

## Correspondence

EDITED BY KHALIDA ISMAIL

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### Racism in psychiatry

Professor Tyrer's editorial (2005) is welcome and long overdue. He highlights a serious inequality between the contributions of authors from the industrialised and non-industrialised world. What Professor Tyrer failed to discuss is a more deeply imbedded problem of the institutionalised racism that lies at the heart of the conceptual systems we use in psychiatry. This is, of course, an understandably even harder and more painful issue for our profession to face; it is, however, necessary that we examine the potential for the concepts that we use to be inherently discriminatory.

For example, is the consistently higher rate of diagnosis of schizophrenia in second-generation British–Caribbean people a result of incorrect diagnosis, or the potential for a reductionistic biomedical model of mental health to label whole communities as 'mad' with the resulting stigma these communities then suffer (as well as masking from us the impact of social issues such as immigration and racism)? Another example relates to the concept of depression, which is meaningless in some cultures. What impact does imposing a meaningless diagnosis have on someone's willingness and motivation to engage with services? This obviously has the potential to discriminate in a subtle way against whole communities on their ability to develop meaningful relationships with their treating psychiatrists.

We should not be surprised that there are inherently racist concepts embedded in our 'institutionalised' ways of thinking about mental health problems, how to conceptualise them, what to do about them, and what value system we take into our daily practice. Mental health ideology and technology have developed not as the result of the discovery of testable physical pathology, but through a system of consensus resulting from powerful psychiatrists' interpretation of the existing evidence.

These psychiatrists have carried their own cultural assumptions (derived from the dominant Western culture) without apparently being aware of this, and developed a system thinking and acting for psychiatrists based on these Western cultural ideals. Thus, from its conception, modern psychiatry has been imposing these Western, culturally constructed ideas on communities who have very different models for understanding mental health problems and what to do about them.

Sadly, I am not sure how ready our profession is to engage in some self-reflection and a thorough re-examination of these issues. I guess that may be just too painful; however, if we do not do this, we will not get rid of the scourge of institutional racism from our profession.

**Tyrer, P. (2005)** Combating editorial racism in psychiatric publications. *British Journal of Psychiatry*, **186**, 1–3.

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**Author's reply:** Dr Timimi raises the much larger issue of scientific racism in psychiatry in his letter. How much of this is institutional is difficult to determine but I contend that this is not the primary responsibility of journal editors to correct. The duty of an editor is to inform, to promulgate and explicate rather than to direct and legislate, and if this is done successfully it can help, together with many other influences, in changing minds and opinions. So we carry this out using the approach of Harriet Beecher Stowe rather than that of Abraham Lincoln and, if we change public opinion through the written word, we can also influence the climate of psychiatric practice favourably.

I hope that the *Journal* is helping to change opinion more in Dr Timimi's

direction in the spirit of my editorial (Tyrer, 2005). So we accept that our definitions of psychiatric illness are indeed too centred on the developed world and point out, for example, that the ICD–10 and DSM–IV diagnostic classification descriptions of anorexia nervosa are deficient in Ghana as those with the condition there 'would not be classed as having anorexia nervosa, as they had neither a morbid fear of fatness nor a pervasive need to be slim. Rather, they reported a desire to exert self-control through deliberate self-starvation' (Bennett *et al*, 2004). Similarly, in changing our attitudes towards British–Caribbean people who have schizophrenia, if we appreciate that stigma is likely to be a consequence of delayed presentation and compulsory admission (Morgan *et al*, 2005), then we are able to both give an explanation and possibly gain from the experience of other countries in getting services provided early to a stigmatised group (Chatterjee *et al*, 2003). I therefore do not share Dr Timimi's pessimism; by opening up the debate we have moved from 'powerful psychiatrists interpreting the existing evidence' in their favour, to powerful evidence from around the world influencing the responses of all psychiatrists, irrespective of their status. Long may this process continue.

**Bennett, D., Sharpe, M., Freeman, C., et al (2004)** Anorexia nervosa among female secondary school students in Ghana. *British Journal of Psychiatry*, **185**, 312–317.

**Chatterjee, S., Patel, V., Chatterjee, A., et al (2003)** Evaluation of a community-based rehabilitation model for chronic schizophrenia in rural India. *British Journal of Psychiatry*, **182**, 57–62.

**Morgan, C., Mallett, R., Hutchinson, G., et al (2005)** Pathways to care and ethnicity. 2: Source of referral and help-seeking. Report from the AESOP study. *British Journal of Psychiatry*, **186**, 290–296.

**Tyrer, P. (2005)** Combating editorial racism in psychiatric publications. *British Journal of Psychiatry*, **186**, 1–3.

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### Phenomenology of psychosis

I read with interest the title of the editorial by Harland *et al* (2004), which promised a fascinating synthesis of phenomenology, anthropology and the psychology of the self to formulate a new model for the aetiology of psychosis. Sadly, this was not achieved by the authors and I was left wondering how this had been lost on the Editor.

My response to the authors' striking claim that they propose a new model (even if only 'an outline sketch of a potential model') is: what model? Unfortunately, careful reading of the paper in search of this model resulted in little that is new and certainly nothing approaching a testable hypothesis.

Is it a new model to state that the environment affects the configuration of the self and that this can somehow lead to psychosis? The authors cite the example of migration and its association with increased risk of psychosis to illustrate their point, but it does not seem that they have anything new to say about this fascinating area.

