Correspondence

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Cultural consultation in psychiatric practice

While Bhui/Sashidharan (2003) raise important questions in the debate on whether there should be separate psychiatric services for ethnic minorities in the UK, a cross-national comparative perspective can shed light on alternative models, which could valuably inform British debate (Kirmayer & Minas, 2000). For example, a substantial research literature has arisen in Australia regarding the importance of providing services to minorities in their own languages (e.g. Ziguras *et al*, 2003). Similarly, in the USA there is an important literature on the effectiveness of services that ethnically match service users and professionals (e.g. Rosenheck *et al*, 1995). These issues may be fundamental in any encounter between providers and users and deserve the appropriate attention.

The cultural consultation model developed in Canada (Kirmayer *et al*, 2003) attempts to take into account culture-specific factors to improve diagnostic assessment, treatment planning and case management. The enormous diversity of Canadian society is not captured by the broad ethno-racial categories commonly used in the UK and USA; thus, specialised clinics for each minority group are not feasible. The consultation model does not assume that any clinician can be a 'fount of all wisdom', intimately knowing all ethnic, cultural and linguistic groups. The consultation draws on a bank of translators, culture-brokers, anthropologists, religious informants, traditional healers and mental health professionals who can be appropriately assembled to help referring clinicians with assessment and treatment. The aim is to improve the quality of care at all levels of the health care system rather than segregate ethnic-groups. Every consultation is an opportunity for in-service training of referring clinicians, with an emphasis on transfer of knowledge. This increases their cultural competence and facilitates collaborative work with culture-specific resources in both the health care system and the community.

Bhui rightly notes that this model, like any other service, will fail without sustained funding. There are also medico-legal issues related to the use of culture-brokers that must be addressed before implementation. However, the model provides an important resource that can promote the appropriate diagnosis and treatment of service-users, while gradually enhancing cultural awareness throughout the health care system.

Bhui, K./Sashidharan, S. P. (2003) Should there be separate psychiatric services for ethnic minority groups (debate)? *British Journal of Psychiatry*, **182**, 10–12.

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R. Whitley, L. J. Kirmayer, G. E. Jarvis Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, 1033 Pine Avenue West, Montréal, Québec, Canada, H3A 1A1. E-mail: robert.whitley@mail.mcgill.ca

Author's reply: The debate on specialist services for Black and minority groups is a most welcome opportunity to compare and contrast international models of culturally capable services. Whitley, Kirmayer & Jarvis echo the proposal by Waheed *et al* (2003) that the consultation model established in Canada is to be commended, irrespective of the context in which service models are located. The Canadian approach to diversity in society and in mental health services appears to be more welcoming and supportive in terms of financial investment; furthermore, such an approach endorses the view that specialist rather than separate provision can be useful and is necessary to meet the needs of ethnic minority citizens.

The issue in the UK is that separate funding for special services is rarely available and, as outlined in the original debate (Bhui/Sashidharan, 2003), is ideologically opposed by providers in favour of an integrationist solution. However, this strategy has failed to ensure that generic mental health services are culturally capable or appropriate. Two recent policy documents launched by the Department of Health (2003*a*,*b*) attack this issue from quite distinct perspectives, but neither promotes specialist service provision or the consultation model, which, in the UK at least, has often been championed by charismatic and highly motivated clinicians, without the support of sustained investment or a spread of learning throughout the workforce. The first of these policy documents (*Inside Outside*; Department of Health, 2003*a*) recommended a cultural capability framework in which a consultation model may have been usefully located but, to date, there is no implementation plan. In some ways these issues are not dissimilar to debates about models of assertive outreach or early intervention, and whether such services are similarly valuable in different cultural and service contexts, irrespective of the transferability of the model. By default, specialist services are being provided in the voluntary sector in the UK; perhaps the consultation model can be commended to policy makers and service providers in the UK as an approach worthy of investment and evaluation. This will need commitment to improve clinical practice skills, and a reorganisation of services, including specialist provision where appropriate.

Bhui, K./Sashidharan, S. P. (2003) Should there be separate psychiatric services for ethnic minority groups (debate)? *British Journal of Psychiatry*, **182**, 10–12.

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Department of Health (2003*b*) *Delivering Race Equality: A Framework for Action. Mental Health Services Consultation Document*. London: Department of Health.

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K. Bhui Barts & The London School of Medicine, Queen Mary, London E1 4NS, UK

Dhat syndrome: a functional somatic syndrome?

