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Psychotropic medication and antisocial behaviour in a mental handicap hospital

SIR: As a contribution to the debate about phasing out mental institutions, I recently reviewed antisocial behaviour and the use of psychotropic medication (as aspects of perceived prospects for discharge) in all 131 patients (average stay 26 years) of a mental handicap hospital.

Thirty patients (23% of the total) were currently taking neuroleptics like chlorpromazine or haloperidol, and had been for years. This is fairly modest compared with the 40–50% found in surveys of the mental handicap literature (Aman & Singh, 1983). However, there was a striking correlation between the use of neuroleptic (and other) psychotropic drugs and difficult or antisocial behaviour as identified by nursing staff in this survey. Fifty-nine patients (45%) were judged to show behaviour of this kind, albeit of varying severity, and nearly two-thirds of these had a history of exposure to long-term neuroleptics; indeed, all but 4 of the 30 patients mentioned above currently taking them showed difficult behaviour. In addition, 34% of those in the 'difficult behaviour' group were or had been on extended courses of benzodiazepines and 22% on antidepressants, increased proportions compared with the rest of the hospital. These associations were even more striking in respect of a core subgroup of 16 patients whose behaviour was judged to be the most intractably difficult in the hospital. Eighty-eight per cent of these had been on long-term neuroleptics, 40% on benzodiazepines, and 31% on antidepressants.

There were few cases of documented psychosis or other specific mental illness (admitting the problems of diagnosing in this field), and it was clear that psychotropic medication had almost always been aimed directly at behaviour. These patients may have been more manageable in hospital as a result, although without obvious improvement in their prospects for a life outside the institution. In almost all cases their behaviour was cited by nursing staff as a major barrier to discharge.

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De Clérambault's Syndrome in Unipolar Depression

SIR: Signer & Swinson (*Journal*, December 1987, **151**, 853–855) described two cases of erotomania in bipolar affective disorder. The delusion appeared during periods of mania, hypomania or euthymia. This association is not uncommon (Guirguis, 1981; Remington & Book, 1984). However, de Clérambault's syndrome is rare in unipolar depression. We have recently seen a patient with this clinical picture.

Case report: Mrs T is a 34-year-old married woman whose mother had bipolar affective disorder; her sister has recurrent depression. Her past medical history was unremarkable. Her first psychiatric illness was at 15, when she had a brief depressive episode. Ten years later she showed clear symptoms of puerperal depression.

At the age of 33, the patient exhibited this affective picture: tearfulness, hopelessness, suicidal ideation, insomnia, loss of energy, poor appetite, loss of interest in hobbies, and slowing of thoughts and movements. There were no obvious precipitant events. A diagnosis of depression was made, and imipramine (150 mg daily) prescribed. She responded well to this treatment. However, the drug was discontinued after three months, and depressive symptoms recurred. At the same time, Mrs T imagined she was the object of affection of her daughter's teacher. He sent a gift to the child, and the patient believed he was really sending a love message to her. Later she claimed he followed her in his red car each day.

When examined, the patient was sad and anxious, with suicidal thoughts, indecisiveness, and feelings of guilt. Imipramine (150 mg daily) normalised the affective state, and delusional erotomania vanished.

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Carbamazepine and ECT

SIR: With the increasing use of carbamazepine in patients with psychiatric disorders, it is necessary to remember that this drug is also an effective anticonvulsant. Its use in patients undergoing electroconvulsive therapy may result in giving an anaesthetic (along with the risks that this involves) unnecessarily, since one may fail to induce a seizure. We have recently observed a patient who was being given both carbamazepine and ECT, in whom ECT failed to induce a fit on two separate occasions before the paradoxical combination of therapies was noticed. After stopping the carbamazepine the patient had a normal response to ECT.

Case report: The patient was a 45-year-old West Indian female with a 22-year history of recurrent episodes of depression. In 1985 she had a longer refractory period of depression, and was given ECT for the first time. She had a normal response with all nine administrations of 4 s bilateral ECT, and made a good recovery. In 1987 she again presented with depression, and over the ensuing 2 weeks became worse and also tended towards unpredictable violent outbursts. She was already taking amitryptiline and chlorpromazine, and at this point carbamazepine (200 mg t.d.s.) was added. Five days later she began a course of ECT, but on the first administration a bilaterally applied current for 4 s failed to produce a fit despite two attempts. Four days later, at the second administration, two consecutive bilateral applications of current for 5 s again failed to produce a fit. The carbamazepine was stopped, and after a further 7 days a third administration of ECT now produced a modified seizure. Three more successful ECT treatments were then administered over the next 2 weeks. The anaesthetic technique used for this patient was identical in 1985 and 1987. In order to rule out the possibility of a clinically unobserved fit having occurred due to excessive muscle relaxant, the patient was questioned 12 h after the second anaesthetic about events immediately prior to and following the episode. She had good recall of these events, showing no evidence of amnesia.

There has only been one previous report of ECT being given along with carbamazepine (Cantor, 1986), and in this case the ECT induced seizures as usual. However, on the strength of the aforementioned case we would suggest that clinicians are cautious in using this combination of therapies, since there is no evidence that it is efficacious in humans, and it may even be hazardous for the patient.

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Dressing Disorder

SIR: Going through psychopathology handbooks, we realise how little attention is paid to dressing disorder, or to the relationship between man and his clothes. Psychoanalytical texts have devoted more space, in relation to abnormal sexual behaviours such as transvestism. Nevertheless, one's own appearance, figure, and clothes are communications of psychopathological value, as Frankenburg & Yurgelun (1984) suggested when they put forward the existence of a 'dressing disorder' which, in spite of its frequency and seriousness, is not included in our current nosology. It consists of an imperious and irresistible necessity to buying clothes and ornaments in order to dress fashionably or to imitate the style of famous people, even though they might be expensive, uncomfortable or unsightly. Recently, we have attended two women showing similar behaviour.

Case reports: (i) ADL, aged 33, had previously suffered from three depressive episodes of moderate intensity, and she consulted about a similar one, which lasted several months, precipitated by a psychosocial stress. In contrast to the prevailing symptoms – sadness, anhedonia, little self-esteem, irritability, anorexia, and tiredness – throughout her depressive episodes she showed an imperious need to dress herself in a smart and expensive way, buying too many clothes and ornaments and trying to smarten herself up in an exaggerated way, quite unlike her usual tastes. This behaviour always disappeared once her depressive episodes were solved, and she returned to a casual and simple way of dressing.

(ii) BOG, aged 21, had suffered a serious post-traumatic stress disorder after being attacked with a knife by her boyfriend, her life being in danger. Later on, after she had partly recovered, a typically bulimic pattern (DSM–III) arose, which was put down to the beginning of a new and stressful job. This pattern, when she consulted us, was accompanied by an unavoidable need of going shopping and buying clothes and ornaments in great amounts (for instance, dozens of trousers or shirts), offering as a justification the desire to dress fashionably, to find herself slimmer and to diminish her anxiety and low self-esteem associated with