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Western depression is not a universal condition

Thornicroft *et al*[1] assume that 'mental disorder' is an entity essentially lying outside situation, society and culture, which is identifiable anywhere using a common (Western) methodology such as the Composite International Diagnostic Interview (CIDI). Biologically triumphalist studies like this simply have to be challenged, because once something – in this case, depression as a unitary pathological entity arising naturalistically anywhere in the world – is declared real, it becomes real in its consequences.

The authors cite at the outset the World Health Organization (WHO) claim that depression is the first or second most burdensome disease, disability-wise, in the world. To me this is perhaps the most bizarre statement to come out of a major medical institution in the modern era: more burdensome than AIDS or tuberculosis, which each take around 1.5 million lives per year, and with millions more disabled over the years? The disability-adjusted life-years metric (DALY) on which the WHO claim rests is epistemologically lamentable when applied in this way.

The CIDI is described by the WHO as a survey instrument produced for standard use across cultures. This does not mean it is valid. The authors concede that 'no attempt was made to go beyond DSM-IV criteria to assess depression-equivalents that might be unique to specific countries', and that 'the reliability and validity of diagnoses made with the WMH CIDI may vary across countries'. This doesn't appear to deter the authors, yet it renders their conclusions risible.

Western psychiatric templates simply cannot generate a universally valid knowledge base, since they fail the core test of validity, which relates to the 'nature of reality' of subjects under study. Invalid approaches cannot be redeemed by 'reliability' – using a standard, reproducible method – since the very ground they stand on is unsound.[2] This is hardly surprising since, organic categories aside, diagnoses are merely descriptive constructions, conceptual devices, and are drawn up by us, not by nature. Ironically there is a WHO study, reported by Sir David Goldberg and colleagues, which showed that in 15 cities around the world those people recognised as depressed by doctors did no better (indeed they did slightly worse) than comparable others who were not so recognised.[3]

Depression has no exact equivalent in non-Western cultures, not least because these do not share a Western ethnopsychology that defines 'emotion' as internal, often biological, unintentioned, distinct from cognition, and a feature of individuals rather than situations.[4] Here we see the Western psychological discourse setting out abroad to instruct, regulate and modernise, presenting contemporary Western mentality and ways of being a person as definitive anywhere. Why should this imperialism suit the rest of the world?[5]

Half the countries surveyed here were low-income ones. What is 'mental health' in the poverty-haunted, near-broken parts of the world? Thinking of my own country, Zimbabwe, how would invalid approaches distinguish between depression and situational distress? Does Africa need the category of Western depression at all, and does it need the marketing of antidepressants which will ride in on the back of papers like this in international psychiatric journals? I think not.

1 Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, et al. Undertreatment of people with major depressive disorder in 21 countries. *Br J Psychiatry* 2017; **210**: 119–24.

2 Summerfield D. How scientifically valid is the knowledge base of global mental health? *BMJ* 2008; **336**: 992–4.

3 Goldberg D, Privett M, Ustun B, Simon G, Linden M. The effects of detection and treatment on the outcome of major depression in primary care: a naturalistic study in 15 cities. *Br J Gen Pract* 1998; **48**: 1840–4.

4 Lutz C. Depression and the translation of emotional worlds. In *Culture and Depression. Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (eds A Kleinman, B Good): 63–110. University of California Press, 1985.

5 Summerfield D. Afterword: Against global mental health. *Transcult Psych* 2012; **49**: 519–30.

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Does prescribing psychiatric medication really make it less likely that alcohol is involved in a self-poisoning?

Making causal assertions from complex cross-sectional data is risky and may lead to erroneous clinical advice. Although a negative association has been revealed between alcohol ingestion in self-poisoning and taking psychiatric medications (particularly a tricyclic or a typical antipsychotic),[1] individuals who are prescribed these medications may be different from those who are not, even after adjusting in covariate analysis for a generic category of 'psychiatric diagnosis'. This association even led Chitty *et al* to speculate that D2 antagonists might reduce the use of alcohol. However, there is evidence to the contrary: flupenthixol led to more drinking when tested in randomised controlled trials (RCTS),[2] and olanzapine caused a similar trend.[3] In the remaining 10 of 13 RCTs found in a systematic review, antipsychotics did not reduce drinking.[4]

Clearly, there are various interpretations of the association that was found. For example, perhaps people who have access to highly sedating and potentially lethal drugs such as tricyclics and antipsychotics can self-poison seriously without recourse to added alcohol.

While Chitty *et al* raise some interesting questions, we are concerned that those reading the abstract alone might misperceive a role for antipsychotics in drinkers. Suicide rates in people who drink heavily might be best prevented by improving treatment and access to treatment for alcohol use disorders.

1 Chitty KM, Dobbins T, Dawson AH, Isbister GK, Buckley NA. Relationship between prescribed psychotropic medications and co-ingested alcohol in intentional self-poisonings. *Br J Psychiatry* 2017; **210**: 203–8.