Beneficial delusions?

DEAR SIRS

Gary Hosty in 'Beneficial delusions' (correspondence, *Psychiatric Bulletin*, June 1992, **16**, 373) raises the question of whether intervention can be justified in cases where the individual finds hallucinations and delusions to be life-enhancing. I hope that the consensual answer from the psychiatric profession is a resounding "no". The purpose of psychiatric intervention, especially against the patient's will, can only be to relieve suffering on the part of the patient, or stress which he or she may be inflicting on his family and society at large and where there is a reasonable expectation that our intervention will be effective in producing a happier state of affairs. To give any other response would bring us dangerously close to endorsing the kind of abuses of psychiatry that obtained in the old Soviet Union.

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Management training for overseas trainees

DEAR SIRS

I was dismayed to read the article by Mbwambo and colleagues (*Psychiatric Bulletin*, June 1992, **16**, 352–354) on the training of psychiatrists for the developing world. It is inappropriate to advocate training psychiatrists to be administrators. "Administration" is keeping the ship on a course determined by someone else. However, management is a proactive process requiring decisions about where an organisation is going, strategies for achieving stated goals, implementation of the strategies and evaluations of the outcome (Waters, 1985).

While trainees in the United Kingdom have begun to embrace the concept of management training (Junaid, 1992) too it is necessary to ensure trainees from overseas recognise the need and receive training in management techniques.

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Training and support for research in developing countries

I wish to support Guinness' (1992) views about the training of psychiatrists for work in developing countries. Recently the need has increasingly been felt (Tantam, 1990; The Royal College of Psychiatrists, 1990) but very little has been done practically.

Guinness recommends planning research before arrival on site in the developing countries. This seems to be based on her rather optimistic view that agencies like WHO play an important role in consultation and support for such work. As far as I know, suitable funding and support for research in their own countries by third world psychiatrists get even less attention than suitable training.

These issues have assumed more significance since the advent of training programmes like the Overseas Doctors Training Scheme which assume that trainees will return to their countries after completion of their training. The lack of relevant training and inability to find suitable support for research in the developing world are important factors that force the trained psychiatrists to stay in this country, thus defeating the reason for their training (Patel & Araya, 1992).

I wish one could see greater collaboration between the trainees and institutions responsible for their training to resolve these issues. It would open new vistas for research and clinical practice, and perhaps also enable Western psychiatrists to gain valuable insights into disorders rarely encountered in the UK.

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DEAR SIRS

There are three alternatives for promoting fruitful contact between first and third world psychiatrists in training and research. One is to design more relevant courses for overseas trainees. The different cultural context is the challenge. Clinical presentations, work loads, feasible treatment options, models of service provision are all rather different. The returning trainee will inevitably face major adaptation as Dr Farooq says.

The second option is to support in-country training; ODA for example is setting up research fellowships in the developing world.

A third option, which would lead to a more fertile exchange of ideas and moreover increase awareness of cross-cultural and global issues in Western psychiatrists, is to set up secondment schemes between centres. Postgraduate psychiatrists (senior registrar level in UK) could contribute to training, boost manpower and morale, and with backing from their home base facilitate research. A three year secondment would be the minimum on account of the adaptation required. In return, developing country psychiatrists might find overseas experience more meaningful after basic training in their relevant environment. WHO, ODA and the Commonwealth Secretariat have expressed an interest in such schemes.

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Psychiatry and philosophy

DEAR SIRS

Morris's statement (*Psychiatric Bulletin*, May 1992, **16**, 294–295) that the two opposing theoretical positions in psychiatry (the psychodynamic and the biological) "are part of a fundamental debate running through the history of philosophy, between the traditions in the philosophy of metaphysics of materialism and idealism" is a dogmatic assertion, unsupported by evidence or argument. There are no conceptual or historical connections between these two positions and the debates surrounding the idealism/realism issue in the history of philosophy. The practice of clinical psychiatry is based upon acceptance of the existence of such phenomena as mental processes, psycho-social structures, cerebral pathology and neuro-chemical changes. The clinician or research worker adopts the stance characterised by the philosopher as 'common-sense realism'. Philosophical reflection upon this basic position/'experience of the world' can complicate matters by showing that its ultimate analysis can lead to the philosophical theses of either metaphysical idealism or metaphysical realism. Thus, common-sense realism can not only be extended (by philosophical considerations) to a form of metaphysical realism (or naturalism or materialism) but shown to be fully compatible with metaphysical idealism (Acton, 1967).

Philosophical idealism of the traditional variety has no serious adherents in contemporary philosophy. Many different kinds of realism compete today in the philosophical marketplace: the 'scientific realism' of many philosophers of science, the 'Realism with a Human Face' of Hilary Putnam and the 'transcendental realism' of phenomenologists.

The most serious lacuna in Morris's account is the failure to mention the major philosophical school of phenomenology. Its two divergent manifestations – the 'transcendental phenomenology' of Husserl and the 'fundamental ontology' of Heidegger – are based on a fundamental conviction and claim to have definitively overcome the ages-old dichotomy of idealism/realism – this is the source of their philosophical interest. Philosophical phenomenology has had a decisive impact on the theory and practice of psychiatry, psychology and psychotherapy on the European continent and North America but only marginally so in Britain.

In their extreme forms the two opposed views (psychodynamic and biological) are related to the central issue of whether the focus is on human beings as persons or as (biological) organisms. Although this conceptual polarity is deeply embedded in our modern 'scientific' culture, I do not think it is related to the idealism/realism debate, rather a reflection of tendencies and thought-patterns which have been developing in our culture over the past three hundred years. The exploration of these issues has now become a matter of urgent importance.

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Reply

DEAR SIRS

I welcome with interest Dr Raschid's contribution, in particular his clarification of "materialism" as a type of philosophical realism. I think we are fundamentally in agreement, that there is a conceptual polarity in psychiatry the patient being a "person" or an "organism". I believe that the philosophical expression of these cultural thought patterns is the idealist/realist debate; another incarnation is the mind/body debate. Dr Raschid disagrees, although he does not argue this position.

Phenomenology argues that it is only those things that are directly available to experience that can be studied. Sadly for biological psychiatry, however, this rules out such notions as dopamine receptors and monoamine reuptake inhibitors. There is nothing in a phenomenological metaphysic to decide whether the "Dasein" (being-in-the-world) of the patient who believes the CIA control his brain is any more or less valid than the "Dasein" of the psychiatrist who believes