LEFF, J. (1988) *Psychiatry Around the Globe* (2nd edn). London: Gaskell.

PERERA, R., OWENS, D. G. C. & JOHNSTONE, E. C. (1991) VIII. Ethnic aspects: a comparison of three matched groups. *British Journal of Psychiatry*, **159** (suppl. 13), 40–42.

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SIR: The recent paper by Dr Birchwood *et al* (*Journal*, December 1992, **161**, 783–790) purported to show a better outcome for Asians with schizophrenia, as compared with white and Afro-Caribbean patients. They examined rates of hospital readmission in the year following discharge for patients known to have remained resident within the area, and found these rates to be 3 out of 19 for Asians, 17 out of 35 for Afro-Caribbeans, and 14 out of 47 for whites. They then proceeded to do a 3 by 2 χ^2 test, which was statistically significant, and reached the conclusion that this showed Asian patients to have a better outcome.

The significant χ^2 test, however, does not indicate this at all; merely that there was a significant difference between the three groups. Indeed, if one carries out a 2 by 2 χ^2 test comparing Asian patients with Afro-Caribbeans and whites combined, there is no significant difference between these groups. On the other hand, if one compares Afro-Caribbeans with Asians and whites combined, there is a significant difference between the groups ($\chi^2 = 4.36$, $P < 0.05$).

Therefore, the most sensible conclusion from the data would be that Afro-Caribbean patients show a poorer prognosis than do the other two ethnic groups. Given that the Afro-Caribbeans in this study were less likely to be discharged to live with their families, the finding does not refute the authors' contention that social reintegration may be a protective factor in the prognosis of schizophrenia. However, as with the higher rates of unemployment among the Afro-Caribbeans at follow-up, the absence of social reintegration may be a result rather than a cause of continuing schizophrenic symptoms.

While the authors do not, in my view, reach the right conclusions from their data, and while the great majority of the paper relates to possible psychosocial influences upon outcome, it is heartening that they acknowledge the possibility that there may be genuine differences in the severity of schizophrenia between different ethnic groups.

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AUTHORS' REPLY: Our study of the early course of schizophrenia among patients from the Indian subcontinent living in the UK replicates closely the results of Dr Gupta (1991) (whose study appeared after our paper entered the review process) in finding a lower rate of relapse readmission compared to other groups. As we were at pains to point out in our paper, we offered our study as exploratory and hypothesis-generating; thus we have no difficulty in suggesting that the results may be accounted for by service underuse ('the camouflaging hypothesis'), or by differences in progression of illness before first contact influencing subsequent relapse risk. Similarly, the size of the sample studied leads us to conclude that we shall have to double our sample size of Asian patients to at least 40 to test the hypothesis in a prospective study. Such a study must be epidemiologically based; centre-based matched samples could distort any effects as Dr Perera indicates.

Dr Perera observes rightly that immigrants tend to be at greater risk for serious mental disorder than indigenous groups, thus complicating the testing of differential course and outcome hypotheses. However, we would be predicting a more *favourable* outcome among Asian groups, and not a worse one as might be expected if factors raising morbidity were at play in prognosis. What is of interest to us are the *correlates* of ethnicity rather than any 'endogenous' differences to which Dr Eagles refers, although such a possibility cannot be discounted.

The recent report from the WHO's two-year follow-up of schizophrenic patients taking part in the ten-country first-contact study (Jablensky *et al*, 1992) confirms previous findings that the early course of schizophrenia in developed countries is markedly inferior to those living in the less industrialised nations: in spite of greater use of neuroleptic medication and better service infrastructure. Mode of onset, gender, illicit drug use, and clinical presentation could not account for this effect. These findings suggest that the concept of schizophrenia as the manifestation of an entirely malignant process is incomplete. We agree with the views of Dr Gupta that a study of Asian patients in the UK has important implications for public health and policy, but it also presents researchers in the UK with important opportunities for research on these issues.

