

## Correspondence

EDITED BY MATTHEW HOTOPF

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### Culture-specific psychiatric illness?

It is depressing that an editorial in a major psychiatric journal can still maintain that "there is no solid evidence for a real difference in the prevalence of common psychiatric disorders across cultures" (Cheng, 2001). Cheng collapses the socioculturally determined understandings that patients bring to bear on their active appraisal of their predicament and on their expressions of distress and help-seeking to the term "illness behaviour". The (Western) psychiatrist is to see through this mere packaging to the psychopathology within, which he knows to be universal and the 'real' problem. Cheng goes on to assert that disturbed people in "less-developed" societies present somatically because of their "limited knowledge of mental disorders". There is a distinct echo here of the imperial era, when it was pressed upon indigenous people that there were different types of knowledge and that theirs was second-rate. Sociocultural and sociopolitical phenomena were framed in European terms and the responsible pursuit of traditional values was regarded as evidence of backwardness (Summerfield, 1999).

All of psychiatry is culture-bounded, not just a few syndromes in the DSM or ICD: even presentations by patients with organic disorders are embedded in particular 'lifeworlds' and local forms of knowledge. Western psychiatry is but one among many ethnopsychiatries. Cheng commits what Kleinman (1987) called a category fallacy: the assumption that because phenomena can be identified in different social settings, they mean the same thing in those settings.

The World Health Organization is falling into the same trap in its claims that 'depression' is a worldwide epidemic that within 20 years will be second only to cardiovascular disease as the world's most debilitating illness. The implication of such medicalisation is to deflect attention away

from what millions of people might cite as the basis of their suffering, for example, poverty. In whose interests, apart from the pharmaceutical industry's, can this be?

We need a psychiatry that recognises the limitations of a technical approach and sees acknowledgement of sociocultural and political contexts as an ethical obligation (Bracken & Thomas, 2001). If Cheng were to see this as a challenge to the whole project – to (Western) psychiatry as a global enterprise propagating supposedly universal and morally neutral facts – then so be it.

**Bracken, P. & Thomas, P. (2001)** Postpsychiatry: a new direction for mental health. *BMJ*, **322**, 724–727.

**Cheng, A. T. A. (2001)** Case definition and culture: are people all the same? *British Journal of Psychiatry*, **179**, 1–3.

**Kleinman, A. (1987)** Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, **151**, 447–454.

**Summerfield, D. (1999)** A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, **48**, 1449–1462.

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Andrew Cheng's contribution (2001) to the debate on the universality *v.* cultural particularity of psychopathology follows the conventional distinction between the pathogenic form of the illness, presumed to be biological, and its pathoplastic content of psychological or social origin (Littlewood, 1996). In his rephrasing, content is merely the "subjective complaint" or "illness behaviour", form the "objective symptoms". He then dissects such culture-specific patterns as koro into the 'real' illness (panic attacks) and the 'false belief' apparently found in people of "low intelligence" with "limited knowledge of mental disorders", thus proving his case.

His procedure is an act of faith in the possibility (and usefulness) of this Kantian distinction, which has been an article of psychiatric belief since Kraepelin and Birnbaum (Littlewood, 1990). While possibly of some utility for the major psychoses where we may trace some biological aetiology, it seems bizarre to assume that we will find universality in all patterns of psychiatric interest. Eating disorders, multiple personality disorder, overdosing, shoplifting, agoraphobia, school refusal, to mention some Western patterns alone: each is constructed by context and meaning as it is constructed by biological difference. Could we consider school refusal as a universal pattern in the absence of elementary schools in certain societies? What would be left here without social context? What then our analogues of school refusal?

To assert that the business of psychiatry is only the biological (and why should that presume the universal?) is to restrict our discipline to veterinary science. To ignore meanings as potentially causal is to offer an etiolated psychopathology, one presumed to be 'scientific' in advance (Kleinman, 1988). To offer a general model of all psychopathology with fixed relations between the social and the biological is certainly non-empirical, and only potentially redeemed if we then exclude the social *a priori* from any potential patterns. To search for universality is doubtless laudable: to presume it is not.

**Cheng, A. T. A. (2001)** Case definition and culture: are people all the same? *British Journal of Psychiatry*, **179**, 1–3.

**Kleinman, A. (1988)** *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.

**Littlewood, R. (1990)** From categories to contexts: a decade of the 'new cross-cultural psychiatry'. *British Journal of Psychiatry*, **156**, 308–327.

— (1996) Psychiatry's culture. *International Journal of Social Psychiatry*, **42**, 245–268.

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**Author's reply:** Littlewood states, "In his rephrasing, content is merely the 'subjective complaint' or 'illness behaviour', form the 'objective symptoms'". This is a misunderstanding of what I have tried to emphasise in my editorial. One of the major points in my work is that the patient's subjective

complaint belongs to 'illness behaviour', which is different from 'objective symptoms' assessed by psychiatrists, preferably using a standardised procedure.

