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### Prion disease in Sri Lanka

Butler (2006) emphasises the importance of psychiatrists being aware of prion disease. We feel that psychiatrists in low- and middle-income countries also need to be aware of these disorders. The low prevalence rate in such countries might be attributable to underdiagnosis and underreporting. Prion diseases are not included in the list of notifiable diseases in countries such as Sri Lanka and even diagnosed cases are not notified.

Butler & Fleming (2001) stated that approximately two-thirds of patients with new-variant Creutzfeldt–Jakob disease (CJD) present with psychiatric symptoms such as anxiety, depression, apathy and withdrawal. Somatic symptoms are a common presentation of depression in countries such as Sri Lanka. Even neurological symptoms such as pain and headache can be features of depression and the diagnosis of prion disease might be easily missed.

Two cases of prion disease have been diagnosed in the psychiatry unit at North Colombo Teaching Hospital over the past 10 years. Both patients were referred for the assessment of depression and later developed neurological symptoms such as myoclonus. Electroencephalography revealed a characteristic pattern of CJD (further details available from the authors). Other patients with CJD who presented with psychiatric symptoms have been reported from different units in Sri Lanka (Gunathilake *et al*, 1998). All these cases appear to be of the sporadic type.

Although CJD is a known cause of dementia, a patient presenting with dementia might not always be investigated for prion diseases because of the perceived low prevalence of the disease in low- and middle-income countries.

Moreover, CJD is a transmissible disease, and a lack of awareness of its true prevalence might lead to a lax attitude regarding precautions against spread. Prion

protein is not destroyed by ordinary sterilisation procedures but requires sophisticated methods of sterilisation which might not be available in low- and middle-income countries. Prion diseases can also be transmitted through meat. Although there are regulations regarding meat production and sale, these are not strictly adhered to in most low- and middle-income countries, so although prion diseases might not be common in these countries, the risk of transmission might be higher. Furthermore, the healthcare systems might be unprepared to meet the challenges of an epidemic. Therefore, it is important to raise awareness of prion diseases among clinicians worldwide.

**Butler, R. (2006)** Prion diseases in humans: an update. *British Journal of Psychiatry*, **189**, 295–296.

**Butler, R. & Fleming, S. (2001)** Creutzfeldt–Jakob disease and its implications for psychiatric management. *Advances in Psychiatric Treatment*, **7**, 50–56.

**Gunathilake, S. B., de Silva, A. P., Jayamanne, S. F., et al (1998)** Two cases of Creutzfeldt–Jakob disease. *Ceylon Medical Journal*, **43**, 246–247.

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### ‘Major depression’ in Ethiopia: validity is the problem

Mogga *et al* (2006) like the majority of published studies of people from low- and middle-income countries rely exclusively on Western measures of psychopathology (Hollifield *et al*, 2002). Culture is seen as mere packaging and is disregarded while standardised methodologies (‘reliability’) applied to universal psychobiological man get at the ‘real’ problem (Summerfield, 2004). This is a form of imperialism.

‘Reliability’ cannot redeem a study that commits a category error: the assumption that because phenomena can be identified from one setting to another, they mean the same everywhere. African cultures emphatically do not share a Western ethnopsychology that defines ‘emotion’ as a feature of individuals rather than situations, being internal, often biological, involuntary, distinct from cognition, a cause of pathology and targetable by technical interventions (Lutz, 1985). ‘Major depression’ is not a timeless, free-standing, internally coherent,

universally valid, pathological entity requiring medical intervention (Summerfield, 2006).

The hard truth, which if owned would totally disrupt business as usual, is that psychiatric measures are the products of a Western epistemology, including models of mind and definition of personhood. They simply cannot be turned into universally valid instruments – no matter how much tinkering with criteria and translation.

Noting the raised ‘disability’ scores and increased attendance at traditional healers, I do not doubt that something was ailing some of those with ‘persistent depression’. However, it is likely that this was a very heterogeneous group and that undiagnosed physical illness, particularly the diseases of poverty, was a major determinant. The only solution offered was antidepressants and it is no surprise that adherence was poor.

In the last few lines Mogga *et al* state that ‘more information is needed regarding the characteristics, beliefs, knowledge and illness attributes’ of the population. These domains should have been the point of departure of the study, not a mere afterthought. What can emerge when researchers know so little of the lived lives of participants?

**Hollifield, M., Warner, T., Lian, N., et al (2002)** Measuring trauma and health status in refugees: a critical review. *JAMA*, **288**, 611–616.

**Lutz, C. (1985)** Depression and the translation of emotional worlds. In *Culture and Depression. Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (eds A. Kleinman & B. Good), pp. 63–100. University of California Press.

**Mogga, S., Prince, M., Alem, A., et al (2006)** Outcome of major depression in Ethiopia. Population-based study. *British Journal of Psychiatry*, **189**, 241–246.

**Summerfield, D. (2004)** Cross-cultural perspectives on the medicalisation of human suffering. In *Posttraumatic Stress Disorder. Issues and Controversies* (ed. G. Rosen), pp. 233–245. John Wiley.

**Summerfield, D. (2006)** Depression: epidemic or pseudo-epidemic? *Journal of the Royal Society of Medicine*, **99**, 161–162.

