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Correspondence

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The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

TRANSCULTURAL PSYCHIATRY

DEAR SIR,

Dr Rodney Morice (*Journal*, January 1978, **132**, 87–95) is to be commended for his excellent study of Pintupi Aboriginal Psychiatry in Central Australia. He gathered his data with the use of the only Pintupi-English dictionary available, and though much information bearing on the qualitative and culturally unique aspects of such two-person interactions might well have been lost in the process, it is a step in the right direction. It is not generally realized that, although both occidental and indigenous psychiatrists have worked fruitfully among traditional peoples, few indeed have moved out of the larger towns in the course of their work. When one considers the populations of non-Western countries it becomes apparent that most members of the human species have never been examined by a psychiatrist (Burton-Bradley, 1977). Dr Morice's work could become a model for all future MD thesis aspirants if the study of psychiatry would only move away from its present narrow confines into the larger world of *Homo sapiens* as a whole.

For these reasons it is a pity that his final paragraph entitled emic categorizations, guileless and misleading as it is, in reality reflects only a list of values. It advances an anti-cultural thesis. It should have been deleted. We are told that with the aid of lexical categories, *generally accepted nosologies* will come into their own. On this theory the Pintupi patient must express his symptoms in terms of a remote European construct in order to be understood.

Yap's study of culture-bound syndromes grew out of Asian psychiatrists' dissatisfaction with Western psychiatry. I doubt it was his intention to infer that similar entities might not occur in other geographical areas. These conditions are more in the nature of culture-related and culture-concentrated diseases, and to ignore their cultural content is to throw out the baby with the bath water. But they are required on Dr Morice's account to line up with concepts developed in Vienna, Munich and Zurich. He sees such a trend as beneficial in treatment and one liable to promote communication between psychiatrists. The likelihood is quite the opposite. Diagnoses that exclude the cultural factor are disastrous, and the type of communication with colleagues suggested is likely to confirm some in their already existing Eurocentric biases. The continued use of the pejorative term *preliterate* is unfortunate for it implies inferiority and that cultural development necessarily follows a particular sequence. Such an assumption concerning the evolutionary development of societies is no longer accepted. *Nonliterate* is more appropriate.

The psychiatrist stationed among so-called third world peoples soon comes to recognize cultural factors as inextricably interwoven with all aspects of the medical enterprise, and to disregard their pertinence in diagnostic procedures is to restrict our knowledge of human behaviour. Yamamoto (1977) points to the need in the future of a culturally pluralistic psychiatrist alert to the blind spots in our European traditions, and I hope that the younger generation at least will steer clear of these obstacles in the interest of a proper understanding.

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BRITISH PSYCHIATRY'S LOVE AFFAIR

DEAR SIR,

I found Professor Kathleen Jones' 51st Maudsley Lecture—'Society Looks at the Psychiatrist' (*Journal*, April 1978, **132**, 321–32), a balanced but thoroughly depressing critique of current British psychiatric practice. Following four years as a registrar in Scotland, I obtained leave of absence to spend one year in Toronto working as a senior resident in a university teaching hospital. This experience has clearly highlighted some of the major points made by Professor Jones.

From the earliest point in their training, psychiatric residents in Toronto are given systematic instruction

in psychotherapy of the analytically orientated type. They are encouraged to conceptualize and formulate their patients' problems in the broadest sense; treating them as members of a family group and considering relevant cultural factors. Although by no means abandoning the medical model, this is set in the much broader context of the whole person and his interaction with his fellow men.

As a medical student I found myself increasingly disenchanted with the dry narrow 'scientific' view of man. I was forced to the inescapable conclusion that human suffering cannot be reduced to a series of biochemical formulae, and unlike many I failed to find patients who derived much benefit from medication, but found many whose suffering was in fact worsened by misguided therapeutic zeal. It was for this reason that I chose psychiatry in the hope that here, at least, I could improve the quality of people's lives. It is therefore with growing disillusionment that I watch British psychiatry's love affair with medicine. If only the mountain had moved to Mohammed things might have been so different.

Looking at Britain from a distance one is immediately struck by the quality of British contributors to the field of human understanding, who have made so little impact on British psychiatry, while transforming attitudes across the Atlantic. Melanie Klein, Anna Freud, John Bowlby, Michael Balint, Donald Winnicott, Harry Guntripp, Ronald Fairbairn, Wilfred Bion, Henry Ezriel . . . the list is endless. Surely we should take pride in this psychological heritage and attempt to build on it.

I, for one, willingly respond to Professor Jones' challenge. But will I be given the opportunity; or forced to look elsewhere, where pastures are greener and more receptive? Who will be the loser?

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MEASUREMENT IN PSYCHOTHERAPY

DEAR SIR,

Any constructive comment on the vexed question of how to measure outcome in psychotherapy is welcome. The suggestion by Adams (*Journal*, June 1978, **132**, 595–97) that Post-Test Only Control Group Design is adequate to identify statistically significant differences in morbidity between groups exposed to different treatment schedules is statistically attractive, but it surely allows room for dangerous misinterpretation. For any significant difference in severity between groups at least two rather different explanations must be considered. One is that treatment has helped each group to different extents, the other is that treatment has harmed each group to different extents. Clearly several possible permutations exist.

The author considers that a pre-treatment measure is of secondary importance in answering the outcome question. I suggest that unless such a measure is included we cannot decide whether a treatment has been 'more therapeutic' than another or merely 'less damaging'.

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IS PARENTHOOD TEACHABLE?

DEAR SIR,

The recent Government paper 'Violence to Children' (1), presented to Parliament in March 1978, raises some controversial issues. I would like to comment on one of them concerning 'Education for Parenthood' (Para 11–18).

The report encourages the spending of more money on 'education for parenthood', since the Health Education Council has had its resources recently increased by £1 million. The report recommends that 'the Government should ensure that education for parenthood is available for boys and girls of all levels of intellectual ability'. This raises the important issue of whether parenthood is teachable. Can we in fact educate severely disturbed and violent people so that they become good parents? I do not think that we can.

Paulson and Blake (2) have cautioned against viewing battering parents as a function of educational disadvantage, and Steele and Pollock (3) regard educational factors as irrelevant and place more emphasis on the maladjustment resulting from violent childhood experiences. Kempe (4) found that all social classes were represented in his sample of battering parents, and it is the experience of many clinicians that highly qualified and well-educated people are not immune to violence; they may have all the knowledge of child care but they may be unable to apply what they know in real life.

There is no convincing study to show that violent parents lack the knowledge of proper parenthood, but most of the studies do show that they lack the ability to practise it.

People learn to be good parents by following the example of their own parents, and not by reading