

Menken's view, to which he refers. I also, like him, look forward to the time when psychiatrists and neurologists speak the same language. Both will need to change a good deal for this to be possible, but increasing understanding of the cerebral substrate of emotions and cognition will eventually provide a powerful stimulus to both specialities. I was not, though, suggesting that we should talk of psychiatric illnesses instead of mental illnesses because I prefer Greek to Latin derivations. The term 'mental illness' implies a disorder of the mind. By substituting 'psychiatric illness' I wished to imply simply that these are disorders which, if they come to specialist attention, are normally treated by psychiatrists. I should emphasise, too, that my objections to the term 'physical illness' are almost as great as to 'mental illness'. Both encourage doctors and patients alike to make inappropriate and damaging assumptions and to ignore the role of psychological and social influences across the whole spectrum of illness. That is why I do not think it is appropriate simply to combine mental and neurological disorders as 'brain disorders'.

In reply to Dr Crichton, I did not quote Lady Mary Wortley Montagu with either approval or disapproval, but simply to illustrate the fact that in the mid-18th century it was still the accepted view that madness was no different from other diseases. More importantly, Dr Crichton is confusing the difference between mental and physical events and what are misleadingly called mental and physical illnesses. There are indeed still many mysteries about the relationship between mental and physical (cerebral) events and no unanimity among either philosophers or neuroscientists about the nature of that relationship (although Descartes' original 'substance dualism' has passed into history). But this, although important, is irrelevant to my argument that there is no fundamental or qualitative difference between the heterogeneous collections of illnesses we currently distinguish as physical and mental. Both physical and mental phenomena are conspicuous in both – as aetiological factors, as features of the illness itself and as influences on outcome. And pain is indeed a purely subjective phenomenon, even though there are good reasons for assuming that it usually, perhaps always, has physical (cerebral) concomitants.

In reply to Dr Foreman I can only say that he should have read my editorial rather

more carefully. I did not argue that psychiatric disorders *are* physical disorders. Rather, I drew attention to the extensive evidence of somatic abnormalities in almost all common mental disorders and to the lack of any characteristic features of either the symptomatology or the aetiology of so-called mental illnesses that reliably distinguished them from physical illnesses (and vice versa). Nor did I declare "mental to be meaningless", or argue that there are no important differences between mental and physical illnesses. My argument was that "the differences between mental and physical illnesses, striking though some of them are, are quantitative rather than qualitative, differences of emphasis rather than fundamental differences, and no more profound than the differences between diseases of the circulatory system and those of the digestive system, or between kidney diseases and skin diseases". And far from wanting mental illnesses to be regarded as physical illnesses, I argued that both terms are misleading. Finally, I did not say that "no alternative has been found" for the term mental illness. On the contrary, I suggested that "we should talk of psychiatric illnesses or disorders" instead. Nor was this merely a suggestion. The most recent edition of the *Companion to Psychiatric Studies*, which I co-edited (Kendell & Zealley, 1993), deliberately refers to psychiatric illnesses or disorders rather than to mental disorders throughout its 950 pages, and explains the reasons for doing so.

**Kendell, R. E. & Zealley, A. K. (eds) (1993)**

*Companion to Psychiatric Studies* (5th edn). Edinburgh: Churchill Livingstone.

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### General psychiatry and suicide prevention

I am grateful to Eagles *et al* (2001) for their recent editorial on the role of psychiatrists in the prediction and prevention of suicide. I am a member of the Royal Australian and New Zealand College of Psychiatrists' working group on suicide, and we are currently deliberating how to vote on a proposal to disband our group and hand responsibilities back to the College – after all, suicide is part of mental health.

Eagles *et al* start with how traumatic it is for psychiatrists when their patients commit suicide. Is this not a bit self-indulgent? Our surgical colleagues dealing in trauma frequently contend with the death of ordinary people in the operating theatre. More importantly, the authors do not even mention the suffering of family members affected by suicide.

In their conclusions Eagles *et al* focus on four points: first, they advocate less epidemiology and more multi-centre treatment trials with suicidal people; second, they advocate more support for traumatised psychiatrists; third, they make a plea to politicians and health service planners to realise what a difficult task suicide prevention is for us; fourth, they note that prediction is a very limited art (I entirely agree), but claim that "all of our patients are at increased risk of suicide". Taking their first and last points together, perhaps if they were more aware of epidemiological data they would realise Blair-West *et al*'s (1999) calculations have refuted the suggestion that 15% of people with depression eventually kill themselves: for this to be true, the annual number of suicides would have to be several times greater than it currently is. They recalculated the lifetime risk of suicide in people with depression as 3.4% with a lifetime risk of 7% for males and 1% for females.

As regards traumatised psychiatrists, I would simply say that all traumatised workers deserve support and that support should be in proportion to their trauma. I suspect that psychiatrists would rank well down the list, below fire, ambulance and police officers and many other medical workers – not to mention contemporary farmers in the UK!

The point relating to re-educating politicians and health planners about our limitations in influencing suicide rates has some validity. However, prevention is much more than that which might result from prediction. Nowhere in the editorial did I find any mention of basic public health concepts such as primary, secondary and tertiary prevention (Silverman & Maris, 1995). If general psychiatrists have not woken up to the fact that this is the basis of national suicide prevention strategies, I think I will have to vote in favour of retaining our local specialist-interest suicide prevention group.

**Blair-West, G. W., Cantor, C. H., Mellsop, G. W. et al (1999)** Lifetime suicide risk in major depression:

sex and age determinants. *Journal of Affective Disorders*, **55**, 171–178.

