mental health is a question that is not scientifically testable, as women with unwanted pregnancies cannot be randomly assigned to abortion *v.* abortion denied groups. It seems inappropriate therefore for Casey to talk of potential litigation against abortion providers for failing to provide information on a possible causal link between abortion and subsequent mental health problems.'

Debates on this topic and others such as racism tend to be endless, so I suggest that if anyone wishes to continue further, they should do so by direct personal emails.

1 Fergusson DM, Horwood LJ, Boden IM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

2 Rowlands S, Guthrie K. Abortion and mental health. *Br J Psychiatry* 2009; **195**: 83.

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Response to the Editor: We were dismayed and deeply concerned to learn, from the Editor's note to Professor Cooper's letter,[1] that we had been characterised as holding a pro-choice position in our commentary on Fergusson *et al*'s paper.[2] This was not mentioned in the commissioning process and, if it had been, the invitation would have been declined. Our commentary acknowledged a range of opinions among ourselves. Our arguments were based on an analysis of Fergusson *et al*'s paper, explicitly eschewing any partisan approach, and stating quite clearly that the debate on the rights and wrongs of abortion is primarily moral, legal and ethical rather than psychiatric or indeed scientific. We hoped we had been very clear in this approach, and most strongly reject any suggestion that our commentary was based in beliefs from either 'side of the debate'.

1 Tyrer P. Editor's note. *Br J Psychiatry* 2009; **194**: 571.

2 Fergusson DM, Horwood LJ, Boden JM. Abortion and mental health disorders: evidence from a 30-year longitudinal study. *Br J Psychiatry* 2008; **193**: 444–51.

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Editor's note: This correspondence is now closed.

Diagnosing chronic fatigue syndrome

In their comparative epidemiological study of chronic fatigue syndrome in Brazil and London, Cho *et al*[1] conclude that cultural differences affect only the recognition, rather than occurrence, of this condition. Although a reasonable interpretation of the epidemiological data, without complementary consideration of the cultural context this assertion is likely to obscure some of the most salient features and clinical significance of the study. The authors note that 'both population and healthcare professionals seem unfamiliar with the construct of the syndrome.' Recognition of the community and professional inattention to and low priority of chronic fatigue syndrome, however, is not necessarily a failing; it may also be regarded as an updated example of Kleinman's[2] formulation of the category fallacy – the imposition of alien diagnostic concepts where they lack local validity. The assertion of underrecognition is incomplete without consideration of alternative formulations of the problems that in some respects resemble the syndrome, but are not diagnosed. Do conditions such as neurasthenia in East Asia and dhat syndrome in South Asia have characteristic patterning of distress or meaning in Brazil?

If one accepts the authors' tacit premise that the constructs of chronic fatigue syndrome and related UK formulations (encephalomyelitis and fibromyalgia) are unquestionably valid diagnoses for use everywhere, then the conclusion that chronic fatigue syndrome is neglected by professionals but no less important in the Brazilian population is valid. Accepting that premise, however, requires that we ignore the fact that the syndrome is neither in the ICD or DSM, and neurasthenia was rejected after consideration in the draft version of DSM–IV.[3] Standard texts in the field of cultural psychiatry regard chronic fatigue syndrome as a North American culture-bound syndrome.[4] Earlier research by some of the same Brazilian authors also highlights the social determinants of essential features of chronic fatigue, rather than the categorical diagnosis of the syndrome.[5]

Culturally sensitive clinical care will benefit from a reconsideration of cultural interpretations of these study data and from additional cross-cultural research. Are other diagnoses or local clinical and cultural formulations used to manage and treat such patients locally? Are other non-medical sources of help and social interventions given higher priority by patients and communities in Brazil?

Findings of Karasz & McKinley[6] showing the tendency of North Americans to 'medicalise' and South Asians to 'socialise' similar clinical vignettes recommend consideration of that point. Among patients studied by Cho *et al*, one might also ask whether higher rates of associated common mental disorders suggest that these psychiatric conditions are more likely to be the focus of treatment. The emphasis on underrecognition of chronic fatigue syndrome is likely to prove less important for community mental health and culturally sensitive care than questions of how such clinical patterns are understood in the population and explained by professionals.

