personality. In validation studies of the scale, people classified clinically as Personality Disorders were differentiated from people not so classified by the frequency with which they affirmed the presence of a certain cluster of symptoms. This cluster was called the Personality Disorder Scale. The defining characteristics of Personality Disorders used by clinicians are in terms of personality variables. Significantly more of the loss-of-control alcoholics, as reported in the paper, were classified by the scale as Personality Disorders. The mean Personality Disorder Scale score of the inability-to-abstain males in the sample was 3·35, standard deviation 1·74, and the mean score of the loss-of-control males was 6·09, standard deviation 2·28 ($t<3·62$; $p<·002$). Mr. Kear-Colwell may want to look up the references to the scale (2, 3), one of which I provided with the paper.

He is also wrong about "the Foulds' system of conceptualization". It proposes unequivocally (4): "All personality disorders are within the universe of discourse of personality" (p. 86).

In his last paragraph Mr. Kear-Colwell again misreports me and also misreads a section of the paper. I did not claim that the two types of alcoholics are "clearly defined". Indeed, at the top of p. 762 I go into detail that, among an earlier sample of alcoholics studied (5), classification of drinking pattern produced the following distribution: 34 per cent. were of loss-of-control type, and 22 per cent. of inability-to-abstain type; this left almost half with the addiction pattern not so clear-cut, 17 closer to the former and 27 closer to the latter clinical type. In this study, given the relative clinical atypicality of many cases, subjects were classified on an either/or basis to one of the two categories.

Also in the final paragraph, Mr. Kear-Colwell conveys an incomprehension, supposing that the "total misclassification rate" refers to this assignment to categories; as stated on p. 765, it refers to a multiple correlation between drinking pattern and a battery of nine tests, three of them clinical ratings and six personality tests. He will pardon my preference for the advice of the statistician with whom I collaborated that the misclassification rate was acceptably low.

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SUICIDE IN THE NORTHERN SUDAN

DEAR SIR,

In the Northern Sudan there are marked differences in both the epidemiology of suicide and in the methods used as compared with those in Britain and the Western world. The Northern Sudanese culture pattern has been summarized elsewhere in this *Journal*, "Psychiatry in the Northern Sudan: a study in Comparative Psychiatry" (this issue, pp. 945–958), and it is assumed that the manifestations of suicide are influenced by this pattern.

The overall incidence of suicide in the Northern Sudan is very low indeed; it is estimated that it is just under 1:100,000 of the population. Even among the mentally ill and those with abnormal personalities the incidence is much lower than in the West. This may be because family ties are powerful, and because the people live with common beliefs and purposes and under the restraint of a common religion (Islam) which expressly prohibits suicide. Clinical impressions suggest that suicide, whether attempted or consummated, is virtually unknown among elderly people. It is the custom in the Sudan for three generations of a family to live in the same household, and consequently the old people do not suffer from loneliness but are sheltered from want, and are positively made to feel needed, important, and indispensable; their wisdom and their advice are sought to solve inter-family problems. It must be remembered also that relatively few Northern Sudanese reach the senium; the average expectation of life is still under 40 years.

Attempted and consummated suicides occur mainly among single young women between the ages of 17 and 30, and seem to be committed impulsively and for apparently trivial reasons. A typical example was the girl who was prevented by her parents or older brother from attending a neighbour's wedding and made to stay at home instead. Women in the Northern Sudan live in subjection, so it is possible that many of them suffer from a chronic state of despair, and that only a little additional stress is needed to tip the balance in favour of suicide. Of course, there are more serious causes of suicide: illegitimate pregnancy

or aversion to an arranged marriage with an older man are among the most common of these.

The most common method of suicide is by burning, the girl pouring kerosene or petrol over her clothes and setting herself alight. The choice of this horrible way of dying is difficult to explain, especially when one takes into account the great disparity between it and the apparent triviality of the reason for the act. It is possible that the operation of circumcision may engender in the girl phantasies of mutilation which are satisfied by burning; in my experience, the very few men who have committed suicide in this way had been circumcised at puberty. The Koran frequently threatens hell-fire in after-life for those who disobey God, but a sub-conscious desire either to avoid this by having already suffered it in this world or to "suffer hell" is not discernible. There is, of course, a relative lack of other means of suicide in the Sudan. Sleeping pills are not usually available; gas is not there to use. Kerosene is sometimes drunk, and does not kill, except by causing pneumonia; it is often used in this way by the girl who wants to mould her environment in her favour. Drowning in the River Nile has been committed by some, and drowning in wells by a few who live in remote parts of the Sudan away from the Nile.

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HEALTH EDUCATION AND PSYCHIATRY

Dear Sir,

My review of Dr. Gatherer's "Public Attitudes and Mental Health Education" (1) refers to the immensity of public ignorance on this question and the overwhelming need to provide information, particularly if community care is to mean anything.

One might have thought that some awareness of these matters would have penetrated to official levels. But the National Health Education Council—recently constituted after prolonged delays—contains not a single member with any specialized knowledge of psychiatry or mental health problems. Furthermore, the Ministry of Health has indicated clearly that it does not intend to consider any alterations in the composition of the Council.

This is bad enough in itself, but it is yet another indication of that ignorance and contempt for psychiatry amongst the medical Establishment to which I have drawn attention elsewhere (2). The fault presumably lies in the professional advice which the Ministry receives. Are we, as a speciality, going to accept this situation indefinitely, or will it require a sit-in at the Elephant and Castle before the Ministry recognizes the place of psychiatry in a modern health service?

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2. *Lancet* (1965), *i*, 589.

UNILATERAL E.C.T.

Dear Sir,

My attention has been drawn to an important omission in my paper on "The Clinical Evaluation of Unilateral Electroconvulsive Therapy" (*Journal*, April, 1968, 459–463). The paper stated that laterality was determined by means of dominance test battery, and that only right-handed patients were included. It was implied that the unilateral group all received E.C.T. to the non-dominant, i.e. the right hemisphere, although this was not explicitly set down.

I should like to take the opportunity of making it clear that in the unilateral group the electrodes were invariably applied to the right side of the head.

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COMMUNITY AS DOCTOR: HENDERSON HOSPITAL

Dear Sir,

On reading Dr. Morrice's review of *Community as Doctor* (*Journal*, June, 1968, p. 792) I had the feeling that he was consigning the work to the archives, and a little prematurely, and I would like to make some comment.

It is true that "the Unit studied by Rapoport and his colleagues no longer exists" *as such*, but this is largely due to the second point made by Dr. Morrice, that the country's social structure and climate have also altered significantly.

The fact that the Unit has also changed in the 10–15 years since the study was initiated is some evidence of its continued viability. From its inception the Unit has shown an ability to respond to changing social needs, and the period from the war years up to the Rapoport period probably was the period of most significant change both in the Unit and in the external social climate.

The ability for self-examination, evaluation and change without collapse is what the therapeutic