the chance to examine schizophrenia discordant MZ twins from other centres for this and other asepcts of our study.

ADRIANNE M. REVELEY

Institute of Psychiatry,
De Crespigny Park,
Denmark Hill

MICHAEL A. REVELEY

Charing Cross Hospital Medical School

ROBIN M. MURRAY

Institute of Psychiatry

References

HUSSEIN, L., SINDARTO, E. & GOEDDE, H. W. (1980) Twin studies and substrate differences in platelet monoamine oxidase activity. *Human Heredity*, **30**, 65–70.

KOIDE, Y., EBERHARD, G., SÄAF, J., ROSS, S. B., WAHLUND, L-O. & WETTERBERG, L. (1981) Kinetic aspects of monoamine oxidase activity in twins with psychosis. *Clinical Genetics.*

NIES, A., ROBINSON, D. S., LAMBORN, K. R. & LAMPERT, R. P. (1973) Genetic control of platelet and plasma monoamine oxidase activity. *Archives of General Psychiatry*, **28**, 834–8.

OWEN, F., BOURNE, R. C., CROW, T. J., FADHLI, A. A. & JOHNSTONE, E. C. (1981) Platelet monoamine oxidase activity in acute schizophrenia: Relationship to symptomatology and neuroleptic medication. *British Journal of Psychiatry*, **139**, 16–22.

REVELEY, M. A., GURLING, H. M. D., GLASS, A., GLOVER, V. & SANDLER, M. (1980) Platelet and amirobutyric acid-aminotransferase and monoamine oxidase in schizophrenia. *Neuropharmacology*, **19**, 1249–50.

SPITZER, R., ENDICOTT, J. & ROBINS, E. (1975) Research Diagnostic Criteria. Instrument No 58. New York: New York State Psychiatric Institute.

WINTER, H., HERSCHEL, M., PROPPING, P., FRIEDEL, W. & VOGEL, F. (1978) A twin study in three enzymes. (DBH, COMT, MAO) of catecholamine metabolism: Correlations with MMPI. *Psychopharmacology*, **57**, 63–9.

WYATT, R. J., MURPHY, D. L., BELMAKER, R., COHEN, S., DONNELLY, C. H. & POLLIN, W. (1973) Reduced monoamine oxidase activity in platelets: A possible genetic marker for vulnerability to schizophrenia. *Science*, **173**, 916–18.

RESEARCH DIAGNOSTIC CRITERIA FOR PRIMARY AFFECTIVE DISORDER

DEAR SIR,

The St Louis Criteria (Feighner *et al*, 1972) and the Research Diagnostic Criteria (Spitzer *et al*, 1978), although widely used in research on depression, have been recently criticized. It has been stressed that this diagnostic approach does not provide homogeneous groups (Nelson *et al*, 1978; Feinberg *et al*, 1979; Nelson and Charney, 1980).

One classical way to test the consistency of a nosological grouping is to follow the course of the disease over time.

Therefore a sample of patients previously diagnosed as having a primary affective disorder (PAD) has been followed up for a period of four years. One hundred and fourteen patients that met the criteria for definite PAD (and also meeting the diagnosis of major depressive disorder, primary subtype) were hospitalized at the Department of Clinical Psychiatry of the University of Florence during the years 1975–6. Seventy-eight cases out of the total were subsequently followed up as out-patients for at least 4 years; at the end of this period new assessments, on the basis of the newly acquired knowledge, were made by experienced psychiatrists not informed about the earlier diagnoses. The inter-diagnoser agreement was satisfactory ($k = .92$, $n = 44$).

The diagnoses of 63 patients (80.8 per cent) were still consistent with the former ones: 25 patients relapsed into episodes again diagnosable as PAD, whilst 38 had a four year period of well-being. Conversely 15 cases (19.2 per cent) had subsequent diagnoses other than affective: 7 patients showed paranoid symptoms, 7 had clearly hysterical signs, and one became an alcoholic.

Whether further diagnoses of schizophrenia, hysteria or alcoholism are compatible with that of affective disorder, depends on one's view of the natural history of such a disease. In fact it is still controversial whether a patient suffering from a major psychiatric disorder, such as depression, can recover and then be affected by a different major psychopathy, e.g. schizophrenia. However, most biological or psychological theories of depression assume that this disorder is incompatible with non-affective states. In any case, as the RDC are aimed to select homogeneous groups for research purposes, the exclusion of false negatives ought to be preferred to the inclusion of false positives. Thus, diagnoses changing over time have to be seen as at least dubious. Indeed it appears reasonable that some depressive onsets of schizophrenia, some affective signs superimposed onto hysterical personalities, or other secondary dysthymias, may be misdiagnosed as PAD.

