regular depot neuroleptics. In spite of being fitted with an I.U.C.D. shortly after delivery, she managed to become pregnant again by a casual boyfriend. She declined further neuroleptic injections because of the pregnancy, in spite of reassurance and persuasion to the contrary. She now has a four-week-old baby (who is being fostered short-term) and her two-year-old child (who is with the patient's mother) and has returned to her flat alone. Her mental state is slowly deteriorating, as happened following her first pregnancy, and I have no doubt we shall shortly be admitting her compulsorily again.

The overall management of such a case includes the desirability of preventing further pregnancies, for psychiatric as well as social reasons. In view of the failure of other contraceptive methods, would one be entitled to give her a depot contraceptive injection, even against her wishes? Enclosure to DDL (84) 4 from the Mental Health Act Commission "Guidance to Responsible Medical Officers on Consent to Treatment" states that the R.M.O. must decide whether a particular form of treatment, including medicines, falls within the requirements of Section 58 of the Mental Health Act (1983). Drugs prescribed solely for treatment of physical illness do not come within the scope of Section 58. As the law stands, if Section 58 is considered to apply to the administration of a depot contraceptive injection—because preventing a further pregnancy will significantly benefit the patient's future mental health—the first injection (which lasts three months) could presumably be given without further formalities and against the patient's wishes if necessary. Thereafter, Section 58 requires that the Mental Health Act Commission's independent doctor should certify that despite the patient's refusing consent, the treatment is likely to alleviate or prevent deterioration of the patient's condition and should continue to be given. I think this is a point of view which could be argued quite strongly by the R.M.O. in such a case.

The more general point is that such cases must arise all the time throughout the country in young women suffering chronic or recurrent mental illness and/or mental handicap (both equally "mentally impaired" in the writer's opinion, but not according to the Mental Health Act). If an increasing number of such cases come to the attention of the Mental Health Act Commission, one wonders whether depot contraceptive injections will be considered to be in the same category as surgical implantation of hormones to reduce male sexual drive, and therefore be made the subject of Section 57 provisions in due course. A final point is that surgical sterilisation procedures, which may be equally relevant to the long term mental health of such patients, are also procedures for which a case could be made for inclusion within Section 57 of the Mental Health Act.

FABIAN HAGGIS

The Old Manor Hospital,
Wilton Road,
Salisbury SP2 7EP

The PSE in the Transcultural Setting

DEAR SIR,

The paper by Swartz *et al* (*Journal*, April 1985, **146**, 391–394) raised questions concerning the strengths and limitations of the Present State Examination (PSE) in a multi-cultural setting and examined the assumptions implicit in the design of the instrument.

I wish to draw attention to issues raised by the method of translation. The accepted method is that the original English version of the PSE is translated into a local language and then back-translated into English by another person. The back-translation is assessed by an English-speaking psychiatrist who compares this translation with the original, and inconsistencies are removed (Leff, 1973). This method is designed to maintain the congruence of the instrument across languages, and therefore, its validity.

However, it is apparent that as cultural and conceptual differences increase, it becomes difficult to achieve linguistic equivalence (i.e. equivalence of meaning). This is especially so when the translation is across language groups, e.g. from Indo-European into non Indo-European languages. Translations from English into Yoruba (a West African language) and vice-versa pose different problems respectively. 'Depression' can be translated into a number of Yoruba words: *ibanuje, irewesi, ironu* or *idori-kodo*: Whereas '*ibanuje*' would be strictly translated into the 'spoiling of one's insides', its equivalent would be 'depression'. The decision of which translation to render would be determined by the context, the understanding which the translator has of the use to which the instrument would be put, and the familiarity of the translator with colloquial UK English as opposed to African English.

The current method of translation has an explicit dependence on the original English version, to a degree which imposes limitations on the validity of the translation. In addition, the method does not provide operational guidelines designed to assist the technical translators in making appropriate choices

in problematic situations. Figuiredo (1976) attempts to overcome some of these difficulties by providing his translators with specific guidelines, broadly designated as Wording, Redundacy, Context and Decentering.

The general aim of the process of translation should be to arrive at a consensus translation, rather than one that focuses principally on the source language. The technical translator, bilingual psychiatrist and English-speaking psychiatrist should initially examine individual items independently and then confer, in order to arrive at an acceptable translation. I believe that the PSE translation into several languages is a step towards developing a standardised instrument to collect validly comparable data across cultures, but I suggest that the method of translation may have to be reviewed.

FEMI OYEBODE

Newcastle General Hospital,
Westgate Road,
Newcastle upon Tyne NE4 6BE

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Transcultural Psychiatry

DEAR SIR,

If cultural psychiatry is to move beyond the collection of exotic phenomena which escape our supposedly culture-free Western classifications, it will have to examine more closely the actual phenomena which colonial psychiatry has bequeathed to us.

The papers of Swartz *et al* and Farmer *et al* (*Journal*, April 1985, **146**, 391–394, 446–448) refer to *Witiko* and 'pointing the bone'. *Witiko* (*Windigo*) is a 'near mythical syndrome' (Neutra *et al*, 1977) with perhaps three actual instances, and one which has never been observed by outsiders (Shore & Manson, 1981; Marano, 1982). Similar doubts have been cast on 'pointing the bone', popularly known as 'voodoo death' (Lewis, 1977; Eastwell, 1982), although Gomez (1982), maintains the notion has some validity.

ROLAND LITTLEWOOD

All Saints Hospital,
Lodge Road,
Birmingham B18 5SD

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Is Mania Incompatible with Down's Syndrome

DEAR SIR,

I was interested to read the paper by Drs Sovner, Hurley and Labrie (*Journal*, March 1985, **146**, 319–320) and note, as I have done with some other work from the United States, an apparent unfamiliarity with recent British research.

My colleagues and I investigated a series of 40 mentally disordered patients with mental handicap, 16 of whom suffered from an affective psychosis diagnosed using strict criteria. The other 24 cases suffered from schizophrenia, again diagnosed using rigorous criteria similar to those of DSM III.

In investigating possible aetiological factors we karyotyped all the index patients plus 40 controls from the same hospital for the mentally retarded who did not have mental illness. None of the cases with affective disorders were associated with chromosome abnormalities, whereas one of the schizophrenics and five of the controls were found to have trisomy 21 (Down's syndrome), some of them showing various degrees of mosaicism. However, there was no statistical significance in the differences between these groups.

In my review of the literature on this subject I found no cases of Down's syndrome in association with affective disorder. The absence of such an association is certainly worth pursuing as there is no question from our own work and that of others that affective disorders can occur amongst the mentally handicapped and can be identified even in those whose intellectual capacities are very low indeed (Hucker *et al*, 1979).

S. J. HUCKER

Clarke Institute of Psychiatry,
250 College Street,
Toronto M5T 1R8

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