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SIR: I read with interest Professor Cawley's article (*Journal*, February 1993, **162**, 154–160). His emphasis on the presence of a "non-science dimension" within psychiatry is important and timely in view of the increasing emphasis on biologism in recent years. In addition, he suggests that the study of philosophy in relation to psychiatry may enable "orientation of the non-science aspects of psychiatry in the world of knowledge and thought".

I would like to suggest that much psychiatric thinking is already some way out of step with an important shift in scientific philosophy which re-introduces a sense of humanity into the scientific realm. The 'new physics' which has emerged in recent decades has had such an impact on the philosophy of scientific materialism (based on Newtonian mechanics) that physicists such as Paul Davies and John Gribben consider science to be moving into a new 'post-mechanistic' paradigm. Einstein's theory of relativity, which successfully challenged Newtonian concepts of space and time, was followed by quantum theory which changed our concept of the subatomic world from a simple deterministic one to a "shadowy and paradoxical conjunction of waves and particles governed by the laws of chance" (Davies & Gribben, 1992). More recently, chaos theory has shown that 'non-linear' systems can become unstable and change in random and totally unpredictable ways. The implications of these discoveries are vast and will touch many disciplines. A whole new cosmology is emerging which places man firmly in the universe interacting intimately with it, rather than standing back as an aloof observer.

What are the implications for psychiatrists? Studies have started to appear in recent years applying the theory of chaos to such subjects as schizophrenia (Schmid, 1991), neurosynaptic transmission (Mandell, 1983), and the dynamics of psychotherapy (Lonie, 1991). In addition, the philosophical implications of this new 'post-mechanistic' science move away from positivism towards appreciation of the validity of non-scientific understandings of our world and ourselves. Perhaps most importantly, when we conceptualise ourselves within this novel scientific paradigm, we can no longer view ourselves in a reductionistic fashion. Human beings become more than biological machines. In fact the 'high-priests' of science – the theoretical physicists – are telling us that we are no longer able to conceive the universe or ourselves as machine-like systems but rather as holistic, indeterministic open systems, vibrant with potentials and possessing infinite richness. It appears to me that such a view overlaps significantly with the six axioms which Professor Cawley describes as "primary features of human experience". In the view of today's theoretical physicists, Ryle (1990) was right to dismiss the notion of the "ghost in the machine" – "not because there is no ghost, but because there is no machine" (Davies & Gribben, 1992).

I believe that these changes in thinking will not only validate the importance of Professor Cawley's 'non-science' component, but will also incorporate aspects of it, such as the area of subjective experiences and inner life, into the science of the 21st century.

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Ethnicity and relapse in schizophrenia

SIR: I read with interest the paper by Birchwood *et al* (*Journal*, December 1992, **161**, 783–790). They do not, however, refer to the study carried out at the Bethlem Royal and Maudsley Hospitals ('Joint Hospital'), an account of which was published the previous year (Gupta, 1991). Although the two studies do differ in a number of respects, many of their findings are similar. In both, for example, the Asian group had fewer readmissions to the hospital in question than the white group. Also the attrition rate at follow-up was greater in the former than in the latter (Gupta, 1992). What is not clear is whether these findings reflect differences in outcome or differences in the way in which different ethnic groups interact with medical and psychiatric services.

The social and family environment may of course affect both morbidity and service utilisation. Birchwood *et al* show that their Asian group were

more likely to be married or living with parents at the end of the follow-up period than the other two groups. Similarly, in the study at the Joint Hospital, significantly more of the Asian group than the white group were living with a partner at the time of the index episode. However, this study also compared the Asian group in London with a similar group of patients on the Indian subcontinent. Preliminary findings show that the former were significantly less likely to be living with a partner than the latter (Gupta *et al*, 1991). This suggests that immigrant status may be associated with erosion of the traditional family supports available to Asian patients. This, combined with cultural barriers to the use of conventional services, could place many Asians in this country in an isolated position (Beliappa, 1991).

I would agree with Birchwood *et al* that further, more detailed studies (both in the UK and on the Indian subcontinent) would be very helpful in shedding light on the patterns of psychiatric disorder among different ethnic groups in this country. These patterns are a matter for concern at governmental as well as local level (Department of Health, 1992) as they may have important implications for public health and policy.

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SIR: The findings of Birchwood *et al* (*Journal*, December 1992, **161**, 783–790) contrast with those of Perera *et al* (1991), who found no significant difference between Asians, Afro-Caribbeans and Caucasians in terms of (a) age of onset, (b) time between onset of illness and first psychiatric contact and (c) number of readmissions in their Harrow study. This may be because their study was restricted to those subjects fulfilling the Feighner criteria for schizophrenia who were matched for age and sex, or because of demographic variability between Harrow and Birmingham. It was unfortunate that Birchwood *et al* decided not to consider the differential use of illicit drugs by the three groups, as the Harrow study found illicit drugs to be mainly a Caucasian/Afro-Caribbean problem. Birchwood *et al* suggested greater tolerance of disturbance by extended families and the underuse of psychiatric services may be 'camouflaging' relapse among Asians, yet go on to suggest that the reduced rate of relapse may be the result of a limited progression of illness and prompt access to services by virtue of the greater visibility of disturbed behaviour in an extended family!

It is difficult to isolate cultural factors that may be contributing to a more favourable outcome for schizophrenia in developing countries by studying immigrant groups, as factors leading to a higher incidence of schizophrenia among immigrants are as yet ill-defined and cannot be corrected for. In respect of the latter I would like to suggest the lack of congruence between expectation of acceptance by the foster culture and the perceived acceptance by it as a factor contributing to high levels of schizophrenia among immigrants. (This may act by a similar mechanism to high expressed emotion.) In support of this is the high rates for schizophrenia among Afro-Caribbeans, and moderately high rates for Asian immigrants in Britain, compared to native British. (See Leff (1988) for a review of the relevant studies.)

English is the mother tongue of Afro-Caribbeans and they regard Britain as a sort of parent country. Hence they have high expectations of being accepted by the foster culture. For Asians, English is not the mother tongue (some of them may not even speak English) and they try to preserve their culture and values by aggregating, in an attempt to insulate themselves from the foster culture. Hence their need and expectation of being accepted by the foster culture is less. Harrison *et al*'s (1988) finding that second-generation Afro-Caribbeans showed an even higher rate of schizophrenia than Afro-Caribbean immigrants lends further support to this hypothesis. Afro-Caribbeans who were born and grew up in Britain would expect to be accepted into British society even more than their immigrant parents. Further circumstantial support comes from the Harrow study which found that Caucasians socialised significantly more outside their place of residence compared to Afro-Caribbeans and Asians. A joint psychiatric and anthropological study may throw further light on this interesting question.

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