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ISSN 1723-8617

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The World Psychiatric Association (WPA)

The WPA is an association of psychiatric societies aimed to increase knowledge and skills necessary for work in the field of mental health and the care for the mentally ill. Its member societies are presently 130, spanning 113 different countries and representing more than 180,000 psychiatrists. The WPA organizes the World Congress of Psychiatry every three years. It also organizes international and regional congresses and meetings, and thematic conferences. It has 64 scientific sections, aimed to disseminate information and promote collaborative work in specific domains of psychiatry. It has produced recently several educational programmes and series of books. It has developed ethical guidelines for psychiatric practice, including the Madrid Declaration (1996). Further information on the WPA can be found on the website www.wpanet.org.

World Psychiatry

World Psychiatry is the official journal of the World Psychiatric Association. It is published in three issues per year and is sent free of charge to psychiatrists whose names and addresses are provided by WPA member societies and sections. State-of-the-art, research and mental health policy papers are welcome for publication in the journal. The relevant proposals should be sent to the office of the Editor.

Institutional consolidation and global impact: towards a psychiatry for the person

JUAN E. MEZZICH

President, World Psychiatric Association

I would like to share with the readers of *World Psychiatry* the President's workplan for 2005-2008 that I have prepared in recent months interacting with the Executive Committee and other advisors. The plan includes the following goals, concepts and activities.

PROMOTING THE FULFILLMENT OF THE STRATEGIC PLAN 2005-2008

This involves overseeing the implementation of the broad and specific goals of the Strategic Plan by the various components of WPA and helping to monitor the attainment of these goals. The implementation of the Strategic Plan starts with the formulation of detailed workplans by Executive Committee members, Zonal Representatives and leaders of Standing and Operational Committees and Institutional Programs. The set of all these workplans complementing the Strategic Plan will constitute the WPA Governance Plan 2005-2008.

Monitoring mechanisms include the following: a) annual reports from each of the WPA officers and components mentioned above; b) WPA Forums at the various WPA congresses; c) the Triennial General Survey of WPA; d) external mechanisms relevant to WPA activities and programs with likely global visibility and impact, including contacts with heads of international organizations concerned with mental health, health ministries, university departments of psychiatry, and patient/family representatives; and e) the overall Evaluation of the Strategic Plan to be presented at the next General Assembly.

DEVELOPING THE PRESIDENTIAL THEME "INSTITUTIONAL CONSOLIDATION AND GLOBAL IMPACT: TOWARDS A PSYCHIATRY FOR THE PERSON"

This presidential theme is in line with the thrust of the WPA Strategic Plan 2005-2008. The activities listed below are particularly relevant to the elements of the theme and are to be conducted by pertinent WPA components.

Institutional consolidation refers to enhancing WPA's identity, to respecting its normative instruments, to emphasizing democratic, transparent and participatory governance, as well as to strengthening its infrastructure and operational capacity. This will include the following activities:

- A WPA history project in connection with the Henry Ey Foundation, Perpignan, France, and the WPA Section on History of Psychiatry, utilizing the WPA historical archives.
- Full development of the WPA Permanent Secretariat in Geneva, which, in addition to central administrative tasks, will provide organizational support to WPA Zonal Offices, WPA Regional endeavors, and other major WPA structures, particularly in developing countries.
- The WPA fund raising plan, including the Corporate Supporters Program.

Global impact aims at ensuring that WPA fulfills its mission of advancing psychiatry and mental health across the world by engaging all governmental and non-governmental health stakeholders (patients, families, health professionals, public health policy makers, industry, journalists), through a variety of interactive means, to be responsive to mental health problems (e.g., illnesses, disasters and violence), to attend to disparities within and across countries, and to contribute to mental health promotion worldwide. This will include the following activities:

- Organizing during WPA congresses the following activities in collaboration with our local Member Societies: a) meetings with heads of international organizations concerned with mental health, b) contacts with health ministers, heads of university departments of psychiatry, representatives of broad health professional organizations, and patient/family organization representatives, c) a press conference with formal representatives of the national and international press, and d) visits to major psychiatric inpatient and community facilities.
- Improving electronic communication and informational resources by upgrading the WPA Website as a WPA Portal with both internal institutional sections and a component aimed at public education on psychiatry and mental health as well as by developing multimedia programs on the institutional profile of WPA and other domains.
- An expanded WPA publications program, including greater interactions with WPA education, Sections and meetings activities, partnering with the World Health Organization and other organizations to expand oppor-

tunities for authors in developing countries and for national psychiatric journals, and pursuing options for upgrading the publishing capacity of WPA.

A movement towards a *Psychiatry for the Person* promotes a contextualized and integrative perspective, seeking to articulate science and humanism in the service of the wholeness of the person who consults, within the community, consistent with what is the fundamental soul of medicine and psychiatry. In line with this, integration of mental health, general health and social services should be promoted. This holistic and Hippocratic perspective also serves as foundation for the promotion of ethics in psychiatry. The program will include the following activities:

- The conduction of the WPA Institutional Program on "Psychiatry for the Person: From Clinical Practice to Public Health", including among its components specific conceptual, clinical diagnosis, clinical care, and public health projects.
- Shaping the overall themes and scientific organization of major WPA Congresses, including those in Istanbul 2006 ("Psychiatry: Uniqueness and Universality"), Melbourne 2007 ("Working Together for Mental Health: Partnerships for Policy and Practice"), and Prague 2008 ("Science and Humanism: Towards a Person-Centered Psychiatry").
- Specific presence in a number of major international forums such as the Presidential Symposium on "International Advocacy towards a Psychiatry for the Person" at the American Psychiatric Association's 2006 Annual Meeting in Toronto, as well as a range of publications such as a WPA book series on psychiatry for the person.

CHAIRING THE WPA INSTITUTIONAL PROGRAM FOR YOUNG PSYCHIATRISTS

This encompasses as main activities the organization of fellowships at International and World Congresses of Psychiatry, the nurturing of the Young Psychiatrists Council and the Young Psychiatrists Network, and the promotion of special courses and other initiatives towards enhancing the scientific and leadership skills of our younger colleagues, who are the future of our field.

FULFILLING THE STATUTORY RESPONSIBILITIES OF THE PRESIDENT

These are specified in item 24 of the Statutes, including the following provisions:

- The President chairs all meetings of the General Assembly, the Board, the Executive Committee, and the Council and is responsible for the implementation of the decisions of these bodies.
- The President will promote the activities of the different components of the Association and their mutual collaboration to achieve the goals of the WPA.
- The President will seek funds to support the work of the WPA and can authorize others to do the same.
- The President convenes the Executive Committee and decides upon its agenda after consultation with its members.
- The President nominates the chairpersons and the members of the Standing and Operational Committees, when not otherwise specified in the Statutes or By-laws, as well as Special Advisors to the President, upon recommendation by the Executive Committee.
- The President chairs the Nomination Committee and appoints its members, with the approval of the Executive Committee.
- The President presides over the World Congress of Psychiatry.
- The President represents the Association in all official matters.
- The President reports to the Executive Committee.

This plan is aimed at measurably and qualitatively upgrading the institutional identity and capabilities of WPA and its global presence and significance, promoting the development of a Psychiatry for the Person as articulation of science and humanism. It is hoped that the work of this triennium will help the efforts of the new leaders of WPA in 2008 and in future periods to continue building our institution and fulfilling its high and noble aspirations.

Returning the debt: how rich countries can invest in mental health capacity in developing countries

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A number of recent articles (1-3) have highlighted the increasing reliance of developed countries on doctors and nurses trained in much poorer countries. US commentators have noted that "moral outrage over the poaching behavior on the part of the rich countries has reached a crescendo" (4). This year's World Health Report focuses on the subject of the severe shortage of health manpower in many countries, and the role of migration of health workers as one contributing factor (5). This topic has generated controversy and diversity of opinion (1). Nevertheless there are some imperatives: a) recruitment of health professionals from developing countries damages their fragile health systems; b) international medical migration is here to stay and it would be impractical and unethical to block it; c) improvements in working conditions and career structures are required for health professionals in developing countries; and d) developed countries owe a debt to poorer nations and could do more to assist this process of capacity development. Some suggestions have been proposed for building capacity, from developing and licensing clinical training programs to more radical suggestions to compensate the source countries through direct financial investment (1-3). This article highlights examples of efforts made by psychiatrists working in the UK mental health system to "return the debt".

For this destination country, and in this discipline, the unequal distribution of costs and benefits arising from medical migration are particularly stark. The UK stands out from the other big importers of medical expertise in having the highest proportion of doctors from low income countries (6). Among UK consultant psychiatrists, 26.4% in general psychiatry, 32.2% in old age psychiatry, and 58.9% in learning disability were trained overseas (7). While the UK has around 40 psychiatrists per million population, sub-Saharan Africa has fewer than one and India around four per million (8). Yet, India and some sub-Saharan African countries are the most important contributors to the mental health workforce in the UK. The National Health Service's (NHS) International Fellowship Scheme targeted senior consultant psychiatrists, often those working in medical schools, simultaneously undermining clinical resources and the training capacity for the next generation of specialists (9). Inevitably, there are now reports of unfilled vacancies in public mental health services in developing countries (10).

STRATEGIES FOR BUILDING CAPACITY

We sought out examples from UK NHS Trusts and colleagues whom we knew had worked in developing countries to contribute narrative descriptions of their experiences.

Trainee psychiatrists working overseas

Typically these were people who had taken time out from the final stages of their specialist training in the UK to live and work abroad: Melanie Abas (MA) for two and a half years in Harare, Zimbabwe; Jeremy Wallace (JW) for one year in Mbarara, Uganda; Atif Rahman (AR) for two years in Rawalpindi, Pakistan; Lynn Jones (LJ) intermittently for ten years in the Balkans and Kosovo. MA and LJ took time out when arrangements for doing so were relatively informal in the UK. AR and JW applied formally to their Deaneries for permission to take an "out of scheme experience", usually limited to one or two years. MA and JW took unpaid leave from their UK positions and relied upon local salaries. AR was supported with a Wellcome Trust Tropical Medicine Research Training Fellowship. They all held responsible positions in poorly resourced services and sought to develop the services in which they were working and to train specialist and primary care staff.

"I spent two sessions a week supervising colleagues in child psychiatry at the local teaching hospital (the Institute of Psychiatry). This not only helped me keep my clinical skills alive but also enabled me to set up a child and adolescent special interest group that continued to function after the project ended – I still provide supervision through the internet." (AR)

"With funding from the University and the Tropical Health Education Trust (THET), we resumed outreach clinics to rural health centres, teaching medical students in field clinics. We secured funding through THET for an education and support programme to rural health care workers. We invited the medical officers and nurses from strategic primary health centres for a training workshop, and made links with traditional healers." (JW)

"We worked hard as a team to attract local students to psychiatry, through maintaining a high standard of

clinical practice and of teaching. I also taught basic psychiatry to rural general health workers, for which guidance in cultural practices and beliefs from a Zimbabwean medical sociologist at the University proved essential. I made links with primary care, and with the main mental health NGO." (MA)

The challenge was to sustain the benefits accruing from these placements after the trainee had returned home.

"Upon completion of my doctorate, I was able to obtain a research Career Development Fellowship from the Wellcome Trust to continue the work in Pakistan. I now supervise three PhD students in Rawalpindi working to develop suitable interventions for depression in low-income populations." (AR)

"Over the decade of Balkan wars I realised that short term crisis interventions made no sense. The Department of Developmental Psychiatry in Cambridge allowed me to take prolonged leave from the final year of my specialist registrar training to work for Child Advocacy International to establish a child psychiatry service in Kosovo (11). For the last two years I have worked full time for International Medical Corps, integrating mental health services into their primary health care capacity building initiatives in Sierra Leone, Chad, Sri Lanka and Indonesia." (LJ)

Consultant psychiatrists working abroad

We elicited narratives from three consultant psychiatrists: Ama Addo (AA), a child and learning disability psychiatrist who worked in Ghana; Michael Radford (MR), an adult psychiatrist who works in Bangladesh; and Jack Piachaud (JP), a learning disability psychiatrist who works in the former Yugoslavia. Although these consultants were only in a position to spend weeks at a time working abroad, they nevertheless developed and sustained valuable long-term commitments.

"Lectures were geared to local conditions after intensive preparatory links with local senior medical staff. Three lectures on Child and Adolescent Psychiatry and Psychiatry of Learning Disability were supplemented with one on Psychosocial Paediatrics after an impromptu contact with the Department of Child Health. The feedback from students and medical staff was very positive, despite the comments about my Scottish accent, and I was offered the post of a part-time (Honorary) Lecturer with a request for annual lecture visits." (AA)

"My first visit to Dhaka affected me deeply and I have been back nine times so far for two to four weeks at a time. Following visits to village projects with various potential partners, we became excited about the inherent strengths of the rural communities to ameliorate and contain problems associated with severe mental illness. We sponsored

training for the committee of the Bangladesh Village Doctors' Welfare Association. This has been generously supported by some courageous senior psychiatrists who have grasped the potential of working (against official policy) with village doctors. We have arranged for the translation and printing of a Bangla version of "Where There Is No Psychiatrist" (12) as a vademecum for village doctors and non-medical workers in local NGOs." (MR)

"Our group made contact with a variety of people for training and greater understanding, and eventually made contact with the UNICEF psychosocial programme office in Zagreb. Eight people became involved in a "Help to the Helpers" programme. My own work in Serbia consisted of a series of ten days visits with a psychotherapist colleague starting in 1994 and continuing till 1999. In the first two years we made eight visits. We got to know key organisers of mental health services for children based at the Institute of Mental Health in Belgrade and the University of Novi Sad. We offered an interactive consultancy based on mutual interests, not claiming special expertise. We saw the emergence of programmes on self-esteem, of brief therapeutic interventions, of training for teachers and primary health staff (13)." (JP)

Capacity building through research

Several of the clinical attachments described above included research components. These contributed significantly to sustainable development of mental health capacity (14,15). The work of the 10/66 Dementia Research Group is a specific example of the potential for research capacity building to assist in the development of policy and practice. The UK based coordinating team provided initial training and methodological support for small pilot studies. Dedicated local investigators worked around their busy clinical practice to gather the data. The net result was 2885 interviews in 26 centres from 16 developing countries and a key publication in the Lancet demonstrating the feasibility and validity of the dementia diagnostic protocol (16).

"We are now engaged in a program of population-based research and testing the effectiveness of an intervention comprising education and training of caregivers, to be delivered by local community health workers. The collaboration between academics and an international non-governmental organization provided an ideal framework for the initiation of our practically orientated research program. Training for research has stimulated local interest in the development of clinical skills in dementia care." (MP)

NHS Trusts supporting links

We elicited narratives on two NHS mental health trusts

supporting links with Uganda: the East London and City Mental Health Trust, which supported staff training at the Butabika Hospital, and the Sheffield Care Trust (SCT), which has established links with providers in the Adjumani district, a region which has endured continuing armed conflict since 1986. Both schemes have had support from their Trust Boards, and senior managers from the Trusts have visited Uganda to formulate plans and agreements with local clinicians and hospitals. These developments are supported by the THET, who have helped to apply for and administrate project funds.

"The scheme aims to form a reciprocal relationship between Adjumani and SCT, building on work already done in Adjumani to examine community needs and priorities. The Chief Executive of SCT visited Adjumani to discuss the link and SCT will release staff to work with services in Adjumani for short periods. They supported a sensitisation seminar for local workers and an initiative to support health workers from district primary care facilities. Two week-long workshops for PCOs gave opportunities for over 30 PCOs to get together and share experiences, develop plans for local projects, as well as to update their knowledge and skills." (EO)

DISCUSSION

In this article, we have highlighted ten examples of UK initiated strategies to "return the debt", each representing modest, practical attempts to build mental health capacity in developing countries. These initiatives relied heavily upon the motivation and commitment of individual psychiatrists. There was little direct financial contribution from UK institutions to facilitate the process. Formal partnerships between NHS mental health trusts (17) are notable exceptions to this general rule. Most initiatives described here were funded by research charities, non-governmental organizations, individual donations or the contributions made by developing country institutions. This is despite the obvious reciprocal benefits: UK mental health professionals benefit from having their cultural sensitivity and clinical skills enhanced, and learning from working in less well resourced health systems (18,19).

While our narratives demonstrate some of the approaches to return the debt, much more could be achieved with strategic planning, coordination and funding. Capacity building initiatives need to extend beyond the specialist mental health professional groups (20) to include the community and general health workers at the frontline of primary health care (21). Capacity building should generally be carried out in the developing country, always in collaboration with local institutions and with accreditation from the local ministry so that trained health workers have a clear career path. If health professionals are invited to a rich country, for example to enhance leadership or when there is

a marked lack of local skills, such training should be explicitly linked with efforts to ensure the newly skilled practitioners are able to implement these skills upon their return.

Most importantly, we believe that the governments of rich countries which rely on mental health professionals from developing countries have a particular obligation, as the monopoly employer of health practitioners, to establish and fund a framework through which such initiatives may be supported in a more systematic manner. Core funding could be channeled through the ministries of health and individual health management organizations. As a benchmark for estimating the size of this fund, we suggest it should be at least roughly proportionate to the economic savings the rich country enjoys by employing health professionals it has not had to train. In the meantime, the government could do much more to facilitate practitioners to work in developing countries, for example by encouraging employers to release staff on paid long-leave or facilitate short-leave in emergency situations such as the recent natural disasters in south Asia.

We welcome the initiative of the Royal College of Psychiatrists (UK) to encourage trainee psychiatrists and retired psychiatrists to work in developing countries, by accrediting up to 12 months of supervised training abroad for the higher specialist training and maintaining a database of developing country institutions which welcome trainees. A link with the non-governmental organization Voluntary Services Overseas may help to provide appropriate placements and also offers a local salary stipend. However, those with dependents and mortgages in their home countries may be deterred. The Wellcome Trust pays UK salaries to its researchers working in developing countries; we think that other rich country employers should do the same for their trainees gaining valuable "out of scheme" experience.

We recommend that consultants, many of whom were trained in developing countries, are able, if they choose, to spend time in developing countries training health workers and assisting in the development of sustainable local services. We are aware of several examples of UK consultants negotiating clauses in their contracts assuring annual paid study leave for this purpose. This individual approach needs formal recognition as a means of returning the debt. Finally, as the era of revalidation dawns on European medical systems, Medical Councils must explore ways of ensuring that doctors who choose to work in developing countries, often in disorganized health systems, are not penalized for their efforts.

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The science of well-being: an integrated approach to mental health and its disorders

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Psychiatry has failed to improve the average levels of happiness and well-being in the general population, despite vast expenditures on psychotropic drugs and psychotherapy manuals. The practical failure of psychiatry to improve well-being is the result of an excessive focus on stigmatizing aspects of mental disorders and the neglect of methods to enhance positive emotions, character development, life satisfaction, and spirituality. In this paper, a simple and practical approach to well-being is described by integrating biological, psychological, social, and spiritual methods for enhancing mental health. Evidence is presented showing that people can be helped to develop their character and happiness by a catalytic sequence of practical clinical methods. People can learn to flourish and to be more self-directed by becoming more calm, accepting their limitations, and letting go of their fears and conflicts. People can learn to be more cooperative by increasing in mindfulness and working in the service of others. In addition, people can learn to be more self-transcendent by growing in self-awareness of the perspectives that lead to beliefs and assumptions about life which produce negative emotions and limit the experience of positive emotions. The personality traits of self-directedness, cooperativeness, and self-transcendence are each essential for well-being. They can be reliably measured using the Temperament and Character Inventory. A psychoeducational program for well-being has been developed, called "The happy life: voyages to well-being". It is a multi-stage universal-style intervention by which anyone who wants to be happier and healthier can do so through self-help and/or professional therapy.

Key words: Well-being, character development, spirituality, happiness, psychobiology

Despite vast expenditures on psychotropic drugs and extensive efforts to manualize psychotherapy methods, there has been as yet no substantial improvement in average levels of happiness and well-being in general populations, as well documented in Western societies like the USA (1,2).

The practical failure of psychiatry to improve well-being is not surprising for several reasons. First, the focus of psychiatry has been on mental disorders, not on the understanding or development of positive mental health. Morbidity and mortality are more strongly related to the absence of positive emotions than to the presence of negative emotions (3). It is possible to cultivate the development of positive emotions, as shown by recent randomized controlled trials (4).

Second, a focus on discrete categories of disease provides an easy way to label patients with disorders, but the validity of the categorical separation is doubtful (5). In addition to being of doubtful validity, categorical distinctions are inherently stigmatizing: some people are suggested to be defective, whereas others are normal. As a result, many people are ashamed of being mentally ill and avoid treatment. A focus on universal interventions to cultivate mental health for everyone can be destigmatizing, by recognizing that all people share much in common with one another.

Third, psychiatric methods of assessment and treatment often require prolonged training with complex jargon for psychotherapy or expensive medications and equipment for biological therapies. These cost and distribution characteristics limit the availability of effective treatments around the world. Integrative psychobiological treatments can be highly effective and inexpensive, harnessing the spontaneous resilience of human beings in a therapeutic milieu that can be provided by a wide range of mental health workers with varying levels of professional expertise.

Fourth, treatments that focus on the body and/or mind have usually been anti-spiritual in their orientation. This anti-spiritual bias in psychiatry has many roots, including questionable assumptions of Freudian psychoanalysis, behaviorism, and the overly simplistic reductionism of materialists. Yet, human beings are spiritual beings who spend more time in prayer or meditation than they do having sex (6). Cultivation of spirituality provides an inexpensive and powerful way to enhance well-being, as shown by recent randomized controlled trials of spiritual treatment methods that are reviewed later in this article.

These considerations have led me to develop a simple approach to helping people to be happy that can be made available to everyone. My approach is integrative, combining biological, psychological, social, and spiritual approaches to mental health. The scientific basis for this science of well-being has been summarized in a recent book (7). Now I am writing a more clinically oriented book to explain how to apply this approach in clinical practice and am developing a series of psychoeducational modules that can be distributed widely.

Here I will summarize available data about the need to reduce disability, the spiritual needs of people, and the effectiveness of spiritually-oriented well-being therapies. Then I will describe the key clinical concepts about the stages of self-awareness. Finally, I will describe the series of psychotherapy modules that are being produced, to illustrate an efficient catalytic sequence of interventions that help everyone become more mature and happy.

THE NEED TO REDUCE DISABILITY WORLDWIDE

Despite modern advances in psychiatry, mental disor-

ders remain the leading causes of disability throughout the world (8). Major depression alone results in the average loss worldwide of more than 6 years of healthy life. Combining major depression with alcohol use, drug use, and other mental disorders brings the total burden from mental disorders to over 20 years of the lives of every person age 5 and older. Mental disorders are a staggering burden for societies around the world regardless of the ethnic and economic diversity of countries.

The treatment of mental disorders has been improved with the introduction of many medications and psychotherapy techniques that show acute benefits in randomized controlled trials. Nevertheless, available treatments are unfortunately associated with frequent dropout, relapse, and recurrence of illness. For example, in the treatment of major depression, the acute response to antidepressants or cognitive behavioral therapy is only moderate. Substantial improvement occurs in about 50% to 65% of patients receiving active treatment, compared to 30% to 45% in control subjects (9). Relapse is rapid in subjects who drop out or prematurely discontinue treatment, because the interventions are directed at symptoms and do not correct the underlying causes of the disorder. Most patients with major depression who do improve acutely have recurrences within the next three years despite use of medications and cognitive behavioral therapy (10). The outcomes are likewise inadequate from available treatments for other disorders, such as schizophrenia, bipolar disorder, anxiety disorders, alcohol and drug dependence. The available medications for drug and alcohol dependence have weak acute effects and high rates of relapse and recurrence, even when clinical subtypes are distinguished (11,12). Likewise, 74% of patients with schizophrenia discontinued the antipsychotic they were prescribed before 18 months in a recent trial comparing available second-generation (atypical) antipsychotics to the first-generation (typical) drug perphenazine (13). All available drugs were discontinued with nearly equal frequency because of high rates of non-response, intolerable side effects, and non-adherence. The inadequacy of available treatments for most patients with mental disorders results in persistent residual symptoms of disease and distress, as well as low levels of life satisfaction and well-being.

WHAT DOES REDUCE DISABILITY AND ENHANCE WELL-BEING?

Well-being is not enhanced by wealth, power, or fame, despite many people acting as if such accomplishments could bring lasting satisfaction. Character development does bring about greater self-awareness and hence greater happiness. Fortunately, recent work on well-being has shown that it is possible to improve character, thereby increasing well-being and reducing disability in the general population, and in most, if not all, mental disorders

(4,7,10,14-16). The most effective methods of intervention all focus on the development of positive emotions and the character traits that underlie well-being.

Randomized controlled trials of therapies to enhance well-being in patients with mental disorders show improvements in happiness and character strengths that increase treatment adherence and reduce relapse and recurrence rates when compared to cognitive-behavioral therapy or psychotropic medication alone (10,14,15). Randomized controlled trials showed that interventions to enhance well-being are also effective in samples of students and volunteers from the general population (4,17).

