Lithium in the Treatment of Aggression in Mentally Handicapped Patients

SIR: The report of a double-blind trial of lithium in aggressive mentally handicapped patients (Craft *et al, Journal,* May 1987, **150,** 685–689) is important. A paper published seven years ago was similar in content (Dale, 1980). Both report on patients who had been in hospital for varying lengths of time (Craft, 0–49 years; Dale, 2–42 years), the average stay being 12 years in each. My study was a retrospective one, while that of Craft *et al* was prospective. The methods of analysing the findings are very different, but the results remarkably similar.

Lithium therapy must now be seen as having a definite place in this difficult group of patients. If given earlier in the condition instead of as a treatment of last resort, as it is now, then the necessity of long-term admission may be obviated. This would be of benefit to patient, relatives, and staff.

Lithium is a relatively simple and safe form of treatment in skilled hands, which could have wider use in this clinical context. The economic advantages which would accrue from its early use have some relevance too.

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Compensation Psychosis

SIR: White *et al* (*Journal,* May 1987, **150,** 692–694) report the case of an episode of paranoid psychosis in a patient who had suffered concussive head injury and had become involved in litigation for compensation; his delusions centered around the latter. While post-traumatic psychoses are rare, paranoid ideation occurs frequently in the course of prolonged litigation.

In the introduction to their paper the authors mention a number of old and recent aetiological issues which deserve attention. Quoting White (1981), they state that "there was no statistical difference between those victims in whom the accident had given rise to litigation and in whom the case was still proceeding and those victims where compensation was not an issue". This may be correct as far as statistical evidence goes. However, the most important factor should not be overlooked, i.e. the responsibility for the accident and its consequences. The majority of accidents in which compensation is not an issue are those occurring in the home, in sports, and on the road (in the latter case the accident victim being the responsible party). The neurotic disability process does not start with litigation for compensation, which is a much later development; it starts as soon as the victim realises that someone else (employer, property owner, driver, etc.) is at fault, followed by the attending physician's mistaken belief that he is helping his patient by ordering rest from work and activity. Compensation is but one significant factor in the development and maintenance of post-traumatic disorders. Other equally important factors subsumed under the heading of 'secondary gains' from disease are attention, protection, and over-solicitousness on the part of the patient's environment that constitute a serious obstacle to response to treatment, spontaneous recovery, and rehabilitation. Occupational and marital dissatisfaction, latent before the traumatic event of the accident, may frequently manifest themselves as symptoms of the neurotic disorder.

In analogy with the notion of iatrogenic disorders I have coined the term 'nomogenic disorders' (from the Greek *nomos* – the law) (Tyndel, 1974) to describe those psychopathological disorders in which the law and its application is playing an aetiological role in the development, enhancement, and perpetuation of these disorders. The case reported by White *et al* represents a typical example.

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References

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Tuberous Sclerosis and Psychosis

SIR: This year the *Journal* has published two case reports of psychotic behaviour in tuberous sclerosis (TS) (Lawlor & Maurer, *Journal,* March 1987, **150,** 396–397; Clarke *et al, Journal,* May 1987, **150,** 702–703). These suggest that psychosis in tuberous sclerosis is a rare manifestation of a rare disease. We draw attention to our study of the psychiatric status of 90 children with tuberous sclerosis (Hunt & Dennis, 1987). At five years of age, over 50% showed psychotic behaviour (predominantly autistic), 59% were

hyperkinetic, and 13% were severely aggressive. Psychosis therefore appears to be a common rather than a rare manifestation of the severe effects of the TS gene.

Furthermore, a conservative estimate of the prevalence of TS, for which there is no absolute marker, is 1 in 15 400 for children under 5 (Hunt & Lindenbaum, 1984). The disorder is thus not as rare as previously thought.

Our study of TS leads us to propose that profound language delay, severe impairment of social interactions, hyperkinesis, and sleep disturbance constitute a behavioural phenotype. Although not pathognomonic, this occurs so frequently in tuberous sclerosis that we consider that it should be included among the diagnostic criteria for the disorder.

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Amnesia: Organic and Psychogenic

SIR: In his review of amnesia (*Journal*, April 1987, **150**, 428–442) Kopelman fails to deal with the questions of whether individuals who say they have lost their memory, in the absence of any organic cause, are truly amnesic, and of how genuine amnesia may be distinguished from feigned amnesia. He seems to assume that all those suffering from what are often referred to as fugues and hysterical amnesias have genuinely lost their memory.

The question of psychogenic amnesia seems to have attracted little interest in recent years, and it is significant that many of the publications quoted by Kopelman are more than 40 years old. In the Podola case (Furneaux, 1960) the genuineness of claimed amnesia was rigorously probed during several days of a highly publicised trial, on the issue of fitness to plead. Several psychiatrists and other doctors gave evidence; some of them provided the unedifying spectacle, to which psychiatry seems uniquely prone, of disagreeing with one another about the most basic symptoms of the condition about which they were giving expert testimony. Leigh stated that a patient with hysterical amnesia for the whole of his life would not be able to recognise common objects or tie his shoe laces, but Stafford-Clark said that this was entirely wrong. In fact, Podola had made a number of apparent blunders tending to show that he did remember things he claimed to have forgotten, and the jury found his amnesia to be feigned.

The views of the late Sir Charles Symonds (quoted by Merskey, 1979) are of interest:

> I suspect also that all so-called hysterical fugues are examples of malingering. Forty years ago a young man was brought to this hospital (the National Hospital, Queen Square) as an out-patient to B Room, where I was working, with loss of memory for a period of a week. I had a heavy load of patients and it was a hot afternoon. I did not want to admit him and could not face the prospect of a prolonged psychotherapeutic session. I said to him "I'm quite sure you can remember if you try: here are paper and pencil. Write me out your story, and I will do what I can to help you". With that I put him into the side room, closed the door and went on with my work. At the end of my session I had forgotten about him, but as I was about to leave there was a tap on the door of the side room and he emerged with two sheets of close written foolscap.
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> His story was this. He worked in a shop in Birmingham, had recently married, and took £10 from the till to cover the expenses of his honeymoon. He had, as he said, "borrowed" it. On his return home he found that a previous misdemeanour had been discovered, and that he had been sacked. So there he was with no prospect of repaying the £10 before his theft would be discovered. He concluded that the only way out was suicide and that the right way would be to jump off the cliffs at Lands End. So he made his way down to Lands End but there was no suitable cliff. It was dark and cold. He went to the nearest police station and declared that he had lost his memory and knew neither his name nor address. He was then transferred to hospital at Penzance and subsequently referred to Queen Square.
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> Since then I must have seen half a dozen cases of so-called hysterical fugue in private practice and have adopted the following plan. I have said to the patient "I know from experience that your pretended loss of memory is the result of some intolerable emotional situation. If you will tell me the whole story I promise absolutely to respect your confidence, will give you all the help that I can and will say to your doctors and relatives that I cured you by hypnotism". This approach has never failed, and I have been told some dramatic stories".

It is not uncommon for loss of memory to be claimed for the period immediately surrounding the commission of an offence, such as shoplifting. In these cases it usually becomes clear that the person concerned does have some, possibly vague, recollection of events, and such clouding of memory as is present can often be explained by the effects of drugs or alcohol, or both. Classical 'hysterical amnesia' seems to be (like other dramatic 'hysterical'