

Sporadic Pick's disease

SIR: We read with interest the case report by Mowadat *et al* (*Journal*, February 1993, **162**, 259–262) describing a 28-year-old woman diagnosed with Pick's disease after receiving electroconvulsive therapy (ECT) for 'functional psychosis'. We take exception to the assertion that ECT may have caused or worsened her frontal lobe atrophy. It is curious to note that a pre-ECT brain scan was not performed and that the abnormal findings on the post-ECT computerised tomographic scan were attributed to ECT, rather than to her illness alone.

Despite criticisms against it, ECT has remained an exceptionally well tolerated and effective treatment for severe psychiatric illness. In particular, it has been shown to be helpful in patients with severe mood or thought disorders and concurrent neurologic illness (Kellner & Bernstein, 1993). The study by Calloway *et al* (1981) cited by the authors was a retrospective study of post-ECT brain scans in ECT patients. Since pre-ECT scans were not available, Calloway *et al* failed to show causality and they did not control for structural brain abnormalities commonly seen in psychiatric patients. A large study comparing pre- and post-ECT magnetic resonance imaging brain scans failed to show any change in brain volume or structure (Coffrey *et al*, 1991).

ECT has been plagued by unsubstantiated reports of brain damage for many years. We believe this sort of misinformation only serves to perpetuate myths about ECT and may ultimately interfere with proper prescription of ECT for patients for whom it could be lifesaving.

CALLOWAY, S. P., DOLAN, R. J., JACOBY, R. J., *et al* (1981) ECT and cerebral atrophy. *Acta Psychiatrica Scandinavica*, **64**, 443–445.

COFFEY, C. E., WEINER, R. D., DJANG, W. T., *et al* (1991) Brain anatomic effects of electroconvulsive therapy. A Prospective magnetic resonance imaging study. *Archives of General Psychiatry*, **48**, 1013–1021.

KELLNER, C. H. & BERNSTEIN, H. J. (1993) ECT as a treatment for neurologic illness. In *The Clinical Science of Electroconvulsive Therapy*, Vol. 38 (ed. C. Edward Coffey), pp. 183–210. Washington, DC: American Psychiatric Press.

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Importance of stratification by age

SIR: Thomas *et al*'s finding (*Journal*, July 1993, **163**, 91–99), of increased rates of formal admission among only those Afro-Caribbean patients aged 30

years or older, underlines the importance of stratifying by age. May I suggest that future work in this important area takes further into account the influence of socio-demographic and cultural variables *within* ethnic groups?

My own retrospective follow-up study of patients admitted with a hospital diagnosis of schizophrenia found that 42% of patients born in Jamaica (10 out of 24) had an admission under Section 136 of the Mental Health Act compared with none of the 10 patients born in Barbados ($\chi^2 = 4.62$, $P < 0.05$). The heterogeneity of 'Afro-Caribbean' patients needs to be recognised, and inter-island differences should be explored (Glover, 1989).

GLOVER, G. (1989) Differences in psychiatric admission patterns between Caribbeans from different islands. *Social Psychiatry*, **24**, 209–211.

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Long-term antidepressant treatment in the elderly

SIR: In Flint's letter (*Journal*, July 1993, **163**, 126), commenting on the Old Age Depression Interest Group (OADIG) study (*Journal*, February 1993, **162**, 175–182), he writes "There is evidence . . . that elderly persons with a first episode of depression are at the same risk of recurrence, within two years . . . as those with recurrent depression". He would like to know what OADIG found in this regard.

I am pleased to report that we observed no statistical difference in relapse rate between patients with a first depression and those with a recurrence. Contrary to expectation perhaps, there was a non-significant trend for more relapses in the group with a first depression. I therefore wholeheartedly agree with Flint "that *all* patients over the age of 60 years with major depression should continue with treatment for a minimum of two years following recovery".

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Patient's perception of family emotional climate

SIR: We welcome the paper by Lebell *et al* (*Journal*, June 1993, **162**, 751–754), concerning the patient's perception of the family emotional climate and

outcome, because the extent to which the patient's attitude can determine his own outcome needs bringing forward more emphatically.

