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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.

DEREK SUMMERFIELD

Drugs Dependency Unit
Clare House
St George's Hospital
London SW17 0QT

Reference

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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.

LUIS M. IRUELA
MARÍA A. MARCOS

Clínica Puerta de Hierro
San Martín de Porres 4
28035 Madrid
Spain