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Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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Disclosure of religious beliefs

Surely after more than 200 years, psychiatry has become reasonably sophisticated and we can assume that there is no such thing as an unbiased comment. Professor Cooper's attack on Professor Casey for being 'a sincere member of the Roman Catholic Church'[1] is only justified if he also states, as the Editor does, that the other comment comes from Dr Oates, who is a 'representative of the pro-choice group'.[2] These senior psychiatrists were asked by the Editor to comment because they had both a special interest and special expertise.

There is a more general issue at stake here. It seems a sad reversion to attitudes in psychiatry of the 1960s when taking a religiously inspired position was seen as being unacceptably prejudiced, whereas taking a non-religious stance, even at the expense of the patient's discomfort, was regarded as normal practice. Professor Casey has been asked to wear her religious belief publicly, like some yellow Star of David, with the intention to undermine the validity of her professional opinion.

As a former chairman of the Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group, I would hope that we could now give equal value to the viewpoints of psychiatrists with different philosophical and religious backgrounds. Dr Oates should be permitted, even in your august pages, to express a personal position, and so should Professor Casey. Yes, I do express a personal interest.

1 Cooper JE. Abortion and mental health disorders. *Br J Psychiatry* 2009; **194**: 570.

2 Tyrer P. Editor's note. *Br J Psychiatry* 2009; **194**: 571.

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Cooper[1] states 'we all start from a position determined in part by personal background, and readers will not fully understand comments unless such things are known', referring to Casey's[2] commentary on Fergusson *et al*[3] and her Catholic faith. This seems to suggest that however sound our reasoning may be, it must be taken with a pinch of salt because one is a Catholic. Perhaps a Black man's arguments against racism would be similarly invalid. No doubt Professor Cooper would not want an upsurge in anti-Catholic bigotry, but his suggestions may not prevent it.

1 Cooper JE. Abortion and mental health disorders. *Br J Psychiatry* 2009; **194**: 570.

2 Casey P, Oates M, Jones I, Cantwell R. Invited commentaries on . . . Abortion and mental health disorders. *Br J Psychiatry* 2008; **193**: 452–4.

3 Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

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Professors Fergusson and Tyrer admirably address the scientific issues raised in the letter by Professor Cooper.[1] However, one phrase remains of concern: Professor Casey's personal religious faith is declared by Professor Cooper. Should the public declaration of someone else's religious faith by a third party be encouraged? If a person wishes to 'come out' publicly about their faith as part of a publication, perhaps that is acceptable, or perhaps a scientific international journal is not the appropriate forum for the exposé of such matters?

1 Cooper JE. Abortion and mental health disorders. *Br J Psychiatry* 2009; **194**: 570.

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Author's reply: I am very pleased to have the opportunity to respond to the letters of Drs Blackwell and Aitchison, and Professor Sims. They are all relevant to the important general issue of whether authors of papers on topics known to be controversial (such as abortion and ethnicity) should always be obliged to state their own background position in full. I suggest that the answer to this must always be 'Yes, definitely.'

In scientific research, all possible attempts should be made to keep biases to a minimum, but unavoidable human influences can still be there and need to be known by readers if they are to understand both the data and the conclusions. These include the reasons for the research or review, the conclusions of any previous related studies by the same authors, possible biases in the methods of collection and analysis of the data, and possible biases in the conclusions of the authors. Different readers may then interpret the findings in different ways, depending upon their own viewpoint. If authors of papers on controversial topics follow these guidelines, and always state whether their conclusions are based solely upon the data of the study or also upon other background personal reasons, then the question of 'outing' will never arise. Similarly, on this line of reasoning, the simple statement of undisputed facts should not be regarded as 'an attack'. There is wide agreement that financial rewards in the background must always be declared, so surely the same should apply to other potentially biasing influences.

Professor Sims's reference to the 'psychiatry of the 1960s' puzzles me, and without specific examples I cannot comment on this.

The overall point at issue is that readers should be able to make up their own minds, and not be limited only to what the authors believe to be the best interpretation of the study. This may be rather perfectionist advice, but at least it gives a model as a target.

A more specific issue relates directly to the paper by Fergusson *et al*[1] and to the comments by Professor Casey suggesting that this study constitutes evidence that special emphasis on the potential psychiatric hazards of abortion should be an obligatory part of psychiatric educational programmes.

Drs Rowlands & Guthrie[2] seem to me to give a good summary of this whole problem: 'Whether abortion causes harm to women's

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mental health is a question that is not scientifically testable, as women with unwanted pregnancies cannot be randomly assigned to abortion *v*. abortion denied groups. It seems inappropriate therefore for Casey to talk of potential litigation against abortion providers for failing to provide information on a possible causal link between abortion and subsequent mental health problems.'

Debates on this topic and others such as racism tend to be endless, so I suggest that if anyone wishes to continue further, they should do so by direct personal emails.

