Turton *et al* (2001) describe substantial morbidity in pregnant women whose previous pregnancy (or pregnancies) had ended in spontaneous loss after 18 weeks' gestation. She found that 21% of women reporting stillbirth as a criterion A stressor had post-traumatic stress disorder (PTSD) symptoms at caseness level in the third trimester of the next pregnancy. Turton *et al* conclude that women are vulnerable to PTSD in the pregnancy following stillbirth.

I take issue with these findings. There are several methodological problems with the study. First, stillbirth is not defined as pregnancy loss after 18 weeks' gestation. An infant born after the 28th week of gestation who does not breathe after birth or show any other sign of life is termed a stillbirth (Beischer & Mackay, 1988). Hence, by definition, Turton *et al* have included 41 women (out of their total number of 66 subjects) who have had miscarriages. It would have been better to report foetal loss figures on babies with a birth-weight of <500 g, which is current widespread practice. Second, the authors state that 14 out of 66 women did not see their stillborn infants. No reason is given for this. Was this because of the gestational age of the infant (<28 weeks' gestation)? Third, the use of the term PTSD must be questioned. The authors describe stillbirth as a criterion A stressor. One would therefore expect the onset of PTSD within 6 months of the stillbirth. The authors appear to have ignored this time criterion in making a diagnosis of PTSD (World Health Organization, 1993). Similarly, it is difficult to see how the persistent avoidance criterion (criterion C) was met. None of the subjects avoided pregnancy but became pregnant following stillbirth. What the authors describe are symptoms precipitated by the subsequent pregnancy, with the previous 'stillbirth' as a vulnerability or predisposing factor. Perhaps the diagnosis of adjustment disorder would be more appropriate

Beischer, N. A. & Mackay, E. V. (1988) *Obstetrics and the Newborn*. London: Baillière Tindall.

Turton, P., Hughes, P., Evans, C. D. H., *et al* (2001) Incidence, correlates and predictors of post-traumatic stress disorder in the pregnancy after stillbirth. *British Journal of Psychiatry*, **178**, 556–560.

World Health Organization (1993) *The ICD–10 Classification of Mental and Behavioural Disorders. Diagnostic Criteria for Research*. Geneva: WHO.

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Author's response: Legal and operational definitions of stillbirth have changed over time, partly in response to medical advances in pre-term baby care which continue to push back the technical age of viability. UK law currently defines stillbirth as the birth of a dead child after 24 weeks' gestation (the legal age of viability). Definitions also vary across nations; in Australia for example, the birth of a dead child after the 20th week of pregnancy is described as stillbirth. Clinicians in every country tend to use parents' experience of their baby's maturity as a guide and generally recognise a loss in the second half of pregnancy as representing a lost child to the parents. As 18 weeks is the gestational age when mothers typically detect foetal movement, and because mothers deliver in the labour ward rather than the gynaecology ward after this date, we operationally defined any infant born without sign of life after 18 weeks' gestation as stillborn.

Women whose pregnancy had reached 28 weeks ($n=25$) were significantly more likely to have seen their dead baby than those whose pregnancy ended before 28 weeks ($n=41$). However, as the paper reports, there was no significant association between gestational age and PTSD.

We reported both current and lifetime prevalence rates for PTSD. Lifetime diagnosis rates were higher than for current diagnosis, presumably reflecting Dr Sheehan's point regarding the time criterion. None the less, the high rate of PTSD in the pregnancy following stillbirth compared with 1 year postpartum (birth of healthy baby) does suggest that pregnancy may act as a reactivating stressor, as the paper suggests.

Section C of the PTSD interview identifies seven items associated with 'persistent avoidance'; subjects are required to have above-threshold scores on four or more to qualify. Avoidance of another pregnancy would be a singularly harsh and absolute criterion to apply, as well as being unrelated to the terms of the assessment interview, which shows close correspondence with DSM–III–R standards (American Psychiatric Association, 1987).

American Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised) (DSM–III–R). Washington, DC: APA.

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Psychiatric services in developing countries

We read with interest the editorial on community psychiatry in developing countries (Jacob, 2001). Historically, in the West, community psychiatry arose in the context of the deinstitutionalisation movement and anti-psychiatry. In developing countries, however, the impetus for developing community-based care was the lack of universally accessible services. Thus, without any ideological baggage to contend with, the emphasis should be on integrated services rather than an artificial schism between hospital and community psychiatry.

We agree with Jacob that psychiatrists should concentrate on what they know best – the identification and treatment of mental illness. The mental health programmes in many developing countries set lofty goals of primary prevention that cannot succeed unless backed by overall social and economic development. But we take issue with his inclusion of epilepsy as a potential target of community psychiatry. It is the authors' experience, while working at the Community Psychiatry Unit at Bangalore, India, that this results in the programme becoming a glorified antiepileptic medication clinic.

Jacob's criticism of vertical mental health programmes ignores the practical reality that there is a limit to what generic health workers can deliver given their commitments to other public health programmes such as immunisation. A practical way of getting around this would be to have mental health workers, based at primary health centres, whose skills are intermediate between community psychiatric nurses and generic health workers. There is also a need to develop simple psychosocial interventions which can be delivered by these workers and draw from the strengths of the family or the local community. Community-based rehabilitation is also a priority area as the prevalent concept of good prognosis of mental disorders in developing countries is being challenged (Mojtabai *et al*, 2001).

One of the stated goals of community psychiatry is to deliver evidence-based treatments to people with mental disorders (Szmukler & Thornicroft, 2001). It may be heartening for psychiatrists in developing countries to know that the conventional psychotropic medications still remain first-line treatments (Geddes *et al*, 2001; Barbui & Hotopf, 2001). The challenge is to ensure

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that all primary health centres stock essential psychotropic medications and that primary care physicians are trained in the detection and management of common disorders.