We read with interest the historical overview on *dhat* syndrome by Sumathipala *et al* (2004). We agree with the authors' contention that categorising it as a culture-bound syndrome is not likely to advance research. The authors examine the nosological significance of this disorder and suggest the possibility of culturally influenced somatoform disorder, although they do not offer a detailed model. In the spirit of Sumathipala *et al*'s conclusion that there are no absolute truths when it comes to classificatory systems, we propose the following formulation.

Fatigue is a common symptom in *dhat* syndrome (Bhatia & Malik, 1991). Disorders with fatigue as the main symptom are often grouped together as functional somatic syndromes (Barsky & Borus, 1999). The basic cognitive formulation offered to explain these disorders is based on somatosensory amplification, misattribution and abnormal illness behaviour. We have incorporated societal and cultural factors along the lines of the socio-somatic model (Kirmayer & Young, 1998) to explain *dhat* syndrome as a functional somatic syndrome.

In cultures where open discussion about sexual issues is taboo and fears about masturbation exist, the urogenital system is likely to be the focus of preoccupation. Under stress, persons predisposed to amplification of somatic symptoms and health anxiety may focus attention on physiological changes such as turbidity of urine and tiredness, and misattribute them to loss of semen in the light of widely prevalent health beliefs. These beliefs may then be confirmed by friends and other lay sources as well as by local practitioners subscribing to similar models.

We have recently completed a study showing significantly higher scores on measures of amplification, hypochondriacal beliefs and abnormal illness behaviour in patients with *dhat* syndrome compared with medical controls. The above model needs to be examined further in both quantitative and qualitative studies. The practical implication of this formulation is that it suggests a viable treatment model based on psychoeducation and culturally informed cognitive–behavioural therapy, which has been demonstrated to be feasible in the Indian subcontinent (Sumathipala *et al*, 2000).

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G. Ranjith South London and Maudsley NHS Trust, Norwood CMHT, 19–21 Knights Hill, London SE27 0HS, UK

R. Mohan Health Service Research Department, Institute of Psychiatry, London, UK

Jaspers' concept of primary delusion

Jaspers has appeared recently in the pages of the *Journal* both to support the impossibility of studying psychopathology scientifically (Turner, 2003) and to defend the notion of a delusion arising as a consequence of the modularisation of a non-modular belief system, linked to dopamine dysfunction (Jones, in Jones *et al*, 2003), and thus of a scientific psychopathology. Jaspers has also been cited as an outmoded influence on psychopathological thinking, which should now be discarded (Delespaul & van Os, in Jones *et al*, 2003). Such a disagreement may hinge upon Jaspers' conception of a primary delusion.

For Jaspers the primary delusion has two elements. First, there is a radical change in subjectivity: 'We observe that a new world has come into being' (Jaspers, 1963: p. 284). Such a new world is more than the presence of a false belief, it is a transformation of experience as a whole. Second, there is the element of meaning: 'All primary experience of delusion is an experience of meaning' (Jaspers, 1963: p. 103). 'The experiences of primary delusion are analogous to this seeing of meaning, but the awareness of meaning undergoes a radical transformation' (Jaspers, 1963: p. 99).

Jones, drawing on Campbell's work on delusions (Campbell, 2002), wishes to recruit Jaspers as a rationalist. This is the concept that pathological top-down mechanisms can render delusions explicable. Portraying Jaspers thus misrepresents his position, as the conception he offers us of primary delusion is one of a new state of consciousness, and this may be as resistant to mechanistic explanation as is normal consciousness (the so-called 'hard problem'; Chalmers, 1996). In this respect, Jaspers may be better thought of as a 'mysterian' (McGinn, 1993). Mysterians hold that although consciousness is biologically mediated, it is inexplicable mechanistically. Nowhere in the *General Psychopathology* does Jaspers discuss the mechanism of primary delusion and he explicitly rejects a modular conception of psychopathology, as envisaged by his contemporary Wernicke: 'As soon as this theory is transferred to everything psychic as if it were analogous it ceases to further our knowledge' (Jaspers, 1963: p. 537). The existence of primary delusion is left as an 'ununderstandable' fact.

Delespaul & van Os want to discard the concept of primary delusion. In doing so they address only what Jaspers terms 'delusion-like ideas'. Jaspers would have had no difficulty regarding these on a continuum with normal beliefs and it is by virtue of this that he regarded them as understandable. Primary delusions are left untouched on this account and yet they remain central to the clinical experience of major psychosis – the radical and sometimes rapid transformation from a given way of perceiving, thinking, affecting, acting to another, which colours all of subjective experience.

We agree that progress in psychopathology is dependent upon overcoming Jaspers' pessimism about understanding primary delusion. How this can be achieved remains an open question but progress may not come if we misrepresent Jaspers' great contribution.

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