

began during pregnancy. It is important to disentangle the impact on the infant of the mother–infant relationship and the environment she provides for her child from those genetic factors which place the infant at risk.

Neurobiological features are suggested by reports that: variations in maternal care in the rat promote hippocampal synaptogenesis and spatial learning and memory through systems known to mediate experience-dependent neural development (Liu *et al.*, 2000); schizophrenia is a disorder of developmentally reduced synaptic connectivity (McGlashan & Hoffman, 2000); and selective deficits in early-stage sensory processing in schizophrenia are due to a failure to support the entrainment of intrinsic gamma-frequency oscillations (30–50 Hz or broader, centred on 40 Hz) (Friedman & Coats, 2000) involved in processes associated with encoding into sensory memory both at the cellular level (synaptic potentiation) and at the cognitive level (Haenschel *et al.*, 2000).

This hypothesis is supported by short-term laboratory experience demonstrating that adult female speech production is sufficient to influence infant speech production occurring in the silent intervals between the adult vocalisations of the order of 3 seconds. This is linked with increased coherence of electroencephalograph gamma-band activity associated with the execution of more complex tasks (Friedman & Coats, 2000); language discrimination by human newborns may be influenced by hearing rhythmic aspects of speech while in the womb, a period in development during which exposure may have a more profound impact on the organisation of the brain than does learning after birth (Ramus *et al.*, 2000).

These findings prompt the possibility of prevention of neurocognitive defects (at least those of a sensory and perceptual nature) by establishing effective cortical oscillations, starting during pregnancy as suggested by Yoshida *et al.*

**Friedman, E. H. & Coats, A. J. S. (2000)**

Neurobiology of exaggerated heart rate oscillations during two meditative techniques (letter). *International Journal of Cardiology*, **73**, 199.

**Haenschel, C., Baldeweg, T., Croft, R. J., et al (2000)**

Gamma and beta frequency oscillations in response to novel auditory stimuli: A comparison of human electroencephalogram (EEG) data with *in vitro* models. *Proceedings of the National Academy of Sciences of the United States of America*, **97**, 7645–7650.

**Liu, D., Diorio, J., Francis, D. D., et al (2000)** Maternal care, hippocampal synaptogenesis and cognitive development in rats. *Nature Neuroscience*, **3**, 799–806.

**McGlashan, T. H. & Hoffman, R. E. (2000)**

Schizophrenia as a disorder of developmentally reduced synaptic connectivity. *Archives of General Psychiatry*, **57**, 637–648.

**Ramus, F., Hauser, M. D., Miller, C., et al (2000)**

Language discrimination by human newborns and by cotton-top tamarin monkeys. *Science*, **288**, 349–351.

**Yoshida, K., Marks, M. N., Craggs, M., et al (1999)**

Sensorimotor and cognitive development of infants of mothers with schizophrenia. *British Journal of Psychiatry*, **175**, 380–387.

**E. H. Friedman** 1831 Forest Hills Boulevard,  
Cleveland, OH 44112, USA

### Disclosing the diagnosis of dementia

We read with interest the paper about truth-telling and the diagnosis of dementia (Pinner, 2000). The thrust of the article is that people with dementia should be told the diagnosis in the same way that patients are told that they are suffering from cancer. The disadvantages of this approach are stated but underplayed. In clinical practice it is common to see patients who have been told the diagnosis of cancer, sometimes with such frankness that they have gone on to develop major psychological sequelae and sometimes fatal decline.

We experienced this recently when a 58-year-old woman, after being made aware of her diagnosis of dementia, developed severe depression and suicidal ideas. The depression worsened her cognitive state and made her non-compliant to intervention. Cognitive decline makes patients more vulnerable and reduces their ability to cope with stress (Clafferty, 1999). Suicides after disclosure of diagnosis have been described (Rohde *et al.*, 1995). Insight regarding progressive cognitive decline is an important determinant of reaction to disclosure. In insightful patients the risk of depressive reactions and suicide must be seriously considered after disclosure of any major illness (Maguire *et al.*, 1996).

