'ghettoisation' and further marginalisation of those already marginalised.

With Professor Sashidharan's dislike for words such as 'separate', 'different' and 'them', one gets the impression that he wants a 'melting pot' approach to address inequalities in service provision. Whatever perspective we may have, ethnic groups have their own identity and specific needs; thus, a 'mosaic'-like approach, with better awareness of individual needs in a broader perspective is required.

Caution is needed regarding reference to cultural matters. Sometimes, everything is attributed to ethnicity or culture, while at other times the existence of cultural impact is completely denied. Concentrating on cultural differences may lead to important diagnostic signs being missed. Cultural sensitivity is not a fixation on culture and it should not be a synonym for unexplained variance.

On the basis of our own experiences in Manchester and Toronto, we propose a third approach – founded on Professor Kirmayer's 'cultural consultation model' (Kirmayer *et al*, 2003) – as an interim option. This in some respects lies midway between the opposite poles of the debate. This model proposes the operation of a specialised multi-disciplinary team that brings together clinical experience with cultural knowledge and linguistic skills essential to working with patients from diverse cultural backgrounds. A team built on the cultural consultation model aims to give advice to other clinicians rather than take on patients for continuing care. The latter will be reserved for cases where there are difficulties in understanding, diagnosing and treating patients where cultural factors may be important. The assessment will usually involve two or three interviews with the patient and his or her family, which should result in a clear cultural formulation, diagnosis and treatment plan. The members of this team will be a resource for clinicians in primary care, social services, mental health and other related disciplines. They will also be involved in the training of interpreters, culture link workers and members of the mainstream and existing community services.

Until 'they' become 'us' we have to find a way forward that is both financially and logistically viable and that allows mainstream services to provide a culturally sensitive approach to all groups rather than a service to a minority of those in need.

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

Kirmayer, L. J., Grolean, D., Guzder, J., *et al* (2003) Cultural consultation: a model of mental health service for multicultural societies. *Canadian Journal of Psychiatry*, **48**, 145–153.

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Author's reply: Waheed and colleagues raise some important dilemmas in the debate on specialist services for ethnic minorities. We already have specialist services for many cultural groups in the voluntary sector and statutory sector. I agree that within the statutory sector, there would be insufficient funds to equip a large number of new specialist services in all parts of the country for all subcultural groups. Yet, we currently rely on just such an underfunded solution within the voluntary sector to plug gaps in psychiatric service provision. Specialist services may continue to exist in response to unmet need rather than by design.

There are some problems with the cultural consultation model. First, this solution is not novel, and was established in Bradford some two decades ago, only to be brought to an end due, I believe, to lack of funds for such a specialist service! The approach can be successful, but not because of the structure it imposes. Improvements in the quality of care will not be achieved by simply restructuring the services, as entrenched attitudes and skills deficits will simply be transferred into new services. All practitioners should have the necessary skills, knowledge and attitudes for a modern multiculturally capable service. Who will be qualified to lead such a service, and what are the capabilities necessary for workers in such a service? Moodley (2002) addressed these issues for psychiatrists following development work by the Transcultural Special Interest Group within the Royal College of Psychiatrists.

Irrespective of the service model, any service can respond to the needs of Black and minority groups only if the workforce is skilled and continues to acquire new knowledge and skills to work with new migrants. Motivating the workforce to acquire skills is essential, but current workloads, rapid changes in services and waves of new policy deter the acquisition of new skills and the development of innovative paradigms for service delivery. Until these issues are addressed, we rely heavily on specialist services that have managed to attract and motivate staff to be creative and tailor packages of care. A specific problem of the consultation model is that specialists are expected to be the fount of all wisdom on cultural issues, absolving the rest of the workforce from these responsibilities (Bhui *et al*, 2001). Furthermore, no single consultant can ever claim to be an expert on all cultures of the world. However, a consultant can reasonably be expected to communicate general principles, aptitude and methods in order to discover more about mental distress in the context of unfamiliar cultures using, for example, ethnographic approaches. Yet, those seeking advice from such a service must be able to change their practice. Business efficiency can work against improving the cultural capability of services and warrants more attention by purchasers and providers (see Bhui, 2002). Irrespective of the service model, organisational cultural capability, a motivated workforce and optimal learning conditions will diminish the need for specialist services, but not in the foreseeable future. In the meantime we can learn from these specialist services, but their existence is inevitable and necessary if the cultural capability of the NHS workforce does not improve.

Declaration of interest

K.B. is Secretary to the Transcultural Special Interest Group of the Royal College of Psychiatrists, and Director of the MSc programme in transcultural mental healthcare at Queen Mary, University of London.

Bhui, K. (2002) *Racism and Mental Health*. London: Jessica Kingsley.

___, Bhugra, D. & McKenzie, K. (2001) *Specialist Services for Minority Ethnic Groups?* Maudsley Discussion paper No. 8. London: Institute of Psychiatry.

Moodley, P. (2002) Building a culturally capable workforce – an educational approach to delivering equitable mental health services. *Psychiatric Bulletin*, **26**, 63–65.

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Neuroimaging psychopathy: lessons from Lombroso

Blair (2003) outlined a neurobiological basis for psychopathy. The orbitofrontal cortex has also been implicated in psychopathy by other authors (Dolan, 1999). A

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strength of Blair's article was its proposal of an integrated model of psychopathy in which the process of socialisation is impeded at a neural level. Such a 'biosocial' theory seems to make intuitive sense. However, concerns arise based on the drawing of parallels with research done over a century ago by Cesare Lombroso, an Italian psychiatrist and criminologist. Modern researchers share with Lombroso (and some of his predecessors, such as Pella and Gall; see Walsh, 2003) a desire to explain criminality in terms of innate biology. But as Gould states (Gould, 1980), 'Major ideas have subtle and far reaching extensions' and a brief glance at Lombroso's theory and its 'social extension' can flag up the dangers associated with modern neuroimaging in this area.