The methods of improving well-being can be understood as working on the development of the three branches of mental self-government that can be measured as character traits using the Temperament and Character Inventory (TCI) (6,18). These three TCI character traits are called self-directedness (i.e., responsible, purposeful, and resourceful), cooperativeness (i.e., tolerant, helpful, compassionate), and self-transcendence (i.e., intuitive, judicious, spiritual). In essence, high scorers in all these character traits have frequent positive emotions (i.e., happy, joyful, satisfied, optimistic) and infrequent negative emotions (i.e., anxious, sad, angry, pessimistic).

Our findings are illustrated in Figure 1. Using the TCI, we distinguished people who were in the top third of self-directedness (S), cooperativeness (C), and self-transcendence (T), from those in the lowest third (s, c, t), or in the middle third on each test (-). About a third of people who were low in self-directedness were depressed. The percentage of those low in self-directedness who were happy was 5% if people were also neither cooperative nor transcendent, and increased to 26% if they were both cooperative and transcendent. Furthermore, if self-directedness or cooperativeness was high, but not both, then people did not differ much in mood from those with average character profiles. If both self-directedness and cooperativeness

S – top third of self-directedness; s – lowest third of self-directedness; T – top third of self-transcendence; t – lowest third of self-transcendence; C – top third of cooperativeness; c – lowest third of cooperativeness; --- middle third on each test
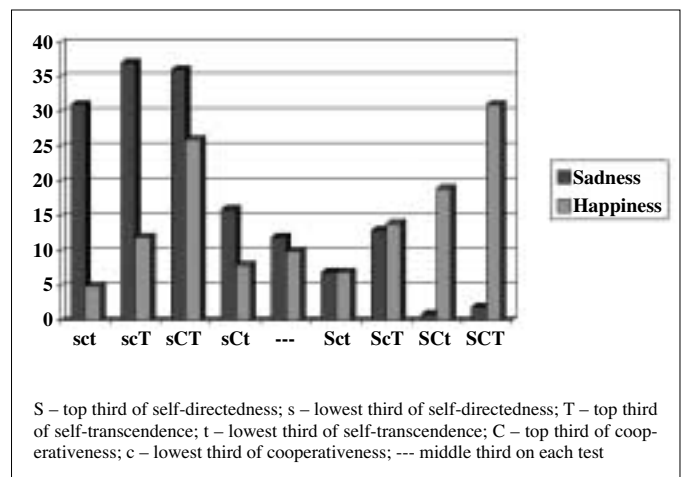
Figure 1 Percentages of people with prominent sadness or prominent happiness, according to their character profile (adapted from 7)

were elevated, then happiness was much more frequent than sadness (19% versus 1%). Finally, people who were elevated on all three aspects of character had the highest percentage of happiness (26%). In other words, the development of well-being (i.e., presence of happiness and absence of sadness) depends on the combination of all three aspects of self-aware consciousness. The lack of development of any one of the three factors leaves a person vulnerable to the emergence of conflicts that can lead to a downward spiral of thought into a state of depression.

These character traits can be exercised and developed by interventions that encourage a sense of hope and mastery for self-directedness, kindness and forgiveness for cooperativeness, and awareness and meaning greater than oneself for self-transcendence.

Low TCI self-directedness is a strong indicator of vulnerability to major depressive disorders (19). TCI self-directedness is a predictor of rapid and stable response to both antidepressants (20,21) and cognitive behavioral therapy (CBT) (22). Encouragement of problem solving leads to increases in autonomy and sense of personal mastery, which facilitate greater hope and well-being in ways that are common in effective psychotherapies, including CBT (23-25) or CBT augmented with modules for awareness of positive emotions (10,14,15), mindfulness (26,27), or spiritual meaning (15,16,23). The addition of modules for cultivating positive emotions, mindfulness, and/or spiritual meaning reduces drop-outs, relapse, and recurrence rates substantially. For example, in the treatment of patients with recurrent depression, additional work on positive emotions lowered relapse and recurrence rates from 80% to 25% over 2 years in recurrent depressives (15). Likewise, mindfulness training reduced the relapses from 78% to 36% at 60 weeks in depressives with three or more episodes (26-28). Finding of spiritual meaning through self-transcendent values also reduced relapse and improved well-being in randomized controlled trials of patients with depression, schizophrenia, and terminal diseases (16).

Improvements in each of these areas is beneficial, but emotional consistency and resilience depends on the balanced development of all three major dimensions of character (6,7,18). Western concepts of mental health usually emphasize self-directedness and cooperativeness, but neglect the crucial role of spiritual awareness and meaning based on self-transcendent values.

THE NEED FOR SPIRITUAL MEANING

Most psychiatric patients want their therapist to be aware of their spiritual beliefs and needs, because human spirituality has an essential role in coping with challenges and enjoying life (16). Human consciousness is characterized by a capacity for self-awareness and free choices that are not fully determined by past experience (7). The great mystery of neuroscience is that human consciousness cannot be explained or reduced to materialistic processes (29,30).

As a result of the fact that human consciousness transcends materialistic explanations, psychiatry now finds itself at an important crossroad. The fostering of spirituality and well-being is crucial for psychiatry to achieve its meaning and purpose, but spirituality and well-being have been neglected because of a tendency toward materialistic reductionism. Psychiatry has now the opportunity to promote a broader understanding of what it means to be a human being. Humanity cannot be reduced to matter, as in behaviorism or molecular psychiatry. Humanity also cannot be reduced to the dualism of body and mind, as in cognitive-behavioral approaches.

Self-awareness requires an understanding of the physical, mental, and spiritual aspects of a human being. To foster fuller self-awareness, CBT can be augmented with an added focus on existential issues, such as finding self-acceptance and meaning in coping with life challenges. Meaning can be found by encountering someone or something that is valued, acting with kindness and purpose in the service of others, or developing attitudes such as compassion and humor that give meaning to suffering (16,31,32). Spiritually-augmented therapy is more effective than CBT in activating feelings of hope and life satisfaction (16,31,32). It is also shown in randomized controlled trials to reduce relapse rates and enhance the quality of functional recovery (16). The reduction in relapse rates suggests that fostering the search for meaning may sometimes help people develop their character to new levels in which they have reduced vulnerability to future episodes.

In order to incorporate a fuller understanding of spiritual development into general clinical practice, it is necessary to understand the way that people normally develop their sense of well-being. Fostering the development of character traits such as being self-directed, cooperative, and spiritual, automatically leads to a good quality of life. Understanding the ways to foster spiritual development allows a therapist to treat the full range of psychopathology, provided the therapist knows appropriate ways for dealing with the many obstacles that patients may encounter along the path to well-being.

STAGES IN THE PATH TO WELL-BEING

There are three major stages of self-awareness along the path to well-being, as summarized in Table 1, based on extensive work by many people, as I have described in more detail elsewhere (7). The absence of self-awareness occurs in severe personality disorders and psychoses, in which there is little or no insightful awareness of the preverbal outlook or beliefs and interpretations that automatically lead to emotional drives and actions. Lacking self-awareness, people act on their immediate likes and dislikes, which is usually described as an immature or "child-like" ego state.

The first stage of self-awareness is typical of most adults

Table 1 Stages of self-awareness on the path to well-being

Stage	Description	Psychological characteristics
0	Unaware	Immature, seeking immediate gratification ("child-like" ego-state)
1	Average adult	Purposeful but egocentric; cognition able to delay gratification, but has frequent negative emotions (anxiety, anger, disgust) ("adult" ego-state)
2	Meta-cognition	Mature and allocentric; aware of own subconscious thinking; calm and patient, so able to supervise conflicts and relationships ("parental" ego-state, "mindfulness")
3	Contemplation	Effortless calm, impartial awareness; wise, creative, and loving; able to access what was previously unconscious as needed without effort or distress ("state of well-being", "soulfulness")

most of the time. Ordinary adult cognition involves a capacity to delay gratification in order to attain personal goals, but remains egocentric and defensive. Ordinary adult cognition is associated with frequent distress when attachments and desires are frustrated. Hence the average person can function well under good conditions, but may frequently experience problems under stress. Most people ordinarily think in ways that are defensive, so they frequently struggle to justify why they are right and others are wrong. However, at this stage of self-awareness, a person is able to make a choice to relax and let go of negative emotions, thereby setting the stage for acceptance of reality and movement to higher stages of coherent understanding.

The second stage of self-aware consciousness is typical of adults when they operate like a "good parent". Good parents are allocentric in perspective – that is, they are "other-centered" and capable of calmly considering the perspective and needs of their children and other people in a balanced way that leads to satisfaction and harmony. This state is experienced when a person is able to observe his own subconscious thoughts and consider the thought processes of others in a similar way to his observing his own thoughts. Hence the second stage is described as "meta-cognitive" awareness, mindfulness, or "mentalizing". The ability to the mind to observe itself allows for more flexibility in action by reducing dichotomous thinking (26). At this stage, a person is able to observe himself and others for understanding, without judging or blaming. However, in a mindful state people still experience the emotions that emerge from a dualistic perspective, and so they must struggle effortfully to discipline and control their emotional responses. Such effort is tiring and only partially successful, so mindfulness is only moderately effective in improving well-being (7).

The third stage of self-awareness is called contemplation, because it is the direct perception of one's initial perspective – that is, the preverbal outlook or schemas that direct our attention and provide the frame that organizes our expectations, attitudes, and interpretation of events.

Direct awareness of our outlook allows the enlarging of consciousness by accessing previously unconscious material, thereby letting go of wishful thinking and the impartial questioning of basic assumptions and core beliefs about life, such as "I am helpless", "I am unlovable", or "faith is an illusion". The third stage of self-awareness can also be described as "soulful", because in this state a person becomes aware of deep pre-verbal feelings that emerge spontaneously from a unitive perspective, such as hope, compassion, and reverence (7). Soulfulness is much more powerful in transforming personality than is mindfulness, which often fails to reduce feelings of hopelessness (33). However, most people never achieve a stable contemplative state in contemporary societies, which are replete with materialistic and anti-spiritual messages.

Extensive empirical work has shown that movement through these stages of development can be described and quantified in terms of steps in character development or psychosocial development, as in Vaillant's work (34) on Erikson's stages of ego development. Such development can be visualized as a spiral of expanding height, width, and depth as a person matures or increases in coherence of personality. Likewise, the movement of thought from week to week or month to month has the same spiral form regardless of the time scale. Such "self-similarity" in form regardless of time scale is a property characteristic of complex adaptive systems, which are typical of psychosocial processes in general (7). The clinical utility of this property is that therapists can teach people to exercise their capacity for self-awareness, moving through each of the stages of awareness just described. Their ability to do so, and the difficulties they have, reveals the way they are able to face challenges in life.

Based on studies of stages in character development and emotional consistency, I have developed a psychotherapy program that involves a sequence of 15 intervention modules to guide a person along the path to well-being (Table 2). These are described as scripts of a dialogue

Table 2 Titles and topics of the 15 modules of "Voyages to well-being"

Set 1	Module 1: What makes you happy? – Recognizing what brings joy
	Module 2: What makes you unhappy? – Understanding traps in thinking
	Module 3: Experiencing well-being – Quieting the mind's turmoil
	Module 4: Union in nature – Awakening your physical senses
	Module 5: Finding meaning — Awakening your spiritual senses
Set 2	Module 6: Beyond mindfulness – Cultivating soulfulness
	Module 7: Observing and elevating your thoughts
	Module 8: Observing and elevating your human relationships
	Module 9: Charting your maturity and integration
	Module 10: Contemplation of being
Set 3	Module 11: Can you learn to reduce stress?
	Module 12: Calming your fears
	Module 13: Observing the power-seekers in your life
	Module 14: Contemplation of mysteries
	Module 15: Constant awareness

with a patient going through therapy to become more healthy and happy. This therapeutic sequence corresponds to the natural sequence by which a person grows in self-awareness, adapted to provide therapeutic guidance and self-help exercises in a way that will provide systematic progress toward well-being. Each module is about 50 minutes long, suitable for use in a self-help format or as an adjunct to individual or group therapy. It is designed as a universal intervention that can be enjoyed by anyone regardless of his or her level of physical and mental health as long as they have the reading comprehension of an average 14 year old (i.e., eighth grade education). The therapist does not have to repeat instructions or go through standard material, but is free to discuss individualized issues with the patient and suggest applications and homework that is especially appropriate to their particular situation. The pacing of intervals between modules in the series can be determined by the motivation and situation of the patient, and orchestrated by the therapist.

All of the techniques have been tested in clinical work (18), and most have been tested in randomized controlled trials described earlier in this article. A randomized controlled trial of the interventions as a complete set is being planned. It is interesting to note that the first set of modules emphasizes behavioral methods focused on positive emotions along with basic concepts of cognitive processing. The second set of modules goes beyond mindfulness to stimulate deeper meta-cognitive awareness of the perspectives that underlie subconscious thoughts. The third set of modules involves contemplative access to and recognition of the meaning of preverbal symbols by which internal and external influences that are usually unconscious communicate by framing subconscious expectations, as in dreams and some forms of advertising, social movements, and other powerful situations. These stages of therapy correspond to stages of spiritual development but are based on explicit psychobiological principles, as I have described in detail elsewhere (7).

It is my hope that providing an explicit description of a sequence of interventions will help therapists overcome their unfortunate reluctance to attend to their patient's spiritual needs. I have found it possible to be non-judgmental in raising questions about spiritual values for my patients. I emphasize that each person must question all authorities, including me, and focus on providing private exercises by which they can obtain answers for themselves. This allows attention to spirituality based on principles of psychobiology with roots in compassion and tolerance, rather than on the basis of dogmatic judgments that are rooted in fear and intolerance. My experience has been that this has made my therapy more effective and more enjoyable for both my patients and myself. Only by addressing spirituality in a scientific and non-judgmental manner can we make psychiatry into a science of well-being that is able to reduce the stigma and disability of mental disorder.

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The social brain hypothesis of schizophrenia

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The social brain hypothesis is a useful heuristic for understanding schizophrenia. It focuses attention on the core Bleulerian concept of autistic alienation and is consistent with well-replicated findings of social brain dysfunction in schizophrenia as well as contemporary theories of human cognitive and brain evolution. The contributions of Heidegger, Merleau-Ponty and Wittgenstein allow us to arrive at a new "philosophy of interpersonal relatedness", which better reflects the "embodied mind" and signifies the end of Cartesian dualistic thinking. In this paper I review the evolution, development and neurobiology of the social brain – the anatomical and functional substrate for adaptive social behaviour and cognition. Functional imaging identifies fronto-temporal and fronto-parietal cortical networks as comprising the social brain, while the discovery of "mirror neurons" provides an understanding of social cognition at a cellular level. Patients with schizophrenia display abnormalities in a wide range of social cognition tasks such as emotion recognition, theory of mind and affective responsiveness. Furthermore, recent research indicates that schizophrenia is a disorder of functional and structural connectivity of social brain networks. These findings lend support to the claim that schizophrenia represents a costly by-product of social brain evolution in Homo sapiens. Individuals with this disorder find themselves seriously disadvantaged in the social arena and vulnerable to the stresses of their complex social environments. This state of "disembodiment" and interpersonal alienation is the core phenomenon of schizophrenia and the root cause of intolerable suffering in the lives of those affected.

Key words: Schizophrenia, social brain, autism, evolution, connectivity

For more than a century we have witnessed within psychiatry the emergence of numerous explanatory models or hypotheses of schizophrenia. In this article I introduce the concept of an evolved social brain in Homo sapiens that is vulnerable to developmental disturbances, which manifest as psychopathologies such as psychosis. This social brain hypothesis is a useful heuristic for understanding schizophrenia, since it accommodates existing models of the disorder and in addition focuses our attention on perhaps the most devastating and consistently reported symptoms: the loss of social cognitive skills and the alienation of the self from the social world.

Furthermore, the social brain hypothesis is consistent with contemporary theories of human cognitive and brain evolution, individual cognitive, emotional and social development, and the anatomical and physiological structure and function of neural networks underlying complex social cognition and behaviour. Finally, this hypothesis reflects the recent change in the philosophical approach to the mind/brain issue (1,2).

Most contemporary philosophers and phenomenologists of mind have abandoned the Cartesian model of an isolated ethereal mind separated from body and environment, in favour of a physically and socially integrated construct of mind, embodied in the living world. For 400 years Rene Descartes' dualistic model dominated thinking within the biological and social sciences (3) and its pervasive influence is evident in the "mind-body split" that characterises our modern construct of mental life. In recent decades, and in response to the obvious failures of Cartesianism, philosophers such as Martin Heidegger (4) and Maurice Merleau-Ponty (5) have developed a new philosophical basis for the study and understanding of human behavioural and mental phenomena – a philosophy that reflects the interpersonal nature of mental life. According to Bracken (6), Heidegger describes the world as existing "a

priori", i.e. before our human representation of it as thought. Bracken explains: "Existence, in the sense of lived human existence, involved and embedded in the world, is the necessary precedent and the enabling condition of thought" (6). In his famous "The phenomenology of perception", Merleau-Ponty (5) wrote of the human condition as fundamentally "being-in-the-world"; the mind exists as an "embodied" phenomenon, constructed by and engaged in the physical world of the body and society. These great thinkers (and their successors) have provided us with "a powerful antidote to the dominance of Cartesianism in the humanities and the human sciences" (6) – a new "philosophy of interpersonal relatedness" that resonates strongly with state-of-the-art research findings in the cognitive, developmental and evolutionary neurosciences.

THE SOCIAL BRAIN

The "social brain" concept originated in the fields of evolutionary biology, primatology and comparative neuroscience, but more recently has become a dominant theme throughout the cognitive and behavioural sciences. In an influential paper, Brothers described "the social brain" as the higher cognitive and affective systems in the brain that evolved as a result of increasingly complex social selective pressures (7). These systems underlie our ability to function as highly social animals and provide the substrate for intact social cognition, social behaviour and affective responsiveness.

Chance and Mead (8) were among the first to suggest that social dynamics might constitute the major driving force in hominid brain evolution. They stated that "the ascent of man has been due in part to a competition for social position" (8). Chance and Mead's insight was largely overlooked for the next two decades, although a handful of authors

such as Jolly (9) and Kummer (10) touched on the theme of social intelligence in their analyses of the social behaviour of lemurs and Hamadryas baboons respectively. According to primatologists Byrne and Whiten (11), it was Humphrey's essay "The social function of intellect" (12) that really ushered in the new field of study we now term "social cognitive neuroscience". Humphrey argued that social cohesion is fundamental to a context in which the transmission and learning of skills and knowledge necessary for survival can occur. And social cohesion within a group depends upon the possession of complex social cognitive skills by members of that group. Group dynamics are not static – they are often ambiguous and fluctuate constantly. Thus, in order to survive, group members need to be skilled in the arts of detection, interpretation and calculation of the relative benefits and costs of chosen behaviours.

The skills required to manage social relationships effectively are encompassed in the term "social cognition". Grady and Keightley (13) include the following functions within social cognition: face perception; emotional processing (including both perception of emotional information in the environment and regulation of mood); "theory of mind" (see below); and self-reference and working memory. As is common in the cognitive and behavioural sciences, a range of terminology has emerged in relation to the concept of social cognition. For example, in relation to apes' capacity to recognize or infer mental states in other individuals, Byrne and Whiten (14) have used the term "metarepresentation". As Brüne (15) puts it, one has "metarepresentations about the social world" and this in turn indicates the possession of "social metacognition". Drawing on the social machinations of Machiavelli's Prince, De Waal (16) introduced the term "Machiavellian intelligence" to describe the social and political behaviour of chimpanzees. Others have referred to "mentalizing" (17), "folk psychology" (18) and "the intentional stance" (19). The most familiar term within psychiatry is probably "theory of mind". This describes the assumption one makes during communication that another individual possesses a mind just like one's own. Theory of mind is the ability to attribute mental states to others and thus forms the very basis of social interaction and communication. Having theory of mind ability enables individuals to engage cognitively in the social arena. Thus it is a core aspect of social cognition.

Social cognitive skills develop in human infants according to a predictable pattern. Contemporary developmental psychologists such as Meltzoff, Gopnick and Trevarthen (20) argue that the child's sense of "self" and individual consciousness arises from a primary shared intersubjectivity between mother and infant. In her book "Friday's footprint: how society shapes the human mind", social brain pioneer Leslie Brothers (21) discusses the work of George Herbert Mead, who argued that "meanings… arise in social interaction" and that "self-consciousness arises in the process of social experience. The generalized attitude of others toward oneself becomes linked with the sensations of one's body, to produce the feelings of personal existence with which we are familiar". Thus, individual consciousness is derived from collective meanings and, following the Austrian philosopher Ludwig Wittgenstein, words and language only have meaning that is derived from the social context of which they are a part. If we focus on the development of mature social cognition and theory of mind ability in normal healthy children, it is generally accepted that this is achieved by four years of age (22). Avis and Harris (23) studied Baka pygmy children in Cameroon and concluded that this is reliable cross-culturally. However, Lillard (24) argues that, in terms of the actual manifestation of theory of mind, cultural variations do exist.

With functional imaging modalities such as positron emission tomography, single photon emission computed tomography, and functional magnetic resonance imaging, we are now able to identify the anatomical and functional neural basis for social cognition and theory of mind ability. We can therefore describe the geographical location of the "social brain". It turns out that the anatomy of the social brain is best understood in terms of a network of complex neural interconnections linking the prefrontal lobes to the temporal and parietal lobes of the brain. These networks are primarily cortical and they principally connect frontal and posterior cortical association regions to each other, but there are also vertical links connecting the superficial cortex to deeper and phylogenetically older structures of the brain such as the limbic system. When normal subjects are scanned performing social cognitive tasks (such as viewing facial expressions of emotion, performing theory of mind exercises or predicting intentions), a number of specific brain regions commonly activate. These include the dorsolateral prefrontal cortex, the orbitofrontal cortex, the anterior cingulate cortex, the amygdala, the superior temporal gyrus, and the parietal association cortex (25-29). The complex comprised of these regions and their interconnecting neural circuits can be defined "the social brain".

The discovery of so-called "mirror neurons" in the early 1990s provided an understanding of social cognition at a cellular level. First located in Broca's area of the prefrontal cortex in macaques (30), mirror neurons have since been identified in Broca's area, the premotor cortex, the superior temporal sulcus and the posterior parietal cortex in humans (31-33). Mirror neurons activate when the subject observes goal-directed action in another individual. Thus they serve to mirror or simulate observed intentional actions within the motor cortex of the observer – they internally "represent" an action (31,34). Other mirror neurons represent stimuli in non-visual modalities – for example "audiovisual mirror neurons" that activate in response to auditory signals of intended action (35,36). It has been argued that this mirror neuron system forms the basis for a "shared manifold" of interpersonal experience (37,38), and it has been proposed that it provides a basis for human empathy (39) or the "experiential understanding of the

emotions of others" (40). Thus, in the mirror neuron system we have an embedded mechanism for actively engaging in and responding to interpersonal stimuli emanating from the social world in which we exist. Not surprisingly, this system is located within the anatomical region we have termed "the social brain".

SCHIZOPHRENIA AND THE SOCIAL BRAIN

The "social brain" is a useful concept in describing the clinical manifestations and biological basis of a wide spectrum of psychopathology. There is good evidence for social brain dysfunction in a variety of mental disorders, both psychotic and neurotic in nature. For example, autism has long been conceived as a social brain disorder (41,42). In my view, this is in part due to the historical focus on social dysfunction in autism, while in schizophrenia clinicians have always tended to become distracted by the more "flamboyant" disturbances such as delusions and hallucinations. However, abnormalities of social cognition and theory of mind ability have also been demonstrated in bipolar disorder (43,44), psychopathy (45) and dementia (46). These findings have led Brüne (47) to assert that the entire spectrum of functional psychoses, and perhaps all forms of psychopathology, should be regarded as "social brain disorders". However, psychosis, and perhaps classic schizophrenia in particular, represents the "ultimate" or "arch" social brain disorder. In fact, it is in schizophrenia that we encounter a disturbance of mind that epitomizes dysfunction in every sphere of social cognition and behaviour.

Constructs of schizophrenia have for a long time been dominated by a focus on symptoms such as auditory hallucinations, delusions and disorganised thoughts and behaviour. These so-called "positive symptoms", however, are by no means unique to schizophrenia – most clinicians have encountered all of these disturbances in patients suffering from mood disorders, dementias, dissociative disorders and substance-related syndromes. Furthermore, within that protean collection of clinical presentations we consider to be schizophrenia, we encounter significant variation in "positive" phenomenology. These disconcerting facts have led a number of authors to return to Bleuler's work in an effort to identify the core characteristic of schizophrenia. Bleuler (48) believed that schizophrenia "is characterised by a specific kind of alteration of thinking and feeling, and of the relations with the outer world that occur nowhere else". Underneath the often obvious but also varied symptoms such as hallucinations and delusions, there existed, he argued, a less obvious inner unity. He characterized this unity in terms of four "basic symptoms": disturbances of association, ambivalence, affective disturbance, and autism.