The debate about this issue is a further example of the importance of dealing with each patient as an individual. It is good practice for every patient to be informed about the illness and its implications. It is equally important to accept that some patients do not want to know the nature of their illness and informing them is harmful. This perspective needs greater emphasis in

a climate when telling everyone is sometimes seen as the only approach.

**Clafferty, R. A. (1999)** Dignity in knowledge. Informing patients with Alzheimer's disease about their diagnosis. *Psychiatric Bulletin*, **23**, 394–396.

**Maguire, C. P., Kirby, M., Coen, R., et al (1996)** Family members' attitudes towards telling the patient with Alzheimer's disease their diagnosis. *British Medical Journal*, **313**, 529–530.

**Pinner, G. (2000)** Truth-telling and the diagnosis of dementia. *British Journal of Psychiatry*, **176**, 514–515.

**Rohde, K., Peskind, E. R. & Raskind, M. A. (1995)** Suicide in two patients with Alzheimer's disease. *Journal of the American Geriatric Society*, **43**, 187–189.

**A. Ahujn, D. D. R. Williams** Cefn Coed  
Hospital, Waunarlwydd Road, Cockett, Swansea  
SA2 0GH

### Need for neuropathological studies in pre-senile dementia

Kay *et al.*'s paper (2000) on long-term survival in pre-senile dementia adds a useful and important contribution to this under-researched area. While acknowledging the difficulties faced in drawing valid conclusions from a non-neuropathologically confirmed study, there are several points of interest and concern not raised by the authors.

Pre-senile dementia is a heterogeneous group of disorders and the report that only 19 of 233 cases were not pre-senile dementia of Alzheimer type or pre-senile vascular dementia is a concern. The authors previously recognised that cases defined as Alzheimer's disease by clinical criteria alone may include conditions with non-Alzheimer type pathology, such as Pick's disease (Newens *et al.*, 1993), but felt this reflected only a small number of patients. However, recent evidence suggests that the fronto-temporal dementia (FTD) may account for up to a quarter of patients presenting before the age of 65 (Snowden *et al.*, 1996). Retrospective analysis of case notes using the NINCDS–ADRDA criteria (McKhann *et al.*, 1984) for diagnosing Alzheimer's disease may well include many FTDs, as the criteria for a diagnosis of probable Alzheimer's disease are also features of this subgroup.

The diagnosis was reportedly confirmed in a proportion as part of a case–control study, although there is a risk of selection bias by possible exclusion of the more behaviourally challenging uncooperative FTD patients.

The unrepresentative nature of the pre-senile vascular dementia group is acknowledged by the authors, and patients with mixed Alzheimer's and vascular pathology are also likely to be included in this vascular category. To date it is unclear as to the degree to which the two conditions coexist. As it is apparent that the Alzheimer's disease group may also be unrepresentative, the question begs to be asked, what groups are actually being compared? The overall suggestion that pre-senile Alzheimer's disease and vascular dementia have a similar prognosis needs to be taken in the context of these limitations and highlights the need for neuropathological studies in this area.

**Kay, D. W. K., Forster, D. P. & Newens, A. J. (2000)** Long-term survival, place of death, and death certification in clinically diagnosed pre-senile dementia in northern England. Follow-up after 8–12 years. *British Journal of Psychiatry*, **177**, 156–162.

**McKhann, G., Drachman, D., Folstein, M., et al (1984)** Clinical diagnosis of Alzheimer's disease: report of the NINCDS–ADRDA work group and the auspices of Department of Health, and Human Services Task Force on Alzheimer's disease. *Neurology*, **34**, 939–944.

**Newens, A. J., Forster, D. P., Kay, D. W., et al (1993)** Clinically diagnosed presenile dementia of the Alzheimer type in the Northern health region: ascertainment, prevalence, incidence, and survival. *Psychological Medicine*, **23**, 631–644.

**Snowden, J. S., Neary, D. & Mann, D. M. A. (1996)** Fronto-temporal lobar degeneration. In *Fronto-Temporal Dementia, Progressive Aphasia, Semantic Dementia*, pp. 1–227. Edinburgh: Churchill Livingstone.

