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Correspondence

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Shooting the messenger: the problem is widespread

Professor Singh has raised very important issues in his editorial.[1] I would like to point out that the problems he has highlighted lie at the very heart of discourse in transcultural psychiatry as a whole, not just in relation to the ethnicity research. The discourse in transcultural psychiatry has mostly been driven by ideological points of view and there are not many examples of converting the ideological and philosophical assertions into testable scientific hypothesis. Worse still, the field has rarely addressed issues of practical clinical significance.

A good example is the language barrier. Language is the key investigative and therapeutic tool in mental health, and the unmet language need is considered as one the one of key drivers of social exclusion and inequity in access to services.[2] The language barrier presents at two levels: translation and interpretation. There are scores of articles on translation of written material and questionnaires in the literature. Undoubtedly, this research has great value, but this is mostly limited to detecting and quantifying the disorders in research and field studies, and has limited applicability outside the research setting. Even as screening tools these have found limited applicability in practice. This may well be due to fact that the quality of these translation varies widely and these may not be acceptable to the indigenous population. Transcultural psychiatry has failed to develop consensus guidelines or a gold standard which could guide the translation and reporting of the scales/questionnaires when used in non-English-speaking communities.

Even worse is the case of interpreters in psychiatry. The use of interpreters requires skills which are neither taught in psychiatric training nor addressed in research. The literature in this vital area is limited to a few descriptive studies which is lamentable considering the practical significance of the subject.[3] This is perhaps just one of the reflections of the field being bogged down by an agenda which has helped neither scientific study nor services. Jablensky claimed that transcultural psychiatry is an applied science.[4] However, to sustain this position, transcultural psychiatry will need a fresh research agenda which could guide the development of research-derived concepts into reliable health strategies.

1 Singh SP. Shooting the messenger: the science and politics of ethnicity research. *Br J Psychiatry* 2009; **195**: 1–2.

2 Aspinall PJ. Why the next census needs to ask about language. *BMJ* 2005; **331**: 363–4.

3 Farooq S, Fear C. Working through interpreters. *Adv Psychiatr Treat* 2003; **9**: 104–9.

4 Jablensky A (1994) Whither transcultural psychiatry? A comment on a project for a national strategy. *Australas Psychiatry* 1994; **2**: 59–61.

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Author's reply: I entirely agree with Professor Farooq that transcultural psychiatry has often ignored the very real, immediate and pressing clinical issues that are relevant to the mental health needs of ethnic minorities, while pursuing ideologically driven and empirically unverifiable agendas. Blaming psychiatry for ethnic differences in mental healthcare has simply shifted focus away from the social adversities that underlie such differences. Selten & Cantor-Graae[1] have recently pointed out that such a shift of focus is convenient for politicians, since it makes it both safe (and cheap) to ignore the 'epidemic of psychosis' among ethnic minorities. In the UK, there appears to be a genuine desire within the Department of Health to address ethnic minority issues in mental health. This is in sharp contrast to much of continental Europe, where the issue barely registers, even in countries with large minority populations.

Language barriers and the role of interpreters in mental health are excellent examples of areas of practical and clinical significance which have received little research attention. Understanding and being understood must be the prerequisites of any therapeutic interaction, and yet so little research has been conducted on interpretation in mental healthcare. Interpretation is not simply translation; it is the process to ensure that the full linguistic and cultural meaning of what is said is truly conveyed. Scientific literature in the field is, however, restricted to descriptive reports about difficulties that occur in clinical encounters when interpreters are used, rather than on what influences the process and outcome of interpretation.[2] For transcultural psychiatry to make a real difference to the health outcomes of ethnic minorities, it is research and evidence in this and similar areas that will yield benefits to our minority groups, rather than psychiatry-bashing.

1 Selten JP, Cantor-Graae E. The denial of a psychosis epidemic. *Psychol Med* 2009; Apr 20: 1–3. Epub ahead of print, doi: 10.1017/S0033291709005686.

2 Tribe R, Lane P. Working with interpreters across language and culture in mental health. *J Ment Health* 2009; **18**: 233–41.

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Schizophrenia, homicide and long-term follow-up

The increase in the number of homicides committed by people with schizophrenia, revealed in the 2009 Annual Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, is a cause for concern.[1] The report suggests that the increase is accounted for by individuals not classified as 'patients', i.e. those who have not been in contact with services in the past 12 months. If the total of the data is represented in the report, then one should be able to derive the number of 'non-patients' by simply subtracting the 'patients' from the total of the schizophrenia homicide group. That resulting figure does not appear to support the hypothesis. It appears to show that the entire increase is due to 'patients'. This increase may be as a result of follow-up failings.