complaint belongs to 'illness behaviour', which is different from 'objective symptoms' assessed by psychiatrists, preferably using a standardised procedure.

Littlewood mentions the Western patterns of eating disorders, multiple personality disorder, overdosing, shoplifting, agoraphobia and school refusal. Many of these, if not all, are also found in non-Western societies (e.g., see Kleinman & Lin, 1981). Furthermore, school refusal is not a formal diagnosis in either the ICD–10 or the DSM–IV; rather, it is a behavioural problem possibly with underlying 'etic' psychopathology (depression, separation anxiety, phobia, learning disorders and so forth) and socio-environmental factors. In any society, primitive or modern, there are certain forms of teaching activity not run by modern school institutions. Presumably, the same refusal to attend these various forms of 'school' exists, with similar underlying psychiatric and socio-environmental factors. The ways of this refusal and the context of the socio-environmental factors are likely to be 'emic'. For effective management of school refusal, both the underlying potential etic psychopathology and the emic illness behaviour and socio-environmental factors must be carefully examined. This is an alternative example of what I intended to elaborate using the example of koro.

The long-standing debate over etic/emic and semantic issues in cross-cultural psychiatry is unlikely to be satisfactorily resolved in the near future. However, it is believed that the development of standardised clinical interviews with emphasis on cross-cultural equivalence at the level of symptoms (e.g., Cheng *et al*, 2001) helps to avoid the so-called "category fallacy" (Kleinman, 1987).

It should be stressed that the underreporting of psychological symptoms by interviewees from developing nations that I mentioned in my editorial does not mean that these people do not have, or cannot differentiate, emotions. People are people, and the very low rate of reporting of psychological symptoms to doctors by people in developing countries may be due to greater social stigma towards mental illness, their lack of knowledge about mental illness and a much less psychologically oriented medical practice. More studies into this area are needed, and I believe that anthropologically oriented researchers can make a great contribution to this endeavour.

The etic/emic approach to psychopathology does not imply that psychiatry is confined only to biology. The emic pathoplastic shaping and illness behaviour closely associated with different sociocultural settings are equally important in psychiatry and require culture-specific approaches in combination with biological treatment. After all, mental disorders are believed to be the product of gene/environment interaction (Cheng & Cooper, 2001).

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Cross-cultural psychiatric interviews and research instruments

We read Andrew Cheng's (2001) editorial with much interest. We strongly agree that the development of cross-culturally comparable diagnostic interviews is a pressing need.

In a recent survey in our unit in Sri Lanka of 43 patients presenting with depressive disorder, one-third of these on presentation made a subjective complaint of a "burning sensation of the body" (literal translation) and related secondary distress and denied having most of the core depressive symptoms although the symptom manifestation was of a depressive disorder. Thus, finding semantic or psycholinguistic equivalence for psychiatric symptoms across cultures will be a challenging, albeit necessary, exercise.

We believe that the lack of valid diagnostic tools is an important factor in the limited capacity for psychiatric research in developing countries, which in turn contributes to the underrepresentation of such research in high-impact journals noted by Patel & Sumathipala (2001).

A case in point is that in Sri Lanka the only validated psychiatric rating scales in the native languages are the Mini-Mental State Examination (MMSE) and the General Health Questionnaire (GHQ–30). Efforts at validating the Hospital Anxiety and Depression (HAD) scale (D. de Silva, personal communication, 2001) in Sinhala (the language of the majority) show that the sensitivity and specificity of such an instrument is low. This is noteworthy considering the fact that locally developed diagnostic instruments may not find ready acceptance in high-impact journals.

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Mental and physical illness

The editorial by Kendell (2001) independently reflects the view of Baker & Menken (2001) that it is time to abandon the term 'mental illness'. All three authors emphasise that an important reason for so doing is that the term is stigmatising and undermining of the care and treatment of millions of psychiatric (Kendell) and neurological patients (Baker & Menken). Interestingly, Kendell suggests that the term 'psychiatric illness' is more acceptable, whereas Baker & Menken propose instead 'brain illness'. The former seems to replace the mind by the psyche and the latter by the brain.

Like Kendell, I have reviewed the historical processes that have led to the evolution and divergence of psychiatry and neurology as separate disciplines with all the ensuing confusing theoretical and practical uncertainties and complications for professionals and patients alike, including stigma (Reynolds, 1990). Modern neuroscience, which has demonstrated how brain function is profoundly influenced by psychological and social as well as biological factors, has opened the way for resolving some of these uncertainties and divisions. I share the view that one way forward is to build practical bridges between neurology and psychiatry (Reynolds & Trimble, 1989). For example, it does not make sense for neurologists and psychiatrists quite separately to tackle the problem of stigma towards brain and mental illnesses without

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