Correspondence

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Explanatory models in psychiatry

Dein (2002) comments on our editorial on explanatory models (Bhui & Bhugra, 2002), but fails to apprehend the conceptual flaws in his assertions, promotes a complacent attitude to the challenges of cultural psychiatry, and is threatened by a patient's explanatory model that differs from his own. Dein agrees with us that explanatory models are not stable, and are dynamic, complex, shifting entities, making more research necessary for any consistent theory about their role in routine clinical practice. None the less, their role in improving understanding of patients' cultural world views has not previously been in dispute (American Psychiatric Association, 2002). Although Dein gives greater weight to behavioural expressions of explanatory models, he does not question whether explanatory models can or should be considered as a psychological construct of the individual, or as a group or social–behavioural phenomenon, or both. Each of these conceptualisations is certainly distorted by theorising more concrete, but more easily understood, expressions of explanatory models. Contrary to the historical anthropological paradigm, it is not useful to psychiatric practice if valuable anthropological critiques simply ignore psychological and non-behavioural data. More worryingly, Dein assigns a patriarchal role to the psychiatrist, a role that cannot lead to a collaborative therapeutic relationship. It seems Dr Dein is not prepared to accept that a patient may pursue his or her own explanatory model and associated interventions, alongside those recommended by the psychiatrist. A fuller discussion of these alongside the psychiatrist's own models allows for a shared vision of treatment and recovery.

Why is an exorcism problematic for the psychiatrist? It is not in the realms of psychiatric knowledge or skills, and if helpful for recovery from illness, rather than disease, it should not be hindered. Dein appears to show contempt for a territory in which psychiatrists are not expert (possession and exorcisms: see Pereira *et al*, 1995), and certainly does not show the respect for cultural beliefs that is part and parcel of a scientific or anthropological study of healing, let alone clinical practice. His approach smacks of a patriarchal conviction that the diagnosis is more than a theory, and that psychiatric interventions are not to be questioned. To diagnose is to classify and to predict a course and treatment based on the vagaries of statistics and experience: it is to take what can be a serious risk (Romanucci-Ross *et al*, 1991).

Although he cites a single example, it is not the case that the evidence base of traditional healing approaches are researched to the levels of esoteric knowledge found in biomedicine, except for, perhaps, acupuncture and Ayurveda where there is a growing literature. People will always be keen to try anything that helps them, biomedicine or culturally sanctioned traditional therapies. Surely he does not mean that we as psychiatrists have nothing to learn about treating illness from the traditional and complementary sector. Our view is we have plenty to learn and research. Eliciting explanatory models is a beginning of the process in consultations and offers an easily understandable method of learning about a patient's culture. However, Dein's view appears to be that we know enough, and need not discover more. We are surprised at this view and cannot agree.

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Ethnic differences in prisoners: describing trauma and stress

I read with interest the two articles by Coid *et al* (2002*a*,*b*) but was puzzled by the use of the term 'post-traumatic stress' to describe the psychiatric response of prisoners who had experienced adverse or negative life events. The authors use the term post-traumatic stress without specifying whether they are referring to the specific diagnosis of post-traumatic stress disorder (PTSD), a recognised psychiatric condition in the DMS–IV (American Psychiatric Association, 1994) or simply a vague amalgam of neurotic symptoms which the authors infer are a consequence of the various stresses the prisoners experienced in their lifetimes. The confused terminology in this respect, which is present in both papers, is unhelpful in assessing what precisely is psychiatrically wrong with these prisoners. A Criterion A trauma, that is a trauma that may precipitate PTSD in some individuals, is specifically defined and described in the DSM–IV as an event in which the person experiences, witnesses or is confronted with an event or events that involves actual or threatened death or serious injury to the self or to others, and to which the individual responds with intense fear, helplessness or horror. The experiences that were screened for in the original study by Singleton *et al* (1998) would not normally be considered to represent a Criterion A event, but merely negative or adverse life events which have no specific aetiological links with any distinct clinical diagnosis. The experiences included by the authors in their screening include bullying and marital separation, which do not constitute Criterion A events for the purpose of making a PTSD diagnosis. Similarly, many other traumatic experiences were not apparently screened for by the authors, such as rape or adult sexual assault, combat, being assaulted in the street (although violence in the home or at work are included). Thus, the selection, definition and description of these events as traumatic is misleading, while the inclusion of negative life events that are clearly more traumatic

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