**Eagles, J. M., Klein, S., Gray, N. M., et al (2001)** Role of psychiatrists in the prediction and prevention of suicide: a perspective from north-east Scotland. *British Journal of Psychiatry*, **178**, 494–496.

**Silverman, M. M. & Maris, R. W. (1995)** The prevention of suicidal behaviours: an overview. *Suicide and Life-Threatening Behavior*, **25**, 10–21.

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**Authors' reply:** Dr Cantor seems to have misconstrued the intended scope and content of our editorial. We did not set out to comment upon national suicide prevention strategies but, as the title suggested, we sought to discuss the role of psychiatrists specifically in attempting to prevent suicide among the patients we treat. We agree wholeheartedly that any strategy that focused exclusively on psychiatrists as the agents of suicide prevention would be absurd. Indeed, this was one of the main points we were trying to make.

Dr Cantor thinks that our ignorance of the epidemiological data makes us state that “all of our patients are at increased risk of suicide”. This is in fact an epidemiological statement, which he interprets concretely. The fact that the lifetime risk of suicide among people with recurrent depression has been adjusted downwards actually renders statistical prediction of a rare event even more difficult. Largely for this reason we cannot predict which of our patients will commit suicide or when they might do so, and thus we must regard the entire cohort of patients we see as collectively at increased risk of dying by suicide and view their clinical management accordingly.

We take issue that it is “self-indulgent” to suggest that psychiatrists find the suicide of their patients to be traumatic. We know this to be the case from our survey in Scotland (Alexander *et al*, 2000) and from other, more qualitative accounts (Hendin *et al*, 2000). While valid comparisons among professional groups are difficult to make accurately, we in Aberdeen are more than a little interested in the impact of ‘critical incidents’ on colleagues in the caring and emergency services (e.g. Alexander, 1993; Alexander & Klein, 2001). One crucial difference between psychiatrists on the one hand and other doctors and other professionals on the other is the issue of blame. While, as we try to point out, it is often illogical for psychiatrists to take responsibility for the suicide of our patients, we

frequently do, and this distinguishes it from the deaths that other professionals encounter. Finally, presumably we would wish our patients (and their families) to feel cared for and understood. Surely, as professionals in psychiatric services, we should accord the same opportunities to each other.

**Alexander, D. A. (1993)** Stress among police body handlers: a long-term follow-up. *British Journal of Psychiatry*, **163**, 806–808.

— & Klein, S. (2001) Ambulance personnel and critical incidents. Impact of accident and emergency work on mental health and emotional well-being. *British Journal of Psychiatry*, **178**, 76–81.

—, —, Gray, N. M., et al (2000) Suicide by patients: questionnaire study of its effect on consultant psychiatrists. *BMJ*, **320**, 1571–1574.

**Hendin, H., Lipschitz, A., Maltzberger, J. T., et al (2000)** Therapists' reactions to patients' suicides. *American Journal of Psychiatry*, **157**, 2022–2027.

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### Psychiatric training in developing countries

Jacob (2001) successfully highlights the problems of community care of people with mental disorders in developing countries. Both he and the *Journal* are to be commended for addressing the mental health issues of the vast populations of such countries, a topic generally overlooked in the literature. The author is right to point out that most programmes have failed to deliver and that the success of local model projects has not been repeated at a national level. From personal experience as both a trainee and a trainer and from discussion with colleagues in a similar situation, I believe the most important reason for this is the inappropriate training of psychiatrists in developing countries.

The suitability of the training in developed countries for psychiatrists who will ultimately work in developing countries is increasingly being questioned (Mubbashar & Humayun, 1999), but questions have rarely been asked about the training in their own countries. Unfortunately, the training in most developing countries is still based on models of psychiatric services and theories derived from developed nations. An obvious example is the concept of community psychiatry. This concept and its enactment, derived from the history of modern Western psychiatry, cannot be applied in developing countries (Farooq &

Minhas, 2001). Young psychiatrists from developing nations who trained in this model of community psychiatry will find the realities of psychiatric services in their own countries totally different from what they have learnt in training.

Moreover, the training in many developing countries remains narrowly focused on acquiring clinical skills. This is despite the fact that a World Health Organization expert committee recommended long ago that trained mental health professionals should devote “only part of their working hours” to the clinical care of patients (World Health Organization, 1975). As Jacob points out, the realities of mental health care in the community in developing countries demand that training is broad-based and equips the psychiatrist to work effectively with other disciplines, particularly primary care. This, however, is rarely the case in many developing countries.

The training of psychiatrists in developing countries needs a total paradigm shift to address the problems raised by Jacob. Both the mental health professionals and the policy makers need to address this as a priority. If they do not, most of the mental health initiatives in these countries will fail.

**Farooq, S. & Minhas, F. A. (2001)** Community psychiatry in developing countries – a misnomer? *Psychiatric Bulletin*, **25**, 226–227.

**Jacob, K. S. (2001)** Community care for people with mental disorders in developing countries. Problems and possible solutions. *British Journal of Psychiatry*, **178**, 296–298.

**Mubbashar, M. H. & Humayun, A. (1999)** Training psychiatrists in Britain to work in developing countries. *Advances in Psychiatric Treatment*, **5**, 443–446.

**World Health Organization (1975)** *Organisation of Mental Health Services in Developing Countries. Sixteenth Report of the WHO Committee on Mental Health*. Geneva: WHO.

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### Vascular risk factors for stroke and depression

Stewart *et al* (2001) present an important study of the association between the vascular risk factors for stroke and depression. Although the non-participation rates and levels of physical morbidity were high in the sample, they did not find any association between risk factors for vascular disease and level of depression in the older