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**Authors’ reply:** We agree that there is inevitably a limitation in the use of measures developed in a different cultural setting. Our measure of depression, the Composite

International Diagnostic Interview (CIDI), lacks sensitivity because of the strict diagnostic rule. This could account for the low prevalence rate in our study and the fact that we may have picked up only those most seriously affected. However, we do not doubt the presence of depression in our society. The impetus for our study came from the 'lived lives' of Ethiopian psychiatrists working within Ethiopia who commonly encounter people presenting with symptoms according to a 'Western' construct of depression in a tertiary care setting. These people respond to antidepressants by showing good recovery from symptoms and regaining their original level of functionality. In an ongoing intervention programme, we have found the same for people with depression identified by the CIDI in Butajira (study ongoing).

The CIDI was translated, back-translated and modified by experienced Ethiopian psychiatrists who considered the symptom questions to have face validity and applicability. In addition, convergent validity of CIDI-defined depression was indicated by our finding of strong associations between depression and disability. We believe that the CIDI is unlikely to be merely detecting physical ill health because first, it incorporates specific measures to screen out symptoms that seem to have a physical cause and second, our study participants with persistent depression were most disabled in social domains rather than in those domains of functioning more likely to be influenced by physical impairment (e.g. mobility).

We believe that the difference in mental health across cultures is mainly in the presenting features, not in the nature of the disorder. In low- and middle-income countries it has been said that people tend to present with somatic symptoms (Mumford *et al*, 1997; Parker *et al*, 2001). However, this view of cultural difference between the West and the rest of the world was challenged by the World Health Organization cross-cultural study in primary care (Gureje *et al*, 1997). Although the presentation of depression clearly does vary across cultures, in an African setting depression was found to be better characterised by core depressive symptoms than by somatic complaints (Okulate *et al*, 2004).

**Gureje, O., Simon, G. E., Ustun, T. B., et al (1997)**  
Somatization in cross-cultural perspective: a World Health Organization study in primary care. *American Journal of Psychiatry*, **154**, 989–995.

**Mumford, D. B., Saeed, K., Ahmad, I., et al (1997)**  
Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*, **170**, 473–478.

**Okulate, G. T., Olayinka, M. O. & Jones, O. B. E. (2004)**  
Somatic symptoms in depression: evaluation of their diagnostic weight in an African setting. *British Journal of Psychiatry*, **184**, 422–427.

**Parker, G., Gladstone, G. & Chee, K. T. (2001)**  
Depression in the planet's largest ethnic group: the Chinese. *American Journal of Psychiatry*, **158**, 857–864.

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### Suicide risk and perinatal circumstances

Riordan *et al* (2006) present evidence that maternal circumstances and foetal experience may have an impact upon the subsequent mental health of the offspring. Many studies describe gestational insults, obstetric complications and perinatal environment as risk factors for mental illness in later life. Such evidence has often been based upon longitudinal cohort studies which have the advantage of large sample sizes and masked assessments at both exposure and outcome. Such strategies have generated evidence supporting the neurodevelopmental hypothesis of schizophrenia (Done *et al*, 1991; Jones *et al*, 1994). There can be little doubt that such epidemiological evidence can lead to hypotheses of the pathogenesis of psychiatric illness. As suggested by Riordan *et al*, foetal nutrition, intra-uterine stressors, hypothalamic-pituitary-adrenal axis dysfunction and attachment theory may all be putative mechanisms by which the foetal-maternal interaction contributes to future psychiatric illness.

However, there are several inherent limitations to this methodology. Longitudinal studies have traditionally concentrated on descriptions of the progeny. Data relating to many maternal factors in birth cohort studies are limited or unavailable. Important confounding factors cannot be, and have not been, eliminated in such work. Social class, alluded to by Riordan *et al*, cannot be ignored as an important confounder for all of the findings. Riordan *et al* concede that assessment of economic circumstances is based only on parental occupation. Is such a measure valid over several generations? How can social class (a factor relating both to parity, and to young

maternal age and depression and suicide) not be considered an important confounding variable? The importance of housing and maternal diet, alcohol, smoking and drug use will certainly influence birth weight and depression and suicide in later life. Family history of psychiatric illness is probably the most important confounding factor that has not been, and unfortunately cannot be, assessed in this study. Maternal depression may have an impact upon birth weight as an environmental factor, but may exert a genetic effect on psychiatric illness and suicide of the offspring. Although such a study does suggest important epidemiological trends, hypothesising that biological mechanisms are involved in psychiatric illness of offspring is premature without controlling for these important confounders.

**Done, D. J., Johnstone, E. C., Frith, C. D., et al (1991)**  
Complications of pregnancy and delivery in relation to psychosis in adult life: data from the British perinatal mortality survey sample. *BMJ*, **302**, 1576–1580.

**Jones, P., Rodgers, B., Murray, R., et al (1994)**  
Child development risk factors for adult schizophrenia in the British 1946 birth cohort. *Lancet*, **344**, 1398–1402.

**Riordan, D. V., Selvaraj, S., Stark, C., et al (2006)**  
Perinatal circumstances and risk of offspring suicide: birth cohort study. *British Journal of Psychiatry*, **189**, 502–507.

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**Authors' reply:** Dr Baig may be correct in reiterating the inherent weaknesses of longitudinal birth cohort studies, but we do not accept that it is premature to hypothesise. Future studies into these potentially important epidemiological trends will require modified study designs and therefore hypotheses to guide these. We have discussed a heterogeneous group of potential confounding and mediating factors, biological influences being just one possible aspect of what is probably a complex picture of multifactorial aetiology. Hypothesising about the exclusive involvement of biological factors would indeed be premature, but not to consider them at all would place undue restrictions on future study design.

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