observer-rated personality questionnaire with a high reliability score in both normal and mentally handicapped populations (Mann *et al*, 1981; Reid & Ballinger, 1987). As the diagnosis of personality disorder in the mentally handicapped population remains difficult and controversial, it seems important to use an observer-rated questionnaire which has a good tested reliability on mentally handicapped populations. Neither DSM–III nor DSM–III–R has that advantage. The T-L scale, however, was used by Bear & Fedio (1977) to detect the personality characters which they claimed to be specifically associated with epilepsy.

It is true, as Drs Tyrer & Moore have pointed out, that we found the epileptic patients living in the community to have a significantly higher T-L personality abnormality, particularly 'persistence and repetitive' type than those without epilepsy. However, such behaviour is not uncommon in people with a mental handicap, the numbers in each group were very small and in the context of a high number of statistical tests these few positive findings may have been obtained by chance. On the question of the protective effect of carbamazepine on maladaptive behaviour, we agree that in a cross-sectional survey it is difficult to ascertain cause and effect relationships; however to overcome that difficulty we used a carefully matched control population and compared the effect of each monopharmacy group separately to avoid contamination effect. Analysis of our data does not support their assumption that behavioural effects may have been due to the associated factors (e.g. less severe brain damage, less frequent seizures, etc.) rather than the influence of carbamazepine monopharmacy *per se*. When the combined subgroups of epileptic patients (both from hospital and from the community) with evidence of severe brain damage (e.g. those who had multiple types of seizure and also frequent seizures) were compared with their counterpart of non-epileptic adults, no significant difference in the maladaptive behaviour was observed. On the contrary, the severely mentally handicapped adults with epilepsy showed significantly less maladaptive behaviour when compared with the adults without epilepsy. Although as a group those who received monopharmacy had shown significantly less aggressive behaviour, this did not prove true for any monopharmacy group other than carbamazepine, whereas associated brain damage factors should have remained the same in all monopharmacy groups.

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Ethical problems in genetic linkage studies

SIR: We were most interested to read Alexander *et al*'s contribution to the long-overdue discussion of the ethical issues and problems inherent in genetic linkage studies of psychiatric disorders (*Journal*, January 1992, **160**, 98–102). We applaud the thoughtful nature and general thrust of their approach, but feel it might be useful to share our experience in the method of making the all-important initial contact with the proband's relatives.

Dr Alexander *et al* state that family members "are often taken aback" by "the initial contact [which] is usually by telephone". While we are aware that there may well be considerable cultural differences in the way telephone communications are offered and received in different countries, such a response to an unexpected call by a member of a psychiatric research team should perhaps not come as a surprise to the caller; it is for this reason that our policy in Scotland is to make initial contact by means of a brief letter explaining in general terms the nature and purpose of our research, which is then followed up within a week by a telephone call and a request to meet personally. In this way, family members have the opportunity to think over the issues before any demands are made on them, and consider any questions they may wish to ask. In our experience the procedure may be marginally more time-consuming than a straightforward telephone call, but the extra effort is repaid in terms of less anxiety for future participants in our studies and very high degree of cooperation and goodwill in the longer term.

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Western psychotherapy and non-Western populations

SIR: It was interesting to read about the difficulties our Saudi Arabian colleagues experienced (*Journal*,

March 1992, **160**, 425), which are quite similar to our experience here in Hong Kong with the Chinese population. The very discussion of the applicability of Western psychotherapy to a non-Western population raises the issue of whether non-Western cultures have the same psychological problems as are found in the West, which are dealt with by their psychotherapy. Doi (1984) has questioned this assumption, although with increasing Westernisation of the non-Western cultures, we may also acquire their problems.

There is no Western 'model' of psychotherapy but Western 'models' of psychotherapy (Karasu, 1977). It has been found, within Western society, that sub-cultural groups respond to different therapeutic approaches differently. Our difficulties with the non-Western population may be a reflection of similar difficulties with specific sub-cultural groups in the West.

No two patients are the same, and indeed, no two therapists are the same, each therapy session with each patient by a specific therapist is in some sense specific, and influenced by a whole gamut of factors impossible to disentangle. Ethnicity of the patient is only a particular aspect of this specificity.

It may be more useful in discussions of psychotherapy to talk of horizontal cultures rather than vertical cultures. This means that perhaps middle class Americans in New York city are more like the middle class Chinese in Hong Kong than the lower socioeconomic class Americans in the same city. From this perspective, the idea of a culture-specific psychotherapy would make more sense, and this definitely agrees with my experience of having treated patients both in the Western society and in Hong Kong.

As the idea of role-induction (Hoehn-Saric *et al*, 1964) has shown, even in the Western society there is a need to clarify with our patients their expectations of psychotherapy. Logically, therefore, in a culture where psychotherapy has not taken root, public (and patient) education would be necessary. With increasing public awareness of the workings of psychotherapy, some of the problems we experience in the initial phase of introduction of this treatment method to our individual cultures would disappear. We should remember that therapist expectation might also work against ourselves if we believe that patients in our culture would not benefit from explorative psychotherapy. My experience in Hong Kong, of lower-middle class patients, is that this type of therapy is applicable.

In an earlier paper, my colleague and I suggested that with each psychotherapeutic encounter, the universal, the group-specific and the unique aspects of both the therapist and the patient are important considerations (Cheng & Lo, 1991), and that "every person in different ways is like all persons, like some persons, and like no other persons" (Kluckhohn & Murray, 1953). From this philosophical basis I feel, and I have found that with perseverance and persistence, that it is possible to use Western models of psychotherapy with a non-Western population.

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SIR: I read with interest El Sherbini & Chaleby's letter discussing their difficulties in using Western models of psychotherapy in a Middle Eastern setting (*Journal*, March 1992, **160**, 425). This certainly accords with my own experience in using Western psychotherapy techniques both among Middle Eastern and Asian immigrants in the UK as well as Middle Eastern patients living in their country of birth.

In addition to the points mentioned in the author's letter, there are other culture-related issues in the therapy process. Most Western psychotherapies, whether psychodynamic or cognitive, encourage personal autonomy and individualism. In non-Western cultures, and especially Middle Eastern culture, social integration and acceptance is a much more valued attribute and, therefore, to go down the individualistic path carries a risk of real social sanctions and ostracism. One deeply embedded process in Arab culture is the early and consistent use of shame by parents, teachers and others as a method of ensuring social conformity and adherence to social values. The consequence of this is a deeply rooted and extremely powerful fear of social disgrace that is largely impervious to challenge or modification in the psychotherapeutic process.