sample quoted, it is obvious that the patients tested had a longstanding illness, and that lithium had substantially reduced their relapses. This, by itself, is a sign that they were good compliance subjects, and brings into question the generalisability of the findings to poorly compliant patients: in particular that lithium leads to better compliance and therefore fewer relapses.

Secondly, as regards the method, it seems that the authors did not control for input of time. The education group had an educational-video presentation while the control group had nothing. This weakens the results of the study further, as it could be argued that any video presentation on a subject of mental health could have an effect on the patients' attitudes in itself.

We would like to draw attention to the fact that, while using the lithium knowledge test (LKT) repeatedly during this study, no account seems to have been taken of practice effect. I would have been interested to have seen the questionnaires themselves as well as their reliability and validation data.

Finally, we felt it would be of great use to see if the long-term effects of the study improved compliance and safety, and reduced relapse. This would require a longer follow-up than the 24 weeks of this study.

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AUTHORS' REPLY: We thank Drs Douzenis & Brener for their interest in our work, concerning which they raise a number of points of method and interpretation.

The primary finding of our study was that the lithium information package led to a substantial improvement in patient knowledge about their treatment, which was sustained over 24 week follow-up. It is difficult to understand what Drs Douzenis & Brener mean by their statement that our study took no account of practice effects with the lithium knowledge test (LKT), when a control group was used to take such effects into account.

With regard to the effect of the educational programme on attitudes towards lithium, we state quite clearly in our article that improved attitude was not mainly due to the information programme, but that other factors in the study probably contributed. The point we make is simply that attitude to lithium was not harmed by a research programme in which information was presented about its adverse effects and, in fact, there was a modest improvement in attitude.

The patients attending our lithium clinic were all at different stages of treatment, not always of prolonged duration. In our experience, the mix of patients is typical of that found in lithium clinics elsewhere in the country. It is, therefore, likely that our findings are generalisable to other lithium clinic populations. We plan, with the help of sponsorship, to make the full educational programme widely available so that others can see for themselves.

The patients were not selected by us as 'good compliance' subjects, and we have examined self-selection in the two years up to the study. Eighteen patients left the clinic in that time. They were of comparable age and sex, and the mean durations of their illnesses and remissions were similar to those for patients still attending. Their reasons for leaving appear to relate to social mobility, physical illness or old age. Those remaining, on entering the education programme, showed attitudes on the lithium attitudes questionnaire (LAQ) suggesting doubtful compliance. As many as 45% expressed opposition to continuing with their lithium treatment.

Finally, the question of whether compliance would be improved, and relapse rate reduced, over the long term, as a result of proper education, remains to be answered. Our study was not designed to address this issue. Unfortunately, it would not be possible to perform such a study using a parallel control group, because of the ethical problems of purposely leaving a large group of patients relatively uninformed about their treatment. In our own case, long-term follow-up of patients has been handicapped by the dispersal of patients from the Lithium Clinic, due to the introduction of sector-related services in Sheffield.

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Computerised tomography in schizophrenia

SIR: Thank you for asking me to reply to Dr Miller's letter (*Journal*, June 1991, **158**, 863). "Unnecessarily dogmatic" I happily accept: "probably wrong" I think is unlikely. Nonetheless, Dr Miller raises an important issue. The realisation that the minor structural brain abnormalities seen in some schizophrenic patients might be non-progressive has been important in the conceptual shift from schizophrenia being a neurodegenerative disorder, to a neurodevelopmental view. To my eyes, the weight of evidence does not allow us to reject the null hypothesis that there is no progressive enlargement of

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