Interpretation of historical evidence

SIR: Hare's paper on 'Schizophrenia as a recent disease' (*Journal*, October 1988, **153**, 521–531) has attracted a considerable correspondence. Yet for such a theme, a much more detailed analysis is required than narrow research based on medical textbooks or annual statistics. Casting aspersions on Haslam's probity (*Journal*, September 1989, **155**, 418–419) or forgetting that two leading London physicians actually believed James Tilly Matthews *not* to be insane (*Illustrations of Madness* (Haslam, 1810), is now available in reprint, so readers can easily decide) is also not historically illuminating.

Historical evidence in this context must not be selective. Writings on mental illness flourished in the late 18th and early 19th century, for unknown reasons. To suggest that a new form of illness, schizophrenia of adolescent onset, arose at this time is akin to believing that 'germ theory' arose because germs were new (rather than because new microscopic techniques allowed them to be studied properly for the first time).

In 1813 Thomas Sutton outlined delirium tremens; in 1817 James Parkinson delineated the 'shaking palsy'. Are we to believe that these were also new diseases? Given the extraordinary changes in English society between 1780 and 1820 – a period often called the 'Industrial Revolution' in traditional textbooks – and the shift from an agrarian to an urban lifestyle, is it not more sensible to highlight a new perspective rather than a new form of illness? There are similar changes in medical practice (e.g. Laennec's first use of the stethoscope) at this time, and even by the end of the century 'hebephrenia' was regarded as a rare disorder (Dawson, 1903).

The financial aspects of asylum care also need examination. To what extent did some Victorian 'medical men' rely on lunacy certification for a significant part of their income? Was it cheaper for parish guardians to keep disordered individuals in asylums – after 1867 there was a 4 shilling subsidy – or workhouses? What was the cost of caring for an insane relative at home?

Major epidemiological theories in the history of psychiatry are too important to be confined to the clinical. The task of understanding becomes much more complex, but that is the joy of history. While there is no doubt a value in asserting the primacy of *illness* in generating an asylum population, we cannot ignore the multiplier effects of industrial working hours, the population explosion, economic incentives, and degeneration theory, to say nothing of evangelical concern and a broader appreciation of psychiatric diagnoses. Admission under legal certification was and is a social event, not an act of refined nosology. Dr Hare's honesty in describing his evidence as "flimsy" deserves respect, but the view of schizophrenia as a persistent, genetically-based disorder may have sounder historical roots.

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Nicotine and Alzheimer's disease

SIR: We were pleased to read in the recent letter by Grant *et al* (*Journal*, November 1989, **155**, 716) that they found our results (*Journal*, June 1989, **154**, 797–800) interesting and warranting further evaluation.

We agree with the point raised in their letter: that for the reasons they specify, patients who are regular smokers *may* not respond in the same way as non-smokers. However, as Dr Grant *et al* would agree, changes in density of nicotinic receptors in the brain following repeated smoking does not provide evidence on its own of a *functional* change.

Dr Grant *et al* argue that the "heterogeneity of the patient population" may have resulted in a failure to detect a positive effect of nicotine on our test of short-term memory. However, heterogeneity of patient population on its own would not be a sufficient explanation of our results, since we found marked and specific improvement in attention and information processing, including working memory.

Therefore one would have to resort to a more convoluted explanation involving perhaps some combination of factors, including differences in test sensitivity and a mixture of smoking and non-smoking patients. Since our Section is dedicated to assessing the efficacy of pharmacological treatments for dementia of the Alzheimer type (DAT), we would be only too pleased to find effects of nicotine on tests of spatial short-term memory. However, recent literature on experimental animals for spatial memory supports our findings (Mundy & Iwamato, 1988).

Furthermore, we have just completed a large study of 71 subjects or patients (36 smokers and 35 non-smokers) in order to investigate this question of response to nicotine in smokers and non-smokers. Results of our larger study have replicated nearly completely those of our earlier, smaller one, and we

found no overall differences in the effect of nicotine on the performance of smokers and non-smokers.

With regard to patient variability, this is an inevitable consequence of working with DAT patients. We attempt to reduce this by careful diagnosis and staging of patients (Philpot & Levy, 1987), and it is impressive that we are able to detect such significant improvements in attention, rapid information processing, and working memory, *despite* such increased variance.

The alternative design suggested by Dr Grant *et al* would not be an improvement. Firstly, to include two test sessions on one day would be likely to increase test variability as a result of frustration, fatigue, and possible noncompliance. Secondly, in psychopharmacological studies in experimental animals, where it might be argued that compliance is less of a problem, one would not adopt such a paradigm for fear of carry-over effects, even given the relatively short action of nicotine.

We hope that this has clarified matters for Dr Grant *et al* and we look forward to receiving their comments on the publication of our larger study, which will shortly be in submission.

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Forensic aspects of mental handicap

SIR: I read with interest the paper by Turk (*Journal*, November 1989, **155**, 591–594), and would like to expand on some of the points raised.

Under the Sexual Offences Act 1956 it is unlawful for a male to have sexual intercourse with a severely mentally handicapped female (provided he was aware of her handicap), and Dr Turk seems, quite reasonably, to regard this legislation as a valuable safeguard against the exploitation of vulnerable women. However, he does not point out the risk that this legislation may deprive women with a mental handicap of pleasurable sexual contact. Somehow, a balance must be struck between the need to protect on the one hand and the need for freedom of sexual expression on the other.

Dr Turk, in addressing the issue of the disposal of offenders with a mental handicap, states that the choice of disposal depends on the availability of treatment or training facilities locally and the court's view as to whether residential placement is necessary for protection of the public. Recently, difficulties have occurred locally because of a lack of suitable facilities for offenders whom the courts believed did present a risk to the public, and thus require residential care. As the mental handicap hospitals contract, a range of alternative residential placements will need to be made available for this small group of patients. Whether this involves developing more specialised units, planning an individual service for each patient within a community setting such as a staffed group home, or a combination of these approaches, remains a matter for debate. What is certain is that if such provision is not made, more people with mental handicap will go to prison.

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Supermarket management

SIR: While I am not competent to comment on the scientific debate concerning brief intermittent neuroleptic prophylaxis for selected schizophrenic outpatients (McClelland *et al*, *Journal*, November 1989, **155**, 702), I feel that the assumptions underlying Dr Soni's last paragraph cannot go unchallenged. He writes: "A final point relates to cost-effectiveness: maintenance neuroleptic therapy is relatively inexpensive; continuous, careful monitoring of patients, on the other hand, requires much staff time and vigilance, as well as active involvement and education of relatives or carers." The fact that supermarket management assumptions are dominant in the present political climate makes it even more vital for the profession to maintain humane and ethical standards. It is always cost effective to neglect or kill off the old, the mentally ill or the physically disabled, unless human values are placed first in the equation. Dr Soni's high-cost alternative reads like a description of good practice (whether neuroleptics are continuous or intermittent); if all we can offer is a monthly injection from a grossly overworked Community Psychiatric Nurse, we should protest.

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