

busy casualty department in a distressed state, apparently having taken a serious overdose of paracetamol, diazepam and alcohol. His story was supported by a letter, headed 'Robert Brothers Circus', in which his employer explained that the patient, a lion tamer with the circus, had seemed unwell for some time, and had recently made three attempts to end his life—once by throwing himself under the wheels of a moving lorry, once by inciting his lions to attack him, and now by overdose.

He was assessed medically and gastric lavage and N-acetylcysteine infusion was instituted. He was admitted to a medical bed and the following day was interviewed by a registrar in psychiatry, who, thinking him to be suicidal, transferred him to a psychiatric hospital.

There he gave a history of six months' increasing unhappiness, with poor concentration and interrupted sleep. He had been preoccupied with a large sebaceous cyst above his left eye, which had made him feel self-conscious in the circus ring—indeed he had attempted to hack this off with a razor blade. A crisis had occurred three months before the overdose when his mother, with whom he shared a caravan, had died suddenly of a heart attack. Since then he had been in a shocked and bewildered state. A diagnosis of bereavement reaction in an abnormal personality was suggested.

He was observed in the ward setting, where he was encouraged to express his grief, and where his behaviour seemed congruous with the harrowing history—until six days later when the charge nurse telephoned the circus about an incidental matter. We learned that his story was an elaborate fabrication—the circus management explained that the patient had never been in their employ, but that over a five year period they had been contacted by several hospitals where the patient had been admitted posing as a lion tamer. It was confirmed that the referral letter was in the patient's own handwriting (and the heading printed by him) and that he had been discharged from the neighbouring psychiatric hospital only two days previously. On confrontation our patient clung to his story steadfastly, but went "absent without leave" later in the day.

Although Asher originally described three well known varieties of Munchausen's syndrome—namely "the acute abdominal", "the haemorrhagic" and "the neurological type"—more recently a psychiatric type seems to be emerging. However, it seems to be a relatively unusual presentation, and perhaps this is why we were not on our guard. We are familiar with "hospital addicts" who use psychiatric symptoms to gain admission for

food, shelter and company but this did not seem to be our patient's motive—as he turned down the invitation to stay in hospital, presumably in favour of practising his deception elsewhere.

ERICA M. JONES
M. P. STERNBERG

Barrow Hospital, Bristol, BS19 3SG

DST Results and Platelet MAO Activity

DEAR SIR,

The article by Schatzberg *et al* (*Journal*, June 1985, 146, 633–637) on a possible correlation between platelet MAO activity and 4 p.m. post-dexamethasone cortisol levels in patients with a depressive disorder prompted us to re-examine our data on these parameters. We have simultaneously done the DST and the determination of platelet MAO routinely on over 400 patients admitted to our hospital. In the whole group we found no correlation between the two supposed biological markers. Evidently most patients were suspected of having a depressive disorder as a DST was requested. Even in a subset of patients with routine diagnosis of major depressive episode, based on the clinical intake evaluation done by psychiatric residents supervised by senior psychiatrists, no correlation between non-suppression in the DST and high platelet MAO activity could be detected.

Fortunately, out of this group a psychiatric resident and his supervising psychiatrist appeared to have selected, for another study and blind to the biochemical data, a number of patients fulfilling the DSM-III criteria for major depressive episode. Looking for a possible correlation between the two markers in the latter group, which consisted of 32 patients, mean age 43.6 ± 11.5 (s.d.) years, range 24 to 61 years, 7 males, 25 females, a striking similarity between our results and those by Schatzberg *et al* became evident. After dividing the group of patients along the median of the MAO activity, as they did, and defining suppression in the DST as a post-dexamethasone cortisol level at 4 p.m. of less than $0.14 \mu\text{mol/l}$, we found 14 (44%) non-suppressors, 11 of them in the high MAO group. Of the suppressors, 13 were in the low MAO group. Analysis of the data using the Fisher exact test showed a highly significant difference ($P=0.011$) in the non-suppression rates between high and low MAO patients.

All patients had received 1 mg of dexamethasone at 11 p.m. and the exclusion criteria for the DST were those given by Carroll *et al* (1981).

We confirm the results presented by Schatzberg *et*

al that a significant correlation exists between high platelet MAO activity and non-suppression in the DST in a group of well diagnosed patients with a major depression. Follow-up and treatment response studies in sub-groups like the one defined by high platelet MAO activity and non-suppression in the DST might be rewarding. We also support evidence (Spitzer *et al*, 1982) that routine clinical diagnoses by trainees are not accurate enough to be used for research purposes.

E. G. TH. M. HARTONG
J. G. GOEKOOP
E. J. M. PENNING
G. M. J. VAN KEMPEN

*Psychiatric Hospital, Endegeest,
POB 1250,
2340 BG Oegstgeest,
The Netherlands*

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Ageing and First Admissions for Affective Disorders

DEAR SIR,
Eagles and Whalley (*Journal*, August 1985, **147**, 180–187) have demonstrated a relationship between age at admission and first admission rates for affective disorders. They have *not* demonstrated a relationship between *ageing* and first admissions for affective disorders.

The well-known distinction between the effects of ageing itself, however mediated, and so-called “cohort effects” needs to be emphasised again. A cross-sectional slice (10 years thick) tells us nothing of longitudinal trends. For instance, some, all (or none) of the cohorts glimpsed in this study may have had *declining* rates of admission, as they aged, up to 1969.

We all appreciate how difficult longitudinal studies are, and it may be that such studies are impossible if based on official diagnoses, since these have changed so markedly over the years. But this is no excuse: there is a tendency to think that if, in order to answer a question, the study you have to do is impossible, another study will do. There is much of interest in Eagles and Whalley’s data, but no light

is shed on the central question.

A. J. D. MACDONALD
*United Medical and Dental Schools,
Guy’s Hospital,
London Bridge, London SE1*

Elective Mutism

DEAR SIR,
Dr Wilkins’ comparison of elective mutism and emotional disorders in children (*Journal*, February 1985, **146**, 198–203) appears to justify the need for recognising the former as a distinct clinical syndrome. However, in the sample of controls, he has included patients with diverse psychopathology ranging from enuresis to hysteria, all under the rubric of ‘emotional disorders’. Although this might have been necessary to obtain a comparable group, it considerably dilutes the argument for a separate syndrome of mutism.

Interestingly, shyness, anxiety and depression seem to be features more common among the electively mute group, while in the ICD-9, these are cardinal features of different sub-categories of emotional disorders. There is no mention of whether transient or persistent mutism had at all been encountered in the control group.

While the ICD-9 rather arbitrarily describes elective mutism as a possible feature of the ‘emotional disorder with anxiety and fearfulness’, it does not mention its occurrence among other disorders. A comparison of patients with mutism with one or more of the emotional disorders as defined by ICD-9 seems necessary before one advocates a separate syndrome of mutism.

AJIT V. BHIDE
*St. John’s Medical College,
Bangalore, India*

SHOBA SRINATH
NIMHANS, Bangalore, India

Using the PSE in Arabic Culture

DEAR SIR,
I read with great interest the article by L. Swartz, O. Ben-Arie and A. F. Teggin (*Journal*, 1985, **146**, 391). I myself translated the PSE 9th Edition into the Arabic language in cooperation with my colleagues, Drs M. Al-Yassiri, A. Salem and M. Al-Ajam. This translation was completed in October 1979. A standardised process of iterative back translation was employed and the instrument was then used in a study of life events and schizophrenia in the Najd region of Saudi Arabia (Al-Khani, 1983; Al-Khani *et al*, 1985a).

The difficulties faced were similar to those