'Freedom is more important than health': Thomas Szasz and the problem of paternalism

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When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists' annual meeting in Edinburgh in 2010, he declared that 'freedom is more important than health'. Psychiatry is the arena in which the conflict between freedom and health comes most sharply into focus, according to Szasz. This paper proposes some parallels with medicine in low-income countries for pointers towards a resolution of this conflict.

When Thomas Szasz summed up his philosophical principles at the Royal College of Psychiatrists' annual meeting in Edinburgh in 2010, he declared that 'freedom is more important than health' This view was nurtured by his experience of fleeing the Nazis in the 1930s, and his eventual arrival in the USA, the land of the free. For the whole of his career Szasz maintained that fostering the ability of individuals to make their own choices was the most important principle of a modern society, 'a society in which man has a chance, however small, to develop his own powers and to become an individual' (Szasz, 1988, p. 128). He opposed prohibitions on the use of any class of drug, restrictions designed to prevent suicide and anything that he perceived as state interference in the private lives and actions of individuals.

The importance Szasz placed on freedom was associated with a concern for human dignity, and a belief that dignity comes from the ability to live an independent, self-determined life, free of control and potential humiliation at the hands of others. Since freedom (and responsibility) is the 'crucial moral characteristic of the human condition' (Szasz, 1988, p. xv), any circumstance that renders people dependent on others to make decisions for them automatically makes individuals less than fully human, and consequently reduces the dignity of human life.

Sickness and infirmity involve dependency and hence a loss of dignity, but medical treatment also renders the 'invalid' dependent on the doctor or healer, and in this sense treatment is also inherently undignified. In this position Szasz is close to Ivan Illich, and the thesis set out in the latter's classic book, *Medical Nemesis*, that the dependency-inducing effects of modern medicine have depleted the natural resources of human beings to endure and combat suffering. Rather than enhancing life, medicine has, in this view, diminished humanity as a whole (Illich, 1976).

When people are very sick, they may become incapable of making informed and thoughtful decisions about what they want to be done. In this situation, relatives, friends, carers and doctors have to make judgements on the patient's behalf. The idea that people can make judgements that are solely in another person's best interests is what we call 'paternalism' Szasz, among others, was perennially suspicious of paternalism, seeing it as an evil to be avoided if possible and quoting Kant, who said 'nobody may compel me to be happy in his own way. Paternalism is the greatest despotism imaginable' (cited in Szasz, 1990, p. 39).

As well as infringing the autonomy of the individual, paternalism is dangerous, according to Szasz, because it disguises the fact that other motivations are always at stake. No decision about how to treat another human being is ever truly neutral or objective. In medical situations, there are always interests other than the patient's that intrude, whether this be the interests of the family, the doctor or the community or organisation the doctor represents. The idea of paternalism only obfuscates these other influences (Szasz, 1988).

It has been argued, however, that freedom is a preoccupation of those who are already healthy, wealthy and secure. Where daily existence remains a struggle, the self-determination of each individual may seem relatively unimportant. The French philosopher Georges Canguilhem cited the surgeon René Leriche when he described health as the 'silence of the organs' and drew attention to the fact that the impact of disease and infirmity is often not appreciated when good health is taken for granted (Canguilhem, 2012). In some low-and middle-income countries, as in the ghettos of Western cities, where freedom means the freedom to scratch a living from the margins of affluent society, its loss may not be greatly mourned. Moreover, the health problems that continue to beset much of Africa for example – malnutrition and infectious disease – are significantly reduced by simple procedures such as improved sanitation, nutrition, immunisation and the administration of antibiotics that involve little loss of dignity. The health benefits that accrue help to increase individuals' capacity to lead autonomous and independent lives.

Even in high-income countries, freedom is sometimes subordinated to the general health of the populace. In the USA, for example, vaccination of children is mandated because the immunity of society in general is prioritised over the choice

of individual families. Similarly, many countries, including the UK, have public health laws that contain measures to enforce treatment of tuberculosis, including the forcible confinement of an infected individual if this is thought necessary.

