finer details, if not the grosser features, of surgery and obstetrics fade rapidly, although one hopes to retain a broad knowledge of general medicine. The conflict between the demands of the PLAB test and the need for overseas trainees in psychiatry to have prior experience of their native psychiatric practice appears to be irreconcilable. A strong case can be made for exempting from the PLAB test psychiatric trainees who will return to their home countries at the completion of training. These difficult problems prompt the question—is it all worthwhile? Why should overseas doctors bother to learn British psychiatry when it is so lacking in relevance to local conditions? Why should British psychiatric institutions bother to offer training facilities to overseas doctors?

To answer these questions we have to eschew false modesty and at the risk of appearing chauvinistic declare that we believe British psychiatry to be the best in the world. Even if the time given and attention paid to careful diagnostic assessment and to appraisal of the patient's social environment cannot be duplicated in a developing country, nevertheless, this represents the standard to be aimed at. Having seen what can be achieved with highly trained and plentiful staff, the overseas trainee on returning home is often faced with the problem of trying to achieve the same standards with poorly trained staff that are few in number. This does not mean that he should jettison all he has learned here; rather that his training should include discussion of applying what he has learned to his home situation. The practical problems involved cannot be solved by armchair thinking on the part of British psychiatrists. Fortunately there are in this country a number of senior psychiatrists who have had the experience of working in developing countries and coping with rudimentary facilities. It is very important to tap their experience and include them as advisors in training courses for overseas psychiatrists.

The reasons why we should put ourselves out to maintain and develop such training programmes are currently dominated by the economic situation. Indeed the view that British education is a marketable commodity has led to the recent decision to more than double the fees for overseas students to an annual sum of five thousand pounds. If we can avoid being dazzled by the cash for a moment, other advantages may be discerned. In many developing countries, nearly all the senior psychiatrists have been trained in the United Kingdom. We are now seeing a new crop of emergent nations who are sending their first generation of psychiatrists to be trained here; Kenya and the Sudan are examples. To illustrate the point further, the first Zulu psychiatrist and the first psychiatrist from Sierra Leone are currently undergoing training in this country. As a result, in many countries around the world psychiatry bears a British hallmark. This is an important boost to the prestige and influence of Britain, and has the additional advantage that the most senior psychiatrists in many of these countries retain strong links with their teachers here and seek their advice on training and on development of psychiatric services. The common experience of a British psychiatric education also results in an international community of psychiatrists who speak the same language in more ways than one. That this can act as an important resource is demonstrated by the *International Pilot Study of Schizophrenia* (WHO, 1973), in which many of the key psychiatrists had experienced a British training.

These are strong arguments for continuing to cater to the training needs of overseas psychiatrists. However, it must be recognized that the steep increase in fees will inevitably alter the type of trainee coming to this country. Up to the present it has been possible to maintain a balance between trainees from different areas of the world by selection procedures, so that the available places are not monopolized by one or two countries. However, the cost of training in future will tilt the balance towards those developing countries that can best afford it, namely the oil-producers, while others will be forced out of the market. We may gain some new friends as a result of this policy, but we will certainly lose some old ones.

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Dr Leff was for a number of years the Sub-Dean at the Institute of Psychiatry for Overseas Students. The opinions he expresses are his own and not any official statement.

Julian Leff

WOMEN WITH DRINKING PROBLEMS

Traditionally drinking in general and particularly excessive or harmful drinking have been regarded as male activities. Until recently the literature on alcohol-related problems paid only scant attention to females. Most studies of problem drinkers in treatment agencies have been confined to men. Other investigations have neglected to specify the sex of their subjects, presumably because it was assumed that there were few, if any, important differences between men and women. However, recent British population surveys have indicated that male drinkers consume between two to five times as much alcohol as female drinkers. In addition, roughly 15 per cent of British

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women report that they are total abstainers compared with only 5 per cent of men.

In the past twenty years male predominance in this field has been steadily eroded. For example, since 1964 the number of men admitted to psychiatric hospitals in England and Wales under a diagnosis of alcoholism doubled: the corresponding number of women so diagnosed *trebled*. In addition there has been a disproportionate increase in women's rates of convictions for drunkenness (including drunken driving), and for liver cirrhosis deaths and other forms of alcohol-related mortality. Agencies providing help for problem drinkers have universally recorded a steady, and often dramatic, increase in the percentage of their clients who are female. Councils on alcoholism report a much higher percentage of women amongst their clients, often a third (even in Scotland) and half of these were under the age of 30 in some areas.

A number of studies have now been published in Britain, in North America and elsewhere which support the view that, in certain respects, women with drinking problems are different from men. This distinctiveness will be documented and emphasized by the publication this autumn of the first British book on the subject, *Women and Alcohol* (Camberwell Council on Alcoholism, 1980).

Thus women problem drinkers known to treatment agencies drink far less than their male counterparts, sometimes only half. This conclusion is complicated by the widespread female preference for 'stronger drinks' such as special lagers, wines and spirits. In spite of their much lower consumption they generally report as wide a range of harmful consequences as men (Plant and Plant, 1979).

With a shorter career of excessive drinking begun later in life than men they experience alcohol-related problems relatively soon thereafter. In particular they are more vulnerable to liver disease, and less likely to recover even if they cease their drinking. Research in Britain and North America suggests that women are less likely than men simply to drift into problem drinking through social reasons. They more often develop drinking problems in reaction to specific life events, such as bereavements, divorce or because their roles in life become ambiguous. Very often women attribute the onset of excessive drinking to the departure from home of their children. This situation is known as the 'empty nest syndrome' (Otto, 1977).

A recent review by Smart (1979) of mainly North American evidence suggested that female problem drinkers are more socially isolated, more often divorced, have experienced more childhood disruption and are in poorer general health than males. Similar conclusions have been drawn from British data. It is possible that husbands are less willing or able to tolerate excessive drinking by their wives than is the case the other way round, and it is certain that there persists a greater stigma attached to alcohol misuse by women. In consequence women with drinking problems may be less likely than would men to seek help for their difficulties. Female problem drinkers are often perceived by their families, the community at large, therapists and fellow clients or patients in a less sympathetic manner. Women problem drinkers are more widely noted than males to have low self-esteem and feel far more guilt about their drinking. They are more often dependent on tranquillizers, prescribed by doctors unaware of their drinking.

There is probably a case for providing special facilities, or at least special attention, for women with drinking problems, particularly because of their growing number. Thus crèches, nurseries and different hours for consultation may be required. In addition, therapists may need to ask different questions about causes and be more active in encouraging women to seek help.

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Martin Plant

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