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Psychiatric services for ethnic minority groups: a third way (letter)? *British Journal of Psychiatry*, **183**, 562–563.

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Dhat syndrome: a functional somatic syndrome?

We read with interest the historical overview on *dhat* syndrome by Sumathipala *et al* (2004). We agree with the authors' contention that categorising it as a culture-bound syndrome is not likely to advance research. The authors examine the nosological significance of this disorder and suggest the possibility of culturally influenced somatoform disorder, although they do not offer a detailed model. In the spirit of Sumathipala *et al*'s conclusion that there are no absolute truths when it comes to classificatory systems, we propose the following formulation.

Fatigue is a common symptom in *dhat* syndrome (Bhatia & Malik, 1991). Disorders with fatigue as the main symptom are often grouped together as functional somatic syndromes (Barsky & Borus, 1999). The basic cognitive formulation offered to explain these disorders is based on somatosensory amplification, misattribution and abnormal illness behaviour. We have incorporated societal and cultural factors along the lines of the socio-somatic model (Kirmayer & Young, 1998) to explain *dhat* syndrome as a functional somatic syndrome.

In cultures where open discussion about sexual issues is taboo and fears about masturbation exist, the urogenital system is likely to be the focus of preoccupation. Under stress, persons predisposed to amplification of somatic symptoms and health anxiety may focus attention on physiological changes such as turbidity of urine and tiredness, and misattribute them to loss of semen in the light of widely prevalent health beliefs. These beliefs may then be confirmed by friends and other lay sources as well as by local practitioners subscribing to similar models.

We have recently completed a study showing significantly higher scores on measures of amplification, hypochondriacal beliefs and abnormal illness behaviour in patients with *dhat* syndrome compared with medical controls. The above model needs to be examined further in both quantitative and qualitative studies. The

practical implication of this formulation is that it suggests a viable treatment model based on psychoeducation and culturally informed cognitive-behavioural therapy, which has been demonstrated to be feasible in the Indian subcontinent (Sumathipala *et al*, 2000).

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Jaspers' concept of primary delusion

Jaspers has appeared recently in the pages of the *Journal* both to support the impossibility of studying psychopathology scientifically (Turner, 2003) and to defend the notion of a delusion arising as a consequence of the modularisation of a non-modular belief system, linked to dopamine dysfunction (Jones, in Jones *et al*, 2003), and thus of a scientific psychopathology. Jaspers has also been cited as an outmoded influence on psychopathological thinking, which should now be discarded (Delespaul & van Os, in Jones *et al*, 2003). Such a disagreement may hinge upon Jaspers' conception of a primary delusion.

For Jaspers the primary delusion has two elements. First, there is a radical change in subjectivity: 'We observe that a new world has come into being' (Jaspers, 1963: p.284). Such a new world is more than the presence of a false belief, it is a transformation of experience as a whole. Second, there is the element of meaning: 'All primary experience of delusion is an experience of meaning' (Jaspers, 1963: p.103). 'The experiences of primary delusion are analogous to this seeing of meaning, but the awareness of meaning

undergoes a radical transformation' (Jaspers, 1963: p.99).

Jones, drawing on Campbell's work on delusions (Campbell, 2002), wishes to recruit Jaspers as a rationalist. This is the concept that pathological top-down mechanisms can render delusions explicable. Portraying Jaspers thus misrepresents his position, as the conception he offers us of primary delusion is one of a new state of consciousness, and this may be as resistant to mechanistic explanation as is normal consciousness (the so-called 'hard problem'; Chalmers, 1996). In this respect, Jaspers may be better thought of as a 'mysterian' (McGinn, 1993). Mysterians hold that although consciousness is biologically mediated, it is inexplicable mechanistically. Nowhere in the *General Psychopathology* does Jaspers discuss the mechanism of primary delusion and he explicitly rejects a modular conception of psychopathology, as envisaged by his contemporary Wernicke: 'As soon as this theory is transferred to everything psychic as if it were analogous it ceases to further our knowledge' (Jaspers, 1963: p.537). The existence of primary delusion is left as an 'ununderstandable' fact.

Delespaul & van Os want to discard the concept of primary delusion. In doing so they address only what Jaspers terms 'delusion-like ideas'. Jaspers would have had no difficulty regarding these on a continuum with normal beliefs and it is by virtue of this that he regarded them as understandable. Primary delusions are left untouched on this account and yet they remain central to the clinical experience of major psychosis – the radical and sometimes rapid transformation from a given way of perceiving, thinking, affecting, acting to another, which colours all of subjective experience.

We agree that progress in psychopathology is dependent upon overcoming Jaspers' pessimism about understanding primary delusion. How this can be achieved remains an open question but progress may not come if we misrepresent Jaspers' great contribution.

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Cannabis as a psychotropic medication

I considered Arseneault *et al's* (2004) search for evidence of the association between cannabis and psychosis as quite skewed. They did not explore the evidence regarding positive, therapeutic or beneficial psychoactive effects of cannabis in mental health in the context of appropriate, rational and clinical usage.

It is now known that the major psychoactive constituent of cannabis and endogenous cannabinoid ligands signal

through G-protein-coupled cannabinoid receptors localised to regions of the brain associated with important neurological processes (Iversen, 2003). Signalling, mostly inhibitory, suggests a role for cannabinoids as therapeutic agents in central nervous system disease where inhibition of neurotransmitter release would be beneficial. Evidence suggests that cannabinoids inhibit the neurotransmitter glutamate, counteract oxidative damage to dopaminergic neurons and may be potent neuroprotective agents (Croxford, 2003). These findings open the door to exploration of the physiological role of the anandamide system, and its involvement with mood, memory and cognition, perception, movement, coordination, sleep, thermoregulation, appetite, and immune response. Cannabis users have reported effectiveness of cannabis in relieving aches and pains, fatigue and tiredness, numbing the symptoms of opiate withdrawal, improving sleep, reducing anxiety, and alleviating the vomiting, anorexia, and depression associated with AIDS-related disorders (Robson, 1998). The

anxiolytic, hypnotic, appetite-stimulating and antidepressant properties are a compelling reason for research into the use of cannabinoids in psychiatric therapeutics; controlled clinical trials are needed. The role of cannabinoids in modern therapeutics remains uncertain, but there is evidence that it would be irrational not to explore it (Robson, 1998) and, knowing its potent neuroprotective function, its potential role in psychiatric practice should not be discarded lightly.

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One hundred years ago

Medico-Psychological Association of Great Britain and Ireland, Northern and Midland Division

MEDICO-PSYCHOLOGICAL ASSOCIATION OF GREAT BRITAIN AND IRELAND, NORTHERN AND MIDLAND DIVISION.—The spring meeting of this society was held on April 7th, at Scalebor Park, Burley-in Wharfedale, the new asylum erected by the West Riding County Council exclusively for the reception of private patients.—Dr. J. R. Gilmour, the medical superintendent, who was in the chair, read a paper on the Value

of Saline Injections in Certain Acute Cases of Mental Disease. His method was first to empty the rectum by an ordinary enema and then to inject 15 ounces of a 0.75 per cent. solution of common salt three or four times daily. Improvement in many cases followed, the mental symptoms quietening and the pulse-rate falling. The injection was rarely returned and no bad effects had been observed. The bladder had to be watched. The treatment was most useful in severe delirious cases where the strength was much reduced.—Dr. Eddison expressed the opinion that the improvement

was similar to that occurring in the febrile cases in which restlessness and excitement abated when plenty of fluid was given. In such cases the nervous system shared largely in the benefit produced by the much needed water.

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Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey