

reanalyse their data using probabilities that take into account the effect of single sex selection.

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SIR: Lacey *et al* (*Journal*, August 1991, **159**, 291) have repeated their claim that female bulimics from two-child families would be expected, by chance, to have twice as many brothers as sisters. This erroneous claim led them to interpret their own data that brothers and sisters were roughly equally common as evidence that all-female sibships represent a risk factor for bulimia. They are right, of course, that male-female sibships are roughly twice as common in the general population as female-female sibships. They have forgotten, however, that they were twice as likely to ascertain the latter since either sister could present at their clinic. Assume, for example, that bulimia led to clinic referral in 1 in 1000 females. Lacey *et al* would then have had a 1 in 1000 chance of including any sibship with just one female (such as a male-female sibship), but a 2 in 1000 chance of including any sibship with two females (assuming the risk was equal but independent for both sisters). After allowing for this unequal ascertainment, male-female and female-female sibships should have been equally common in their sample. Since their results do not differ significantly from this expectation, their findings do *not* suggest that women from all-female sibships are at greater risk of bulimia.

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Apparent decrease in schizophrenia

SIR: Eagles (*Journal*, June 1991, **158**, 834–835) comments on the findings of Der *et al* (1990) as part of a growing body of evidence that suggests the incidence of schizophrenia is decreasing (e.g. Eagles *et al*, 1988). Methodological and diagnostic complexities notwithstanding, these observations are compelling, as they have been noted in both hospital (first-admission) and community-based populations.

Eagles cites possible explanations for this phenomenon, including changing environmental risk factors such as decreased perinatal injury and decreased prevalence and/or incidence of various infectious diseases. To this list we would like to add changing patterns of exposure to illicit and recreational drugs.

Bowers (1987) studied data from Connecticut state hospitals for the years 1967–1979 and concluded that an increase in first admissions of substance-abusing patients was followed in three to five years by an increase in first admission rates for schizophrenic and paranoid disorders. The association was particularly strong for young psychotic patients. Similarly, McLellan *et al* (1979) reported that five out of 11 military veterans with stimulant and hallucinogen abuse requiring repeated hospital admission developed psychotic disorders during a six-year follow-up. Psychoses were specific to stimulant abusers when compared to patients abusing depressants and opiates.

We agree with Eagles that study of the social and demographic features of the specific population which has shown the greatest decline of schizophrenia would be helpful in explaining this apparent decrease. Among those features worth investigating would be recreational drug use and its relationship to the incidence and course of psychotic illness in that population.

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The human brain and political behaviour

SIR: Hugh Freeman's explanation of political behaviour in largely psychological – psychopathological terms made interesting reading (*Journal*, July 1991, **159**, 19–32). However, to extend the argument, “a crooked molecule behind a crooked thought” to “a crooked molecule behind a crooked policy” appears too simplistic, hardly capable of explaining any complex sociocultural phenomenon.

The paper's major thrust is that social and political changes result from individual actions, which are in turn influenced by personality and psychopathology. Although individuals as leaders do seem to change