

After the sixth ECT her depression—rated daily on a Phipps Behaviour Chart—had disappeared, and her insulin requirement declined dramatically, this being signalled by an unexpected hypoglycaemic attack. After 10 days her depression began to return, heavy glycosuria reappeared, and insulin had to be resumed. Two further ECT produced fresh recovery and she was able to be discharged on oral glibenclamide.

Plasma cortisol and urinary free cortisol, and also urinary vanillyl mandelic acid (VMA) derived from adrenalin, were examined on two occasions during her depression, and all values were within the normal ranges, making it unlikely that change in cortisol or circulating adrenalin could explain the increased insulin requirement. During her manic phases, in contrast, no change in diabetic treatment was required.

There is a great need to identify further cases where insulin requirement rises during depression in spite of good control of diet, and to explore whether growth hormone, or some other factor plays any part in it.

It is interesting that last year Fakhri *et al* reported from Baghdad in the *Lancet* (1980, *ii*, 775–77) that ECT was a successful treatment of maturity onset diabetes. We are grateful for Dr R. Donmal's help.

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DEAR SIR,

In his review article on this subject (*Journal*, January 1981, 138, 1–9), Dr Wilkinson alluded to a possible relationship between diabetes mellitus and affective disorder, but found little evidence in the literature to support this conclusion. Recent developments in the psychoendocrinology of the affective disorders have shown lowered glucose utilization rate and insulin resistance in patients with endogenous depression (Mueller *et al*, 1969; Carroll, 1969; Wright *et al*, 1978). Although the diabetogenic

effects of such metabolic abnormalities are of doubtful clinical significance in the depressed patient with no medical problems, the occasional diabetic patient who also suffers an episode of depression will often find his diabetes more difficult to control during the course of his depressive illness.

We recently treated a 66-year-old man with a long history of insulin-dependent diabetes mellitus for a recurrent unipolar endogenous depression. During his stay in hospital, his serum glucose concentration was monitored at 8.00 a.m. and 4.00 p.m. daily, and his Hamilton depression rating scale (Hamilton, 1967) was monitored weekly. His insulin requirements were adjusted according to the serum glucose concentrations, with the goal of keeping his serum glucose level in the 100–200 mg/100 ml range. Although there were fluctuations in the glucose concentrations and insulin requirements from day to day, there was a trend, as shown in Table I, for higher serum glucose concentrations and higher insulin requirements during the depressive episode (Hamilton score 16) than following recovery (Hamilton score 6). Diet and physical activity remained constant, and thus could not account for the changes in glucose concentrations and insulin requirements. The dose of imipramine was increased, but imipramine is not known to have an anti-diabetic effect.

During a severe episode of depression, the insulin antagonists growth hormone (Mueller *et al*, 1969), cortisol (Carroll *et al*, 1976) and epinephrine (Wyatt *et al*, 1971) are often secreted in excessive amounts. This is most likely the basis for the instability of diabetic patients who also suffer from depression. Further studies among larger samples of diabetic patients are needed to enhance our understanding of the relation between diabetes mellitus and depression.

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TABLE I

Day	Hamilton*	Serum glucose, mg/100 ml			Insulin, u/24 hrs	Imipramine, dose
		8.00 a.m.	4.00 p.m.	8.00 a.m.**		
20	16	223	286	193	48	150
35	6	204	88	163	30	225

* Hamilton depression rating scale.

** Serum glucose concentration at 8.00 a.m. of the following day.

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Book Reviews

Adjustment of Schizophrenics in the Community. By George Serban. Lancaster, Lancs: MTP Press. 1980. Pp 294. £18.95.

Serban's is a name already well known in schizophrenia research as a scrupulous investigator and lucid writer, but this present volume is his *magnum opus*. Starting from the position that "enthusiasm for de-institutionalization should have been supported by more conclusive research regarding what could or could not be done for chronic schizophrenics in the community", he studied 641 schizophrenics admitted to Bellevue Hospital, New York between 1971 and 1975. Of these, 419 were followed-up for two years, while a large number of relatives were also investigated and 100 normal controls examined for comparison with the patients. Not being satisfied with existing instruments, Serban developed new tests to measure both motivation, and psychosocial functioning and stress. It is an impressive body of work, which has perhaps made surprisingly little impact since its completion.

The reason may be that, for all his sophisticated approach to the theoretical and methodological issues involved, Serban has not been able to distance himself sufficiently from others in the field, and at the end one is back with the old familiar problems. Undoubtedly, stress does have the predominant role in schizophrenia which the author gives it, but his actual procedure for measuring it seems to depend on rather subjective measures. He is very critical of Birley and Brown's work on life events, emphasizing that these are just triggering mechanisms on a process which long antedates the appearance of florid symptoms, but this seems to be setting up an artificial antithesis for the purpose of knocking it down.

The points most strongly emphasized here are, firstly, that schizophrenia is a process usually starting with poor adjustment in childhood and emerging as psychosis some years later, and secondly, that the patient who has 'recovered' from an acute illness is in fact only partly recovered, remaining abnormally

vulnerable to stress. Serban points to such a person's need for specific new skills to cope with the environment, particularly the stress of social interactions, but cannot say how this is to be done. He also introduces the concept of 'pseudo-ambulatory', whose level of handicap requires the equivalent of hospital care, and rightly states that they are largely unable to profit from presently available community facilities.

If the book leaves a feeling of disappointment, then, it is mainly because neither basic knowledge of schizophrenia nor its management have really progressed as far as we like to think; but it should certainly be read.

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Narcolepsy and Hypersomnia. By BEDRICH ROTH. Translated by MARGARET SCHIERLOVA. Revised and edited by R. BROUGHTON. Basel: S. Karger. 1980. Pp 310. \$58.75.

This reviewer must admit a penchant for single author works, though the question is inevitably raised—"Can one man cope adequately with the topic?" At least on the evidence of this volume, with translation and some editing, it is not only possible but highly rewarding. In my view, the result is one of the best of the many books on sleep recently to have been published. The title is accurate but a bit too restrictive, in that there is a general section on the physiology of sleep and its investigation, and the text ranges widely within the confines of the topics mentioned in the title. The narrowness of the title may account for the high cost, which is a pity as the book should appeal to a wide audience. Roth has worked in this field for more than 20 years and his views reflect a thorough study of a patient sample of over 600. The findings support the increasingly understood distinction between the states in which excessive sleep occur, the various diagnostic possibilities and lines of treatment. Statements that a