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Correspondence

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Asperger's syndrome and violence

SIR: Scragg & Shah's paper on the prevalence of Asperger's syndrome (AS) in Broadmoor Hospital (*BJP*, November 1994, **165,** 679–682) is important because it alerts us to a group of people in special hospitals whose pattern of disability means that they have special needs and may be particularly vulnerable. Indeed there may be others with undiagnosed AS elsewhere in the criminal justice system.

Scragg & Shah assert that the prevalence of AS is significantly greater in Broadmoor Hospital than in the general community and that this supports an association between AS and violent behaviour. We would dispute whether the Ehlers & Gillberg (1993) study took a representative sample of the general community with which the Broadmoor population can be compared. They studied people from a different country (Sweden), of a different age (schoolchildren), of a different social background (predominantly middle class) and different educational background (all attended mainstream school). We therefore do not think that any difference in prevalence between the two groups can necessarily be attributed to an increased tendency for violent behaviour in the Broadmoor sample.

We would also dispute whether a significant difference in prevalence has in fact been demonstrated. Ehlers & Gillberg do not unfortunately report confidence intervals for their male subsample, but even taking their (lower) figures for the whole sample, we find that the confidence intervals in the two studies overlap. For definite AS, Ehlers & Gillberg (1993) found a prevalence of 0.36% (95% CI 0.11%–0.84%) among Swedish schoolchildren, and Scragg & Shah found 1.5% (95% CI 0.6%–3.3%) among men in Broadmoor. For figures including all possible cases, Ehlers & Gillberg found a prevalence of 0.71% (95% CI 0.34%–1.31%) and Scragg & Shah found 2.3% (95% CI 1.1%–4.3%). It cannot therefore be reasonably concluded that the differences in prevalence found were not due to chance alone.

Given the recent publicity surrounding the case of the 13-year-old boy with AS who killed an 85-year-old woman in Wimborne, Dorset (Wright, 1994), it is important that readers do not conclude that AS is associated with a increased tendency to commit violent acts when this has not been proven.

EHLERS, S. & GILLBERG, C. (1993) The epidemiology of Asperger syndrome. A total population study. *Journal of Child Psychology and Psychiatry,* **34,** 1327–1350.

WRIGHT, S. (1994) Bullied boy with an urge to kill. *Daily Mail,* 2 November, 10–11.

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Mental health reforms in Europe

SIR: Grove's editorial on reform of mental health care in Europe (*BJP*, October 1994, **165,** 431–433) was timely and wise. He correctly states that the medical role in psychiatry is increasingly being marginalised. This is very unfortunate as several of the developments in mental health care in recent years were initiated by psychiatrists.

Grove fails, however, to offer directions towards the future of mental health services either within the European Union or in Europe as a whole. The structural, organisational and funding changes in the health service systems occurring in most European countries will not leave the mental health services unaffected.

The current trends of staff skills mixing, the increasing participation of users and the quality of mental health service provision will be some of the issues to dominate the agenda in the next decade and beyond. What psychiatry will have to offer to

people involved with the law without having a diagnosable mental illness, will also be a problem requiring clarification.

Professional alliances in the mental health field will be a necessity, aiming to work towards global aims and good practices. The sooner the psychiatry of our times adopts this approach the better for everyone, especially the people we serve.

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ECT seizure threshold and fluoxetine

SIR: We describe the case of a patient given electroconvulsive therapy, where resulting convulsions were either shortened or absent despite conventional measures to lower seizure threshold. This problem was overcome by the simultaneous prescription of fluoxetine.

A 50-year-old man with a severe depressive disorder and suicidal ideation failed to improve despite treatment with amitriptyline 300 mg/day augmented by lithium carbonate. Physical examination and laboratory investigations were unremarkable. A course of bilateral ECT (Ectron series 5) was commenced; however, the convulsions generated were either short (less than 25 seconds) or absent, even at the maximum output of the apparatus and despite attempts to lower the seizure threshold, including pretreatment with caffeine sodium benzoate (Abrams, 1992). After 14 treatments the patient showed only slight improvement and ECT was withheld. Mean and total seizure duration were 6 and 108 seconds respectively (range 0–30). The medication regime was reviewed and the antidepressant changed to fluoxetine, increased to a dose of 40 mg/day. After a five week interval the patients' mental state deteriorated, culminating in a serious suicide attempt. A second course of ECT was commenced, a total of eight treatments were given in the same way as previously described, however on each occasion convulsions were now in excess of 25 seconds duration (mean 31 seconds, range 26–45; total duration 220 seconds). At the end of eight treatments the patient was judged to be markedly improved, he denied depressed mood or suicidal ideation, showed an improvement in sleep and appetite, and began interacting with fellow patients and engaging in occupational therapy.

The effects of antidepressants on seizure threshold and duration are variable and unpredictable (Pritchett *et al*, 1993). Fluoxetine is reported to have been associated with prolonged seizures in patients receiving ECT (ABPI data sheet compendium), however Guitierrez-Estinou & Pope (1989) found no difference in seizure duration in patients given ECT plus fluoxetine compared with patients given ECT alone. In the case of our patient the addition to fluoxetine did appear to be associated with prolongation of seizure length and with outcome. This raises the possibility of an idiosyncratic effect of the drug on seizure threshold.

ABRAMS, R. (1992) *Electroconvulsive Therapy* (2nd edn). New York: Oxford University Press.

GUITIERREZ-ESTINOU, R. & POPE, H.G. (1989) Does fluoxetine prolong electrically induced seizures? *Convulsive Therapy*, **5**, 344–348.

PRITCHETT, J. T., BERNSTEIN, H. J. & KELLNER, C. H. (1993) Combined ECT and antidepressant drug therapy. *Convulsive Therapy*, **9**, 256–261.

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Discrepancies on prescribing antipsychotics

SIR: Recently, much effort has been directed towards reaching a consensus on the use of antipsychotic medication in the United Kingdom (Thompson, 1994). Anecdotal evidence suggests, however, that any differences that may exist between practitioners in the UK are only minor in comparison to those between practitioners in the various countries in the European Union (Van Os *et al*, 1993). In this context, we investigated differences in antipsychotic prescribing practice among French and UK psychiatrists. Patients with an RDC or DSM–III–R diagnosis of schizophrenia were drawn from two British and French cohorts consisting of consecutive admissions. French patients (n=107) were much more likely to have been prescribed two or more oral antipsychotics than British ones (38.3% v. 1.4%; $P<0.0001$). British patients (n=70) were more likely to have received a single depot antipsychotic (35.7% v. 7.5%; $P<0.0001$), but there was also a slight excess in the number of patients who were prescribed a depot antipsychotic in combination with a different oral compound (24.3% v. 12.1%; NS). The same large and significant differences were present in men and women, in the under-30s and in the over-30s, in acute in-patients and in out-patients, and in recent onset and chronic patients alike. The discrepancy in prescribing habits presented in this study may also be relevant to the issue of high-dose antipsychotic