Correspondence
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Understanding violence

There are potentially significant absences in Professor Fonagy’s otherwise illuminating editorial on the developmental aspects of violence, and he neglects to consider other related theories (Fonagy, 2003).

The word ‘father’ does not appear in his review and this would seem a major absence in the context of research showing consistent absences of stable paternal figures in those exhibiting antisocial behaviour, which is itself associated with violence (Pfohner et al, 2001). It is particularly puzzling, as Professor Fonagy has himself explored the possible role of the absent father in the development of violent propensities (Fonagy & Target, 1995).

It is also perhaps premature to dismiss (or pathologise) the use of the term ‘psychopathy’. The literature, which includes distinguished psychoanalytic contributions (Reid Meloy, 2001), as well as explorations of possible biological factors (Dolan, 1994), suggests that the term has considerable utility in research, treatment and risk management, as well as potential dangers (Edens, 2001).

Other social aspects of violence are also not explored, including group dynamic aspects, which are possibly best illustrated by the breakdown of normal social mores in conflict and war. A relatively recent example is the Rwandan genocide, where individuals capable of perpetrating atrocities were then able to return to everyday existences.

Fonagy’s review was also clearly concerned with violence at a population level and in relation to normal development. He does not consider, however, the important question of how violence in people with mental disorders might potentially differ from that in the general population, and how this issue needs continuing exploration by mental health professionals.


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Author’s reply: Dr Beales makes several important points and I disagree with none of them, but discussion of each would have taken the length of my editorial beyond its permitted limits. The absence of a male figure in the developmental history of the child may contribute to the emergence of violence because the dominant role models are more likely to be violent peers rather than mature adults, or, as I have suggested (Fonagy, 2003), because of the deficit in social perspective-taking that being deprived of the opportunity to identify with a person observing one’s relationship with another can generate.

I agree that psychopathy is a helpful clinical concept and that even among children we find those whose aggressive behaviour is not associated with the behaviour of attachment figures (Wootton et al, 1997). However, an overemphasis on constitutional predisposition is risky, insofar as it can lead to an underestimation of both the importance of psychosocial factors in the causation of violence and the opportunities for change.

I particularly regretted that I did not have space to explore the effect of group factors on violence. The anonymisation of the individual by the large group is a risk factor, specifically because it removes the inhibition that the developmental process of encultration imposes on a natural human propensity for violence. Examples such as Rwanda or the current proliferation of terrorist attacks palpably demonstrate how a group process can obliterate personal awareness of the other as an intentional being, reducing others to the status of stereotypes invested with powerful negative valences. The ability of the suicide bomber to bring a violent end to his or her own life at the same time as destroying those of others suggests just how easily undermined the developmental process that brings our capacity for violence under control might be. To isolate the violent individual as somehow inherently and radically different from the rest of us, which a clinical perspective can sometimes do (Hering, 1997), may also serve to reassure us that we are at no risk of perpetrating mindless violence. Tragically, history tells us that this is simply not so. Violence is impossible for us to contemplate precisely because it is ultimately an act of humanity (Abrahamsen, 1973).


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Suicide and sexual orientation

King et al (2003) have published a valuable contribution to the literature regarding the mental health of lesbians and gay men. However, they erred in asserting that, ‘No study has examined whether gay and lesbian people have elevated rates of completed suicide.’…’ (p.557). This is important because studies of sexual orientation and attempted suicide have yielded different results. Nearly all studies of sexual orientation and attempted suicide have found that gay men and lesbians have
higher rates of self-harm than heterosexuals. Conversely, all studies of sexual orientation and completed suicide have concluded that gay men and lesbians do not die by suicide at a higher rate than heterosexuals.

Spencer (1959) followed 100 Oxford undergraduates referred by their general practitioners. Relative to 35% of controls \((n=100)\), a significantly greater proportion of patients (51%) had homosexual behaviour, fantasies or desires. ‘No patient was lost by suicide’ but 9 of 10 who attempted suicide were ‘persistently homosexual’ (pp. 402–403). Cohen (1961) found only one same-sex couple (1.7%) among 58 completed suicide pacts. O’Hara (1963) found only 4% lesbians and gay men in a 1-year incidence study of double suicides in Japan. Rich et al. (1986) reported that 13 (11%) of 119 males aged 21–42 who died by suicide in Los Angeles had disclosed a homosexual identity prior to death.

