

descriptive study. An inclusive approach would seem particularly appropriate for those with severe handicap where the aetiology of repetitive movements is speculative.

Therefore the descriptive categories of the DIS-Co or DISCUS can be appropriately employed, provided that attention is adequately paid to co-operation levels and their influence on study results. It must also be recognised that other movements, while not regarded as forming part of a tardive dyskinesia spectrum, represent aspects of motor disorder and are relevant. On this basis, a Nottingham group is currently examining abnormal movements in people with severe impairments.

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#### Delusional jealousy in paranoid disorders

SIR: Soyka *et al* (*Journal*, April 1991, **158**, 549–553) examined the prevalence of delusional jealousy in various psychiatric disorders and reported 6.7% in paranoid disorders. This might be an underestimate because of the low admission rates of patients in whom delusional jealousy is the only symptom of their illness, unlike patients with other psychotic syndromes. The authors themselves had highlighted the reluctance on the part of patients, and their spouses, to talk about this particular symptom, sometimes leading to difficulty in diagnosis. One would naturally expect more reluctance in treatment acceptance, especially when it comes to admission to psychiatric hospital. Thus by studying only in-patients, the authors could not exclude the possibility of selection bias affecting the prevalence of delusional jealousy.

We reviewed the case records of 297 patients diagnosed to have a paranoid disorder (ICD-9; World Health Organization, 1978) who presented to our department over a 10-year period (1979–1989). Of the 93 patients who received a diagnosis of a paranoid disorder, delusional jealousy was documented in 15

individuals, giving the symptom a prevalence of 16%. Among the 16 patients with paranoid disorders who received in-patient treatment, only one individual had delusions of jealousy. In our series, the prevalence of this symptom among in-patients is similar to that of Soyka *et al*. Thus, our findings show marked differences in the prevalence of the symptom dependent on the admission status, with a higher figure for out-patients than among those admitted to the wards.

When DSM-III-R criteria were applied to these case records, only 60 individuals met the criteria for delusional disorder. Interestingly, all the patients with delusions of jealousy met the criteria, thus increasing the prevalence of delusional jealousy to 25% among patients with delusional disorder. This suggests that the actual prevalence of delusional jealousy could be higher with the use of more restrictive criteria. However, the prevalence of this symptom in the community would probably be different and would be difficult to document.

WORLD HEALTH ORGANIZATION (1978) *Mental Disorders: Glossary and Guide to their Classification in accordance with the ninth revision of the International Classification of Diseases (ICD-9)*. Geneva: WHO.

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SIR: We read with interest Soyka *et al*'s study (*Journal*, April 1991, **158**, 549–553) of the prevalence of delusional jealousy, and would like to offer the following comments.

Firstly, delusional jealousy involves the lover, marital or sexual partner and hence occurs in those who have or have ever had one. Therefore, considering the whole patient population, ignoring the marital or sexual status and history, and including those who never had a lover or partner, as done in this study, would give erroneously low figures.

Secondly, the authors suggest that the difference in prevalence of delusional jealousy in affective disorders (0.1%) and schizophrenia (2.5%) may be of value in the differential diagnosis of the two disorders. This opinion is rather far fetched in view of the fact that among those with delusional jealousy 3–16% had depressive illness, while 17–44% had schizophrenia (Gelder *et al*, 1989).

Finally, this study supports the surprising earlier observations (Gelder *et al*, 1989) of 'delusional' jealousy occurring in 'neuroses'.

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### Is schizophrenia disappearing?

SIR: Could the fall in rate of diagnosis of schizophrenia be linked with the emergence of child and adolescent psychiatry?

During the time under consideration by Eagles (*Journal*, June 1991, 158, 834–835), there has been a proliferation of what might collectively be called mental health services for children and adolescents. A few were in existence before World War II but following the 1944 Education Act, and generally with the increasing acceptability of such services, there was a vast expansion of child and adolescent psychiatric services, child guidance services, school psychological services, special schools for disturbed children and better psychological care in local authority children's homes. Would these not have had some impact on reducing the incidence of adult mental illness, including schizophrenia?

There were similar increases in such services throughout Europe at much the same time; the USA was always somewhat ahead of Europe.

The emergence of child and adolescent psychiatry has been considered sufficiently important for all candidates sitting the membership exam of the Royal College of Psychiatrists to have to demonstrate some knowledge of child and adolescent psychiatry. It is my experience that this greater awareness of the emotional disorders of young people shown by the majority of psychiatrists has led increasingly to their referral to appropriate services rather than to admission to adult mental hospitals; a regrettable practice that occurred all too often in the past.

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### Lateral ventricular size, educational level and patient subtypes in schizophrenia

SIR: Since the first report of lateral ventricular enlargement in schizophrenia, a number of studies have addressed this issue, reporting positive findings in general (for a review see Shelton & Weinberger, 1986).

Differences in the population from which schizophrenics are drawn are widely recognised as possibly affecting neuromorphological findings (Luchins,

1982) and severe and chronic forms of schizophrenia are reported to show greater computerised tomography (CT) abnormalities (Goldberg *et al*, 1988). Educational status also seems to affect neuromorphological measurements obtained through brain imaging techniques (for a discussion see Andreasen, 1988).

In order to see how the choice of patient subtypes and educational level matching could be related to the finding of statistically significant differences in neuromorphological measurements between schizophrenics and healthy subjects, we have compared the mean ventricular brain ratio (VBR) in a controlled magnetic resonance imaging (MRI) study (Rossi *et al*, 1990a) and a subsequent MRI replication study (Rossi *et al*, 1990b).

In the first study, patients and controls were matched for age (within three years) and sex, but not for educational level, whereas patients in the second study were also strictly matched educationally (within one year) with the controls. The first patient group consisted of 39 patients, 33 of whom were relapsing patients with a relatively good outcome, all able to live in the community with out-patient care, and six severe patients who met the operational criteria of Keefe *et al* (1987) for Kraepelin's dementia praecox. The mean VBR for the overall patient group was 5.1; for the Kraepelinian subgroup it was 6.8 and for the relapsing subgroup it was 4.8. The mean age of the 39 patients was 31.23 years (s.d. 7.04) and their mean length of illness was 6.97 years (s.d. 4.69); mean educational levels of patients and controls were 10.51 (s.d. 3.03) and 17.03 (s.d. 2.42) years respectively. The Kraepelinian and relapsing patients had a mean educational level of 10.33 (s.d. 3.32) and 10.54 (s.d. 3.03) years, respectively.

The second patient group was represented only by relapsing patients, living in the community, with a mean age of 26.47 years (s.d. 4.82) and a length of illness of 4.41 years (s.d. 2.50). Their mean educational level was 10.94 (s.d. 4.19) years and that of the matched healthy controls 11.61 (s.d. 3.15) years.

The mean values in the two studies are slightly different but they were conducted with different MRI machines and by different raters, so between-study comparisons cannot be made. The first MRI study shows a statistically significant VBR increase in the overall patient group when compared with controls (two-tailed *t*-test,  $t=2.56$ ,  $P<0.01$ ). When the Kraepelinian patients were excluded, this difference was no more significant, as was the case in the replication MRI study. Nonetheless, the residual VBR difference showed a strong trend towards significance (two-tailed *t*-test,  $t=1.89$ ,  $P<0.06$ ), which might be due to differences in educational level