There has thus been support for this finding and for providing this simpler form of surgery, which can be done at a regional level (Snaith, 1989).

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SIR: In their recent paper, Lovett *et al* (*Journal*, October 1989, **155**, 547–550) repeat the advice from a previous paper (Lovett & Shaw, 1987) that stereotactic tractotomy may give a poorer outcome in patients with organic cerebral changes. They again quote a bipolar case (no. 4) from their 1987 series as showing a particularly poor course after, and possibly before, the woman's second operation in 1981. This was associated with embolic cerebral damage.

Unknown to the authors, this woman, two-and-a-half years after her second operation, showed an almost complete resolution of affective symptoms that allowed her eventually to be transferred from long-stay to out-patient care. For the last five-and-a-half years she has suffered from neither mania nor depression, and her only psychotropics are diazepam (5 mg) in the morning and temazepam (20 mg) at night. If anything, her organic cerebral changes came on after the extension operation, since a preoperative Emergency Medical Information scan was reported as normal. Since that time she has experienced several cerebral infarctions in both frontal areas from emboli due to mitral valve disease, but has recovered well from the resulting brief hemiplegia and dysphasia.

She walks normally, although her speech can become muddled when she is under pressure, and very occasionally she is a little 'high' and 'interfering' for some hours at a time.

I have no doubt that this woman would never have been discharged nor have been free of affective illness without tractotomy. The recovery two-and-a-half years after the operation may seem late, but it may possibly have been delayed by the stroke eighteen months after operation, or alternatively the stroke may have represented a further and curative extension of the limited surgery to her frontal tracts.

Certainly, it would seem too early to regard cerebral changes as an absolute contraindication to psychosurgery.

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Forensic aspects of mental handicap

SIR: Turk's annotation on the forensic aspects of mental handicap (*Journal*, November 1989, **155**, 591–594) is timely in bringing this issue to prominence. However, I feel that he omits to mention an important cause of distortion in the available figures relating to mental handicap and criminal offences, namely the great reluctance of the police to prosecute people with a mental handicap. As a result, the available figures on any relationship which may exist between crime and mental handicap are not a true reflection of the situation. For example, over the last six months I have seen six individuals each of whom have committed what would normally be regarded as criminal offences, including assault, theft, destruction of property, sexual offences, and various minor nuisance offences. None of these people were prosecuted by the police although they were, in three cases, brought into our hospital by the police. It is of course debatable how far prosecuting an individual with a mental handicap serves any useful purpose, and this is not a plea for the wholesale prosecution and imprisonment of all mentally handicapped offenders. However, until we can collect more accurate figures about offences committed by people with mental handicap, it is misleading to use existing figures on convicted persons as an indication of the presence or absence of relationships between intellectual retardation and criminal behaviour.

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Asian patients and the HAD scale

SIR: I was puzzled by the letter from Chaturvedi (*Journal*, January 1990, **156**, 133) as it appears he has failed to grasp the content of my article (*Journal*,

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October 1989, **155,** 545–547). My article was not about a 'mere translation' of a scale for use with Asian psychiatric patients, but a study to validate a translated version of the Hospital Anxiety Depression (HAD) Scale against the Standardised Psychiatric Interview. In fact, I came to the conclusion that 'in its present form the translated version of the HAD scale has a limited role as a screening instrument', and I have stated that I do not recommend its use for the diagnostic purpose.

The myth of depression in Asian patients with its different presentation is not valid any more. The World Health Organisation (WHO) study (1983) is one of many which suggest that the core symptoms of depression are similar in different cultures. With appropriate examination, one can elicit psychological symptoms of mood disorder in patients from Asian or any other culture. As my studies suggested, somatic symptoms did not correlate with depression, not only on the HAD Scale but also on the Clinical Interview Schedule (CIS) (this interview has been used previously in many cultures by different authors).

I fully agree with Dr Chaturvedi that without proper validation an instrument should not be used in a different culture. In fact, my study supports the notion that to avoid the western bias the psychiatric instrument should be built from scratch in that very culture (Leff, 1988). While such works (as I know from personal contact) are being carried out in other countries, the modified form of instruments from western cultures have a role in bridging the gap. The cross-cultural studies are important for better understanding of mental illness; this type of work will help by giving a starting point from which to carry out further research.

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SIR: Chaturvedi's (*Journal*, January 1990, **156,** 133) criticism of the use of the HAD Scale with Asian patients is too sweeping although it is true that Nayani's evaluation of his own Urdu translation of the HAD Scale (*Journal*, October 1989, **155,** 545–547) is incomplete and that previous cross-cultural research in psychiatry has often ignored issues of cultural and conceptual validity.

Together with colleagues in Lahore, Pakistan, I have recently completed an evaluation of a new translation of the HAD Scale in Urdu (Mumford *et al*, 1989). We used a five-stage process: (a) initial drafting in Urdu by six independent translators; (b) translations back into English and modification of the Urdu version; (c) evaluation of linguistic equivalence of items in a large bilingual population; (d) evaluation of conceptual equivalence by examining item-subscale correlations; and (e) evaluation of scale equivalence by two-way classification of high and low scorers.

Our results do not justify the scepticism of Dr Chaturvedi, but suggest that the HAD Scale may be a useful and reliable instrument for use in Pakistan. Further validation studies in clinical populations are in progress.

The eventual aim is of course to develop new psychological tests for use in Pakistan. However, the translation of selected western instruments into non-western languages can be a useful interim measure. When properly evaluated and validated, these do have the advantage of allowing some cross-cultural comparisons to be made.

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Physical health and unmet needs

SIR: Brugha *et al*'s paper (*Journal*, December 1989, **155,** 777–781) on medical needs of the chronically mentally ill in community care recommends close medical supervision and regular checks on physical health.

If one considers the high co-morbidity of medical and psychiatric disease, we agree that regular attention to physical health should be given to this vulnerable population. However, the way in which this attention should be given remains unclear from their paper. Surely the authors cannot justify regular laboratory tests on the basis of their data. Of their sample of 145 patients, only 12 patients had unmet medical needs (8%) requiring further medical investigation (10 cases) or treatment (2 cases). These data are in line with findings of Maricle *et al* (1987) and Honig *et al* (1989).

Unmet medical needs can often be dealt with by the patients' family doctor (Maricle *et al* 1987, Honig

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