However, their research requires to be put into perspective. They start their presentation with a quotation from Hooley & Teasdale (1989) that "it is surprising that no study has sought to obtain data directly from patients themselves concerning their perceptions of criticism from family members" (p. 230). They also continue in their paper to say that "Patients' perceptions of their key relatives have only recently been studied, and it now appears that they may also have prognostic significance".

This in fact is not correct. Since the 1970s Scott and his co-workers have published a number of reports on their research into specific factors in the dyadic and triadic relation between schizophrenic patients and their parents which relate to outcome (Scott & Casson, 1970; Scott, 1973; Scott & Alwyn, 1978; Scott *et al.*, *Journal*, July 1993, 163, 62–68). They used the Family Interpersonal Perception Test (FIPT), a self-rating questionnaire containing terms ranging from the very negative and critical (such as emotionally inadequate, interfering), to the very positive (such as secure, self-confident). The FIPT is scored by the patient and parents at the same session. They score how they see themselves, how they see each other, and how they expect to be seen by each of the others. From the scoring, factors were identified which have a well defined relation to outcome.

It is interesting that the essential findings from the research of Scott *et al.* and Lebell *et al.* have much in common. In both a poor outcome is associated with the patient expecting a negative view from their relative(s), and with the relative(s) taking a negative view of the patient. In both there is a correlation between how the relative sees the patient and how the patient thinks he/she is seen (indicating that the patient has an accurate awareness of the relation), although in Scott *et al.*'s studies this is so only for poor-outcome patients. Thus both groups of researchers give the patient a key role in influencing his/her own outcome, with the patient's scoring predicting it better than that of his/her parents (Scott *et al.*, *Journal*, July 1993, 163, 62–68).

HOOLEY, J. M. & TEASDALE, J. D. (1989) Predictors of relapse in unipolar depressives: expressed emotion, marital distress, and perceived criticism. *Journal of Abnormal Psychology*, 94, 229–235.

SCOTT, R. D. (1973) The treatment barrier: part 2. The patient as an unrecognised agent. *British Journal of Medical Psychology*, 46, 57–67.

— & CASSON, P. D. (1970) Violation of parental role structure and outcome in schizophrenia. A scored analysis of the parent-patient relationship. *Social Science and Medicine*, 4, 41–64.

— & ALWYN, S. (1978) Patient-parent relationships and the course and outcome of schizophrenia. *British Journal of Medical Psychology*, 51, 343–355.

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Down's syndrome, dementia, and superoxide dismutase

SIR: Drs Dickinson & Singh (*Journal*, June 1993, 162, 811–817) discuss the possible relationship between cognitive decline and raised mean cell volume (MCV) in people with Down's syndrome (DS). We recently investigated 92 people with DS (Mean age 44.2 years, range 19–72, s.d. 12.3) for an ICD-10 psychiatric diagnosis for dementia in Alzheimer's disease with early onset and for a diagnosis of a depressive episode. All cases were investigated for raised MCV (> 98 fl, normal range 80–98 fl).

For an association between raised MCV and clinical dementia to be valid, the changes in MCV must be due to increasing age *per se*. For our sample, no statistically significant association was found for these two parameters (Pearson's coefficient = 0.448).

Twenty-two subjects (mean age 54.0 years, range 42–72, s.d. 8.09) fulfilled ICD-10 criteria for dementia. A statistically significant association, using χ^2 tests, between the diagnosis of clinical dementia and a raised MCV was found ($P=0.01$). Two patients fulfilled ICD-10 criteria for depression, but neither had raised MCV values.

We support previous findings (Lansdall Welfare & Hewitt, *Journal*, April 1986, 148, 482–483) of an association between intellectual deterioration in people with DS and macrocytosis, and tentatively rule out that changes in MCV are secondary to mental illness *per se*.

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Home-based acute psychiatric services

SIR: I read with interest the two papers by Burns *et al.* (*Journal*, July 1993, 163, 49–54, 55–61) on a controlled trial of home-based acute psychiatric services.