Bleuler used the term "autism" to describe detachment from outer reality and immersion in inner life. Minkowski later viewed schizophrenia as a rupture between intellect and intuition – the former "associated with analysis and abstract reason" and the latter "based on ... the vitality and temporal dynamism of experience as it is actually lived". This leads to a loss of the "primal sense of vitality or vital connectedness with the world, often accompanied by a hypertrophy of intellectual tendencies" (48). Sass and Parnas (49) have recently described two basic schizophrenic phenomena: "diminished self-affection", which is a diminished sense of basic self-presence or "implicit sense of existing as a vital and self-possessed subject of awareness"; and "hyperreflexivity", which is an "exaggerated self-consciousness" that leads to externalised objectification of the self. Blankenburg's "loss of natural self-evidence" (50) and Kimura's dominance of the "noematic" ("thinking") self over the "noetic" ("existing") self (51) can be considered descriptions of the same process.

If we reflect on Merleau-Ponty's concept of the mind as an "embodied" phenomenon, constructed by and engaged in the physical world of the body and society (5), we can see the way in which all the above viewpoints coincide. Schizophrenia represents an alienation from the embodied self and world: a detachment from Minkowski's "primal sense of vitality"; a loss of Blankenburg's "natural self-evidence"; and a detachment from Kimura's "noetic" sense of being an embodied presence in the world. One might therefore conclude that the weight of 20th century phenomenological efforts to capture the essential disturbance of schizophrenia supports the idea that the basic problem faced by these patients relates to their sense of detachment and disembodiment from "social self" and "social world".

Several studies have consistently reported abnormalities in a wide range of social cognition tasks in schizophrenia. For example, impaired judgement of the direction of eye gaze (52); altered face processing, both in the processing of neutral faces (53) and in the perception of emotional expressions on faces (54,55); and deficits in response and conflict-monitoring (56,57). Theory of mind abnormalities have also been demonstrated in patients using a range of experiments which reveal their difficulty in attributing mental states and detecting deception and false beliefs (58-60). Brüne (61) argues that these emotion recognition problems are trait- rather than state-dependent, citing well-replicated research (54,62) which suggests that social cognition problems are enduring "deficits" that characterize the disorder itself. A first episode study by Edwards et al (63) found early manifestations of emotion recognition deficits, indicating that social brain problems might even precede the onset of the disorder.

Structural and functional imaging studies situate social cognition and theory of mind deficits in schizophrenia within a connected network of prefrontal, temporal and parietal association areas. Structures implicated include the dorsolateral prefrontal cortex (64,65), the orbitofrontal cortex (66), the superior temporal gyrus (65,67), the amygdala (68), the anterior cingulate cortex (57) and the inferior parietal cortex (66,69). Given the role of the mirror neuron system in social cognition, it is not surprising that mirror

neuron abnormalities are now being detected in schizophrenia (70,71) and this is likely to represent an important domain for future research (72). We may therefore conclude that the primary cognitive deficits in schizophrenia lie within the domain of social cognition, while the primary structural and functional abnormalities are located within the distributed cortical networks of the social brain.

Finally, recent research suggests that there are specific abnormalities in the structural integrity of the white matter tracts that connect prefrontal and temporo-parietal cortices (73). These findings support the hypothesis that schizophrenia is a disorder of functional and structural connectivity linking different regions of the cortex to each other and to deeper subcortical structures of the brain (74,75). Since these networks delineate the exact framework of the social brain in humans, I maintain that this maladaptive disorder can be rightly regarded as a costly by-product of social brain evolution in Homo sapiens. We are a species highly adapted and attuned to a complex social world. In schizophrenia, we encounter a disorder of this evolved social brain network. Thus, individuals with this disease find themselves seriously disadvantaged in the social arena, unable to correctly read and respond to social signals, and vulnerable to the stresses of their complex social environments. This state of "disembodiment" and interpersonal alienation is the core phenomenon of schizophrenia and the root cause of intolerable suffering in the lives of those affected.

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Recent developments in the theory of dissociation

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Although the construct of dissociation was introduced into psychiatry at the end of the 19th century by Pierre Janet, the term still lacks a coherent conceptualization, which is partially reflected by differences in the classification of dissociative and conversion disorders in ICD-10 and DSM-IV. Given the clinical significance of dissociative psychopathology in numerous clinical conditions, it is very valuable that various efforts have been made to refine and to specify current conceptualizations in recent years. The most promising and convincing approaches converge in subdividing dissociation into qualitatively different types, i.e. pathological versus non-pathological dissociation, and "detachment" versus "compartmentalization". We review these concepts and discuss their scientific and clinical potential as well as their limitations.

Key words: Pathological dissociation, detachment, compartmentalization, classification

Dissociation is the core feature of the dissociative disorders (1-3). Furthermore, dissociative experiences are among the diagnostic criteria for acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) as well as borderline personality disorder (1,4-6). Moreover, dissociative psychopathology is found in a wide variety of mental disorders (e.g., schizophrenia, affective disorders, obsessive-compulsive disorder and somatoform disorders) and has been associated with distinct personality traits (7-13). It has been linked to traumatic experiences (4,14,15) and seems to be an important predictor for poor treatment response and high relapse rates, at least in patients with panic and obsessive-compulsive disorders (16,17).

Despite the recognized clinical significance of dissociation, there is an ongoing controversy about its conceptualization. The notion that it "lacks a single, coherent referent … that all investigators in the field embrace" (18) is reflected by differences in the definition and classification of dissociative disorders in the ICD-10 and the DSM-IV. While the latter characterizes dissociation as "disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (1), the former defines it as "partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements" (2). In sum, both classification systems agree that dissociation relates to the (autobiographical) memory system, consciousness and the domain of personal identity. However, the ICD-10 acknowledges that it also may involve the sensory and motor systems, leading to symptoms which are subsumed under the term of conversion. In contrast, the DSM-IV restricts dissociation to the level of psychic functions and systems. Consequently, conversion disorders are one among the somatoform disorders in the DSM-IV, while the ICD-10 claims that dissociative and conversion disorders represent one category that is independent from the somatoform disorders.

Beyond this "academic" controversy, the clinical utility of both the ICD-10 and the DSM-IV classifications of dissociative disorders has been called into question. For example, in a large North American study with 11,292 general psychiatric patients, 57% of those with a dissociative disorder were classified as "atypical" because their symptomatology did not correspond well to any of the dissociative disorder types mentioned in the DSM (19). Correspondingly, in a subgroup of general psychiatric patients with clinically relevant levels of dissociation, 60% warranted the "catch-all" diagnosis of "dissociative disorders not otherwise specified" (DDNOS) (20). Similar discomfort with the classification has been reported from non-Western countries, e.g. India and Uganda (21,22). In India, 90% of outpatients with a dissociative disorder were assigned to the subcategory DDNOS (23). Thus, it is not surprising that several authors have proposed additional diagnostic categories within the dissociative disorders (24). For example, clinicians from India suggested the diagnosis of "brief dissociative stupor", which is somewhat similar to the North American proposal of a "dissociative trance disorder" (25,26), that might also encompass the transculturally important syndrome of possession states (27).

In any way, these inconsistencies between ICD-10, DSM-IV and clinical reality not only illustrate the confusion surrounding the complex issue of dissociation, but may also serve to perpetuate it (28). Fortunately, both clinicians and researchers have become more and more aware of the semantic openness of the term dissociation and its arguably too all-encompassing definitions (18,28). Various efforts have been made to refine and specify current conceptualizations, and all of them converge in subdividing dissociation into qualitatively different forms. For the purpose of this article, we will briefly review and discuss the most promising and convincing approaches, i.e. the distinction between pathological and non-pathological dissociation, and the proposal to separate "detachment" from "compartmentalization" within the domain of dissociation.

PATHOLOGICAL DISSOCIATION

It was Pierre Janet, at the end of the 19th century, who systematically elaborated on the concept of dissociation

(29), which he viewed as a discontinuous phenomenon that is only seen in individuals with mental disorders, particularly hysteria, and is absent in healthy people (30). In contrast, his contemporaries William James (31) and Morton Prince (32) and later investigators (33,34) have conceptualized dissociation as a dimensional process existing along a continuum from normal and relatively common dissociative experiences such as daydreaming to severe and clinically relevant forms such as the dissociative disorders.

Until recently, this so-called "dissociative continuum" has been one of the prevalent key principles in the field of dissociation (33,34). However, the controversy about whether dissociation represents a dimensional or typological construct has re-emerged (8). A sophisticated taxometric analysis of the Dissociative Experiences Scale (DES), the most widely used self-report measure of dissociation (35,36), empirically validated the distinction between a dimensional, non-pathological type and a discontinuous, pathological class of dissociation (37). This pathological dissociation can be identified by a subset of eight items of the DES, the so-called "DES-Taxon" (DES-T). These items mainly assess depersonalization (e.g., the feeling that one's own body does not belong to oneself) and derealization (e.g., the feeling as if other people, objects, and the world around are not real). Although scores on the DES-T are numerically continuous, the underlying factor is class-like rather than trait-like and represents a distinct taxonic category to which an individual either belongs to or does not. The biometric structure of pathological dissociation was replicated in a large general population sample (38).

The prevalence of pathological dissociation in the general population of North America was estimated to range between 2 and 3.3% (38,39). European studies reported prevalence rates of 0.3% for a non-clinical population and between 1.8 and 2.9% for student samples (40,41). In randomly selected psychiatric inpatients, the prevalence of pathological dissociation was found to range between 5.4 and 12.7% (40,41). Specific diagnostic groups display higher frequencies: in women with eating disorders, the prevalence of pathological dissociation varied between 4.8 and 48.6%, depending on the type of eating disorder, with binge-purge anorexia showing the highest and binge eating disorder the lowest prevalence (41,42). Sixty-four percent of patients with depersonalization disorder (DPD) showed pathological dissociation (43).

Although the link between taxonic membership and clinical diagnoses, particularly those of dissociative disorders, is still a matter of intense debate (40,43,44), it was suggested that subjects with pathological dissociation qualify for the diagnoses of dissociative disorder (37), PTSD or, to a lesser extent, schizophrenia (38). These findings have been called into question by other researchers (8,40,43,45), and it has already been noted that pathological dissociation is frequent in eating disorders (42) and personality disorders (41,46). Moreover, Putnam et al (1996) reported that high dissociating subjects are distributed across all diagnostic groups.

The relationship between demographic variables and pathological dissociation remains inconclusive. While some studies found that pathological dissociation seems to be more frequent in younger individuals (38,39,41,47), there was no such association in DPD patients (43). The majority of studies have failed to find gender differences in pathological dissociation (38,43,47,48); in contrast, one investigation found an association of DES-T scores with male gender (39). With respect to the marital status, subjects with pathological dissociation tend to be singles (39,41).

Although most researchers agree that the pathological dissociation taxon is a useful tool (42,43), its clinical and scientific value might be reduced by methodological problems. Initially, it was recommended to assign subjects to the taxonic class by a complex statistical procedure (38). However, other investigations (39,42) relied on dimensional threshold values (e.g., 20 or 30), while others (38) argued against the uncritical use of rigid cut-off scores. Thus, results of the different studies are difficult to compare and, consequently, future research is needed to establish a generally acceptable method for empirically defining pathological dissociation. Another methodological issue relates to the temporal stability of both the dimensional DES-T scores and the categorical taxon membership, which was found to be low over a two-month period (49), underscoring the limitations of cross-sectional designs when studying pathological dissociation. In addition, there is still the unresolved matter of whether pathological dissociation is indeed a typological construct (43). Even more generally, its existence has been called into question (49). Future research is warranted to clarify these issues.

DETACHMENT AND COMPARTMENTALIZATION

Since there is no consistent agreement about precisely what dissociation "is", it was Cardena's valuable contribution to provide an elaborated and systematic overview of the various uses of the term (18). He described dissociation in three distinct ways: as a lack of integration of mental modules or systems, as an altered state of consciousness, and as a defense mechanism. While the third category largely reflects the function of the other two, the first and second category qualitatively differ from each other. The majority of recent conceptualizations converge on this dichotomy, and it has been suggested to label these two types of dissociation as "compartmentalization" and "detachment" (28,50).

Compartmentalization is characterized by a partial or even complete failure to deliberately control processes and take actions that can normally be influenced by an act of volition, e.g. an inability to bring usually accessible information into conscious awareness. It is constitutive for this category that the "compartmentalized" processes, information and functions continue to "work" normally (apart from that they are inaccessible to volitional control); thus, they keep influencing emotion, cognition and behavior.

Clinically, the manifestations of compartmentalization comprise dissociative amnesia and conversion symptoms, possibly even other instances of the so-called "somato-form dissociation" (51).

In contrast, detachment is defined by the subjective experience of an altered state of consciousness characterized by "alienation" of oneself or the external world. During these altered states, there is often an absence or flattening of emotional experiences. On a descriptive level, detachment becomes evident as derealization and/or depersonalization, e.g. out-of-body experiences. These phenomena have been associated with trauma and PTSD, and detachment shares numerous similarities with the concepts of peri-traumatic dissociation (i.e., dissociative experiences during a traumatic event) and emotional numbing (28). It was even suggested that intrusive memories and flashbacks may be explained by peri-traumatic detachment: the altered state of consciousness characteristic for detachment may interfere with the encoding and consolidation of (traumatic) information, resulting in poorly integrated representations which themselves are considered vital in the development of intrusions (52).

Further evidence for the conceptually and phenomenologically convincing distinction between compartmentalization and detachment stems from clinical, psychometric and experimental research. For example, patients with disorders characterized by compartmentalization (e.g. somatization disorders) have been found to hardly display symptoms typical for detachment and vice versa (7,43,53,54). Furthermore, the majority of DES factor analytic studies (35,36) have consistently separated factors of depersonalization/derealization (i.e., detachment) and amnesia (representing the compartmentalization type of dissociation) (55). Finally, experimental research has indicated that detachment constitutes a specific mental state with a core neurophysiological profile characterized by the top-down inhibition of limbic emotional systems and an activation of the right prefrontal cortex (56). This kind of state serves the evolutionary function to minimize anxiety and to maintain behavioral control in the face of extreme threat. However, it is evident that such a state becomes very dysfunctional if triggered in the absence of threat or becomes a chronic condition. In contrast, compartmentalization has not been associated with a distinct neurophysiological profile.

Last, but certainly not least, the above outlined dichotomy is clinically meaningful and might even hold treatment implications (28). A prototypic example of the detachment form of dissociation would be DPD, whereas conversion disorder is conceived as a typical example of compartmentalization. PTSD is considered a clinical condition comprising both compartmentalization and detachment. With respect to therapeutic approaches, it has been argued that compartmentalization may be successfully treated by reactivation and reintegration of the compartmentalized elements using hypnosis, direct and indirect suggestions (e.g., to return to normal function in conversion disorder) and reliving procedures designed to access procedural repre-sentations about pre-morbid functioning (28,57). Because detachment represents a specific state of consciousness, therapeutic strategies need to focus on the identification of potential triggers, how to stop these triggers to induce detachment and finally, how to end it once triggered. Cognitive behavioral techniques, such as attention training, or elements of dialectical behavior therapy, such as skill training, might be beneficial for patients suffering from detachment (58,59). Certainly, future research is warranted to evaluate these treatment approaches.

Some critical aspects should also be outlined. It has been claimed that patients with somatization and conversion disorders, which are considered the clinical manifestations of compartmentalization, do usually not exhibit symptoms of detachment (7,54). However, numerous clinical studies have demonstrated high levels of dissociative experiences in patients with conversion disorders in general and those with psychogenic non-epileptic seizures (pseudoseizures) in particular (60-63). From a clinical point of view, it might even be difficult to draw the line correctly between detachment and compartmentalization. For example, a patient's experience of perceiving his environment as if he is looking through a tunnel might be interpreted as both derealization and conversion with a continuous transition (64). Another critical issue relates to dissociative amnesia, which is considered as representing compartmentalization in that there is a failure of volition to bring specific memories into conscious awareness (i.e., a retrieval deficit). However, in some cases detachment as an altered state of consciousness might interfere with the encoding and storage of information, particular in cases of traumatic material (28). Thus, dissociative amnesia might be due to either compartmentalization (i.e., retrieval failure) or to detachment (i.e., encoding and storage deficit) or even both. Again, it becomes obvious that it is not always easy to disentangle the proposed types of dissociation.

CONCLUSIONS

Despite its clinical importance, dissociation represents a semantically open term leading to conceptual confusions which – in turn – might restrict its value. Thus, it is fortunate that recent developments have attempted to refine current conceptualizations. These approaches converge in subdividing dissociation into qualitatively distinct types, i.e. pathological versus non-pathological dissociation and detachment versus compartmentalization. However, the scientific and clinical value of these promising refinements of the dissociation theory remains to be proven.

Future research will need to focus on the following issues: a) further elaboration of the theoretical conceptualization; b) empirical validation of the emerging concepts; c) applying the concepts to clinical questions, in particular to aspects of classification, differential diagnosis, pathogenetic mechanisms and therapeutic relevance, possibly

from a transcultural perspective; d) evaluation of the concepts' utility for other domains involving dissociation, e.g. ASD, PTSD or borderline personality disorder.

Considering the unique history of the dissociation theory, with a first peak of interest in the last two decades of the 19th century followed by a decline at the beginning of the 20th century and a resurgence since the 1970s (34), we are confident that the recent developments in the field will help to further establish the importance of dissociation in psychiatry, psychotherapy and psychosomatic medicine.

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Forensic psychiatry: contemporary scope, challenges and controversies

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Forensic psychiatry is the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law, and with the flow of mentally disordered offenders along a continuum of social systems. Modern forensic psychiatry has benefited from four key developments: the evolution in the understanding and appreciation of the relationship between mental illness and criminality; the evolution of the legal tests to define legal insanity; the new methodologies for the treatment of mental conditions providing alternatives to custodial care; and the changes in attitudes and perceptions of mental illness among the public. This paper reviews the current scope of forensic psychiatry and the ethical dilemmas that this subspecialty is facing worldwide.

Key words: Forensic psychiatry, mental health legislation, mental health services, ethical controversies

From an obscure and small group of psychiatrists who dedicated their efforts to the study of mental conditions among prisoners and their treatment, and who occasionally would appear in courts of law, forensic psychiatrists have now developed into an established and recognized group of super-specialists, an influential group that is transforming the practice of psychiatry and that has made deep incursions into the workings of the law. This status has not come without misgivings about the basic identity of forensic psychiatry and concerns about its utility and its ethics.

Modern forensic psychiatry has benefited from four key developments: the evolution in the medico-legal understanding and appreciation of the relationship between mental illness and criminality; the evolution of the legal tests to define legal insanity; the new methodologies for the treatment of mental conditions that provide alternatives to custodial care; and the changes in public attitudes and perceptions about mental conditions in general. These four moments underlie the expansion recently seen in forensic psychiatry from issues entirely related to criminal prosecutions and the treatment of mentally ill offenders to many other fields of law and mental health policy.

SCOPE AND CHALLENGES

The subspecialty of forensic psychiatry is commonly defined as "the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law" (1). This definition, however, is somewhat restrictive, in that a good portion of the work in forensic psychiatry is to help the mentally ill in trouble with the law to navigate three completely inimical social systems: mental health, justice and correctional. The definition, therefore, should be modified to read "the branch of psychiatry that deals with issues arising in the interface between psychiatry and the law, and with the flow of mentally disordered offenders along a continuum of social systems". Forensic psychiatry deals with issues at the interface of penal or criminal law as well as with matters arising in evaluations on civil law cases and in the development and application of mental health legislation.

Penal law

Worldwide, a wider understanding of the relationship between mental states and crime has led to an increased utilization of forensic experts in courts of law at different levels of legal action.

On entering into the legal system, three major areas need consideration: fitness to stand trial, insanity regulations and dangerousness applications. The major developments on the issue of fitness to stand trial pertain to rulings that defenders found not fit to stand trial are sent to psychiatric facilities, with the expectation that their compe-

tence to be tried is to be restored: the question for clinicians revolves on what parameters to use to predict restorability of competence, which should be based on an adequate response to treatment (2). Insanity regulations pertain to legal tests used to decide whether the impact of mental illness on competence to understand or appreciate the nature of a crime could be used to declare an offender "not criminally responsible because of a mental condition", "not guilty by reasons of insanity" or any other wording used in different countries. Applications to declare a person a "dangerous offender" usually demand a high level of expertise on the part of forensic experts, who are expected to provide courts with technical and scientific information on risk assessment and prediction of future violence.

Once an offender has been adjudicated, a major task for forensic psychiatrists is to gauge the level of systems interface in relation to different types of receiving and treating institutions. Hospitals for the criminally insane, mental hospitals for the civilly committed patients, penitentiary hospitals for mentally ill inmates, as well as hospital wings in local jails, are all part of the mental health system, and their interdependency has to be acknowledged for purposes of system integration and budgeting (3). How mental patients are managed in prisons is also a major matter of concern. Table 1 shows some of the currently available alternatives.

Finally, on exit from the legal-correc-

tional system, forensic psychiatrists are expected to provide expert knowledge on matters such as readiness for parole, predictions of recidivism, commitment legislation applicable to exiting offenders, and the phenomenon of double revolving doors for the mentally ill in prisons and hospitals.

Civil law

Psychiatrists and other mental health specialists are often required to conduct assessments with a view to determine the presence of mental or emotional problems in one of the parties. These types of assessments are needed in multiple situations, ranging from examinations to specify the impact of injuries on a third party involved in a motor vehicle accident, to evaluations of the capacity to write a will or to enter into contracts, to psychological autopsies in order to assess testamentary capacity in suicidal cases or sudden death, or evaluations for fitness to work and, of late in many countries, evaluations to determine access to benefits contemplated in disability insurance. In most of these situations, the issue at hand is a determination of capacity and competence to perform some function, or the evaluation of autonomous decision making by impaired persons. A determination of incapacity leading to a finding of incompetence becomes a matter of social control that is used to legitimize the application of social strictures on a particular individual. This imposes on clinicians an increased ethical duty to make sure that their decisions have been thoroughly based on the best available clinical evidence.

Ordinarily, there is a presumption of capacity and, hence, that a particular person is competent. A person is assumed to be competent to make decisions, unless proven otherwise (4). The presence of a major mental or physical condition does not in and of itself produce incapacity in general or for specific functions. In addition, despite the presence of a condition that may affect capacity, a person may still be competent to carry out some functions, mostly because the capacity may fluctuate from time to time, and because competence is not an all or none concept, but it is tied to the specific decision or function to be accomplished. In addition, a finding of incapacity should be time-limited; that is, it will have to be reviewed from time to time. For example, a stroke may have rendered a person incapacitated to drive a motor vehicle and hence the person will be deemed incompetent to drive, but the person could still have the capacity and be competent to enter into contracts or to manage personal financial affairs. With time and proper rehabilitation, the person may be able to regain capacity and competence to drive. Ordinarily, a person has to consent to an assessment of incapacity or a legal order has to be obtained to make the person cooperate to the assessment or to proceed to collect information otherwise. It is advisable to use a screening test of capacity and to do a full assessment only if the person fails the screening test. This will prevent imposing an onerous burden on the person subject of the assessment if the screening test is easily passed.

Mental health legislation and systems

The double revolving door phenomenon, whereby mental patients circulate between mental institutions and prisons, has made forensic psychiatrists deeply aware of the interactions in the mental health system and the links between this system and the justice and correctional systems. By virtue of their involvement in legal matters, forensic psychiatrists have developed a major interest in the drafting and application of mental health legislation, especially on the issues of involuntary commitment, that in many countries is based on determination of dangerousness as opposed to just need for treatment, of management of mentally ill offenders and of legal protections for incompetent persons (5). Given that one major area of their expertise is the assessment of violence and the possibility of future violent behaviour, forensic psychiatrists are usually called upon to make decisions on risk posed by violent civilly committed patients.

There is a close interaction between legislation, development of adequate mental health systems and delivery of care, whether in institutions or in the community. Mental health legislation with overly restrictive commitment clauses even for short-term commitment, deinstitutionalization resulting from the closure of old mental hospitals, changes in health care delivery systems towards short admissions to general psychiatric units and subsequent treatment in the community, and the large number of mental patients that end up in jails, have created in many countries a sense that the mental health system is adrift. The growth of forensic psychiatry may be due to changes in the

Table 1 Models for the delivery of mental health care to mentally disordered offenders

Ambulatory treatment within prison
Mental patients remain with other inmates in the regular cells and tiers of the prison and come for visits to the infirmary during psychiatric clinic

Special wing within the prison
Mental patients are transferred to this wing for the duration of the episode or duration of their incarceration

Specialized security hospitals (penitentiary hospitals)
Mental patients or those with special criminal pathology such as sexual offenders are transferred out to these hospitals, usually for the duration of their incarceration

Contractual arrangements with outside psychiatric facilities
Mental patients are transferred out to these hospitals or psychiatric units for the duration of the episode

Forensic community corrections
Every effort is made to prevent that mental patients enter the prison system or, if released from prison, to ensure that they not go back

law and to a more liberal acceptance of psychiatric explanations of behaviour, but a more immediate reason is the large number of mental patients in forensic facilities, jails, prisons, and penitentiaries. Failures of the general mental health system may, therefore, be at the root of the growing importance of forensic psychiatry (6).