Littlewood mentions the Western patterns of eating disorders, multiple personality disorder, overdosing, shoplifting, agoraphobia and school refusal. Many of these, if not all, are also found in non-Western societies (e.g., see Kleinman & Lin, 1981). Furthermore, school refusal is not a formal diagnosis in either the ICD-10 or the DSM-IV; rather, it is a behavioural problem possibly with underlying 'etic' psychopathology (depression, separation anxiety, phobia, learning disorders and so forth) and socio-environmental factors. In any society, primitive or modern, there are certain forms of teaching activity not run by modern school institutions. Presumably, the same refusal to attend these various forms of 'school' exists, with similar underlying psychiatric and socio-environmental factors. The ways of this refusal and the context of the socio-environmental factors are likely to be 'emic'. For effective management of school refusal, both the underlying potential etic psychopathology and the emic illness behaviour and socio-environmental factors must be carefully examined. This is an alternative example of what I intended to elaborate using the example of koro.

The long-standing debate over etic/emic and semantic issues in cross-cultural psychiatry is unlikely to be satisfactorily resolved in the near future. However, it is believed that the development of standardised clinical interviews with emphasis on cross-cultural equivalence at the level of symptoms (e.g., Cheng *et al*, 2001) helps to avoid the so-called "category fallacy" (Kleinman, 1987).

It should be stressed that the under-reporting of psychological symptoms by interviewees from developing nations that I mentioned in my editorial does not mean that these people do not have, or cannot differentiate, emotions. People are people, and the very low rate of reporting of psychological symptoms to doctors by people in developing countries may be due to greater social stigma towards mental illness, their lack of knowledge about mental illness and a much less psychologically oriented medical practice. More studies into this area are needed, and I believe that anthropologically oriented researchers can make a great contribution to this endeavour.

The etic/emic approach to psychopathology does not imply that psychiatry

is confined only to biology. The emic pathoplastic shaping and illness behaviour closely associated with different sociocultural settings are equally important in psychiatry and require culture-specific approaches in combination with biological treatment. After all, mental disorders are believed to be the product of gene/environment interaction (Cheng & Cooper, 2001).

**Cheng, A. T. A. & Cooper, B. (eds) (2001)** Genome and envirome: their roles and interaction in psychiatric epidemiology. *British Journal of Psychiatry*, **178** (suppl. 40).

—, **Tien, A. Y., Chang, C. J., et al (2001)** Cross-cultural implementation of a Chinese version of the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) in Taiwan. *British Journal of Psychiatry*, **178**, 567–572.

**Kleinman, A. (1987)** Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, **151**, 447–454.

— & **Lin, T. Y. (eds) (1981)** *Normal and Abnormal Behaviour in Chinese Culture*. Dordrecht: D. Reidel.

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### Cross-cultural psychiatric interviews and research instruments

We read Andrew Cheng's (2001) editorial with much interest. We strongly agree that the development of cross-culturally comparable diagnostic interviews is a pressing need.

In a recent survey in our unit in Sri Lanka of 43 patients presenting with depressive disorder, one-third of these on presentation made a subjective complaint of a "burning sensation of the body" (literal translation) and related secondary distress and denied having most of the core depressive symptoms although the symptom manifestation was of a depressive disorder. Thus, finding semantic or psycholinguistic equivalence for psychiatric symptoms across cultures will be a challenging, albeit necessary, exercise.

We believe that the lack of valid diagnostic tools is an important factor in the limited capacity for psychiatric research in developing countries, which in turn contributes to the underrepresentation of such research in high-impact journals noted by Patel & Sumathipala (2001).

A case in point is that in Sri Lanka the only validated psychiatric rating scales in the native languages are the Mini-Mental State Examination (MMSE) and the General Health Questionnaire (GHQ-30). Efforts

at validating the Hospital Anxiety and Depression (HAD) scale (D. de Silva, personal communication, 2001) in Sinhala (the language of the majority) show that the sensitivity and specificity of such an instrument is low. This is noteworthy considering the fact that locally developed diagnostic instruments may not find ready acceptance in high-impact journals.

**Cheng, A. T. A. (2001)** Case definition and culture: are people all the same? *British Journal of Psychiatry*, **179**, 1–3.

**Patel, V. & Sumathipala, A. (2001)** International representation in psychiatric literature. Survey of six leading journals. *British Journal of Psychiatry*, **178**, 406–409.

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### Mental and physical illness

The editorial by Kendell (2001) independently reflects the view of Baker & Menken (2001) that it is time to abandon the term 'mental illness'. All three authors emphasise that an important reason for so doing is that the term is stigmatising and undermining of the care and treatment of millions of psychiatric (Kendell) and neurological patients (Baker & Menken). Interestingly, Kendell suggests that the term 'psychiatric illness' is more acceptable, whereas Baker & Menken propose instead 'brain illness'. The former seems to replace the mind by the psyche and the latter by the brain.

Like Kendell, I have reviewed the historical processes that have led to the evolution and divergence of psychiatry and neurology as separate disciplines with all the ensuing confusing theoretical and practical uncertainties and complications for professionals and patients alike, including stigma (Reynolds, 1990). Modern neuroscience, which has demonstrated how brain function is profoundly influenced by psychological and social as well as biological factors, has opened the way for resolving some of these uncertainties and divisions. I share the view that one way forward is to build practical bridges between neurology and psychiatry (Reynolds & Trimble, 1989). For example, it does not make sense for neurologists and psychiatrists quite separately to tackle the problem of stigma towards brain and mental illnesses without