In New York City, Shaffer et al. (1995) found that in 3 (2.5%) of 120 completed youths (aged ≤20 years) suicide cases the individual was gay. However, they found no gay or lesbian young people among 147 living controls matched for age, gender and ethnicity.

Thus, contrary to King et al.’s assertion, at least five peer-reviewed studies of sexual orientation and completed suicide have been published.


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**Occupational psychiatry**

In their editorial on work and employment for people with psychiatric illness, Boardman et al. (2003) overlook an important group of patients with mental ill health who are not ‘mental health service users’, yet who experience difficulty coping in the modern workplace. Occupational physicians are seeing an increasing number of patients with mental ill health, and a national surveillance scheme recently reported that, along with musculoskeletal symptoms, mental ill health is among the commonest reasons for consultation (see http://www.coeh.man.ac.uk/thor/opra.htm). Furthermore, mental ill health is responsible for a large proportion of early retentions due to ill health (Poole, 1997) and a large proportion of incapacity benefits are currently being paid for medically unexplained illnesses (Waddell, 2002).

Much of the burden of occupational ill health is managed in primary care, but overburdened general practitioners may miss the psychological or workplace components in these patients. To make matters worse, current psychiatric practice is dominated by ‘serious’ mental illness such as schizophrenia and ‘dual diagnosis’ patients, to the exclusion of patients with minor mental illnesses such as anxiety, depression, and the functional disorders. Yet it is these latter conditions that are commonly being seen in the workplace, in primary care and in those on state benefits by doctors who have little training in mental illness. Unfortunately, some psychiatrists do not receive adequate training in the management of these disorders (Bass et al., 2001), in part because they are presenting in locations outside of psychiatric services (Henderson et al., 2001). Good evidence exists that these illnesses can be treated effectively using, for example, cognitive–behavioural therapy and interpersonal therapy (Creed et al., 2003). A key feature of these studies is that the best results are usually achieved at the site where the patient presents, which is likely to be outside the province of the community mental health team.

We believe that there is a lack of expertise in the management of occupational mental ill health at its site of presentation. Psychiatrists need to engage with occupational physicians to improve the diagnosis and management of patients with psychiatric illnesses that are preventing them from working. There is also a need for more collaborative training in occupational psychiatry for psychiatrists, occupational physicians and general practitioners. Such training should be integrated into the syllabuses of all three professional groups. A diploma in occupational psychiatry might be very popular.


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**Globalisation and biculturalism**

In their recent review article, Bhugra & Mastrogianni (2004) describe the cultural and mental health aspects of what is now called globalisation, and its present and future impact upon mental disorders, with a special reference to depression. Among the many unknowns in that matter, the authors point towards the issue of whether cultures will homogenise, which seems improbable, or whether the tendency for communities to reassert their distinctive ethnic identities will prevail. Eventually, it seems reasonable to believe that different forms of equilibrium will develop between these apparently opposed forces, including what anthropologists call ‘creolisation of cultures’. In that perspective, the issue of biculturalism deserves further elaboration.

Until recently, biculturalism was considered mainly in the perspective of partnership for ethnic minorities in a mainstream cultural environment. Different models of second-culture acquisition have been recognised and studied. In their classical work, LaFromboise et al. (1993) reviewed typical patterns of biculturalism: the assimilation, acculturation, alternation, multicultural and fusion models. In that acceptance of biculturalism, the ideal goal for an individual...
is seen as becoming a socially competent person in a second culture without losing the same competence in his or her culture of origin. However, new concepts of bioculturalism and bicultural identity are emerging that are relevant to globalisation. Traditional definitions imply migration processes, either voluntary or forced, as in the case of refugees. Migrant individuals then form ethnic minorities, while different pathways towards biculturalism take place among specific communities. However, if globalisation can be conceptualised as 'a compression of time and space', biculturalism should be considered in the absence of peoples' geographical displacement.

Some authors argue that most people around the world will develop a different form of bicultural identity, combining their local identity with an identity linked to the global culture. This phenomenon is particularly relevant in adolescents, as contemporary urban teenagers worldwide tend to follow similar consumption patterns and do not have memories of times when their ancestral culture was preserved from globalisation (Arnett, 2002). This new form of biculturalism could be both an opportunity for personal fulfilment and a source of identity confusion. Factors influencing these possible outcomes one way or the other should be integrated in cultural psychiatry research agendas.


