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Trapped

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are characterised by more markers of social adversity such as deprivation and unemployment than are White people. A smaller percentage of South Asians were in the most deprived quintile than were Black African or Black Caribbean patients, which provides one possible explanation for the lower rates of suicide reported in this group.

The study also reports that ethnic group might influence which mental health services are received. More minority ethnic patients were admitted to hospital involuntarily or on community treatment orders, despite lower clinician perceptions of risk, and fewer were under the care of home crisis services, a fact frequently reported in the literature.^{1,5,7,8} The continuation of this trend in Hunt and colleagues' work, despite the recent nature of the data which only spanned the last 15 years, identifies an ongoing requirement to evaluate how the experience of and routes into mental health support can be improved for people from minority ethnic backgrounds.⁶ Mental health services should work towards establishing a means of assessing the need for care that limits potentially implicit biases and ensures that adequate care is readily accessible and provided promptly and in the least restrictive means possible.⁷

The Article has several strengths alongside the examination of sociodemographic factors, including the consideration of temporal changes in rates over time. However, the research is limited by the lack of data on length of time spent in mental health treatment, and more specific treatment details, meaning that understanding the effectiveness of current suicide prevention efforts in different mental health services

is not possible. Similarly, information regarding routes into care, such as whether police were involved, is predictive of negative outcomes such as disengagement from services,⁵ and might have provided additional insights into different experiences of treatment. Finally, as the authors acknowledge, inclusion of people who have had treatment as a denominator in the rate calculations can produce biased estimates. However, this study provides valuable insights into how suicide rates differ across ethnic groups and potential influencing factors.

I declare no competing interests.

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Trapped: rigidity in psychiatric disorders

In the past decades, it has been shown to be difficult to predict the course of psychiatric disorders, because the mechanisms underlying their development and recovery process remain poorly understood.¹ These difficulties have been attributed to the fact that previous research was mostly performed from a categorical, diagnostic label point of view and on a single level (ie, psychological or biological), typically on the basis of static measures with low ecological validity.¹ To improve the prediction of course of illness, we propose

to adopt a transdiagnostic, cross-level, mechanistic approach informed by clinical observations on rigidity in psychiatric patients.

Clinicians frequently observe that patients, regardless of their diagnostic label, develop more rigid cognitions, emotions, and behaviour during the progression of their psychiatric disorder.² Although context is clearly important for patients, these observations suggest that the degree of perseveration of cognitions, emotions, and behaviour could be more relevant when searching

for mechanisms underlying the course of psychiatric disorders. Prolonged rigidity in these domains might ultimately result in the development of maladaptive schemas and traits, which in themselves increase the risk for psychiatric chronicity.^{2,3} Hence, rigidity may be an informative concept on the position of a patient on a transdiagnostic continuum of severity of psychiatric symptoms.

On the basis of these clinical observations and in line with growing research interest in such overarching aspects of psychiatric disorders,¹ we propose to devote research efforts to investigating the concept of rigidity, defined as an inability to flexibly adapt cognitions, emotions, and behaviour in response to changes in the environment.³ Specifically, we suggest studying (1) the aforementioned domains dynamically, using repeated measurements over time during daily life (psychological level); (2) how this form of psychological rigidity is related to rigidity in dynamic functioning of the brain (biological level); and (3) how associations between these two rigidity measures dynamically change during illness progression and recovery to uncover markers regarding the course of illness.

To our knowledge, there are currently no longitudinal studies investigating whether rigidity indeed increases during the progression of different psychiatric disorders and whether this concept has predictive value for the course of these disorders. Studying rigidity in this way might foster progress in psychiatric research for two reasons. First, the dynamic and contextual nature of this concept connects well with clinical complexity and reality. Second, the transdiagnostic and mechanistic character of this concept makes it an ideal vehicle to investigate markers of course of illness across psychiatric disorders and research levels.

