encounered in translating any schedule in psychiatry or psychology, i.e., the possible variety of different dialects, registers, styles and modes of the source and target languages (Catford, 1965), as well as the wide socio-cultural differences between the two societies, English and Arabic. In such a work, not only should the translation be correct, but the word chosen in the translation should also carry, as much as possible, the connotation in the source language. The iterative back translation technique solved most of these difficulties.

So far, I have applied this Arabic version to over two hundred and fifty patients, with different kinds of mental disorders, mainly psychoses. I have found that some modification of wording to take account of local slang is necessary to clarify the items, as was the addition of examples from familiar surroundings and further illustrative questions, especially for some non-educated subjects. This was particularly encountered with item 47: depersonalisation; and in item 49: delusional mood.

I found that the Arabic language allows precise expression of deep inner distress and it is worth mentioning in the light of Leff's (1981) work that it is not difficult to differentiate between affective states in Najdis, even when the feelings are closely related.

Women, especially .younger Bedouin women, when accompanied by their husband or father, sit very quietly and unresponsively, because it is considered impolite to display affect in the presence of a strange male (the interviewer). This sometimes makes the rating of item 110: "slowness and underactivity"; and even item 128: "blunted affect", very difficult. It was possible to overcome these difficulties by asking the attendant to leave the room for a while and convincing the patient that she was in a medical situation and emphasising that the interviewer was a physician.

Saudis, in general, adopt an external locus of control. They consider various external sources control their life in a certain way according to Islamic principles: Allah (God), fate, nature, the head of the tribe, etc. Moreover, some of them have beliefs that magic, the "evil eye" and witchcraft play an important role, although in a negative way. The response to item (55) and item (77) must therefore be interpreted with care and additional illustrative questions were required to clarify them. Because of the hierarchical structure of Saudi society, item 29 "what is your opinion of yourself compared with other people?", causes some confusion and an illustrative question must be added to emphasise that the comparison is between oneself and peers.

These limited modifications of wording and illustrative additions to the interview will not distort the rating if the concept behind the item and embodied in the glossary is clear in the mind of the examiner. Similar points have been made by others (Orley & Wing, 1979; Okasha & Ashore, 1981; Gillis, 1982).

Concerning the difficulties of the terms used for certain experiences in one particular culture such as depression, obsession, hallucination, this difficulty was encountered and solved through the stages of iterative back translation. These terms had been collected and some of them discussed in section 7 of Al-Khani (1985b).

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Investigations in Demented Patients Admitted to Psychiatric Hospital

DEAR SIR,

The article by Renvoize *et al* stressed the importance and usefulness of comprehensive physical investigations in the assessment of demented patients. However, in their findings they reported that a folate deficiency was present in 44.8% of their patients. This was based on serum folate assay, and it is noteworthy that despite this high prevalence of "folate deficiency" as they call it, no reference is made to this finding in their discussion. There are two important points to be made here. First of all, it is probable that the elderly as a population tend to have a lower serum folate (Caird, 1973; Fox *et al*,

https://doi.org/10.1192/S0007125000209082 Published online by Cambridge University Press

1975) and therefore the reference range used should be stated. But more importantly, it is now established that a low serum folate is not diagnostic of "folate deficiency". It has been stressed (Chanarin, 1983) that a low serum folate may better be interpreted as negative folate balance, possibly dietary in origin, but for the diagnosis of folate deficiency red blood cell folate level is required. It is therefore more appropriate to perform red blood cell folate assay in the investigation of demented patients.

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Vitamin Supplement to Alcoholic Beverages

DEAR SIR,

Dr Weller (*Journal,* March 1984, **144**, 329) is correct in asserting that prompt use of thiamine can reverse or prevent some of the more serious side-effects of alcohol abuse. Contrary to his assertion however, thiamine deficiency in alcohol abuse arises from inadequate dietary intake of vitamin B1, impaired absorption of the vitamin across the intestine and reduced hepatic activation of vitamin B1 to its metabolically active form Thiamine Pyrophosphate (T.P.P.) (Thompson *et al,* 1980). It follows then that, "Wernicke's encephalopathy following glucose infusion and upon refeeding prisoners of war or patients following a starvation diet", is due to the sudden flooding of the carbohydrate metabolic pathways and consequent increased utilisation of T.P.P. co-factor leading to acute deficiency of the co-factor in an already nutritionally compromised individual.

Therefore, addition of vitamin B1 to alcoholic beverages would not necessarily increase the available pool of biologically active T.P.P. I am concerned that drinkers may be falsely assured that added vitamin B1 counteracts any possible sequelae of their alcohol abuse. It has been shown (Brin, 1964) that as little as 200 days of a diet containing 200 micrograms of Thiamine, approximately one tenth of the normal daily requirement, can cause Wernicke's encephalopathy.

I submit that more concern for the nutritional state of alcohol abusers and less assurances to them that additives make drinking safer would be more appropriate.

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Hazards of Hard Contact Lenses in Psychotic Patients

DEAR SIR,

Psychotic individuals are more likely than normals to ignore the rules for contact lens wearers (Scheie & Albert, 1977; Cooper & Constable, 1977). Our two case histories illustrate this point.

Case i: A 37 year old male paranoid schizophrenic was admitted to our hospital with loosening of associations, delusions and gaze avoidance. For several weeks he had lived in complete darkness, using mirrors in the windows to reflect the sun's light outwards. He had been wearing contact lenses continuously for three weeks. Examination revealed hard contact lenses, severe bilateral conjunctivitis, and abrasions of the left cornea. These slowly recovered with treatment: chloramphenicol drops and an eye patch.

Case ii: A 30 year old male was admitted with schizophrenic mutism and extreme gaze avoidance. The latter clinical feature was attributed to his disturbed mental state. The nursing staff discovered an empty contact lenses carrying case among his possessions. A second physical examination revealed hard contact lenses and bilateral severe conjunctivitis. The latter cleared with sulphacetamide eye drops. A collateral history revealed that the lenses had been worn day and night for one week before admission.

Caution should be exercised when prescribing contact lenses to patients with severe psychiatric illness. Their presence should be considered in the evaluation of gaze avoidance amongst psychotics, especially in schizophrenia.

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https://doi.org/10.1192/S0007125000209082 Published online by Cambridge University Press