One reason that has been most commonly advanced to explain the large number of mental patients surfacing in the justice/correctional system is the policy of deinstitutionalization that governments have implemented over the past fifty years. In general, deinstitutionalization refers to legislative decisions to close large mental hospitals and resettle patients into the community, providing short admissions to general hospital psychiatric units, outpatient treatment options, psychosocial rehabilitation, alternative housing and other community services. Sometimes, however, these decisions did not respond to any planning, or any assessment of the needs of those patients that were going to be resettled, or deinstitutionalized. Neither was there a clear idea about the nature of services to be provided, or the characteristics of the communities where patients were going to be relocated. The decisions, therefore, were mostly made on rhetorical and political beliefs, rather than on proper scientific reasoning.

The idea and policies of deinstitutionalization have been both praised and vilified. To some, deinstitutionalization is an enlightened, progressive and humane set of policies that has placed the needs of the mentally ill front and centre in many communities. In this regard, deinstitutionalization has been very effective. Deinstitutionalization should be credited with an increase in the involvement of patients in their own care and rehabilitation, it has raised questions that challenge the therapeutic nihilism rampant in a previous era, it has increased the visibility of mental patients in the community and in general hospitals and academic centres, it has allowed for a better understanding of the disease process which, previously, had been distorted by the negative effects of prolonged institutionalization, it has provided an impetus

for research and learning, and it has increased awareness of the human and civil rights of mental patients.

On the other hand, deinstitutionalization has also been credited with a host of negative effects. Legally, along with legal activism, deinstitutionalization has been blamed for giving impulse to litigation and costly over-legalization and over-regulation of psychiatric practice (7). Socially, a series of pernicious effects have impacted directly on the fate of the mentally ill in the community. These have included reports of "revolving door patients" (those patients in need of repeated and frequent admissions) (8), and the rise among the homeless populations in that at least 30% among them are chronically mentally ill persons (9). Even when housing is available, it is often in rundown tenements in inner cities or psychiatric ghettos of large urban centres, where dispossessed and confused mental patients walk about in a daze talking to themselves, and where they are easy victims of robbery, rape, abuse, and physical violence. Some simply die of exposure in the streets in frigid winter nights (10). Deinstitutionalization has also been blamed for the criminalization (11) and the transmigration of mental patients from the mental health system to the justice/correctional system and for violent behaviour displayed by some mental patients in the community.

The most pointed criticisms to deinstitutionalization, however, are no longer aimed at the idea of resettling the patients back into their communities, but about how the idea has been implemented. Whether because of financial constraints or shortsighted administrations, the fact is that, in many communities, mental hospitals have been emptied faster than the development of adequate community resources and community alternatives as they were envisioned in the original policies.

These unfortunate after-effects of deinstitutionalization should be counteracted with the realization that treatment alternatives to custodial care exist in the form of better medications with enhanced efficacy and effectiveness, that are becoming widely available, and

psychosocial treatment strategies, that are also providing new proven ways for management of mentally ill persons in the community (12). In this respect, the development of mental health courts in some countries, diversion alternatives to imprisonment, assertive community treatment and intense case management modalities, as well as the use of community treatment orders (13), along with better policies in housing, point toward a social move to resolve the inequities of deinstitutionalization in order to stabilize community tenure for the mentally ill. At the same time, evaluations of anti-stigma programs seem to indicate that some of these initiatives are helping in changing public attitudes toward mental illness (14) and increasing awareness about the human rights issues in the treatment and management of the mentally ill in many countries (15,16).

ETHICAL CONTROVERSIES

Because of its dual role in medicine and in law, the practice of forensic psychiatry is fraught with ethical dilemmas worldwide. A forensic psychiatrist is first of all a clinician with theoretical and practical knowledge of general psychiatry and forensic psychiatry, and experience in making rational decisions from a clearly stated scientific base. In law, forensic psychiatrists must know the legal definitions, the legal policies and procedures, the legal precedents relating to the question or case at hand (17). Forensic psychiatrists must have knowledge of courtroom activity and must possess an ability to communicate their findings clearly and to the point and to do so under the difficult situation of cross examination. The double knowledge in psychiatry and law defines the subspecialty of forensic psychiatry and provides the ethical foundations for its practitioners. This double knowledge should be reflected from the very beginning in the way the forensic psychiatrist first agrees to get involved in an evaluation, the way the forensic psychiatrist approaches the person to be evaluated, and the

caveats that have to be provided. At this stage, the most important issue for the forensic psychiatrist is to make sure that the person subject of the evaluation is not misled into believing that, because the psychiatrist is a medical doctor, the relationship to be unfolded is one of physician-patient, in which the doctor is expected to do the best for the patient and always to act to maximize the patient's benefit, while reassuring the patient that privacy and confidentiality are protected. In forensic psychiatry the relationship is one of evaluation, where the foundation of neutrality demanded from the evaluator, and the fact that the evaluator is in no position to reassure the person on matters of confidentiality or privacy (18), could mean that negative findings will endanger the interests and cause harm to the person being evaluated, regardless of this person's health and the evaluator being a physician. Because of this, forensic psychiatrists may even be implicated in the criminalization of mentally ill persons (19).

To some commentators, the social control role of forensic psychiatrists sets them apart from the ethics of medicine and of psychiatry (20,21). These commentators waver on whether in their legal work forensic psychiatrists are operating as physicians – a point of view that has led to much controversy. From inception to appearance in court, the forensic psychiatrist derives the authority to act from the fact of being once and foremost a physician, hence having to uphold the ethics of medicine, but the end point effects of forensic evaluations are usually at the hand of other parties. This imposes on forensic psychiatrists an ethical obligation to scrutinize their motives and the motivations and possible final actions of those who hire them for evaluations, including ways on how data are obtained, how the evaluator arrives at opinions, how legal materials such as reports, memos, and expert evidence are prepared, and most importantly, what would be the final use of their findings.

A major controversy stemming from the double roles that forensic psychiatrists and other psychiatrists, such as those in the military, are called to fulfill relates to the use of psychiatric judicial hospitals in the Soviet Union and, more recently, in China, and psychiatrists' participation in interrogations of prisoners and detainees that could lead to allegations of torture, especially in the present climate of concern with terrorist activities (22). This includes turning over to interrogators confidential psychiatric material that could be used to pinpoint weaknesses and vulnerabilities of the prisoner (23), providing consultations on interrogation techniques or actively participating in deception techniques to gather intelligence (24). It is in this context that the end point motivations of those calling for evaluations cannot be lost on forensic psychiatrists or physicians in general. Participation on anything that could lead to torture will be a major trespass on the ethics of medicine. This also should be a clear reminder to forensic psychiatrists that medical ethical rules cannot be trespassed, no matter what the demands of the master (25).

CONCLUSIONS

We have identified four moments in the development of legal-psychiatric thinking. The first two moments – evolution in the understanding and appreciation of the relationship between mental illness and criminality, and consequent changes in the different tests of legal insanity – were applied to underline the increasing scope of forensic psychiatry in practically all areas of criminal law and in a large number of situations in civil law. The last two moments – new methodologies for the treatment of mental conditions that provide alternatives to custodial care, and changes of attitudes and perceptions of mental illness among the public – were applied to activities of forensic psychiatrists outside of courts of law. These activities range from the development and implementation of mental health legislation to how their knowledge of systems help mentally disordered offenders to navigate three inimical social systems and how they should be involved in the protection of human rights of mentally disordered offenders and the mentally ill in general.

On the matter of ethics, we have dealt with the controversies that the enlarged scope of action of forensic psychiatrists have created in the understanding of their social functions, from definitional problems to wavering about whose ethics they should abide by and on to the latest concerns about the use of clinical knowledge for purposes that should be completely out of their ethical boundaries.

Practitioners of forensic psychiatry have moved their specialty to a frontal role in society. They now have an obligation to make sure that they remain foremost physicians and that their ethics and motivations are beyond reproach and impeachment.

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Forensic psychiatry: a developing subspecialty

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Arboleda-Flórez's paper traverses the landscape of forensic psychiatry. He describes many of the roles of today's forensic psychiatrist, whose identity has stretched far beyond the usual expectations of a medical practitioner.

One of the issues canvassed in the paper is the dual agency of the forensic psychiatrist. The debate as to whether forensic psychiatrists are bound by medical ethics is drawing to a close. The cogent argument put forward by Arboleda-Flórez is that forensic psychiatrists have only reached their position of authority and acknowledged expertise by virtue of being medical practitioners and psychiatrists. If they move away from being medical practitioners, they lose that mantle of authority. It follows, therefore, that they must remain, firstly, psychiatrists, and therefore, they need to adhere to the principles of medical ethics.

The argument that forensic psychiatrists in some way breach medical ethics by assisting the court, thereby doing harm to one party or the other, is based on the ethical principle that doctors should not do harm. However, the ethical principle espoused does not require doctors to *never* do harm. There are competing ethical principles at stake when there is an imperative to do good.

Those principles are keenly tested in forensic psychiatry, whether in a custodial environment where advice may be given not to grant easing of security restrictions because of dangerousness, or in the courtroom when opinions are given that may indirectly result in conviction. The forensic psychiatrist sits in the often difficult position of having dual responsibilities: to community and to the individual. He or she endeavours to do the least harm and the maximum good.

Because those obligations sit neatly inside medical ethics, the WPA Section of Forensic Psychiatry is in the process of developing a range of consensus papers relating to the ethical practice of forensic psychiatry. The first set of papers will cover the areas of guidelines for independent medical examinations, policies for prison psychiatry, risk assessment, sexual violence and the status of functional magnetic resonance imaging in courts of law. In time, the Section will develop consensus guidelines, collaboratively within the profession, covering the entire range of forensic practice. Because there is constant shifting of areas of practice, those consensus papers will require "sunset" clauses to ensure they are reviewed and updated in a timely manner.

Another key area covered by Arboleda-Flórez's paper is the notion that forensic psychiatry has grown dramatically in scope, partly as a consequence of deinstitutionalization over the last 50 years. The emptying of asylums and move away from placing individuals in long-term psychiatric facilities has resulted in the well documented neglect of many people with disabling mental disorders. We now know that many of those individuals come into contact with the justice system, either for petty crime or more serious violent offences.

Forensic research (1-3) has been able to debunk the popular notion of three decades ago that there was no association between mental illness and violence. Unfortunately, even where governments have tried to put in place community-based services to replace what was provided in long-term facilities, such services are so expensive to provide that individuals with severe psychiatric problems still fall through the cracks and we have an over-representation of mentally disordered individuals in prisons around the globe. Arboleda-Flórez has identified the sense in many countries that the mental health system is adrift. As medical directors have decreasing decision-making powers in large health provider organizations increasingly managed by non-medical bureaucrats, resources are rationalized and patients with chronic mental illness are squeezed out of long-term care. Patients in such systems are often provided with the cheapest possible care, which means that their treatment is provided by the lowest paid person who can fulfil the role. When patients with treatment resistant illness relapse, often through a combination of non-compliance and drug abuse, there is frequently no facility available to admit them. When hospital bed numbers are reduced so far that inpatient units operate at 100% occupancy, under extreme pressure the system of care becomes clinically and economically inefficient (4).

In that environment, forensic psychiatry has emerged to pick up the pieces. As a consequence, it is attracting many enthusiastic and talented young psychiatric graduates to its ranks. Unfortunately, with a few exceptions, forensic psychiatry is not a recognized subspecialty in many countries. Psychiatrists are a scarce resource in Africa and Asia, especially, and general psychiatrists are small in number, let alone psychiatrists with specialized training in forensic work. Therefore, psychiatrists pick up their skills on the job. As a worldwide profession, there is a need for us to develop a curriculum for training forensic psychiatrists. There are some sophisticated training programmes in North America and Europe and the lead should come from those countries in assisting other psychiatric colleges to develop recognized training programmes in forensic psychiatry.

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Forensic psychiatry in dubious ascent

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In his review, Arboleda-Flórez describes modern forensic psychiatry as having benefited from several developments. I would like to add that the successful treatment of mentally ill offenders in catamnestic studies, measured by the recurrence rate of criminal behavior, has improved the reputation of forensic psychiatry, but has also increased the expectations placed upon it.

For example, in Germany, between 1970 and 1990, both the number of psychiatric beds was reduced from 117,596 to 70,570 and the number of patients being committed to forensic psychiatric hospitals based on the expectation of future offenses decreased from 4222 to 2489 (1), while the number of prisoners only slightly increased from 35,209 to 39,178 (2). Forensic psychiatry is generally attributed with greater competence with regard to prevention of criminal recidivism, even if studies comparing recidivism after release from forensic psychiatric hospitals with that after release from prisons are, at least, methodologically problematic, due to the uncontrollable selection effects (3). This is in line with the fact that elements of psychiatric and psychotherapeutic methods like cognitive therapy are used in programs (e.g., reasoning and rehabilitation, R&R) that are primarily directed at improving the legal prognosis and are applied in penal institutions (4). The attribution of higher competence is accompanied by the hitherto unfulfilled expectation that forensic psychiatry can decisively reduce the relapse rate in individuals with personality disorders, especially in offenders with dissocial personality disorders, as found in the international psychiatric classification systems, particularly the subgroup of "psychopaths" (5). There is a special need for therapy research in these patient groups that are rejected by many – even forensic – psychiatrists.

As Arboleda-Flórez so aptly states, forensic psychiatry is also attributed with special prognostic abilities in addition to therapeutic competence. However, this does not go so far within the specialty as to call upon forensic psychiatrists to routinely make decisions on the risks posed by violent civilly committed patients. There is hardly a European country that would delegate this task from general psychiatry to forensic psychiatry (6). However, risk assessment for legal prognostic questions has many methodological similarities to that dealing with the suicidality of prisoners (7).

The increased consultation of forensic psychiatry in this area reflects the interest of the competent agencies in reducing the generally much higher suicide rate in prisons and jails compared to the general population, which is considered to be a marker of the inadequate or even inhumane treatment in these institutions.

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The ethical implications of forensic psychiatry practice

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It is unquestionably true that forensic psychiatry has reached its coming of age and is now respected as one of the major subspecialties of psychiatry. However, some controversies still remain that challenge the value system underlying this subspecialty and question the way it is practiced. Actually, it has even been questioned whether the value system of forensic psychiatry to some extent contradicts that of psychiatry or medicine.

Probably the majority of forensic psychiatrists would find no objections in working for the prosecution in cases where their collaboration is going to increase the severity of the sentence, while some psychiatrists who do not practice in the forensic arena would find it cruel and inhuman. An example of this situation is the case of Andrea Yates (1), a woman suffering from schizoaffective disorder who, while on a delusional state, drowned her five children in her home bathtub in Houston. A group of the most distinguished forensic psychiatrists in the country were involved in the case, working either for the prosecution or the defense. Experts of both sides agreed on the diagnosis and on the fact that the defendant was clearly psychotic

at the time of the crime. The disagreements came when the criminal behaviour was analysed and different opinions were expressed about which part of the behaviour was to be considered rational or irrational. Andrea Yates surprisingly received a prison sentence for life. However, a court of appeals has ordered a new trial of the case.

The psychiatrist who worked for the prosecution was under a strong attack from the defense lawyers and had to acknowledge a mistake he made during his testimony (2). He was also criticized by legal scholars (3) and by psychiatrists questioning the legal system from a gender perspective (4,5). This emphasizes a problem that forensic practitioners increasingly have to deal with: the harassment by the different parties involved in the trial (6,7).

The problem is how we can reconcile forensic practice in situations like the Yates' case with the traditional values of the practice of medicine. Appelbaum (8) wrote that "psychiatrists operate outside the medical framework when they enter the forensic realm, and the ethical principles by which their behaviour is justified are simply not the same". The principles of beneficence and non-maleficence lose their primacy to the principle of truth and objectivity in the forensic setting. Probably forensic psychiatrists would lose their main "medical essence" if they just regarded objectivity as the supreme value. Therefore, respect for persons should be regarded as a second moral rule (9). This is an extension of the informed consent doctrine to the practice of forensic psychiatry. The evaluee should be aware of the implications of

the forensic assessment and that the information he is providing to the examiner may be used against him by the prosecution. It must be very clear that there is no obligation of confidentiality.

Thus, two main values should guide our practice: objectivity and respect for the person. But, can we consider that enough? Probably not. That would leave the forensic psychiatrists quite far from the core values of medicine. Is it possible for us to still feel we are members of the medical profession? Weinstock (10) refers to Candilis (11) in providing an answer to this question. According to these authors, each profession "has its own historical narrative and an internal set of duties, values and ideals, essential for professional identity and integrity". "The historical narrative anchors the profession in values that resist the vagaries of social and situational forces" (10). A narrow view can be held of forensic psychiatrist as an agent of the society and the court, but a broader view of professional integrity allows traditional physician-based values to influence the forensic role.

As Arboleda-Flórez illustrates in his paper, forensic psychiatry is far more than collaborating as an expert witness in a trial. Our specialty provides a body of knowledge and a methodology that helps to illuminate areas of practice where different value systems face each other. We have learnt to preserve our medical ethics, even when we work for the prosecution, as in the Andrea Yates' case. Even there we play our role as physicians, but also serving as professionals the values of our society.

Forensic psychiatry is a fascinating

specialty whose practitioners have to face continuous ethical challenges if they want to preserve the ethical heritage of the medical profession. The fact that we are immersed in an adversarial legal system should not make us feel pessimistic. Regardless of the side we are in, it is possible to preserve some of our traditional medical values.

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Psychiatry and torture

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I would like to add to Julio Arboleda-Flórez's excellent discussion of the problem of psychiatric participation in interrogations. There is considerable international support for asking psychiatrists

and other physicians not only to decline to participate in torture and related practices, but also to speak out vigorously against its use by governments.

While medical ethics surely disapproves such practices, they are also widely condemned in other quarters. For example, in its aspirational "Body

of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment", the United Nations General Assembly, after asserting that "no person under any form of detention or imprisonment shall be subject to torture or to cruel, inhuman, or degrading treatment or punishment",

adds in a note: "The term 'cruel, inhuman or degrading treatment or punishment' should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time" (1).

In addition, the Body of Principles requires that "no detained person while being interrogated shall be subject to violence, threats or methods of interrogation which impair his capacity of decision or his judgement" (1).

Psychiatrists are in a unique position to understand and communicate the importance of these principles and should denounce torture strongly in every possible venue. As Sagan and Jonsen (2) observed, because the medical skills used for healing can be maliciously perverted "with devastating effects on the spirit and the body", it is "incumbent upon the medical profession and upon all of its practitioners to protest in effective ways against torture as an instrument of political control". This is even more urgently true today than when it was written thirty years ago.

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Crime and mental illness: it is time to take action

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From a medical point of view, forensic psychiatry occupies a special position. It exists within a cultural, legal and institutional framework, and it is society, through legislation, that largely determines which persons at a given time and place will make up the forensic patient population. Moreover, the nature and extent of the offences committed by mentally abnormal persons will depend on the existing possibilities of treatment within general psychiatry, the prevailing treatment ideology and the resources available, as well as on the current social situation of the mentally abnormal person(s) in question.

During the last decades, the number of mentally ill offenders has increased in many countries. The number of inmates with severe mental illness is unacceptably high – many of the cases are not identified by the prison and probation system in most countries (1) – and high relative crime rates among mentally ill have been described in many studies (2,3).

Although deinstitutionalization possibly plays an important role in the criminalization of the mentally ill (4), this is not a simple relation and very much depends on how the process is being implemented. It must also be emphasized that mentally ill people are in great risk of violent victimisation, which should also be an important issue for the people who are treating them.

The role of the forensic psychiatrist has never been more crucial and many-sided. Forensic psychiatry today is not only forensic examinations and assessments. Handling and treatment of an increasing number of mentally ill inmates is a major challenge. The increasing numbers of mentally ill offenders is neither acceptable for the patients nor for the society and reflects the state and efficacy of the entire psychiatric treatment system in the specific region.

Some major challenges for today forensic psychiatry are: a) diversion (initiating and participating in diversion programs helping to identify mentally ill in the correctional system so they can have access to proper psychiatric treatment); b) assessment and treatment (improving and implementing risk assessment and relevant interventions in general as well as in forensic psychiatry and thereby improving monitoring and treatment of dangerousness); c) forensic research, providing the basis for an ongoing adaptation and adjustment of forensic services (epidemiological research should register any changes in the size and composition of the forensic patient population, it should try to throw light on the causes of fluctuations, and it should discuss and validate possibilities of taking relevant preventive measures and of improving treatment).

Three decades ago John Gunn (5) described the "stage army": "...and they move from hospital to prison, to doss house and back again like a stage army tramping round and round, making much greater impression than their numbers warrant simply because we have no facilities for them". The problem is that the "stage army" is now very numerous. The mentally ill criminals need intensive treatment and care as well and we have to prevent further increase in their numbers.

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Forensic psychiatry today: a Latin American view

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Forensic psychiatry in Latin America generally fits the description provided by Julio Arboleda-Flórez. However, the enormous heterogeneity of the region from the historical, political and economic viewpoints has determined a different development of the discipline in the various countries.

Regarding penal law, the widespread public concern about the issue of violence and criminality has generated a great interest in the development of objective criteria for risk assessment (1,2). However, a lot remains to be done in this area, because unfortunately most of the risk assessment is still carried out empirically, mainly on the basis of the examiner's own experience and expertise.

The issue of fitness to stand trial is not relevant to Latin American reality: in fact, this is a concept pertaining to common law, while Latin American countries follow the Roman juridical tradition (1). On the other hand, the issue of assessment of criminal competence (imputability) does not arouse significant controversy, as the legal tests adopted in Latin American countries are all quite similar and have not undergone major changes in the last decades. As a rule, the assessment consists of a cognitive prong and a volitive prong, like the American Law Institute's legal test (3).

Concerning civil law, the most common issues were traditionally the interdict of a mentally disordered, the assessment of the capacity to make a contract or a will, and the retrospective assessment of the validity of a will. Furthermore, psychiatric assessment in child custody trials was also greatly relevant. Currently, a variety of civil assessments (fitness to work, disability insurance, driving, etc.) are commonly required, which suggests an increasing complexity of social relations in the region. A further type of civil assessment which is now often carried out is that concerning tort proceedings: in these cases, the main issue is whether the plaintiff presents any mental disorder and whether this mental disorder bears a cause-effect relationship with the illicit act committed by the defendant (4). Mounting urban violence will certainly lead to an increase of legal actions related to post-traumatic stress disorder.

Arboleda-Flórez also addresses the issue of mental health legislation and systems. The Declaration of Caracas (5) has encouraged the countries of this continent to introduce changes in their mental health legislations which, depending on the social, economic, and political conditions of each country, have been modest or significant (6). All of them share the shift from a hospital-centered to a community-based model, but also the non-inclusion of forensic psychiatric hospitals in the psychiatric reform.

The total dissociation between correctional and public health systems represents one of the greatest problems of forensic psychiatric practice in Latin America. The double revolving door phenomenon is very common: a recent survey conducted in one of the largest forensic psychiatric hospitals in Brazil showed that approximately 55% of its population of 618 mentally disordered offenders had previously received inpatient psychiatric treatment in the public health system on account of the same disorder that had favoured the later offense (7). On the other hand, the average time of permanence of patients in forensic psychiatric facilities highly exceed their need, in part because the public mental health system is reluctant to accept these "dangerous" patients.

Another relevant aspect of the psychiatric reform has been the introduction of more rigid and complex rules for involuntary psychiatric hospitalization, which has resulted in a growing number of trials against psychiatrists, but also in a greater awareness by psychiatrists about the need to find a balance between Hippocratic paternalism – so ingrained in the Latin culture – and the principle of autonomy.

Finally, as pointed out by Arboleda-Flórez, the practice of forensic psychiatry is fraught with ethical dilemmas worldwide. In Latin America, most forensic assessments are carried out by professionals who are not experts in the field. Thus, the occurrence of ethical faults – due to technical ignorance more than to bad faith – is frequent. One of the commonest errors is failing to clarify to the person being examined that the relationship that is being established will not follow the traditional physician-patient relationship rules. This distinction, already difficult to understand for less educated people, becomes even less clear when the expert himself is unable to perceive it correctly.

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Forensic psychiatry: the African experience

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The practice of forensic psychiatry in Africa is shrouded in both mystery and confusion. Most of those who work in the field are likely to be self taught individuals who have been forced by time or misfortune to remain in the very poorly resourced mental institutions that characterize the African continent. Most mental hospitals in Africa are located in the "economic ghettos" of cities, and the forensic units are in turn located in the "ghettos" of these hospitals, in locations often termed maximum security units. Though located in hospitals, these units are practically extensions of prisons, only worse because they exist as "orphan" units that do not belong to either the medical or prison systems. In addition to the lack of adequate facilities, most countries have an average of one psychiatrist to a million. Those patients with the added need for forensic care have even less, and therefore for many people commitment to one of these units means a life sentence on a daily dose of chlorpromazine, carbamazepine and malnutrition.

A visit to many of these institutions leads to despair about the state of human rights and dignity in our continent. Those who are considered lucky are seen by a demoralized, poorly trained, and inadequately paid doctor who passes by the ward once every few weeks, to see only those patients who are most disturbed. For those who are of no trouble, there is no review. It is against this backdrop of great need that the rest of society is served in the field of forensic psychiatry in sub-Saharan Africa.

