Schizophrenia-like psychosis in African and Caribbean elders

The interesting study reported by Reeves *et al* (2001) draws attention to mental health service provision for ethnic minority elders. However, their findings could be misleading as they repeat common errors of cross-cultural research.

By definition, African and Caribbean elders are not a homogeneous group. Neither are they synonymous with 'African–Caribbean'. As a population, they are of different history, ethnicity and culture. Furthermore, as migrants from different geographical regions of the world it is important that their different identities are appreciated, especially in their 'third age'. Unlike the melting pot of second and third generations, these elders maintain distinct values that influence their social and help-seeking interactions. Migration pathways between the groups are diverse as well, ranging from long-term to recent, academic pursuit to meeting labour needs and the 'culture-shocked' to the assimilated.

There are also fundamental problems with defining cases by place of birth. 'African-born' includes Algerians, Egyptians, East African Asians and White South Africans. Similarly, 'Caribbean-born' persons of African, Asian and mixed-race provide a richly heterogeneous population of elders. How does one draw meaningful scientific conclusions?

The authors did not clarify the proportion of subjects from each of the African and Caribbean groups in the study. This may influence analysis and outcomes. One must also make a clear distinction between onset of illness and contact with services. First contact above age 65 years does not necessarily imply late onset of illness as alternative care pathways and help-seeking patterns may prevail (e.g. years of Pentecostal church attendance). Psychotic symptoms may go undisclosed for many years, particularly among groups suspicious or mistrusting of mental health services. On the other hand, reports of witchcraft or communication with ancestors, previously culturally sanctioned, may be mistaken for psychotic (or schizophrenia-like) experiences.

The authors argue that referral bias by primary care and community physicians is unlikely, as evidenced by low contact rates for anxiety disorders and depression. This is of concern, however, as other researchers (Abas, 1996; Shah, 1998) have reported underdiagnosis of these disorders in ethnic minority populations, with a focus on psychotic and behavioural over affective symptoms.

Although Reeves *et al* opine that rates may be influenced by social isolation, physical ill health and social exclusion, this was not supported by evidence from their study.

The conclusions of this study are by no means generalisable and highlight ethnic and cultural confusion, as well as the neglect of depression and anxiety disorders, in research involving African and Caribbean elders. In the words of an elderly African, 'if the heart is too heavy with sorrow, it may disturb the mind'. As clinicians we must not ignore this cry.

Abas, M. (1996) Depression and anxiety among older Caribbean people in the UK: screening unmet need and the provision of appropriate services. *International Journal of Geriatric Psychiatry*, **11**, 377–382.

Reeves, S. J., Sauer, J., Stewart, R., *et al* (2001) Increased first-contact rates for very-late-onset schizophrenia-like psychosis in African- and Caribbean-born elders. *British Journal of Psychiatry*, **179**, 172–174.

Shah, A. K. (1998) The psychiatric needs of ethnic minority elders in the United Kingdom. *Age and Ageing*, **27**, 267–269.

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Authors' reply: We thank Dr Ayonrinde for raising the issue of heterogeneity within ethnic groups and would fully agree that this is particularly pertinent to the comparison groups chosen for our study. Very-late-onset schizophrenia-like psychosis is a relatively rare disorder and large populations would have to be surveyed to make any reasonable estimate of community incidence rates. The method we employed involved the enumeration of referrals to secondary care over a defined period and the estimation of source populations using census-derived data. In our case-note study, the ethnicity of referrals was defined by objective criteria (birthplace). However, subjective criteria were used in the 1991 census coding. For example, a person born in the Caribbean might choose to define him- or herself in their census return as Black Caribbean, Black African or Black Other. For this reason, we decided to include all African- and Caribbean-born referrals and all Black groups within the denominator populations. In fact, 96% of referrals were Caribbean-born and there are relatively few African-born people within the age ranges considered in south London.

All populations are heterogeneous, whether these are defined according to geography, culture, religion or shared ancestry. For research involving ethnic groups, the purist might argue that the only solution would be not to attempt any comparisons between categories, which will always be inadequate. This would mean that the evidence base for service provision and public health interventions would be derived entirely from the majority population. A fundamental objective of epidemiology is to describe and explain the distribution of health states across populations. Our findings suggest that incidence rates for an important disabling disorder are markedly different between two coarsely defined populations. Further research is clearly required to refine and explain this observation.

We cannot exclude from our data the possibility that a specific referral bias existed in relation to psychotic symptoms in African- and Caribbean-born individuals. However, for this alone to have accounted for the observed differences, the bias would need to have been at least ten times greater for African and Caribbean individuals. This would not accord with our experience of referral patterns to an old age psychiatry service in south London.

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Attitudes to depot antipsychotics

Walburn *et al* (2001) are correct to place their conclusions regarding patients' favourable attitude to depot antipsychotic medication in the context of the paucity of studies using unselected patient samples. Indeed, depot preparations tend often to be used for patients who are otherwise unlikely and/or unwilling to accept antipsychotic medication, and a true reflection of patient attitudes to depot antipsychotics can be established only from research based on representative samples of patients with psychotic illnesses.

