Correspondence

EDITED BY STANLEY ZAMMIT

A new dawn for the yellow journal?

I welcome the new Editor's plans to bring the *Journal* firmly into the 21st century by making it intellectually stimulating but also inviting and readable for all (Tyrer, 2003). The previous Editor may have done much to improve the *Journal*'s impact factor to the scientific community by increasing its citation rate but what has not been studied are the views of the core readership. Should not a survey of readers be carried out to see what people think of the *Journal* and who reads how much and of what? I suspect the answer may be not much of very little, and that for most of us the *Journal* has a fairly short 'wrapper off to bookshelf time'.

The *Journal*'s core readers are many thousands of jobbing psychiatrists. We are looking for important new information that has bearing on our day-to-day clinical practice. Yes, we have the *Psychiatric Bulletin*, with its zippy and original offerings, but sometimes a subject needs a more academic and lengthy airing. Perhaps the readership could suggest subjects for editorials, and why not have each book review written by both an expert in the field and an ordinary reader, so as to capture different perspectives? I hope that the new Editor can increase the interaction between the *Journal* and all psychiatrists. Good luck.

Tyrer, P. (2003) Entertaining eminence in the *British Journal of Psychiatry*. *British Journal of Psychiatry*, **183**, 1–2.

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Editor's response: Dr Haw is probably right in her assertions that the jobbing psychiatrist is likely to become the bobbing psychiatrist when reading the *Journal* – jumping from one item to the next with little close examination of the content – and it is clear from a recent paper that the ability of good ghostwriting to make an arresting impact on the reader pays dividends (Healy & Cattell, 2003). We are taking notice of this by trying to improve and shorten the titles of papers submitted to the *Journal*; prospective authors please note. However, Dr Haw has stimulated me to go further; I have a hypothesis that readers of the *Journal* might help me in testing. It is a hypothesis that is best kept blind at this stage, and I am disclosing it only to the Associate Editors. For each of the main sections of the *Journal* (editorials, debates, original papers, review articles, book reviews and correspondence) I invite readers to score on a four-point scale (0=rarely or never read, 1=seldom read, 2=frequently read and 3=regularly or always read) in which 'read' is taken to be a reasonably full examination of the article (a good test of this is that you could summarise the main impact of the article to others). Could you send your responses to me at the address below by the end of January 2004, and I will report the results – and the hypothesis – shortly afterwards.

Meanwhile, I hope our readers are aware of a third journal published by the Royal College of Psychiatrists – *Advances in Psychiatric Treatment* (APT). Although not an organ for original research, APT publishes expert, in-depth reviews of topics of current clinical interest (http://apt.rcpsych.org/).

Healy, D. & Cattell, D. (2003) Interface between authorship, industry and science in the domain of therapeutics. *British Journal of Psychiatry*, **183**, 22–27.

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Mental health of refugees

Using quantitative measures Turner *et al* (2003) found that about half of a sample of 842 Kosovan refugees in the UK had post-traumatic stress disorder, with substantial comorbid depressive disorder and anxiety disorder. But there is more to be reported. I was involved in having a few open-ended questions tacked on to the study, tapping subjects' own views of their health/mental health and what they saw as their most urgent priorities for recovery. Only a tiny number saw themselves as having a mental health problem of any kind, bearing out observations by refugee workers in the reception centres housing them that there was no interest in counselling. Almost everyone nominated work, schooling and family reunion as their major concerns. This chimes with what I and others have found in clinical settings with refugees over many years. Significant psychopathology is uncommon (Summerfield, 2002).

The responses to the open-ended questions paint a picture that is a world away from that reported by Turner and colleagues; how is this contradiction to be explained? First, the question of validity. Translation/back-translation of psychiatric inventories originating in the USA and Western Europe does not by itself overcome the category fallacy to which Kleinman (1987) pointed: particular phenomena may be identified in different settings but it does not follow that they mean the same thing in each setting. Moreover, refugees in distressed and insecure circumstances may be particularly susceptible to the demand characteristics of questionnaires. Second, and fundamentally, how human beings experience an adverse event, and what they say and do about it, is primarily a function of the social meanings and understandings attached to it. No psychiatric category captures this active appraisal and meaning-making.

Quantitative methodologies serving psychiatric categorisations risk a distorting pathologisation of refugee distress, with what is social and collective being reassigned as individual and biological (Summerfield, 1999). Turner *et al* caution against 'the tendency of some to reject the diagnostic paradigm in refugee populations', but they do not make a persuasive case here that they know better than the Kosovan refugees themselves, and that many of the refugees really do need psychiatric treatment. There is simply no good evidence to back their conclusion that refugee populations anywhere are carrying a major burden of clinically significant mental ill health. As the answers to my questions demonstrated, refugees see recovery as primarily something that must

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happen in their social worlds, not in the space between their ears.