The authors call for greater rigour in future conceptual models that integrate the biological and the social in the aetiology of psychosis. It is, therefore, doubly surprising that they advocate the integration of hermeneutically oriented social sciences into such future models. Given that hermeneutics is disconnected from the rigours of the laws of causation that govern the material world, one wonders how this would reduce the 'vagueness' that the authors warn us against. It is also of interest that the two other concepts central to the authors' model are the 'self' – a concept that has numerous competing definitions (one article cited 21 competing concepts of the self; see Zahavi, 2003) – and 'social capital', which has no operational definition (see McKenzie *et al*, 2002). It seems to me that the authors should have followed their own admonition against vagueness or else produced their own clear definitions of these concepts.

Also, the authors commit an elementary error by confusing the concept of 'biological' with 'genetic' or 'genomic' in their critique of current theories on schizophrenia, citing the work of Eisenberg (2004). When we consider the role of a given environmental factor in shaping a particular trait, we are most certainly dealing with a biological process. Can we discuss the effect of sunlight on tanning of the skin without considering melanocytes and melanin (see Gaulin & McBurney, 2001)? Similarly, if the human brain/mind has the propensity, under certain environmental conditions and given a particular genetic make-up and early-life experience, to produce the clinical picture we call psychosis, this cannot be understood outside of biology. Phenotypes, we should remember, are not simply the obligate expression

of genes but the complex outcome of the interaction of the genome with the environment. In other words, the identification of an environmental risk factor for a particular disorder is not the end of the story. To achieve a real understanding of how the phenotypic trait was shaped, we still need to understand the intra-organismic process that led to the said trait.

**Eisenberg, L. (2004)** Social psychiatry and the human genome: contextualising heritability. *British Journal of Psychiatry*, **184**, 101–103.

**Gaulin, S. J. C. & McBurney, D. H. (2001)** *Psychology: An Evolutionary Approach*. New Jersey: Prentice Hall.

**Harland, R., Morgan, C. & Hutchinson, G. (2004)** Phenomenology, science and the anthropology of the self: a new model for the aetiology of psychosis. *British Journal of Psychiatry*, **185**, 361–362.

**McKenzie, K., Whitley, R. & Weich, S. (2002)** Social capital and mental health. *British Journal of Psychiatry*, **181**, 280–283.

**Zahavi, D. (2003)** Phenomenology of self. In *The Self in Neuroscience and Psychiatry* (eds T. Kircher & A. David), pp. 56–75. Cambridge: Cambridge University Press.

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**Authors' reply:** In suggesting that the environment acts to produce biologically based phenotypes depending on genetic propensity, through 'intra-organismic' processes, this letter points to one mantra of modern psychiatry. But in looking for how our editorial contributes to the incremental nature of this important science it misunderstands our intent.

By 'a new model' we are describing an alternative way of seeing the problem, as opposed to the box and line model we have become more familiar with when considering a novel testable hypothesis. Phenomenology, conceived by Husserl, developed through Heidegger, Ricoeur and others, is notoriously difficult. On these terms there may be those who feel that what we have attempted is misconceived. However, it is a tradition that influenced many of the early scientific thinkers in our field, including Jaspers, Schneider, Minkowski and Lewis, and it continues to influence today (e.g. Cutting, 1997; Sass, 2004; Stanghellini, 2004).

To precis Dan Zahavi (2003: p. 59) we cannot ask what it is like to be a bar of soap or a rock. However, we can ask what it is like to be a mouse, a human or, indeed, to experience schizophrenia. This 'what it is

like' has an internal structure that phenomenology attempts to capture. Likewise, in our editorial we suggest that migration can provoke changes in 'what it is like to be' on a similar level and that the field of anthropology (which draws on phenomenology) offers insights here. We then link these changes to the increased rates of psychotic illness in some groups and suggest that this fits well with the current psychiatric thesis that the brain is the product of its own historical trajectory.

We remain open to whether biological or environmental correlates with identified phenomenological structures can meaningfully be found. But a reinvigoration of phenomenology is perhaps just what psychiatry needs at this time. We would do well to bring to mind that despite our best efforts we have yet to find aetiological factors in environmental or biological terms that take us beyond the group effect to the individual.

Above all the purpose of writing the editorial was to stimulate debate.

**Cutting, J. (1997)** *Principles of Psychopathology*. Oxford: Oxford University Press.

**Sass, L. (2004)** 'Negative symptoms', common sense and cultural disembedding in the modern age. In *Schizophrenia, Culture, and Subjectivity* (eds J. Hunter Jenkins & R. J. Barrett), pp. 303–328. New York: Cambridge University Press.

**Stanghellini, G. (2004)** *Disembodied Spirits and Deanimated Bodies*. Oxford: Oxford University Press.

**Zahavi, D. (2003)** Phenomenology of the self. In *The Self in Neuroscience and Psychiatry* (eds T. Kircher & A. David), pp. 56–75. Cambridge: Cambridge University Press.

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### Personality and attachment in adolescence

It was encouraging to see the study by Westen *et al* (2005) published in a mainstream journal such as the *British Journal of Psychiatry*. For a variety of reasons, there is a reluctance among many British adolescent mental health clinicians to diagnose personality disorders in their patients, despite the clear presence often of the requisite diagnostic features. This study shows that personality disorders in adolescents can be validly diagnosed, whether using an established framework such as the DSM-IV or a new, empirically derived taxonomy.