In civil law, medical and psychiatric reports are often written by general practitioners with little or no training in mental health who claim ability to measure novel (and idiosyncratic) concepts like "45% psychological damage" following a road traffic accident. Magistrates (and judges) have to make rulings on the basis of such "expert reports". In such cases, civil matters drag on for years in the absence of any meaningful communication between the law and doctors.

Most African countries do not have a mental health legislation. Among the others, some have outdated colonial versions that predate independence. Fewer have mental health policies and hardly any have specific budgets for mental health. In this hierarchy of disadvantage, civilly committed persons are at the bottom of the pecking order. Arboleda-Flórez seems to describe sub-Saharan Africa when he states "dispossessed and confused mental patients walk about in a daze talking to themselves". To complicate this near desperate picture is the near total absence of medical staff and medication. The 2006 World Health Report (1) states that, with 24% of the disease burden, Africa spends less than 3% of the global budget on health. Taking this disparity to forensic services, the plight of African people in their need assumes desperate dimensions.

Arboleda-Flórez, describing ethical controversies, states that "forensic psychiatrists must have knowledge of courtroom activity". For the African psychiatrist, one must add, "if one can hear what is going on". Many courtrooms in sub-Saharan Africa are but extensions of hot dusty market places, where those with nothing better to do congregate for the spectacle of watching the goings on. Cases involving psychiatric issues are of special interest to these noisy crowds. The lack of knowledge in mental health on the part of the cross examining lawyers transform many of these sessions into futile attempts at communicating. The sight of a psychiatrist in court is a matter of both curiosity and amusement for both the lawyers and the crowds, as both are eager to find out about the "crazy" world.

In many parts of sub-Saharan Africa, attempted suicide is a criminal offence. The African psychiatrist is often to be seen in the courtroom trying to explain to a packed court why a person who tried to kill himself should be taken to hospital and not to jail. Ironically, however, the same psychiatrists have used the threat of "reporting the patient to police" as a means of keeping the patient in hospital for full evaluation. At a similar though different level, most legal systems in Africa (except South Africa) treat homosexuality as a criminal matter, and being gay in these societies is taken as either evidence of insanity or, at the very best, a criminal offence. The psychiatrist living and working in these communities has the challenge of working with the beliefs and practices of his community, which may be at a variance with his own, and those of his professional training. Social, political and sometimes legal pressure is applied to make "medical" findings in the matter of sexual orientation.

The challenges and controversies captured by Arboleda-Flórez are real in the African context, exist in a more magnified form of seriousness, and range from matters of poor legal and policy frameworks, through problems of funding, but also embracing moral, sexual and ethical dimensions.

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Exploring evolving concepts and challenges in forensic psychiatry

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Arboleda-Flórez's paper covers a wide range of interesting and interconnected issues concerning the interface between law, criminality and psychiatry. The

scope and challenges of forensic psychiatry can be viewed from many vantage points, in which medical, legal and ethical issues coexist in the background of each country's cultural, sociopolitical and legal framework. Although it is often assumed that disciplines like law and medicine work in isolation from each other, this is a misconception. The primary function of law is to regulate human behavior in a given culture. The mental sciences on their part are also closely connected with human behavior. To grasp controversial concepts in these two fields, one should first view them historically and philosophically and then relate them to the present day scientific and legal framework. A philosophical view may not settle a debate about controversies in the field of forensic psychiatry, but it usually helps to clarify what underlying concepts are in dispute and what are the strengths and weaknesses of the arguments being used by either profession (1,2).

There have been a number of developments in recent years, which indicate closer research and professional interactions between the fields of law and psychiatry. On the other hand, there may be conflicts between lawyers and mental health professionals, due to differing philosophical and value orientations and governing paradigms. Understandably, professionals tend to view things from the perspective of their own field and in the context of their social roles, career and profession contingencies.

The ethical issues in forensic psychiatry are more complex and controversial than in general psychiatry. Forensic psychiatry, more than other disciplines, has been targeted as an area most in need to provide protection of patient's rights. In the field of forensic psychiatry, therefore, legal activism and media criticism have played a dominant role. The debate on these ethical issues has to keep pace with the growth of science, socioeconomic conditions and changing democratic processes.

One example of the above-mentioned ethical issues is that of the participation of forensic psychiatrists in a competency evaluation of a prisoner to be executed (3). Professional medical societies like the WPA have clearly rejected the direct participation of psychiatrists in capital punishment activities (4). However, there is no generally recognized ethical prescription against psychiatrists conducting pretrial competency, criminal responsibility or post-conviction sentencing evaluation.

Another important issue of interest to forensic psychiatry is that of stigma associated to mental illness. The implications of labels such as "lunatic" or "insane" used by legal experts and by courts are rarely taken into account. Social stigma surrounds mental illness globally and impinges on the human rights of the affected individuals.

In recent years, due to the increased awareness and the process of democratization, the judiciary system is becoming more penetrative also in developing countries, dealing with issues like the right to proper treatment and the right to refuse treatment. Moreover, there is an increasing resort to courts by individuals and groups seeking redress for their specific grievances as well as by those seeking broad reforms in such areas as the rights of children, women's rights, the rights of minorities and other social groups.

Arboleda-Flórez's paper is an important and provocative contribution to this evolving debate.

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Forensic psychiatric practice: worldwide similarities and differences

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As described by Arboleda-Flórez, forensic psychiatry has undergone many changes worldwide during the last decades. Forensic psychiatrists are nowadays widely accepted as high level professionals who are able to provide a competent opinion in difficult judicial situations. However, they are also facing ethical and professional difficulties in their everyday practice, especially when they have to address the conflicts between the patients' and public interests, or when they are under pressure by social control institutions to solve all the problems of patients' dangerous behaviour. These difficulties can be identified in forensic psychiatry practice all over the world.

Despite some similarities, there are however important differences in forensic psychiatry practice worldwide. First, in many countries forensic psychiatry is not identified as a distinct subspecialty. Second, even where it is, there are huge variations in the duration of training and in the curriculum. Third, the differences in judicial practice worldwide do not allow the development of unified standards in forensic psychiatry practice. Fourth, there are huge differences from one country to another in the range of forensic psychiatry services available and in the modalities these services are utilized.

In Bulgaria, education in forensic psychiatry has been introduced in the curriculum of medical students and of gen-

eral practitioners. Those specializing in general psychiatry have a three-month training in forensic psychiatry. There is a subspecialization in forensic psychiatry whose duration is two years. Forensic psychiatry services include specialized high security units, general medium security units and outpatient low security services. Among the problems we are facing at the moment are the scarcity of outpatient services for the resocialization of patients, the need for continuing medical education of expert psychiatrists, and the lack of a structured education in forensic psychiatry for lawyers.

We believe that the WPA can play a significant role in promoting an international consensus on the basic terminology in forensic psychiatry, the core forensic psychiatry subspecialty curriculum, and the services which should be available for forensic psychiatry practice in high-, medium- and low-income countries.

Treatment of patients with first-episode psychosis: two-year outcome data from the Danish National Schizophrenia Project

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First episode psychosis interventions have been in focus in the last two decades in an attempt to improve the course and outcome of schizophrenic disorders. The Danish National Schizophrenia Project began in 1997 its intake of patients, aged 16-35, with a first psychotic episode of a schizophrenic spectrum disorder, diagnosed by ICD-10 (F20-29). The study was carried out as a prospective, longitudinal, multicentre investigation, encompassing 16 centres, spread all over the country. The sample consists of 562 patients consecutively diagnosed during two years. Patients were treated with "supportive psychodynamic psychotherapy as a supplement to treatment as usual", "integrated, assertive, psychosocial and educational treatment programme", or "treatment as usual". Data on symptoms and social function and sociodemographic data were obtained at inclusion, and at year 1 and 2. The three sub-cohorts did not differ at baseline. After one year, the total sample of patients improved significantly concerning symptoms and social function. The significance of the improvement remained after two years. After one year, patients in the two intervention groups improved more concerning symptoms and social function than patients in the treatment-as-usual group. Improvement in the intervention groups continued into the second year. Patients receiving integrated assertive treatment faired better than those being treated with the less intensive method of supportive psychodynamic psychotherapy, and the latter group improved more than the treatment-as-usual group.

Key words: First episode psychosis, integrated treatment, supportive psychodynamic psychotherapy, two-year outcome

A leading hypothesis, originally proposed in the 1950s and later turned into object of research, assumes that a critical period exists in the first years of first-episode psychosis, in which crucial biological and psychosocial changes are laid down in the mind of the patient, forming the predictors of long-term outcome. During the last 15 years, an effort has been made internationally to collect evidence-based support for that assumption, and to evaluate the long-term results of interventions in that critical period (1-9).

Several simultaneous factors led, in the latter part of the 1990s, to the establishment of a Danish clinical contribution to the field of early secondary prevention for schizophrenia and related disorders. Denmark had a few years earlier contributed to a Nordic study of early psychotherapeutic approaches to schizophrenia (1), but the small Danish sample called for another investigation with large-scale ambitions.

Moreover, in the beginning of 1990s, figures were published in Denmark concerning criminality, suicide and homelessness in people with schizophrenia. Governmental money was granted to investigate and counteract these problems as well as minimize the individual damages that hindered young psychotics to enter the working market and led them to acquire a social pension at a young age. Programmes of early, rapid and sustained interventions after the first signs of psychosis were requested.

Since the 1930s, the Danish Mental Health Service has had a tradition for equal access to and economically free treatment for all inhabitants regardless of their location of living, income, race or religion. In this welfare system, private psychiatric hospitals or clinics for severe psychiatric conditions do not exist. Mental health treatment is organized according to sectorized psychiatry, in which district psychiatric offices (with staff ranging from 6 to 20 persons), located outside the hospital, work in close connection with the hospital units. General practitioners and private practicing specialists only care for a small percentage of the patients treated for schizophrenia and related disorders. Pathways to treatment of psychotic patients and the quality of their care can be considered equal in the country.

METHODS

The Danish National Schizophrenia Project is a prospective, comparative, longitudinal study with a minimum intervention period of two years and the assessment of participants at baseline and at 1, 2 and 5 years after inclusion (10). Participants were allocated to three different treatments: a) "supportive psychodynamic psychotherapy" (N=119), in which they were offered scheduled, manualized, supportive individual psychotherapy (one 45-min session per week, for a period of 1-3 years) and/or group psychotherapy (one 60-min session per week for a period of 1-3 years), in addition to treatment as usual; b) "inte-

grated treatment" (N=139), in which they were offered an integrated treatment package (a scheduled, 2-year programme consisting of assertive community treatment, psychoeducational multifamily treatment, social skills training, and antipsychotic medication) (11); c) treatment as usual (N=304), in which they were offered many different therapies (psychological methods, medication, medical advice and treatment by the inpatient and day-hospital service), administered according to patients' needs, and the available resources of the clinic at the time of treatment, not delivered in any prescheduled manner.

Participants were consecutively referred patients aged 16-35 years, with a first-episode psychosis of the schizophrenic spectrum (ICD-10, F20-29). Written informed consent was obtained from all patients, although not necessarily in the initial phase of the treatment. Patients were excluded if they had a diagnosis of mental retardation or other organic brain damage, severe alcohol or drug abuse, or were not sufficiently proficient Danish speakers.

Patients with first-episode psychosis, admitted to either the inpatient unit or the community mental health centre, were systematically assessed within two weeks, and included if they fulfilled the above criteria. The assessments were conducted by trained, independent research teams, connected to each centre.

The test battery was applied shortly after inclusion, and at year 1 and 2. The battery included the following variables: a) demographic and socioeconomic data; b) diagnosis according to ICD-10 research criteria determined by clinical observation and judgement, and further confirmed by the Operational Criteria Checklist for Psychotic Illness (OPCRIT) (12); c) clinical status determined by the OPCRIT, the Global Assessment of Functioning (GAF) in DSM-IV (13), the Strauss-Carpenter Outcome Scale (14,15), and the Positive and Negative Syndrome Scale (PANSS) (16).

Supportive psychodynamic psychotherapy and the integrated treatment were conducted according to manuals. Regular supervision was provided for both kinds of interventions to enhance adherence to the manuals. The manualized psychodynamic psychotherapy for group treatment and for individual treatment aimed at a realistic cognition of psychosocial events (encompassing attitudes towards illness and medication, the creation of realistic social goals and affectively meaningful interactions in daily-life interpersonal relationships) and was focussed on the understanding of emotions from the past as well as in the present. The manuals described the initial, the middle and the terminating phase of the dynamic treatment.

The psychoeducational family treatment was manualized according to McFarlane et al (17). The focus of each session was problem solving and the development of skills to cope with aspects of the illness. The social skills training was manualized, based on selected modules from Liberman (18) and Bellack (19).

Logistic regression with generalized estimating equations was used for dichotomous variables and linear mixed models were used for continuous variables. These methods were used to compare the three sub-cohorts at baseline, at year 1 and 2, and for differences between baseline and year 1 and 2. In the calculation of changes from baseline to year 1 and 2, the analyses were adjusted for the baseline values. All tests were two-sided and the level of significance was 0.05. The Bonferroni correction was used in the interpretation of the results.

RESULTS

A total number of 562 patients (361 males and 201 females; age range 16.2-35.9 years, mean 24.1 years), mainly of Nordic origin (92%), met the inclusion criteria and gave informed consent.

The three cohorts were similar at baseline concerning age, diagnosis, PANSS positive score, GAF symptom score, GAF function score, GAF total score, and admission/non-admission to hospital during the last year before inclusion to the study.

At year 1 and 2, data were obtained from respectively 450 patients (80%) and 362 patients (64.4%). The remaining patients in the three groups did not differ from the group from which data were not obtained concerning age, sex, diagnosis, GAF and PANSS total scores. There were no sociodemographic differences at year 1 and 2 between the three investigated groups. In the F20 group of patients with schizophrenia, 80% participated in the rating at year 1 and 68% at year 2.

At year 1, a significant improvement was found for GAF symptom score, GAF function score, GAF total score, PANSS positive score (p<0.0001), and PANSS negative score (p<0.04) when the three sub-cohorts were sampled together. More than half of the patients (54%) had more contact with friends at year 1 compared to baseline, 18% had more work and 58% had fewer symptoms. For year 2, the same comparison showed that 57% had more contact with friends, 27% had more work and 65% had fewer symptoms.

Similarly, from baseline to year 2 significant changes appeared in the GAF and PANSS variables (p<0.0001) when the three treatment groups were sampled together. In general, changes from baseline to year 1 were bigger than the changes from year 1 to 2. However, the latter changes were significant for scores of GAF symptoms, GAF total and PANSS negative (p<0.009) (Table 1).

A comparison of the improvements in the three groups at year 1 revealed a clear tendency in favour of the two intervention groups compared with the treatment-as-usual group. When drug and alcohol misuse were taken into consideration as confounding factors, we found that both interventions produced significant improvements in GAF function score (p<0.02) and PANSS negative score (p<0.02); the significance remained with the Bonferroni correction.

After two years, the two intervention groups had a greater improvement than the treatment-as-usual group concerning

Table 1 Clinical and social outcome for first episode psychotic patients in three different treatment modalities: changes from baseline to year 2

	SPP	IT	TaU	p
GAF symptoms	4.60 (-0.93; 10.13)	6.06 (-0.63; 12.75)	0	0.1072
GAF function	4.04 (-0.60; 8.68)	7.20 (2.46; 11.94)	0	0.0086
GAF total	3.63 (-1.13; 8.39)	6.42 (1.22; 11.62)	0	0.0400
PANSS positive symptoms	-1.27 (-2.79; 0.25)	-1.96 (-3.59; -0.32)	0	0.0406
PANSS negative symptoms	1.73 (-0.46; 3.91)	-3.05 (-5.57; -0.54)	0	0.0035

Results from generalized linear mixed model (odds ratio) or linear mixed model (parameter estimate) with 95% confidence interval, adjusted for baseline value.
SPP – supportive psychodynamic psychotherapy; IT – integrated treatment; TaU – treatment as usual; GAF – Global Assessment of Functioning;
PANSS – Positive and Negative Syndrome Scale

the scores of GAF function, GAF total and PANSS positive. The integrated treatment showed the greatest improvement and this improvement reached the level of statistical significance compared to treatment as usual for scores of GAF and PANSS, except from GAF symptoms (Table 1). After the Bonferroni correction, PANSS negative and GAF function remained significant.

DISCUSSION

The strengths of our study were: a) the number of consecutively referred patients; b) the inclusion of different types of treatment centres (small/big, urban/rural, university/non-university) in all three groups being compared; c) the percentage of the Danish population covered by the study (about 45%); d) the comparison of two different treatment modalities with standard treatment of a supposedly good quality; e) the treatment conducted mainly by average trained therapists and not by master clinicians.

The Danish National Schizophrenia Project was thus carried out in a naturalistic and realistic manner, and it mimicked the natural conditions of the National Health System at that moment of its development (1998-2000). This supports the generalization of the results as well as the possibility of recommending in the future the use of both clinical measures and treatment methods in the day-to-day practice of psychiatry. It is furthermore in accordance with the current evidence according to which pragmatically defined integrated treatment programmes and effectiveness studies are more useful in the planning of schizophrenia prevention than narrowly defined regulatory models and efficacy studies (20).

An additional positive element is the creation of a tenable and durable network of centres that collaborate with the same treatment methods, the same measurement scales, and on the ground of the same treatment values. The collaboration needs a sort of idealistic tenor, and it has to take place in spite of the possibility of no funding. The reward for each centre is the qualification of interviewers being trained in the use of psychometric scales, and therapists being trained in the chosen methods of treatment.

Our study found that integrated treatment and supportive psychodynamic psychotherapy may improve outcome after one year of treatment for people with first-episode psychosis compared to treatment as usual. After two years this tendency clearly continued, significantly for the integrated treatment on some variables of PANSS and GAF.

Previous studies have found a positive outcome of different kinds of integrated treatment programmes compared to standard treatment (21). These programmes contain different curative elements, and some also include the possibility of offering psychodynamic psychotherapy to selected patients. It is, however, not immediately possible to detect and distil the specific curative factors of the integrated programmes. Possible curative factors in the integrated treatment of our study could be: a) the multifamily therapy and the rapid, consistent, integrated long-term involvement of the treatment team with a low case load (10 patients per staff person), spending more hours with the patient per week than the one-hour/week individual psychotherapy added to the treatment as usual; b) the specific targeting of the patient's return to the working market, school or other educational programme; c) the specific targeting of reverting the patient's status from inpatient to outpatient; and d) the cognitive approach and the social skills training.

Previous studies comparing psychodynamic psychotherapy to standard treatment have shown diverse results, some in favour of the psychodynamic treatment (22), others against (23). Positive outcome has mainly been associated with very experienced therapists or master clinicians, who rapidly could create and maintain a therapeutic alliance. However, none of the previous studies concerned first-episode psychosis, and it is by no means given that we can extend the knowledge from these elder studies of psychotherapy of schizophrenia to our sample.

Possible curative factors in the supportive psychodynamic psychotherapy of our study could be: a) the establishment of a tenable working alliance; b) the use of the interactions in the therapeutic space to understand emotion and cognition in the daily communication and psychosocial processes; c) making the patient aware of both the helpful and the destructive aspects of his/her coping style and defence mechanisms; d) helping the patient integrating feelings and narratives (turning sense impressions into thoughts, and thoughts into thinking); e) focussing on the non-psychotic aspects of the human being and addressing the psychotic parts from that perspective; f) re-orient-

ing the mind in its process of overcoming and defending against the painful losses it has experienced. Future integrated programmes may consider integrating also these psychodynamic aspects in the treatment.

One limitation of the study is the lack of individual randomization of all patients. Another limitation to the interpretation of the results is the lack of data for 32% of the patients after two years. This was not expected, but was mainly due to one major centre. A third limitation is the relatively few variables we can use in the project to compare all three treatment modalities. However, separate projects exist which will use more variables to compare integrated treatment and supportive psychodynamic psychotherapy separately with treatment-as-usual groups.

Acknowledgements

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Do beliefs about causation influence attitudes to mental illness?

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Studies indicate that stigmatizing attitudes to mental illness are rampant in the community worldwide. It is unclear whether views about the causation of mental disorders identify persons with more negative attitudes. Using data collected as part of a community study of knowledge of and attitudes to mental illness in Nigeria, we examined the relationships between views about causation and attitudes. Persons holding exclusively biopsychosocial views of causation were not different from those holding exclusively religious-magical views in regard to socio-demographic attributes, and the two groups were not very dissimilar when general knowledge of the nature of mental illness was compared. However, religious-magical views of causation were more associated with negative and stigmatizing attitudes to the mentally ill. Findings demonstrate the challenge of developing and delivering an educational program to change public attitudes to mental illness.

Key words: Mental illness, stigma, beliefs about causation

Several authors suggest that an effective way to change public attitudes to the mentally ill and reduce the stigmatization of mental illness is by education. The content of such educational programmes would commonly include the provision of information about the nature and causation of mental illness. However, it is unclear to what extent views about causation are related to attitudes to mental illness or indeed to knowledge about the nature of mental illness.

Few studies have related beliefs about causation to the general knowledge of mental illness and to its stigmatization by the public. It is of course plausible to expect that beliefs about causation reflect general knowledge, and that both influence attitudes. Erroneous beliefs about causation and lack of adequate knowledge have been found to sustain deep-seated negative attitudes about mental illness (1). Conversely, better knowledge is often reported to result in improved attitudes towards people with mental illness (2) and a belief that mental illnesses are treatable can encourage early treatment seeking and promote better outcomes. Even among those who have known people treated for schizophrenia, Stuart and Arboleda-Flórez (2) showed that knowledge of the illness, and not mere exposure to it, was a central modifiable correlate of negative attitudes. Thus, one can speculate that improved knowledge about causation may lead to improved overall knowledge about mental illness and promote a more tolerant attitude to the mentally ill.

In a survey intended to examine changes in public beliefs about social and environmental variables as risk factors for mental disorders in Australia and Japan over an 8 year period, Nakane et al (3) found that there was an increase in the proportion of the public who believed in the genetic causes of both depression and schizophrenia, and speculated that this might have resulted from publicity concerning the genome projects. Though increased belief in biological causes was noticed, this was not at the expense of belief in social causes (4).

There is evidence for significant national (or perhaps, cultural) differences in the beliefs about the causation of mental illness. For example, in the study conducted by Nakane et al (3), while infection, allergies and genetics were the predominant causes of mental illness reported in Australia, nervousness and perceived constitutional weakness were more often reported in Japan (3). Another comparative study of young adults in Hong Kong and England found that, while the Hong Kong youths believed that social factors were the likely causes of schizophrenia, the English youths were more likely to report genetic factors as a cause (5). In Turkey, about 60% of a rural population held the view that personal weakness might be a cause of schizophrenia (6). In a recent survey (7), we reported that as many as one third of a large sample of community respondents in Nigeria suggested that possession by evil spirits could be a cause of mental illness.

In this paper, we explore the relationships between beliefs about causation of mental illness on the one hand and knowledge of the nature of such illness and attitudes to the mentally ill on the other. We do this by comparing those of our respondents who held beliefs of social, psychological or biological causation (termed "biopsychosocial" causation) with those who held beliefs of supernatural or religious causation (termed "religious-magical" causation) in regard to their views of and attitudes to the mentally ill. We hypothesized that persons with biopsychosocial views of the causation of mental illness would have better knowledge of the nature of mental illness and be less stigmatizing of those afflicted.

METHODS

The survey was conducted in three Yoruba-speaking states in south-western Nigeria (Ogun, Osun and Oyo) between March and August 2002. A stratified multistage clustered probability sampling of household residents aged 18 years or older in the selected states was implemented. First, stratification was based on states (three categories) and size of the pri-

mary stage units, which were the local government areas (two categories). The second stage was to select two primary stage units per stratum, with probability of selection proportional to size. The third stage was the random selection of four enumeration areas from each of the local government areas. Selection was made from enumerated households in the selected areas. Finally, one resident aged 18 years or over was approached for participation in each selected household. We used the Kish method to identify the potential respondent (8). Survey questionnaires were administered by trained lay interviewers from the Department of Psychiatry, University of Ibadan. The study was approved by the University of Ibadan and University College Hospital joint ethics committee. A total of 2040 persons participated in the survey, representing a response rate of 74.2%.

A modified version of the questionnaire developed for the World Psychiatric Association Programme to Reduce Stigma and Discrimination Because of Schizophrenia was used (2,9). The questionnaire is focused mainly on knowledge of and attitudes to schizophrenia. Among other things, it enquired from respondents their views about the causes of mental illness. They could pick up to three possible causes from a list consisting of: disease of the brain, intrauterine infection, genetic inheritance, poor upbringing, physical abuse, drug or alcohol misuse, stress, traumatic event or shock, poverty, biological factors (other than brain disease or genetic inheritance), possession by evil spirits, and God's punishment. The questionnaire was modified largely to take account of the focus of this survey, which was mental illness rather than schizophrenia. Thus, in addition to substituting the term "mental illness" for "schizophrenia", specific items relating to the symptoms of schizophrenia were deleted. The questionnaire was translated to Yoruba by a panel of bilingual mental health research workers using the iterative back-translation method.

