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Correspondence

Differentiation of emotions

DEAR SIRS

Dr Campling (*Psychiatric Bulletin*, October 1989, **13**, 550–551) quotes an early publication of mine on the differentiation of emotions with implied disapproval, an attitude I share with her. Since then (1977) my views have changed (?evolved). At the time I assumed that babies experience undifferentiated emotions which are shaped by cultural influences either towards differentiated somatic experiences (non-western cultures) or differentiated psychological experiences (western cultures). Criticism from anthropologists (e.g. Good *et al*, 1985) and recent research on the abilities of infants (e.g. Stern, 1984) have rendered that view untenable. It has been demonstrated by modern technology that infants are capable of differentiating emotions from a very early age. Hence, it is likely that the full range of somatic and psychological emotional experiences is available to all humankind. Nevertheless, it is still necessary to explain the different patterns of illness that present to doctors in western and non-western countries. For example, hysteria has declined in incidence in this country since the Second World War, while it remains a common presentation in non-western countries. It is now my view (Leff, 1988) that this difference is partly explicable in terms of the attitudes and expectations of healers, be they traditional or trained in western medicine, and of their clients. Each client brings to the healer the type of complaints they know him to be conversant with. Traditional healers who specialise in divination are expert in decoding somatic complaints into the disturbed family relationships that engender the underlying distress. Their prescriptions are designed to regularise the client's relationships with family members. Although the language in which the prescription is couched may be symbolic, it is shared in common with the client and his/her family, so that no re-education is necessary.

By contrast, the western psychotherapist uses a symbolic language, embodying the conceptual framework of his or her particular school, which the client has to learn in order to make communication possible. The question Dr Campling raises about the suitability of psychotherapy for black patients is then seen to hinge on how readily the client can adopt the therapist's language. The same question is of course crucial for white patients. However, in the case of black patients (and here we encounter a serious problem with such a comprehensive category), there exists a wide variety of folk concepts of illness, of distress, and of appropriate treatments. I would postulate that the distance between the concepts held by the client and the ideology of the therapist will determine the acceptability of the therapist's language and hence the viability of therapy. It has been shown that unless therapists are prepared to negotiate with their clients on discrepancies between their respective ideologies of illness, prescriptions are unlikely to be followed (Health Education Studies Unit, 1982). A prerequisite for such negotiation is an exploration of the clients' belief system about their complaints. Herein may lie a method of engaging a more equitable proportion of black clients in psychotherapy.

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HIV/AIDS and mental handicap

DEAR SIRS

We read the article by Dr Catalan *et al* (*Psychiatric Bulletin*, June 1989) with interest, having recently produced a policy document for our own Unit, which is linked to catchment areas which form the same territory as that from which half the recorded cases of AIDS in the UK emanate.

The four cornerstones of our strategy are:

(a) Sex education for the patients. An AIDS Awareness/Sex Education Project has been established, an essential part of which will be instruction in safe sexual practices
(b) counselling and support for known HIV carriers and their carers
(c) where possible, to identify HIV carriers who may carry out high risk activities with resi-

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dents who are unable to make considered judgements and as a result are vulnerable

(d) maintaining safe nursing practices which are already operational to protect against Hepatitis B.

Patients who are to be counselled should have an advocate to advise them. We feel that social workers are best suited to carry out this role (in practice, this would normally be the hospital social worker). The role of the counsellor contrasts with that of the advocate in that counsellors present the facts neutrally and do not advise.

The patient who consents to HIV test after fully comprehended counselling can be tested without further ado.

When a patient is unable to comprehend and so give valid consent, or when a resident refuses consent, the Health Authority should go to the High Court to make a person under 18 a Ward of Court, or seek a Declaration for someone older. This is thought to be necessary because identifying a patient's seropositivity might seriously compromise his or her quality of life. This predicament is regarded as being of a similar contentious nature to that pertaining when a mentally handicapped woman becomes or may become pregnant, where good medical practice dictates she should undergo termination of pregnancy and/or sterilisation. In this situation a Declaration is required for each case (Dyer, 1987). This conclusion has been supported by the Mental Health Act Commission (1987). It is possible that in the case of HIV infection one Court Declaration will set a precedent which will render further Declarations unnecessary.

Exceptionally the consultant may feel that the situation is too urgent to incur a delay by going to court. In this case the consultant taking responsibility for performing the test should be prepared to justify such action in court (GMC, 1988). The consultant would be advised to discuss the decision with medical colleagues before taking action.

The management of a proven HIV carrier may be problematic. The patient must be informed of the dangers to any partner and as a result may well end the practice of high risk activities. If a partner is unable to make considered judgements or it is considered likely that there will be such a partner, prevention of transmission of HIV becomes a priority.

It is not possible to anticipate every circumstance and make specific recommendations. Section 3 of the Mental Health Act 1983 is not indicated to control a patient's behaviour if she/he is mildly mentally handicapped, where the sectioning will not benefit him/her.

If the partner is able to make considered judgements it *may* be appropriate to inform that partner of the danger in the same way the General Medical Council has given cautious approval to doctors informing spouses (GMC, 1988).

Patients in a mental handicap hospital have as much right to confidentiality as people who live in the community. Those informed would be on a 'need to know' basis, although it could be possible that precautions required to protect other patients from an HIV patient are so unusual or transparent that their significance would be obvious.

Our Mental Handicap Unit Working Party on AIDS and HIV Infection meets regularly to update the policy and monitor the implementation of its recommendations.

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The impact of 'Working for Patients' on psychiatric services

DEAR SIRS

The publication last year of the Government's proposals for the National Health Service and Community Services in *Working for Patients* and *Caring for People* augurs many changes to the provision of care for acute and chronic patients (Department of Health, January and November 1989). The Royal Colleges have responded to the first of these White Papers with some reservations and suggestions for safeguards, but the exact implications for services are unknown and without adequate widespread clinical trials (Conference of Medical Royal Colleges, 1989).

In an attempt to assess the future trends of general practitioner (GP) referrals to a Sub-Regional Alcohol Unit I circulated a questionnaire to 100 consecutive Merseyside GPs who had referred patients to the Lakeside and Windsor Clinics for the combined out-patient and in-patient alcohol assessment and treatment services. The purpose of the questionnaire was explained as a feasibility study into the proposals contained in *Working for Patients*. Eighty per cent of GPs responded using the pre-paid envelope.

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