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

et al 1989). A well-informed general practitioner (GP) can perform an interview followed by a physical examination, and if necessary, specific laboratory tests. However, the GP needs a lot of support to be able to do this properly in the chronic psychiatric population.

A more feasible approach therefore for any community mental-health-care worker is to alert oneself to possible signs and symptoms of physical disease whenever a patient is seen. When in doubt, the supervising community psychiatrist or the patient's GP should be consulted. If necessary, a direct contact between the patient and the GP should be established even if this would mean accompanying the patient to the GP's surgery and explaining the problems. This procedure would promote the reintegration of the patient back into the appropriate ambulatory medical service. A close co-operation between the community mental health service and the patient's GP would be more effective, of higher medical quality (clinical assessment, physical examination and specific laboratory tests) and less expensive than the suggested routine checks in the day-hospital setting. This physical screening procedure is satisfactorily in use in our Community Psychiatric Unit.

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Was Hitler a Christian?

SIR: I found myself agreeing with the central anti-racist thrust of Samuel's letter (*Journal*, October 1989, **155**, 568–569) but cannot let pass his extraordinary assertion that "Stalin, Hitler, Mussolini, Franco and Rudolph Hoess were all Christians". The Shorter Oxford Dictionary defines a Christian as a "person believing in, professing or practising the religion of Christ ... a person showing character consistent with Christ's teaching". My nodding aquaintance with 20th century history suggests that none of these figures fit even this wide and non-denominational definition. Stalin was actively anti-Christian while Hitler, Mussolini and Franco saw the Church as a useful institution to be manipulated for political ends, nothing more. I know no details of Herr Hoess' theological views.

Dr Samuel's letter perhaps reveals a common misuse of the word 'Christian' as a synonym for 'Western'. It is inaccurate, misleading and potentially offensive to both Christians and non-Christians.

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Intestinal permeability in schizophrenia

SIR: Lambert *et al* (*Journal*, November 1989, **155**, 619–622) recently reported that the intestinal permeability of schizophrenic patients, determined by urinary excretion of ingested ^{51}Cr EDTA, was not significantly different from that of normal subjects. They concluded, "schizophrenia is, at least in the majority of cases, unrelated to coeliac disease" since the latter shows a highly significant increase in intestinal permeability to ^{51}Cr EDTA.

These authors imply their results are relevant to my hypothesis of the genetic relationship between the two diseases (Dohan, 1988). They overlook the possibility that *some but not all genes* necessary for susceptibility to coeliac disease are also present in those hereditarily susceptible to idiopathic schizophrenia. This possibility was suggested by clinical observations indicating the two diseases occurred in about 2–5% of patients with a primary diagnosis of either disease – at least 10 times as frequently as chance expectancy. As expected from the co-occurrence of the two diseases noted above, two of the 24 schizophrenic patients (8%) studied by these authors exhibited intestinal permeability well within the coeliac disease range. However, no diagnostic studies for coeliac disease were mentioned.

I have hypothesised (Dohan, 1988) that abnormal alleles in both diseases code for enhanced gut-cell receptor activity for the glutamine-rich gluten peptides and that aberrant alleles at two or three loci coding for defective systemic enzymes catabolising gluten peptides are the same in coeliac disease and idiopathic schizophrenia. In addition, I postulate idiopathic schizophrenia also requires a schizophrenia-specific gene. This I suspect causes brain dysfunction because of preferential binding of opioid peptides, exorphins, derived from glutens