Nigeria (Lambo, 1964). They hint that such collaboration is "undesirable on moral grounds". This authoritative censure is made in connection with a reference to our co-operative relationship with traditional healers in a different culture area, that of the Northwest Coast Indians of North America. The therapeutic ceremonials described (Jilek & Todd, 1974) have nothing to do with witches, witchcraft or sorcery. The witch-doctors referred to in our article endeavour to assist, by means of a culture-congenial traditional psychotherapy and sociotherapy, those North American Indians who under the impact of rapid socio-cultural change are showing symptoms of anomic depression and anxiety.

While working with tribal societies in three continents, I have had the experience that friendly contacts and monitoring collaboration with traditional practitioners who have an established role in their community is more beneficial to the patient than ignoring or condemning them. Such collaboration becomes a necessity in the planning of comprehensive primary health and mental health care in a developing country with limited professional manpower resources (Jilek, 1985).

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Depression in Schizophrenia

SIR: The paper by Elk *et al* (*Journal*, August 1986, **149**, 228–229), looking at rates of depressive symptoms in schizophrenic patients from three "racial" groups, raises a number of issues.

One might question results based on small numbers (groups of 19, 15 and 22 patients) but, more importantly, is it methodologically valid to compare three such disparate groups without considering other variables? No information is given in the paper about patients' social circumstances or how typical they are of patient populations in the three "racial" groups. Referees and readers of the *Journal* may not know that black, coloured and white patients in South Africa by law have to be nursed in separate wards, usually separate hospitals, and that black and coloured people have extremely limited access to medical care.

A further point is that the reasons for comparing these three groups are not explained; is it because they were thought to be biologically different or were from different social backgrounds? Referees should ensure that the assumptions underlying a research project are clarified for the readership in either the introduction or the discussion.

Finally, there are many who would suggest that at the present time, papers from South Africa should not be published by British journals. It would be helpful to have some editorial comment on this issue.

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Macrocytosis and Cognitive Decline in Down's Syndrome

SIR: Welfare & Hewitt (*Journal*, April 1986, **148**, 482–483) suggest that in Down's syndrome cognitive decline and macrocytosis may be related. The causal relationship they suggest is unlikely. While red blood cell (RBC) membranes may age more rapidly in patients with Down's syndrome, this would lead to these RBC becoming smaller rather than larger. The macrocytosis seen in patients with accelerated ageing of RBCs due to thalassaemia or haemolysis is caused by the large size of the reticulocytes produced in response to the RBC loss (Beard, 1978).

Welfare & Hewitt state that in their Down's syndrome patients "there was no evidence of vitamin B12 or folate deficiency to account for this further increase" in RBC size. Eastham & Jancar (1983) state that Down's syndrome patients with macrocytosis were "not being treated with anticonvulsants and were not anaemic". It is well recognised that functionally significant folate deficiency in association with macrocytosis may be present in patients without megaloblastic anaemia being apparent (Botez &