chance expectancy (Stallone *et al*, 1975). Contact with trial lithium patients, therefore, can lead to unblinding.

As the Cochrane Collaboration proceeds in its systematic review of clinical trials it has sought to determine whether controlled trials are properly randomised. In the Cochrane Pregnancy and Childbirth Database evidence of complete randomisation is associated with less treatment effect (Schulz *et al*, 1995). However, it may be necessary to conclude that a truly double-blind trial of lithium cannot be performed (Double, 1995).

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SIR: The editorial by Moncrieff (1995) contained a number of errors in reference to our paper (Coppen *et al*, 1971) on a prospective trial of lithium in the prophylaxis of unipolar and bipolar patients.

The report was concerned with 68 patients who completed the trial. The patients' plasma lithium was regularly monitored and it was found that six patients were poor compliers with inadequate or absent lithium levels. The results were still highly significant after adding these poor compliers. Thirteen patients dropped out of the trial during the initial 16 weeks of the trial, two were on lithium and 11 on placebo. A global rating of response was made independently by a social worker and the psychiatrist in charge of the patients. The two ratings were highly concordant. Eighty-six per cent of lithium patients were rated as showing little or no morbidity compared to only 8% of the placebo group. Similar results were found for unipolar and bipolar patients analysed separately. Other indices of response included time spent in hospital or with an out-patient episode and other treatment required. They all indicated a highly significant difference between the lithium and placebo patients. A particularly striking difference was found in the use of electroconvulsive therapy; no patient on lithium required this therapy as compared to 43% of the placebo group.

Following our trial we set up a mood disorder clinic in our unit and follow-up studies after many years have shown a very low morbidity in these patients. (Coppen & Abou-Saleh, 1988) and as Professor Goodwin pointed out a very low suicide rate.

The most comprehensive meta-analysis of lithium treatment is by Davis *et al* (1993) using only double blind, random assignment, placebo controlled studies. In eight studies of maintenance treatment by lithium in unipolar depression they found an improvement in response rate (compared to placebo) of 34% ($P<3 \times 10^{-9}$); in bipolar illness (10 studies) they found a difference of 55% in response rate ($P<10^{-29}$). They comment that this is roughly the order of magnitude of improvement shown with streptomycin treatment in comparison to bed rest alone for patients with tuberculosis.

The poor results of management of mood disorder may be attributed to the medical profession who, by and large, have failed to adequately treat the common, serious and potentially lethal conditions of depressive and mood disorders.

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SIR: It seems possible to me that the results of the early trials of lithium were influenced by the highly emotional climate in which they took place. In the 1960s and '70s, the so-called Cinderella of psychopharmacology was a pioneering drug, a cause célèbre. Handicapped by its toxicity problems and lack of interest from drug companies, it took on something of the mantle of the depressives it treated, and champions emerged to rescue its reputation and fight for its recognition.

In the Baastrup *et al* study of 1970, for example, patients who sensed from the side-effects that they

were on the real thing may have unconsciously demonstrated their faith and loyalty by remaining well. They are unlikely to have excluded themselves from the trial by owning up, as the Scandinavian researchers expected.

But this does not explain the magical benefits we still see from lithium today, when it is just one treatment among many, used at levels which hardly produce side-effects. The 50-year old Cinderella should be allowed to go to the ball in peace; she has already outlived many of her critics.

BAASTRUP, P. C., POULSON, J. C., SCHOU, M. *et al* (1970) Prophylactic lithium double blind discontinuation in manic depressive disorders. *Lancet*, *ii*, 326–330.

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GP monitoring of lithium levels

SIR: Lithium has a well established place in the treatment of psychiatric disorders, but the most appropriate setting for lithium supervision has been a matter of debate. Given the increasing tendency for GPs to take responsibility for such matters, I undertook a study of lithium monitoring standards in GP and psychiatric out-patient settings.

The computerised record of all serum lithium estimations in south Manchester during a ten month period in 1994 was examined. Two groups of patients were compared; those who had two or more levels done by GPs and none in out-patients ($n=94$) and those who had two or more levels done in out-patients but none by GPs ($n=140$).

There were no significant differences between the groups in numbers of intervals between tests greater than 90 days (OPD 182/390 *v.* GP 112/264) or 180 days (OPD 30/390 *v.* GP 21/264). Although there was a non-significant trend towards higher lithium levels in the GP group (lithium $\geqslant 1{\cdot}1$mmol/l OPD 15/542 *v.* GP 19/363) the proportion of results above the therapeutic range was lower than both GP and hospital monitored patients in the studies of Masterton *et al* (1988) and Kehoe & Mander (1992).

GP monitoring of lithium levels is commonplace in south Manchester, and there is little evidence from examination of current practice to suggest this is inappropriate.

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Long-term treatment with clozapine in schizophrenia

SIR: Avnon & Rabinowitz (1995) in an article on clozapine and neuroleptic resistant schizophrenia observe that "some patients experience a vacuum in the absence of delusions and hallucinations" and conclude that their success was due to a multi-family group to help with the patients' anxieties on entering the real world.

We have been running such a group for over five years and an audit on the families' perceptions of the changes since their relatives began clozapine produced some unexpected results. There was anxiety expressed by the families about their relative entering the real world with their lack of necessary skills, social and otherwise, and this has been alluded to in the popular press as awakening. But in addition the families recognised that clozapine had produced significant change in the degree of affective warmth and that a return to the pre-clozapine days would be a major blow. This change in affective warmth may be the key to why those of us with large cohorts of clozapine patients see progressive changes with time as both the patient and the family become conditioned to the changes and to why Lindstrom (1988) in this 13 year study had 39% of his 96 patients in employment.

AVNON, M. & RABINOWITZ, J. (1995) Effectiveness of clozapine in hospitalised people with chronic neuroleptic resistant schizophrenia. *British Journal of Psychiatry*, **167**, 760–764.

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Psychological debriefing techniques

SIR: We were surprised that Busuttil *et al* (1995) chose to use the term psychological debriefing to describe some of the techniques used in their