Correspondence

EDITED BY STANLEY ZAMMIT

A new dawn for the yellow journal?

I welcome the new Editor's plans to bring the *Journal* firmly into the 21st century by making it intellectually stimulating but also inviting and readable for all (Tyrer, 2003). The previous Editor may have done much to improve the *Journal*'s impact factor to the scientific community by increasing its citation rate but what has not been studied are the views of the core readership. Should not a survey of readers be carried out to see what people think of the *Journal* and who reads how much and of what? I suspect the answer may be not much of very little, and that for most of us the *Journal* has a fairly short 'wrapper off to bookshelf time'.

The *Journal*'s core readers are many thousands of jobbing psychiatrists. We are looking for important new information that has bearing on our day-to-day clinical practice. Yes, we have the *Psychiatric Bulletin*, with its zippy and original offerings, but sometimes a subject needs a more academic and lengthy airing. Perhaps the readership could suggest subjects for editorials, and why not have each book review written by both an expert in the field and an ordinary reader, so as to capture different perspectives? I hope that the new Editor can increase the interaction between the *Journal* and all psychiatrists. Good luck.

Tyrer, P. (2003) Entertaining eminence in the *British Journal of Psychiatry*. *British Journal of Psychiatry*, **183**, 1–2.

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Editor's response: Dr Haw is probably right in her assertions that the jobbing psychiatrist is likely to become the bobbing psychiatrist when reading the *Journal* – jumping from one item to the next with little close examination of the content – and it is clear from a recent paper that the ability of good ghostwriting to make an arresting impact on the reader pays dividends (Healy & Cattell, 2003). We are taking notice of this by trying to improve and shorten the titles of papers submitted to the *Journal*; prospective authors please note. However, Dr Haw has stimulated me to go further; I have a hypothesis that readers of the *Journal* might help me in testing. It is a hypothesis that is best kept blind at this stage, and I am disclosing it only to the Associate Editors. For each of the main sections of the *Journal* (editorials, debates, original papers, review articles, book reviews and correspondence) I invite readers to score on a four-point scale (0=rarely or never read, 1=seldom read, 2=frequently read and 3=regularly or always read) in which 'read' is taken to be a reasonably full examination of the article (a good test of this is that you could summarise the main impact of the article to others). Could you send your responses to me at the address below by the end of January 2004, and I will report the results – and the hypothesis – shortly afterwards.

Meanwhile, I hope our readers are aware of a third journal published by the Royal College of Psychiatrists – *Advances in Psychiatric Treatment* (APT). Although not an organ for original research, APT publishes expert, in-depth reviews of topics of current clinical interest (http://apt.rcpsych.org/).

Healy, D. & Cattell, D. (2003) Interface between authorship, industry and science in the domain of therapeutics. *British Journal of Psychiatry*, **183**, 22–27.

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Mental health of refugees

Using quantitative measures Turner *et al* (2003) found that about half of a sample of 842 Kosovan refugees in the UK had post-traumatic stress disorder, with substantial comorbid depressive disorder and anxiety disorder. But there is more to be reported. I was involved in having a few open-ended questions tacked on to the study, tapping subjects' own views of their health/mental health and what they saw as their most urgent priorities for recovery. Only a tiny number saw themselves as having a mental health problem of any kind, bearing out observations by refugee workers in the reception centres housing them that there was no interest in counselling. Almost everyone nominated work, schooling and family reunion as their major concerns. This chimes with what I and others have found in clinical settings with refugees over many years. Significant psychopathology is uncommon (Summerfield, 2002).

The responses to the open-ended questions paint a picture that is a world away from that reported by Turner and colleagues; how is this contradiction to be explained? First, the question of validity. Translation/back-translation of psychiatric inventories originating in the USA and Western Europe does not by itself overcome the category fallacy to which Kleinman (1987) pointed: particular phenomena may be identified in different settings but it does not follow that they mean the same thing in each setting. Moreover, refugees in distressed and insecure circumstances may be particularly susceptible to the demand characteristics of questionnaires. Second, and fundamentally, how human beings experience an adverse event, and what they say and do about it, is primarily a function of the social meanings and understandings attached to it. No psychiatric category captures this active appraisal and meaning-making.

Quantitative methodologies serving psychiatric categorisations risk a distorting pathologisation of refugee distress, with what is social and collective being reassigned as individual and biological (Summerfield, 1999). Turner *et al* caution against 'the tendency of some to reject the diagnostic paradigm in refugee populations', but they do not make a persuasive case here that they know better than the Kosovan refugees themselves, and that many of the refugees really do need psychiatric treatment. There is simply no good evidence to back their conclusion that refugee populations anywhere are carrying a major burden of clinically significant mental ill health. As the answers to my questions demonstrated, refugees see recovery as primarily something that must

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