

JABLENSKY, A., SARTORIUS, N., ERNBERG, G., *et al* (1992) Schizophrenia: manifestations, incidence and course in different cultures. *Psychological Medicine* (Monograph), suppl. 20.

homogeneity: secular trends towards early-onset and male preponderance. *Schizophrenia Research*, 6, 101.

MAX BIRCHWOOD  
RAY COCHRANE  
FIONA MACMILLAN

DAVID CASTLE  
*Genetics Section, Institute of Psychiatry  
De Crespigny Park  
London SE5 8AF*

*The Archer Centre  
All Saints Hospital  
Lodge Road  
Birmingham B18 5SD*

#### Decline in the incidence of schizophrenia

SIR: Kendell *et al* (*Journal*, February 1993, 162, 212–218) make a spirited attempt to explain away their findings of a decline in the incidence of schizophrenia in Edinburgh between 1971 and 1989. Adjustment for out-patients and “delayed diagnoses attributed to year of diagnosis” (their Table 2) altered the trends for men, but women still showed a 35% decline in incidence over the period under study. Furthermore, the authors report evidence of a change in diagnostic habit between 1971 and 1989 for men and early-onset cases, but state that a similar effect was not seen for women and later-onset cases.

Thus, it appears the case for the decline in rates being spurious does not hold up, for women at least. It is of interest that in Ireland, Waddington & Youssef (1992) found the relative risk of schizophrenia for persons born between 1940 and 1969, compared with those born between 1920 and 1939, to be 0.63, and that this effect was significant only for women and later-onset cases. It is also intriguing that in an analysis of the “schizophrenogenic effect” of the 1957 influenza epidemic, O’Callaghan *et al* (1991), using data from England and Wales, and Mednick *et al* (1990), in a reanalysis of Scottish data, found the effect to be confined to women. Such findings should reinforce, to schizophrenia researchers, that the disease affects men and women differently, and that consideration of such differences could provide useful clues to the aetiology of the condition (Castle & Murray, 1991).

CASTLE, D. J. & MURRAY, R. M. (1991) The neurodevelopmental basis of sex differences in schizophrenia. *Psychological Medicine*, 21, 565–575.

MEDNICK, S. A., MACHON, R. A., HUTTENEN, M. O., *et al* (1990) Influenza and schizophrenia. *Archives of General Psychiatry*, 47, 875–877.

O’CALLAGHAN, E., SHAM, P. C., TAKEI, N., *et al* (1991) Schizophrenia after prenatal exposure to 1957 A2 influenza epidemic. *Lancet*, 337, 1248–1250.

WADDINGTON, J. L. & YOUSSEF, H. A. (1992) The declining incidence of schizophrenia in a rural Irish population of unusual

#### Resource implications of Munchausen’s syndrome

SIR: The report by Drs Powell & Boast (*Journal*, February 1993, 162, 253–256) describes a man with Munchausen’s syndrome and the resource implications of his case. I would like to comment on their proposed treatment using the provisions of the Mental Health Act 1983.

Firstly, he may not be legally detainable. Even if it is accepted that he is suffering from psychopathic disorder, as defined in the Act, it is arguable whether detention is necessary, either for his health and safety, or for the protection of others (as described, the main threat he poses to others is the squandering of public funds). Neither is it clear that treatment is likely to alleviate his condition or prevent a deterioration. They describe his condition as “treatment-resistant”, and an aggregated three years of psychiatric admission seems to have conferred no benefit.

Their ethical justification for detention is that his behaviour is “not volitional” and so requires a paternalistic approach. It seems from their article that this behaviour is deliberate and purposeful. The lifestyle adopted by Munchausen patients, while not one that would appeal to most professional commentators, does have obvious rewards – accommodation, company, and status enhancing professional attention etc. – which make it likely to be a matter of choice.

Ultimately, their justification for detention is that by treating this man his quality of life would be improved and he would present less of a strain on public resources. The rationale for what they admit is a speculative treatment programme of coping skills, social skills, training, and education can be seen; but there is scant empirical evidence that such a programme is likely to change his behaviour. Furthermore, to benefit from such a programme he would need to actively participate, and it is difficult to see the place that legal compulsion can play.

