 10 641 people who participated in the study met the criteria for neurasthenia in the past year. For females aged between 18 and 24 years, the 12-month prevalence rises to 2.4%.

If it is reasonable to compare the Australian and the British populations, we could probably expect a similar proportion of people here to be affected by this psychiatric disorder; the question here is what diagnosis is applied to them? If it is the case that CFS/ME is suggested, this would have adverse implications both for these patients essentially in need of treatment for a psychiatric disorder, and for any research on the aetiology and the treatment of CFS/ME.

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Explanatory models in psychiatry

Bhui & Bhugra (2002) rightly identify the importance of eliciting patient explanatory models in routine clinical psychiatric practice. Also, they highlight the difficulties in applying this socio-anthropological perspective in routine clinical practice and mental health research. The reductionistic nature of psychiatric classifications, the inherent diversity within diagnostic categories, the fact that choice of therapy is not category-specific but is based on clinical presentation and symptoms, and the variability of outcomes demand the individualisation of care (Jacob, 1999). Bhui & Bhugra attempt to address this complex reality related to mental illness by taking a pragmatic approach.

I agree with Bhui & Bhugra that the transition from illness experience to disorder is determined by social decision points rather than biomedically determined levels of disorder. This is conceptually sound from a socio-anthropological point of view which has approached the issues from a sociocultural perspective. Hitherto, medical anthropologists and sociologists viewed individuals' explanatory models as alternatives to the biomedical model. This would be an oversimplified application of an anthropological perspective in psychiatric practice. Although individual explanatory models are arguably more appropriate, they are not alternatives. Given the incomplete understanding of mental illness by the scientific community, it is not clear whether explanatory models alone are able to capture the complex mental health needs of patients across cultures.

As Bhui & Bhugra mentioned, in many cases the clinical reality is that individual explanatory models and biomedical diagnostic categories are not mutually exclusive but complementary. Medical/biological perspectives and cultural/anthropological views in isolation are inadequate for the understanding of mental disorders (Jacob, 1999). Examining the interconnection between the biomedical model and the individual explanatory model will produce a comprehensive assessment schedule that will be both internationally and locally valid and can form the basis of culturally appropriate modes of treatment that take into account the effect of culture, as well as individual differences, on courses and outcomes. This attempt may furnish the clinician with an opportunity to consider how best to help the patient.

Bhui, K. & Bhugra, D. (2002) Explanatory models for mental distress: implications for clinical practice and research. *British Journal of Psychiatry*, **181**, 6–7.

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I read Drs Bhui & Bhugra's (2002) editorial with interest. The authors advocate a socio-anthropologically informed method for both clinical and academic psychiatry, an opinion with which I strongly agree and one that may have come to psychiatry earlier. If one returns to the pages of Jaspers' *General Psychopathology* (Jaspers, 1913, current edition in English translation 1997), and his seminal paper 'The phenomenological approach in psychopathology' (Jaspers, 1912), there is a clear tension between his claim to practise a phenomenology of mental illness, where the transcendentally ideal mental state abnormalities are elucidated and described, and his call to 'understand' the patient's symptoms in the light of their world view. This latter approach owes much to his mentor Weber's conception of 'ideal types' and there is a clear debt to the hermeneutics and historicism of Dilthey in his suggestion that *Verstehen* (variously translated as interpretive understanding or empathy) is the correct method for psychopathology, rather than the phenomenology of Husserl (Berrios, 1993). The approach of Husserl in *Logical Investigations* (1913, current edition in English translation 2001) could be described as the search for certain features of consciousness that are ideal, pure and *a priori* and structure the meaning of experience and as such are true for all men at all times. Dilthey, in contrast, would argue for the contingency of world view which could only be viewed in others by a thorough, and possibly impossible, immersion in the meaningful structure of their lived environment – *Verstehen* (Outhwaite, 1986). This latter method is likely to be only partially successful, even in the hands of a very skilled practitioner, as in a very real sense, one's life can only ever be lived from 'within' and it is a question of degree as to how far an external observer could ever appreciate its subtleties. For the attempt to be made, however, would require a depth of knowledge of the various socio-anthropological models before an investigator could

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even begin to frame hypotheses regarding explanatory models of distress.

