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CORRESPONDENCE

To the Editor:

O'Carroll *et al*. (1997) reported that performance on the delayed word recall (DWR) test failed to discriminate clearly between depression and Alzheimer's disease (AD), and that the Mini-Mental State Examination (MMSE) was superior to the DWR test in this capacity. Their AD patients were in the moderate to severe range of global cognitive impairment (MMSE mean = $16{\cdot}1 \pm 5{\cdot}2$), and the MMSE has previously been shown to differentiate well between depression and moderate to severe AD (Geffen *et al*. 1993). However, the clinical differentiation of depression and dementia is particularly problematical when dementia severity is very mild (Gainotti & Marra, 1994; Lachner & Engel, 1994). We investigated the accuracy of the DWR test in distinguishing 26 very mild non-depressed AD patients (MMSE score $\geqslant 23$, mean = $24{\cdot}58 \pm 1{\cdot}3$) from 20 age matched, community dwelling depressed/dysthymic patients (Coen *et al*. 1997). Mean severity of depression on the 21-item HAM-D was $18{\cdot}5 \pm 2{\cdot}97$ (depressed MMSE mean = $27{\cdot}35 \pm 1{\cdot}76$). Sensitivity and specificity were respectively: 96%, 100% for DWR free recall; 92%, 100% for DWR recognition; and 12%, 90% for the MMSE. The DWR test was, therefore, highly accurate in discriminating very mild AD patients from community dwelling depressed patients, and superior to the MMSE. Both the severity of depression and the degree of associated cognitive impairment were generally mild in our sample of depressed patients. As found by O'Carroll *et al*., for more severely depressed patients a significant number score below the DWR cut-off for AD. However, the clinical dilemma of the differential diagnosis of very mild AD or depression may present, in particular, when the depressive symptoms are mild or persistent, as was the case among our depressed patients. We, therefore, conclude that: (*i*) the DWR test is highly sensitive to AD; (*ii*) it may be useful in discriminating mild to moderately depressed patients from AD patients: and (*iii*) it is of limited use in discriminating more severely depressed patients from AD patients.

REFERENCES

Coen, R. F., Kirby, M., Swanwick, G. R. J., Maguire, C., Walsh, J. B., Coakley, D., O'Neill, D. & Lawlor, B. A. (1997). Distinguishing between patients with depression or very mild Alzheimer's disease using the delayed word recall test. *Dementia and Geriatric Cognitive Disorders* **8**, 244–247.

Gainotti, G. & Marra, C. (1994). Some aspects of memory disorders clearly distinguish dementia of the Alzheimer's type from depressive pseudo-dementia. *Journal of Clinical and Experimental Neuropsychology* **16**, 65–78.

Geffen, G., Bate, A., Wright, M., Rozenbilds, U. & Geffen, L. (1993). A comparison of cognitive impairments in dementia of the Alzheimer type and depression in the elderly. *Dementia* **4**, 294–300.

Lachner, G. & Engel, R. R. (1994). Differentiation of dementia and depression by memory tests. A meta-analysis. *Journal of Nervous and Mental Disorders* **182**, 34–39.

O'Carroll, R. E., Conway, S., Ryman, A. & Prentice, N. (1997). Performance on the delayed word recall test (DWR) fails to differentiate clearly between depression and Alzheimer's disease in the elderly. *Psychological Medicine* **27**, 967–971.

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The Author replies:

Coen *et al*. present data arguing for the usefulness of the DWR in distinguishing mild AD patients from mildly depressed community dwelling depressed patients. They agree with our principal finding that the DWR is of limited use in discriminating moderately severely depressed patients from AD patients. They contend, however, that the clinical dilemma of the

differential diagnosis of very mild AD *versus* depression presents 'in particular, when the depressive symptoms are mild or persistent'. We disagree, and argue that the main problem of differential diagnosis is in separating mild AD from moderate to severe depression, where cognitive impairment is most prominent (Austin *et al*. 1992). If a neuropsychological instrument is to be of real clinical value, it is in this area of potential misdiagnosis that it must prove itself. Our data suggest that the DWR is not specific enough to distinguish clearly patients with AD from elderly patients with major depression of moderate severity.

REFERENCE

Austin, M.-P., Ross, M., Murray, C., O'Carroll, R. E., Ebmeier, K. P. & Goodwin, G. M. (1992). Cognitive function in major depression. *Journal of Affective Disorders* **25**, 21–30.

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To the Editor:

Studies into issues of 'race' and culture in psychiatry carry far reaching social implications and so the methodology used in them, as well as their presentation in journals, should be approached with caution and sensitivity. The July issue of *Psychological Medicine* contains four papers devoted to the rates at which schizophrenia has been diagnosed among ethnic minorities or so-called 'migrants' in three European countries (Bhugra *et al*. 1997; Harrison *et al*. 1997; Mortensen *et al*. 1997; Selten *et al*. 1997).

