Hawton *et al* (*Journal*, May 1985, **146**, 459–463) I feel sure that these authors would wish to acknowledge that a statistical association between suicidal behaviour and cruelty to children was demonstrated 13 years ago by McCulloch & Philip (1972). Their important painstaking study deserves wider recognition than it has received hitherto.

S. GREER

King's College Hospital,
London SE5 9RS

Reference

MCCULLOCH, J. W. & PHILIP, A. E. (1972) *Suicidal Behaviour*. Oxford: Pergamon.

Research into Non-Organic Physical Symptoms

DEAR SIR,

Further psychiatric research is needed into non-organic physical presentations and in this respect the study reported by Wilson-Barnett & Trimble (*Journal*, June 1985, **146**, 601–608) is welcome and interesting. There have been a number of similar studies lately in which psychiatric and psychological measures have been made in groups of patients with non-organic symptoms (for example, Bass *et al*, 1983; Blumer & Heilbronn, 1982; Macdonald & Bouchier, 1980; Gomez & Dally, 1977; Beard *et al*, 1977). In most of these studies comparison has been made between a non-organic group and a group with diagnosed organic disease, and the non-organic group has been found to have higher rates of psychiatric and psychological abnormalities. A conclusion common to most of the authors of these studies is that the physical symptoms represent unexpressed psychiatric disorder or unexpressed emotional distress.

In methodology all of these studies have limitations and the authors should perhaps have been more cautious in reaching their conclusions. All studies are cross-sectional in design and have generally investigated patients after they have been experiencing unexplained symptoms for several years. It therefore cannot be assumed that any abnormalities found are causal, whether these be in psychiatric health, personality inventories, history of childhood events, history of impaired sexual functioning, etc. That these abnormalities are effects of longstanding symptoms cannot be excluded. The organic comparison groups used in many of these studies have not been satisfactory. Severity of symptoms has never been matched, and it is possible that symptom severity has been less in the organic groups given that organic disease can often be treated and can sometimes remit. Furthermore, patients in these groups have known that an explanation for symptoms has been found and that treatment should follow.

Another criticism that can be made of the report by Wilson-Barnett & Trimble and of the other studies referred to, is that the non-organic group was analysed as a single one, and conclusions appear to refer to all patients. This group of patients may be very heterogeneous and subclassification may be helpful. Patients in whom psychiatric disorder, masked or unmasked, seems to be the explanation for symptoms could be analysed separately. The remainder could be subclassified in terms of physical symptom variables seldom described in detail in the above studies—duration, course, nature of onset, severity in terms of distress and disability, history of frequent non-organic consultations, presence of illness fears, among others.

The sort of research needed to answer my points would be formidable, but until it is done I do not think we can claim to understand non-organic physical symptomatology with any certainty.

DONALD I. MELVILLE

Royal South Hants Hospital,
Southampton SO9 4PE

References

BASS, C., WADE, C., HAND, D. & JACKSON, G. (1983) Patients with angina with normal and near normal coronary arteries: clinical and psychosocial state 12 months after angiogram. *British Medical Journal*, **287**, 1505–1508.

BEARD, R. W., BELSEY, E. M., LIEBERMAN, B. A. & WILKINSON, J. L. M. (1977) Pelvic pain in women. *American Journal of Obstetrics and Gynaecology*, **128**, 566–570.

BLUMER, D. & HEILBRONN, M. (1982) Chronic pain as a variant of depressive disease. The pain-prone disorder. *Journal of Nervous and Mental Disease*, **170**, 381–394.

GOMEZ, J. & DALLY, P. (1977) Psychologically mediated abdominal pain in surgical and medical outpatient clinics. *British Medical Journal*, **1**, 1451–1453.

MACDONALD, A. J. & BOUCHIER, I. A. D. (1980) Non-organic gastrointestinal illness: a medical and psychiatric study. *British Journal of Psychiatry*, **136**, 276–283.

