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## Puerperal affective psychosis: is there a case for lithium prophylaxis?

SIR: I read with interest Austin's research report (*Journal*, November 1992, **161**, 692–694) where she concluded that lithium prophylaxis in puerperal affective psychoses prevented significant post-partum relapse in contrast to no medication. Stewart (1988) advocated lithium treatment immediately after delivery for women with bipolar illness or a history of puerperal psychoses. This approach probably prevented some relapses.

We also have experience of using medication (lithium, haloperidol, or carbamazepine) immediately after delivery for bipolar patients. In our study, 27% of patients (3 out of 11) who used prophylaxis after delivery had a relapse (manic or depressive) in the first three months, compared with 60% of the patients (3 out of 5) who refused medication (van Gent & Verhoeven, 1992). One patient who became manic, in spite of an adequate serum lithium level (0.82 mmol/l), had used bromocriptine to reduce lactation. Indeed, some authors (Kemperman & Zwanikken, 1987) have reported mania associated with bromocriptine. Since then, in our protocol for lithium prophylaxis after pregnancy, we have warned against inhibiting lactation by means of bromocriptine.

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SIR: The interesting retrospective study by Austin (*Journal*, November 1992, **161**, 692–694) suggested that lithium is effective in reducing the risk of recurrence of puerperal psychosis after subsequent pregnancies. One of us (McKenzie, 1991) has recently completed an outcome study of women suffering from post-partum psychosis who were admitted to a mother-and-baby unit in Manchester between 1978 and 1988. Only women who were suffering from a first episode of psychosis were included. A small number of the study group were discharged on lithium (9 out of 69). However, in the six months following discharge, none of the patients on lithium had a relapse, whereas almost half the patients not receiving lithium relapsed (27 out of 60; $P=0.02$, $\chi^2$ test), many needing readmission (16 out of 60; $P=0.09$, $\chi^2$ test). The difference occurred despite more severe illness in those discharged on lithium, as reflected in their longer admission. These findings suggest lithium is indicated in the treatment of first episodes of puerperal psychosis, in addition to its prophylactic use, as suggested by Austin.

Almost half of the women (34 out of 69) had a subsequent episode of illness within six years. This is likely to be an underestimate since some cases were followed up for a shorter period of time, and episodes of illness in women who moved out of the area were not recorded. The high rate of recurrence suggests the need for prophylaxis. However, in this study most of the further episodes of illness were unrelated to the puerperium (43 non-puerperal episodes compared with 13 post-partum). Previous studies have had similar findings (Protheroe, 1969; Lindsay &

Pollard, 1978). Although further childbirth is an easily identifiable time of risk when prophylactic medication can be offered, confining lithium treatment to the post-partum period would not have prevented most of the episodes of further illness in this study.

Only two out of the nine women started on lithium continued with the medication for a long period: one had no further recorded episodes of illness; the other remained well for two years but had a further episode of illness nine months after stopping lithium treatment, so was restarted on it.

In conclusion, treatment with lithium should be considered for patients discharged following a first episode of puerperal psychosis, and there would seem to be a strong case for longer-term lithium prophylaxis.

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**Assessment of insight in Singapore**

SIR: The assessment of insight in psychotic patients has always been difficult, even though it is an integral part of the mental state examination. Therefore, I was highly interested in the paper by David *et al* (*Journal*, November 1992, **161**, 599–602). The authors have demonstrated the value and the applicability of the schedule for assessing the components of insight (David, 1990) in psychotic patients. There are three components of this schedule (treatment compliance, recognition of illness, and ability to relabel the psychotic experience as abnormal) which David argued form the core features of insight.

The authors have sought to correlate the three components with variables such as intelligence quotient (IQ), sex, age, diagnosis, number of previous admissions, and psychopathology. They showed that the total insight score is inversely related to the psychopathology measured by the Present State Examination (PSE; Wing *et al*, 1974), while compliance and illness recognition correlated to IQ, but not to the other variables. However, an additional variable may influence assessment of insight (especially if one works in a multiracial society as I do in Singapore): that of cultural beliefs.

Each of the different races in Singapore (Malays, Chinese, and Indians) have their own beliefs about the abnormal behaviour and experiences which the West terms as mental illness. These beliefs include the person being possessed by evil spirits, the soul being stolen, lost or sick, and the patient being cursed or charmed. As a result, the patients and their families often do not recognise the abnormal phenomena as mental illnesses, but will seek treatment from traditional healers or temple priests who often reinforce these beliefs. Salleh (1989) showed that 73% of Malay psychiatric out-patients had sought traditional healers, compared with only 25% of general medical out-patients. Although this study has been conducted in a less developed part of Malaysia, we still often see patients who have sought traditional healers before seeking psychiatric help.

It is possible that patients may be compliant with the treatment prescribed by a traditional healer, may relabel their experiences as abnormal according to their own set of beliefs, and yet may not see themselves as having a mental illness, or that psychiatric medication is necessary. To the psychiatrist, it is possible to interpret these beliefs as delusional, and patients as lacking in insight, unless they take into account their cultural and ethnic beliefs. It may be unjust to label the patient as lacking in insight, as he does have the insight to seek help from the traditional healer.

It may be possible to apply the components of insight, as advocated by David (1990), to the patients of different cultures, albeit with some allowance. Treatment compliance may be interpreted as either to traditional treatment, or to psychiatric treatment; awareness of illness may be modified to awareness of suffering, and relabelling of psychotic experiences as appropriate to the patient's ethnic and cultural beliefs. This is possible if one has an understanding of the patients' different beliefs. However, I would be rather hesitant to apply his schedule strictly in assessing insight in these patients.

The authors have stressed an indirect approach to help the patient recognise his/her illness so as to improve treatment compliance, rather than tackling non-compliance head on which can only lead