Contrary to the experience at the Crichton Royal, our major difficulty is providing in-patient beds for the functionally ill, which again may be a local problem. Functional patients will always require in-patient services while one could argue that the long-term care of dementia need not, or should not, be in a hospital ward. We no longer have long-stay dementia beds and it seems highly likely that all areas will find their long-term care beds being dismantled. Our concern is that while we pursue a largely futile case for more long-term dementia beds, the problem of acute functional illness may be forgotten.

Functional illness remains more prevalent than dementia, active psychogeriatric services generate increased demand for in-patient treatment for functional illness (Joint Colleges' Report, 1989) and the 'graduate' population in the community continues to increase. This will inevitably drift into the psychogeriatric domain and may prove a considerable drain on resources. It will be a mistake to underestimate the future demands of functional illness in old age.

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References

BLESSED, G. (1988) Long stay beds for the elderly severely mentally ill. *Bulletin of the Royal College of Psychiatrists*, **12**, 250–252.

ROYAL COLLEGE OF PHYSICIANS AND ROYAL COLLEGE OF PSYCHIATRISTS (1989) Care of elderly people with mental illness (Joint report). London: Royal Colleges of Physicians and Psychiatrists.

How old are the elderly?

SIR: I read with interest the paper by Cook *et al* on depression and previous alcoholism in the elderly (*Journal*, January 1991, **158**, 72–75). The majority of psychogeriatricians in the UK deal with clientele above the age of 65, and in some cases the age limit goes to 75. Interestingly, the authors consider subjects above the age of 55 as elderly and the mean ages for subjects with alcoholism and no alcoholism were 57.7 years and 62.5 years respectively. Probably this reflects the differing views of what age is considered as being elderly?

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The 'new cross-cultural psychiatry'

SIR: Professor Leff has the advantage of having his letter (*Journal*, December 1990, **157**, 932–933) published in the month following mine. My own letter (*Journal*, November 1990, **157**, 775–776) languished somewhat after its submission in March and the original argument may no longer be so fresh to readers of the Journal. In his editorial preceding my review of the 'new cross-cultural psychiatry' (Leff, *Journal*, March 1990, **156**, 305–307; Littlewood, *Journal*, March 1990, **156**, 308–327) Leff made a number of errors of fact and interpretation, to two of which he replies.

My point on the 'existence' and gender of smallpox deities was essentially factual. Professor Leff answers more generally on evaluative questions, inevitable for a pragmatically-orientated psychiatry as opposed to a more distanced if nuanced anthropological position. I am far from certain that "an anthropologist is neutral as to whether or not people die of smallpox"; I for one am not. As I described in my paper, clinically-applied anthropology, including understanding of local beliefs about sickness, is now a part of the provision of clinical services (Chrisman & Maretzki, 1982; Kleinman, *Journal*, August 1990, **157**, 295–296), a development which both of us appear to value.

The fundamental difference between the two disciplines seems now to be one of the degree of 'objectivity' claimed. Neither, of course, are context-independent reflections of some transcendental reality existing independently of our procedures of observation, but it is interesting that social anthropology, once regarded by biomedical science as somehow dealing in 'soft' data, seems here to have acquired a harsher objectivity (cf. Clifford & Marcus, 1986) in a way psychiatry has not, conflating as it does fact and value whilst mistaking the latter for the former. There is an irony here in that disciplines which allow for observer bias suddenly seem to switch from extreme subjectivism to super objectivism.

I would, of course, hardly quarrel with Leff's restatement of the value of our examining local meanings before carrying out comparative studies. Indeed this may be taken as the central 'motif' of the 'new cross-cultural psychiatry' (Kleinman, 1977). Nor would one be surprised that this procedure might not prove to be feasible, either for economic, organisational or ideological reasons. But our failure to carry out a study of local contexts must be accompanied by an appreciation of the limits of the data we can collect without it. Inevitably, a purely epidemiological study employing diagnostic criteria derived from one society alone will lead to our 'conventional error'. Attempting to remove culture from the whole study initially to control for it as an independent variable later leads to a fictitious construction of the whole field, in which culture is simply