trained personnel and the scarcity of newer antidepressants in the public sector makes the use of evidence-based treatment methods impractical in developing countries. However, as Dr Crawford (2004) points out, this does not mean that the likelihood of recovery from depression is worse than in resource-rich regions.

Even though there is limited access to specialised mental health services and newer antidepressant medication, many developing countries have evolved innovative techniques to overcome these apparent hurdles (Swartz & Rollman, 2003). The majority of patients are treated effectively using older and cheaper antidepressants. Electroconvulsive therapy is used widely in a more liberal manner than in the West; one reason being the need for a quick cure to decrease the patient load, which is far greater than the number of beds available. Cognitive–behavioural therapy is an affordable form of psychotherapy that is used. Even in the absence of formal psychological interventions, the closely knit extended families and networks of friends provide supportive therapy in an informal manner.

In addition, the available primary health care facilities are used in an effective manner to combat the difficulties created by inadequate resources. One such example is the Chinese model of village health workers functioning at a local level to identify patients in need and referring to medical personnel in local clinics (Swartz & Rollman, 2003).

In Iran the concept of health houses has been reported, where local inhabitants are screened for mental and physical illnesses by health workers, and patients presenting with more complex problems are referred on for more intensive care (Swartz & Rollman, 2003).

These models employed in some developing countries in response to the scarcity of resources should be commended. Instead of letting what we do not have incapacitate us, it is time we made use of our existing resources to provide better care for people with mental illnesses.

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ADHD in developing countries

It is with much interest that we read the editorial on attention-deficit hyperactivity disorder (ADHD) by Paul McArdle (2004). The argument regarding culture and ADHD was of particular interest to us.

ADHD is a condition that was unheard of in developing countries a few decades ago. However, clinicians now see it in increasing numbers. It was assumed that the extended families seen in developing countries act as a protective factor against psychiatric illness in childhood (Nikapotha, 1991). The low prevalence of ADHD in developing countries was attributed to this. Many hypothesise that the increase in ADHD seen now is caused by the breakdown of the family network resulting from Western influences and urbanisation.

However, it is debatable whether this is a genuine increase in prevalence or merely a perceived increase as more cases of ADHD are detected than before. We suggest that the breakdown of the family network may be one of the causative factors for this perceived increase. In developing countries with extended and closely knit families the burden of childcare was shared among many family members. With the breakdown of this structure the responsibility of childcare falls solely on the parents. This situation is made worse by both parents having to work to meet the financial demands of a family. All these factors may contribute to a low level of tolerance. Parents who are unable to tolerate difficult behaviour may seek help from medical professionals.

A decade ago difficult behaviour was not perceived as requiring help or treatment from medical professionals but rather as a situation requiring advice or discipline from family elders and community leaders (Nikapotha, 1991). This too has now changed because of increased awareness that difficult behaviour can be caused by psychiatric conditions.

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One hundred years ago

Clinical notes and cases

Clinical and Pathological Notes. – II. By Dr. M. J. NOLAN, Resident Medical Superintendent, Down District Asylum, Downpatrick.

CASE 5. *Microcephalic idiocy*; *epilepsy*; *cerebral asymmetry*; *microgyria*; *ulegyria*; *scalp suggestive of atavism*. – H. C – , æt. 41 years, admitted to asylum from a workhouse August 4th 1902; died of epilepsy December 22nd, 1902. No previous history obtained.

His physical appearance would have rejoiced the heart of an evolutionist, as *prima facie* he was a perfect specimen of the Simian type. His dwarfed figure was bent forwards; his coarse grinning face seemed to protrude from between the misshapen spreading ears. The small receding skull was encased in an ill-fitting scalp, on which the rough black hair grew in ridges. He progressed by means of a side shuffle, preserving his equilibrium by spreading out

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