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From the Editor's desk

By Peter Tyrer

British Made Foreign Journal

I am writing this just after returning from India and Sri Lanka and, after being exposed to a welter of cultures and religions in the past few days, I have had cause to reflect on the *Journal*'s aspirations to be international. I think I can detect a touch of sophistry here. Professor Navendra Wig, one of the most distinguished of Indian psychiatrists, puts it better. He describes how the government excise records in India refer to locally produced spirits such as brandy and whisky as IMFL – 'Indian Made Foreign Liquor'[1] – and this made him realise that, at heart, he was an IMFD, an 'Indian Made Foreign Doctor', as he could never escape his cultural heritage however much he tried. Similarly, I cannot escape the conclusion that we are seen by all non-UK-born readers as a British Made Foreign Journal, with a style and substance that cannot genuinely resonate with all our readers. But we can learn much from each other, as this issue shows. Manoranjitham *et al* (pp. 26–30) show that even if we were successful in both identifying and treating depressive illness over in the West, it might have little impact on suicide in south India as there overt depression appears to be rare prior to suicide, and what matters much more is simple stress and isolation following loss. Why south India is different from the UK, and even Pakistan[2] here, is a puzzle, but such research shows that we cannot export or import evidence derived from only one country if it is at least partly dependent on culture and setting. Fottrell *et al* (pp. 18–25) similarly demonstrate the tremendous value of one of the most joyous of events, childbirth, in Benin where perinatal mortality is high, so that even the trauma of a baby almost dying can be overcome triumphantly by the exuberance of successful motherhood. But it is equally important to report results that are entirely consistent with those in countries of different cultures, and Chen *et al* (pp. 31–35) find that recurrence of self-harm in Taiwan follows a pattern that is virtually identical to that in Western countries.[3–5] Large international studies can allow for cultural and national variations and Bottomley *et al* (pp. 13–17) illustrate this in comparing risk factors for both onset of depression and recovery. Bisson *et al* (pp. 69–74) do likewise and in their guidelines for psychosocial care after disasters involved experts from 25 nations across the world – quite a feat.

'Does it really matter what happens in another country?', the isolationist may complain, 'let's stick to our own last and others do as they will'. This is mean-minded and short-sighted, not least as 'the others' may include many of different cultures who have arrived as immigrants. The findings of Velayudhan *et al* (pp. 36–40) suggesting a causal link between diabetes mellitus, cognitive impairment and dementia are potentially disturbing for those of South Asian origin as diabetes is more common in this group. More reassuringly, the high but clinically unimportant prevalence of auditory and visual hallucinations in young Dutch children (Bartels-Velthuis *et al*, pp. 41–46) should reassure parents and health professionals around the world and avoid the premature label 'high-risk group for psychosis' that might otherwise be attached.[6] A larger and more generous perspective of the world should also help us to promote equity at home, and Bennewith *et al* (pp. 75–76) add another tier of data to the growing pile of evidence[7] that coercion in psychiatry is free of selection by ethnicity. One attraction of biological enquiries in psychiatry is that here the findings, if correct, respect no international boundaries and apply universally; Yatham *et al* (pp. 47–51) and Macritchie *et al* (pp. 52–58) can feel confident that failure to replicate any of their findings cannot in any way be blamed on the country where they are carried out.

But however hard we try, we are bound to see the panorama of psychiatry through British spectacles and I will be among the first to acknowledge that these may well create an astigmatic view that distorts some realities. I can nonetheless turn to, and am increasingly grateful for, a growing body of international editors and referees to provide corrective lenses that bring my vision nearly back to normal. *British Made Internationally Influenced Journal of Psychiatry* is perhaps our full title and although at times I still have to fight off my first whim to have a journal title change[8] I am getting to feel that a title that denies geography and culture would just be seen as phoney.

Authorship, bias and declarations of interest

In this season of gifts and good tidings for most of our readers – as a British Made Foreign Journal I am trying not to presume too much – there is one caution to be introduced. The International Committee of Medical Journal Editors has just agreed uniform requirements for disclosure of potential conflicts of interest that we at the *British Journal of Psychiatry* are going to implement immediately. Details are available on their website (www.icmje.org/) and the core principles will be incorporated into our instructions for authors. In addition to the now standard declaration of sources of support for the work described, we now require this declaration to extend to all sources of financial support relevant to the work that have been received by the authors' spouses or partners and children, or their institutions, in the previous 36 months, as well as 'any relevant non-financial associations or interests (personal, professional, political, institutional, religious, or other) that a reasonable reader would want to know about in relation to the submitted work'. The difficult words here are 'personal', 'relevant' and 'reasonable' as has been illustrated very recently in our columns.[9] Here I would apply the Mandy Rice Davies Test (MRDT). Mandy has now descended into respectability but in 1963 she was less fussy and in the court case of Stephen Ward following the Profumo inquiry (a very British sexual scandal) she replied 'well he would, wouldn't he?' when Lord Astor denied having an affair or ever having even met her. If an average reader feels 'they would write that, wouldn't they?' after reading an article and looking at the declarations of interest, then I would judge the declarations to be both relevant and reasonable, and authors will need to be tough on themselves in disclosing these.

1 Wig NN. Mental health and spiritual values: a view from the East. In *Spirituality & Mental Health* (ed A Sharma, on behalf of the Indian Psychiatric Society): 5–21. Public Printing (Delhi) Service, 2009.

2 Khan MM, Mahmud S, Karim MS, Zaman M, Prince M. Case–control study of suicide in Karachi, Pakistan. *Br J Psychiatry* 2008; **193**: 402–5.

3 Zahl DL, Hawton K. Repetition of deliberate self-harm and subsequent suicide risk: long-term follow-up study of 11 583 patients. *Br J Psychiatry* 2004; **185**: 70–5.

4 Heyerdahl F, Bjornaas MA, Dahl R, Hovda KE, Nore AK, Ekeberg O, et al. Repetition of acute poisoning in Oslo: 1-year prospective study. *Br J Psychiatry* 2009; **194**: 73–9.

5 Lilley R, Owens D, Horrocks J, House A, Noble R, Bergen H, et al. Hospital care and repetition following self-harm: multicentre comparison of self-poisoning and self-injury. *Br J Psychiatry* 2008; **192**: 440–5.

6 Fusar-Poli P, Meneghelli A, Valmaggia L, Allen P, Galvan F, McGuire P, et al. Duration of untreated prodromal symptoms and 12-month functional outcome of individuals at risk of psychosis. *Br J Psychiatry* 2009; **194**: 181–2.

7 Singh SP, Greenwood N, White S, Churchill R. Ethnicity and the Mental Health Act 1983. *Br J Psychiatry* 2007; **191**: 99–105.

8 Tyrer P. From the Editor's Desk. *Br J Psychiatry* 2004; **184**: 100.

9 Cooper JE. Abortion and mental health disorders. *Br J Psychiatry* 2009; **194**: 570.