1 Cho HJ, Menezes PR, Hotopf M, Bhugra D, Wessely S. Comparative epidemiology of chronic fatigue syndrome in Brazilian and British primary care: prevalence and recognition. *Br J Psychiatry* 2009; **194**: 117–22.

2 Kleinman A. Depression, somatization, and the new cross-cultural psychiatry. *Soc Sci Med* 1977; **11**: 3–10.

3 Paralikar V, Sarmukaddam S, Agashe M, Weiss, MG. Diagnostic concordance of neurasthenia spectrum disorders in Pune, India. *Soc Psychiatry Psychiatr Epidemiol* 2007; **42**: 561–72.

4 Griffith EE, Gonzalez CA, Blue HC. Introduction to cultural psychiatry. In *Textbook of Clinical Psychiatry, Fourth Edition* (eds R Hales & S Yudofsky): 1551–83. American Psychiatric Publishing, 2003.

5 de Fatima Marinho de Souza M, Messing K, Menezes PR, Cho HJ. Chronic fatigue among bank workers in Brazil. *Occup Med (Lond)* 2002; **52**: 187–94.

6 Karasz A, McKinley PS. Cultural differences in conceptual models of everyday fatigue: a vignette study. *J Health Psychol* 2007; **12**: 613–26.

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Authors' reply: The assertion that chronic fatigue syndrome is a culture-bound syndrome of high-income Western countries may be largely based on the observation that 'clinical descriptions of chronic fatigue syndrome, also known in some countries as myalgic encephalomyelitis, have arisen from a limited number

of high-income countries in Northern Europe, North America and Oceania'.[1] We aimed to examine the reasons for this particular observation: proving or disproving the above assertion was beyond the scope of our study. Without any pre-assumptions regarding the local validity of the construct of chronic fatigue syndrome, we used this 'etic' construct (originating from high-income Western countries) in Brazil in order to examine whether this foreign concept defines a similar proportion of individuals as 'cases'. We found that, using the current Centers for Disease Control (CDC) case definition of chronic fatigue syndrome, similar proportions of primary care attendees were defined as cases in São Paulo and London. However, Brazilian doctors were unlikely to recognise and/or label such patients as cases.

In a way, we actually used Kleinman's[2] formulation of the category fallacy as a research method in our study. That is, by imposing an alien diagnostic concept where its local validity is untested and unknown, we examined which component of this alien construct is not sanctioned by the local cultural context: the occurrence itself or the recognition/labelling. In Brazil, although unexplained fatigue as formulated by the Western medical community indeed does occur, 'it is not sanctioned as a medical condition worthy of medical treatment, sick leave or sickness benefit, and it may be more likely to be considered as part of everyday adversity and less likely to be recognised as a medical disorder'.[1]

Furthermore, although Paralikar *et al* suggest that our paper lacked consideration of the cultural context, we actually discussed and interpreted these findings mostly in light of the sociocultural context. For example, based on previous studies and our own data, we discussed that sociocultural differences such as the degree of medicalisation of the population and awareness of chronic fatigue syndrome among the population and the medical professionals might have contributed to the current findings.[1,3,4]

We have not specifically addressed alternative local formulations for the problems resembling chronic fatigue syndrome in Brazil. However, our case vignette study using a typical history of the syndrome according to the CDC definition revealed that the most common diagnoses given by Brazilian doctors were psychological disorders,[4] hence providing some information regarding the question raised by Paralikar *et al*. In order to address this and other important questions, we have collected qualitative data through in-depth interviews of individuals with chronic fatigue in Brazil and these data are currently being analysed.

We agree with Paralikar *et al* that the pattern of recognition and labelling observed in Brazil is not a failing, since this pattern is probably due to the sociocultural context rather than to medical incompetence. Indeed, we never suggested it was a failure.

