

We are rather concerned that five of the patients kept in hospital over the Christmas period were there mainly because of the low levels of staffing of social services and community psychiatric services at Christmas. Although ideally everybody would like time off work to be with their families at this time of year, can the skeleton services provided currently be ethically justified in the light of the figures from our census?

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'Vital exhaustion' and myocardial infarction

SIR: Appels (*Journal*, April 1990, 156, 465–471) draws attention to the mental precursors of myocardial infarction. We would like to add the findings of our recent study of 50 Indian patients with acute myocardial infarction and 50 age- and sex-matched healthy controls. The frequency and intensity of type-A behaviour, life events occurring during the period of one year preceding myocardial infarction and the levels of anxiety and depression following myocardial infarction were studied.

According to Jenkins activity survey (form C; Jenkins *et al*, 1979), type-A behaviour was detected in 72% of patients as compared with 18% of the control group. With regard to different components of type-A behaviour, type A and factor S (measuring speed and impatience) were significantly higher in the study group, while factors J (measuring job involvement) and H (measuring hard driving and competitiveness) did not differ significantly between the two groups. The patients also had significantly greater mean frequency of stress scores on the Presumptive Stressful Life Events Scale (Singh *et al*, 1983) which measures both total life events and subgroups of this – the desirable, undesirable, personal, impersonal and ambiguous life events.

The stressful life events which discriminated the patients from controls were (in decreasing significance): marital conflicts, financial loss, change in working condition, major personal illness, trouble at work, death of a family member, and change/expansion of business. The mean scores of anxiety (as assessed by the Hamilton Rating Scale) and depression (as measured on Beck's Depression Inventory) showed statistically significant falls over the periods of two weeks, one month and three months after infarction, but became insignificant subsequently.

In conclusion, type-A behaviour and stressful life events are significantly associated with the risk of myocardial infarction.

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SIR: The 'vital exhaustion' preceding myocardial infarction in men discussed by Appels (*Journal*, April 1990, 156, 465–471) is supported by a correlation of type B with somatic risk factors of coronary heart disease in adolescent boys (Keltikangas-Jarvinen & Jokinen, 1989). It is also supported by speech hesitation pauses of one second or more occurring more than twice a minute, a component of type-B style but not of global type-A, predicting a six-fold increase in coronary incidence in two groups of normal coronary-prone men followed prospectively for ten years (Case *et al*, 1988). The correlation of the 'traditional' type-A components like impatience and sense of hurry with somatic risk factors of coronary heart disease in adolescent girls (Keltikangas-Jarvinen & Jokinen, 1989) may have been due to their higher metabolic rate (Baxter *et al*, 1988) and dopamine lateralised to the right hemisphere (Friedman; *Journal*, February 1990, 156, 285). The role of gender-related hemispheric differences is supported by increased dopaminergic activity manifested by mania in a 76-year-old woman with improved Parkinsonism (Menza & Chastka, 1989) compared with reduction of obsessive slowness in a 17-year-old boy in response to fluoxetine, with a return to normality of decreased tracer deposition in the right basal ganglia and adjacent temporal lobe (Hamlin *et al*, 1989).

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‘Slowly progressive schizophrenia’

SIR: By criticising the concept of slowly progressive or sluggish schizophrenia adopted by Snezhnevsky and his school in the USSR, Shafran *et al* (*Journal*, August 1989, **155**, 174–177) reject not only the existence of this concept but also that of simple schizophrenia. The main support for the authors' idea comes from DSM–III. They point out that “Simple schizophrenia by name has disappeared from DSM–III–R”, and that the concept of latent schizophrenia which appeared in DSM–II “was, of course, radically changed for DSM–III”.

It is amazing that the authors do not even mention ICD–9 which is the internationally approved classification and which describes simple schizophrenia. In the preliminary version of ICD–10 (World Health Organization, 1987) it is included again under F21.1. Black & Boffeli (1989) suggest that it might even reappear in the next version of DSM. It should not be forgotten that the rejection of simple schizophrenia in DSM was due mainly to the overdiagnosis of this disorder in the USA. Even if a diagnosis can lead to mistakes, it does not mean that it does not exist.

An important argument used by Shafran against simple schizophrenia is Schneider's concept of the first-rank symptoms: “. . . the Schneiderian backlash put an end to his [Bleulers'] concept of schizophrenia”. Although invaluable for the diagnosis and for research purposes, the importance of first-rank symptoms is clearly overestimated. It is worth remembering Schneider's (1950) own words: “. . . which we call first rank symptoms not because we regard them as ‘basic disturbances’ but because they have special significance for the *diagnosis* both against nonpsychotic mental abnormalities, as well as against cyclothymia. . . . Nothing is said about the

theory of schizophrenia, unlike Bleuler's basic and accessory symptoms or the primary and secondary symptoms of other authors. . . . First rank symptoms do not have to be present for the diagnosis of schizophrenia. . . .”

Over-reliance on first-rank symptoms (and on positive symptoms as a whole) could lead to diagnosing only one form – paranoid schizophrenia. The characteristic ‘negative’ features of residual and simple schizophrenia, which are also prominent in the hebephrenic form, are at least as important in diagnosing and understanding schizophrenic illness. If more attention is paid to the variety of symptoms, some of them very subtle, more diagnostic entities will emerge. Not only Snezhnevsky has described many forms. Leonhard (1986), for instance, listed 19 subforms of schizophrenia apart from the three cycloid psychoses. Such efforts for greater diagnostic precision should not be discouraged, even if they make life more difficult.

Simple schizophrenia has the right to exist because here we see the basic symptoms which are more specific of the schizophrenic deterioration than anything else. They include the peculiar change in the personality which is not seen anywhere else in human pathology, namely that the person loses the core of their personality and is completely different in their reactions to important things in their surroundings. In this respect we could probably cite Ey *et al* (1974): “. . . schizophrenia is not at the beginning of the evolution but at its end”.

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Temporal lobe atrophy versus open operculum in Asperger's syndrome

SIR: The report by Jones & Kerwin (*Journal*, April 1990, **156**, 570–572) concluded that the patient with Asperger syndrome had atrophy of the left temporal lobe. On the basis of the computerised tomography