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Correspondence

Contents: Suicide prevention in Gotland/Defeating depression in Zimbabwe/Chromosomal aberration and bipolar affective disorder/Genetics, chance and dysmorphogenesis in schizophrenia/Cognitive–behavioural therapy for schizophrenia/Anorexia nervosa and schizophrenia/Mental retardation and pandemic influenza/Ejaculation associated with zuclopenthixol/Sleep disturbance in schizophrenia.

Suicide prevention in Gotland

SIR: The reinterpretation by MacDonald (*BJP*, August 1993, **163**, 260) of the Gotland suicide data (Rutz *et al*, 1992) has provoked debate about suicide prevention initiatives. However, MacDonald made a simple but critical error in his analysis of the Gotland data. Using a five year moving average, he suggested that the suicide rate following the GP depression education programme was part of a longer downward trend in the suicide rate on Gotland.

Taking a moving average of time series data is a well-recognised method of smoothing a graph so that trends may be seen more clearly. However, if an intervention is introduced, the moving window must stop at the last data point *before* the intervention. Otherwise the window is gradually contaminated by more and more data points from the intervention phase. MacDonald did not do this.

Using MacDonald's five year moving average but stopping the window prior to the intervention gives a different picture. Prior to the intervention there are three successive drops in the smoothed graph (of 1.9, 1.2 and 2.7 per 100 000 respectively). However, the first post-intervention data point is 7.0 per 100 000 lower again than the last point prior to the intervention. This is a much larger drop than that between any two prior data points, and much larger than the apparent figures shown by MacDonald. Taken together with the recent evidence from Hungary of a relation between the number of physicians available, the rate of diagnosed depression and the suicide rate (Rihmer *et al*, 1993), we believe that the implications for suicide prevention by general practitioners cannot be ignored.

RIHMER, Z., RUTZ, W. & BARSI, J. (1993) Suicide rate, prevalence of diagnosed depression and prevalence of working physicians in Hungary. *Acta Psychiatrica Scandinavica*, **88**, 391–394.

RUTZ, W., VON KNORRING, L. & WALINDER, J. (1992) Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. *Acta Psychiatrica Scandinavica*, **85**, 83–88.

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Defeating depression in Zimbabwe

SIR: We thank Vik Patel (*BJP*, August 1994, **165**, 270–271) for drawing attention to our editorial (*BJP*, March 1994, **164**, 293–196) but are puzzled by some of his comments.

We have not said that the Zimbabwean Shona term 'thinking too much' is equivalent to depression. While agreeing that the term seems conceptually linked to worry we would add that it includes a change in one's normal demeanour as a consequence of worrying. Thinking too much in combination with particular symptoms of 'heart' discomfort seemed to encapsulate depression for most women meeting 'etic' caseness criteria drawn from a random population sample in Harare. These 'heart' symptoms proved to be idioms for grief, emotional pain, fear and disappointment and should not be ignored or misconstrued.

The linked bilingual term 'kufungisisa–depression' was adopted at a workshop by community participants to denote a condition viewed locally as caused by thinking too much about problems. While no term can be perfect, plumping for a consensus on the day allowed us to move on to address issues of prevention and management. Contrary to the purist anthropological view that depression (and anxiety) in non-Western settings is cloaked in mystery (Lutz, 1985), people in Harare recognised it easily and were enthusiastic to look at strategies for change.

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