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From the Editor's desk

By Peter Tyrer

Colonising minds

My title, taken from Silove's perceptive editorial (pp. 255–257), is an apposite one as we have two papers from lesser-known countries (Nepal and Jordan) (Kohrt *et al*, pp. 268–275; Jordans *et al*, pp. 276–281), and special attention given to the mental health of Cambodians, Vietnamese, Bangladeshis and Black Africans and Caribbeans in another paper (Das-Munshi *et al*, pp. 282–290). But the concept extends to much more than the study of particular ethnic groups. It refers to the tendency of the current dominant nations of the world to look at the problems of others as though they were relatives in their own backyard, and to recommend solutions accordingly. It may go even further, as in our management of individual patients we may colonise their minds with our own constructions, fondly believing them to be correct, when in truth we are inserting an alien incubus that will be ejected from the psyche as soon as the coloniser goes away. Cecil *et al* (pp. 291–297) show in their beautifully designed longitudinal twin analysis study that such harsh parenting – for this is how it is often perceived – is not likely to improve further behaviour, and so we need to be a little more humble in our therapeutic approaches,[1] and to recognise, for example, that what we would regard as normal interaction is perceived as highly stressful by someone who is disadvantaged and feels excluded (van Os, pp. 258–259). Similarly, we must not assume in so-called 'developed' countries that the comprehensive service we generously offer to those who attempt suicide is the reason for our presumed better care, when it is attitudes to treatment that seem to need changing more than the provision of services.[2,3] Colonising behaviour is fundamentally presumptuous; it assumes superiority when none is present, and can be illustrated in the diagnosis of what Eliot Slater called 'hysteria 311'[4] that Reynolds (pp. 253–254) wants to give a more neutral name, as well as in lazy assumptions that what is true in our backyards must be true on everyone else's front patios. When there is a 90-fold difference in the prevalence of anxiety between rural China and urban Peru[5] we have to take into account both culture and environment in giving an explanation, and it is unlikely to be explained in terms of conflict experience as in the study by Kohrt *et al* (pp. 268–275). The 'daddy knows best' presumption also applies to the growing influence of leverage in psychiatric services[6] and is almost always accompanied by reduced autonomy for patients in the belief that they cannot choose for themselves.

At the same time, we cannot ignore the findings of studies carried out in one cultural setting just because they are affected by special local influences.[7] Bhui[8] has pointed out the dangers here; 'trials of culturally adapted interventions risk being of value only for people from the cultures under study', and so lose out on dissemination and generalisability that applies more commonly to biological studies such as that by Herbert *et al* (pp. 313–319), where one would expect cultural influences to be low. So colonialism has a role, and it need not be one which is dictatorial or controlling. Perhaps the best example is the Danish colonisation of Norway between 1536 and 1814. At this point in their development the Danes had lost their aggressive Viking tendencies of a century earlier, or perhaps left them incubating in England to practise for future conflict, and in taking over Norway they simply allowed the Norwegians to get on with their lives and share their cultures, so that Norway was brought more into the mainstream of Europe. There was virtually no leverage, no imposed rules, no mercantilism, and no bossing around, and consequently, no resentment about past actions. And, just in case you think I hadn't noticed, the first sentence of this piece also displays my hidden Viking colonial tendencies – are Nepal and Jordan 'lesser-known countries'? Not to the people of the Middle East and South-East Asia they're not, so please take off those cultural sunglasses, Editor.

DSM-free and ICD

Some authors who write papers about the DSM classification system and submit them to the *Journal* are possibly a little surprised when I write back reminding them that the UK is a 'DSM-free zone'. The influence of DSM is strong but some see it as an example of American colonialism, and we in the UK, being sensitive about our history, detect this a little more than most. But a lot of jockeying for position has taken place in the past few years as the DSM-5 manual will be published in May 2013 and it is natural that many have sought to influence its final form, which has come under heavy criticism.[9] But I hope that this new version can be left to earn its spurs in practice once it is published and we will now move on to the other kid on the block, the *International Classification of Diseases* (ICD), the 11th revision of which is forthcoming, which we will doubtless see subjected to at least as much criticism as praise. Already we are seeing likely differences between this and the DSM-5[10] system in critical areas of classification, and so harmonisation may be difficult to achieve. But as we all know, forced agreement harks back to colonialism, and we would like its five syllables tinkered with a little so it is changed to collaboration.

1 Crawford MJ, Dunlea E. Providing patients with information about treatment choices: do unto others? *Br J Psychiatry* 2010; **197**: 429–30.

2 Pitman A, Osborn DPJ. Cross-cultural attitudes to help-seeking among individuals who are suicidal: new perspective for policy-makers. *Br J Psychiatry* 2011; **199**: 8–10.

3 Bruffaerts R, Demyttenaere K, Hwang I, Chiu WT, Sampson N, Kessler RC, et al. Treatment of suicidal people around the world. *Br J Psychiatry* 2011; **199**: 64–70.

4 Slater E. The Thirty-Fifth Maudsley Lecture: ''Hysteria 311''. *Br J Psychiatry* 1961; **107**: 359–81.

5 Prina AM, Ferri CP, Guerra M, Brayne C, Prince M. Prevalence of anxiety and its correlates among older adults in Latin America, India and China: cross-cultural study. *Br J Psychiatry* 2011; **199**: 485–91.

6 Burns T, Yeeles K, Molodynski A, Nightingale H, Vazquez-Montes M, Sheehan K, et al. Pressures to adhere to treatment ('leverage') in English mental healthcare. *Br J Psychiatry* 2011; **199**: 145–50.

7 Vaage AB, Thomsen PH, Silove D, Wentzel-Larsen T, Van Ta T, Hauff E. Long-term mental health of Vietnamese refugees in the aftermath of trauma. *Br J Psychiatry* 2010; **196**: 122–5.

8 Bhui K. Culture and complex interventions: lessons for evidence, policy and practice. *Br J Psychiatry* 2010; **197**: 172–3.

9 Frances A. The first draft of DSM-V. *BMJ* 2010; **340**: c1168.

10 Ostergaard SD, Rothschild AJ, Bertelsen A, Mors O. Rethinking the classification of mixed affective episodes in ICD-11. *J Affect Disord* 2012; **138**: 170–2.