1 Fergusson DM, Horwood LJ, Boden IM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

2 Rowlands S, Guthrie K. Abortion and mental health. *Br J Psychiatry* 2009; **195**: 83.

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Response to the Editor: We were dismayed and deeply concerned to learn, from the Editor's note to Professor Cooper's letter,[1] that we had been characterised as holding a pro-choice position in our commentary on Fergusson *et al*'s paper.[2] This was not mentioned in the commissioning process and, if it had been, the invitation would have been declined. Our commentary acknowledged a range of opinions among ourselves. Our arguments were based on an analysis of Fergusson *et al*'s paper, explicitly eschewing any partisan approach, and stating quite clearly that the debate on the rights and wrongs of abortion is primarily moral, legal and ethical rather than psychiatric or indeed scientific. We hoped we had been very clear in this approach, and most strongly reject any suggestion that our commentary was based in beliefs from either 'side of the debate'.

1 Tyrer P. Editor's note. *Br J Psychiatry* 2009; **194**: 571.

2 Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

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Editor's note: This correspondence is now closed.

Diagnosing chronic fatigue syndrome

In their comparative epidemiological study of chronic fatigue syndrome in Brazil and London, Cho *et al*[1] conclude that cultural differences affect only the recognition, rather than occurrence, of this condition. Although a reasonable interpretation of the epidemiological data, without complementary consideration of the cultural context this assertion is likely to obscure some of the most salient features and clinical significance of the study. The authors note that 'both population and healthcare professionals seem unfamiliar with the construct of the syndrome.' Recognition of the community and professional inattention to and low priority of chronic fatigue syndrome, however, is not necessarily a failing; it may also be regarded as an updated example of Kleinman's[2] formulation of the category fallacy – the imposition of alien diagnostic concepts where they lack local validity. The assertion of underrecognition is incomplete without consideration of alternative formulations of the problems that in some respects resemble the syndrome, but are not diagnosed. Do conditions such as neurasthenia in East Asia and dhat syndrome in South Asia have characteristic patterning of distress or meaning in Brazil?

If one accepts the authors' tacit premise that the constructs of chronic fatigue syndrome and related UK formulations (encephalomyelitis and fibromyalgia) are unquestionably valid diagnoses for use everywhere, then the conclusion that chronic fatigue syndrome is neglected by professionals but no less important in the Brazilian population is valid. Accepting that premise, however, requires that we ignore the fact that the syndrome is neither in the ICD or DSM, and neurasthenia was rejected after consideration in the draft version of DSM–IV.[3] Standard texts in the field of cultural psychiatry regard chronic fatigue syndrome as a North American culture-bound syndrome.[4] Earlier research by some of the same Brazilian authors also highlights the social determinants of essential features of chronic fatigue, rather than the categorical diagnosis of the syndrome.[5]

Culturally sensitive clinical care will benefit from a reconsideration of cultural interpretations of these study data and from additional cross-cultural research. Are other diagnoses or local clinical and cultural formulations used to manage and treat such patients locally? Are other non-medical sources of help and social interventions given higher priority by patients and communities in Brazil?

Findings of Karasz & McKinley[6] showing the tendency of North Americans to 'medicalise' and South Asians to 'socialise' similar clinical vignettes recommend consideration of that point. Among patients studied by Cho *et al*, one might also ask whether higher rates of associated common mental disorders suggest that these psychiatric conditions are more likely to be the focus of treatment. The emphasis on underrecognition of chronic fatigue syndrome is likely to prove less important for community mental health and culturally sensitive care than questions of how such clinical patterns are understood in the population and explained by professionals.

1 Cho HJ, Menezes PR, Hotopf M, Bhugra D, Wessely S. Comparative epidemiology of chronic fatigue syndrome in Brazilian and British primary care: prevalence and recognition. *Br J Psychiatry* 2009; **194**: 117–22.

2 Kleinman A. Depression, somatization, and the new cross-cultural psychiatry. *Soc Sci Med* 1977; **11**: 3–10.

3 Paralikar V, Sarmukaddam S, Agashe M, Weiss, MG. Diagnostic concordance of neurasthenia spectrum disorders in Pune, India. *Soc Psychiatry Psychiatr Epidemiol* 2007; **42**: 561–72.

4 Griffith EE, Gonzalez CA, Blue HC. Introduction to cultural psychiatry. In *Textbook of Clinical Psychiatry, Fourth Edition* (eds R Hales & S Yudofsky): 1551–83. American Psychiatric Publishing, 2003.

5 de Fatima Marinho de Souza M, Messing K, Menezes PR, Cho HJ. Chronic fatigue among bank workers in Brazil. *Occup Med (Lond)* 2002; **52**: 187–94.

6 Karasz A, McKinley PS. Cultural differences in conceptual models of everyday fatigue: a vignette study. *J Health Psychol* 2007; **12**: 613–26.

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Authors' reply: The assertion that chronic fatigue syndrome is a culture-bound syndrome of high-income Western countries may be largely based on the observation that 'clinical descriptions of chronic fatigue syndrome, also known in some countries as myalgic encephalomyelitis, have arisen from a limited number

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