The worrying thing is, of course, that despite the shortcomings of current approaches to categorisation, aetiology and treatment, mental illness does exist, and hence psychiatry has a role to play in its understanding and treatment. Our job, if we remain interested in being doctors, is to see (based on what evidence we have) where the medical model can add to the care of someone mentally unwell.

If this is hopeless, as some (e.g. Szasz, 1960) have argued, then what are we doing in psychiatry? Given this position, the responsibility for looking after the mentally unwell is surely better handed to others. The irony is that many of the most nihilistic psychiatrists prescribe psychotropics; either this amounts to extreme hypocrisy, or the methodology and results of biological research do matter after all.

With biological research becoming increasingly specialised and complex, a new technology will only be understood by relatively few. In the humanities, the language remains esoteric and hard for the uninitiated to engage with. If the proponents from both ends of the debate do not see the worth in the others' business, when will the results or arguments of one ever be valid for the other?

In essence, in response to Turner's assertion (2003) that biological psychiatrists wish to take the humanity out of the humanities, we fear that he hints at a desire within the humanities to take the medical science out of psychiatry. If this is the position, then we fear a psychiatrist is left adding nothing to the multidisciplinary team other than personal opinion. Although much empirical research is burdened with vested interests, criticised for not being conscious enough of its assumptions, and maladapted to studying the profound experimental suffering we see in mental illness, it remains the only way to replace opinion with anything more certain.

The humanities help us to see what mental illness is, but there will always be an accompanying biology and we have always known that modulating the biology can modulate the illness. If we value the treatment of mental illness, we must value both humanistic and biological investigations.


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Humanity and biology in psychiatry

Further to our previous letter (Owen et al, 2003) we are writing to respond to Dr Turner's assertion (Turner, 2003) that biological psychiatrists secretly wish to take the humanity out of the humanities. This highlights a conceptual division within psychiatry and one partisan misunderstanding that stymies the debate.

It can be argued that academic psychiatrists are divided into two camps. The first is those who were drawn to the higher functioning of the brain as a conceptual frontier, and see logico-deductive empirical methodology as leading to the accumulation of universally applicable valid evidence. The second is those who were attracted to psychiatry (often away from other branches of medicine) because of its shared space with the humanities. The latter group focus on the difficulties of applying scientific method to the interpretation of meanings and intentions, emphasising cultural relativity, and issues of power and politics.

Highlighting the above division is not new. What we suggest is that the proponents of both camps, by their unwillingness to engage with or understand the field of the other, risk conceptual disaster at both extremes.

The argument from the humanities is of relevance to any scientist. The late-20th century critique of the hubris, historicism and relativity of science strikes at the core of the assumptions of biological psychiatry. Unfortunately, it is an argument that many do not even feel to be relevant. This seems to be an opinion based largely on a lay view that anything within the humanities is of little utility.

This is the very hubris that leads to the name-calling that Dr Turner exemplifies in his response to our perceived 'biological' letter. However, this assumption, among many in the humanities, that the biological psychiatrists are all washed up — applying a suspect statistical method in suspect circumstances — has led to them dangerously disengaging from any medical aspect of their profession. If our assertion is right, and this is a motivation for coming to psychiatry in the first place, this is hardly surprising.

The worrying thing is, of course, that despite the shortcomings of current approaches to categorisation, aetiology and treatment, mental illness does exist, and hence psychiatry has a role to play in its understanding and treatment. Our job, if we remain interested in being doctors, is to see (based on what evidence we have) where the medical model can add to the care of someone mentally unwell.

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Heroic, not disordered: creativity and mental illness revisited

Dr Wills (2004) assumes that I have overlooked Jamison’s 1993 work. In fact, the hyperbolic Touched with Fire only compounds the research problems of her original (1989) study. No matter how many famous artists she collects to ‘prove’ her case, there is no triumph in finding so much disturbance when your self-selected
sample is padded with it, giving scant or no attention to creative people who manage to be both prolific and stable. Jamison (1993) herself warns that ‘labeling as manic-depressive anyone who is unusually creative, accomplished, energetic, intense, moody or eccentric both diminishes the notion of individuality in the arts and trivializes a very serious, often deadly illness’ (p. 8) – yet she proceeds to do precisely that. Blurring the distinction between serious bipolar disorder and cyclothymia, with chapter titles like ‘Their Life a Storm Whereon They Ride’ she relies heavily on the overblown anguish of Romantic poets to hammer her case home. This makes thrilling reading, but it is not science.

