patients will have adequate seizures and satisfactory clinical response with a constant current stimulus of 275–325 mC lasting about 3.25 s at a pulse rate of 50 to 60/s. The apparatus should provide for the possible delivery of a lower or higher charge than this to meet the needs of the minority with low or high thresholds.

If results of ECT are to be compared, full details of the stimulus must be stated. This necessitates the use of up-to-date equipment which will give a readout of the actual dosage in mC received by the patient so that proper records can be kept.

For 50 years many of us have blindly used ECT on a hit or miss basis, falsely believing that the only thing that mattered was to achieve some sort of seizure. Much more is now known about ECT even than 10 years ago. This knowledge, together with adequate training in the technique, is essential for those who administer the treatment if it is to be used rationally and not to fall into disrepute.

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Chronic Schizophrenia and Long-Term Hospitalisation

SIR: May I be allowed briefly to record puzzlement that my last letter is considered by Professor Wing to contain the "new statement that attitudes to discharge from hospital are entirely explained in schizophrenic patients by the severity of their disorder." (*Journal*, January 1988, **152**, 144–145).

No such statement or any comment related to it appears in the letter (*Journal*, November 1987, **151**, 708). Such a statement would be entirely contrary to my known views (Abrahamson & Brenner, 1982; Abrahamson *et al*, 1986) and practice, which emphasise that schizophrenic patients' attitudes to discharge are expressions of personal choice not reducible to the effects of either illness or "institutionalism".

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Incest and Anorexia Nervosa

SIR: We read with interest Dr D. M. Hambidge's letter (*Journal*, January 1988, **152**, 145–146), and agree entirely with his observation of a "recent large increase in the number of women referred for assessment and management of the longer-term consequences of sexual abuse in childhood and adolescence." We also have come across several such new referrals recently.

We support Dr Hambidge's views on a causal link, but would like to add a few points. Although Oppenheimer *et al* (1985) and Sloane & Leichner (1986) have discussed the possible relationship between adverse sexual experiences or abuse and eating disorders, all the cases taken into consideration were of either anorexia nervosa with weight loss or normal-weight bulimia nervosa. We wish to extend this possible link to the whole spectrum of eating behaviour disorders: to include cases of obesity as well. Of the four most recent cases in our series, two were significantly overweight and two underweight, their weight on presentation being more than 20% above or below their average normal weight for their height and age.

We were fascinated by the comments made by two obese women about their 'body image'. In view of their adverse sexual experiences in childhood, they did not wish to be seen as sexually attractive to the opposite sex, thus subconsciously eating more to distort their body shape. Both obese women were married, and there were marked differences in the premorbid personality of the obese and anorexic/bulimic patients. In our experience, obese patients also tend to have lesser degrees of difficulty in subsequent sexual adjustment.

Scott & Thoner (1986) investigated 30 female anorexic in-patients, 30 female incest victims, and 30 female control subjects using the Minnesota Multiphasic Personality Inventory (MMPI), and reported remarkable similarities between anorexic and incest groups, with characterological elevations on five clinical scales and lower scores on Barron's ego strength scale. Details of childhood sexual experiences in the anorexic group and of eating behaviour in the incest group were not reported in the paper.

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Compensation Psychosis

SIR: Involvement in an accident and subsequent compensation issues can be a significant psychogenic stimulus to precipitation of an endogenous depressive psychosis, particularly in individuals with a genetic predisposition. This would seem to be so in the case described by Pilowsky & Lee (*Journal*, December 1987, **151**, 868–869). Such a depressive psychosis should respond to antidepressant medication and ECT (we assume there was some physical contraindication to ECT in this case). We find it difficult to accept a primary diagnosis of morbid grief reaction 'complicated' by a psychotic depression when the wife's death and the husband's involvement in litigation began fifteen months prior to the onset of the depressive psychosis. In psychopathological terms, the wife's death and the compensation issues 'colour' the psychosis and are part of the content, but they are not aetiological in nature and to label the psychosis in terms of its content is incorrect.

In the original case of so-called 'compensation psychosis' (White *et al*, *Journal*, May 1987, **150**, 692–694) the patient had received a head injury and sustained brain damage, albeit minimally, which was manifest in a chronic amnestic syndrome. To label this organic psychosis as a 'compensation psychosis' is again to ascribe a primary aetiology to the issues of compensation when the primary aetiology is one of brain damage. It would seem to us that the lawyers got it right when they awarded this patient substantial damages (£50 000) for the brain damage he sustained in the accident and not for compensation.

We would contend that the concept of a 'compensation psychosis' is not only nosologically incorrect and fallacious, but in medico-legal terms misleading.

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SIR: Drs Hay and Johnson correctly identify nosological and medico-legal dangers in premature acceptance of a journalistic term such as 'compensation psychosis' as a diagnosis. We share their view. This is why we called for a systematic investigation and review of such cases.

We do not agree with their formulation of the case that we reported, although we do wish that we shared their certainty. Our patient's losses and the compensation issues may have been merely precipitants and pathoplastic features of an endogenous depression. But we were also impressed by the complex interplay of grief and compensation as having a direct aetiological and maintaining role in the illness. Surely there is room here for a multifactorial aetiology?

Our main point remains. However their illnesses are categorised, these patients are a group of growing importance who have special needs and who warrant further study.

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SIR: Drs Johnson and Hay wish to reject the concept of compensation psychosis on the grounds that in the case described the syndrome arose in the setting of an organic psychosis caused by a head injury. We would agree that brain damage may well have been the underlying organic pathology, but the name 'compensation psychosis' does not imply that the compensation factor was the primary cause but rather that the nature of the delusions was influenced by an ongoing compensation case. (We would contend that in most cases of compensation neurosis it is the accident which *causes* the neurosis, but the condition may be aggravated by litigation proceedings). In other "uncommon psychiatric syndromes" (Enoch *et al*, 1967), e.g. de Clérambault syndrome and Capgras syndrome, it is the nature of the delusions which characterise these syndromes – not the cause (Sims & White, 1973).

In the case described, the patient was awarded damages partially on account of the suffering he had endured, but particularly because it was considered that he would not be able to return to his job of work – the details of his disability hardly figured in the negotiations! Solicitors are not overly interested in syndromes.

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