BJPsych The British Journal of Psychiatry (2016)
208, 499–500

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

- Ethnic density and risk of postnatal depression and personality dysfunction
- Stigma and architecture of mental health facilities

Ethnic density and risk of postnatal depression and personality dysfunction

The subtle relationship between depression, gender and life events (such as motherhood) creates a global challenge to the United Nations' sustainable development goals.[1] Du Preez and colleagues make a fascinating contribution to the epidemiology of postnatal depression.[2] However, as someone interested in family and household effects on mental health[3] I wonder if they missed a key 'protective' aspect of having 'higher own ethnic density' in a mother's locality?[2] My own observation on British White mothers in a mixed community with marked deprivation and high levels of postnatal depression[4] was that having close relatives (like the baby's grandmother) living nearby made for a healthier new mum. Close relatives tend to belong to the same ethnic group, as do those 'good neighbours' who maintain frequent visits. The local risk of developing depression seems to be influenced by very short-range social networks of close relatives and neighbours.[5] In that poor community with so much postnatal depression,[4] it transpired that many mothers had no relatives in the area and did not see any friends among their neighbours.

1 Caan W. The global crisis of depression: the low of the 21st century? *Perspect Public Health* 2015; **135**: 62.

2 Du Preez A, Conroy S, Pawlby S, Moran P, Pariante CM. Differential effects of ethnic density on the risk of postnatal depression and personality dysfunction. *Br J Psychiatry* 2016; **208**: 49–55.

3 Caan W. How family friendly is the UK? *BMJ* 2011; **343**: 331–2.

4 Northrop M, Pittam G, Caan W. The expectations of families and patterns of participation in a trailblazer sure start. *Community Pract* 2008; **81**: 24–8.

5 Christakis NA, Fowler JH. Social contagion theory: examining dynamic social networks and human behaviour. *Stat Med* 2013; **32**: 556–7.

Woody Caan, Editor, *Journal of Public Mental Health*, Royal Society for Public Health, John Snow House, 59 Mansell Street, London E1 8AN, UK. Email: wcaan@rsph.org.uk

doi: 10.1192/bjp.208.5.499

Authors' reply: We thank Professor Caan for his interesting correspondence on our paper and for providing some further insight into how ethnic density may impact on the risk of postnatal depression in our sample. The protective effect of ethnic density is thought to operate predominately through either (a) reducing exposure to racism, or (b) improved social support and social networks,[1,2] and indeed, the latter is highly important in this context, given that poor social support is a strong predictor of postnatal depression.[3]

We agree that family and household effects can have profound consequences on mental health,[4] and that the proximity and ease of access to close friends and relatives is highly beneficial, especially for new mothers. Although our article refers to the importance of social support, and how this may be driving the protective effects of high ethnic density in our sample, we failed to dissect fully the mechanisms underpinning the associations between ethnic density and postnatal depression. This area would certainly benefit from further research, by enquiring about the locality of close family friends and relatives, so we may begin to understand more fully how high ethnic density may be exerting its protective effects.

1 Bécares L, Nazroo J, Stafford M. The buffering effects of ethnic density on experienced racism and health. *Health Place* 2009; **15**: 670–8.

2 Bhugra D, Becker M. Migration, cultural bereavement and cultural identity. *World Psychiatry* 2005; **4**: 18–24.

3 Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. *Am J Obstet Gynecol* 2010; **202**: 5–14.

4 Caan W. How family friendly is the UK? *BMJ* 2011; **343**: 331–2.

Andrea Du Preez, Susan Conroy, Susan Pawlby, Paul Moran, Carmine M. Pariante, Institute of Psychiatry, Psychology and Neuroscience, King's College London, UK. Email: andrea.du_preez@kcl.ac.uk

doi: 10.1192/bjp.208.5.499a

Stigma and architecture of mental health facilities

Stigma associated with mental illness is very common. Patients face prejudices, stereotypes, misunderstanding, discrimination, and self-stigma. They are afraid of being labelled. Another fear is the fear of mental health services, which makes patients avoid taking up treatment.[1] Apprehension of treatment increases when a patient has to be treated in a psychiatric hospital. Fear of stigma associated with a facility appears. For many patients, hospitals become their home for weeks or months. Despite all improvements introduced to mental health facilities, they are still labelled and stigmatised. Psychiatric hospitals are often associated with a penitentiary, an asylum, or a substitute of a panopticon. The stereotypical image of a psychiatric hospital is inseparably linked with this object.

The architecture of psychiatric hospitals is sometimes referred to as the architecture of madness. That applies to both the architectural form and the quality of the built environment. Very often, architecture not only fails to guarantee appropriate conditions of stay, but it is also inadequate for its function. Some psychiatric hospitals were not adapted to the changing requirements for healthcare facilities, and in some cases they were not designed to accommodate people. That creates inappropriate spatial and functional connections and results in inability to introduce required changes, provide particular technical conditions, and create a suitable environment for patients.

The popular perception of mental health architecture, considering all local issues, is closely related to the mental illness label. Existing technical and functional problems and the low quality of buildings arise from popular attitudes both to people with mental illness and to mental healthcare. Poorly financed and organised, the system cannot provide adequate conditions for in-patients.[2] That may lead to further discrimination of people with mental illness through the quality of the mental healthcare setting. Moreover, extrapolating a Western approach that is irrelevant to local determinants may fail to respond to patients' needs and further increase stigma.[3] When cultural and local issues are not implemented in the design process, the outcome often falls short of the required mental health facility standards.

https://doi.org/10.1192/bjp.208.5.499a Published online by Cambridge University Press