

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.