

the study by Katona & Roth (1985), cited by Dr Kumar, also reports, in the authors' own words, 'an increased frequency of HPA axis abnormality' in schizoaffective depression.

We agree that our study would have been more complete if we had measured the adrenal gland size. Indeed, measuring hormonal levels would have been an important addition to the study. We will take this advice into consideration in our future studies.

Finally, we support Dr Kumar's view that hyperactivity of the HPA axis occurs in a large number of conditions associated with stress. Indeed, we suggested in our paper that glucocorticoid resistance could be the molecular mechanism by which stress induces HPA axis hyperactivity in patients with different mental disorders (see Discussion, p. 8). We never suggested that this biological abnormality could have any diagnostic value. However, we believe that measuring specific biological markers can give us further insight into the pathological mechanisms affecting the brains (and the bodies) of our patients.

**Banki, C. M., Bissette, G., Arato, M., et al (1987)** CSF corticotropin-releasing factor-like immunoreactivity in depression and schizophrenia. *American Journal of Psychiatry*, **144**, 873–877.

**Brooks, B. S., el Gammal, T., Allison, J. D., et al (1989)** Frequency and variation of the posterior pituitary bright signal on MR images. *American Journal of Neuroradiology*, **10**, 943–948.

**Herz, M. I., Fava, G. A., Molnar, G., et al (1985)** The dexamethasone suppression test in newly hospitalised schizophrenic patients. *American Journal of Psychiatry*, **142**, 127–129.

**Ismail, K., Murray, R. M., Wheeler, M. J., et al (1998)** The dexamethasone suppression test in schizophrenia. *Psychological Medicine*, **28**, 311–317.

**Katona, C. L. & Roth, M. (1985)** The dexamethasone suppression test in schizo-affective depression. *Journal of Affective Disorders*, **8**, 107–112.

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**Pariante, C. M., Vassilopoulou, K., Velakoulis, D., et al (2004)** Pituitary volume in psychosis. *British Journal of Psychiatry*, **185**, 5–10.

**Sachar, E. J., Kanter, S. S., Buie, D., et al (1970)** Psychoendocrinology of ego disintegration. *American Journal of Psychiatry*, **126**, 1067–1078.

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### CBT for psychosis

Although the study by Tarrier *et al* (2004) appears to be methodologically more rigorous than the similar study of cognitive-behavioural therapy (CBT) in post-acute schizophrenia by Turkington *et al* (2002), I am a little confused by the authors' conclusions. After clearly demonstrating no superior effect for CBT over supportive counselling on measures of symptom reduction and relapse rates, the authors conclude their paper by stating that they 'suggest that the optimum psychosocial management of early schizophrenia would include a combination of CBT and family intervention'. Would it be rude to suggest that the authors take into account their own findings before making such a statement? It is also more than a little irritating that the authors refer to their sample as being diagnosed with 'early schizophrenia' throughout the paper. Examining the inclusion criteria for this study shows that patients were included who had schizophreniform disorders, delusional disorders and unspecified psychoses. Regarding the criterion for 'early', most clinicians would define the duration of schizophrenia from symptom onset to commencement of treatment (hence the concept of the duration of untreated psychosis). Unless the authors specify illness duration, the criterion of 'early' cannot be asserted. Thus, this appears to be a study of patients within 2 years of their first episode of non-affective psychoses and not those with early schizophrenia *per se*.

**Tarrier, N., Lewis, S., Haddock, G., et al (2004)** Cognitive-behavioural therapy in first-episode and early schizophrenia: 18-month follow-up of a randomised controlled trial. *British Journal of Psychiatry*, **184**, 231–239.

**Turkington, D., Kingdon, D. & Turner, T. (2002)** Effectiveness of a brief cognitive-behavioural intervention in the treatment of schizophrenia. *British Journal of Psychiatry*, **180**, 523–527.

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**Authors' reply:** Dr Mitchell professes both confusion and irritation at our report of the follow-up results of the SoCRATES study. I will attempt to clarify. When implemented with standard care, CBT has consistently been found to result in clinical benefits in terms of symptom relief compared with standard care alone. This has been found in post-acute illness, as with

the reported study, and chronic phases (Pilling *et al*, 2002). Cognitive-behavioural therapy is a structured psychological treatment usually implemented from a manual, which makes it relatively amenable to 'roll-out'; CBT has less impact on relapse rates. Family interventions have been shown to have the benefit of significantly reducing relapse rates (Pilling *et al*, 2002). Thus, combining both CBT and family interventions would appear to be the most parsimonious way of capitalising on these developments to improve patient care by reducing symptoms of psychosis and reducing risk of subsequent relapse. In addition, both service users and carers have been increasingly vocal in wishing a greater range of interventions to be made available, including both psychological treatments and assistance for families. It is regrettable that Dr Mitchell's comments implicitly appear to wish to deny them these further options. With respect to his comment on our inclusion criteria for the trial, a first episode of psychosis resulting in treatment by mental health services is an event that can be identified with reasonable accuracy (at least, much more accurately than emergence of symptoms prior to this). As 80% of study participants had first-episode illness using this criterion, the use of the term 'recent onset' is not unreasonable. The inclusion of those suffering from schizophreniform psychosis, delusional disorders and unspecified psychosis reflects clinical practice and conforms to convention on large pragmatic clinical trials in having broad inclusion criteria to aid generalisation (see Johnson, 1998).