We compared two groups of respondents: those with exclusively biopsychosocial views of the causation of mental illness and those with exclusively religious-magical views. The former group consisted of those whose identified causes of mental illness from the list did not include "possession by evil spirits" or "God's punishment". The latter group consisted of persons who identified only "possession by evil spirits" or "God's punishment" but no other cause from the list. In grouping the respondents in this way, we did not take into account the item "drug or alcohol misuse", because we found that this view of causation, selected by over 80% of our sample, was not discriminatory between the two groups.

The results presented here have been weighed to reflect the within-household probability of selection and to incorporate a post-stratification adjustment, such that the sample is representative of the age by gender distribution of the projected population of Nigeria in 2000. Income was categorized into four groups: "low" (defined as less than or equal to median of the pre-tax income per household), "low average" (greater than "low" up to two times the median value), "high

average" (greater than "low average" up to three times the median value) and "high" (greater than "high average"). Residence was classified as rural (fewer than 12,000 households), semi-urban (12,000-20,000 households per local government area) and urban (more than 20,000 households).

Simple cross-tabulations were used to calculate proportions and their distributions in different groups. To take account of the sampling procedure, with clustering and weighing of cases, standard errors of proportions were estimated with jack-knife methods implemented in the STATA software. Statistical significance was evaluated at the 0.05 level and based on two-sided design-based tests.

RESULTS

We classified 1163 persons to either of the two exclusive groups: 84.6% of them in the biopsychosocial group and 15.4% in the religious-magical group.

Table 1 shows the socio-demographic characteristics of the respondents. There were no differences between the two groups in regard to any of the factors. Consistent with

Table 1 Socio-demographic attributes of the subjects

	Biopsychosocial views of causation (N = 984)	Religious-magical views of causation (N = 179)	p
Sex (%)			
Female	50.7	45.3	0.244
Years of education (%)			
0	15.8	15.7	
1-6	23.7	22.5	0.949
7-12	42.5	44.1	
13+	18.0	17.7	
Age group (years, %)			
18-25	32.9	33.0	
26-40	40.1	33.6	0.319
41-64	20.9	27.6	
65+	6.1	5.8	
Income group (%)			
High	47.6	47.9	
High average	16.3	23.1	0.184
Low average	27.3	21.7	
Low	8.8	7.3	
Currently married (%)			
Yes	62.2	61.3	0.832
Residence (%)			
Urban	43.6	39.3	
Semi-urban	26.0	30.7	0.372
Rural	30.4	30.0	
Ever worked in a facility providing treatment for mental illness (%)			
Yes	2.0	2.6	0.720
Have you or anyone known to you ever been treated for mental illness (%)			
Yes	4.8	5.0	0.874

the population profile in Nigeria, most respondents were below the age of 40 years. Only a minority had had up to or more than 13 years of education. Only very few in either group had worked in any facility providing treatment for mental illness or responded positively to the question about whether they or someone known to them had suffered from mental illness.

Knowledge of mental illness was generally poor. Table 2 shows that only a minority held such views as the possibility of successful treatment of mental illness outside hospital or that persons with mental illness could work in regular jobs. There were two significant differences between the groups in regard to knowledge of mental illness: persons with a biopsychosocial view of causation were more likely to believe in the possibility of successful treatment of mental illness outside hospital, but they were also more likely to hold the view that persons with mental illness hear strange voices telling them what to do (even though the latter difference between the two groups was of much less strength than the former).

Consistent with the generally poor knowledge, attitudes to the mentally ill were predominantly negative. However, there was a more consistent pattern in the differences between the two groups in regard to attitudes. Other than in the willingness to consider marrying a person with mental illness, where the biopsychosocial group was slightly less tolerant than the religious-magical, the former group was more likely to have a more accepting disposition to the mentally ill in all other areas assessed. The differences were significant in two areas: the biopsychosocial group was less likely to be upset or disturbed about working with someone with mental illness and more likely to consider maintaining friendship with such a person (Table 3).

DISCUSSION

In this report, we have shown that views about what causes mental illness are associated with attitudes to the mentally ill. Even though general knowledge about the nature of mental illness is uniformly poor for those holding biopsychosocial views as well as those holding religious-magical views, with no consistent difference between the two, their attitudes to the mentally ill are significantly different. A biopsychosocial view of the causation of mental illness is associated with a more tolerant and less stigmatizing attitude than is a view that is informed by supernatural beliefs.

Our findings complement those of others who have observed that views about causation are strongly associated with stigmatizing attitudes to mental illness (10-12) and that educational programs on mental illness often lead to improved attitudes (13,14). However, and as noted by Haghighat (15), the link between knowledge and attitudes is not a simple one, and social judgement is often determined by the "feeling" rather than by the "cognitive" component of attitudes. The contradictory findings we report

in this paper, suggesting that persons with biopsychosocial views of causation who also tended to have a more positive attitude to the mentally ill had nevertheless a poor general knowledge of the illness, further indicate the complexity of the relationships.

Public education remains the only strategy for changing attitudes to mental illness. Despite contradictory findings about their efficacy (13,16,17), such programs nevertheless hold the promise of challenging stigmatizers to reflect on

Table 2 Association of views on causation with knowledge of mental illness

Items	Biopsychosocial views of causation (N = 984)	Religious-magical views of causation (N = 179)	x^2	p
Can be successfully treated outside hospital	47.8	33.8	9.85	0.004
Tend to be mentally retarded	92.4	90.0	1.65	0.211
Hear strange voices telling them what to do	92.7	87.6	4.53	0.044
Need prescribed drugs from doctor	92.3	93.9	0.55	0.464
Are a public nuisance	95.8	97.8	2.17	0.154
Can work in regular jobs	28.4	22.8	3.09	0.091
Are dangerous because of violent behaviour	96.7	96.2	0.08	0.777

Table 3 Association of views on causation with attitudes towards mentally ill persons

Items	Biopsychosocial views of causation (N = 984)	Religious-magical views of causation (N = 179)	x^2	p
Afraid to have a conversation with someone who has mental illness	80.5	86.4	1.99	0.171
Upset or disturbed about working with someone with mental illness	77.2	84.8	10.01	0.004
Could maintain a friendship	20.5	11.4	4.56	0.043
Unwilling to share a room	82.8	84.5	0.276	0.604
Ashamed if people knew someone in one's family has been diagnosed with mental illness	82.7	86.1	1.599	0.218
Could marry a person with mental illness	3.5	3.7	0.029	0.866
Establishment of group at home for the mentally ill in one's neighbourhood:				
- agree	42.4	40.8		
- disagree	49.5	50.2	0.111	0.814
- indifferent	8.1	9.0		

their feelings and lead to some form of circumspection (15,18). In our survey, persons holding the religious-magical views of mental illness causation were less than those holding biopsychosocial views, but, rather disappointingly, they were not identifiable on the basis of social or demographic attributes that might help in delivering targeted educational or enlightenment programs. The challenge in our setting is therefore to devise strategies that will increase the general knowledge of the community in regard to mental illness while also sending focussed information to those with supernatural views about the causes of mental illness, with the hope that their attitudes to the mentally ill can be improved.

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Palestinian mothers' perceptions of child mental health problems and services

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The aim of this study was to explore Palestinian mothers' perceptions of child mental health problems and their understanding of their causes; to determine Palestinian mothers' awareness of existing services and sources of help and support; to identify professionals in the community whom Palestinian mothers would consult if their child had mental health problems; and to establish their views on ways of increasing awareness of child mental health issues and services. Checklists exploring the above issues were completed by 249 Palestinian mothers living in refugee camps in the Gaza Strip. Palestinian mothers equally perceived emotional, behavioural and psychotic symptoms as suggestive of mental ill health in childhood. Mothers perceived multiple causes of child mental health problems, including family problems, parental psychiatric illness and social adversity. A substantial proportion (42.6%) had knowledge of local child mental health care services. Overall, mothers preferred Western over traditional types of treatment, and were keen to increase mental health awareness within their society. Despite a different cultural tradition, Palestinian mothers appear open to a range of services and interventions for child mental health problems. As in other non-Western societies, child mental health service provision should be integrated with existing primary health care, schools, and community structures.

Key words: Mothers, child mental health, child mental health services, Palestine

Socio-cultural factors play a major role in the presentation and recognition of child and adolescent mental health problems and disorders (1,2). Attitudes to child rearing and expectations of children's behaviour have been found to differ between cultural groups (3). Moreover, cross-cultural differences appear to be linked to more reporting of either internalizing problems such as withdrawal, somatic complaints and anxiety/depression symptoms in non-Western child populations, or externalizing problems such as attention problems and delinquent and aggressive behaviour in Western groups (4). Culture is not the only factor accounting for these differences. For example, child psychopathology may be mediated by socio-economic adversity across all cultural groups (1,5).

Cross-cultural differences appear to endure when people immigrate to different societies. There seem to be differences in parents' reporting of children's problems between the indigenous population and the ethnic minorities living in Western countries (6). Some studies have found a higher prevalence of psychiatric disorders within ethnic minority children living in the West, but these findings are far from conclusive, partly because risk factors have been found to have a different effect in different communities (7-9). The limited awareness of ethnic minorities about appropriate services in their new community may severely limit the utilization of such services (9).

There has been substantial research on the epidemiology of child psychiatric disorders across different cultures and societies (10). An early World Health Organization cross-national study, based on parent and teacher ratings of child behavioural and emotional problems, established a wide variation of prevalence rates (between 7 and 19% for parents, and between 4 and 14% for teachers) in Japan, China and Korea (11). This variation may reflect the measures,

definition and threshold of child mental health problems (12), or the discrepancy between informants, with parents being more likely to over-report behavioural (externalizing) and to under-report emotional (internalizing) symptoms (13). When psychiatric interviews were used or weighted prevalence rates of child psychiatric disorders were estimated, these were found similar to those in Western societies (around 10%), e.g. in studies in South India (14), Brazil (15), or the Middle East (16). These rates have been higher among clinical populations, such as children attending primary health care services in Nigeria (17).

Despite the increasing evidence on the prevalence of child mental health problems and disorders in non-Western societies, there has been limited research on how these problems are perceived by parents in different societies, and what types of supports, help and services they would wish to receive. In particular, it is unknown whether there are cultural and ethnic differences in parental beliefs about the causes of children's problems and appropriate interventions (18). Such knowledge is important in planning child mental health and related services, and was the rationale for this study among Palestinian mothers living in the Gaza Strip.

Traditionally, in the Arab world, political and religious forces have always been intimately intertwined, and Islam is a crucial factor in all aspects of life. In most Middle Eastern countries, until relatively recently, mental illness was thought to be due to possession by demons, failure to follow rituals, or fate (19). Nowadays, psychiatry is well established in Arab societies (20), though traditional and religious healers also play a major role in primary psychiatric care (21). Recent studies have found an increasing recognition by health professionals (e.g., in the United Arab Emirates) (16), and similar patterns and mechanisms of child psychopathology as in Western societies (e.g., in general

population studies in the Gaza Strip) (13,22). However, less is known on parents' awareness and perceptions of different services and sources of help for children with mental health problems, hence the rationale for this study.

METHODS

The aim of the study was to establish mothers' perceptions of child mental health problems, aetiology and methods of intervention. Based on the researched literature, it was hypothesized that: a) traditional Palestinian views of mental illness would be narrower than in the Western world, and only severe symptomatology such as psychosis would be considered as mental illness; b) parents would preferably seek the help of traditional healers rather than Western style treatments, as their awareness of available services is limited.

The provinces of the Gaza Strip comprise a narrow zone of land along the Mediterranean Sea, between Israel and Egypt. The Gaza Strip is 50 kilometres long and 5-12 kilometres wide. There are 808,000 registered refugees, over 55% of whom (443,000) live in eight refugee camps, and the rest live in the towns and cities of the Strip. The United Nations for Relief and Work Agency (UNRWA) provides education for 159,892 pupils, as well as health and relief services to refugees living inside and outside the camps. Within the refugee population, the birth rate is 55 per 1000, with a neonatal mortality rate of 20 deaths per 1000 live births, and an infant mortality rate of 33 per 1000 live births. The live expectancy is 71.7 years. Young people under the age of 15 years constitute 43.6% of the general population, and the average refugee family size is six persons (23).

The study was designed to survey the mothers of a cross-sectional sample of Palestinian children living in the El-Nusirate refugee camp in Gaza, which has a population of 44,685 (23). One section (locality) of the camp was selected. Every third household with children under the age of 16 years living in the camp locality was selected for the study (N=260). Eleven families refused to participate in the study, with the remaining 249 families taking part.

A checklist was devised on parents' perceptions of what constitutes child mental health problems, perceived causes of child mental health problems, appropriate services and interventions they would approach to seek help for child mental health problems, and ways of increasing awareness of child mental health problems. The list of the different services available to children and adolescents included governmental, United Nations, non-governmental and other services in the community. The list of types of treatment offered by the different organizations included religious, medical and psychological modalities.

As the aim of the study was not to establish rates of psychiatric morbidity in the sample, but rather to establish parents' perceptions of what constituted mental health problems, we opted not to use a rating scale of emotional and behavioural problems or a semi-structured diagnostic inter-

view. Instead, the checklist included a range of emotional, cognitive and behavioural manifestations, which were described by the researcher to the mother. The mother then rated whether each manifestation constituted, in her opinion, a mental health problem (i.e., an undesirable symptom which might deviate from what is normal or expected, and which may require help or treatment in order to improve). Reports did not refer to individual children, although it is acknowledged that mothers' reports may have been influenced by their personal or their children's experiences.

Socio-demographic data on parental occupation, education, number of siblings and family income were collected from the mothers.

RESULTS

As shown in Table 1, despite families' low income and refugee status, parents had received different levels of education, possibly reflecting the relative stability of Palestinian families, which have been living in the same area for the last 50 years.

Tables 2 and 3 show how frequently the various emotional, cognitive and behavioural manifestations were perceived by the mothers as mental health problems in a child.

When asked about their opinion on the causes of child mental health problems, most mothers reported multiple

Table 1 Socio-demographic characteristics of the sample (N=249)

	N	%
Paternal employment status		
Unemployed	40	16.0
Unskilled worker	50	20.1
Skilled worker	49	19.7
Civil employee	96	38.6
Merchant	14	5.6
Paternal education status		
Illiterate	6	2.4
Elementary school	27	10.9
Primary school	56	22.5
Secondary school	68	27.3
Diploma	43	17.2
University	42	16.9
Post-graduate	7	2.8
Maternal employment status		
Housewife	222	89.2
Employee	27	10.8
Maternal education status		
Illiterate	30	12.0
Elementary school	68	27.3
Primary school	102	41.1
Secondary school	25	10.0
Diploma	1	0.4
University	23	9.2
Family monthly income		
Less than 300 US$	67	26.9
300-500 US$	125	50.2
More than 500 US$	57	22.9

Table 2 How frequently mothers perceived various emotional and cognitive manifestations as mental health problems (N=249)

	N	%
Phobias (excessive fears)	165	66.0
Somatic complaints	108	43.2
Depression	107	42.8
School refusal	75	30.0
Day time wetting of clothes	52	20.8
Suicidal thoughts	56	22.4
Suicidal behaviour	49	19.6
Inattention	146	58.4
Hallucinations	107	42.8
False beliefs	69	27.6

Table 3 How frequently mothers perceived various behavioural manifestations as mental health problems (N=249)

	N	%
Disobedience	174	69.9
Sleep problems	82	32.8
Fighting	123	49.2
Destructive behaviour	102	40.8
Outburst of anger	157	63.2
Verbal abuse of others	139	55.6
Lying	117	46.8
Physical abuse of others	119	47.8
Fire setting	76	30.4
Escape from home	71	28.4
Truancy from school	60	24.1
Drug use	39	15.6

reasons: 221 (89.1%) attributed them to family problems, 212 (85.5%) to parental mental illness, 208 (83.9%) to socio-economic adversity, 164 (66.1%) to accidents, 157 (63.3%) to genetic disease, 152 (61.3%) to organic brain lesions, and 86 (34.7%) to being "possessed".

When asked about their awareness of child mental health centres and services, 106 mothers (42.6%) were aware of them, with the vast majority (N=230, 92.7%) stating the need for such services. Seventy percent of mothers (N=174) said that they would take their children to a primary health care centre if concerned about any of the previous mental health problems, 158 (63.2%) would see a psychologist or psychiatrist, 131 (52.4)% a social worker, while 10 mothers (4%) would take their child for cauterisation (traditional Arab treatment).

When asked about their preferred type of treatment, 211 mothers (84.7%) stated that they would prefer some kind of "talking treatment" (psychotherapy), 157 (63.1%) would prefer medication, 152 (61.0%) treatment by recit-

ing the Quraan to their children, and 38 (15.3%) would take their child to a smoking setting to inhale Bokhour.

Finally, mothers were asked what could help children and parents to understand better the nature of mental health problems, and identify appropriate services within their society. Most mothers (N=226, or 91.1%) mentioned series of lectures for teachers and parents, 218 (87.9%) suggested TV programmes directed at children and adolescents, 199 (77%) regular leaflets containing information and advice about child mental health problems, and 167 (67.3%) public meetings between parents and professionals.

DISCUSSION

Child mental health problems and disorders constitute an increasingly wide concept, with variable perceptions and attributions by parents and professionals. Despite some evidence of similar diagnostic patterns and prevalence across different cultural and ethnic groups, there is limited knowledge on the impact of cultural factors on such perceptions (5,24). This study explored this question among Palestinian mothers living in a refugee camp in the Gaza Strip. Contrary to our hypothesis, mothers' perceptions of child mental health problems, their causes and preferred types of services were broad and not substantially different from those within Western societies.

Mothers equally perceived emotional, behavioural and psychotic symptoms as representing mental health problems. The value traditionally attributed to discipline within the family and extended community may explain the high rate of mothers considering disobedience and outburst of anger as potentially deviant. The relatively low percentage of mothers perceiving suicidal thoughts or acts as representing mental health problems may reflect religious beliefs, and indeed low self-harm and suicide rates within the general population (20). This is in contrast with the perceptions not only of Western but also of Asian parents (3,9).

While a large proportion of mothers considered family factors to be a cause of child mental health problems, equally large numbers mentioned social adversities, and a substantial minority mentioned possession by evil spirits. Interestingly, most mothers considered several possible causes, i.e. cultural perceptions or attributions were not incompatible with environmental, genetic or organic explanations. Again, the importance of the nuclear family within the Palestinian society did not prevent mothers to consider family factors in the development of child mental health problems. Indeed, in a Lebanese study, Zahr (25) found family-related factors to mediate external stressors and child psychopathology.

Also contrary to our hypothesis, Palestinian mothers reported that they would contact health centres or specialist mental health professionals rather than traditional healers. This may be in contrast with other contemporary Arab societies, where traditional healers still play a significant role (21). This finding may be explained by the participants'

educational status. The role of primary health services, as well as schools, is particularly important for the detection of child mental health problems in developing countries, with referral of the more severe disorders to the limited specialist child mental health services (26,27).

The proportion of Palestinian mothers who appeared aware of local child mental health services may be considered high, even compared with findings from Western countries (28). As the locality of the study was covered by a community mental health centre for adults and children (29), this frequency may be lower in other areas of the Gaza Strip. However, even mothers not aware of the local service acknowledged the need for such provision. Within these "Western style" services, Palestinian mothers reported their preference for "talking treatment" (a loose definition of psychotherapy) and pharmacological treatment. Religious or cultural sources of help were considered important (such as reciting the Quaaran and attending smoking settings), but again not incompatible with mental health interventions. Interestingly, mothers rated positively the opportunity to find out more on child mental health issues and services through awareness meetings, talks and information material from professionals. We have recently established similar wishes for community psychoeducation among Asian families living in the UK (3).

Establishing parents' views and expectations of child mental health services is as important in developing countries as in Western societies. This is one of the factors that should be considered in setting priorities and rationalizing small service resources. Assessment of local needs and maximization of existing community services and other sources of support are essential (30). In addition, these findings support the importance of flexibility in the types of services and interventions. A "help-seeking" model of offering choice from identification to treatment (31) would be useful in any cultural and social context.

There were several limitations to this study. The sample of mothers may not be representative of all Palestinian society, or of other Arab populations. Although the aim of the study was not to establish prevalence of child psychiatric disorders, the checklist items on child psychopathology were not validated and could have been under- or over-reported by respondents. Similarly, a semi-structured interview, rather than a checklist, would have resulted in a better understanding of mothers' views, experiences and attributions, although a qualitative approach would have constrained the sample size. Future research should expand this information on service users' perspectives, which should be triangulated with children/young people's and professionals' perceptions.

Acknowledgements

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Challenges for psychiatry: delivering the Mental Health Declaration for Europe

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Mental health care is in the process of transformation across the European Region, due to a combination of recognition of disease burden, poor treatment conditions and demand from clinicians and the public. This transformation affects the scope of mental health, increasingly including promotion and prevention, and the structure and process of care, shifting to community based delivery. Many psychiatrists are in leadership positions, able to influence policies and strategies. But their work is also seriously affected by the consequences of these policies. New roles and responsibilities of all members of a multi-disciplinary team need to be planned, and education and training have to be designed to prepare professionals to deal with expectations and demands. Psychiatrists face major challenges, since their complex roles are affected in multiple ways by the psychiatric and general health system. Some of these challenges can be addressed by the psychiatric profession and their partners, including patient and family organizations; others require wide ranging changes in attitude and system design.

Key words: Mental health care, psychiatrists, Helsinki Declaration, leadership

The last few years have seen very active policy developments transforming mental health care in all parts of the European Region. Gradually, over the course of the last 30 years, principles of community based services have been introduced. The World Health Report 2001 (1) stated the principles, and the Mental Health Declaration for Europe (Helsinki Declaration) (2) placed them in a European context. Many countries in the European Region of the World Health Organization (WHO) are now actively drafting and implementing new mental health policies and legislation, and developing community based services.

These developments have been driven by several factors, all relevant to the countries in the Region, if of varying relative importance. All governments are concerned about the high and growing burden of mental disorders (3), the suffering of individuals and the cost to society, both in social and economic terms. More specifically, there is a growing awareness of the public health aspects of mental health, including promotion and prevention, which implies a government responsibility for action, rather than delegating action to the medical profession. An example is banning of toxic substances by law in order to prevent suicide.

Many drivers are not top down, dictated by governments, but are bottom up, most effectively so when demanded by a coalition of the public and professionals. The gradual reduction of stigma related to common mental disorders such as anxiety and depression has resulted in an increasing demand of treatment. The empowerment of the population in many countries and a growing knowledge of the availability and effectiveness of new treatments, such as the iconic status of drugs such as Prozac, has put great pressure on governments and professionals alike to supply adequate capacity for care, provided on terms desired by users and carers. People no longer accept degrading forms of care for their friends or relatives, whether neglect in institutions or long waiting lists, and demand access to information. There has been a growing emphasis on human rights, supported by the Convention for the Protection of Human Rights (4).

Demonstrably, the influence of professionals has been crucial, mostly psychiatrists who acted as champions of change, such as Pinel in France in the 19th century and Basaglia in Italy in the 20th. They offered visions of new models of humane and effective care, revolutionary for their times, replacing inadequate and abusive traditional services. Their real achievement was the ability to inspire politicians to champion these visions and persuade colleagues to implement them, thus enabling real and sustainable change.

However, charismatic leaders and a supportive public are essential, but not sufficient. It has become clear that mental health reform is not a cheap option, and it is therefore unlikely to be coincidence that comprehensive reforms have taken place in countries that could afford increased public expenditure and investment in health, allowing the development of new services and growing numbers of staff.

An important fact to bear in mind is that few conditions are identical at any point in time across the 52 member states of WHO-EURO, and priorities are therefore very different, ranging from subtle implications of social exclusion in employment settings to preoccupations with obtaining a meal in asylums. The European Region of WHO is very diverse, comprising some of the richest countries in the world, especially the members of the old European Union, as well as countries with high levels of poverty and deprivation. On average, the mental health budget is 5.6% of the total health budget, but varies from less than 1% to about 12% (5). Similarly varied are rates of psychiatrists, nurses and other staff groups.

Despite the evidence, if not overall agreement, that community based care is advantageous for most people with mental health problems, there are a number of challenges that need facing. First, we are living in times when economic pressures have introduced greater scrutiny of cost effectiveness in psychiatry, both at the level of service

models and interventions. Second, a unique challenge is the public perception of mental illness and in particular schizophrenia as a risk category, and the demand that psychiatry safeguards society by locking away securely anyone who could pose a potential risk. Third, mental health care is experiencing recruitment difficulties, when specialization and decentralization demand a fast growing number of staff. A factor negatively affecting all these challenges is stigma and discrimination.

Taking into account these factors, differences and challenges, mental health strategy is converging in a remarkable fashion across Europe. This is illustrated by the consensus achieved at the WHO European Ministerial Conference on Mental Health in Helsinki, where the representatives of the 52 member states endorsed the Mental Health Declaration and Action Plan for Europe (2). The Declaration formulates the scope and priorities for mental health care in the next decade and the actions and responsibilities member states and the WHO Regional Office for Europe commit themselves to in order to reduce the burden and suffering caused by mental health problems.

