setting for a multi-disciplinary review of patients than does a traditional ward round when individual patients are interviewed by a whole team. Firstly it avoids the sort of intimidation that an individual patient might feel when confronted by several members of staff *en masse*—'much worse than vivas' according to your correspondent (*Journal*, January 1978, **132,** 112). The group setting seems to enable patients to question staff in a way which is seldom seen in the traditional ward round. We feel that this approach is conducive to the sharing of decision-making with patients and therefore therapeutic in itself; patients seem to be able to feel their way towards participating in making decisions without arousing too much staff anxiety, or insecurity in themselves. Secondly our type of approach is a way of enforcing rather than undermining the therapeutic momentum of self-help among patients—a force which I believe is potentially a highly effective tool in the treatment of psychiatric illness. Finally our ward round provides a suitable framework in which members of staff can examine their own motives and wishes during decision-making, thereby improving the quality of decisions.

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CHRONIC ANXIETY IN ABORIGINALS

DEAR SIR,

Morice (1978), in an interesting approach to psychiatric illness among Australian Pintubi aboriginals, infers the existence of anxiety and depression from the presence of words in their vocabulary describing these affects. From his glossary it is apparent that these people include an inner feeling state, autonomic correlates, 'varying degrees of severity and differing provoking situations' as correlates. These observations are totally in accord with our experience of psychiatric symptoms in western desert aboriginals (Jones, 1972; Jones and Horne, 1973), but we called these phenomena 'fear'. We found very few examples of this state persisted for more than a few hours, although we drew our data from a survey of approximately 2,300 persons including some Pintubi. It will be noted that Dr Morice's glossary only includes descriptions of acute states. We concluded that chronic anxiety (which perhaps inadvisedly we called 'overt anxiety') was rare. His paper seems to give support to this proposition rather than refutation of it.

If these observations can be further supported they could be of value in highlighting a transcultural difference; presumably of developmental origin. Chronic states which might be anxiety equivalents do exist, for example hypochondriacal syndromes are common but these are usually quite free from autonomic correlates of anxiety.

Whether the proposition that chronic anxiety is infrequent in tribal aboriginals can now be established is, unfortunately, less than certain: even the most distant aboriginal groups are taking on white Australian ways and mores while losing their own culture. If the difference is real and culturally determined, one might expect more cases of anxiety to appear. If despite these social changes chronic overt anxiety remains infrequent, the question would be even more worthwhile investigating since it may indicate a biological difference. This difference in anxiety and the infrequent occurrence of homosexuality were the major findings in our studies. Most other psychiatric states were seen in recognizable form (Jones and Horne, 1972).

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References

JONES, I. H. & HORNE, D. J. (1972) Diagnosis of psychiatric disorders among tribal Aboriginals. *Medical Journal of Australia*, **1,** 345–9.

—— (1972) Psychiatric disorders of Aborigines of the Australian Western desert (ii). *Social Science and Medicine*, **6,** 263–7.

—— & HORNE, D. J. DE L. (1973) Psychiatric disorders among Aborigines of the Australian Western desert. *Social Science and Medicine*, **7,** 219–28.

—— & ROBINSON, I. (1977) Severe illness with anxiety following a reputed magical act on an Australian Aboriginal. *Medical Journal of Australia*, **2,** 93–6.

MORICE, R. (1978) Psychiatric diagnosis in a transcultural setting. *British Journal of Psychiatry*, **132,** 87–95.

BIOACTIVE AMINES

DEAR SIR,

Research into central nervous system functions of different bioactive amines has yet to come up with some unifying hypotheses. I wish to propose an hypothesis that seeks to explain an apparent coincidence that substances released in skin injury (e.g. histamine) and vascular injury (serotonin) are also suspected of being regulator substances in the C.N.S.

