Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

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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.


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-Graae1 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.


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.

Assessing patients for mental health review tribunals, I have noted that many teams often simply discharge patients when they do not cooperate with follow-up. The ‘positive attitude of hope and recovery’, adopted by some community teams and encouraged in New Ways of Working,2 fails to acknowledge the typically chronic or relapsing course of schizophrenia. New Ways of Working also appears to discourage consultant psychiatrists from engaging in long-term follow-up by talking of a ‘shrinking and more focused role for senior professionals, shedding repetitive activities or doing them more smartly’. These approaches and the fragmentation of services into myriad teams risk losing opportunities to form and maintain therapeutic relationships with patients and their families, and to gain understanding of the long-term course of patients’ illnesses. It can subsequently become a bewildering task for families of discharged patients, or for concerned others, to receive help. When they do make contact, this will often be with professionals unknown to the patient and to whom the patient is unknown.

Given the increased investment and increased numbers of psychiatrists documented in New Ways of Working, it is difficult to see why psychiatrists and other professionals should have less time to allocate to the important task of maintaining links with this high-priority group. The 2007 progress report on New Ways of Working states: ‘The aim is to achieve a cultural shift in services that enables those with the most experience and skills to work face to face with those with the most complex needs.’ Schizophrenia is a severe and usually chronic or recurrent illness associated with a high suicide risk and relatively high homicide risk. It is commonly associated with substance misuse. Long-term prophylactic medication and psychological and psychosocial interventions can reduce relapse rates. Long-term medical treatment carries risks of adverse effects. Consultant psychiatrists are commonly among the longest-serving members of their teams. The complex elements of schizophrenia and the advantages of long-term follow-up provide an important and valid role for psychiatrists.

The Inquiry should gather data on how many of those with schizophrenia, committing homicide, have been under psychiatric care, how and why they ceased to be so, and in how many cases others had been trying to involve psychiatric services prior to the homicide. There may be a lesson that long-term follow-up of patients with schizophrenia is justified, even if the patient appears well.


4 Neuroimaging studies suggest that the basal ganglia and ventral prefrontal cortex are most frequently implicated in OCD in adults. If brain dysfunction underlies OCD, decrements on neuropsychological tests should be found. With this in mind, it is difficult to understand how people had neuropsychological deficits prior to developing OCD, when evidence suggests that children with OCD do not exhibit significant cognitive deficits early in the illness.

Evidence is in favour of executive dysfunction and auditory attention problems in late-onset OCD (age 13–17) rather than the early-onset (prior to 12 years) disorder. Performing poorly on the neuropsychological tests is not very conclusive as they may help to identify a dysfunction in a particular anatomical area, but provide little evidence on the actual cause leading to the pathology. Late-onset OCD is also associated with poorer visual memory relative to healthy comparison groups. Roth et al’s findings suggest that early- and late-onset OCD may be the result of at least partially differing neurobiological mechanisms.

There is not much evidence at present to show the effects of therapeutic interventions on neuropsychological deficits in OCD, and if any, are they curative in order to avoid the illness in future? The majority of people who had OCD also had comorbid illnesses – was it these illnesses that were the cause of neuropsychological deficits that later led to developing OCD (chemical abnormalities such as serotonin)? Perhaps studies on this aspect may be an area of interest for the authors.

The number of participants in the study is so small that no definitive statements should be made at this stage. We also wonder whether there are children and adolescents with neuropsychological deficits but not diagnosable psychiatric disorders and how we might compare them with individuals with conditions such as OCD.


Our study aimed to test for neuropsychological risk factors for obsessive-compulsive disorder (OCD). We hypothesized that neuropsychological deficits might be present in individuals with OCD, even before the onset of their symptoms. This hypothesis is based on the idea that OCD might reflect a dysfunction in certain brain regions, and that such dysfunction could be detected through neuropsychological tests.

We recruited a cohort of children who were diagnosed with OCD at a psychiatric institute, whereas the Dunedin cohort comprises a non-treatment-seeking population cohort of children with obsessive-compulsive disorder. The Dunedin cohort was used to provide a comparison group for our study, to ensure that any neuropsychological deficits we found were specific to the OCD group.

We administered a battery of neuropsychological tests to our participants, including measures of attention, memory, and executive function. Our results showed that individuals with OCD, even those who were diagnosed with OCD but not treated, had significantly lower scores on several neuropsychological tests compared to a group of healthy controls. This suggests that OCD is associated with underlying neuropsychological deficits.

However, our results do not provide conclusive evidence for the cause of the pathology. Although our research suggests that children with OCD may have underlying neuropsychological deficits, this does not necessarily mean that these deficits cause OCD. Further research is needed to understand the relationship between neuropsychological deficits and the development of OCD.

In conclusion, our study provides evidence for the presence of neuropsychological deficits in children with OCD, even before the onset of their symptoms. These deficits may represent underlying brain dysfunction that contributes to the development of OCD. Future research is needed to understand the nature of these deficits and their role in the pathology of OCD.
read Jaspers in the original German text. This made me smile, as I had an almost identical experience as a senior house officer in neurology in Dublin. At the time, I was working for a prominent neurologist, Hugh Staunton – who, by the by, went to the same school as Joyce. During a morning ward round I was minded by Dr Staunton that the reason I had failed to spot a neurological sign in a man with von Recklinghausen’s disease was that I had not read the author of this eponymous condition in the original German text. Somewhat belittled at the time, I now know I am in esteemed company.


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The Insect Twins (2009)
Lucinda Richards

Lucinda Richards is a foundation trainee (year 2) at King’s College Hospital, London. This work portrays the world as seen by patients with delirium that she has cared for.

‘I wanted to consider how patients with delirium experience a sudden change in how they perceive the world around them. I am especially interested in how objects or people that normally provoke a neutral or positive reaction can become distorted into something terrifying. The terror and hallucinations that can occur in delirium are represented by the larger-than-life insects and the transformation of the seemingly innocent children into something disturbing and sinister. In addition, the juxtaposition of the apparently joyful chain of people with the dark, oppressive flats in the background has the effect of making the expression of joy seem false and fragile. The lightning strike, forming cracks in the architecture represents the destruction of normal brain architecture. The disturbances in temporal and spatial orientation are portrayed by the images of both night and day, and the distortion in the size of the architecture and insects.’

Edited by Allan Beveridge.
James Joyce and Asperger syndrome
Paul J. Whelan
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References
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