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Correspondence

Differentiation of emotions

DEAR SIRS

Dr Campling (*Psychiatric Bulletin*, October 1989, **13**, 550–551) quotes an early publication of mine on the differentiation of emotions with implied disapproval, an attitude I share with her. Since then (1977) my views have changed (?evolved). At the time I assumed that babies experience undifferentiated emotions which are shaped by cultural influences either towards differentiated somatic experiences (non-western cultures) or differentiated psychological experiences (western cultures). Criticism from anthropologists (e.g. Good *et al*, 1985) and recent research on the abilities of infants (e.g. Stern, 1984) have rendered that view untenable. It has been demonstrated by modern technology that infants are capable of differentiating emotions from a very early age. Hence, it is likely that the full range of somatic and psychological emotional experiences is available to all humankind. Nevertheless, it is still necessary to explain the different patterns of illness that present to doctors in western and non-western countries. For example, hysteria has declined in incidence in this country since the Second World War, while it remains a common presentation in non-western countries. It is now my view (Leff, 1988) that this difference is partly explicable in terms of the attitudes and expectations of healers, be they traditional or trained in western medicine, and of their clients. Each client brings to the healer the type of complaints they know him to be conversant with. Traditional healers who specialise in divination are expert in decoding somatic complaints into the disturbed family relationships that engender the underlying distress. Their prescriptions are designed to regularise the client's relationships with family members. Although the language in which the prescription is couched may be symbolic, it is shared in common with the client and his/her family, so that no re-education is necessary.

By contrast, the western psychotherapist uses a symbolic language, embodying the conceptual framework of his or her particular school, which the client has to learn in order to make communication possible. The question Dr Campling raises about the suitability of psychotherapy for black patients is then seen to hinge on how readily the client can adopt the therapist's language. The same question is of course crucial for white patients. However, in the case of black patients (and here we encounter a serious problem with such a comprehensive category), there exists a wide variety of folk concepts of illness, of distress, and of appropriate treatments. I would postulate that the distance between the concepts held by the client and the ideology of the therapist will determine the acceptability of the therapist's language and hence the viability of therapy. It has been shown that unless therapists are prepared to negotiate with their clients on discrepancies between their respective ideologies of illness, prescriptions are unlikely to be followed (Health Education Studies Unit, 1982). A prerequisite for such negotiation is an exploration of the clients' belief system about their complaints. Herein may lie a method of engaging a more equitable proportion of black clients in psychotherapy.

JULIAN LEFF

MRC Social and Community Psychiatry Unit
Institute of Psychiatry
Denmark Hill, London SE5 8AF

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HIV/AIDS and mental handicap

DEAR SIRS

We read the article by Dr Catalan *et al* (*Psychiatric Bulletin*, June 1989) with interest, having recently produced a policy document for our own Unit, which is linked to catchment areas which form the same territory as that from which half the recorded cases of AIDS in the UK emanate.

The four cornerstones of our strategy are:

(a) Sex education for the patients. An AIDS Awareness/Sex Education Project has been established, an essential part of which will be instruction in safe sexual practices

(b) counselling and support for known HIV carriers and their carers

(c) where possible, to identify HIV carriers who may carry out high risk activities with resi-