In Australia, the study of Low Prevalence (Psychotic) Disorders (Jablensky *et al*, 2000), conducted in 1997–1998, allowed an arguably more accurate evaluation of patients' attitudes to depot medication. In this study, 998 persons with a non-organic psychosis were randomly selected from all

https://doi.org/10.1192/bjp.180.2.187-a Published online by Cambridge University Press

patients in contact with services during an index month, as well as selected groups who were not in contact with services in the index month, but had been in the previous 3 years. Also included was a group ascertained through 'marginal' services, such as homeless shelters.

The study established diagnoses, symptoms, disability and service utilisation for each participant. In terms of medication, around half were on 'typical' antipsychotics, with half of these being administered in depot form. A further 8.3% were on clozapine, 13.3% on risperidone and 8.8% on olanzapine. Demographic and illness parameters did not distinguish medication groups, although usage varied across different service providers. Clozapine tended to be used in patients with a long illness duration, compared with other agents.

Patients reported a mean of around 3.5 of a possible 14 medication side-effects. Some 83% of those using depot medication reported side-effects, compared with 79% of those using typical oral medication. Patients on depot preparations of typical antipsychotics reported the highest rates of akathisia, and were also least likely to perceive their medication as helpful; indeed, 17% rated it as 'not helpful' *v.* 12% of those on oral typical antipsychotics, 10% of those on olanzapine/risperidone and 5% of those on clozapine.

Thus, in unselected patient populations, patient perception of depot medications appears less favourable than the studies reviewed by Walburn *et al* might lead us to believe. Clinicians should attempt to enhance adherence to antipsychotics by means other than necessarily resorting to depot medication.

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Walburn, J., Gray, R., Gournay, K., *et al* (2001) Systematic review of patient and nurse attitudes to depot antipsychotic medication. *British Journal of Psychiatry*, **179**, 300–307.

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Depot injections and nut allergy

Many clinicians may be unaware of the use of nut oil as a vehicle within antipsychotic depot preparations. We report a case of possible coconut hypersensitivity which occurred during treatment with flupenthixol decanoate.

An elderly woman with a diagnosis of paranoid schizophrenia was commenced on a 3-weekly depot of flupenthixol decanoate (20 mg). After 5 months (seven injections), she complained of soreness and swelling around the injection site. The depot was subsequently administered at a different site and in a lower volume of oil. Within 1 hour, she experienced intense local irritation and a generalised pruritus. Her systemic symptoms began to resolve within 24 hours, but continued scratching at the injection site led to a localised infection. Since then she has refused further depot medication and is hostile towards psychiatric services. Enquiries revealed that all depot preparations of flupenthixol contain coconut oil.

The symptoms described by the patient might be attributable to a late hypersensitivity reaction to flupenthixol decanoate, but they may also be a manifestation of a previously undiagnosed coconut allergy. The patient has refused to be tested for specific immunoglobulin E antibodies to coconut and is guarded when questioned about her dietary habits. Although coconut hypersensitivity is relatively rare, coconut allergens show immunological cross-reactivity with both soy and walnut proteins (Teuber & Peterson, 1999). The prevalence of allergies to peanut and tree nut (e.g. walnut, brazil nut) is increasing (Sicherer *et al*, 2000). Similarly, the number of reported cases of hypersensitivity to sesame seed and sesame oil has risen in recent years (Levy & Danon, 2001). In sensitised individuals, non-ingestion exposure to food allergens results in less-severe reactions than are observed following inhalation or ingestion (Sicherer *et al*, 1999).

Depot preparations consist of an ester of the antipsychotic drug in a solution of coconut oil (flupenthixol, zuclopenthixol) or sesame oil (haloperidol, pipothiazine, fluphenazine). Currently, the *British National Formulary* (British Medical Association & Royal Pharmaceutical Society of Great Britain, 2001) provides no information regarding the oils used in depot preparations. Individual drug datasheets can also be misleading: coconut oil is referred to as 'vegetable oil' in the flupenthixol datasheet. Although guidelines regarding the labelling of food products are sometimes seen as overinclusive, they allow consumers to make an informed choice. Depot medications are in widespread use, particularly in patients with a history of non-compliance (Adams *et al*, 2001). To avoid further alienating such patients from psychiatric services, it is essential that both clinicians and patients are able to make informed treatment decisions. This can only occur if the constituents of depot preparations, particularly those relating to nut and seed products, are more clearly labelled.

Declaration of interest

S. R. has received support for attendance at conferences from Lilly and Janssen; R. H. has received support for attending conferences from Janssen, Eisai and Pfizer and has been on advisory boards for Janssen, Pfizer and Shire.

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Stigma, suicide and religion

A comment by Tadros & Jolly (2001) that 'Hinduism and Buddhism, among other Eastern religions, have not had a traditionally negative view of suicide' is not totally correct. According to Hinduism, 'The law of action is inexorable and inescapable. It is not bound by the chain of time. If you

https://doi.org/10.1192/bjp.180.2.187-a Published online by Cambridge University Press