This lack of homogeneity is not surprising if one considers that the RDC are mere checklists of symptoms, which ignore other sources of clinical knowledge, such as premorbid personality, family history, physiopathological markers, longitudinal course of the illness, etc. These factors have been the basis of the clinical method and nosology since Sydenham onwards.

In my opinion, therefore, the RDC, although helpful for improving standardization and diagnostic agreement, still fail to provide homogeneous samples.

Furthermore, as the RDC are arbitrary pragmatic conventions, with no underlying theory, there is little chance of reaching, with these means, a natural classification of mental disorders.

CARLO FARAVELLI

Department of Clinical Psychiatry,
University of Florence,
Italy

References

FEIGHNER, J. P., ROBINS, E., GUZE, S. B., WOODRUFF, R. A., WINOKUR, G. & MUNOZ, R. (1972) Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*, **26**, 57–63.

FEINBERG, M., CARROLL, B. J., STEINER, M. & COMMORATO, A. J. (1979) Misdiagnoses of endogenous depression with research diagnostic criteria. *Lancet*, *i*, 267.

NELSON, J. C., CHARNEY, D. S. & VINGIANO, A. W. (1978) False-positive diagnosis with primary affective disorder criteria. *Lancet*, *ii*, 1252–3.

—— —— (1980): Primary affective disorder criteria and the endogenous-reactive distinction. *Archives of General Psychiatry*, **37**, 787–93.

SPITZER, R. L., ENDICOTT, J. & ROBINS, E. (1978) *Research Diagnostic Criteria (RDC) for a Selected Group of Functional Disorders*. 3rd Edition. New York: Biometrics Research, New York State Psychiatric Institute.

ENDOGENOUS DEPRESSIVE SYNDROME

DEAR SIR,

Matussek, Söldner and Nagel (*Journal*, May 1981, **138**, 361–72) were unable to diagnose 14 per cent of their depressed patients as either 'endogenous' or 'neurotic'. These authors supported Eysenck's (1970) contention that such patients can carry components of *both* depressive syndromes. We believe that the expression *during childhood* of varying degrees of inherited endogenous depressive illness contributes to the concurrent development of neuroticism. Endogenous (primary, major, melancholic) childhood depression has an incidence of at least 1½–2 per cent (Kashani and Simonds, 1979; Staton and Brumback, 1981), but is seldom diagnosed as a biological disorder. When this illness is treated in childhood with tricyclic antidepressants, however, significant improvement occurs in cognitive function (Brumback *et al*, 1980; Staton *et al*, 1981) and in socially maladaptive behaviour (unpublished data).

Akiskal (1981) describes the high incidences of affective episodes and familial affective illness in adult patients given the diagnosis of borderline personality disorder, and concludes that borderline psychopathology can be a *secondary* manifestation of affective disorder. Akiskal suggests that chronically unpredictable mood changes, often subtle and having their onset before adulthood, lead to lifelong social maladjustment and impaired self-esteem. Our studies of depressed children support Akiskal's conclusions. Treatable affective disorder is often obscured by secondary symptoms of personality disorder or neuroticism in both adults and children.

R. D. STATON
R. A. BRUMBACK

Department of Neuroscience,
School of Medicine,
University of North Dakota,
VA Medical Center,
Fargo, North Dakota 58102, USA

References

AKISKAL, H. S. (1981) Subaffective disorders: Dysthymic, cyclothymic and bipolar II disorders in the 'borderline' realm. *Psychiatric Clinics of North America*, **4**, 25–46.

BRUMBACK, R. A., STATON, R. D. & WILSON, H. (1980) Neuropsychological study of children during and after remission of endogenous depressive episodes. *Perceptual and Motor Skills*, **50**, 1163–7.

EYSENCK, H. J. (1970) The classification of depressive illnesses. *British Journal of Psychiatry*, **117**, 241–50.

KASHANI, J. & SIMONDS, J. F. (1979) The incidence of depression in children. *American Journal of Psychiatry*, **136**, 1203–5.

STATON, R. D. & BRUMBACK, R. A. (1981) Non-specificity of motor hyperactivity as a diagnostic criterion. *Perceptual and Motor Skills*, **52**, 323–32.

—— WILSON, H. & BRUMBACK, R. A. (1981) Cognitive improvement associated with tricyclic antidepressant treatment of childhood major depressive illness. *Perceptual and Motor Skills*, **53**, (in press).