Although Szasz may have acknowledged that a self-aware paternalism was necessary in the care of people who are seriously physically sick, he was critical of the extension of the paternalistic principle to other areas of life, including psychiatry. In fact, Szasz argued that the reason for constructing certain forms of behaviour as illness is precisely in order to justify managing them in a paternalistic fashion. Famously, for Szasz 'mental illness' is not the same sort of entity as a bodily illness or disease, and can be rightly understood as an illness only in a metaphorical sense. The metaphor has been mistaken for reality because of the social functions it serves, one of which is to provide a convenient mechanism for the management of socially disruptive and unpredictable behaviour.

The purpose of the concept of mental illness in this account is thus 'to disguise and render more palatable the bitter pill of moral conflict in human relations' (Szasz, 1970, p. 24). Defining such situations as the illness of a particular individual enables the freedom of that individual to be curtailed and interventions to adjust unwanted behaviour to be represented as 'treatment' In other words, an individual can be subjected to the will of others, including being removed from society, confined in an institution and forced to take mind-altering substances, but these actions can be construed as being in the individual's 'best interests'. So psychiatry is the arena in which the conflict between freedom and health comes most sharply into focus, but it is also an artificial conflict, according to Szasz. The language of health and illness is only a gloss that is applied to the daily struggles that occur between people who want to behave in a certain way, and those who want them to behave otherwise.

Mental health problems do not need to be conceived of as illnesses in order to justify paternalistic intervention, however. Although ultimately rejected by the British government, the notion of basing mental health legislation on the concept of 'capacity' has been proposed by various commentators, including the government-appointed Richardson committee in 1999 (Department of Health, 1999). Under these proposals, intervention that was judged to be in an individual's 'best interests' could be justified when that individual was deemed to have lost the capacity to make rational decisions, whether the loss of capacity was occasioned by a bona fide brain disease or an episode of mental disturbance that would be diagnosed as a mental disorder of some kind.

Reservations about paternalism apply regardless of how mental disorder is conceptualised, and judgements about the nature of 'incapacity' and what really constitutes the individual's 'best interests' are always going to be subjective. Removing the link with illness might make the nature and

purpose of coercive interventions in psychiatry more apparent, however.

Szasz felt that individuals should not be forced to receive an intervention they do not want, even if their life without such an intervention appears to be squalid, limited, unrewarding and uncomfortable. In contrast to physical medicine, where paternalism might sometimes be a necessary evil, in psychiatry it is unacceptable, because it denies human beings the dignity of making their own choices, however unwise or self-destructive those choices might sometimes seem to be. Reflecting on Canguilhem's insights, however, suggests that, although from the point of view of sanity it may be possible to value the dignity of human freedom above the ability to function in the actual world, someone has to have a basic level of rational capacity in order to make that judgement. When this is impaired, then a paternalistic approach that aims to restore that capacity could be seen as supporting human dignity and autonomy, rather than depleting them.

Psychiatrists who work with people who are severely mentally ill face these dilemmas daily. Do they leave patients who are deeply psychotic to themselves, allowing them to sink into a state of extreme apathy and internal preoccupation, or do they force them to take antipsychotic medication that might restore some degree of contact with the external world? Similarly, do they attempt to engage such individuals in some social interaction that, initially at least, they might resist, in order to try and establish what appears to be a more rewarding and socially engaged life? If all patients woke up from their psychosis and thanked their psychiatrists for restoring them to sanity, the quandary would not exist. But most do not. Many people who are forced to receive psychiatric treatment, such as antipsychotic drugs, against their wishes either feel they have not benefited, or that the benefits do not outweigh the negative impact of the treatment. Although symptoms may be reduced, some people feel that an important aspect of their personality has been lost too, and that their mental life has become more limited. One patient summed up the dilemma like this: 'In losing my periods of madness, I have had to pay with my soul' (Wescott, 1979, p. 989).

