Correspondence

Understanding different cultures

Sir: Drs Sheikh and Farooq raise several important issues that multidisciplinary teams need to consider when dealing with patients from ethnic minority groups (*Psychiatric Bulletin*, 1994, **18**, 739). They err, however, in the tone of their article, which conveys a sense of absolutism and certainty, portraying minority communities in a way that confirms the stereotypes of the British media. For instance, while some mixed-race marriages do not work (and a third of white marriages do not, either), the authors' assertion that "marriages across religious and racial boundaries cause immense difficulties for an individual" is too sweeping a generalisation to be of any relevance. Similarly, while some young people forced into arranged marriages against their will may become unhappy, the authors' statement that "it leads *only* to unhappiness, difficulties in adjustments, a life of existence rather than enjoyment" (my italics) completely ignores the fact that the majority of people from ethnic minorities have managed a successful transition across the cultural divide and do not spend their lives trapped in unmitigated misery.

This criticism may appear pedantic, and the authors' choice of words may only be to emphasise certain aspects of their basic argument. I think, though, that a wider reason may be the viewing of cultural difference as a static, impenetrable barrier between people that, if breached, can only lead to suffering and difficulties. Immigrant populations all over the world live in 'imaginary homelands'. While the country of origin may itself have undergone major cultural and economic changes, immigrant populations can continue to live by values that existed at the time of their departure from their country of origin. This is as true of Asian people in Britain as it is of British people settled in Calcutta or Singapore. Host populations then tend to view immigrants as rigid and accuse them of not integrating into the dominant culture, further strengthening the immigrant's desire to maintain a distinct cultural identity.

One way to resolve such differences is to accept the underlying unity of humanity across the diversity of cultures. For instance, some of the problems mentioned by the authors, such as issues around authority, the 'new generation', break-up of family bonds, etc., are problems that middle-aged and elderly white populations find equally distressing in their culture. All over the Western world, the dominant paradigm of rampant individualism is increasingly being challenged by communitarian politicians and sociologists who now extol the virtues of family and community. Differences between cultures need not necessarily be seen to be divisive or threatening to one or the other culture. Cultural diversity can, and should produce a sense of 'multiplicity of identity'. From personal experience, I can say that I find myself in many ways enhanced as an individual after moving to Britain, enriched both in my sense of identity, and my understanding of different cultures. I carry some 'Britishness' with me every time I visit India, while I continue to maintain a sense of being Indian while I live in Britain. Such a view of culture, which joins rather than divides, is the only way to reduce ignorance and prejudice, while ensuring that respect for different cultures will allow health professionals to cater appropriately to the cultural needs of all under their care.

SWARAN P. SINGH, *Mapperley Hospital, Nottingham NG3 6AA*

Sir: We feel that the objections made by Dr Singh to our statements make them seem rather sweeping, but if read in the whole context they only reflect the reality on the ground. We would like to share some of the philosophical idealism of Dr Singh's letter, and would very much want society to be as understanding as he proposes. In reality, when it comes down to psychiatric services and treatment of mental illness, one has to recognise the problems encountered by professionals when offering to provide a therapeutic service.

Our paper was not meant to be judgemental but was an attempt to make professionals aware of a group of people, however small, who have real problems relating to their culture, beliefs and language.

A. JAWAD SHEIKH and SAEED FAROOQ, *Mental Health Services, Bruce Burns Centre, Solihull Hospital, West Midlands B91 2JL*

Risk of violence to junior doctors

Sir: Even if the commendable recommendations on the physical layout of assessment areas made in Lillywhite's article (*Psychiatric Bulletin*, January 1994, **19**, 24–27) were met, I believe that junior doctors would still be at high risk of being the target of violent patients. The initiative of the College to familiarise junior doctors with 'breakaway' techniques will certainly improve the chances of doctors to reduce injury to themselves and patients, although if these skills are to be effective, they should be practised and revised at shorter and more frequent intervals than currently.

A useful addition to helping reduce the risk is to consider ways to prevent aggression before it begins. I propound training to improve skills in two areas: detection of cues of impending physical aggression of patients during interviews and learning methods to defuse verbal aggression of patients, so often present and at times the prelude to physical violence. I suggest the use of expert tuition using video and role-play techniques.

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Supervision registers: is there the need for a referendum among psychiatrists?

Sir: I wish to join the growing number of psychiatrists who say that 'strong concern' about the guidance on the introduction of supervision registers is not enough. I am in complete agreement with Dr David Gill (*Psychiatric Bulletin*, 1994, **18**, 773–774) that we must not collude with something which not only "threatens civil liberties and breaches confidentiality" but also increases stigma and implicitly endorses a simplistic direct link between violence and mental illness, which is incorrect.

Like him, I have been amazed at the number of psychiatrists who appear to conform because the government says they should. However, I remain optimistic that many of my colleagues are individually resisting and I would like to suggest a referendum or similar measure. If the majority of Members and Fellows of the College voted to refuse to implement the register, the NHS Executive would have no choice but to withdraw the present guidelines.

At the risk of stating the obvious, it is vital that psychiatrists clearly emphasise that the most, indeed the only, effective mental health services are ones which are well-resourced and user-friendly and which engage the large majority of seriously mentally ill patients in voluntary participation and treatment. An efficient care programme approach can and should incorporate all that is necessary to identify, target, actively assess and review, with assertive outreach and multi-agency and multi-district communication when appropriate, the same particularly vulnerable group outlined in the supervision register guidelines. Therapeutically the register is both superfluous and counter-productive.

The government is now pursuing new legislation in the form of a supervised discharge order. Should this controversial proposal become law, there would, of course, be a logical basis for a supervision register within a clear legal framework.

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NHS superannuation regulations

Sir: May I draw attention to some errors in Dr M. J. Harris's note on the NHS superannuation regulations (*Psychiatric Bulletin*, 1994, **18**, 713).

Under the regulations a mental health officer is a whole-time member of the staff of a hospital used for the treatment of persons suffering from mental disorders who is employed for the whole, or almost the whole, of his time in the treatment or care of such persons or a maximum part-time specialist employed solely in the treatment of the mentally disordered.

It should be noted that, to qualify for mental health officer status, whole-time employees must be employed "for the whole, or almost