The Declaration was signed on behalf of ministers of health and was endorsed by a unique range of non-governmental organizations, including the WPA and other professional bodies as well as patients' and carers' organizations. The Declaration and Action Plan offer a great opportunity for psychiatry and psychiatrists to advance the claim that mental health is a priority for governments, and that it is timely to not only design and implement strategies, but also to support them financially and legally. Psychiatrists are central to any progress, since in many countries they occupy roles of responsibility such as advising on strategy, drafting action plans and leading the implementation and delivery of care.

THE HELSINKI DECLARATION

The Helsinki Declaration details 12 areas of action and the resulting responsibilities for the ministries of health in member states. An area that required attention at the drafting stage was the scope of mental health care. It proved necessary, considering the expansion of responsibilities of mental health well beyond the traditional roles of psychiatry in hospitals and outpatient settings, to clarify boundaries and to determine priorities. It is within this scope and its priorities that the challenges to be met by psychiatry are presented.

Scope

A key sentence in the Declaration is that "policy and services are striving to achieve social inclusion and equity, taking a comprehensive perspective of the balance between the needs and benefits of diverse mental health activities aimed at the population as a whole, groups at risk and peo-

ple with mental health problems". This means that the scope of mental health care has shifted from a narrow focus on the treatment of people with severe mental illness to cover also population interventions that could increase the well-being of vulnerable groups. Mental health promotion and prevention have gained a prominent position in the thinking of governments. However, it is acknowledged that this requires a careful balance, taking into account the needs of target groups and the effectiveness and efficiency of actions. Implications are that any policy has to be judged on its potential benefits at population level, but effectiveness, cost, desirability and fairness have to be taken into account, i.e. whether policies have the potential to be of most benefit to those with greatest needs.

Priorities

The priorities set the agenda for action for health ministries over the next decade (Table 1).

These priorities are specified in the 12 action points of the Declaration. The Action Plan, endorsed in the Declaration, details the desirable steps to implement the Declaration. The Declaration and Action Plan propose a model of mental health activities that places mental health at the heart of policy making, emphasizing well-being, human dignity, recovery and social inclusion. This implies partnerships between health and other government sectors. But such a model is only feasible if there is a recognition and commitment by governments not just of drafting of policies, but also of the long-term need for investment in modern models of interventions, a sufficient and competent workforce, enabling legislation, finance and evaluation.

CHALLENGES FOR PSYCHIATRY

The Declaration offers a powerful opportunity for change, but there are a number of challenges, starting with the very different context of countries. Despite the differences, in every country services are in transition, and the direction of travel and some of the essential principles of change are remarkably similar, including the challenges and opportunities for psychiatrists.

Table 1 Priorities of the Helsinki Declaration

1. Foster awareness of the importance of mental well-being
2. Collectively tackle stigma, discrimination and inequality and empower and support people with mental health problems and their families to be actively engaged in this process
3. Design and implement comprehensive, integrated and efficient mental health systems that cover promotion, prevention, treatment and rehabilitation, care and recovery
4. Address the need for a competent workforce, effective in all these areas
5. Recognise the experience and knowledge of service users and carers as an important basis for planning and developing services

The broadening scope and the shift to community based mental health services introduce greater levels of complexity, affecting the role of psychiatrists. Psychiatry now has to consider its role in areas such as promotion and social inclusion. Psychiatrists will work in more settings, with more staff groups. Planning and management will take a more central place, and accountability is likely to become more transparent.

However, psychiatrists are not passive recipients in this process of designing, implementing and delivering mental health activities. They possess a unique expertise, and occupy leading positions in most countries, functioning as advisers to governments and chairing drafting groups that are responsible for the production of policies and action plans. There are countries where such groups comprise only psychiatrists. They have therefore a unique opportunity to shape the process of reform in the best interest of patients, families and carers, the public and staff.

The number of countries that are developing and implementing policies is remarkably high. Similarities between strategies are noticeable, including some of the challenges emerging in many countries. There is also considerable duplication of effort. Although there is a fair point to be made that each country should be allowed to develop its own strategies based on its own unique circumstances, there is also a point to be made about inefficiencies of reinventing the wheel and value of learning from other people's successes and failures, especially at a time when governments are committed following the Ministerial Conference in Helsinki. The next step should be a sharing of experiences by psychiatrists and other experts of implementing strategies, since those steps are likely to include some similar challenges.

Service model

The model of care drives practice, and many challenges can be predicted from the planned structures and processes. An example is the role of community mental health centres and their remit to prevent admission or to rehabilitate people with long-term problems, and their authority in respect of hospital admissions or discharges. Another is the diagnosis and treatment responsibility of primary care, very underdeveloped in many countries. Each strategic decision for one part of the system will have consequences, often also unintended ones, on other parts of the system. It is therefore crucial that psychiatrists are closely involved in strategic planning, and have the expertise to influence this process, but these examples also suggest that other professions also need to have ownership.

Clinical roles and responsibilities

Community based services require differences in attitude, knowledge and skills from traditional forms of care. For psychiatrists to be effective, new roles need to be adopted, often very complex since they require a good grasp of the needs of patients in multiple settings and the ability to work intensively with staff from a variety of backgrounds. These different aspects of the psychiatrist's role raise a variety of challenges not very well addressed in many strategies:

Therapeutic role

Although the essential role of most psychiatrists will remain their therapeutic work with patients, the type of problems presented by people in a community setting and their expectations of psychiatrists' activities will be radically different. No longer is a detached medical role sufficient. Patients will also want personal attention for their problems living in a social environment. This raises the challenge of what this means for the role of the psychiatrist. Questions to be addressed are any desirable shifts in: exclusive responsibility of psychiatrists based on special expertise, such as diagnosis and prescribing; shared roles in areas such as follow-up, co-ordination and providing information; and common activities which can be done equally well or better by other and lower paid staff groups with suitable skills such as housing assessments and support with basic social activities.

Membership of multi-disciplinary team

Implementation of community based practice requires team work, offering in combination a variety of skills. How diverse individuals within a team can function most effectively together, working jointly comprehensively but individually efficiently, requires careful consideration of roles, responsibilities and training.

Functioning in diverse roles and settings

Many psychiatrists function in a diversity of clinical roles, spending a proportion of their time in hospital, community teams, management and other settings. This raises new challenges about responsibilities and skills. Time management, ability to delegate but also role clarity are essential requirements if psychiatrists are to operate effectively.

Broadening societal scope of psychiatry

The shift in scope from psychiatric care for persons with severe mental health problems to offer mental health activities for all persons at risk of mental health problems has been accompanied by a broadening of responsibilities of mental health professionals, now expected to be also active in mental health promotion and prevention. At the other

end of the scale, greater emphasis is being placed on the balance between human rights of the individual and the avoidance of any risk to society. This results in a very complex set of challenges driven by contradictory values and yet to be clarified implications for practice, including the capacity and role of psychiatrists and other professionals.

Partnership working

The needs of patients and families in modern mental health practice are beyond the capacity of a single sector, and partnership working is increasingly accepted as essential. This includes health and social care agencies, employment, benefit, housing and education agencies. Such an interactive way of working introduces new challenges about boundaries, leadership and accountability, not only at practice level, but also at legislative level, since many ministries are responsible. Who decides priorities, and who is responsible for continuity of care or poor quality care? What is the role and where is the position, within these spider webs, of psychiatrists?

Leadership

Complex service models require strong and transparent leadership, whether of interventions, teams, organizations or systems. The leadership of strategic change processes, service delivery and staff is essential for good and efficient care delivery, but this will rarely be the responsibility of the same person. At each level, quality of implementation and delivery is often associated with a competent identifiable individual. A distinction needs to be made between leadership and executive management. Traditionally psychiatrists have been in charge of mental hospitals, supported by administrators. In community based services, lines of authority and management are less straightforward and therefore more challenging, and different leadership roles and leaders can be required even within one team. Poor functioning of services can often be attributed to role confusion, and training of individuals and teams in these skills is a key challenge. The question that constantly re-emerges is the optimal leadership role of psychiatrists in modern mental health services, and the interface between such leadership, service management and clinical work.

Information systems

The complexity of community care systems can result in the unintentional lack of care or duplication of services. For psychiatrists to work effectively, they require information to plan, act and evaluate. It is an obvious statement that systems and processes need to be introduced that assist efficient clinical work, budget control, planning and inspection. However, in reality such systems are highly complex and costly. Information functions all require inputs and analysis. There is too often a tension between expectations of clinicians and managers for minimum input by themselves but maximum information provided by the system. Designers do not always take into account time requirements and clinical reality, and expectations of validity can be extremely optimistic. Considering the importance of information for clinical practice, management and accountability, involvement of clinicians in the design of systems and staff training is rarely adequate.

Research

Research is essential to both inspire and validate innovations in care, but it needs careful interpretation. There are too many examples of ignorance of well established evidence or inappropriate acceptance of irrelevant and/or bad research, and psychiatrists need to be able to assess the quality and potential local relevance and inform decision makers. In turn, the introduction of new service models and interventions locally needs to be subject to audit and evaluation in order to judge benefits and need for adaptation. It is yet uncertain to what extent research is a specialist role or should be a core part of psychiatric expertise.

Competence

A key challenge, and one of the priorities in the Declaration, is the competence of the workforce. The transformation of services and practice demands changes in attitudes, training and education. This means a reconsideration of competency development, producing psychiatrists fit for purpose. The role of psychiatrists has to be considered in conjunction with other professional groups, which can be a major struggle due to different agencies responsible for the development of curricula and the delivery of training, both within and across staff groups. Particularly numbers and competencies of nurses and social workers are very poorly developed in many countries. The international opening of borders for practice also requires quality standards that are uniform across countries, such as competence in evidence-based psychotherapies. Organizations such as the WPA and the European Union of Medical Specialists (UEMS) will have a major role to play. A related and complex challenge is the migration of trained staff in some countries, creating disincentives to train mental health staff in the first place.

Career development

The system of mental health care indicated suggests a

growing number of roles for psychiatrists. No single person can acquire all the expertise to be a service leader, clinical expert in diverse specialist areas, researcher or trainer. The variety and constantly changing roles of psychiatrists in mental health care suggest that basic training can only prepare for the fundamentals, and that further specialization is necessary to function in the multiple roles psychiatrists can take on. This could create a stimulating opportunity for continuous education and further specialization linked to career stages on the basis of experience, interest and aptitude.

Status and funding

If psychiatry is to function effectively, it needs to be attractive as a specialty within medicine. If effective community services are to be developed, they should have a status at least comparable to hospital care. Neither is generally the case. The status of psychiatric services is mostly very low. Presently mental health funding is very low in many countries, not allowing the development of modern service delivery (5). There are also often disincentives against the delivery of community based services such as reimbursements based on hospital bed days and limited funding for community treatments. Most psychiatrists are comparatively poor earners due to reimbursement rates discriminating against mental illness. Examples are reliance on co-payments by poor patients suffering from severe mental health problems or exclusion of psychotherapies. Some countries also offer lower salaries to staff working in the community as compared to hospitals.

Legislation

Mental health legislation needs to create a value base for positive mental health care by establishing a balance between the rights to autonomy of people with mental health problems and their protection on behalf of society. Legislation also needs to provide a framework for effective practice, again balancing the clinical judgment of clinicians and the rights of patients and/or their relatives and/or society. The protection of clinicians also needs to be safeguarded. Although these balances will never be totally satisfactory to all interested parties, presently legislation in some countries is dysfunctional, hindering service innovation. There are also some examples where legislation is so innovative that it is out of touch with reality, and therefore ignored, creating a lack of respect for mental health and disinterest in modern practice.

Stigma

The negative consequences of stigma affect every part of mental health and much can be explained by its impact. Stigma leads to discrimination against patients and relatives. It causes the marginalization of psychiatry, and demoralizes the workforce. The intake of medical students into psychiatric training is low and declining in many countries at a time when more psychiatrists are needed. Psychiatric units are frequently placed in the most deprived part of general hospitals, if tolerated at all. This has a major negative impact on the status and effectiveness of psychiatrists, and is probably the key challenge to address to turn around the crisis faced by psychiatry in some countries.

CONCLUSION

The consensus achieved by the Helsinki Declaration, accepted by all 52 member states of WHO-EURO, offers a once in a generation opportunity to drive reform, and is already leading to considerable activity in areas of policy and practice. The strategies and legislation that are emerging across the Region endorse community based services. However, they also expose the challenges that have to be addressed for services to serve effectively and efficiently the needs of patients, families and staff. Psychiatrists are placed in leading positions and own much of the required expertise to address these challenges in many countries. There are opportunities to learn from experiences of research, policy and practice in diverse countries. It is an opportunity for professional organizations such as the WPA and the UEMS, in partnership with intergovernmental agencies such as the WHO, to harness the available knowledge and expertise to take on these challenges. The next decade has the potential to be memorable for mental health.

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Culture and mental health of women in South-East Asia

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This article reviews the impact of cultural factors on mental health of South Asian women. Marked gender discrimination in South Asia has led to second class status of women in society. Their mobility, work, self-esteem and self-image, in fact their worth and identity, seem to depend upon the male members of a patriarchal society. Women's lack of empowerment and both financial and emotional dependence have restricted their self-expression and choices in life. This, along with family, social and work pressures, has a definite impact on women's mental health.

Key words: Culture, mental health, women, patriarchal society, cultural violence

South-East Asia is the most heavily populated and amongst the poorest regions in the world. It faces enormous social, economic and health challenges, including pervasive inequality, violence, political instability and high burden of diseases.

When women's health has been addressed in this region, activities have tended to focus on issues associated with reproduction, such as family planning and child-bearing, while women's mental health has been relatively neglected.

In South-East Asia, most of the societies are predominantly patriarchal. The customary thought of people is that "girls are born to be fed throughout their lives" and "boys are born to earn and support the whole family". This thought is reflected through certain discriminative behaviors of people. The birth of a baby boy is celebrated with fervor even in very poor families, and they look for every possibility for celebration on the occasion of birth of a male child even if they have to take loan for it. On the other hand, the birth of a baby girl is not welcomed. The situation is even worse in some rural areas of India where the girls are even deprived of their right to live. Sex selection during pregnancy is still rampant in India, where women are forced to abort a female fetus. In one of the rural areas of India, it happened that, when a woman came home from hospital cradling her newborn daughter, her mother-in-law mashed a poisonous coriander into the dollop of oil and forced it down the infant's throat. The reason behind it was that sacrificing a daughter guarantees a son in next pregnancy. In Pakistan, although such extreme behaviors are not practiced, the couples are often forced by elderly members of family, particularly mother-in-laws, to keep on taking chances for the birth of a baby boy, which in many cases results in the birth of five or six girls.

In this region, some ancient traditions and customs are still followed promoting various forms of violence against women. These include honor killings, exchange marriages, marriage to Quran, Karo-kari, bride price, dowry, female circumcision, questioning women's ability to testify, confinement to home, denying their right to choose the partner. In some rural areas of Sindh, Pakistan and Punjab, India, girls are deprived of their marriage rights only to keep the property in the family. A cruel custom asking the girl to swear on Quran that she will leave her share of property to brothers adds misery to the already miserable lives of these incarcerated women.

The cultural norms prevailing in South-East Asia perpetuate the subordinate position of women socially and economically. In this region, very often young unmarried girls and women suffer tremendous physical and psychological stress due to the violent behavior of men. The nature of violence includes wife-beating, murder of wife, kidnapping, rape, physical assault, and acid throwing. The most frequent causes for acts of violence are domestic quarrels due to the inability of a woman's family to make dowry payments at time of marriage. Besides that, many women and young children from South-East regions are trafficked and forced into prostitution, undesired marriages and bonded labor. Illiteracy, political forces, a feudal and tribal culture, misunderstanding and misinterpretation of religious principles, and above all a girl's low status in the society encourage and sustain sexual exploitation of women. The trafficked victims face violence, intimidation, rape and torture from the employers, brothel owners and even law enforcement agents. This sexual servitude is maintained through overt coercion, physical abuse, emotional blackmail, economic deprivation, social isolation and death threats (1). Customs and traditions are often used to justify violence (2).

The present scenario in South-East Asia is still dramatic particularly in the rural and feudal areas, where the tribal chief and the Jirga remain in command. Non-governmental organizations, women rights movements, Amnesty International and human rights workers periodically manage to follow-up the victims of violence and bring the culprits to justice.

IMPACT OF CULTURAL VIOLENCE ON WOMEN'S MENTAL HEALTH

A meta-analysis of 13 epidemiological studies in different regions of India revealed an overall prevalence rate of mental disorders in women of 64.8 per 1000. Women had

significantly higher prevalence rates for neuroses, affective disorders and organic psychoses than men (3). A survey carried out in Nepal demonstrated that women had a higher psychiatric morbidity than men, with a sex ratio of 2.8:1 in the health post, and 1.1:1 in the district hospital (4). A study in Bangladesh showed that the sex ratio for mental disorders was 2:1 and that for suicide was 3:1 (5).

A study carried out in Pakistan (6) showed that factors associated with depressive disorders in upper and middle class women were marital conflicts (25.5%), conflict with in-laws (13%), financial dependency (10%), lack of meaningful job (14%), and stress of responsibilities at home and at work (9%). Another study conducted in the same country (7) revealed that the most frequent factors forcing women to commit suicide were conflicts with husband and in-laws. The women who face domestic violence from husband and in-laws have no way out, because the system considers these acts of violence as acceptable. The police and law enforcement agencies are normally reluctant to intervene, considering it a domestic dispute. If the woman abandons her marriage, she has to face innumerable problems, like non-acceptance from society, financial constraints and emotional problems of children growing up without father. The tendency of women to internalize pain and stress, and their lower status with less power over their environment, render them more vulnerable to depression when under stress.

It is generally accepted that employment generally has a beneficial effect on psychological health. It brings interest and fulfillment, structure and sense of control as well as income, social status and social contacts. Women in South-East Asia have fewer opportunities for paid jobs, which affects their mental well-being.

In some regions of South East Asia, violence has reached staggering levels; in a recent population-based study from India, nearly half of women reported physical violence (8). In most of South Asian countries, only women are thought to be responsible for producing the next generation, and the blame for the absence of the desired number of children is unquestioningly placed on them, leading to a destabilization of their social status (9-11). Studies have revealed that severe emotional harassment is experienced by a large number of these women in their marital homes in the form of ostracism from family celebrations, taunting and stigmatization, as well as beating, and withholding of food and health care (12,13). A study carried out in Karachi explored the experiences among women suffering from secondary infertility: 10.5% of them reported they were physically and verbally abused by husbands and 16.3% by in-laws. Nearly 70% of women facing physical abuse and 60% of those facing verbal abuse suffered severe mental distress (14).

There are several types of violence against women, not all of which take the form of brutal assaults. Demands by society on widows, however young they were, to lead a rigidly austere life, socially isolated and without any access to men, have been condoned for ages as necessary measures to keep them from temptation and sin. The practice of

"*sati*" in certain parts of India, by which the wife threw herself into the funeral pyre of her husband, has been documented in the not too distant past. Such behaviors of self-denial, torture and even death are indeed sanctified and glorified and there are even temples erected for the goddess of *sati*.

The rate of mental distress has been reported to be high also in working women in South-East Asian countries, and cultural factors are among the contributing variables (15). This mental distress usually remains unacknowledged (16). Finally, the recent economic reforms in South-East Asia have been accompanied by a rise in the incidence of reported domestic violence, rape and alcohol abuse (17).

CONCLUSIONS

Even in the new millennium, women in South Asia are deprived of their socio-economic and legal rights. They live in a system where religious injunctions, tribal codes, feudal traditions and discriminatory laws are prevalent. Thy are beset by a lifetime social and psychological disadvantage, coupled with long years of child bearing. They often end up experiencing poverty, isolation and psychological disability. In some urban regions of South-Asian countries, women's social roles have changed to some extent. They have now comparatively more opportunities for education, employment and enjoyment of civil rights within society. However, the de-stereotyping of the gender roles which have been traditionally assigned by our society is still far away.

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Letter to the Editor

Rosen's impressive article (1) draws on an all-embracing global perspective to propose an anti-stigma strategy for implementation in "day to day practice". This represents a welcome turn (which one hopes will be sustained) in which a serious interest is demonstrated by a Western psychiatrist in incorporating findings from worldwide "ethnographic" material into some sort of general manifesto for change.

Perhaps surprisingly, this position represents a notable development from a previous too pervasive tendency to gather and report ethnographic or anthropological material in a manner which fed into a rather voyeuristic desire in Western psychiatry to gaze on those elements in other cultures which were perceived to be "bizarre", "exotic" or "curious". Terms such as "primitive" and "third world" of course did not help conspiring to mute the West's receptivity to the values/ideas of "Eastern" or "traditional" cultures. Yet the tone of receptivity exemplified by Rosen, if maintained, may well yield fruitful dividends.

Such a global perspective will, I believe, ultimately if somewhat paradoxically bring into clarity the values and assumptions inherent to Western culture which, although not always so tangible, nonetheless constitute the very ground beneath our feet. There may well be a realisation (and it will be a disconcerting and humbling experience at first) that such values, assumptions and tendencies may themselves be implicated in the stigmatisation and alienation of certain groups. Amongst these: dichotomous conceptualizations of health and disease, a cultural idealisation of "rationality" and denigration of all that is "irrational", relative hostility to "non-scientific" explanations be they folk, spiritual, transcendental etc., and the relentless pursuit of categorisation and classification with an insistence that individuals "inhabit" identities which damage their senses of selfhood.

Anthropologists have for decades been observing that social alienation or stigmatisation following psychosis is not as inevitable a phenomenon cross culturally as it is in modern Western society. The anthropologist Devereux, writing in 1956 and remarking on primitive society's response to the psychotic individual, stated: "The structure of society was such that it did not result in the psychotic either 'losing status' or being 'wrenched away' from the setting of his regular life" (2). My own recent observations in rural Northern India support such findings. But Rosen is most in tune with the idea that a worldwide appraisal of the psychotic experience can offer clues to contemporary anti-stigma campaigns illustrating that insights from ethnopsychiatry or anthropology may be "imported" to inform daily psychiatric practice. Rosen also shows that the needs of psychiatry (indeed those of society) are not best met by anthropology (or the humanities in general) maintaining a distant relationship with psychiatry, as currently seems to be the case (see 3), but through a more intimate relationship offering the possibility of mutual enrichment.

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Triennial General Survey of WPA activity (2002-2005)

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The WPA General Survey is aimed at obtaining a deeper understanding of the Association, at monitoring its functioning in the diverse domains of its constitutional responsibilities, and at obtaining a firmer base for informing the development of its strategies and policies. Furthermore, the Survey represents a channel of institutional participation that promotes the interaction and integration of WPA components as well as a thoughtful debate on its procedures and activities.

During the 1993-1996 period, a first survey was carried out. It was centered on ten questions addressed to Member Societies. Responses were presented narratively and many in the language of the responders. In spite of its difficulties, the survey provided some useful information and can be regarded as a valuable precedent for the two more recent exercises.

The 1996-1999 General Survey was extended to all components of the WPA. It covered ten principal areas of activity of the Association through 45 questions. The responses were organized in two modalities: check-off (principally for evaluative ratings) and concise text (for suggestions and individualized information). Almost all the participants used English in their responses.

The General Survey for the period 1999-2002 was extended to all core WPA components and covered twelve areas of WPA activity through 51 questions. Important new areas of WPA work, such as zonal activities and consensus statements, were incorporated, maintaining both check-off responses and narrative comments.

The General Survey for the period 2002-2005 covered new areas of activity reflecting growing institutional development. However, the structure of the previous questionnaire was maintained to facilitate comparisons across governance periods.

The draft of the Survey was designed by the WPA Secretary General and then modified on the basis of the input of the WPA Executive Committee. The Office of the Secretary General at Keele University distributed the questionnaire to officers and leaders of all WPA components. The distribution was made by fax or e-mail. The questionnaire was resent a second and a third time if no response had been received.

The raw baseline number of questionnaires distributed was 261 (125 Member Societies, 55 Sections, 8 Executive Committee members, 18 Zone Representatives, 10 Council members, 20 Standing Committee members and 25 Operational Committee members). However, after eliminating duplications derived from the fact that some officers hold more than one position, 227 questionnaires were used as the reference base. The final response rate was 64% (64% for Member Societies, 73% for Sections, 88% for Executive Committee

Table 1 Fulfillment of WPA statutory purposes

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
To increase knowledge and skills for mental health care	Fulfilled	93.2	89.1	80.6
	Not Fulfilled	2.7	4.9	7.5
	Unrated	4.1	6.0	11.8
To improve care for the mentally ill	Fulfilled	78.1	72.3	57.0
	Not Fulfilled	15.1	20.1	25.8
	Unrated	6.8	7.6	17.2
To promote prevention of mental disorders	Fulfilled	69.9	62.0	42.5
	Not Fulfilled	26.7	29.3	40.9
	Unrated	3.4	8.7	16.7
To promote mental health	Fulfilled	79.5	69.6	50.5
	Not Fulfilled	16.4	22.8	31.2
	Unrated	4.1	7.6	18.3
To preserve the rights of the mentally ill	Fulfilled	82.9	74.5	62.4
	Not Fulfilled	12.3	19.0	21.5
	Unrated	4.8	6.5	16.1
To promote the highest ethical standards in psychiatric care, teaching and research	Fulfilled	87.0	76.1	65.6
	Not Fulfilled	9.6	16.8	19.9
	Unrated	3.4	7.1	14.5
To promote the highest quality standards in psychiatric care, teaching and research	Fulfilled	77.4	64.7	
	Not Fulfilled	17.8	27.7	
	Unrated	4.8	7.6	
To promote non-discrimination (parity) in the provision of care of the mentally ill	Fulfilled	72.6	70.7	50.5
	Not Fulfilled	21.9	22.8	31.2
	Unrated	5.5	6.5	18.3
To protect the rights of psychiatrists	Fulfilled	65.8	50.0	31.7
	Not Fulfilled	26.0	40.2	46.2
	Unrated	8.2	9.8	22.0

Table 2 Performance of WPA Secretariat activities

	2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
Poor	1.4	2.2	8.1
Fair	12.3	10.3	23.7
Good	52.1	38.6	45.7
Excellent	30.8	42.4	18.8
Unrated	3.4	6.5	3.8

members, 88% for Zone Representatives, 14% for Council members and 25% for Standing/Operational Committee members).

