

treatment, compared with normal subjects, or during treatment with antidepressants.

In the light of these findings perhaps the decision to leave out a detailed discussion of the melatonin literature from the review of circadian rhythms is more comprehensible.

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Dr Roy-Byrne and colleagues reply

We want to thank Dr Thompson for pointing out our error. He is correct, of course, in affirming that tricyclic antidepressants slow the frequency of free-running circadian rhythms. Therefore, the effect of oestradiol on circadian rhythms is *opposite* to that of tricyclics. We hope that this theoretical error has not detracted from our attempt to provide a practical overview of the clinical management of the rapid cycling patient.

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TREATMENT OF RAPID CYCLING AFFECTIVE ILLNESS

DEAR SIR,

In their paper Roy-Byrne *et al* (*Journal*, November 1984, **145**, 543–550) indicated a need for further systematic study to assess the definitive role of neuroleptics in treating this condition. The depot preparation of haloperidol decanoate became available in the U.K. on a research basis in the autumn of 1981 and my clinical experience to date includes the treatment of fifteen patients with a diagnosis of manic depressive psychosis, four of whom form a distinct subgroup of rapid cycling affective illness. They have a combined history of eleven hospital admissions for hypomania in the previous two years while on lithium (serum levels 0.50 to 1.0 mmol/l) and oral neuroleptics. These frequent admissions resulted in a total of twenty three months in-patient treatment (almost six months per patient) before starting haloperidol decanoate in a dose range between 100 and 400 mg monthly. There have been no re-admissions for hypomanic relapses, all four patients having received this treatment for over 36 months, and two short lasting depressive episodes in one patient were successfully treated as an out-patient by adding a tricyclic antidepressant. The result of this open study certainly supports the authors' proposition that prolonged neuroleptic treatment, possibly in combination with lithium, may reduce the severity and frequency of manic episodes.

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IS THERE REALLY A SCHIZOPHRENIA? THE LONG-TERM COURSE OF PSYCHOTIC PHENOMENA

DEAR SIR,

As my article (*Journal*, December 1984, **145**, 636–640) could not be published in full, some additional points, included in the original manuscript, may be helpful for understanding my thesis. According to systems theory, identical states may be reached by way of very different combinations of influencing factors (the principle of equifinality). On the other hand, identical states can evolve, under varying circumstances, in very different directions. Both phenomena are currently observed in the long-term course of psychotic states diagnosed as schizophrenia. With other arguments presented in the paper, this speaks against the classical concept of a clearly delimitable disease entity with constant causes, psychopathological picture, and course. A more flexible view, based on the vulnerability- and

information-processing hypothesis, leads to the conclusion that a disease entity "schizophrenia" in the traditional sense does not exist, but only a quite unpredictable and to some extent always open life-process in individuals with a particular kind of vulnerability. If valid, these new concepts have important theoretical and practical implications. Copies of the original manuscript are available on request.

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YOUNG INTELLECTUALLY RETARDED ADULTS

DEAR SIR,

It was with great interest that I read your report of Professor Brimblecombe's lecture on 'The Needs of Young Intellectually Retarded Adults' (*Journal*, January 1985, 146, 5–10). In this context, it struck me that there could be one particular reason why such subjects often fail to integrate well in the community. Though the concept is a simple one, I cannot recall having ever seen it committed to print.

One reason for the non-acceptance of mentally retarded young persons, especially those with demonstrable brain-damage, ties in with the concept popularly designated as 'body-language'. The movements of such subjects tend to be jerky and their posture oddly wooden, while speech itself can often be slurred and/or abrupt. These traits are readily perceived as hostile and induce fear or counter-aggression.

Such a reaction by members of the general public is the more likely to persist, because this physical awkwardness of some retarded subjects is perceived intuitively rather than reasoned at a conscious level. It is this kind of reaction, for example, which causes mentally retarded young adults to be so often accused (usually unjustly) of threatened assault or sexual molestation.

Might it not be worth while, in any scheme that attempts to bring intellectually backward young adults into the community at large, to try and put over this point that 'normal' body-movements (which come readily, perhaps instinctively, to most of us) have often to be slowly and painfully learned by those who have the misfortune to be intellectually impaired?

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ANOTHER BART'S ALUMNUS: W. H. R. RIVERS

DEAR SIR,

I was somewhat disconcerted to note that Anthony Clare's historical review of psychiatry at St Bartholomew's Hospital (*Journal*, February 1985, 146, 120–126), makes no mention of W. H. R. Rivers, perhaps the most eminent of Bart's psychiatrists and surely the only one to become a Fellow of the Royal Society. Rivers trained and taught at Bart's and his first papers appeared in the *Journal* of that hospital (Slobodin, 1978).

Rivers was a polymath who strode across the disciplines of neurology, psychiatry, psychology and anthropology; to quote C. G. Seligman 'perhaps no man has ever approached the investigation of the human mind by so many routes' (Langham, 1981). His early work on physiological psychology including visual perception and the peripheral nervous system culminated in the famous studies with Henry Head on the regeneration of cutaneous nerves, a Fellowship at St John's, Cambridge, and the start of experimental psychology in Britain. Taking part in the Torres Straits expedition of 1898, Rivers pioneered the first studies in cross-cultural psychology after which his interests turned to ethnology. His work on kinship and his rejection of the then current evolutionary hypotheses of cultural differences laid the foundation of the once dominant British School of structural-functionalism (Kuper, 1975).

Rivers returned to psychiatry during the First World War and as the director of the Maghull Hospital in Scotland was immortalised in the fiction of Robert Graves and Siegfried Sassoon, who both became close friends. He was an early champion of Freud in England and practised a pragmatic therapy of traumatic neurosis based on a watered-down version of psychoanalysis: in various books he synthesised psychodynamic and anthropological approaches to become the founder of cultural psychiatry. Rivers' wartime experiences led him, like so many others, to socialism; at the time of his death in 1922 he was the Labour parliamentary candidate for the University of London seat.

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