Clinical use of moclobemide in Kleine-Levin syndrome

SIR: The Kleine-Levin Syndrome (KLS) is a peculiar disorder that primarily affects adolescent males. First described by Kleine (1925), the syndrome is characterised by alternating episodes of hypersomnia and hyperphagia. Critchley (1962) included disturbances of mood and other appetitive functions as symptoms of KLS. KLS patients present with acute onset of stupor, relative ease of arousal, irritability on awakening, and hyperphagia. There is also withdrawal from social contact.

I report below a patient with KLS who was administered moclobemide as treatment for the disorder.

Case report. A 40-year old male patient had a history of alternating hypersomnia, hyperphagia, sadness, and psychomotor retardation spanning 12 years, without fluctuation and occurring in episodes lasting 15–25 days every 3–4 months. Neuroradiological investigations (skull X-ray, computerised tomography (CT) scan) were inconclusive. Repeated electroencephalogram (EEG) showed non-specific slow wave activity alternating with bursts of 8–12 Hz activity, activation of slow-wave activity with eye opening and reduction of sleep spindles. His thyroid function was within normal limits, while the dexamethasone suppression test (DST) was positive during the active phase (> 15 μg/dl) and became non-suppressing after recovery.

Over the years, he had received various tricyclic antidepressants, lithium, carbamazepine and 5-HT reuptake inhibitors, with no significant response. Since June 1991, the patient has been receiving moclobemide (300 mg/day). There has been marked improvement with no relapse of symptoms for 12 months. In addition, no significant side-effects of the drug have yet been reported.

I am not aware of other reports of moclobemide responsiveness in KLS. As we do not yet have an effective treatment for this rare disorder it is suggested that reversible inhibitors of monoamines may be tried in the treatment of KLS.

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Lay theories of schizophrenia

SIR: Without wishing to downplay the value of Furnham & Bower's comparison of academic and lay theories of schizophrenia (*Journal*, August 1992, **161**, 201–210), there are some problems in their interpretation. They have not described here a 'lay theory' but a goodness of fit with professional models. Respondents were provided with a medical term, *schizophrenia* (which Furnham himself has previously shown carries a rather different lay meaning), together with a professionally derived symptom list and set of attributes; clearly the authors themselves have a category in mind which is independent of any conceptualisation, for they talk of "schizophrenia itself". Out of responses to the attributes offered they then derive their lay model and even its structure.

The questionnaire used was entitled 'beliefs' (and this is presumably a term for the readers of the paper, not just the respondents), and the authors themselves make an initial distinction between attitudes ('subjective feelings') and 'objectively verifiable' beliefs, yet the suggested attributes are in part concerned with the moral status of schizophrenia. Rather than have recourse to the debatable psychological distinction between attitudes and beliefs, it might be more helpful to examine the boundaries and context of the model itself; for instance, is it representational or operational (Holy & Stuchlik, 1982)? The context and design of the current study argues for generating a model which is itself somewhat operational or even explanatory (Caws, 1974).

A more serious problem is the authors' assumption that the logical structure of lay (or indeed professional) models is one which is to be revealed in factor analysis, and which is thus independent of respondents' own implicit statements (White, 1982). We are not arguing that there is some real model inside people's heads which they or the authors have failed to ascertain, but that lay theories are more logically messy, variable and contextual than is allowed for in this paper. Given the diversity of the professional (and hence somewhat standardised) models they cite, it might be surprising if lay models had any greater coherence. Perhaps not, but if we reverse the procedure and let psychiatrists give responses to lay models, then the local professional responses themselves approximate to local lay models more than they do to each other (Townsend, 1978).

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