**Johnson, T. (1998)** Clinical trials in psychiatry: background and statistical perspective. *Statistical Methods in Medical Research*, **7**, 209–234.

**Pilling, S., Bebbington, P., Kuipers, E., et al (2002)** Psychological treatments in schizophrenia: I. Meta-analysis of family interventions and cognitive behaviour therapy. *Psychological Medicine*, **32**, 763–782.

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### Depression intervention in resource-poor regions

Depression is recognised as a common problem in developing countries and it is one of the most important causes of morbidity and mortality (Patel *et al*, 2001). Lack of

trained personnel and the scarcity of newer antidepressants in the public sector makes the use of evidence-based treatment methods impractical in developing countries. However, as Dr Crawford (2004) points out, this does not mean that the likelihood of recovery from depression is worse than in resource-rich regions.

Even though there is limited access to specialised mental health services and newer antidepressant medication, many developing countries have evolved innovative techniques to overcome these apparent hurdles (Swartz & Rollman, 2003). The majority of patients are treated effectively using older and cheaper antidepressants. Electroconvulsive therapy is used widely in a more liberal manner than in the West; one reason being the need for a quick cure to decrease the patient load, which is far greater than the number of beds available. Cognitive-behavioural therapy is an affordable form of psychotherapy that is used. Even in the absence of formal psychological interventions, the closely knit extended families and networks of friends provide supportive therapy in an informal manner.

In addition, the available primary health care facilities are used in an effective manner to combat the difficulties created by inadequate resources. One such example is the Chinese model of village health workers functioning at a local level to identify patients in need and referring to medical personnel in local clinics (Swartz & Rollman, 2003).

In Iran the concept of health houses has been reported, where local inhabitants are screened for mental and physical illnesses by health workers, and patients presenting with more complex problems are referred

on for more intensive care (Swartz & Rollman, 2003).

These models employed in some developing countries in response to the scarcity of resources should be commended. Instead of letting what we do not have incapacitate us, it is time we made use of our existing resources to provide better care for people with mental illnesses.

**Crawford, M. J. (2004)** Depression: international intervention for a global problem. *British Journal of Psychiatry*, **184**, 379–380.

**Patel, V., Abas, M., Broadhead, J., et al (2001)** Depression in developing countries: lessons from Zimbabwe. *BMJ*, **322**, 482–484.

**Swartz, H. A. & Rollman, B. L. (2003)** Managing the global burden of depression: lessons from the developing world. *World Psychiatry*, **2**, 162–163.

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### ADHD in developing countries

It is with much interest that we read the editorial on attention-deficit hyperactivity disorder (ADHD) by Paul McArdle (2004). The argument regarding culture and ADHD was of particular interest to us.

ADHD is a condition that was unheard of in developing countries a few decades ago. However, clinicians now see it in increasing numbers. It was assumed that the extended families seen in developing countries act as a protective factor against psychiatric illness in childhood (Nikapotha, 1991). The low prevalence of ADHD in developing countries was attributed to this. Many hypothesise that the increase in ADHD seen now is caused

by the breakdown of the family network resulting from Western influences and urbanisation.

However, it is debatable whether this is a genuine increase in prevalence or merely a perceived increase as more cases of ADHD are detected than before. We suggest that the breakdown of the family network may be one of the causative factors for this perceived increase. In developing countries with extended and closely knit families the burden of childcare was shared among many family members. With the breakdown of this structure the responsibility of childcare falls solely on the parents. This situation is made worse by both parents having to work to meet the financial demands of a family. All these factors may contribute to a low level of tolerance. Parents who are unable to tolerate difficult behaviour may seek help from medical professionals.

A decade ago difficult behaviour was not perceived as requiring help or treatment from medical professionals but rather as a situation requiring advice or discipline from family elders and community leaders (Nikapotha, 1991). This too has now changed because of increased awareness that difficult behaviour can be caused by psychiatric conditions.

**McArdle, P. (2004)** Attention-deficit hyperactivity disorder and life-span development. *British Journal of Psychiatry*, **184**, 468–469.

**Nikapotha, A. D. (1991)** Child psychiatry in developing countries. *British Journal of Psychiatry*, **158**, 743–751.

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## One hundred years ago

### Clinical notes and cases

*Clinical and Pathological Notes.* – II. By Dr. M. J. NOLAN, Resident Medical Superintendent, Down District Asylum, Downpatrick.

CASE 5. *Microcephalic idiocy; epilepsy; cerebral asymmetry; microgyria; ulegyria;*

*scalp suggestive of atavism.* – H. C. –, æt. 41 years, admitted to asylum from a workhouse August 4th 1902; died of epilepsy December 22nd, 1902. No previous history obtained.

His physical appearance would have rejoiced the heart of an evolutionist, as *prima facie* he was a perfect specimen of the

Simian type. His dwarfed figure was bent forwards; his coarse grinning face seemed to protrude from between the misshapen spreading ears. The small receding skull was encased in an ill-fitting scalp, on which the rough black hair grew in ridges. He progressed by means of a side shuffle, preserving his equilibrium by spreading out