

century has been turbulent; where Stalin's repression helped weld together a nation state, Gorbachev's reforms look like heralding its disintegration. In the case of psychiatry, structures legitimising repression have not been fully expunged, offering scope for future restoration in the event of a political backlash. In particular, we must register the parlous state of the Soviet economy, and the continuing impoverishment of the health services in general.

Western psychiatrists continue to face a dilemma: whether to welcome dialogue with Soviet colleagues, or to press for an extension of sanctions until fully satisfied that structural changes have taken place. Most Soviet psychiatrists have never been involved in political abuse, though they and their patients continue to suffer the physical and intellectual privations forced upon them by the system in which they live. It is time to roll up our sleeves; our Soviet colleagues need more than our blessing. If we are to transcend Cold War rhetoric we must offer something more tangible: scholarships, educational exchanges and open academic discourse would be limited but realisable goals.

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#### *The patient's perspective*

DEAR SIRS

It is heartening that British psychiatric researchers are at long last seriously addressing the patient perspective (Ballard & McDowell, *Psychiatric Bulletin*, November 1990, **14**, 674–675). The recent *People First* national survey of psychiatric patients conducted by MIND in collaboration with Anne Rogers and myself at Roehampton Institute will be providing more extensive information of this type in 1991. Could I make three comments for consideration by practising psychiatrists and the Royal College of Psychiatrists at this stage?

First, our findings on perceived helpfulness of medical and nursing staff are less complimentary than the Coventry study. The latter cites satisfaction levels of 90–98%. Our study will cite in the region of 54–57%. Second, we also found substantial concern about informed consent. Ballard & McDowell address this issue but then repeat the profession's

conventional wisdom of striking a balance between information giving and avoiding “necessary worry to the patients”. This unsatisfactory compromise must be seriously addressed by the profession. Most physical treatments, especially major tranquillisers, can have very powerful iatrogenic consequences, which are risked in every case prescribed. The Mental Health Users Movement (Rogers & Pilgrim, 1991) is justifiably demanding a full and honest debate about the risks of treatment. Third, why is the potentially distressing and humiliating experience of “ward rounds” still considered good practice in psychiatric settings? (See also the letter from Dr White on *Talking to Patients* in the same issue.) Who benefits from them? Should this anachronistic ritual, which seems mainly to have existed to massage the egos of psychiatric showmen and pedagogues, be re-negotiated with representatives of users or services in each locality?

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see pp. 363–364

#### *Psychiatry in South Africa*

DEAR SIRS

The recent report to the President by Dr Caldicott and her colleagues (1990) on their visit to South Africa is helpful and informative. However it does not go far enough in its recommendations regarding the Society of Psychiatrists of South Africa.

The SPSA represents about half of all South African psychiatrists but has failed to utilise this unique position to any effect. They have been consistently lethargic in their efforts to promote an efficient mental health care system for all South Africans. Further, they have failed in their training of future psychiatrists. In my two years as a registrar in the ‘black’ hospitals of Hillbrow and Baragwanath, I received no communications or directives from the SPSA.

At least 50% of SPSA members are engaged solely in private practice, offering the sort of care that is inaccessible to the vast majority of South Africans. It is hardly surprising therefore that the SPSA is nothing more than a perfunctory organisation. For its members to lobby for development of a national health care system would conflict with their private practice interests. Psychiatry in South Africa needs

to move rapidly towards an integrated, centrally funded, community based service before even beginning to offer the sort of care needed by a developing nation reeling from years of injustice and conflict.

It is simply not good enough for the SPSA to mouth good intentions. A starting point could be an urgent and thorough review of the psychiatric training programme. Trainees should be discouraged from commencing private practice the day after completing their MMed(Psych). A further period of training, perhaps equivalent to the British senior registrar level, should be introduced. During this time, trainees should commit themselves to a period of academically supervised community based service. This would make post-apartheid South African psychiatrists not only more aware of the needs of the population, but also, safer doctors.

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#### *Mental handicap – by any other name*

DEAR SIRS

The problem nowadays referred to as 'mental handicap' must be in a strong position to claim the distinction of being the human condition which has had the most names applied to it.

During the 20th century there has been a continuing search for more acceptable expressions which are free from stigma and do not devalue the affected individual, and may seek to inspire new hope and enlightenment. The result so far is some 30 and more different terms which have been used at various times.

*Old 'archaic' terms:* oligophrenia, hypophrenia, amentia – 'simple primary amentia'.

*Mental Deficiency Act 1913:* mental defective – idiot, imbecile, feeble-minded or moron.

*Mental Health Act 1959:* subnormality, subnormal (severe)

*Mental Health Act 1983:* mental impairment

*International Classification of Diseases:* mental retardation – borderline (ICD-8), mild, moderate, severe, profound (ICD-9).

*Education:* educational subnormal (ESN), learning difficulty (severe LD), under-achiever.

*Children:* exceptional, unusual, different, special.

*Others:* mental handicap (Royal Society for Mentally Handicapped Children and Adults, 1955,

Mr R. H. S. Crossman, Health Minister 1970). More recently – mental handicaps. Developmental handicap, developmental disability, developmental impairment, developmental psychiatry, defectology, retardology, high grade or low grade defect, 'one in a hundred', 'strangers in their own country', under-intellectualisation, intellectual insufficiency, intellectual disability, diminished people (Bernstein), cognitive impairment.

A reaction to the quest for new nomenclature is the 'no name' school of thought which argues that any name is a label which, by branding people as 'handicapped', perpetuates their treatment as handicapped.

The older terms which conveyed the disgust, fear, intolerance and impatience that mental deficiency formerly evoked have given way to euphemisms, some so obvious that they draw the attention they strive to escape. Some expressions may reflect 'out of sight, out of mind' defence mechanisms. They try to avoid the reality that mental handicap is a fact of life by being neutral or general, and hope to solve the problem of mental handicap by pretending that it does not exist.

A range of titles is found to describe services, for example, mental handicap services, mental handicap division or unit, services for people with mental handicap(s) or for learning difficulty(ies). Also seen have been 'howler' expressions such as 'mentally handicapped nurses', and 'mentally handicapped hospitals', and a few years ago a medical journal published an advertisement for a 'Consultant Psychiatrist (Mentally Handicapped)'.

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#### *Teaching in mental handicap*

DEAR SIRS

Many registrars feel less than satisfied with their teaching experience in mental handicap. Why is this? The mental handicap hospital still expects the doctor to visit all the villas (wards) daily, and to have 24-hour on call, with instant access to the doctor (medical model). The registrars get frustrated by seeming to have to do more GP work than "real psychiatry".

Our own attitude should focus on psychiatry, and we need to explain by day to day contact with patients and case conferences the links between physical symptoms, mental illness and behaviour. Mentally handicapped people often somatise their problems. Someone who cannot talk, cannot talk about their delusions/hallucinations but a change in behaviour can reveal them. It takes time to learn how to communicate with some mentally handicapped