Correspondence

EDITED BY STANLEY ZAMMIT

Contents ■ Explanatory models in psychiatry ■ Ethnic differences in prisoners: describing trauma and stress ■ Specialist care for prisoners? ■ Consent and treatment in prisons ■ Amisulpride-induced mania in a patient with schizophrenia ■ Changing use of ECT ■ Inappropriate use of psychostimulants ■ Stigma as a cause of suicide ■ Social capital and mental health *v.* objective measures of health inThe Netherlands

Explanatory models in psychiatry

Dein (2002) comments on our editorial on explanatory models (Bhui & Bhugra, 2002), but fails to apprehend the conceptual flaws in his assertions, promotes a complacent attitude to the challenges of cultural psychiatry, and is threatened by a patient's explanatory model that differs from his own. Dein agrees with us that explanatory models are not stable, and are dynamic, complex, shifting entities, making more research necessary for any consistent theory about their role in routine clinical practice. None the less, their role in improving understanding of patients' cultural world views has not previously been in dispute (American Psychiatric Association, 2002). Although Dein gives greater weight to behavioural expressions of explanatory models, he does not question whether explanatory models can or should be considered as a psychological construct of the individual, or as a group or social–behavioural phenomenon, or both. Each of these conceptualisations is certainly distorted by theorising more concrete, but more easily understood, expressions of explanatory models. Contrary to the historical anthropological paradigm, it is not useful to psychiatric practice if valuable anthropological critiques simply ignore psychological and non-behavioural data. More worryingly, Dein assigns a patriarchal role to the psychiatrist, a role that cannot lead to a collaborative therapeutic relationship. It seems Dr Dein is not prepared to accept that a patient may pursue his or her own explanatory model and associated interventions, alongside those recommended by the psychiatrist. A fuller discussion of these alongside the psychiatrist's own models allows for a shared vision of treatment and recovery.

Why is an exorcism problematic for the psychiatrist? It is not in the realms of psychiatric knowledge or skills, and if helpful for recovery from illness, rather than disease, it should not be hindered. Dein appears to show contempt for a territory in which psychiatrists are not expert (possession and exorcisms: see Pereira *et al*, 1995), and certainly does not show the respect for cultural beliefs that is part and parcel of a scientific or anthropological study of healing, let alone clinical practice. His approach smacks of a patriarchal conviction that the diagnosis is more than a theory, and that psychiatric interventions are not to be questioned. To diagnose is to classify and to predict a course and treatment based on the vagaries of statistics and experience: it is to take what can be a serious risk (Romanucci-Ross *et al*, 1991).

Although he cites a single example, it is not the case that the evidence base of traditional healing approaches are researched to the levels of esoteric knowledge found in biomedicine, except for, perhaps, acupuncture and Ayurveda where there is a growing literature. People will always be keen to try anything that helps them, biomedicine or culturally sanctioned traditional therapies. Surely he does not mean that we as psychiatrists have nothing to learn about treating illness from the traditional and complementary sector. Our view is we have plenty to learn and research. Eliciting explanatory models is a beginning of the process in consultations and offers an easily understandable method of learning about a patient's culture. However, Dein's view appears to be that we know enough, and need not discover more. We are surprised at this view and cannot agree.

American Psychiatric Association (2002) *Cultural Assessment in Clinical Psychiatry.* Washington, DC: American Psychiatric Publishing.

Bhui, K. & Bhugra, D. (2002) Explanatory models for mental distress. Indications for clinical practice and research. *British Journal of Psychiatry*, **181**, 6–7.

Dein, S. (2002) Transcultural psychiatry (letter). *British Journal of Psychiatry*, **181**, 535–536.

Pereira, S., Bhui, K. & Dein, S. (1995) Making sense of 'possession states': psychopathology and differential diagnosis. *British Journal of Hospital Medicine*, **53**, 582–586.

Romanucci-Ross, L., Moerman, D. E. & Tancredi, D. (1991) *The Anthropology of Medicine: From Culture to Method.* New York: Bergin and Garvey.

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Ethnic differences in prisoners: describing trauma and stress

I read with interest the two articles by Coid *et al* (2002*a*,*b*) but was puzzled by the use of the term 'post-traumatic stress' to describe the psychiatric response of prisoners who had experienced adverse or negative life events. The authors use the term post-traumatic stress without specifying whether they are referring to the specific diagnosis of post-traumatic stress disorder (PTSD), a recognised psychiatric condition in the DMS–IV (American Psychiatric Association, 1994) or simply a vague amalgam of neurotic symptoms which the authors infer are a consequence of the various stresses the prisoners experienced in their lifetimes. The confused terminology in this respect, which is present in both papers, is unhelpful in assessing what precisely is psychiatrically wrong with these prisoners. A Criterion A trauma, that is a trauma that may precipitate PTSD in some individuals, is specifically defined and described in the DSM–IV as an event in which the person experiences, witnesses or is confronted with an event or events that involves actual or threatened death or serious injury to the self or to others, and to which the individual responds with intense fear, helplessness or horror. The experiences that were screened for in the original study by Singleton *et al* (1998) would not normally be considered to represent a Criterion A event, but merely negative or adverse life events which have no specific aetiological links with any distinct clinical diagnosis. The experiences included by the authors in their screening include bullying and marital separation, which do not constitute Criterion A events for the purpose of making a PTSD diagnosis. Similarly, many other traumatic experiences were not apparently screened for by the authors, such as rape or adult sexual assault, combat, being assaulted in the street (although violence in the home or at work are included). Thus, the selection, definition and description of these events as traumatic is misleading, while the inclusion of negative life events that are clearly more traumatic

https://doi.org/10.1192/bjp.183.2.170-a Published online by Cambridge University Press

makes the interpretation of any resulting phenomenology extremely difficult.

