Brit. J. Psychiat. (1971), 118, 591–92

Correspondence

LITHIUM PROPHYLAXIS

DEAR SIR,

I have read with interest the paper by M. Schou and his colleagues (*Journal*, June 1970, 116, p. 615) and the following is a short account of my own experience:

Thirteen patients, all of whom had a history of several in-patient admissions for the treatment of manic-depressive disease, were selected for treatment by lithium carbonate. None showed evidence of heart or kidney disease. Kidney function was tested by routine urine, blood urea, and creatinine clearance tests, and base-line determinations of blood levels were obtained before treatment. Wherever possible twenty-four hour urine samples were used to estimate lithium excretion after the start of treatment. Dosage was adjusted from an initial 250 mg. three times daily until the serum level was within the therapeutic range of 0·8–2·0 m.eq./l. Most patients attained this range on 750 mg. daily, though one required 1,000 mg. daily and another 1,500 mg. One woman requested a long-acting preparation and received 1,200 mg. Priadel each morning. Serum levels of lithium were estimated at first fortnightly and then at intervals of 4 to 6 weeks when patients returned for a further supply of tablets. These tests provided a useful check on the maintenance of therapeutic levels, or could indicate discontinuance of the tablets by the patient.

An arbitrary starting point of 1 January 1966 was taken, although most patients had a history of manic-depression extending well before then. This gave an average period of observation of 3½ years before treatment began, in which time there had been 36 admissions, 4 of them of more than 10 months. If the long-stays are included, the average duration of an in-patient spell was just over 2 months; if they are excluded, it was just over one month. In the average follow-up period of 16 months after the start of treatment only one patient was re-admitted, and he was found to have stopped taking the tablets. On the basis of the pre-treatment experience, 8 or 9 readmissions would have been expected, or alternatively a total in-patient duration of just over a year, or 4 weeks per patient, if shorter spells only are considered (and about twice that period if the longer spells are included). Even if the single post-treatment readmission (of 7 weeks' duration) is not excluded, because of ceasing treatment, the difference from the expected pattern of readmissions is very pronounced.

Among other noticeable improvements, 12 of the 13 patients are not only employed but have not changed their jobs since starting lithium treatment. The thirteenth patient, who had not worked for 5 years before his last hospital admission, is about to start work with the Industrial Therapy Association. No evidence of toxicity was found, nor were any side-effects reported in this series of patients.

There is good evidence, therefore, that for manic-depressive patients lithium carbonate treatment, suitably monitored at regular intervals, can not only afford a good measure of stabilization of behaviour, resulting for instance in a better employment record, but can also greatly reduce the necessity for readmission to hospital.

I should like to thank Dr. Charles Entwistle for permission to use cases of his, and Dr. R. A. Carter and his staff for the laboratory tests.

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CRISIS THEORY AND POSSIBILITIES OF THERAPEUTIC INTERVENTION

DEAR SIR,

Dr. Brandon's valuable paper (1) deserves the widest discussion, particularly in the current context of the Social Services Act and the new Departments of Social Welfare. Intervention by representatives of the community will be increasingly possible to families and individuals in crisis.

The formulation of theory behind such intervention seems of great importance. While great credit is due to Professor Gerald Caplan and Eric Lindemann in the development and extension of 'crisis intervention,' for the future development, no less than for historical accuracy it would be a pity to see 'crisis theory' in the context of ego psychology. Here psychiatry and social work must pay respects to earlier workers, whether their work has 'diffused' or has been rediscovered is somewhat irrelevant to decide. Van Gennep's *Rites de Passage* (5), and Chapple and Coon's (2) rate of interaction formulations cover the issues more cogently than derivations from psychodynamic theory. One has only to consider the tortuous and laborious explanations regarding

initiation ceremonies (3) and the couvade (4) offered from psychodynamic theories vis-à-vis explanations derived through van Gennep and Chapple and Coon to see the importance of this argument.

In the practical field the issue is no less important, since those brought up in psychodynamic theory have to work under the constant discouragement of their only offering second best to their patients and clients. 'The talking cure', whatever its merits and disadvantages in the clinical setting, seems positively disadvantageous in the social context. Whether 'catharsis' or 'dialysis' the logorrhoea of interviews spread over a really long session, one and a half or two hours, makes one shudder at some current practice, and even more, aspirations. Fortunately case loads for crisis intervention often minimize such trauma.

Whether one accepts Dr. Brandon's formulation of an individual as a storehouse of coping mechanisms or no (it raises memories of Janet's psychasthenia too vividly to be comfortable) there can be little debate that a review of strategic deployment of psychiatric resources, no less than of theory is urgently called for, if psychiatry is to make a greater contribution to social needs in the community. Psychiatrists can offer a great deal in the way of support to the new departments, and to professional colleagues who have still to shoulder the as yet unmeasured burdens.

BERNARD BARNETT.

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FAILURES OF PSYCHOANALYSIS

DEAR SIR,

In your January issue (p. 100), Stephanie M. Leese reviews the last volume of *The Psychoanalytic Study of the Child* (Vol. XXIV, 1969). She says: 'Dr. Hartman gives her reflections on twelve young people referred for psychoanalysis, who were on drugs initially or who became drug-takers in the course of the treatment. Only three completed their analysis; five dropped out; ten progressed to hard drugs'. Neither the reviewer nor Dr. Hartman seems to be struck by the ominous implications that psychoanalysis could not prevent or cure, and possibly precipitated, addiction, which is as destructive as most severe physical illness. The first duty of a doctor is not to harm. Psychotherapy has no right to use patients as guinea pigs. Its function should be to help and not to produce material for interesting reflections.

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PARANOIA AND PARANOID

DEAR SIR,

Sir Aubrey Lewis (1) has recently discussed the history of the terms 'paranoia' and 'paranoid', together with the still continuing controversy as to whether disorder of understanding, as in schizophrenia, or disorder of mood is primarily involved. I have for some time (2) favoured the latter alternative, feeling that we have been missing the emotional wood of morbid anger for the trees of abnormal suspicion and distrust in thus far considering paranoid syndromes to be basically schizophrenic. Rage is the only one of the four main moods we experience which does not receive individual treatment in current texts under the rubric of affective disorder, despite ill-controlled aggressiveness being long recognized as a potent psychopathological force. The explanation for this omission I believe lies partly in our over-reliance on verbal usage. The history of the term 'mania' might prove enlightening in this context, since the word does not at face value, in lay use yet, or even by derivation, denote essentially morbid elevation of mood.

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MENTAL HEALTH RESEARCH FELLOWSHIPS

DEAR SIR,

I am writing to draw your readers' attention to Research Fellowships offered each year by the Mental Health Research Fund. Advertisements for these Fellowships, which are for full-time research for up to 5 years at a salary between £1,500 and £4,000, are currently appearing in the medical press. Further details may be obtained from the address below.

J. M. TANNER.
Hon. Secretary.

Mental Health Research Fund, 38 Wigmore Street, London, W1H 9DF.