type (including the use of depot preparations) and characteristics of the clinician, treating team or service. Inevitably, a study that took these factors into account would be restricted to one or two services with consequent loss of statistical power and the dangers of selection or referral bias. Furthermore, our study was able to adjust for more service use confounders than others that have shown positive effects of compulsory community treatment (Bindman, 2002).

However, we disagree that patients who had been discharged from a CTO by a Mental Health Review Board would be a more appropriate control group. Even with careful matching, there would be a reason why the intervention group remained on a CTO while the controls were discharged from their order. For instance, patients who remained on compulsory community treatment could have been less insightful about their illness or more likely to have a history of aggressive behaviour. Neither can we accept that surveys of psychiatrists' views on CTOs have any place in an era of evidence-based practice. This would not be accepted as a reason to introduce any other psychiatric intervention. Why should CTOs with their attendant implications for the civil liberties of patients be treated differently?

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S. Kisely Department of Psychiatry, Dalhousie University, Abbie J. Lane Memorial Building, 5909 Veterans Memorial Lane, Suite 9211, Halifax, Nova Scotia B3H 2E2, Canada

Learning disability services

Bouras & Holt (2004) propose a bold solution to a frustrating problem: in a socially inclusive post-institutional society, how should the mental health needs of people with learning disabilities be met? *Valuing People* (Department of Health, 2001) encourages learning disability services to support access to mainstream services, and only provide specialist services to a minority with particularly complex needs. Their idea of a tertiary level service within adult mental health is, therefore, attractive, although probably more so for people with mild learning disability. Individuals could initially use the same service as everyone else and only be 'referred on' if clinically necessary.

But what would this service look like? What, in fact, *are* the specialist mental health needs of adults with learning disabilities? When do these needs require a specialist learning disability mental health service? If you have a mild learning disability and a new psychotic illness should you go to the 'first-episode psychosis' team, the 'home treatment' team, the 'assertive outreach' team, the 'long-term intervention' team or the 'specialist learning disability' team? What would be 'special' about the specialist learning disability service? It is not only about being 'secondary' or 'tertiary' but finding a way to participate in a new mixed economy of 'mainstream' services, where the number of potential interfaces has grown considerably in recent years.

General psychiatrists often look after mental illnesses in people with mild learning disability and do so extremely well. However, if learning disability psychiatry aspires to tertiary status it will be important to respond to those who will rely on it. This is not just the potential patients, but also staff of the mainstream services who will refer them. In my local service, colleagues want recognition that although some of their patients fall outside traditional eligibility criteria for learning disability services, they would none the less benefit from such services and should have equity of access the other way.

Bouras & Holt propose a new, probably rebranded, subspecialty within adult mental health. This has significant implications not just for the National Health Service, but also for the local authorities and other agencies with which it will work. I hope their views will stimulate wider debate.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century.* London: Stationery Office.

Bouras, N. & Holt, G. (2004) Mental health services for adults with learning disabilities. *British Journal of Psychiatry*, **184**, 291–292.

A. Flynn Oxleas NHS Trust, 183 Lodge Hill, Goldie Leigh, London SE2 0AY, UK

Psychosocial factors in the pathogenesis of mental disorders

In an interesting Editorial, Leon Eisenberg (2004) discussed the possible impact of the recent advances in genetics and genomics on social psychiatry. He suggested that these advances, instead of diminishing the importance of social psychiatry, will instead enhance it.

In this context, psychosocial factors may be important environmental factors in the pathogenesis of primary (idiopathic) mental disorders. Several lines of evidence suggest that the primary mental disorders are a product of the evolution of the human brain and mind (Abed, 2000; Peedicayil, 2001). Among the many hypotheses proposed to explain this evolution, the most plausible is the social brain hypothesis, which has also been referred to as the Machiavellian intelligence hypothesis (Dunbar, 1998). According to this hypothesis, the human brain, especially the neocortex, evolved to the relatively large size it has because of the computational demands of the complex social system of primates.

Epigenetics (heritable changes in gene expression that occur without a change in DNA sequence) is thought to have played a major role in the evolution of the human brain (Rakic, 1995), and it is known to involve marked environmental inputs (Strohman, 1997). Hence, by extension, psychosocial factors may be important environmental factors in the pathogenesis of the primary mental disorders.