**M. C. Dale** Old Age Psychiatry, Fleetwood Hospital, Pharos Street, Fleetwood FY7 6BE

### Psychotherapy and developmental disability

I welcome Holmes' (2000) editorial outlining the application of psychotherapies in psychiatry and across the sub-specialities. He advocates the inclusion of the broad range of psychotherapeutic treatments in all psychiatric practice and the development of a research and evidence base for the work. It is of concern, however, that in spite of his reference to learning disability as a psychiatric speciality in his introduction, he has effectively excluded people with learning disability by failing to include those with a developmental disability in his list of those benefiting from psychotherapeutic techniques.

On account of the neglect of developmental disability by psychotherapy, the

Institute for Disability and Psychotherapy has been founded in order to provide, train in and research effective treatments for people with developmental disability and thus include them in health care. Each method of therapy cited in the editorial from analytic to family therapy is relevant and applicable to the patient group in my practice. Common themes in the experience of their lives are abuse and rejection (Sinason, 1992). The behavioural and psychological manifestations and the effects on personality of these problems in a person with developmental disability have the potential to give invaluable insights into the development of personality and the treatment of personality disorders in the population without developmental disability.

I hope that practitioners of the psychotherapies will have the courage to embrace all that working with people with developmental disability has to offer and to include rather than further compound the exclusion of people from the provision of effective care and treatment.

**Holmes, J. (2000)** Fitting the biopsychosocial jigsaw together. *British Journal of Psychiatry*, **177**, 93–94.

**Sinason, V. (1992)** *Mental Handicap and the Human Condition*. London: Free Association Books.

**K. P. Courtenay** Department of Psychiatry of Disability, St George's Hospital Medical School, Jenner Wing, Cranmer Terrace, London SW17 0RE

### Ethnic differences in forensic hospitalisation

It is sobering to note that Coid *et al* (2000) have once again found that variations in compulsory hospitalisation cannot be entirely attributed to racial bias, as some would lead us to believe. This was a large multi-centre study that did not limit itself to inner-city areas. The authors must be congratulated on their courage in challenging a popular and attractive myth and at the same time suggesting that services should be culture-sensitive.

Regarding their question of whether (predominantly White) forensic psychiatrists actively select White people with personality disorders as more suitable for treatments such as psychotherapy in secure setting, the answer may lie in the fact that maybe White people do have a greater chance of having a personality disorder

(and thus meriting treatment) than the Black or Asian population. There is a study currently taking place at the Institute of Psychiatry and Broadmoor Hospital which is looking at Black patients with personality disorders, and the results should be most interesting. The Asian people in this study show a less than expected degree of morbidity, personality disorder, substance use and previous conviction, in spite of sharing the same socio-economic disadvantage, which is consistent with current knowledge. To paraphrase Freud, maybe a cigar is just a cigar.

**Coid, J., Kahtan, N., Gault, S., et al (2000)** Ethnic differences in admissions to secure forensic psychiatry services. *British Journal of Psychiatry*, **177**, 241–247.

**S. P. Sarkar** Broadmoor Hospital, Crowthorne, Berkshire RG45 7EG

### Stigmatisation: classifying drug and alcohol misuse as mental illness

Crisp *et al's* (2000) article aims "to determine opinions of the British adult population concerning those with mental illnesses as baseline data for a campaign to combat stigmatisation". Specifically, the authors go on to list the disorders investigated: severe depression, panic attacks, schizophrenia, dementia, eating disorders, alcoholism and drug addiction.

I was surprised by the way in which alcoholism and drug addiction were grouped under the label of mental illness as if this was a commonly accepted truth within the scientific community.

The literature on drug and alcohol use and addiction suggests that these phenomena have to be seen as a complex interaction between a variety of factors, including psychosocial ones (McMurrin, 1994). Similarly, views on drug use (and also mental illness) may change over time and are also the result of socio-political and historical contexts (Foucault, 1967; Levine, 1979). Treating drug and alcohol addiction as mental illness is an indication of the way mental illnesses are currently defined by the American Psychiatric Association (Cooksey & Brown, 1998) and should perhaps not be accepted all too readily as truth.

I recognise the psychiatric community's need to categorise mental illnesses. However, by classifying drug and alcohol users as suffering from mental illness, a