I believe future research will demonstrate a general principle that, regardless of species or the particular amines released, those amine substances released from

skin in trivial injury will have an alerting effect in the C.N.S., while those released in vascular injury will have a sedative effect. The survival value of a flight reaction to trivial injury, and lying still in vascular injury, will be obvious.

I worked out this idea some years ago; since then an alerting C.N.S. function of histamine in the hypothalamus (Monnier, 1969), and a sleep-producing function of serotonin in the median raphe nuclei (Jouvet, 1972) have been proposed. I think further research will further support this hypothesis.

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References

JOUVET, M. (1972) Some monoaminergic mechanisms controlling sleep and waking, in *Brain and Human Behaviour*, ed. by Karczmar, A. G. and Eccles, J. C. Berlin, Heidelberg, New York: Springer-Verlag.

MONNIER, M. (1969) Afferent and central activating effects of histamine on the brain. *Fourth International Congress on Pharmacology*. Basel, Switzerland, 14—18 July 1969, p. 168.

GENERAL HEALTH QUESTIONNAIRE

DEAR SIR,

The doubts expressed by Drs Corser and Philip (*Journal*, February 1978, **132,** 172) as to the psychiatric nature of the emotional upset measured by the General Health Questionnaire (GHQ) are clearly of concern to those of us who are using the instrument in epidemiological studies of psychiatric illness. However, the data in Table VI show that 14 of the 15 GHQ-probable patients who consulted partly or wholly with psychological problems were found to have a well defined psychiatric disorder, whereas only 3 out of the 17 GHQ-normals who consulted could be allocated a clear psychiatric diagnosis. This seems to suggest that the GHQ is effective in differentiating 'transient situational disorders' from 'true' psychiatric illness, i.e. anxiety state and reactive depression.

The survey also indicates that the GHQ produced significantly more false positives than false negatives (9 out of 24 as against 3 out of 95: $\chi^2 = 21.28$, $P < 0.001$).

ANTHONY A. SCHIFF

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DEAR SIR,

Thank you for giving us an opportunity to reply to Dr Schiff. We submit the following for your editorial consideration.

Dr Schiff's comments about 'well defined' and 'true' psychiatric illness imply a certainty of diagnosis which would seldom be found in a primary care consultation. Subsequent work in the same general practice (Corser and Ryce, 1977) describes the use of a problem orientated approach which avoids the use of terms such as anxiety state and reactive depression when all the criteria for the syndromes of the same names are not met. Wing (1976) and Foulds (1976) in their different ways provide structural approaches to the classification of psychiatric illness which are well suited to epidemiological studies, in particular, by being quite precise about what they include as illness.

We do not deny the value of the General Health Questionnaire as a preliminary screening instrument. However, too many of its items are 'part symptom—part personality state' measures to lead us to accept that all the emotional upset reflected in high scores is psychiatric in nature without seriously discrediting the illness model which Dr Schiff clearly accepts.

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References

CORSER, C. M. & RYCE, S. W. (1977) Community mental health care: a model based on the primary care team. *British Medical Journal, ii,* 936–8.

FOULDS, G. A. (1976) *The Hierarchical Nature of Personal Illness*. London: Academic Press.

WING, J. K. (1976) A technique for studying psychiatric morbidity in in-patient and out-patient services and in general population samples. *Psychological Medicine,* **6,** 665–72.

CONTRACEPTION

DEAR SIR,

Drs Fleming and Seager rightly state that there is controversy regarding psychological side effects of the contraceptive pill (*Journal*, May 1978, **132,** 431–40). Their own study, however, does little to clarify this state of affairs, for although they consider 'The majority of these papers deal with uncontrolled samples selected without defined criteria for measuring depression' they themselves are open to the same criticisms.

In the absence of data on why past-takers stopped and non-takers never started taking the contraceptive pill, the value of these groups as controls is suspect, as a major factor in this may be existing depression or a potential to develop it as perceived by the prescriber. One is unable to assess the normality of controls in the absence of validity data for the depression rating scale used. Further, data on marital status are not pre-