Furthermore, in our field, we have had difficulty finding suitable instruments. Most are American and do not 'translate' well. They put much emphasis on the financial burden of caring, which has not been an issue in this country (although we recognise that it is becoming a more important factor with changes in health and community care).

One has to decide who is going to undertake the evaluation. It is impossible for a counsellor to evaluate objectively his or her own work. Clients must feel able to respond honestly and without prejudice. In our case, we reassured carers that their relative would suffer no lack of care if they (the carer) decided not to participate in the evaluation, or if their comments were uncomplimentary.

We decided, after much thought and consultation with colleagues in the University of Bristol Social Work Department, to use a balance of quantitative and qualitative data. We used the HAD (Zigmond & Snaith, 1983) together with the CADI and CASI (Nolan *et al*, 1989, 1990) to give us hard data which would provide only a background, and supplemented this with the results of a semi-structured interview administered by an unbiased researcher from the Social Work Department.

We have found that a counselling service for carers of people with dementia is extremely beneficial in helping them to cope with their caring.

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Victims of childhood sexual abuse

Sir: I read with interest the article by Macpherson & Babiker, (*Psychiatric Bulletin*, February 1994, **18**, 70–72) on 'Who works with adult victims of childhood sexual abuse?'. The need for agreed strategies involving training, supervision and inter-agency co-operation to deal with this increasingly common problem should not, however, be confined to adult mental health services alone.

As a child psychiatrist, my major focus in abuse work is directed towards victims who have yet to reach adulthood. My own experience, however, as well as that of other authors (Goodwin *et al*, 1981), is that among incestuous families, mothers have often been victims of child sexual abuse themselves, which has often not been previously disclosed. The importance of the support of the mother in determining the prognosis of the child is recognised within our own service by the provision of professional therapeutic support for non-abusing parents as well as appropriate therapy for the child. While this input for parents is designed primarily to enable them to support their children, our experience would suggest that they often use this contact with professionals to explore issues from their own past, including disclosure of their own experiences of abuse. Many of these women appear to be in need of long-term psychotherapeutic support which lies outside the remit of a child psychiatric service. I would suggest therefore that there is a need for agreed strategies involving close co-operation between child and adult mental health services to deal with the parents of abused children who have themselves been victims of childhood sexual abuse.

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Suicide prevention

I read with interest the letter concerning suicide and its prevention by Ashbridge & Milne (*Psychiatric Bulletin*, February 1994, **18**, 110) and would like to add further, and I think more radically, to the author's comments in questioning the feasibility of achieving the *Health of the Nation* goals.

The reasons and circumstances which lead people to attempt or commit suicide are complex and varied and underlying treatable psychiatric illness is only one factor to be considered.

In the rhetoric of prevention of suicide, the political and personal reasons behind what is essentially a desperate and angry act fail to be addressed. Unemployment and its effects on self-esteem, quality of life, level of distress and suicidal behaviour is an example of a significant factor which is being almost totally overlooked by government in the discourse of suicide prevention and in setting targets for improvement of the nation's health. (For a recent study linking unemployment to suicide risk see Pritchard, 1992).

Aimed to assuage the guilt of the politicians, soothe administrators and encourage the search

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for targets and categories by statisticians and epidemiologists, documents such as the *Health of the Nation* report (Department of Health, 1992) and the literature and correspondence created in its wake, do little to investigate the real motives which impel someone to take his or her own life.

I do not think psychiatrists should be so easily satisfied to accept these frankly crude targets without qualification and without raising political points for discussion. The current moral and political climate engenders despair, and the loss of personal and family security, the impaired quality of existence and the erosion of the sense of conscious, authentic personal responsibility has lead to a weariness of life for which remedy is not easily found. Weariness with life is an emotional and political problem which cannot be treated by less toxic anti-depressants in overdose, or easily set targets.

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Psychiatry in Kurdistan

Sir: I read Dr Berney's article (*Psychiatric Bulletin*, February 1994, **18**, 104–105) with great disappointment. I would remind him that Kurdistan is the northern part of Iraq with a history dating back 5000 years. Therefore I don't understand what he means by the 'Iraqi Invasion' in 1987.

There are 30 million Kurds living in Turkey, Syria and Iran and only a fraction of that number live in northern Iraq. If Dr Berney is really sympathetic to the Kurdish cause he should ask for the independence of the entire nation of Kurdistan and not just that part of Iraq!

Finally, I think Dr Berney agrees with other observers that Iraq's international integrity must be respected.

M. SHABAN, *Hartwood Hospital, Shotts, Lanarkshire*

Sir: I am sorry Dr Shaban was disappointed by my description of a visit which was focused on the furtherance of an aid programme. I included superficial comment on the politics and history as far as I felt it necessary to make sense of the account: brought up in Zimbabwe I recognise that this may sound naive.

I accept that Kurdistan is an ambiguous term. Although the Treaty of Sèvres (1920) provided for a wider Kurdistan, it was never ratified and the Treaty of Lausanne (1923) left the Kurds geographically fragmented. The present term refers to the Kurdish Autonomous Region which was established in 1974 with a separate Executive Council; an autonomy which appears to have become confirmed in the aftermath of the Gulf War. I find 'invasion', the term used within the country, quite appropriate for events which had such genocidal fury as to require United Nations intervention with the creation of the safe havens and no-fly zone.

I would agree that tampering with boundaries is complex and dangerous: Iraq's survival of the Gulf War is a witness to that. I cannot be drawn into a discussion of the policies of Turkey and Iran on whose goodwill depends the survival of the programme.

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Multidisciplinary teams in child and adolescent psychiatry

Sir: In the article by David Cottrell (*Psychiatric Bulletin*, 1993, **17**, 733–735) he refers to my own views on the subject (*Psychiatric Bulletin*, 1992, **16**, 33). He challenges the concept of all referrals being made to the consultant as unworkable as the consultant would need to assess all the cases. In my paper I indicated that the consultant would decide to whom the referrals would be delegated, after discussion at the team meeting. This process provides the best service for the patients and links the clinician on the team most suited for the needs of the patient. This I feel is the essence of multidisciplinary work.

I am aware that psychologists and others on the team receive referrals directly but these will not be brought to the team unless requested by the clinicians. This would clarify the boundaries between cases referred to the team and those referred to individual clinicians on the team.

Cottrell mentions the need for doctors to take charge, but it is not that doctors need to take charge, rather that, if leadership of multidisciplinary teams are not clear, patients are disadvantaged because of lack of clarity as to who is responsible. Therefore I proposed that, in a hospital setting, the consultant should be team leader, such clarity enabling the team the freedom of function to its optimum.

Working in the Mental Health Service of the Royal Children's Hospital, Melbourne for the past year, I had to apply for the team leader's post which was open to all disciplines. Currently

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