Barbui, C. & Hotopf, M. (2001) Amitriptyline *v.* the rest: still the leading antidepressant after 40 years of randomised controlled trials. *British Journal of Psychiatry*, **178**, 129–144.

Geddes, J., Freemantle, N., Harrison, P., *et al* (2000) Atypical antipsychotics in the treatment of schizophrenia: systematic overview and meta-regression analysis. *British Medical Journal*, **321**, 1371–1376.

Jacob, K. S. (2001) Community care for people with mental disorders in developing countries. Problems and possible solutions. *British Journal of Psychiatry*, **178**, 296–298.

Mojtabai, R., Varma, V. K., Malhotra, S., *et al* (2001) Mortality and long-term course in schizophrenia with a poor 2-year course. A study in a developing country. *British Journal of Psychiatry*, **178**, 71–75.

Szmukler, G. & Thornicroft, G. (2001) What is 'community psychiatry'? In *Textbook of Community Psychiatry* (eds G. Thornicroft & G. Szmukler), pp. 1–12. Oxford: Oxford University Press.

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V. Duddu Beechhurst Unit, District General Hospital, Chorley PR7 1PP, UK

Author's response: Drs Ranjith and Duddu argue that primary health care workers, because of their commitments to physical health needs, are not able to deliver mental health care. While this is partly true, I believe that the accomplishment of programmes that have been successfully integrated into primary care depends upon empowerment of the primary care staff to manage these problems. Physicians, nurses and community health workers in many developing countries, with their limited training, are not confident in managing mental disorders. Changes in the basic curriculum, training of trainers within primary care and ongoing support in fieldwork are necessary for skills to be transferred. The empowerment of primary care staff to tackle mental health problems is mandatory for the success of such programmes. Obstetric and immunisation services in many parts of the developing world have succeeded because of such empowerment and consequent integration into primary care.

The successful treatment of epilepsy in many mental health programmes is because the primary care staff are confident and competent in managing these disorders. The lack of these components in the management of psychoses and depression has resulted in programmes mainly treating subjects with epilepsy. The absence of other programmes for treating seizure disorders in the community would argue for retention of this component within mental health initiatives.

The problems of mental illness are complex, with implications for health care, the economy, and social and cultural practices. The current approaches have not delivered reasonable health care in many parts of the developing world. There are no simple solutions. There is a need for debate to generate new and different initiatives in order to overcome the present inertia. A combination of approaches, which harness the available resources, may be more successful than a single strategy.

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Need for paediatric–psychiatric liaison

Bass *et al* (2001) have recently drawn attention to the insufficient recognition given by clinical services to somatoform disorders. Although the authors explicitly exclude children and adolescents, most of the issues they raise apply equally to the younger age groups.

It has long been known that impairing functional aches and pains unexplained by medical disorders are common in children (Garralda, 1999). As in adults, those associated with chronic widespread pain and persistent fatigue have been shown to be associated with marked functional impairment including school non-attendance, which is substantially higher than in serious chronic paediatric conditions (Rangel *et al*, 2000). There is considerable continuity with functional symptoms in adulthood and family aggregation of health problems (Garralda, 2000). Although less extensive than in the adult literature, there is evidence for the effectiveness of psychological treatments in children (Garralda, 1999). However, the development of dedicated psychiatric–paediatric liaison services often has low priority, is poorly coordinated and monitored, and the training of paediatric staff in this area is clearly limited.

In line with Bass *et al* I support the view that young patients with severe forms of somatoform disorders require specialised multi-disciplinary treatment which is not appropriately administered in either a psychiatric or paediatric ward. I would echo the need for a serious joint business case between paediatric and psychiatric providers and general practitioners. Although in itself not sufficient, it might help to increase awareness and action if the Royal College of Psychiatrists were to issue guidelines on the number of paediatric liaison psychiatrists required for a given population and on job specifications.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

Garralda, M. E. (1999) Practitioner review: assessment and management of somatisation in childhood and adolescence: a practical perspective. *Journal of Child Psychology and Psychiatry*, **40**, 1159–1167.

—— (2000) The links between somatisation in children and adults. In *Family Matters: Interfaces between Child and Adult Mental Health* (eds P. Reder, M. McClure & A. Jolley), pp. 122–134. London: Routledge.

Rangel, L. A., Garralda, M. E., Levin, M., *et al* (2000) The course of chronic fatigue syndrome. *Journal of the Royal Society of Medicine*, **93**, 129–134.

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Cannabis regimes – a response

de Zwart & van Laar (2001) provide a thoughtful discussion of our recent article comparing alternative legal regimes for cannabis (MacCoun & Reuter, 2001*a*). We quite agree that any correlation between a rise in cannabis-selling coffee shops and a rise in cannabis prevalence might be coincidental rather than causal; we said so in our article and highlighted this point in its 'Limitations'. Our purpose was not to evaluate the Dutch model on its own terms, but to highlight potential risks and benefits of alternative strategies for the USA.

However, we take issue with several points made by de Zwart & van Laar. First, they question the plausibility of our term 'commercialisation', noting that since 1991 coffee shops have been subject to criminal prosecution for violations of regulations against advertising. But our article explicitly stated that changes in coffee shop regulation probably reduced commercialisation during the 1990s, and for this reason we explicitly argued that our commercialisation hypothesis was limited to the period 1984–1992. At any rate, this argument confuses formal regulations with their implementation; tourists can attest that cannabis is openly promoted in Amsterdam and other cities, with not-so-veiled

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