

case-finding coverage and base population data to derive incidences; Ibadan, Cali, Agra, Prague, and Rochester were excluded. Exclusion of the first three means that the incidence data from developing countries derive solely from Chandigarh – a rather unique ‘model city’ in the Punjab and the site of one of India’s major medical centres. With all of South America, Africa, and most of Asia excluded, the incidence data should not really be referred to the worldwide prevalence question. Secondly, the similarity of incidence worldwide which is claimed by the authors holds only for their S+ category, i.e. ‘nuclear’, Schneiderian schizophrenia; this category shows poor specificity, especially in early cases (Silverstein & Harrow, 1978), and very poor predictability for subsequent outcome diagnosis (Brockington *et al.*, 1978). Furthermore, Schneider’s first-rank symptoms are frequently found in mania, in addition to schizophrenia (Carpenter & Strauss, 1974). The S+ category is thus of doubtful validity for the diagnosis of schizophrenia. Yet it is only with this narrow, S+ definition that the author’s claim of equal incidence and prevalence holds, for there is a large variation in incidence between centres with their broad (CATEGO S, P, O) definition of schizophrenia, with e.g. rural Chandigarh women having four times the incidence of women in Aarhus. This suggests either an epidemic-like pocket of schizophrenia in the rural Punjab, or more likely reflects the high incidence of culturally-based brief psychosis that would probably have been found in the other traditional societies, had they been included in the incidence survey.

The greater prevalence of acute reactive psychosis in developing countries has been long and widely recognised by psychiatrists working in these regions (Dembovitz, 1945; Carothers, 1953; German, 1972). During a three-month period in which JRS served as Consultant Psychiatrist at the School of Medicine of the University of Zimbabwe, it was found that more than half the patients admitted to the psychiatric ward of the Harare Hospital with a diagnosis of schizophrenia failed to meet either RDC or DSM-III criteria for duration of the illness, and that onset was often close to an emotionally traumatic event. Using DSM-III criteria, their diagnosis was acute brief or reactive psychosis (Stevens, 1987).

There is no doubt that typical schizophrenia, meeting RDC, DSM-III, Bleulerian, and Kraepelinian criteria, exists in all parts of the world where it has been looked for. In the absence of some duration criteria, however, the greater incidence of acute, reactive, culturally-based psychoses in developing countries is likely to make an important contribution to the conclusion by the authors that schizophrenia

has a better prognosis in developing countries. For the three reasons mentioned – the questionable validity of the CATEGO S+ category for diagnosis of schizophrenia, the exclusion of all but one developing country in the incidence study, and the inclusion of brief (including culturally-related, drug, and alcohol) psychoses in their study – the authors’ conclusion of worldwide similarity of schizophrenic incidence also seems premature.

JANICE R. STEVENS  
RICHARD JED WYATT

*Neuropsychiatry Branch  
Saint Elizabeths Hospital  
Washington, D.C. 20032, USA*

#### References

- BROCKINGTON, I. F., KENDELL, R. E. & LEFF, J. P. (1978) Definitions of schizophrenia: concordance and prediction of outcome. *Psychological Medicine*, **8**, 387–398.
- CAROTHERS, J. C. (1953) *The African Mind in Health and Disease: A Study of Ethnopsychiatry*. Monograph series No. 17. Geneva: World Health Organization.
- CARPENTER, W. T. & STRAUSS, J. S. (1974) Cross-cultural evaluation of Schneider’s first-rank symptoms of schizophrenia: a report from the International Pilot Study of Schizophrenia. *American Journal of Psychiatry*, **131**, 682–687.
- DEMBOVITZ, N. (1945) Psychiatry amongst West African troops. *Journal of the Royal Army Medical Corps*, **84**, 70–74.
- GERMAN, G. A. (1972) Aspects of clinical psychiatry in sub-Saharan Africa. *British Journal of Psychiatry*, **121**, 291–303.
- SARTORIUS, N., JABLENSKY, A., KORTEN, A., ERNBERG, G., ANKER, M., COOPER, J. E. & DAY, R. (1986) Early manifestations and first-contact incidence of schizophrenia in different cultures. *Psychological Medicine*, **16**, 909–928.
- SILVERSTEIN, M. L. & HARROW, M. (1978) First-rank symptoms in the post-acute schizophrenic: a follow-up study. *American Journal of Psychiatry*, **135**, 1481–1486.
- STEVENS, J. (1987) Brief psychoses: do they contribute to the good prognosis and equal prevalence of schizophrenia in developing countries? *British Journal of Psychiatry* (In press).

SIR: The recently released WHO multi-centre study of the incidence of schizophrenia was said by the authors to lend “support to the notion that the ‘central’ schizophrenic syndrome may be occurring with approximately equal probability in different populations” (Sartorius *et al.*, 1986). The WHO study, however, does not shed much light on the comparative incidence of schizophrenia because all seven centres utilised in the incidence study were located in areas in which previous prevalence studies would suggest no more than a two-fold to three-fold difference; that is exactly what the WHO incidence study found.