All four papers refer to 'incidence' of 'schizophrenia' or 'psychosis' in their titles. This is not correct in the present state of knowledge in transcultural psychiatry explored in several publications (e.g. Kleinman, 1988; Fernando, 1991). With regard to culture, a failure to deal with 'category fallacy', which is the imposition of one culture's diagnostic categories on the people of another culture, has been described by Kleinman (1977) as 'the most basic and certainly the most crucial error one can make in cross-cultural research'. The bias towards diagnosing 'schizophrenia' or 'psychosis' when faced with a black person is established in terms of the experience of British service users (Sasson & Lindow, 1995), personal observations of many black mental health workers, and the only useful piece of research that has investigated racial bias in diagnostic practice (Loring & Powell, 1988). In one of the papers from the UK, the word 'migrant' is used to describe people actually born in the country. None of the papers discuss issues of bias in diagnostic systems or the pressures upon people perceived as outsiders – as 'migrants'.

The papers should have made it clear in their titles that they were reporting diagnoses *given* to people, without establishing the validity of the diagnoses, and the word 'incidence' should not have been used in either title or body of any of these papers; the least that the authors may have done to abide by a scientific approach was to have discussed (to put it mildly) the 'difficulties of applying Western concepts of mental illness to other cultures' (King *et al*. 1995). Words such as 'migrant' should have been clearly defined if used at all, and the effects of racism comprehensively discussed – or reasons given for not doing so.

REFERENCES

Bhugra, D., Leff, J., Mallett, R., Der, G., Corridan, B. & Rudge, S. (1997). Incidence and outcome to schizophrenia in Whites, African-Caribbeans and Asians in London. *Psychological Medicine* **27**, 791–798.

Fernando, S. (1991). *Mental Health, Race and Culture*. Macmillan/MIND: London.

Harrison, G., Glazebrook, C., Brewin, J., Cantwell, R., Dalkin, T., Fox, R., Jones, P. & Medley, I. (1977). Increased incidence of psychotic disorders in migrants from the Caribbean to the United Kingdom. *Psychological Medicine* **27**, 799–806.

King, M., Coker, E. & Leavey, G. (1995). Authors reply, *British Medical Journal* **310**, 333.

Kleinman, A. (1977). Depression, somatization and the 'New Cross-Cultural Psychiatry'. *Social Science and Medicine* **11**, 3–10.

Kleinman, A. (1988). *Rethinking Psychiatry. From Cultural Category to Personal Experience*. Free Press: New York.

Loring, M. & Powell, B. (1988). Gender, race and DSM-III: a study of the objectivity of psychiatric diagnostic behavior. *Journal of Health and Social Behavior* **29**, 1–22.

Mortenson, P. B., Cantor-Graae, E. & McNeil, T. F. (1997). Increased rates of schizophrenia among immigrants: some methodological concerns raised by Danish findings. *Psychological Medicine* **27**, 813–820.

Sassoon, M. & Lindow, V. (1995). Consulting and empowering Black mental health system users. In *Mental Health in a Multi-ethnic Society. A Multi-disciplinary Handbook* (ed. S. Fernando), pp. 89–106. Routledge: London.

Selten, J. P., Slaets, J. P. J. & Kahn, R. S. (1977). Schizophrenia in Surinamese and Dutch Antillean immigrants to The Netherlands: evidence of an increased incidence. *Psychological Medicine* **27**, 807–811.

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The Author replies:

These important points have been discussed many times in the literature, and I think a closer examination of the papers cited will reveal that the various authors are keenly aware of them. Kleinman's notion of 'category fallacy' is well known and has been widely quoted. It would be naive, however, to harness this concept to support an over-simplified categorical view of culture wherein one 'culture' is pitted against another. There is a rich diversity of 'culture' in the UK and, indeed, there is considerable variety of cultural experience among psychiatrists and other clinical staff, as well as among those we think of as patients and clients. The diagnostic process must be sensitive to differences of experience and expression shaped by our individual cultural backgrounds and racism is an evil, which must be opposed wherever it rears its head. But the question of the increased rates of psychotic disorders reported in these papers is too important to be reduced to simplistic formulations; we need to explore all of the potential factors – biological, social, cultural and conceptual. In particular, we must avoid unwise generalizations about mis-diagnosis, which risk alienating mentally ill people from the services they need and which may delay effective and speedy intervention and treatment. The debate needs to continue, and our interpretation of data continually modified, but on the basis of the best research evidence we can make available.

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