Using forced treatment to increase autonomy in mental health services is thus fraught with difficulties. It is impossible to predict reliably who is likely to appreciate the effects of treatment and who might feel diminished by them. Again, a parallel with medicine in low- and middle-income countries might provide pointers to a solution.

Although the benefits of simple health measures such as improved sanitation appear obvious, they may still be resented and resisted if they are imposed from outside. Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals. In a similar way, society as a whole needs to take responsibility for the things we do to people who are

designated as having mental disorders. There needs to be a transparent debate about when it is justifiable to subject someone to forcible confinement and mind-altering interventions. Crucially, the verdicts of people who have experienced such measures need to be heard. As Szasz identified, however, this is unlikely to happen as long as these conditions are defined as medical illness and intervention as 'medical treatment' A system is possible, however, which reduces the gap that sometimes exists between freedom and sanity.

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SPECIAL PAPER

The legacy – or not – of Dr Thomas Szasz (1920–2012)

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Dr Trevor Turner was asked to provide a commentary on the preceding paper in this issue, '"Freedom is more important than health": Thomas Szasz and the problem of paternalism', by Joanna Moncrieff.

During the 1960s and 1970s the arguments put forward by Thomas Szasz, a Hungarian émigré who established himself in the psychoanalytic world of the USA, becoming Professor of Psychiatry at the State University of New York in Syracuse, were widely discussed and even admired. His arguments, made most forcefully in his 1961 book *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*, essentially stated that psychiatry was an emperor with no clothes. He considered that physical health could be dealt with in 'anatomical and physiological terms', while mental health was inextricably tied to the 'social' (including ethical) context in which an individual lives. He regarded the term 'mental illness' as a metaphor, and used the analogy of a defective television set to explain his meaning. It was as if, in his view, a television viewer were 'to send for a TV repair man because he dislikes the programme he sees on the screen'.

As outlined in the previous article in this issue, by Joanna Moncrieff (2014), Szasz held freedom to be more important than anything, seeing psychiatrists as paternalistic and imposing a myth on capacitous individuals whom they deem to have a 'mental illness', but who are actually suffering from degrees of social deviation rather than a formal disorder. He wrote numerous articles and books, and was popular at meetings. In the early 1990s, at a meeting of the European Association of the History of Psychiatry, he was quite charming, impervious to argument, and a little hard to understand because of his unique accent.

Szasz's views over the 30 or 40 years of his working life never changed, the patient being someone who paid you money to receive discussion and advice. He worshipped at the throne of the contractual life, denying schizophrenia's illness status, there being no organic factors. Detention under the Mental Health Act he saw as a threat to individual liberty, not a therapeutic event. Patients seeking help from psychiatrists he found perplexing. The logic of his view, therefore, would see Parkinsonism (when first described in the 19th century) as a non-disease, it being just a description of behaviours rather than linked to physical pathology. Martin Roth (1976) gave an excellent critique of his theories.

What did emerge from the antipsychiatry movement was the realisation that psychiatry needed to get its diagnostic house in order. The development of stricter criteria for defining schizophrenia, led by the World Health Organization, established a most reliable diagnosis. Perversely, this move away from the more psychoanalytic versions (of schizophrenia and hysteria, for example) to the first-rank and functional criteria of the modern period reduced psychiatry's standing in the artistic and intellectual worlds. The psychotherapeutic doctor hero (Szasz, even?) in many 1960s and 1970s films has now become the white-coated figure in a secure unit, injecting people and giving them shock therapy, and even the ultimate psychiatric monster, Dr Hannibal Lecter (an ultra-Szaszian version of how he portrayed psychiatrists).