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.

__ (2002) Mental health of refugees and asylum-seekers. Commentary. *Advances in Psychiatric Treatment*, **8**, 247–248.

Turner, S. W., Bowie, C., Dunn, G., *et al* (2003) Mental health of Kosovan Albanian refugees in the UK. *British Journal of Psychiatry*, **182**, 444–448.

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Author's reply: Newly arrived refugees will often see their problems initially in terms of past experience (e.g. war-violence or torture) rather than emotional impact. They share a need for security and safety. However, it would be illogical to conclude that they are thereby free of psychopathology. It is not a case of either one state or the other. Factors operating in different domains frequently interact. This is the situation here.

Interestingly, as many as 11.1% of 522 subjects responded that they had a mental health problem *and* that they now wanted help (i.e. 'Western' treatment). We would expect help-seeking to increase in those with persisting symptoms, in line with experience in treatment services after any major incident.

To assert that significant psychopathology is 'uncommon' is wrong. It implies that civil war, rape and torture do not have important psychopathological consequences in significant numbers of people. This flies in the face of the evidence. It is reminiscent of the problems that Eitinger and others had when trying to justify reparation for some concentration camp survivors on the basis of psychological injury. Surely we have moved on since then.

In this instance, we do not assert psychopathology on the basis of self-report measures. This would have been an overestimate as we demonstrated in our report. An Albanian-speaking doctor undertook semi-structured clinical interviews (in Albanian).

Summerfield refers to additional data in our survey. We wish to present a factual analysis of these. We asked an open question about respondents' main concerns. The responses to this question are in the respondents' own words but if anxiety, tension, nervousness, stress or trembling are grouped together as likely anxiety symptoms, these were in fact the most frequent of the first priority problems and overall were reported by 21% (of 509 respondents). Sleep disturbance was reported by 16%, depression, hopelessness, sadness, mental problems and (poor) concentration by 8%. Many reported additional somatic complaints or general health problems, probably including a significant additional burden of psychological difficulty. Surprisingly, worries about family and friends were reported by only 17%. Concerns about work/economy (6%) and school/language (3%) were infrequent.

Rather than contradict the responses to the more structured questions, answers to these open questions reinforce our more quantitative findings.

Declaration of interest

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Effect of clozapine on mortality

Duggan *et al* (2003) elegantly model the effect of clozapine on suicide, and highlight that 53 lives could be saved each year if all patients with treatment-resistant schizophrenia were offered clozapine treatment. The model does not, however, take into account the effect of clozapine on mortality from causes other than suicide. Clozapine is associated with weight gain, diabetes mellitus, and increased mortality from pulmonary embolism and other adverse events in addition to the risk of agranulocytosis (Walker *et al*, 1997). Fontaine *et al* (2001) estimated mortality due to clozapine-associated weight gain using data from the Framingham Heart Study. They conclude that the reduction in the suicide rate would be almost entirely offset over 10 years by the increased mortality associated with weight gain of 10 kg. Walker *et al* (1997) report that mortality from causes other than suicide is increased with clozapine treatment, although overall mortality is lower. To completely model the effect of clozapine on mortality, the effects of the alternatives – active treatment and no treatment – on mortality, including suicide and adverse events related to treatment with other antipsychotics, should be included. These remarks do not detract from the main point that clozapine is still the most effective intervention for treatment-resistant schizophrenia, and mortality is only one outcome to be weighed in the overall risk–benefit analysis.

Declaration of interest

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Duggan, A., Warner, J., Knapp, M., *et al* (2003) Modelling the impact of clozapine on suicide in patients with treatment-resistant schizophrenia in the UK. *British Journal of Psychiatry*, **182**, 505–508.

Fontaine, K. R., Heo, M., Harrigan, E. P., *et al* (2001) Estimating the consequences of anti-psychotic induced weight gain on health and mortality rate. *Psychiatry Research*, **101**, 277–288.

Walker, A. M., Lanza, L. L., Arellano, F., *et al* (1997) Mortality in current and former users of clozapine. *Epidemiology*, **8**, 671–677.

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Health care contact and suicide

We read with interest the study by Gairin *et al* (2003), which highlighted the suboptimal working relationship between the accident and emergency department as a first point of contact and psychiatric services. Thirty-nine per cent of suicide victims got in contact with the accident and emergency department at some point in the last year of their lives and, according to the National Confidential Inquiry into Suicides in England and Wales, only a quarter of suicides are preceded by mental health service contact in that same period.

Although I appreciate the above point, I still think that contact with primary services has an equal if not greater role to play

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