Lombroso believed that 40% of criminals were 'born criminals' who could be distinguished by physical features including relatively long arms, prehensile feet with mobile big toes, low and narrow forehead, large ears, thick skull, large jaw, etc. (Gould, 1980). A particularly unnerving aspect of Lombroso's work is that he campaigned on the basis of his theory for a preventive criminology: 'society need not wait for the act itself, for physical and social stigmata define the potential criminal. He can be identified, watched and whisked away at the first manifestation of his irrevocable nature' (Gould, 1980). Lombroso also 'recommended irrevocable detention for life for any recidivist with the telltale stigmata' (Gould, 1980).

This should serve as a warning in the modern era, where the spirit of Lombroso lives on. One fears a scenario in which a brain scan diagnosis of psychopathy legitimises the preventive incarceration of a 'high-risk' individual, and in which a static neurostructural deficit may lead to a therapeutically nihilistic approach to such an individual on the grounds that he is 'beyond rehabilitation'. Combining the above two positions, the perception of an individual as both dangerous and unchanging may lead to a 'lock them up for good' ethos.

Lastly, there are dangers in assuming a causal link between psychopathy and structural brain change. One consequence of this, in terms of individual responsibility, would be the inappropriate invocation of a deterministic argument by a defendant seeking exculpation for an offence.

Blair, R. J. R. (2003) Neurobiological basis of psychopathology. *British Journal of Psychiatry*, **182**, 5–7.

Dolan, R. J. (1999) On the neurology of morals. *Nature Neuroscience*, **2**, 927–929.

Gould, S. J. (1980) *Ever Since Darwin: Reflections in Natural History*. Harmondsworth: Penguin.

Walsh, A. (2003) The Holy Trinity and the legacy of the Italian School of Criminal Anthropology. *Human Nature Review*, **2**, 1–11.

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Scientific psychiatry?

We write in response to the editorial by Dr Turner (2003), who wishes to revitalise Jaspers' view that psychiatry cannot extricate itself from the humanities. With the ascendancy of biological psychiatry this idea is important to remember. However, Dr Turner's article does little to advance this idea and contains some possible misconceptions.

Turner's interpretation of Donald Davidson's work does not clear things up. Academic philosophers are still actively debating what Davidson's philosophy amounts to. In this situation, an appeal simply to his authority is misdirected.

On specific points, Turner needs to be challenged. First, he seems to interpret Davidson as denying the possibility of a scientific psychopathology. Biological psychiatrists are not trying to solve the mind–body problem or trying to discover the strict psychophysical laws that Davidson claims do not exist; rather, they are trying to find correlations between mental phenomena and physical processes. That such correlations exist seems obvious, as anyone who has taken a mind-altering substance can confirm or as Penfield's neurosurgical experiments vividly showed. Davidson's attack on the idea of strict causation between physical events and mental events serves not so much to prohibit the possibility of a science of psychology, but rather to deny such a science predictive powers equal to those of physics. This is a consequence of Davidson's philosophy of mind, whereby despite being ontologically an unabashed materialist he claims that the use of mental predicates is dependent upon normative and holistic concerns of society and language, and that these are not properties of the physical order. Davidson has indeed accepted the points made by some of his critics (Davidson, 1987), that empirically discovered helpful generalisations, so-called *ceteris paribus* laws, may be formalised and be of great utility. This surely is a worthy enough goal for psychology and psychiatry.

Second, Turner also suggests that there is no possibility of improvement in descriptive psychopathology (Turner, 2003). This is simply assertion and suggests that the author believes that phenomenology as a discipline ended with Jaspers in 1913, and further that Jaspers provided an adequate account of the subjective experience of mental disorder. Current opinion seems to regard Jaspers' ideas as either obstructive to progress in psychopathology with his notion of the 'un-understandability' of some psychotic symptoms (e.g. work on cognitive models of psychosis; see Frith, 1992; Garety & Hemsley, 1994) or an obscure first start which petered out because he overcomplicated things (Cutting, 1997). Work on phenomenology continues to inform scientific research and clinical practice (Kapur, 2003).

Our view is that psychiatry's potential adversely to drift from the humanities can be rectified by close attention to the phenomenology that forms the point of entry to the subject. Turner has given up on this project whereas to us it seems barely to have begun!

Cutting, J. (1997) *Principles of Psychopathology*. Oxford: Oxford University Press.

Davidson, D. (1987) Problems in the explanation of action. In *Metaphysics and Morality: Essays in Honour of J. J. C. Smart* (eds P. Pettit, R. Sylvan & J. Norman). Oxford: Blackwell.

Frith, C. D. (1992) *The Cognitive Neuropsychology of Schizophrenia*. Hove: LEA.

Garety, P. A. & Hemsley, D. R. (1994) *Delusions: Investigations into the Psychology of Delusional Reasoning*. Maudsley Monograph 36. Oxford: Oxford University Press.

Kapur, S. (2003) Psychosis as a state of aberrant salience: a framework linking biology, phenomenology, and pharmacology in schizophrenia. *American Journal of Psychiatry*, **160**, 13–23.

Turner, M. A. (2003) Psychiatry and the human sciences. *British Journal of Psychiatry*, **182**, 472–474.

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Dr Turner is quite wrong to argue that Donald Davidson has shown there 'cannot, in any useful sense, be a science of the mental because of the impossibility of either strict psychological or strict psychophysical laws' (Turner, 2003: p. 472). It is true that Davidson (1970) argued that there could not be strict laws relating mental events either to physical events or to each other, but its lack of strict laws does not endanger

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