The results of the Survey, compared to those concerning the 1999-2002 and 1996-1999 periods, are presented in Tables 1-7.

Table 3 Overall quality of WPA Educational Programs

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
	Poor	2.1	3.3	3.8
	Fair	15.1	9.2	16.1
	Good	51.3	53.3	53.8
	Excellent	19.9	16.8	10.2
	Unrated	11.6	17.4	16.1

Table 4 Performance of WPA Sections

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
WPA Sections´ Newsletter	Poor	2.7		
	Fair	14.4		
	Good	61.0		
	Excellent	17.8		
	Unrated	4.1		
Volume "Advances in Psychiatry"	Poor	2.7		
	Fair	10.3		
	Good	46.6		
	Excellent	25.3		
	Unrated	15.1		
Information on WPA Sections	Poor	10.3	20.6	26.9
	Fair	37.0	28.9	36.6
	Good	39.0	34.2	26.3
	Excellent	8.2	8.2	4.8
	Unrated	5.5	7.1	5.4
Internal organization and functioning of individual Sections	Poor	8.2	9.8	
	Fair	33.6	34.8	
	Good	39.7	32.1	
	Excellent	4.8	4.3	
	Unrated	13.7	19.0	
Current extent and functioning of cross-sectional collaboration	Poor	18.5	25.0	
	Fair	39.7	38.0	
	Good	23.3	15.8	
	Excellent	4.8	2.7	
	Unrated	13.7	18.5	
Meetings organized by the Sections	Poor	5.5		
	Fair	17.1		
	Good	45.9		
	Excellent	13.7		
	Unrated	17.8		
Publications produced by individual Sections (books, journals, bulletins, newsletters)	Poor	5.5		
	Fair	23.3		
	Good	43.8		
	Excellent	11.6		
	Unrated	15.8		
Educational programs produced by the Sections	Poor	9.6		
	Fair	22.6		
	Good	44.5		
	Excellent	6.2		
	Unrated	17.1		
Consensus statements produced by the Sections	Poor	8.2		
	Fair	21.9		
	Good	41.8		
	Excellent	10.3		
	Unrated	17.8		
Overall performance of WPA Sections	Poor	5.5	9.2	12.4
	Fair	21.2	29.4	31.7
	Good	50.0	38.0	34.9
	Excellent	8.9	6.5	2.7
	Unrated	14.4	16.9	18.3

With respect to the fulfillment of WPA purposes, ratings were almost consistently high (Table 1). Furthermore, they were higher than those of the 1999-2002 Survey, and these were in turn consistently higher than those of the 1996-1999 Survey. The purposes with the highest fulfillment rates were "to increase knowledge and skills for mental health care" (93.2%), "to promote the highest ethical standards" (87.0%), and "to preserve the rights of the mentally ill" (82.9%). At the other end of the spectrum, the purposes receiving the lowest fulfillment rates were "to promote prevention of mental disorders" (69.9%) and "to protect the rights of psychiatrists" (65.8%). Also to be noted as positive is the decreased percentage of "unrated" responses from the preceding Surveys to the present one. The principal suggestions among the many offered to improve purposes not adequately fulfilled – "to upgrade ethics, human rights and legislation in psychiatric care" and "to improve psychiatric services and to promote prevention for mental illness" – reflect a genuine insistence on crucial aspects of our institutional mission.

Among the needs of Member Societies and other components, "financial, strategic, and logistic support", "quality educational materials and training activities" and "collaboration with and among WPA Sections and Committees" were the most frequently reported.

The performance of the WPA Secretariat (Table 2) was perceived as "excellent" by 30.8% of the respondents and as either "excellent" or "good" by 82.9% (a similar proportion of positive responses to the previous triennium). Careful attention needs to be given, however, to those responses which suggested improvement to the services provided: the principal suggestion was "greater support to WPA components", followed by "more frequent use of modern technology (internet: e-mail, website)" and "increased financial and logistic conditions".

Regarding current WPA zonal structure and activities, the majority of the perceptions were either "good" or "fair". The most frequently mentioned sugges-

tions were "to improve organizational contacts and zonal meetings", "to improve information on Zone activities and plans, and zonal newsletters", and "to adjust the structure and functions of Zones and Zone Representatives". These findings are very consistent with the preceding Survey and require special attention.

Quite encouraging were the positive ratings obtained for the external visibility and impact of WPA, which was rated as "good" or "excellent" by 62.4% of the respondents, a percentage which is similar to that of the 1999-2002 Survey and much higher than that of the 1996-1999 Survey. The most frequent recommendations to improve the external visibility of WPA were "to improve communications and activities with Member Societies, zones and regions", "greater use of mass media, psychiatric journals, and the internet", "to improve editorial and publishing capacity", and "to improve partnership with international organizations and governments".

Within WPA educational activities (Table 3), individual educational programs tended to have more positive ratings than before concerning knowledge about them, their use, their evaluation, and interest in using them. The perceived overall quality of WPA educational programs – 71.2% as "excellent" or "good" – was higher than in the previous two trienniums. Suggestions offered for improving and developing educational programs were focused on "specialized programs in the Sections' domains", "greater distribution of programs through Member Societies, Zones and other psychiatric institutions" and "greater accessibility to educational programs". Interest for WPA educational activities, in addition to educational programs, was also substantial, especially with regard to "public education" and "educational liaisons networks".

The WPA Sections activities (Table 4) received growing ratings over the past governance periods, the best of which corresponded to the Sections Newsletter and "Advances in Psychiatry". Comparative ratings across time, including those for overall Sections performance (58.9% "excellent" or "good"), showed

Table 5 Performance of WPA meetings

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
Scientific quality of latest World Congress of Psychiatry	Did not attend	21.2	12.5	11.3
	Poor	1.4	2.1	1.6
	Fair	11.6	9.8	12.9
	Good	42.5	48.4	45.7
	Excellent	19.9	22.3	24.2
	Unrated	3.4	4.9	4.3
Fellowship and Young Participants Programs at latest World Congress of Psychiatry	Did not attend	26.7	22.3	
	Poor	0.7	0.5	
	Fair	12.3	9.8	
	Good	30.1	35.9	
	Excellent	24.0	25.0	
	Unrated	6.2	6.5	
Social and cultural quality of latest World Congress of Psychiatry	Did not attend	20.5	15.2	11.8
	Poor	4.1	2.2	3.2
	Fair	15.8	20.1	16.7
	Good	35.6	40.7	44.1
	Excellent	17.8	15.8	19.4
	Unrated	6.2	6.0	4.8
Overall quality of recent WPA Regional Meetings	Did not attend	30.1	27.2	50.0
	Poor	0.7	2.2	2.2
	Fair	11.6	8.7	7.5
	Good	41.9	47.8	26.9
	Excellent	8.9	4.9	8.1
	Unrated	6.8	9.2	5.4
Society or component interested in organizing a WPA Meeting	Yes	65.8	57.6	
	No	15.8	16.9	
	Unrated	18.4	25.5	

clear improvement over previous trienniums (44.5% in the 1999-2002 Survey and 37.6% in the 1996-1999 Survey). The most recognized WPA Sections were those on Classification, Diagnostic Assessment and Nomenclature; Affective Disorders; Women's Mental Health; and Preventive Psychiatry.

Regarding WPA meetings (Table 5), the ratings for the World Congress of Psychiatry in Yokohama (e.g., 62.4% "excellent" or "good" for its scientific program) were slightly lower than those of previous World Congresses. The perception of the overall quality of recent WPA Regional Meetings (50.8% "good" or "excellent") was comparable to that of the previous period. The expressions of interest obtained for organizing WPA scientific meetings were quite encouraging (65.8%). The main recommendations to improve WPA congresses and meetings were to enrich the scientific programs (with recent research, courses, debates and continuing medical education), "to improve the professional organization and promotion of the meetings", and "to promote the partici-

pation of leaders of Member Societies and developing countries".

With respect to WPA publications (Table 6), the various components of the WPA publications program, particularly the WPA official journal World Psychiatry (85% "excellent" or "good"), received substantial ratings. The perceived overall quality of the WPA publications program, 76.7% as either "excellent" or "good", was clearly higher than at the preceding Surveys. The suggestions to improve WPA publications focused on "upgrading the WPA program of publications", "improving distribution and accessibility of World Psychiatry", and "more promotion to reach wide audiences".

In regard to WPA consensus statements, 39.1% of the respondents reported being unaware of them or left the item unrated. Most of the specific ratings were either "good" or "excellent" (46.6%). The most prominent topics proposed for consensus statements were related to social and public psychiatry, ethical issues and problematic situations, and psychosocial interventions.

Table 6 Performance of WPA publications

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
"World Psychiatry", official journal of the Association	Poor	0.7		
	Fair	7.5		
	Good	51.4		
	Excellent	33.6		
	Unrated	6.8		
Series "Evidence and Experience in Psychiatry"	Poor	0.7	2.2	
	Fair	11.6	10.9	
	Good	38.4	31.0	
	Excellent	24.0	16.3	
	Unrated	25.3	39.6	
Volumes originating from the World Congress of Psychiatry	Poor	1.4	2.2	
	Fair	13.7	21.2	
	Good	39.6	45.1	
	Excellent	15.8	9.2	
	Unrated	29.5	22.3	
Series "Anthologies in Psychiatry" and "Images of Psychiatry"	Poor	2.1	2.2	
	Fair	15.8	15.2	
	Good	39.7	34.3	
	Excellent	11.6	9.2	
	Unrated	30.8	39.1	
Overall quality of the WPA Publications Program	Poor	0.7	1.1	8.6
	Fair	9.6	12.5	33.9
	Good	50.7	53.8	34.9
	Excellent	26.0	9.2	8.1
	Unrated	13.0	23.4	14.5
Contribution of royalties from publications to WPA finances	Poor	1.4		
	Fair	14.4		
	Good	26.0		
	Excellent	10.3		
	Unrated	47.9		

Table 7 WPA finances

		2002-2005 Survey (%)	1999-2002 Survey (%)	1996-1999 Survey (%)
Information on the financial situation of WPA	Poor	33.6	29.3	40.9
	Fair	30.1	18.5	25.3
	Good	24.0	31.0	19.4
	Excellent	3.4	10.9	3.2
	Unrated	8.9	10.3	11.3
New differential dues structure	Poor	6.2	6.5	
	Fair	19.2	13.1	
	Good	39.0	44.0	
	Excellent	19.2	22.8	
	Unrated	16.4	13.6	
Fund raising activities of WPA	Poor	7.5	9.8	
	Fair	31.5	25.0	
	Good	31.5	35.3	
	Excellent	2.1	2.2	
	Unrated	27.4	27.7	
Allocation and use of WPA financial resources	Poor	4.8	8.7	10.8
	Fair	25.3	21.2	29.0
	Good	39.8	33.7	19.9
	Excellent	3.4	6.0	2.7
	Unrated	26.7	30.4	37.6

Concerning WPA finances (Table 7), the information on the financial situation of the WPA (27.4% "good" or "excellent") was perceived somewhat less positively than in the preceding survey (41.9% "good" or "excellent"). The differential dues structure (based on the World Bank classification of the various countries) received a 58.2% "good" or "excellent" response rate. Fund raising activities were perceived as "good" or "excellent" by 33.6% of respondents. The allocation and use of WPA financial resources (43.2% "good" or "excellent") was rated somewhat higher than previously. The most frequent suggestions to improve fund raising activities and use of WPA financial resources were "to seek funds from international agencies and other fund raising innovative plans", "to distribute financial reports regularly", and "to allocate resources for Section, educational, and publication activities".

With respect to ethical standards and activities, the quality of the WPA Declaration of Madrid and its additional guidelines obtained one of the highest ratings of the Survey (27.4% for "excellent" and 71.9% for "good" or "excellent"). The percentage of Member Societies with ethics committees seems to be increasing (64.4% as compared to 57.6% before). Information on WPA activities concerning review of abuse of psychiatry was rated as "good" or "excellent" by 37.7% of the respondents. About half of the respondents (52.8%) reported massive or substantial local stigma against psychiatry and mental patients, slightly higher than in the preceding triennium (48.3%). The most frequent recommendations to advance ethical standards and activities included "extending high quality ethics activities throughout WPA programs, media and consumers", "adoption of the Madrid Declaration and establishment of national ethics committees", and "joint ethics efforts with international organizations and national governments".

These results reveal the progress achieved by WPA in the fulfillment of its statutory purposes over the course of three trienniums. Also remarkable are the advances obtained in a whole range of institutional activities, including areas that in the past exhibited considerable limitations. Further worth noting is the diversification of WPA sectorial activities reflected in the increased itemization required for the present General

Survey, a diversification that is a referent of institutional vitality.

A major limitation of this Survey is the response rate of 64%. For a postal questionnaire this is acceptable, but this percentage is considerably lower than the 90% for the previous triennium, although similar to that obtained in 1996-1999. Reasons for non-responding may include language problems, lethargy, lack of information and possibly a concern about confidentiality. The characteristics of those Societies and Sections that did not return a completed questionnaire are not such as to unduly bias the results, or make invalid the broad conclusions summarized in this report.

Comparisons with previous trienniums are interesting, but should not be considered as statistically valid or necessarily significant. Not all the strengths and weaknesses of the WPA could be measured in this postal survey: we would recommend that a review is undertaken of the size and content of the questionnaire, as well as its value for money (cost approximately $10,000). The Executive Committee may wish to consider an alternative external audit of WPA institutional structure and function, although it may be difficult to find an individual or a management organization with relevant background experience to undertake this task.

The Survey provides in our opinion ample evidence that the WPA is indeed growing in its breadth and strength. The evidence for this is contained not just in the responses to questionnaire items but also in the constructive and detailed narrative comments. These include many interesting and important suggestions that need to be carefully considered.

WPA Scientific Meetings: the link between sciences and quality of care

PEDRO RUIZ
WPA Secretary for Meetings

I was elected WPA Secretary for Meetings during the 12th World Congress of Psychiatry in 2002, after serving in the WPA Operational Committee on Scientific Meetings for the period 1999-2002. I brought to the WPA my experience as Chairperson of the Scientific Program Committee of the American Psychiatric Association (APA) Annual Meeting in the period 1998-2000, during which I organized the 1999 APA Annual Meeting in Washington, D.C., and the 2000 APA Annual Meeting in Chicago.

With this type of background and prior experience in organizing scientific meetings, I decided to reconceptualize the meaning and vision of the WPA scientific meetings, with the help of the WPA Operational Committee on Scientific Meetings, which during the period 2002-2005 was composed of F. Antun (Lebanon), E. Belfort (Venezuela), M.I. López-Ibor (Spain) and J. Raboch (Czech Republic), plus D. Moussaoui (Morocco) as a consultant.

During our June 2003 Committee meetings in Vienna, we elaborated a new set of bold ideas to be implemented as part of our tasks and functions. Among them: a) to improve the scientific quality of the WPA scientific meetings; b) to initiate a methodological evaluation of World Congresses of Psychiatry, beginning with the 13th World Congress of Psychiatry in 2005; c) to link with the WPA Secretary for Education for the purpose of offering continuing medical education (CME) credits in as many major (sponsored) WPA scientific meetings as possible; d) to expand the number of WPA scientific meetings to be held during the period 2002-2005; e) to attempt to offer WPA scientific meetings in all WPA Zones across the world; f) to offer scientific sessions in as many WPA scientific meetings as possible on the topic of "How to organize scientific meetings".

The essence behind these six objectives was to have as the overall goal of our Committee an overreaching "mission" and "vision". The mission was: a) to increase the number of scientific sessions conducted in our WPA scientific meetings; b) to focus as much as possible on evidence-based knowledge using research-oriented and educationally-oriented presentations; c) to reach out to areas in the world where the need for psychiatric and/or mental health services was most significant; d) to bring in and reach out to as many psychiatrists and other health/mental health professionals, as well as allied health/mental health professionals and/or trainees, as possible via the increase in the number of WPA scientific meetings. Fortunately, our mission for the 2002-2005 period was fully accomplished, as I will demonstrate later in this article. The vision was: "via the dissemination of evidence-based scientific knowledge, along the lines of research and educational activities, to transform these scientific efforts in high quality of psychiatric and mental health care services across the world, particularly where they are needed the most, and through the clinical efforts of the psychiatrists and mental health professionals, as well as allied health/mental health professionals and/or trainees". Empirically, we also accomplished this vision.

THE SCIENTIFIC EFFORT DURING 2002-2005

During the triennium 2002-2005, the WPA Secretary for Meetings' Office, with the assistance of the WPA Operational Committee on Scientific Meetings, helped to organize 12 WPA sponsored scientific meetings; 17 WPA Sections' sponsored scientific meetings; 35 WPA Member Societies' co-sponsored scientific meetings; and 43 WPA co-

sponsored scientific meetings through major international professional organizations.

In total, 107 WPA scientific meetings were organized in this triennium. Never before in the history of the WPA were so many scientific meetings organized in a given triennium. This resulted in an estimated number of 106,801 psychiatrists and mental health professionals as well as allied health/mental health professionals and/or trainees attending these meetings, a number never achieved before in the history of the WPA. Additionally, a scientific evaluation component was fully and successfully implemented in the 13th World Congress of Psychiatry held in Cairo in September 2005. CME credits were offered not only in this World Congress of Psychiatry, but in many other WPA sponsored scientific meetings during this triennium as well. Furthermore, several special scientific sessions on the topic of "How to organize scientific meetings" were conducted. These figures clearly demonstrate that the "mission" that we designed was well accomplished during the 2002-2005 triennium.

The 12 WPA sponsored scientific meetings during the 2002-2005 triennium were held in: Lima, Peru (WPA Regional Meeting, October 2002); Vienna, Austria (WPA Thematic Conference, June 2003); Caracas, Venezuela (WPA International Congress, October 2003); New York, USA (WPA Thematic Conference, May 2004); Prague, Czech Republic (WPA Regional Meeting, June 2004); Lahore, Pakistan (WPA Regional and Interzonal Meeting, September 2004); Florence, Italy (WPA International Congress, November 2004); Craiova, Romania (WPA Regional Meeting, December 2004); Mar del Plata, Argentina (WPA Regional Meeting, April 2005); Athens, Greece (WPA Regional and Intersectional Congress, May 2005); Valencia, Spain (WPA Thematic Conference, June 2005); and Cairo, Egypt (World Congress of Psychiatry, September 2005).

Of major significance was also the distribution of the 107 WPA scientific meetings during the 2002-2005 triennium. They were distributed worldwide as follows: one in Zone 1 (Canada); seven in Zone 2 (United States); seven in Zone 3 (Mexico, Central America and the Caribbean); five in Zone 4 (Northern South America); eighteen in Zone 5 (Southern South America); sixteen in Zone 6 (Western Europe); two in Zone 7 (Northern Europe); nineteen in Zone 8 (Southern Europe); six in Zone 9 (Central Europe); five in Zone 10 (Eastern Europe); three in Zone 11 (Africa and the Middle East); six in Zone 14 (Eastern and Southern Africa); two in Zone 15 (Western and Central Africa); three in Zone 16 (Southern Asia); four in Zone 17 (Eastern Asia); and three in Zone 18 (South Pacific). Never before in the history of the WPA have so many WPA Zones been reached insofar as WPA scientific meetings are concerned in a given triennium. These figures and data seem to demonstrate, empirically, that the "vision" that we designed was almost fully accomplished.

FUTURE OUTLOOK

Undoubtedly, nowadays a major emphasis on scientific knowledge in all aspects of the field of psychiatry has been observed in most industrialized nations; particularly, under the model of evidence-based medicine. This is also reflected in the growth of specializations in the field of medicine, as well as in the emphasis given to special issues such as ethics, ethnic minorities, and primary care. Besides, much attention is also given these days to certification and recertification, as well as core competencies. Given this context of priorities in the field of psychiatry among most industrialized nations, it is imperative that we take them into consideration with respect to the future activities pertaining to WPA scientific meetings.

Following the 13th World Congress of Psychiatry held in Cairo, Egypt in September 2005, a new group of members were appointed to the WPA Operational Committee on Scientific Meetings, which will continue to function under my leadership as Chairperson of this Committee for another triennium (2005-2008). The new group of members are M.I. López-Ibor (Spain), N. Loza (Egypt), H. Ma (China), and J. Raboch (Czech Republic). The new consultants are F. Antun (Lebanon), L. Kuey (Turkey), and T.A. Peon Valdez (Cuba). Most probably, the future trends of our Committee will be similar to the ones of the last triennium, with additional emphasis given to the issues addressed previously with respect to evidence-based medicine, CME, core competencies and special topics such as ethics, primary care, and ethnic as well as cultural factors.

The response from the field is as strong as it was in the 2002-2005 triennium. For instance, there are already 57 WPA scientific meetings scheduled for this triennium (2005-2008), of which 39 will be WPA co-sponsored scientific meetings and 18 WPA sponsored scientific meetings. Among the WPA sponsored scientific meetings, one is the 14th World Congresses of Psychiatry to be held in Prague, Czech Republic in September 19-25, 2008. Two are the WPA International Congresses of Psychiatry (Istanbul, Turkey in July 2006 and Melbourne, Australia in November 2007). Three will be WPA Thematic Conferences (Madrid, Spain, in April 2006, Dresden, Germany, in June 2007, and Granada, Spain, in June 2008). Eight will be WPA Regional Meetings (Mexico, 2005; Cuba, 2006; Peru, 2006; Hungary, 2007; Kenya, 2007; South Korea, 2007; China, 2007; and Argentina, 2007). Finally, four will be WPA Section Meetings (France, 2006; Italy, 2006; Tunisia, 2007; and Morocco, 2007).

With this strong demonstration of interest among WPA Member Societies and the new group of members of the WPA Operational Committee on Scientific Meetings, it looks that we will not only have the same level of success that we had in the 2002-2005 triennium, but will surpass that level. If this prediction and expectation is met, the efforts of this triennium will make, once more, a major contribution to the quality of psychiatric and mental healthcare services offered across the world and, in particular, among emerging countries.

WPA International Congress 2007 (Melbourne, Australia, November 28-December 2)

HELEN HERRMAN

Chairperson, Organizing Committee

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes you to Melbourne in 2007, where it will host the first WPA International Congress in Australasia, from November 28 to December 2. The theme is "Working Together for Mental Health: Partnerships for Policy and Practice".

The Congress aims to encourage the engagement of many groups concerned with mental health. The scientific program will have three major streams: clinical practice, policy and partnerships. Four principles will govern the design of the program: diversity of content; a group of internationally recognized speakers; a regional focus; and community involvement in mental health.

The program will address a range of topics appealing to psychiatrists globally and in the Asia Pacific region. It is also designed to interest mental health professionals, medical and other health professionals, those affected by mental illness, including consumers and carers, and other important groups such as people working in the media and related fields, and community leaders. The Congress will offer a number of unique opportunities for all concerned with mental health, including research and educational institutions, government, community and associated health industries.

A number of the world's leading experts in their field will gather in Melbourne. The scientific program topics will include among others: regional and cross-cultural collaboration; advances in the management of psychosis and mood disorders; psychiatry and physical illness; addiction psychiatry; policy development; psychology; old age; nursing; service models: evidence and implementation; infant, child and adolescent psychiatry; biological psychiatry/psychopharmacology; consumers, carers and community agencies; primary care and mental health.

The Congress will provide a forum for all to hear the latest opinions and research, engage in great discussion and debate and raise the awareness of mental health globally. An exciting social program will give delegates the opportunity to experience Melbourne's vibrant culture, first class entertainment and many opportunities to relax and meet a wide range of people in the mental health field.

J. Mezzich is the Congress President, H. Herrman is Chair of the Organising Committee, M. Maj is Chair of the Scientific Committee. J. Freidin and P. Ruiz are Co-Chairs of the Organising Committee, whose members include S. Tyano, B. Singh and S. Brownie. K. Kirkby is Co-Chair of the Scientific Committee, A. Tasman is Chair of the International Scientific Advisory Council, C. Ng is Chair of the Local Scientific Program Committee.

Abstract proposals can be submitted online from 18 May 2006 for symposia, workshops, free papers and posters. Registration for the Congress opens November 2006. For further information please visit the website www.wpa2007melbourne.com.

This will be the most significant Mental Health Congress held in Australasia – an event not to be missed. We look forward to seeing you in Melbourne in 2007!