Admission Rates and Lithium

SIR: The argument seems to be about the 'efficacy' and perhaps the 'efficiency' of this drug (*Journal*, February 1987, **150**, 264–265). We would like to add further data to this discussion.

Recently, we examined infradian rhythms of mood and allied factors in out-patients with major affective disorders and matched healthy controls (Eastwood *et al*, 1985). Each person was interviewed with the Schedule for Affective Disorders and Schizophrenia, and the index group had to meet the Research Diagnostic Criteria. A sub-group from this study consisted of 11 patients who had been on lithium for an average of seven years, and these were contrasted with 22 healthy controls. These patients were treated independently by other psychiatrists and took only lithium during the study period. Patients, all of whom had bipolar affective disorders, and controls completed visual analogue scales daily (Eastwood *et al*, 1984) for 14 months. The mood ratings for index and control groups were compared using the means, standard deviations, and delta squares. The variability of mood, using chi-square analysis, was significantly skewed towards zero in the lithium group, compared with controls, for the standard deviations and delta squares.

So cases of bipolar affective disorder had less mood variability over 14 months on lithium than normal controls. The Folstein *et al* (1982) short-term finding in this regard (one month) is more than confirmed. Our study speaks to efficacy, in some cases, but says nothing about efficiency. Elsewhere we have shown that prescribing is not completely efficient, since in Toronto approximately two-thirds of patients with bipolar affective disorders receive lithium and two-thirds of those on lithium have bipolar affective disorders (Eastwood *et al*, 1981).

The very effectiveness of lithium could create problems by making patients overly controlled, without spontaneity and creativity (Jamison *et al*, 1979), and cause them to stop taking it. This would fit with Kendell's idea of withdrawal causing relapse and ever more mania. How ironic if patients' noncompliance in this disruptive illness was a function of effectiveness of treatment.

M. R. EASTWOOD
A. M. PETER

Clarke Institute of Psychiatry
250 College Street
Toronto
Ontario M5T 1R8

References

EASTWOOD, M. R., STIASNY, S. & TICE, S. (1981) Estimates of the prevalence of bipolar affective disorder: methods based on treatment with lithium. *Acta Psychiatrica Scandinavica*, **63**, 83–90.

EASTWOOD, M. R., WHITTON, J. L. & KRAMER, P. M. (1984) A brief instrument for longitudinal monitoring of mood states. *Psychiatry Research*, **35**, 773–783.

EASTWOOD, M. R., WHITTON, J. L., KRAMER, P. M. & PETER, A. M. (1985) Infradian rhythms: a comparison of affective disorders and normal persons. *Archives of General Psychiatry*, **42**, 295–299.

FOLSTEIN, M. F., DEPAULO, J. R. & TRIPP, K. (1982) Unusual mood stability in patients taking lithium. *British Journal of Psychiatry*, **140**, 188–190.

JAMISON, K. R., GERNER, R. H. & GOODWIN, F. K. (1979) Patient and physician attitudes toward lithium. *Archives of General Psychiatry*, **36**, 866–869.

Psychiatric Morbidity and the Mentally Handicapped

SIR: Day's (1985) reported morbidity of 30% and 20% for psychiatric disorder in mentally handicapped patients of a mental handicap hospital and a day hospital respectively, may be equally valid with respect to mentally handicapped out-patients.

In a random analysis of one year's attendance of mentally handicapped patients at a small community-based mental handicap out-patient clinic (January–December, 1982) I found that 19% of the 115 out-patients seen were suffering from a significant mental illness: depressive illness 10 (i.e. manic depressive 2, agitated depression 6, depression with epilepsy 1, depression after brain tumour 1); schizophrenia 9 (i.e. paranoid 6, hebephrenic 2, simple 1); and severe personality disorders 3. This excludes behaviour disorders which were present in 36%. Diagnoses were made on the basis of a comprehensive history (from patients' relatives, social workers and community nurses), appropriate clinical criteria and, in doubtful cases, by admission for assessment, observation, and follow-up.

Sturmey's claim (*Journal*, February 1987, **150**, 270) that the behaviour problems due to painful physical conditions (abscesses, nasal infection, etc.), learned behaviour, and anti-social behaviour (wandering, stealing, etc.) may inflate the serious psychiatric morbidity in the mentally handicapped is not borne out by the many well-conducted studies in this field. In fact, most of these studies include major psychiatric illnesses such as schizophrenia, affective disorder, and personality disorder, and exclude the behaviour problems which he mentions.

The diagnosis of major psychiatric illness in mentally handicapped patients has always been difficult, as the signs and symptoms of the illness may be masked by the behavioural expression, as illustrated below.

Case report: A young severely mentally handicapped patient attending a special needs unit expressed his mood changes in a regular pattern of periods of overactivity, agitation, aggression, sleeplessness, and exhaustion, which resulted in loss of weight, chest infections, etc. (hypomanic phase), alternating, after a brief period of stability on medication, with phases of withdrawal, irritability, loss of his usual sociability, and tearfulness (depressive phase). This