In her commentary on Thomas Szasz' work, Dr Moncrieff has suggested that 'Only when healthcare is designed and implemented by the community itself will it be able to foster the development of capable and autonomous individuals'. This view is quite Szaszian, in denying the specialist skills of psychiatry. But while, for example, a

diabetic patient after 10 years of illness may know much about both his symptoms and his treatment needs, the extraordinary debate in the USA about health insurance for everyone (not just the rich) and the shooting of vaccination workers in Pakistan seem to indicate that 'sensible' beliefs about healthcare are not necessarily the norm. We do have intense debates about mental health in the UK (e.g. the 10-year discussion around a new Mental Health Act, an admirable social construction), and the battle against stigma is long and wearying.

Whatever psychiatry is, it is clearly a part of medicine in terms of taking a history, examining patients and reaching a diagnosis to provide treatment, and can be seen as one of the most thoughtful parts of medicine. Everyone has a right to treatment, the best available, and detained patients rarely take umbrage once they become well. Dr Szasz has had his time, and paying him privately is not (in my view) the way to construct modern doctor–patient relationships.

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NEWS AND NOTES

Turning the World Upside Down

'Turning the World Upside Down' is a project that aims to provide a forum for health workers in low- and middle-income countries around the world, in which to share experiences, case studies of good practice and innovation. One of the project's themed competitions – the 'Mental Health Challenge' – sought examples of approaches to mental health in low- and middle-income countries which could be used in high-income countries. This competition culminated in a showcase which was held in November 2013 and chaired by Lord Nigel Crisp. Four case studies were presented, including a telepsychiatry service run from a bus in Kerala which connects to mobile technology, and the winning project: the 'Dream-A-World Cultural Therapy' (DAW CT) programme in Jamaica. Led by Professor Hickling, DAW CT is a multimodal intervention for high-risk primary school children, which fosters impoverished children's creativity to boost their academic performance, self-esteem and behaviour. All 34 case studies submitted to the Mental Health Challenge competition can be viewed on the 'Turning the World Upside Down: Mental Health' website (http://www.ttwud.org/mentalhealth).

Diaspora conference – Academy of Medical Royal Colleges

In November 2013, the Royal College of Physicians hosted a diaspora conference for the Academy of Medical Royal Colleges with the theme of 'models of collaboration between medical diaspora and professional medical organisations' The meeting reinforced the value of the work of these organisations and collaboration between them at a professional and personal level, with benefits both in the UK and overseas. For instance, advocacy work is enabling UK-based volunteers to be released more easily from their work commitments with the National Health Service, and the Medical Initiative Training Programme is underway to allow doctors from overseas to get training experience in the UK. The event also highlighted the need for psychiatrists to engage with Health Education England and equivalent bodies in the UK countries.

Over 30 medical diaspora organisations were in attendance and several of these demonstrated their work in their home countries; there were some remarkable presentations on exciting projects and a masterful poster session. Mental health was well represented, with projects from diverse locations such as Uganda, Latin America and Iraq. For instance, the Zambia UK Health Workforce Alliance (ZUKHWA) is a network of UK-based groups who have united with Zambia-based organisations to support the Zambian government; this model is also being developed in Uganda. There was a lot to learn from the collective experiences on offer at the diaspora conference and there are plans to develop the ideas formulated there and to synergise the work that was exhibited on the day.

UK-Med

The UK has formalised its system for sending humanitarian volunteers to disasters around the world. In the past, there has been a lack of coordination during humanitarian crises but now UK-Med has developed a UK International Emergency Trauma Register.

The register brings together healthcare practitioners with a range of skills and talents from all areas, including mental health professionals, paramedics, nurses and surgeons. All members on the register will be trained and once they have gained some experience they can be deployed for 2–3 weeks when a major international catastrophe occurs, at just 24–48 hours' notice. More information is available on the UK-Med website (http://www.uk-med.org).