GUPTA, S. (1991) Psychosis in migrants from the Indian subcontinent and English-born controls. A preliminary study on the use of psychiatric services. *British Journal of Psychiatry*, **159**, 222–225.

https://doi.org/10.1192/S0007125000181115 Published online by Cambridge University Press

JABLENSKY, A., SARTORIUS, N., ERNBERG, G., *et al* (1992) Schizophrenia: manifestations, incidence and course in different cultures. *Psychological Medicine* (Monograph), suppl. 20.

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Decline in the incidence of schizophrenia

SIR: Kendell *et al* (*Journal*, February 1993, **162**, 212–218) make a spirited attempt to explain away their findings of a decline in the incidence of schizophrenia in Edinburgh between 1971 and 1989. Adjustment for out-patients and "delayed diagnoses attributed to year of diagnosis" (their Table 2) altered the trends for men, but women still showed a 35% decline in incidence over the period under study. Futhermore, the authors report evidence of a change in diagnostic habit between 1971 and 1989 for men and early-onset cases, but state that a similar effect was not seen for women and later-onset cases.

Thus, it appears the case for the decline in rates being spurious does not hold up, for women at least. It is of interest that in Ireland, Waddington & Youssef (1992) found the relative risk of schizophrenia for persons born between 1940 and 1969, compared with those born between 1920 and 1939, to be 0.63, and that this effect was significant only for women and later-onset cases. It is also intriguing that in an analysis of the "schizophrenogenic effect" of the 1957 influenza epidemic, O'Callaghan *et al* (1991), using data from England and Wales, and Mednick *et al* (1990), in a reanalysis of Scottish data, found the effect to be confined to women. Such findings should reinforce, to schizophrenia researchers, that the disease affects men and women differently, and that consideration of such differences could provide useful clues to the aetiology of the condition (Castle & Murray, 1991).

CASTLE, D. J. & MURRAY, R. M. (1991) The neurodevelopmental basis of sex differences in schizophrenia. *Psychological Medicine*, **21**, 565–575.

MEDNICK, S. A., MACHON, R. A., HUTTENEN, M. O., *et al* (1990) Influenza and schizophrenia. *Archives of General Psychiatry*, **47**, 875–877.

O'CALLAGHAN, E., SHAM, P. C., TAKEI, N., *et al* (1991) Schizophrenia after prenatal exposure to 1957 A2 influenza epidemic. *Lancet*, **337**, 1248–1250.

WADDINGTON, J. L. & YOUSSEF, H. A. (1992) The declining incidence of schizophrenia in a rural Irish population of unusual homogeneity: secular trends towards early-onset and male preponderance. *Schizophrenia Research*, **6**, 101.

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Resource implications of Munchausen's syndrome

SIR: The report by Drs Powell & Boast (*Journal*, February 1993, **162**, 253–256) describes a man with Munchausen's syndrome and the resource implications of his case. I would like to comment on their proposed treatment using the provisions of the Mental Health Act 1983.

Firstly, he may not be legally detainable. Even if it is accepted that he is suffering from psychopathic disorder, as defined in the Act, it is arguable whether detention is necessary, either for his health and safety, or for the protection of others (as described, the main threat he poses to others is the squandering of public funds). Neither is it clear that treatment is likely to alleviate his condition or prevent a deterioration. They describe his condition as "treatment-resistant", and an aggregated three years of psychiatric admission seems to have conferred no benefit.

Their ethical justification for detention is that his behaviour is "not volitional" and so requires a paternalistic approach. It seems from their article that this behaviour is deliberate and purposeful. The lifestyle adopted by Munchausen patients, while not one that would appeal to most professional commentators, does have obvious rewards – accommodation, company, and status enhancing professional attention etc. – which make it likely to be a matter of choice.

Ultimately, their justification for detention is that by treating this man his quality of life would be improved and he would present less of a strain on public resources. The rationale for what they admit is a speculative treatment programme of coping skills, social skills, training, and education can be seen; but there is scant empirical evidence that such a programme is likely to change his behaviour. Furthermore, to benefit from such a programme he would need to actively participate, and it is difficult to see the place that legal compulsion can play.

The authors quantify the financial costs of his behaviour to date, but do not estimate the costs of their proposed treatment. It would seem that there is a danger of concentrating the financial burden which this man represents within one area and, by having continuous rather than intermittent hospitalisation for an indefinite period, possibly increasing the

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