I take the last point concerning the age-distribution of the patient groups in the study by Dr. Griffiths and myself. Gregory (1958) pointed out that because of improved mortality rates younger individuals nowadays are much less liable to experience the death of a parent. In our series there may be a slight tendency to underestimate the significance of parent-loss among the schizophrenics, who are probably younger on average than the control individuals. This would not apply to the affective disorders, in which the age distribution would be relatively similar to that of the controls.

This field is bedevilled by conflicting results, failure to make adequate definitions, and a tendency to rush into hasty conclusions, of which we are all guilty. Many of our difficulties are semantic, and I regret that, in my opinion, Dr. Birtchnell's letter has increased rather than decreased such difficulties.

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REFERENCES

BIRTCHNELL, J. (1970). *Brit. J. Psychiat.*, 116, 299–306.
BROWN, F., and EPPS, P. (1966). *Brit. J. Psychiat.*, 112, 1043.
GREGORY, I. (1958). *Amer. J. Psychiat.*, 115, 432.
MUNRO, A. (1965). *Brit. J. prev. soc. Med.*, 19, 69.
—— (1966). *Brit. J. Psychiat.*, 112, 443.
—— (1969). *App. soc. Stud.*, 1, 81.
—— (1969). *Int. Ment. Hlth., Research Newsletter*, 2, 10.
—— and GRIFFITHS, A. B. (1968). *Acta psychiat. Scand.*, 44, 385.

UNILATERAL AND BILATERAL ECT

DEAR SIR,

My apologies to Drs. Sutherland *et al.*, for my inexcusable error in reading their paper (*Journal*, September 1969, pages 1059 to 1064). Unfortunately their letter (*Journal*, January 1970, p. 126) does not answer the points which I raised. Perhaps I could elaborate upon these.

1. One cannot be satisfied that they were in a position to make any statements about the relief of depression, since this was not assessed in their trial. The number of ECTs given is surely not a reliable indication of response to treatment, particularly as several different psychiatrists were involved in deciding what this would be for any particular patient. We all differ in our ways of deciding when a patient has had enough ECT and what constitutes 'an adequate course of treatment'. A therapeutic trial should attempt to minimize this personal and idiosyncratic judgement.

2. They do not tell us how double-blind assessments of such variables as 'time taken to breathe spontaneously' were made. I take this to mean that the observer was not in the room at the time when the shock was given, and that he was informed of the exact time when this had occurred. Since the time intervals involved were relatively short, fairly elaborate arrangements would be needed to avoid any bias on the part of the person administering treatment. One can think of various ways in which this could be done, but the paper does not describe the method adopted. It is also extremely difficult to make a very definite decision about the beginning of spontaneous respiration, since many patients start off with small and almost imperceptible inspirations.

3. I wonder what led the writers to conclude that the EEG assessor was able to guess correctly the method of treatment any more frequently than would be accounted for by chance? Table III shows that the allocation was correct in only 10 of 19 bilateral cases and 11 out of 18 unilateral non-dominant cases. Admittedly the assessor did rather better on the dominant cases (14 out of 22), but I find it difficult to see how these figures could yield a value of $p = \cdot 00003$. Could the writer enlighten us on the statistical procedure employed?

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AMPHETAMINE TAKING AMONG YOUNG OFFENDERS

DEAR SIR,

We were interested to read Drs. Cockett and Marks' article (*Journal*, October 1969, pp. 1203–4). Our interest in this subject was also aroused by Scott and Wilcox' study (1965), and for the past twelve months we have been screening the urine of all boys aged 14–16 admitted to Rose Hill Remand Home, Manchester. Rose Hill receives boys mainly from the Cities and County Boroughs in Lancashire, including Manchester, Salford, Bury, Bolton, Blackburn, Oldham, Preston and Warrington. Many of these places have the sort of clubs which are associated with drug-taking.

Method. Urine was collected from each boy as soon as possible after admission to the remand home. Younger boys in whom drug taking was suspected were also tested. Samples were screened by the method of Mellon and Stiven (1967). Those showing spots in the area Rf 0·70–0·95 were further investigated, in duplicate, by the method of Beckett *et al.* (1967), one extract being run in butanol/acetic acid/water (5 : 4 : 1), the other in isopropanol/5 per cent ammonia (10 : 1). Spots were developed with 0·5 per cent methanolic bromo-cresol green. Coincidence of spots on each system with those of control urines con-