stressful situations and in a state of clear consciousness with no evidence of drug abuse.

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SIR: The flood of sexual abuse complaints is placing a heavy burden on our current terminology. 'Childhood sexual abuse' now has to cover three distinct categories of patients, appearing in increasing numbers. There are sexually abused children; sexually abused children who have now grown up; and adults who come forward volunteering for the first time that they were abused in childhood decades ago.

This last group differs significantly in many respects from orthodox child abuse. Key figures are often dead or abroad. Diagnosis is difficult, as other siblings may vehemently deny that abuse took place. Management is complex, particularly as patients often wish to exhume the past and start legal proceedings against their assailant.

We suggest a new name, 'Eureka syndrome', for this rather new illness. This would recognise a curious characteristic of some of these patients – an autochthonous quality to the abuse memory. Two of our last six patients claimed that they had totally repressed all memories of the sexual abuse at the time, and been totally unaware of the history until some chance event brought it back to their minds this year. They were then suddenly confronted with horrifying recollected scenes, which have drastically changed their feelings towards the family member involved.

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SIR: The article by Mendez (*Journal*, March 1992, **160,** 414–416) contains three case reports – patients 1, 6 and 7 – where the syndrome is identical to that I reported eight years ago (MacCallum, 1984). Dr Mendez expresses some interesting viewpoints in the discussion but does not point out the fact that the mothers fail to appreciate their busy daughters as the same persons as their daughters in the tender caring role, yet somehow know that they exist both ways in a personal relationship, but never as intruders.

The publication *The Delusional Misidentification Syndromes* edited by Christodoulou (1986) contains chapters adding further insights, and in which, for instance, Joseph (1986) discusses the basic syndromes including MacCallum's Syndrome. I would expect that with neurophysiological advances, further elucidation of these syndromes will become clearer to clinicians in the years ahead.

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JOSEPH, A. B. (1986) Focal central nervous system abnormalities in patients with misidentification syndromes. In *The Delusional Misidentification Syndromes* (ed. G. N. Christodoulou) Basel (Switzerland): S. Karger.

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**Are non-Western beliefs false?**

SIR: I refer to the letter by Singh (*Journal*, February 1992, **160,** 280–281).

While I quite share his views on the evolution of the concept of semen loss and the problem of dealing with self-appointed quacks who perpetuate erroneous views; I am puzzled over his concluding paragraph where he states that ideas related to semen loss appear "to be a variation of the centuries-old false beliefs and ignorance", together with his own interpretation of the term 'culture-bound'.

Singh's assumption of semen-loss beliefs in a myth-orientated native population is predicated on the tenet that views of reality generated by Western scientific discourse are 'true', and since the natives' views do not tally with that of Western science, they automatically become false. His gold standard of reality then posits science to be 'the central truth' which has corrected such erroneous views, that at one time also persisted in the Western world, but thanks to 'development' and 'progress', this has now been dispelled from medical and lay minds simultaneously. This is also to suggest that history follows a progressive linear course, thus the past becomes equated with 'faulty', the present (modern) with 'correct', and science is knowledge while non-science is ignorance.

In my own ongoing research looking at popular ideas of psychological distress among white 'natives', I find a similar theme but in the opposite direction: semen *retention* rather than *loss* seems to be perceived as unhealthy, undesirable and its (semen) regular discharge is therefore physiologically necessary. My sample is a population of contemporary Londoners from the middle and lower social classes attending out-patient clinics for depression and volunteers from our own academic department whose responses did not differ from the clinic population. I wonder if Singh would also consider them to be holding false beliefs?

'Culture-bound' as a term used in transcultural literature stands for phenomena that are found

exclusive to a particular culture (and therefore bound to it) and has nothing to do with a gap between a 'scientifically aware medical population' and the 'myth orientated' natives (as Singh mentions). Unfortunately, the term continues to be used predominantly for psychiatric phenomena in non-Western cultures, which have been established and measured by using one cultural scale (mainly Western so far), to judge another. In fact, proponents of the 'new cross-cultural psychiatry' (Klienman, 1981; Littlewood, 1990), have argued that culture influences (Western) psychiatric theories no less than the myth-ridden ideas of natives that Singh refers to. This view may be 'new' to psychiatry but is certainly well established in the social sciences (Foucault, 1961; Gould, 1981).

If we wish to pursue a meaningful inquiry that clarifies the relationship between 'culture' and 'psychopathology', we need to get away from our own self-professed pre-Copernican views. It is certainly noble to convey the benefits of scientific knowledge to society, but that is no excuse for assumptions that breed methodological arrogance, value judgements (of 'true' and 'false' beliefs), and colonise society with views that are no less disorted than those of the 'natives'.

GOULD, S. J. (1981) *The Mismeasure of Man*. Harmondsworth: Penguin.

FOUCAULT, M. (1961) *Folie et Deraison*. Plon: Paris. (Translated by R. Howard 1972 as *Madness and Civilization*. Pantheon Books: New York.)

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SIR: I read Bhatia & Malik's account of the Dhat syndrome (*Journal*, November 1991, **159**, 691–695) with interest. The authors argue that the Dhat syndrome is a true culture-bound syndrome and describe the deeply ingrained cultural influences that underlie the syndrome in the Indian subcontinent. Singh (*Journal*, February 1992, **160**, 280–281) makes the point that it is culture bound only in so far as it represents the immense difference between the scientifically aware medical and a myth-orientated native population.

In a surgical clinic in the United Arab Emirates (UAE) we saw many Indian and Pakistani expatriate workers who presented with lower urinary symptoms including frequency, dysuria, perineal discomfort, whitish urethral discharge, urinary turbidity, or simply loss of semen. Many complained of sexual difficulties and symptoms such as weakness and fatigue. Investigations, which often included an intravenous pyelogram, cystoscopy and prostatic massage, were usually normal. Our diagnoses included chronic prostatitis, prostatic congestion, non-specific urethral syndrome, and 'functional' lower urinary symptoms.

Over 70% of the population of the UAE were expatriate workers, mainly from the Indian subcontinent. Most were single young men, employed as low-paid labourers. Housing and working conditions were poor and the culture was alien, but the greatest hardship was the absence of women in their lives. Our team, which included two Indian doctors, gradually became aware of the psychological origin of many of these symptoms. Unfortunately our approach was unchanged by this insight. Biomedical explanations were more familiar and it was difficult to break out of this mould. It was only after reading about the Dhat syndrome (Chadda, 1990) that I began to understand the experience and realise how misplaced our efforts were. Not all of these patients met the Dhat syndrome but they were all manifesting distress or disease through illness behaviour shaped by similar cultural influences.

Is the Dhat syndrome a true culture-bound syndrome? Before recognising a new disorder, Western medicine requires proof that it is a distinct entity and not a mere variant of other disorders. As yet, it is debatable if such proof exists for the Dhat syndrome. However, the cultural influences that give rise to the Dhat syndrome do significantly modify the clinical picture of psychiatric and physical disorders. This occurs in the Indian subcontinent, among its immigrants, and perhaps their descendants, born abroad. In such situations, when sociocultural factors profoundly influence the clinical picture, Tseng (1981) urges that we should modify our classification. Psychiatry (Littlewood, 1990) is the speciality most likely to recognise that proof is not always practicable and that less rigorous criteria are occasionally necessary before we recognise new conditions, or modify existing diagnostic categories. Unless psychiatry is the first to acknowledge the Dhat syndrome it is unlikely to be accepted by the medical profession as a whole. These cases will remain unrecognised and continue to be misdiagnosed in immigrants throughout the world, including the United Kingdom.

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