Thus, the insights of a sociologically and anthropologically informed psychopathology may have been with us sooner, rather than us constantly having to be on guard against seduction by the ideal forms of psychopathology handed down to us by Jaspers. After all, the psychotic disorders and their symptoms are unlikely to be wholly discrete entities and, similarly, psychosis lies along a continuum with normal reasoning and experiences.

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Bhui, K. & Bhugra, D. (2002) Explanatory models for mental distress: implications for clinical practice and research. *British Journal of Psychiatry*, **181**, 6–7.

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Sexual dysfunction and antipsychotics

The adverse side-effects of antipsychotic medication, including sexual dysfunction, are believed to be one of the main reasons for non-compliance (Smith *et al*, 2002). However, it is the broader issue of sexual behaviour in psychiatry that we need to focus on. Sexuality is important to most patients, as the drive to procreate is strong.

Psychiatric professionals tend not to be interested in discussing sexual behaviour, for reasons such as that they feel it is not important enough, or that it is something private. Apart from embarrassment, worries also arise because of the sensitivity of this issue in the litigation-ridden atmosphere of current practice. Patients' sexual behaviour is usually considered when it is perceived as deviant or when others are felt to be at risk (e.g. in the context of sexual abuse or harassment).

Buckley and colleagues, having emphasised the importance of sexuality to in-patients, have conducted surveys on psychiatric in-patient units. These have shown a 'wide variety of differing management approaches' (Buckley & Robben, 2000) to in-patient sexual behaviour. Also, most mental health facilities perceive sexual behaviour as an 'infrequent problem' (Buckley & Weichers, 1999).

Healthy expression of sexuality is frowned upon and pornographic material is discouraged on most general adult psychiatric wards. This is justified, as it would not be appropriate. Little consideration is given to the idea that freer expression of sexuality may be therapeutic.

Psychiatric in-patients are vulnerable, yet inhibition of sexual behaviour may increase distress, which can be detrimental to mental health. In the era of holistic medicine such an important facet of patient care has to be catered for. We should offer patients ways by which they can express themselves sexually in a safe and private environment. The way forward is to design in-patient wards, and write management policies, that are more 'person-friendly'.

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Smith, S. M., O'Keane, V. & Murray, R. (2002) Sexual dysfunction in patients taking conventional antipsychotic medication. *British Journal of Psychiatry*, **181**, 49–55.

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One hundred years ago

The Edinburgh scheme for a psychiatric clinique

To the Editors of THE LANCET

SIRS, – In your leading article on "The Edinburgh Scheme for a Psychiatric Clinique" in THE LANCET of Feb 1st, p. 318, you appear to bestow your unqualified blessing upon the London County Council scheme for the establishment of reception houses for the preliminary treatment of the insane. You apparently are unaware that each Poor-law district in London possesses one or more such reception houses in the shape of fully-equipped and up-to-date mental wards attached to the various infirmaries. The buildings belonging to the Lewisham Infirmary consist of a handsome separate block, accommodating 11 male and 11 female patients, and fitted with all modern appliances. The system which upon my recommendation has been carried out by the local magistrates and guardians of the poor is to detain all cases of alleged lunacy in the mental block for a variable period before deciding upon their transfer to an asylum. The most gratifying results have attended our treatment. Out of 1382 cases treated during the past seven years 742 have been discharged cured, 144 have died, 20 have been sent to imbecile establishments, and only 476 have been sent to asylums. The majority of the deaths were cases of senile dementia.

The objections to the London County Council scheme are many. The change will simply be from one authority to another, but it will involve the enormous expenditure associated with the building and staffing of at least four large institutions. I anticipate that the buildings alone would cost over £500 000. The expense of collecting the patients from the wide area feeding each reception house must be considered. There is also the hardship inflicted upon the relatives and friends of the patients by making them travel long distances for the purposes of visiting, &c.; but the strongest argument against the proposed change is the stigma of "lunacy" which will rest upon the reputation of every patient who enters a reception house. Under existing

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