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Correspondence

LITHIUM PROPHYLAXIS

DEAR SIR,

I have read with interest the paper by M. Schou and his colleagues (*Journal*, June 1970, 116, p. 615) and the following is a short account of my own experience:

Thirteen patients, all of whom had a history of several in-patient admissions for the treatment of manic-depressive disease, were selected for treatment by lithium carbonate. None showed evidence of heart or kidney disease. Kidney function was tested by routine urine, blood urea, and creatinine clearance tests, and base-line determinations of blood levels were obtained before treatment. Wherever possible twenty-four hour urine samples were used to estimate lithium excretion after the start of treatment. Dosage was adjusted from an initial 250 mg. three times daily until the serum level was within the therapeutic range of 0·8–2·0 m.eq./l. Most patients attained this range on 750 mg. daily, though one required 1,000 mg. daily and another 1,500 mg. One woman requested a long-acting preparation and received 1,200 mg. Priadel each morning. Serum levels of lithium were estimated at first fortnightly and then at intervals of 4 to 6 weeks when patients returned for a further supply of tablets. These tests provided a useful check on the maintenance of therapeutic levels, or could indicate discontinuance of the tablets by the patient.

An arbitrary starting point of 1 January 1966 was taken, although most patients had a history of manic-depression extending well before then. This gave an average period of observation of 3½ years before treatment began, in which time there had been 36 admissions, 4 of them of more than 10 months. If the long-stays are included, the average duration of an in-patient spell was just over 2 months; if they are excluded, it was just over one month. In the average follow-up period of 16 months after the start of treatment only one patient was re-admitted, and he was found to have stopped taking the tablets. On the basis of the pre-treatment experience, 8 or 9 readmissions would have been expected, or alternatively a total in-patient duration of just over a year, or 4 weeks per patient, if shorter spells only are considered (and about twice that period if the longer spells are included). Even if the single post-treatment readmission (of 7 weeks' duration) is not excluded, because of ceasing treatment, the difference from the expected pattern of readmissions is very pronounced.

Among other noticeable improvements, 12 of the 13 patients are not only employed but have not changed their jobs since starting lithium treatment. The thirteenth patient, who had not worked for 5 years before his last hospital admission, is about to start work with the Industrial Therapy Association. No evidence of toxicity was found, nor were any side-effects reported in this series of patients.

There is good evidence, therefore, that for manic-depressive patients lithium carbonate treatment, suitably monitored at regular intervals, can not only afford a good measure of stabilization of behaviour, resulting for instance in a better employment record, but can also greatly reduce the necessity for readmission to hospital.

I should like to thank Dr. Charles Entwistle for permission to use cases of his, and Dr. R. A. Carter and his staff for the laboratory tests.

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CRISIS THEORY AND POSSIBILITIES OF THERAPEUTIC INTERVENTION

DEAR SIR,

Dr. Brandon's valuable paper (1) deserves the widest discussion, particularly in the current context of the Social Services Act and the new Departments of Social Welfare. Intervention by representatives of the community will be increasingly possible to families and individuals in crisis.

The formulation of theory behind such intervention seems of great importance. While great credit is due to Professor Gerald Caplan and Eric Lindemann in the development and extension of 'crisis intervention,' for the future development, no less than for historical accuracy it would be a pity to see 'crisis theory' in the context of ego psychology. Here psychiatry and social work must pay respects to earlier workers, whether their work has 'diffused' or has been rediscovered is somewhat irrelevant to decide. Van Gennep's *Rites de Passage* (5), and Chapple and Coon's (2) rate of interaction formulations cover the issues more cogently than derivations from psychodynamic theory. One has only to consider the tortuous and laborious explanations regarding