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Is schizophrenia disappearing?

SIR: Could the fall in rate of diagnosis of schizophrenia be linked with the emergence of child and adolescent psychiatry?

During the time under consideration by Eagles (*Journal*, June 1991, 158, 834–835), there has been a proliferation of what might collectively be called mental health services for children and adolescents. A few were in existence before World War II but following the 1944 Education Act, and generally with the increasing acceptability of such services, there was a vast expansion of child and adolescent psychiatric services, child guidance services, school psychological services, special schools for disturbed children and better psychological care in local authority children's homes. Would these not have had some impact on reducing the incidence of adult mental illness, including schizophrenia?

There were similar increases in such services throughout Europe at much the same time; the USA was always somewhat ahead of Europe.

The emergence of child and adolescent psychiatry has been considered sufficiently important for all candidates sitting the membership exam of the Royal College of Psychiatrists to have to demonstrate some knowledge of child and adolescent psychiatry. It is my experience that this greater awareness of the emotional disorders of young people shown by the majority of psychiatrists has led increasingly to their referral to appropriate services rather than to admission to adult mental hospitals; a regrettable practice that occurred all too often in the past.

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Lateral ventricular size, educational level and patient subtypes in schizophrenia

SIR: Since the first report of lateral ventricular enlargement in schizophrenia, a number of studies have addressed this issue, reporting positive findings in general (for a review see Shelton & Weinberger, 1986).

Differences in the population from which schizophrenics are drawn are widely recognised as possibly affecting neuromorphological findings (Luchins,

1982) and severe and chronic forms of schizophrenia are reported to show greater computerised tomography (CT) abnormalities (Goldberg *et al*, 1988). Educational status also seems to affect neuromorphological measurements obtained through brain imaging techniques (for a discussion see Andreasen, 1988).

In order to see how the choice of patient subtypes and educational level matching could be related to the finding of statistically significant differences in neuromorphological measurements between schizophrenics and healthy subjects, we have compared the mean ventricular brain ratio (VBR) in a controlled magnetic resonance imaging (MRI) study (Rossi *et al*, 1990a) and a subsequent MRI replication study (Rossi *et al*, 1990b).

In the first study, patients and controls were matched for age (within three years) and sex, but not for educational level, whereas patients in the second study were also strictly matched educationally (within one year) with the controls. The first patient group consisted of 39 patients, 33 of whom were relapsing patients with a relatively good outcome, all able to live in the community with out-patient care, and six severe patients who met the operational criteria of Keefe *et al* (1987) for Kraepelin's dementia praecox. The mean VBR for the overall patient group was 5.1; for the Kraepelinian subgroup it was 6.8 and for the relapsing subgroup it was 4.8. The mean age of the 39 patients was 31.23 years (s.d. 7.04) and their mean length of illness was 6.97 years (s.d. 4.69); mean educational levels of patients and controls were 10.51 (s.d. 3.03) and 17.03 (s.d. 2.42) years respectively. The Kraepelinian and relapsing patients had a mean educational level of 10.33 (s.d. 3.32) and 10.54 (s.d. 3.03) years, respectively.

The second patient group was represented only by relapsing patients, living in the community, with a mean age of 26.47 years (s.d. 4.82) and a length of illness of 4.41 years (s.d. 2.50). Their mean educational level was 10.94 (s.d. 4.19) years and that of the matched healthy controls 11.61 (s.d. 3.15) years.

The mean values in the two studies are slightly different but they were conducted with different MRI machines and by different raters, so between-study comparisons cannot be made. The first MRI study shows a statistically significant VBR increase in the overall patient group when compared with controls (two-tailed *t*-test, $t=2.56$, $P<0.01$). When the Kraepelinian patients were excluded, this difference was no more significant, as was the case in the replication MRI study. Nonetheless, the residual VBR difference showed a strong trend towards significance (two-tailed *t*-test, $t=1.89$, $P<0.06$), which might be due to differences in educational level

between relapsing schizophrenics and controls, although we did not address this issue systematically.

The fact that Kraepelinians and relapsing schizophrenics have similar educational levels supports the hypothesis that VBR is related to disease severity.

Because the relapsing schizophrenics in these two studies were diagnostically very similar, sampled from consecutive admissions, matched demographically with their own controls, and differing only in educational level matching, we argued that the lack of such matching, considering educationally advantaged controls, could explain the remaining VBR difference when Kraepelinians are excluded.

We hypothesise that the most severe patients, 15% of our consecutive admission series, may strongly affect neuromorphological outcome and that if these patients are considered separately in statistical analyses, and educational level is matched, most schizophrenics do not seem to share ventricular enlargements, as in our second study.

Because most published studies on CT and MRI in schizophrenia do not provide information about educational level, outcome measures, or level of functioning in the social milieu, we suggest that researchers investigating neuromorphological correlates of schizophrenia should systematically address such issues.

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Abreaction before ECT?

SIR: There is renewed interest in the use of abreactive techniques. Patrick & Howells (1990) call for a careful and controlled reassessment of the use of barbiturate-assisted interviews for therapeutic and diagnostic purposes in psychiatric practice. In a recent report, Ellis (1990) described a case where he used diazepam instead of amylobarbitone, which was difficult to obtain due to export restrictions in the USA, to treat a case of hysterical paralysis. There have even been reports on the successful use of lorazepam intramuscularly in the treatment of psychogenic catatonia (Salam *et al.*, 1987). The common practice of using diazepam for abreactive interviews in India has also been recently highlighted (Adityanjee *et al.*, 1991). The amylobarbitone interview has been widely used in the assessment and treatment of mute and stuporous patients. These patients often do not eat or drink, are unable to accept or are resistive to oral medication, and present an immediate risk to their own health and safety. They are unable to give informed consent and this causes difficulties from a medico-legal point of view.

In practice, as soon as organic causes are excluded, ECT is usually the treatment of choice. As the patient is incapable of giving informed consent, a second opinion is obtained and, in the case of detained patients, this is done via procedures set out in the Mental Health Act, 1983, in England and Wales. When there is a delay and urgent treatment is necessary, ECT is administered under the provisions of Section 62. If the patient is informal, the clinician still obtains a second opinion as a matter of good practice.

In an audit of patients admitted in a stuporous state to a psychiatric department we found that there had hardly been any use of barbiturate- or diazepam-assisted interview. Our contention is that this evaluative and therapeutic procedure should receive more attention than it does at present. Abreactive techniques are likely to reduce the need to rush into giving ECT. However, the lack of clarity in the law relating to investigative procedures in emergency situations where patients are unable to give informed consent may lead to difficulties (Everall, 1987). Clarification of the law may well lead to increased use of this adjunctive measure in the evaluation of inaccessible patients. We are in the process of carrying out a wider survey to study the attitudes, training and possible legal difficulties experienced in the use of this procedure.

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