Mentally handicapped epileptic patients: psychiatric illness and personality disorder

SIR: I read with interest the articles by Deb & Hunter (*Journal*, December 1991, **159,** 822–834). Although the articles were concerned with comparing epileptic with non-epileptic mentally handicapped patients in terms of maladaptive behaviour, and diagnoses of psychiatric illness and personality disorders, I feel that a more integrated comparison would have been useful. Since the study population was the same for all the comparisons it would be interesting to know the overlap between maladaptive behaviour, psychiatric illness and personality disorder diagnoses. I wonder if closer approximations between the three would not occur. It would be surprising that after diagnosing severe maladaptive behaviour some patients would not be diagnosed as having psychiatric illness or even personality disorders. It seems that all three studies have measured similar variables and have, not surprisingly, arrived at similar conclusions.

Although the authors acknowledge that the diagnosis of personality disorder is difficult in mental handicap, it is surprising that the DSM–III criteria were used to diagnose psychiatric illness but not personality disorder. The personality disorder most commonly diagnosed in the study, the aggressive type, does not correspond to any of the categories currently in use; it must also be difficult to diagnose persistent aggressive behaviour associated with mental handicap and epilepsy as a manifestation of an abnormal personality independent of the associated conditions. The authors should have attempted to address these issues.

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SIR: We were impressed with the industry of Deb & Hunter (*Journal*, December 1991, **159,** 822–834) in their study examining the behaviour, extent of psychiatric illness and personality disorder in mentally handicapped epileptic patients. Arising from their study is support for a persistent, perseverative epileptic personality in these patients living outside hospital.

However, we were concerned about the authors' interpretation of their finding that patients receiving carbamazepine therapy alone were less likely to be affectively and behaviourally disturbed and that this may be due to the mood-stabilising effects of this drug. In a naturalistic survey like the one they have presented, it is not possible to determine cause and effect. Mentally handicapped epileptic patients often receive more than one epileptic drug to control their fits (Fishbacher, 1987; Thinn *et al*, 1990) and this is usually because their secondary epilepsy is difficult to control. In a recent study carried out in mentally handicapped epileptic in-patients, only 7% of those receiving one drug for epilepsy had more than one fit a month whereas 43% of those in the polypharmacy group had fits of this degree of frequency (Thomson *et al*, unpublished).

Drs Deb & Hunter have shown in their papers that patients with frequent and multiple fits are significantly more likely to exhibit maladaptive behaviour than epileptics with less frequent seizures and than a matched sample of non-epileptic patients. The patients receiving monotherapy for epilepsy are consequently better behaved, but this may well be due to less cerebral damage in this group and other factors affecting fit frequency, not to the prescription of carbamazepine.

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AUTHOR'S REPLY: Dr Bhandari has raised an important point regarding the overlap among the diagnostic categories (i.e. maladaptive behaviour, psychiatric illness, and personality disorder) in our study population. Further analysis of the data has shown that those adults with a mental handicap who had a diagnosis of psychiatric illness had a significantly higher rate of severe maladaptive behaviour than those who did not have such a diagnosis. Similarly, those adults who had a diagnosis of personality disorder, particularly the aggressive type, showed a significantly higher rate of severe maladaptive behaviour than those who did not have such a diagnosis. We intend to report these results in a separate paper. It was not possible to report all our study findings in this publication (*Journal*, December 1991, **159,** 822–834) because of lack of space. On the second point of the choice of the diagnostic criteria for personality disorder, we explained in our papers why we used that Standardised Assessment of Personality (SAP) and T-L Personal Behaviour Inventory. SAP is an