The PSE in Different Cultures

DEAR SIR,

Swartz, Ben-Arie and Teggin (*Journal*, April 1985, **146**, 391–394) provide a useful discussion of the rather exiguous opportunities in PSE9 for rating 'subcultural delusions or hallucinations'. I hope they will find the tenth edition, now under development, more satisfactory. The solution is indeed to provide local supplements and, if possible, also to translate these into English.

However, many apparently culture-specific

symptoms turn out to be local variants of symptoms that are familiar all over the world. Thus hypochondriacal preoccupations can be manifested in numerous ways; which one is chosen may depend as much on cultural as on personal factors. Similarly, the somatic symptoms of depression or anxiety may be described quite differently.

The essence of the matter is to translate concepts, not words. 'Butterflies in the stomach' may be readily understood in one setting but cause derisive laughter in another, although the words are easily rendered into the respective languages. The flexibility of the PSE interviewing style is designed to allow the expert interviewer, who should be well aware for example of the difference between a 'possession state' in a Taoist priestess and a 'delusion of control', to avoid solecisms and to rate only the basic psychopathology.

Swartz, Ben-Arie and Teggin pose a question in their last paragraph that has often been posed before. Will the PSE 'find only what is ostensibly common between groups and miss what is different'? My answer, using Popper's analogy, is that the PSE is intended to be more like a telescope than a bucket. Within its specifications it can be used by trained people to look for a limited range of phenomena. Special lenses could be constructed to extend the range or to examine particular parts of the spectrum. This does *not* involve any necessary assumption that the phenomena will indeed be found wherever the instrument is used. Whether or not they are 'common between groups' becomes a matter for empirical investigation. In fact, though their frequency varies in interesting ways, they do seem to occur in most cultures.

By the same token, the instrument is useless outside its specifications. To continue the analogy, if someone tries to use a telescope to measure the temperature it is not Galileo who will look foolish.

J. K. WING

MRC Social Psychiatry Unit,
Institute of Psychiatry,
De Crespigny Park,
London SE5 8AF

Attempted Infanticide

DEAR SIR,

Wilkins' case report (*Journal*, February 1985, **146**, 206–208) of attempted infanticide raises some important questions. Whilst infanticide has been recognised in English law since 1922, Wilkins' case is the first occasion that attempted infanticide has been recognised as an offence. Two issues follow from this, firstly, what medico-legal position will the offence of attempted infanticide be given and, secondly, the relationship between attempted infanticide and serious child abuse.

Since Kempe's (1962) classic paper, the concept of child abuse has been greatly expanded by contributions dealing with sexual abuse (Furniss, 1984), non-accidental poisoning (Rogers, 1976) and other conditions recently reviewed in the British Medical Journal editorial (1985). The question arises whether attempted infanticide should also be included in the concept of child abuse? If so, then the assessment of intent (Briscoe, 1975) will become a central issue in all serious cases of child abuse—and clinicians working with such families will be obliged to consider the question "did you intend to kill your child?"

GEORGE HALASZ

Department of Child & Adolescent
Psychiatric Services,
Austin Hospital,
Heidelberg, Victoria 3084, Australia

References

BRITISH MEDICAL JOURNAL (1985) Editorial. Talking points in child abuse. **290**, 259–260.

BRISCOE, O. V. (1975) Assessment of intent—An approach to the preparation of court reports. *British Journal of Psychiatry*, **127**, 461–465.

FURNISS, T., BINGLEY-MILLER, L. & BENTOVIM, A. (1984) Therapeutic approach to sexual abuse. *Archives of Disease in Childhood*, **59**, 865–870.

KEMPE, C. H., SILBERMAN, F. N. *et al* (1962) The battered-child syndrome. *Journal of the American Medical Association*, **181**, 17–24.

ROGERS, D., TRIPP, J., BENTOVIM, A. *et al* (1976) Non-accidental poisoning: An extended syndrome of child abuse. *British Medical Journal*, **1**, 793–796.

Correction

On pages 91 and 96 (*Journal*, July 1985) the Correspondence running heads should read Volume **147** not **146.**