operate a strict non-prescribing policy. A significant proportion of our notifications were provided by "non-statutory" sources such as voluntary agencies and drug users themselves. Although multisource enumeration methods are expensive and time-consuming, they demonstrate the independence of different sources of information. The value of individual sources for continued monitoring varies from place to place and from time to time, according to patterns of local service provision and the views of the users themselves about the value of the different agencies. Local knowledge is vital for making choices about which agencies reflect trends most accurately, and choices may need to be revised as patterns of service use change over time.

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ECT in Parkinsonism with Affective Disorder

SIR: The paper by Atre-Vaidya & Jampala (*Journal*, January 1988, **152**, 55–58) is a most interesting contribution to, but not a complete solution of, the problem of the effectiveness of ECT in these conditions. Sometimes parkinsonism responds; sometimes depression responds; sometimes both respond; sometimes neither responds.

I have made observations on five patients who were referred to me for ECT for severe depression, who also had independently-made diagnoses of Parkinson's disease, and who had not recently received levodopa or anti-psychotic drugs. As well as clinical observation, several rating scales were used, before treatment and after treatment. Memory was rated by the Mental Status Questionnaire (Kahn *et al*, 1960) and the forward digit span of the Wechsler memory sub-scale (Wechsler, 1965). Depression was rated on the Hamilton scale (Hamilton, 1960). Parkinsonism was rated on the Simpson Angus scale (Simpson & Angus, 1970), and the Webster scale (Webster, 1968).

Treatments were right unilateral, with electroencephalographic recording of adequate seizure activity. In three cases parkinsonism and depression both improved. In one case parkinsonism was not usefully improved (although improved on rating scales), but depression improved. One patient, previously bedridden by parkinsonism, became mobile enough to walk to a window and try to jump out. Her depression was not improved usefully, even after nine treatments.

By the fourth treatment, the Simpson-Angus scores had improved in all cases. By the fifth treatment the Webster scale had improved in all cases. Memory worsened temporarily in one case, and improved in the others.

At follow-up, improvement in parkinsonism is maintained four years later in one patient; it relapsed in one month in one patient and at one to two months in two others. Follow-up is incomplete in one.

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Failure to Convulse with ECT

SIR: Whatever the constitutional or other factors involved, failure to convulse with ECT, as described by Sharpe & Andrew (*Journal*, January 1988, **152**, 134–136), indicates an inadequate or inefficient type of stimulus for that patient.

Since the patient resistance is unknown, but probably between 200 and 500 ohms, the stimulus E2 with Ectron Duopulse IV on setting 2 would have given a dosage of between 215 and 416 mC; E1 on setting 1 of between 328 and 683 mC. In both cases the duration is 1.7 s. The last 4 ms of each semi-sine wave is largely ineffective because of falling potential, so that the effective stimulus is 108–208 mC (E2), and 164–342 mC (E1).

With stimulus T (Transpsycon on 50J setting) the output is between 336 and 540 mC in about 1.25 s. Owing to the rapid exponential fall of potential with this capacitor discharge type of apparatus the effective stimulus is limited to the first 0.5–0.75 s.

The optimum parameter levels for ECT are still uncertain, but the above durations are probably too short, and the effective current too low, to induce seizures in every patient.

It is impossible to allow for all the variables, but the use of a constant current stimulus largely compensates for variation in the patient resistance. Most

patients will have adequate seizures and satisfactory clinical response with a constant current stimulus of 275–325 mC lasting about 3.25 s at a pulse rate of 50 to 60/s. The apparatus should provide for the possible delivery of a lower or higher charge than this to meet the needs of the minority with low or high thresholds.

If results of ECT are to be compared, full details of the stimulus must be stated. This necessitates the use of up-to-date equipment which will give a readout of the actual dosage in mC received by the patient so that proper records can be kept.

For 50 years many of us have blindly used ECT on a hit or miss basis, falsely believing that the only thing that mattered was to achieve some sort of seizure. Much more is now known about ECT even than 10 years ago. This knowledge, together with adequate training in the technique, is essential for those who administer the treatment if it is to be used rationally and not to fall into disrepute.

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Chronic Schizophrenia and Long-Term Hospitalisation

SIR: May I be allowed briefly to record puzzlement that my last letter is considered by Professor Wing to contain the "new statement that attitudes to discharge from hospital are entirely explained in schizophrenic patients by the severity of their disorder." (*Journal*, January 1988, **152**, 144–145).

No such statement or any comment related to it appears in the letter (*Journal*, November 1987, **151**, 708). Such a statement would be entirely contrary to my known views (Abrahamson & Brenner, 1982; Abrahamson *et al*, 1986) and practice, which emphasise that schizophrenic patients' attitudes to discharge are expressions of personal choice not reducible to the effects of either illness or "institutionalism".

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Incest and Anorexia Nervosa

SIR: We read with interest Dr D. M. Hambidge's letter (*Journal*, January 1988, **152**, 145–146), and agree entirely with his observation of a "recent large increase in the number of women referred for assessment and management of the longer-term consequences of sexual abuse in childhood and adolescence." We also have come across several such new referrals recently.

We support Dr Hambidge's views on a causal link, but would like to add a few points. Although Oppenheimer *et al* (1985) and Sloane & Leichner (1986) have discussed the possible relationship between adverse sexual experiences or abuse and eating disorders, all the cases taken into consideration were of either anorexia nervosa with weight loss or normal-weight bulimia nervosa. We wish to extend this possible link to the whole spectrum of eating behaviour disorders: to include cases of obesity as well. Of the four most recent cases in our series, two were significantly overweight and two underweight, their weight on presentation being more than 20% above or below their average normal weight for their height and age.

We were fascinated by the comments made by two obese women about their 'body image'. In view of their adverse sexual experiences in childhood, they did not wish to be seen as sexually attractive to the opposite sex, thus subconsciously eating more to distort their body shape. Both obese women were married, and there were marked differences in the premorbid personality of the obese and anorexic/bulimic patients. In our experience, obese patients also tend to have lesser degrees of difficulty in subsequent sexual adjustment.

Scott & Thoner (1986) investigated 30 female anorexic in-patients, 30 female incest victims, and 30 female control subjects using the Minnesota Multiphasic Personality Inventory (MMPI), and reported remarkable similarities between anorexic and incest groups, with characterological elevations on five clinical scales and lower scores on Barron's ego strength scale. Details of childhood sexual experiences in the anorexic group and of eating behaviour in the incest group were not reported in the paper.

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