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

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J. Peedicayil Department of Pharmacology, Christian Medical College, Vellore 632 002, India

Form–content dichotomy in psychopathology

We read the article on *dhat* syndrome (Sumathipala *et al*, 2004) with interest. The apparent disappearance of the syndrome in the Western world and its persistence in the East can be explained by the form–content dichotomy related to psychopathology. Typically, patients with the

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syndrome present with a variety of 'neurotic' symptoms. The patients also offer 'loss of semen' as the explanation for these disabling symptoms. Such patients are diagnosed as having *dhat* syndrome if the physician is aware of the label and the explanation, and if he or she focuses on the content. These patients could also receive a label of anxiety, depression or somatisation if the physician emphasises the form of the presentation. The patient perspective of 'loss of semen' as the cause of the symptoms would then be perceived as the patient's explanatory model of his illness.

It has long been recognised that contemporary themes are often incorporated into psychopathology. The culture in south Asia tends to highlight sexual causes for a variety of neurotic phenomena. These explanations generate more acceptance and understanding for the patient than anxiety, depression or somatic symptoms would. Such beliefs are reinforced by traditional Indian systems of medicine which subscribe to these concepts and whose physicians and healers are often the first contact in the pathway to care. Thus, such beliefs are reinforced and perpetuated.

Sexual misconceptions related to *dhat* are also observed among patients with schizophrenia, substance dependence, bipolar disorders, delusional disorders and major depression.

The focus on form allows psychiatrists to differentiate the different syndromes (Sims, 1988). International classifications have emphasised form over content as a response to the various treatment modalities, based on the recognition and treatment of the clinical syndrome. This does not imply reduced importance being placed on the person's culture and beliefs. It would mandate the management of the patient's explanatory model. This is also true for other culture-bound syndromes such as *koro*.

Clinicians focusing on content make such presentations appear exotic. Physicians emphasising form are able to recognise behavioural syndromes across cultures. The management of patients with such presentations is the same, irrespective of the diagnostic labels employed.

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Sumathipala, A., Siribaddana, S. H. & Bhugra, D. (2004) Culture-bound syndromes: the story of *dhat* syndrome. *British Journal of Psychiatry*, **184**, 200–209.

G. Rajesh, K. S. Jacob Department of Psychiatry, Christian Medical College, Vellore 632002, India

Author's reply: Drs Rajesh and Jacob's suggestion of a dichotomy between form and content is an interesting one. We acknowledge that some patients' explanations for their distress may be linked to their perception of semen loss or *dhat*. Drs Rajesh and Jacob highlight that contemporary themes are incorporated into psychopathology, and we agree. However, it is interesting to note that patients with *dhat* appear to latch on to a more traditional explanation. The 'disappearance' of similar complaints in the West may be related to changes in socio-economic conditions. The distinction between form and content of a number of psychopathological symptoms is well worth studying and ripe for further research. We think the suggestion that management is the same, irrespective of the diagnostic labels is simplistic – the cultural explanations of distress and their understanding is paramount in delivering services that will be acceptable and in providing treatments that will be adhered to by patients.

D. Bhugra Section of Cultural Psychiatry, PO25, Institute of Psychiatry,
London SE5 8AF, UK

One hundred years ago

The problem of the feeble-minded

DR. TREDGOLD's paper read at the Guildhall Conference on the Feeble-minded has now been printed, and will be found to contain a very succinct discussion of the sociological bearings of the efforts now being widely made to improve the condition of the mentally defective class. He points out "that with the exigencies of civilized life, the demands upon the intellectual faculties of the individual become daily more exacting", and consequently that it is highly important to the community to devise means to prevent those who by original infirmity are incapable of meeting them from swelling the ranks of pauperism, crime and insanity. Defining amentia, or mental deficiency, as the manifestation of an imperfect or arrested development of certain cells of the brain, in the great majority of cases due to a defect inherent in the germinal plasm, Dr. Tredgold deduces from the teachings of experience, as well as of etiology, that cure is out of the question; yet training can do much, at any rate for the milder grades of defect, though effective training involves a large expenditure of time and money. Such an expenditure, however, he argues, is not wasted if thereby such unfortunates may be prevented from drifting into pauper vagrancy, into crime, and into insanity, a course which entails upon the community a charge far in excess of that of even specialized education. He does not agree with the views held by some that "all patients suffering from whatever degree of mental defect should be subject to permanent detention", and contends that "so long as the feeble-minded, or any other section of society, are capable of earning an honest living, it appears unjustifiable to interfere with their liberty". At the same time, he recognizes the necessity of judicious after-care even for them, and alludes to the scope there is for philanthropic persons to form associations for this purpose, and perhaps also to provide

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