The authors quantify the financial costs of his behaviour to date, but do not estimate the costs of their proposed treatment. It would seem that there is a danger of concentrating the financial burden which this man represents within one area and, by having continuous rather than intermittent hospitalisation for an indefinite period, possibly increasing the

overall costs while offering a very limited prospect of any long-term change in his behaviour.

In summing-up, I feel that compulsory treatment of Munchausen patients cannot be legally, ethically, clinically, or financially justified. However, I agree with the authors that such persons have tended to be neglected, if not rejected, and more efforts should be made to engage them in voluntary treatment which can then be properly assessed for its efficacy and cost-effectiveness.

W. BLACK

*Rampton Hospital  
Retford  
Nottinghamshire DN22 0PD*

**AUTHORS' REPLY:** Although the central theme of our paper was that of resources wasted by dysfunctional medical systems, Dr Black's sweeping assertions cannot go unchallenged. We continue to believe that detention could be legally justified under the category 'psychopathic disorder'. This is defined in the Mental Health Act 1983 as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned". There is ample evidence that our patient displays these features. As a result of his disorder, he has sustained numerous physical injuries of such severity that his safety is endangered and his health impaired. He has assaulted people and behaved dangerously (e.g. running in traffic), making him a risk to others. In addition, Dr Black points out correctly that compulsory treatment must be likely to alleviate the condition or prevent a deterioration. The authors are aware of two periods of detention during which his behaviour significantly improved, and although he is treatment-resistant this is not the same as an inability to benefit from any therapy.

The philosophical debate regarding whether a person's behaviour is volitional or determined is familiar in respect to Munchausen patients. One danger in such an approach is that patients deemed responsible for their unpleasant actions can easily be treated punitively or rejected, as sometimes happens to patients who harm themselves. One objective of our report was to avoid the traditionally polarised, moral view but, rather, to take a pragmatic perspective. Furthermore, simply because an individual behaves in an apparently wilful manner does not exclude him or her from having a psychiatric disorder, and one that might respond to treatment.

We agree with Dr Black that a central aim would be to improve quality of life, but we do not advocate

detention merely to avoid straining the public purse. However, more effective use of resources might achieve both these results and is always desirable. Since the patient has profited in the past from relatively unstructured therapy, it is not unreasonable to suggest that he might improve with the treatment programme described. There is evidence that patients can show clinical improvement without actively participating in a behavioural therapy programme. Moreover, most detained patients (and this patient in particular) cooperate to some degree in their treatment. We do not argue that continuous hospitalisation for this case, or for Munchausen patients in general, is either necessary or appropriate.

The authors have not presented a full economic evaluation of this man's treatment. In view of the expense of forgone opportunities to public services and private individuals, the underestimate of direct costs to the National Health Service, and indirect costs (e.g. the halting of a rail network), it is probable that this patient consumes more resources than would be needed to attempt to treat him. It is one of the central tenets of health service contracting that expenses are concentrated "in one area" as this practice improves clinical services and accountability. Under the previous system, the dispersal of costs led to their being obscured and encouraged a therapeutically nihilistic approach.

ROBIN POWELL

*Maudsley Hospital  
Denmark Hill  
London SE5 8AZ*

NEIL BOAST

*Chase Farm Hospital  
Enfield, London*

#### **Mental disorders and adaptive behaviour in people with Down's syndrome**

**SIR:** We read with interest the two related articles by Collacott *et al* (*Journal*, November 1992, 161, 671–674) and by Collacott (*Journal*, November 1992, 161, 675–679), reporting the occurrence of psychiatric disorders and changes in adaptive behaviour in people with Down's syndrome. Although the articles enhance our understanding of mental disorders in people with Down's syndrome, there were a few methodological flaws in both studies.

The authors fail to say whether the diagnosis of Down's syndrome was cytogenetically confirmed or not and, if so, of what type. Just as people with a