Finally, the study by de Fatima de Marinho de Souza *et al*[5] actually used the same questionnaire as our study: the Chalder Fatigue Questionnaire. We also used a more inclusive concept of chronic fatigue as operationalised by this questionnaire, namely unexplained chronic fatigue, as we additionally screened for medical causes. The prevalence of unexplained chronic fatigue was similar in the two settings.

1 Cho HJ, Menezes PR, Hotopf M, Bhugra D, Wessely S. Comparative epidemiology of chronic fatigue syndrome in Brazilian and British primary care: prevalence and recognition. *Br J Psychiatry* 2009; **194**: 117–22.

2 Kleinman A. Depression, somatization, and the new cross-cultural psychiatry. *Soc Sci Med* 1977; **11**: 3–10.

3 Cho HJ, Bhugra D, Wessely S. 'Physical or psychological?' – a comparative study of causal attribution for chronic fatigue in Brazilian and British primary care patients. *Acta Psychiatr Scand* 2008; **118**: 34–41.

4 Cho HJ, Menezes PR, Bhugra D, Wessely S. The awareness of chronic fatigue syndrome: a comparative study in Brazil and the United Kingdom. *J Psychosom Res* 2008; **64**: 351–5.

5 de Fatima Marinho de Souza M, Messing K, Menezes PR, Cho HJ. Chronic fatigue among bank workers in Brazil. *Occup Med (Lond)* 2002; **52**: 187–94.

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Differentiating spiritual from psychotic experiences

Stein[1] raises an interesting and important question – that of differential diagnosis between spiritual experiences and psychotic disorders with religious content – when he shows that Ezekiel, as described in the Old Testament, has experiences that might be interpreted as first-rank symptoms. In addition to the religious implications of making such a diagnosis for the prophet (and possibly other spiritual leaders), there are critical implications for the evaluation and conduct of people that seek our clinical care with similar experiences.

We have conducted research on the relationship between spiritual experiences and psychotic and/or dissociative symptoms. A sample of spiritist mediums in São Paulo, Brazil, reported on average four first-rank symptoms, the same number as Ezekiel. However, the number of symptoms was not correlated to other markers of mental disorders such as scores on the Social Adjustment Scale–Self-Report (SAS–SR), Self-Reporting Psychiatric Screening Questionnaire (SRQ), and history of childhood abuse. Despite showing a high level of what could be interpreted as psychotic and/or dissociative symptoms, the total sample of 115 mediums had a high socioeducational level, a low prevalence of mental disorders and were socially well adjusted.[2,3]

There is an increasing literature showing a high prevalence of psychotic and dissociative symptoms in the general population. However, most of our knowledge of those experiences is based on clinical, often hospitalised, samples. Those and other studies indicate the necessity of being cautious when analysing the clinical significance of anomalous experiences emerging in non-clinical contexts, especially since our knowledge about these experiences is based on clinical samples. It seems that these psychotic or dissociative experiences are not necessarily symptoms of mental disorders. (Similarly, certain medical symptoms such as shortness of breath and tachycardia may be pathological in some circumstances and physiological in others.)

Certain additional features may suggest a non-pathological basis for the experience: lack of suffering or functional impairment, compatibility with the patient's cultural background, absence of comorbidities, control over the experience, and personal growth over time. These criteria are useful pointers, but there is a lack of well-controlled studies.[4]

Experiences like those of Ezekiel have had an important role in the Greek, Jewish and Christian roots of Western society, and in our time they are prevalent in spiritual groups such as those related to spiritism, channelling, Pentecostalism and the Catholic charismatic movement.

Research to clarify our understanding of this aspect of human experience will not only enlarge our knowledge of human nature but also improve the cultural sensitivity and effectiveness of our clinical practice.

1 Stein G. Did Ezekiel have first-rank symptoms? Psychiatry in the Old Testament. *Br J Psychiatry* 2009; **194**: 551.