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Schizophrenia following prenatal exposure to influenza epidemics between 1939 and 1960

SIR: Professor Murray and his colleagues are to be congratulated upon their careful demonstration of an association between the timing of influenza epidemic deaths and the rate of births of individuals who later develop schizophrenia (*Journal*, April 1992, **160,** 461–466). They take this as further support for their proposition that schizophrenia is best viewed as a neurodevelopmental disorder in which prenatal damage arising from viral infection may well play a part in some cases. As they point out, this idea is compatible with their evidence and that of other studies. However, there is at least one alternative explanation. The observed association could arise if those liable to future schizophrenia were more likely to survive prenatal insult such as maternal influenza than those who are not so liable. Were this liability to schizophrenia and to survival of prenatal insult to be genetically determined, it might also explain the persistence of the relevant gene in the population by providing some selective advantage to balance the disadvantage of the low fertility of schizophrenic people.

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Psychotherapy in non-Western cultures

SIR: Long-term psychotherapy is difficult to implement in non-Western countries. Patients who seek help expect immediate relief in a short time. The stigma of mental illness is very powerful, especially in close religious communities. In addition, psychiatry is considered suspect, as a challenge to the existence of God, and many believe that turning to a psychiatrist is an act of weak faith, as it is God who heals all ills (Peteet, 1981).

Cross-cultural psychiatry tries to understand the complaints of people from different cultures in order to verify or modify existing models of mental illness (Kleinman, 1987).

Short-term psychotherapy is used to emphasise problem-solving, with a limited dynamic change. The anxiety generated during the interview may be used as a tool in assisting the patient to change his maladaptive behaviour and to attain a state of improved emotional functioning. This type of psychotherapy is offered to patients with average intelligence, who have shown some affect during interview and are motivated to work hard with their therapists. Therapists encourage the establishment of rapport with their patients, creating a therapeutic alliance by using positive transference feelings and concentrating on the unresolved emotional conflicts underlying patients' symptoms.

Brief therapy and crisis intervention should be offered to seriously disturbed patients who have recently decompensated. The aim here is to decrease or eliminate anxiety, by the use of supportive techniques, such as reassurance or environmental manipulation, with or without medication. The patients need guidance to come to grips with their problems and conflicts.

The therapist has to see the patient one to three times a week, in average 30–40-minute sessions for a period of three to six months. The therapist has to express warmth and caring for the patient. The language is one of understanding, love, insight, and human involvement (Truax, 1964).

He has to show the patient that he is eager to help, and allow him to talk freely without interruption. Appropriate medication is used when necessary. Political and religious views are separately handled. The therapist has to approach the patient through the social organisation of his religious group and not to be influenced by his personal attitude towards religion or politics.

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