We value feedback and contributions for news and notes. We also welcome any comments on current international issues in mental health

Need for decriminalisation of suicide in low- and middle-income countries

Sir: The guest editorial in the February issue by Pathare *et al* (2014) about the need to reform mental health legislation in Commonwealth nations highlighted the fact that many countries have laws that are out of date. The criminalisation of suicide is an important example that warrants urgent attention and reform.

In 13th-century England, 'self-murder' was considered a mortal sin. Those who died by suicide *were denied a Christian burial and their property* was confiscated from their families. Even as recently as 1956, people surviving a suicide attempt were subject to criminal proceedings, with penalties ranging from probation and fines to prison sentences, rather than a psychiatric assessment and treatment. After some urging from both the medical profession and even the churches by that time, in 1961 the British Parliament finally enacted the Suicide Act, whereby attempted suicide ceased to be an offence (Holt, 2011). In contrast, many continental European countries had done so much earlier, beginning with the French Revolution of 1789 (Law Commission of India, 2008).

Unfortunately, as a legacy of British colonialism, the criminalisation of suicide continues in a majority of Commonwealth countries, including India, Bangladesh, Pakistan, Singapore, Malaysia, Ghana and Uganda (Law Commission of India, 2008; Adinkrah, 2012; *The Hindu*, 2013), despite the World Health Organization consistently objecting that labelling suicidal behaviours as a punishable offence has a negative effect on public health (Law Commission of India, 2008). The criminalisation of suicide is known to deter those who are considering suicide from seeking emotional, physical and mental health support. It also skews data collection regarding suicide statistics, as suicide attempts tend to be registered instead as accidental poisonings, for example. The consequent lack of reliable data means that the extent of the problem is unknown, which in turn makes effective intervention strategies more difficult to formulate (Law Commission of India, 2008).

The Law Commission of India (2008) reiterated the conclusion of a 1971 report in highlighting the need to decriminalise suicide. It further stated that suicide attempts 'may be regarded more as a manifestation of a diseased condition of mind deserving treatment and care rather than an offence to be visited with punishment'. It cited the example of Sri Lanka (perhaps an exception among Commonwealth countries), where suicide was decriminalised in early 2000 and where the suicide rate is tending to decrease.

Since 1970, many social activists and mental health professionals in India have been clamouring for the decriminalisation of suicide (Law Commission of India, 2008). Thankfully, in August 2013 a bill to amend the India's mental health law was proposed. The bill seeks to decriminalise acts of suicide by explicitly clarifying that the act of suicide and the mental health of the person are inseparably linked, and have to be seen together rather than in isolation. It is important to note that the bill also seeks to provide for mental healthcare for persons with mental illnesses and to protect, promote and fulfil the rights of such persons during the delivery of mental healthcare and services. We sincerely hope that the bill becomes an Act of Parliament as soon as possible.

More widely, it is imperative that everyone recommends and supports the decriminalisation of suicide as an element of progressive mental health treatment and suicide prevention strategies throughout the Commonwealth as well as in other low- and middle-income countries.

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Forthcoming international events

5–7 June 2014
Neurobiology and Complex Treatment of Psychiatric Disorders and Addiction (World Psychiatric Association Thematic Conference)
Warsaw, Poland
Website: http://www.wpatcwarsaw2014.com

6 June 2014
Cognitive Remediation in Psychiatry: New Directions for the 21st Century
New York, NY, USA
Website: http://www.cognitive-remediation.org/

12–14 June 2014
3rd International Symposium on Controversies in Psychiatry
Mexico City, Mexico
Website: http://www.controversiasmexico.org/

24–27 June 2014
Royal College of Psychiatrists International Congress 2014, 'Psychiatry: The Heartland of Medicine'
The Barbican Centre, London, UK
Website: http://www.rcpsych.ac.uk/trainInpsychiatry/eventsandcourses/internationalcongress2014.aspx

25–29 June 2014
Cognition and Action: The Jagiellonian-Rutgers Conference in Cognitive Science 2014 (CogSciJR14)
Kraków, Poland
Website: http://cognitivescience.eu/