It is also clear from the original publication by Singleton *et al* that no specific assessment for PTSD was carried out, although validated and reliable instruments for this exist (e.g. the Clinical Assessment for PTSD, Blake *et al* (1995) or the Posttraumatic Stress Symptoms Interview (PSSI) or Posttraumatic Stress Symptoms Self-Report (PSS–SR), Foa *et al* (1993)). The authors did a partial screen for a few recognised PTSD symptoms, such as re-experiencing and avoidance, but there was no systematic assessment of the condition that would have allowed them to diagnose the full disorder. It should be recognised that PTSD is a major psychiatric disorder that constitutes a serious burden for the individual and for society (Kessler, 2000). A diagnosis of PTSD has implications in terms of assessing the individual's risk and in terms of treatment recommendations. It is important that the term post-traumatic stress should not be confused or conflated with the term 'post-traumatic stress disorder'. The description of post-traumatic stress made by Coid *et al* cannot be evaluated without deconstructing more precisely what this means. As there are now well-recognised instruments to assess PTSD and lifetime experience of traumatic events in a range of settings, without these being used then terms such as post-traumatic stress should be avoided.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM–IV). Washington, DC: APA.

Blake, D. D., Weathers, F., Nagy, L., *et al* (1995) The development of a clinician administered PTSD scale. *Journal of Traumatic Stress*, **8**, 75–90.

Coid, J., Petruckevitch, A., Bebbington, P., *et al* (2002*a*) Ethnic differences in prisoners. 1: Criminality and psychiatric morbidity. *British Journal of Psychiatry*, **181**, 473–480.

—, —, —, *et al* (2002*b*) Ethnic differences in prisoners. 2: Risk factors and psychiatric service use. *British Journal of Psychiatry*, **181**, 481–487.

Foa, E. B., Riggs, D. S., Dancu, C. V., *et al* (1993) Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress*, **6**, 459–473.

Kessler, R. G. (2000) Posttraumatic stress disorder: the burden to the individual and to society. *Journal of Clinical Psychiatry*, **61** (suppl. 5), 4–12.

Singleton, N., Meltzer, H. & Gatward, R. (1998) *Psychiatric Morbidity Among Prisoners in England and Wales*. London: Stationery Office.

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Specialist care for prisoners?

In his recent editorial on mental health in prisons Dr Reed (2003) urges, understandably and in most cases correctly, that the quicker that patients with psychosis are transferred to specialist psychiatric care, the better.

However, there are prisoners with schizophrenia, willing to take medication, who survive reasonably comfortably in the prison milieu. Their great fear is that they will be transferred to a special psychiatric hospital; 'nutted off' in prisonspeak. They have reason to fear a transfer, for it effectively exchanges a finite sentence for an indefinite one. In the case of those serving a life sentence, it means their fate is in the hands of a mental health review tribunal rather than the Parole Board, the latter, they believe, being less cautious in recommending discharge. As an ex-member of both organisations, I would agree with them.

So, while prison is obviously bad for people with mental illness, hospital is sometimes worse.

Reed, J. (2003) Mental health care in prisons. *British Journal of Psychiatry*, **182**, 287–288.

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Consent and treatment in prisons

I read the article by Earthrowl *et al* (2003) with interest. The issue of providing treatment to prisoners, who are frequently incapable of consenting, will not be unfamiliar to psychiatrists providing mental health care in these establishments. Although the authors correctly state that there is no legislative framework for providing treatment for mental disorders in prisons, this may be slightly disingenuous. The current legislative framework that provides for the treatment of mental disorders, namely the Mental Health Act 1983, is clear that prison health-care wings are not hospitals. It follows that any treatment that is administered forcibly must be consistent with common law. Separate legislation is therefore unnecessary.

They also appear to have overlooked recent guidance on this matter. The Department of Health (2002) in collaboration with the Prison Service has set out, in detail, good practice guidelines for providing care to both competent and incapacitated adult prisoners. These outline circumstances in which prisoners who lack capacity can receive treatment. We have found this very helpful in developing protocols for treatment in the prisons we visit.

The development of policies and protocols will assist in establishing who, when and in which circumstances incapacitated prisoners may be treated and allow us to be more confident when making these difficult decisions.

Department of Health (2002) *Seeking Consent: Working with People in Prison*. London: Department of Health.

Earthrowl, M., O'Grady, J. & Birmingham, L. (2003) Providing treatment to prisoners with mental disorders: development of a policy. Selective literature review and expert consultation exercise. *British Journal of Psychiatry*, **182**, 299–302.

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Authors' reply: We fail to understand Dr Qurashi's comment that 'separate legislation is therefore unnecessary'. Our paper sets out a *policy* for providing treatment to people with mental disorder based on common law (Earthrowl *et al*, 2003). We are not proposing separate legislation.

Dr Qurashi also mentions that we appear to have overlooked recent guidance from the Department of Health (2002). The Department of Health guidelines were produced in July 2002, after our paper was accepted for publication.

These guidelines provide guidance on establishing capacity but, in our opinion, they do not tackle the practical issues relating to the management of prisoners with mental disorder in any great detail, they do not deal with the ethical issues surrounding the provision of an equivalent service in prisons adequately and detailed guidance on making a concerted effort to obtain treatment under the Mental Health Act in hospital before proceeding with treatment under common law is lacking. In our view, these are serious omissions.

Declaration of interest

J.O. is a member of the Department of Health Prison Expert Group.

https://doi.org/10.1192/bjp.183.2.170-a Published online by Cambridge University Press