DEAR SIR,

We note the criticisim of our paper 'Marital Stability following the Birth of a Child with Spina Bifida', made by Dr Stevenson and his co-workers, and accept that due to a major statistical error the rates of divorce occurring among parents of handicapped children in our series were greatly exaggerated. However, what we regard as the main point of our contribution remains intact, namely that the family at greatest risk of divorce is the one where the surviving handicapped child was premaritally conceived, and that this seems to be in sharp contrast to the chance of divorce in those families where the premaritally conceived malformed infant does not survive long.

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PSYCHIATRY FOR STUDENTS OF MEDICINE

DEAR SIR,

In a recent review of *Psychiatry for Students of Medicine* by L. Corbett and myself (*Journal*, August 1977, **131**, p 209), the reviewer stated that we engaged in a polemic against radical psychiatrists, quoting a section 'some of the . . . heroes of the New Left are little more than half-baked and evil charlatans and megalomaniacs'. It is unfortunate that your reviewer replaced a key word in this sentence, 'intellectual', by three dots, thus distorting its meaning. The reference here was to certain philosophers whose writings form the intellectual basis of New Left Psychiatry, namely Hegel and Marx and certain living American and French philosophers. No reference was intended to any practitioner of New Left Psychiatry. The interested reader is referred to Karl Popper's book *The Open Society and its Enemies* which represents a devastating exposé of the evil characteristics of Hegelian and Marxist philosophy. It is of interest that a group of young and influential French philosophers have recently made the claim that Marx was not only an incompetent economist but a highly evil influence on the world. It seems that psychiatry should be aware of the psychological effects of theoretical philosophical systems in practical affairs. This was the basis for drawing the medical student's attention to these matters.

In a day and age when the Royal College of Psychiatrists leads a violent attack on its Russian colleagues such as took place at the recent meeting of the World Psychiatric Congress in Honolulu, it seems that medical students should be educated as to the basis of these political endeavours. If psychiatrists of the West merely remain silent about the consequences for human behavioural patterns of people like Hegel and Marx, then by default the Russians gain an advantage. There is one theory that Marx and Hegel were eminently sensible social scientists, promulgating reasonable courses of action, whose implementation into fact has been distorted by the Russian Communist Party. There is another theory that the systems promulgated by Hegel and Marx are inherently evil and are bound to lead to the Gulag situation, no matter who promulgates them. If the Royal College of Psychiatrists is going to indulge in political activity such as was witnessed at the recent WPA meeting, then students in psychiatry need education in these matters. This was the intention behind this chapter in the book.

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ACUTE PSYCHOTIC REACTIONS IN AFRICANS

DEAR SIR,

In their paper on the diagnostic classification of female psychiatric patients in Zambia (*Journal*, June 1977, **130**, p 573), Drs Rwegellera and Mambwe mention the high rate of depressive illness and the paucity of acute psychotic reactions compared with other recent studies in Africa. Acute psychotic reactions or bouffées délirantes have been commonly reported in Africa, the Caribbean and elsewhere (Constant, 1972; Lambo, 1960; Royes, 1962; Sutter *et al*, 1974).

The authors point out that treatment was delayed until a firm diagnosis was made, using a structured interview, detailed discussion with staff and relatives, and British operational criteria; they suggest this is unusual in Africa and probably accounts for their large number of depressed patients. Some of the admissions were of initially acutely disturbed women who then settled down and 'remained with the clinical features of the underlying psychiatric disorder'. It appears likely that if a proportion of the patients who subsequently were diagnosed as depressed after an initially disturbed presentation had been diagnosed

at the time of admission, the most suitable diagnosis might have been an acute psychotic episode.

If acute psychotic reactions occur in Africa and the West Indies, it is likely that they will be found in Britain in immigrants from those areas. 'Acute psychotic reaction' is not a favoured British diagnosis, and while some authors stress the presence of 'atypical reactions' among them, most suggest that psychoses in immigrants can be easily fitted into Kraepelinian categories (Copeland, 1968; Hemsi, 1967; Rwegellera, 1977). West Indian patients have been reported as having high rates of schizophrenia and low rates of affective illness compared to the British-born population (Cochrane, 1977).

A prospective study we have carried out in East London on a series of patients with religious and 'cultural' delusions yielded 24 African and Caribbean-born patients. A Religious Interest Questionnaire and the Present State Examination were used to interview the patients and their relatives. In the 16 patients without first-rank symptoms of schizophrenia (as defined by the PSE nuclear syndrome) a consistent clinical pattern emerged of an initially disturbed and acute onset with agitation, persecutory delusions involving witchcraft, and auditory hallucinations, in the absence of hypomanic affect or clouding of consciousness. These florid symptoms disappeared within a few days, to be replaced by depressive features such as loss of interest, loss of energy and difficulty in concentration, poor appetite, and in some patients depressed mood. There had been similar episodes, which had been diagnosed as schizophrenia, in 12 patients.

It seems possible that these patients resemble those diagnosed as having acute psychotic reactions in Africa and the Caribbean, and are similar to some of the patients from these areas diagnosed in Britain as being schizophrenic. If this is the case, the diagnoses appear to be largely based on the initial symptoms observed at the time of admission. A diagnosis made a few days later without reference to the state when first seen would perhaps be, more suitably, depression. Such patients could be described as experiencing acute psychotic reactions with later depressive features or essentially depressive illnesses with an initially agitated paranoid presentation.

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RISKS OF TRICYCLIC ANTIDEPRESSANTS

DEAR SIR,

In comparing the relative hazards of antidepressant treatment and death from suicide, Dr David Shaw (*Journal*, May 1977, **130**, pp 432–51) quotes figures from a recent paper by Girdwood (1) which show the number of deaths per million prescriptions to be 2·3 in the case of amitriptyline and 3·6 in the case of imipramine. Girdwood's paper, however, deals only with deaths which occurred at therapeutic doses. His figures exclude the much larger number of deaths due to deliberate over-dosage of tricyclic compounds.

As it happens, I can supply this figure. There were 8·1 million antidepressant prescriptions in 1974, of which about 95 per cent appear to have been tricyclic drugs. I have previously reported a method of calculating the number of fatal suicidal poisonings due to tricyclics which almost certainly gives a conservative estimate (2, 3). There were 167 such deaths in 1974, which means that there were at least 20 deaths per million tricyclic prescriptions. If *all* suicidal, accidental and undetermined deaths involving tricyclics are included, there were twice that number.

In any depressed patient the risk of suicide always exists, and it is therefore particularly important to avoid prescribing drugs with which the patient can easily kill himself. The tricyclics are the most toxic of the commonly prescribed psychotropic drugs (4).