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Contents: The continuum of psychosis and the gene; AIDS panic; Not a case of pseudo-AIDS; Impact of psychiatric illness on the family; Behavioural neurology; Prognosis of depression in old age; Present State Examination Change Rating Scale; Folate, Vitamin B_{12} and posture; Diazepam in subacute organic states; Incidence of schizophrenia worldwide; Psychiatrists' views on treatment of depression; Afternoon radiator-sitting syndrome; Sub-clinical arteriosclerotic dementia.

The Continuum of Psychosis and the Gene

SIR: Owen & Nimgaonkar (*Journal*, April 1987, **150**, 566–567) give reasons why they are persuaded by some of the arguments (Crow, *Journal*, October 1986, **149**, 419–429) for a continuum concept, but do not accept that this reflects on the genetic basis of the recurrent psychoses. The points they raise illustrate some of the issues at stake between the 'classical' Kraepelinian view and a continuum theory.

In stating that none of the studies that show an excess of individuals with schizophrenia among the offspring of patients with affective disorder "employed modern diagnostic criteria" Owen & Nimgaonkar draw attention to a bias intrinsic to most investigations of the genetics of psychosis – the tendency to exclude cases which do not meet a particular preconception of the nature of the disease under investigation. Thus adherents of the Kraepelinian viewpoint have seized eagerly upon DSM-III and similar diagnostic decrees as an opportunity to purify their index samples of 'typical' affective or schizophrenic psychoses. In so doing they eliminate the intermediate states which in my view are the key to the problem. One of the points I made in my paper was that even when DSM-III criteria are adopted (as in the recent studies of Gershon *et al* of affective disorder and Kendler *et al* of schizophrenia) a substantial excess of cases with 'schizoaffective' disorder is seen among the relatives of patients with both prototypical psychoses. According to one's viewpoint these cases represent 'diagnostic error' or evidence for a continuum. When DSM-III criteria are applied they are excluded. Thus the bias inherent in a classical Kraepelinian perspective is further accentuated by application of criteria which are founded on the binary concept.

The point is illustrated by Owen & Nimgaonkar's reference to the work of Elsasser on the children of two psychotic parents. The combined results of Elsasser, Schulz and Kahn are shown in Table I.

Owen & Nimgaonkar quote the rates of illness in the children of parents with manic-depressive and schizophrenic illnesses. However, Elsasser also included a category of "atypical psychosis". Since this

TABLE I
The children of two psychotic parents[1]

No. of parental pairs	*Parental mating*[2]	*No. of children over 16*	*Psychotic children*[3] *S*		*M*		*A*		*? Nature*	
			a	*b*	*a*	*b*	*a*	*b*	*a*	*b*
34	S × S	96	20	8	–	–	–	–	–	–
20	M × M	47	1	–	9	1	2	–	1	–
19	S × M	68	6	2	6	2	1	–	2	–
23	A × S	91	8	–	1	1	3	–	–	2
21	A × M	55	–	–	4	2	4	1	–	–
17	A × A	67	5	–	5	1	10	1	–	2

1. Adapted (the rates of non-psychotic disorders are excluded) from Table 12 of Slater & Cowie (1971).
2. S = schizophrenic, M = manic-depressive, A = atypical.
3. a = diagnosis certain, b = diagnosis uncertain.

category includes 78 (29%) of the total of 268 parents it is not of marginal significance. Among the offspring of the schizophrenic and manic-depressive matings one atypical and two psychoses of uncertain nature were recorded in addition to more typical schizophrenic and affective illnesses. Of more interest is the fact that among the offspring of manic-depressive/manic-depressive matings were observed two cases of atypical psychosis and one of definite schizophrenia, and among the offspring of atypical/atypical matings were observed five certain and one doubtful manic-depressive psychoses, 10 certain and one doubtful atypical psychoses and five definite schizophrenic psychoses. The pattern of transmission appears more complex and the separation between the prototypical psychoses much less clear when atypical psychoses are included.

There is no alternative to confronting the question of the genetics of schizoaffective psychosis. Angst *et al* (1983) have collected more information on this topic than any other group: "The underlying hypothesis of a continuum of psychoses from depression to schizophrenia is not disproved by our results. They show that on a descriptive level of symptoms and syndromes, taking into account the whole course of psychosis, the dichotomy into schizophrenic and affective psychosis is highly questionable. We do not only find transitional groups of schizoaffective patients but also marked affective symptomatology underlying or superimposed on schizophrenia".

An earlier study by Angst *et al* (1979) is relevant to Owen & Nimgaonkar's belief that schizoaffective disorder is no more than a result of the coincidence of schizophrenia and affective disorder in the same family. In 71 of these 150 cases of schizoaffective illness at least one other family member was affected with schizophrenia (S), schizoaffective (SA) disorder or affective (A) (unipolar or bipolar) illness. In only 17 (i.e. a minority) of these 71 families were the illnesses in the secondary cases placed in more than one category (S, SA or A) and in only eight cases did these include schizophrenia and affective disorder. Interestingly, affective disorder was found more frequently than schizophrenia (23:11) in parents of schizoaffective probands, whereas schizophrenia was slightly more frequent (11:13) in siblings. This is compatible with an inter-generational shift along the continuum.

It is little recognised that Kraepelin (1920) himself had doubts about the binary concept: "Perhaps it is... possible to tackle the difficulties which still prevent us from distinguishing reliably between manic-depressive insanity and dementia praecox. No experienced psychiatrist will deny that there is an alarmingly large number of cases in which it seems impossible, in spite of the most careful observation, to make a firm diagnosis... Nevertheless it is becoming increasingly clear that we cannot distinguish satisfactorily between these two illnesses and this brings home the suspicion that our formulation of the problem may be incorrect".

Thus Kraepelin himself was apparently abandoning the position which Owen & Nimgaonkar are defending.

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AIDS Panic

SIR: Jacob *et al* (*Journal*, March 1987, **150**, 412) report on five male patients with 'AIDS phobia'. Generalisations based on small numbers need to be interpreted with caution. Since 1984, we have systematically assessed all patients who were referred to psychiatric services with a clinical picture of panic disorder and a prominent fear of having developed AIDS but were negative for HTLV-III antibodies. Our findings are at variance with those reported by these authors. Of 24 patients in our sample (mean age 38.2 years; range 22–61; 14 females) only four admitted to being bisexual; all the rest were heterosexual. A majority (20) described a recent psychological precipitant, not always of a sexual nature; the latter was discovered in 14 patients, 10 of whom admitted to a recent illegitimate or 'unusual' sexual relationship and 4 to a homosexual contact. A detailed chronological catalogue of media reports was compiled, and an overlay plot of case inceptions showed that although a few cases did occur soon after a major media publicity campaign on AIDS, there was no significant correlation for the sample as a whole.

The mean duration of symptoms before presenting to psychiatric services was 4.5 weeks (range 3–8), and