As for those ‘many academic studies . . . over the past century’ (Wills, 2004), Jamison is more likely to drop names than disclose content in the attempt to build a historical pedigree for her work. Lombroso, to whom she refers most often, claimed that people of high ability were small, pasty and emaciated, with irregular teeth (1895). Unfortunately, since readers are about as likely to consult the original Lombroso (or Nisbet or Moreau) as they are to scrutinise Jamison’s methods, the delusion persists that there is long-standing empirical weight behind the notion of the ‘mad’ creative person.

Dr Wills finds Ludwig’s statistics (1995) acceptable, but I have difficulty with imprecise variables such as ‘any problem’ of parents and siblings, one of the few significant differences found between the families of creative artists and others – and even these, Ludwig himself admits, are ‘very weak’ (Ludwig, 1995: p. 157). And how does one measure ‘non-conformity’, ‘odd behavior’ or ‘anger at mother’ with any precision or reliability?

Although Wills thinks psychological autopsies are worthy tools, their validity is compromised by dependence on self-reports and second- and third-hand accounts, biographers’ natural tendency to shape the story around their opinions of their subjects, and clear experimenter bias – after all, the determined user of psychological autopsy may discover ‘madness’ in anyone’s life. Jamison uses such ‘evidence’ of mental illness as ‘possibly transient hypomanic episodes’ (p. 199), interest in spiritualism, spendthrift tendencies, and vague gossip: ‘thought by others to have had at least a trace of insanity’ (p. 168).

Finally, Wills declares that my view of the creative person (Schlesinger, 2002) is naive, as well as Laingian in its denial. I do not claim that bipolar disorder does not exist, only that there is no hard scientific evidence that creative people are more likely to suffer from it. As for my concerns being passe – reflecting the ‘antipsychiatry movement of the 1960s and 1970s’ – the news is that objection to reckless labelling never disappeared. It is actually growing, particularly in the USA, where even the general public has noticed the link between elastic diagnoses and pharmaceutical profits. And I make no apologies for believing creative people to be heroic – especially when so many assume they are mentally disordered.

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Is epilepsy a functional disease? [extract]

In the Journal of Nervous and Mental Disease for March Professor Allen M. Starr of New York draws attention to the importance of having a correct view regarding epilepsy. In medical text-books from the earliest times epilepsy has been classed as a functional disease and this view does not seem to have been questioned seriously. Yet a careful review of facts ascertained recently, says Professor Starr, seems to demonstrate the fallacy of the prevailing opinion and to prove conclusively “epilepsy is usually, if not always, an organic disease”. This conclusion is based upon a careful study of 2000 cases of epilepsy which have been seen personally and of which satisfactory records were kept. In the first place it was found possible to draw a fairly
sharp line clinically between Jacksonian epilepsy and so-called idiopathic epilepsy. In Jacksonian epilepsy the attack is always recognised by the patient as one of a similar series and consciousness is not lost, at least in the earliest stages of the attack. Four types of Jacksonian epilepsy are recognised – viz., the so-called “motor” type in which the attack starts with a local spasm; the sensory type which is marked by a hallucination (generally crude) of one of the senses at the onset, followed by a temporary suspension of the power of perception in that sense; an aphasic type in which a sudden interference with the function of speech takes place, either in the power of understanding or in the power of uttering speech; and a psychical type in which dreamy states of the mind or imperative ideas dominate consciousness, arresting the normal flow of thought and often leading to automatic acts the object of which is not clear and of which no conscious memory remains. In all these types, says Professor Starr, we consider the Jacksonian attack a sure indication of local irritation of the brain cortex and a symptom of local organic disease. In many cases of idiopathic epilepsy (38 per cent. of Professor Starr’s cases) the attack was preceded by a conscious sensation or aura. This aura was in many cases identical in character with the aura initiating a Jacksonian attack. The only difference between a Jacksonian attack of the “motor” type and an idiopathic attack was the extent of the spasm, which in the former began locally and involved only a portion (seldom the whole) of the body, whereas the latter involved the body in a general convulsion.

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