4–6 August 2014
3rd International Conference and Exhibition on Addiction Research and Therapy
Chicago, USA
Website: http://addictiontherapy2014.conferenceseries.net/index.php

13–17 August 2014
Third International Congress of Psychology and Education
Panamá, Panamá
Website: http://www.medical-events.com/congress/third-international-congress-of-psychology-and-education-4851

25–29 August 2014
7th World Congress for Psychotherapy
Durban, South Africa
Website: http://wcp2014.com/

10–12 September 2014
3rd World Congress of Clinical Safety (3WCCS) Main theme: Clinical Risk Management
Madrid, Spain
Website: http://iarmm.org/3WCCS/

14–18 September 2014
XVI World Congress of Psychiatry: Focusing on access, quality and humane care
Madrid, Spain
Website: http://www.wpamadrid2014.com/

16 September 2014
6th World Congress on Mental Health and Deafness
Belfast, UK
Website: http://www.wcmhd2014.org/

24–26 September 2014
2nd Global Conference: Suicide, Self-harm and Assisted Dying
Oxford, UK
Website: http://www.inter-disciplinary.net/probing-the-boundaries/persons/suicide-self-harm-and-assisted-dying/suicide-self-harm-and-assisted-dying/

10–11 October 2014
Fall Global Psychology Symposium
Los Angeles, USA
Website: http://www.conferencealerts.com/psychiatry.htm

22–24 October 2014
4th International Conference on Violence in the Health Sector
Miami, USA
Website: http://www.oudconsultancy.nl/MiamiSite2014/violence/invitation-fourt.html

30 October–2 November 2014
WPA Thematic Conference on Intersectional Collaboration, 5th European Congress of INA & 2nd Interdisciplinary Congress on Psychiatry and Related Sciences
Athens, Greece
Website: http://www.psych-relatedsciences.org/

4–7 December 2014
10th International Congress on Mental Dysfunction and Non-Motor Features of Parkinson's Disease and Related Disorders
Nice, France
Website: http://www.kenes-group.com/events

12–14 December 2014
WPA Regional Congress, Hong Kong
Hong Kong, China
Website: http://www.wpa2014hongkong.org/

Contents of the *African Journal of Psychiatry* (affiliated journal)
Volume 17   Number 1   January 2014

Editorial
Recurrent panic attack and ubiquinone treatment: a case report
F J. Rodal-Canales, A. Guzmán, L. Perez Campos Mayoral, G. Mayoral Andrade, E. Perez Campos Mayoral, E. Perez Campos

Original articles
Ethnic differences in eating attitudes, body image and self-esteem among adolescent females living in urban South Africa
Tabither M. Gitau, Lisa K. Micklesfield, John M. Pettifor, Shane A. Norris

Handedness in schizophrenia and schizoaffective disorder in an Afrikaner founder population
R. H. Mataboge, M. Joubert, J. C. Jordaan, F Reyneke, J. L. Roos

Unipolar mania reconsidered: evidence from a South African study in KwaZulu-Natal, South Africa
C. Grobler, J. L. Roos, P. Bekker

Defence styles and social adaptation during a depressive episode: bipolar depression vs. major depression
Gökhan Sarısoy, Ozan Pazvantoğlu, Deniz Deniz Özturan, Naile Dila Ay, Tuba Yılman, Sema Mor, Işıl Zabun Korkmaz, Ömer Faruk Kaçar, Kübra Gümüş

Clinical and demographic profile of patients using a liaison-psychiatry service in a general hospital setting in Abeokuta, Nigeria
L. U. Onofa, O. I. Udofia, A. A. Fatiregun, T O. Adebowale, O. E. Majekodunmi, A. O. Akinhanmi

Duration of untreated psychosis and associated factors in first episode psychosis in Mzuzu in Northern Malawi
Harris K. Chilale, Richard Banda, Japhet Muyawa, Atipatsa C. Kaminga

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