The centres utilised in the WHO study and prevalence of schizophrenia per 1000 population reported in previous studies in those countries (Torrey, 1987) included: Nagasaki (2.1–2.3), Nottingham (2.1–3.4),

Moscow (2.6-3.8), and Chandigarh (1.9-5.6 in different areas of India; no prevalence study had been carried out in the Chandigarh region). Honolulu was utilised as the American centre despite the fact that it is very atypical demographically and that previous first admission rates for schizophrenia show Hawaii to rank comparatively low among the states; by contrast New Haven, Baltimore, and St Louis were recently reported to have high prevalence rates of schizophrenia (Myers *et al*, 1984).

Aarhus was used as the Scandinavian centre; previous prevalence studies (2.7 per 1000) (Nielson, 1976) and incidence studies (Munk-Jorgensen, 1986) have shown rates for schizophrenia in Denmark to be comparatively low. By contrast, most studies in Norway, Sweden, and Finland have reported high rates, up to 17.0 per 1000 in the Book *et al* (1978) study of northern Sweden. The final centre used in the WHO study was the St Loman's case register in Dublin. In 1982 schizophrenia prevalence figures from this case register were only 1.7 per 1000 (Walsh, personal communication), less than one-third the 5.9 per 1000 rate for the County Roscommon case register in western Ireland and less than one-seventh the rate of 12.6 per 1000 reported by Torrey *et al* (1984) for a suspected high prevalence pocket in western Ireland.

In summary, the WHO incidence study of schizophrenia studied seven centres for which previous prevalence studies would lead one to expect no more than a two-to-three-fold difference in incidence. That is precisely what was found. Until a multi-centre incidence study is done utilising centres from suspected high incidence (e.g. northern Scandinavia, western Ireland) and low incidence (e.g. some tropical areas) countries it would seem unwise to regard the WHO incidence study as a reflection of worldwide incidence rates.

E. FULLER TORREY

Twin Research Unit  
WAW-St Elizabeths Hospital  
Washington, D.C. 20032, USA

#### References

- BOOK, J. A., WETTERBERG, L. & MODRZEWSKA, K. (1978) Schizophrenia in a North Swedish geographical isolate 1900-1977: epidemiology, genetics and bio-chemistry. *Clinical Genetics*, **14**, 373-394.
- MUNK-JORGENSEN, P. (1986) Schizophrenia in Denmark: incidence and utilization of psychiatric institutions. *Acta Psychiatrica Scandinavica*, **73**, 172-180.
- MYERS, J. K., WEISSMAN, M. M., TISCHLER, G. L., HOLZER, C. E., LEAF, P. J., ORVASCHEL, H., ANTHONY, J. C., BOYD, J. H., BURKE, J. D., KRAMER, M. & STOLTZMAN, R. (1984) Six-month prevalence of psychiatric disorders in three communities. *Archives of General Psychiatry*, **41**, 959-967.
- NIELSEN, J. (1967) The Samsø project from 1967 to 1974. *Acta Psychiatrica Scandinavica*, **54**, 198-222.
- SARTORIUS, N., JABLENSKY, A., KORTEN, A., ERNBERG, G., ANKER, M., COPPER, J. E. & DAY, R. (1986) Early manifestations and first-contact incidence of schizophrenia in different cultures. *Psychological Medicine*, **16**, 909-928.
- TORREY, E. F. (1987) Prevalence studies of schizophrenia. *British Journal of Psychiatry*, **150**, 598-608.
- TORREY, E. F., MCGUIRE, M., O'HARE, A., WALSH, D. and SPELLMAN, M. P. (1984) Endemic psychosis in Western Ireland. *American Journal of Psychiatry*, **141**, 966-969.

#### Psychiatrists' views on Treatment of Depression

SIR: I note Armstrong & Andrew's paper on the treatment of depression by Australian psychiatrists (*Journal*, December 1986, **149**, 742-750). This is one of many papers supported by the Royal Australian & New Zealand College of Psychiatrists under a so-called Quality Assurance Project.

The implications of this work are actually quite astounding. The modal length of treatment for each of the case vignettes is over fifteen hours per patient. Simple arithmetic would suggest that every consultant psychiatrist would have reached total saturation point with the referral of one hundred patients per annum. Quality treatment for these one hundred fortunate people would totally absorb the Quality Assured Practitioner to the exclusion of all other professional activities. This work obviously has more to do with maximising psychiatrists' incomes than with making psychiatry more available to the masses.

In Australia, I would add, this Quality Assurance Project is being held up as a model of excellence to which the College hope all psychiatrists will ultimately aspire, or should I say, conform.

JOHN BOOTH

Havelock Clinic  
1 Havelock Street  
West Perth  
Western Australia 6005

#### 'Afternoon Radiator-Sitting Syndrome': Hypothermia and Early Diagnosis of Self-Induced Water Intoxication

SIR: We report on a patient with schizophrenia and acute self-induced water intoxication (SIWI) who presented with symptoms of hypothermia. Further investigations revealed a clinical sign which may be useful in the early diagnosis of SIWI.

*Case report:* A 37-year-old man, who had been an in-patient for 17 years, presented at 1600 hours with complaints of feeling unwell accompanied by uncontrollable shivering, shaking, and chills. Oral temperature was 35.8°C. Over