To capture dynamic patterns of cognitions, emotions, and behaviour, the experience sampling methodology (ESM) is receiving growing interest. Previous ESM research demonstrated that individuals with psychiatric disorders, compared with individuals without, show increased emotional responses to daily events, slower emotional recovery, and in general less socially and physically active behavior.⁴ Notably to date, there is little research on the association between fluctuations in momentary cognitions and psychiatric symptoms. Yet negative cognitions are strongly associated with the

Panel: Strengths of rigidity markers at psychological and biological levels

Markers at the psychological level (ESM)

- Close to the (subjective) experience of the patient
- Ecologically valid (measured in daily life)
- Feasible for implementation in clinical practice (ie, eHealth tools)
- Provide personalised information on cognitions, emotions, and behaviour useful to inform treatment, specifically when combined with qualitative data

Markers at the biological level (fMRI)

- More objective
- Provide fundamental knowledge on brain functioning useful for psychoeducation
- Provide information for neurostimulative and pharmacological interventions

ESM=experience sampling methodology. fMRI=functional MRI.

experience of negative emotions and the presentation of maladaptive behaviours.

Intuitively, the ability to flexibly adapt to changes in the environment depends on the ability of the brain to flexibly form connections between brain regions, which can be measured with dynamic functional connectivity (DFC) using functional MRI (fMRI).⁵ Indeed, in individuals without psychiatric disorders, neuroimaging studies have shown that DFC is positively associated with cognitive flexibility⁶ and that lower DFC predicted worse behavioural performance in various domains relevant for psychiatry.⁷ Specifically, the combination of flexible reconfiguration of frontal brain networks and a conserved network structure of stable visual and somatosensory-motor brain networks seems key to neural flexibility.⁶

By combining ESM and DFC, we are able to investigate rigidity in an interdisciplinary, dynamic, and ecologically valid way and benefit from the joint strengths of these methods and research levels (panel). Using phase synchronisation calculated on task-based or resting-state fMRI data, it is now possible to obtain information on how brain regions and networks communicate with each other per timepoint.⁸ This approach creates the unique opportunity to integrate findings across methods and research levels by calculating similar statistical measures on ESM and DFC time-series data capturing rigidity (eg, mean in combination with the standard deviation⁹). Ultimately,

these rigidity measures might serve as transdiagnostic markers for severity of psychiatric symptoms in a specific patient.

If these measures are also sensitive to changes in the recovery process, they could function as a course marker as well. In this regard, changes during and after psychological therapy could be of specific interest, because they represent structural changes in cognition with long-term protective benefits for mental health.¹⁰ Importantly, psychological and biological markers each have their own merits and can be used for different purposes (panel). Finally, these markers could help to detect vulnerability for and onset of psychiatric disorders, monitor treatment progress and subsequent potential relapse, and improve the efficacy of transdiagnostic interventions targeted at this core aspect.

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PTSD: equity in diagnostic practice

Post-traumatic stress disorder (PTSD) provides a vocabulary to describe the psychological toll all manner of traumatic events can take. However, although most cases of PTSD are not related to combat, more than 90% of PTSD-related US federal legislation introduced between 1989 and 2009 targeted military populations.¹ The US Department of Defense and the US Department of Veterans Affairs are leading funders of PTSD research.² PTSD has been constructed as a predominantly military-related disorder.

Psychiatric researchers rarely publicly forswear military patronage in defence of scientific integrity, as some social scientists did during the Cold War. Following decades of increased attention to national security after the September 11 attacks, people in the USA have assimilated militarisation into daily life.³ Indeed, critical engagement with the politics of PTSD might seem to dishonour veterans and can thus be politically taboo. Nevertheless, the consequences of military influence on

both the clinical and cultural understandings of PTSD require further scrutiny.

Close reading of the DSM-5 text explicating Criterion A, which specifies types of events that can constitute PTSD-causing trauma, illustrates how the military context of PTSD's origin continue to shape its classification. The discussion of PTSD risk factors in the DSM-5 frames combat as inherently traumatic to both the victims and perpetrators of war-related violence (panel). This value-laden claim, although not directly incorporated into Criterion A, expands the range of war-related events that can constitute trauma by including acts perpetrated by soldiers. Further, by specifying military personnel, this language implicitly excludes non-military situations (panel). To be clear, we are not making a moral equation between the actions of service personnel and civilian perpetrators of violence. However, if it is indeed the case that to act violently—whatever the circumstances—might