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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.

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'.[3] 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.

1 *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England and Wales*. The University of Manchester, 2009 (http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2009.pdf).

2 Royal College of Psychiatrists, National Institute for Mental Health in England. *New Ways of Working for Psychiatrists: Enhancing Effective, Person-Centred Services Through New Ways of Working in Multidisciplinary and Multi-agency Contexts. Final report 'but not the end of the story'*. Department of Health, 2005.

3 Department of Health. *Mental Health: New Ways of Working for Everyone. Developing and Sustaining a Capable and Flexible Workforce. Progress Report*. Department of Health, 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074495.pdf).

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Childhood neuropsychological deficits and adult OCD

We read Grisham *et al*'s paper[1] with some concerns. Without doubt, the study – using longitudinal data instead of cross-sectional designs as in previous studies – adds positively to the subject area, which has not been well researched and the results of which are far from conclusive. However, we have a number of concerns about the reported results.

This study represents only one type of population and also, owing to the small number of obsessive–compulsive disorder (OCD) cases (only 13/700) found in this study, the authors' statement of 'individuals with OCD have premorbid impairment in visuospatial abilities and some forms of executive functioning, consistent with biological models of OCD' will be considered an overstatement and cannot be generalised to other population subsets.

We know that a previous study of OCD with the same birth cohort at age 18 found that the OCD group did not differ significantly on any of the neuropsychological tests at age 13,[2] and it will be interesting to know whether there were any associations at ages 15, 21 and 26, ages at which Grisham *et al*'s cohort was also assessed. Although participants in Grisham *et al*'s study were assessed at 3, 5, 7, 9 and 11 years of age, according to their performance on neuropsychological tests there is some evidence to suggest that there is no cognitive impairment in children with OCD, and that OCD symptoms may not interfere with cognitive abilities early on in the illness.[3] However, disturbance of cognitive functions may become significant over time, as we know that psychotropic medications are the main pharmacological treatment that may also influence neuropsychological function.[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.[3] 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[5] 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,[6] 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.

1 Grisham JR, Anderson TM, Poulton R, Moffitt TE, Andrews G. Childhood neuropsychological deficits associated with adult obsessive–compulsive disorder. *Br J Psychiatry* 2009; **195**: 138–41.

2 Douglass HM, Moffitt TE, Dar R, McGee R, Silva P. Obsessive-compulsive disorder in a birth cohort of 18-year-olds. Prevalence and predictors. *J Am Acad Child Adolesc Psychiatry* 1995; **34**: 1424–31.