Finally, Dr Paulley is right in his assertion that the concept of somatisation has not helped a single patient to get better. Perhaps he can be reassured by the observation that no descriptive diagnosis in the entire field of medicine has ever been particularly useful by itself, but rather because the identification of consistent patterns in terms of symptom profiles and longitudinal course has eventually led to a more comprehensive understanding of the biological and psychological mechanisms that lie behind the disorder, and these in turn to better treatment. What I believe we (and others) have shown is that a relatively rare chronic psychiatric disorder has its origins in one of the most common processes by which emotional turmoil is experienced and expressed in primary care.

Our study has provided tentative evidence for a single spectrum of somatisation in primary and secondary health care and, I believe, strengthens the arguments for attempts to improve detection and management of psychiatric disorder that presents as somatic illness in primary care.

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Declining incidence of schizophrenia

SIR: Geddes *et al* (*BJP*, November 1993, **163,** 620–626) report that the incidence of first admissions for schizophrenia to Scottish hospitals has declined over the period 1969–88. They found no evidence that changes in diagnostic practices were responsible for this decrease.

One diagnosis they did not report was that of drug-induced psychosis. In a study carried out in Dundee looking at the co-morbidity of psychosis and drug abuse (in preparation), 100 patients consecutively admitted during 1992 with psychotic symptoms were studied. For half of these patients, a diagnosis of schizophrenia (ICD–9 295) was recorded, and for 13% a diagnosis of drug-induced psychosis (ICD–9 292). Of the patients diagnosed as suffering from schizophrenia, 12% had been given a previous diagnosis of drug-induced psychosis. An increase in the diagnosis of drug-induced psychosis could account for an apparent reduction in first-admission rates for schizophrenia.

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AUTHORS' REPLY: For the sake of brevity and comparability with previous studies, we presented the age-standardised rates (ASRs) for only selected diagnoses. We are pleased to be able to give rates of first admission to Scottish hospitals over the period 1969–88 with a diagnosis of drug-induced psychosis (ICD–9 292). Because of changes in the ICD, reliable data from the Information and Statistics Division (ISD) for this diagnosis are only available since 1975. As before, we calculated ASRs using the direct method with 1969 mid-year population estimates for Scotland as the standard population. Regression lines were fitted to the logarithms of the rates. The ASR for males in 1975 was 0.4/100 000 and in 1988 was 0.7/100 000 (% annual average change: +6.0%, 95% confidence intervals +1.5% to +10.5%, $P=0.02$). In females, the 1975 ASR was 0.4/100 000) and in 1988 was 0.8/100 000 (% annual average change +0.3%, 95% confidence intervals −0.5% to +5.6%, $P=0.92$). Therefore, although there had been an increase in male first admissions with drug-induced psychosis, the numbers involved are insufficient to explain the decline in schizophrenia.

We also examined rates for personality disorder (ICD–9 301), because an increase in this initial diagnosis also could explain the apparent decline in the rates of schizophrenia. The ASR for males in 1969 was 11.8/100 000 and in 1988 was 4.8/100 000 (% annual average change: −7.0%, 95% confidence intervals −8.2% to −5.8%, $P<0.0001$). In females, the 1969 ASR was 10.2/100 000 and in 1988 was 3.8/100 000 (% annual average change −7.0%, 95% confidence intervals −8.5% to −5.5%, $P<0.0001$).

Kendell *et al* (1993) have pointed out that the argument that a change in diagnostic practice in relation to schizophrenia would result in a reciprocal increase in other diagnoses rests on the assumption that subjects with other diagnoses continue to be as likely to be admitted hospital in 1988 as in 1969. This assumption may not be valid, especially for personality disorders. However, Eagles *et al* (1988) studied all *first contacts* with psychiatric services in north-east Scotland, and still failed to find an increase in other diagnoses which could explain the decline in rates for schizophrenia.

Kendell *et al* (1993) also found that 28% of subjects classified as first admissions by the Lothian Psychiatric Case Register in 1989 had been admitted previously and were therefore misclassified. The ISD data on which our study was based is episode based and is therefore potentially even more vulnerable to misclassification. An improvement in the accuracy of recording over the last 20 years could explain the apparent decline in first admissions for

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schizophrenia. We examined this possibility by performing a record linkage (Kendrick & Clark, 1993) within the ISD database in order to identify subjects who were recorded as first admissions but had been admitted previously. The proportion of subjects correctly classified as first admissions in 1971 was 62.4% and in 1988 was 79.9%. Therefore, misclassification is present and it was worse in the earlier years. The ASR for each year between 1969 and 1988 was corrected for this misclassification and the secular trend was reanalysed. The ASR for males in 1969 was 13.6/100 000 and in 1988 was 6.7/100 000 (% annual average change: −3.0%, 95% confidence intervals −4.0% to −2.0%, $P<0.0001$). In females the 1969 ASR was 10.4/100 000 and in 1988 was 3.8/100 000 (% annual average change −4.2%, 95% confidence intervals −5.2% to −3.2%, $P<0.0001$). Comparing these figures with the unadjusted estimates given in the paper, we conclude that the observed decline is not an artefact produced by this misclassification.

The decline in the diagnosis of schizophrenia in Scotland over the last two decades is not adequately explained by changes in the age structure of the population, diagnostic practice, treatment setting, or misclassification of first admissions. It remains difficult to dismiss a genuine decline in incidence.

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Maintenance therapy for schizophreniform disorder

SIR: Schooler (*BJP*, December 1993, **163** (suppl. 22), 58–65) illustrates the increasing research evidence in support of planning maintenance treatment after an acute episode of schizophrenia. In contrast, there is little guidance available for maintenance treatment of schizophreniform disorder (DSM–III–R), in which all symptoms of the episode must resolve within six months. Although Procci (1989) recommends withdrawing medication after an acute episode, he notes the absence of supporting data.

Schizophreniform disorder is common and has a poor prognosis. Coryell & Tsuang (1982) found that 93 out of 510 patients discharged with a diagnosis of schizophrenia could be retrospectively diagnosed as having schizophreniform disorder. Opjordsmoen (1991) found 56% of patients with a diagnosis of schizophreniform disorder proceeded to schizophrenia within 10 years. Both studies found only one-third of schizophreniform patients with a good outcome at long-term follow-up.

Such findings lead one to ask whether continuation therapy after a schizophreniform episode would reduce relapse, and whether maintenance therapy would reduce recurrence or development into schizophrenia. This hypothesis may be supported by Crow *et al* (1986), who found that the poorest relapse rates during maintenance therapy in schizophrenia occurred in those patients with a longer delay between onset and treatment.

In practice, patients with schizophreniform disorder may well receive maintenance therapy. Marengo *et al* (1991) found 50% of their sample receiving neuroleptic medication at two-year follow-up, and 44% after four years. Whereas Schooler's review reminds us of the rationale for such an approach in schizophrenia, we are unaware of any findings which answer this important question in schizophreniform disorder.

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Onset of the antidepressant effect of ECT

SIR: Scott & Whalley (*BJP*, June 1993, **162**, 725–732) explore a poorly researched area in electroconvulsive therapy (ECT). We would like to add two points to their discussion.

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