116 mmol/l, urea 2.1 mmol/l, serum osmolality 242 mOsm/kg; the plasma ADH level was not determined. Water restriction resulted in clinical and biological improvement.

In the first two cases, the results were consistent with water intoxication secondary to psychogenic polydipsia, with a resetting of the ADH osmostat (Caron *et al*, 1977; Robertson, 1980; Singh *et al*, 1985); the plasma ADH level was inappropriately high for the plasma osmolality. In the third case, the finding of concentrated urine suggested the classic form of SIADH. Our three cases confirm that there are two distinct forms of SIADH—the classical and an atypical one. It can occur in different mental illnesses, with or without the use of neuroleptics. Measuring the plasma ADH level on admission and during a water-loading test ten days later can distinguish between an inappropriate secretion of ADH with a resetting of the osmostat, or a mild form of SIADH (Rosenbaum *et al*, 1979). Our third case, of a patient with tardive dyskinesia and polydipsia, may confirm the hypothesis of hyperdopaminergic activity (Smith & Clark, 1980).

P. BOURGEOIS
D. LEYS
H. PETIT

University of Lille, Hospital B,
2 Av. Oscar Lambret,
F 59037 Lille Cedex, France

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Lithium in Severe Depression

DEAR SIR,

Lithium in combination with tryptophan and a monoamine oxidase inhibitor may be useful in the treatment of chronic or resistant depression (Barker & Eccleston, 1984). Lithium has also been shown to have acute antidepressant activity comparable to imipramine (Worrall *et al*, 1979). We have recently seen a case of recurrent unipolar depressive illness of psychotic intensity which would appear to respond only to lithium but not to ECT or to combinations of antidepressant drugs.

The patient, a 60-year-old man of good work record, no family psychiatric history and no evidence of physical illness or intellectual impairment had an episode of depression seven years ago which responded to a course of ECT. Three years ago he became depressed again with biological depressive symptoms and delusions of guilt and unworthiness. There was no response to six months' treatment which included two courses of ECT, adequate trials of amitriptyline, dothiepin, mianserin and nomifensine, and of phenelzine used singly and in combination with amitriptyline. Eventually lithium alone was tried and he made a rapid and complete recovery after two weeks.

On follow-up his recovery was maintained but later the lithium was discontinued at his own request due to weight gain. He relapsed and was readmitted. Lithium was withheld due to the patient's reluctance. He remained unresponsive for a year to ECT, various tricyclics used singly and in combination with a monoamine oxidase inhibitor (in this instance tranylcypromine) as well as sleep deprivation. Finally lithium was again tried (to achieve a serum level of around 0.7 mmol/l at 12 h post-dose) and he showed a rapid and complete response which began after about two weeks.

It has been suggested (Abou-Saleh & Coppen, 1983) that the *prophylactic* effect of lithium is more marked in patients with high Newcastle scores (i.e psychotic depressives). If this applies also to the *acute* antidepressant effect, as this case suggests, then perhaps a trial of lithium is a reasonable alternative to ECT in certain severely depressed patients who are either unresponsive or unsuitable for electrical treatment or other antidepressant drugs.

ALAN A. FRASER
PRAMOD JAUHAR

Duke Street Hospital,
Glasgow G31 2HX

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Suicidal Behaviour and Child Abuse

DEAR SIR,

Having read with interest the paper on the risk of child abuse among mothers who attempt suicide by

Hawton *et al* (*Journal*, May 1985, **146**, 459–463) I feel sure that these authors would wish to acknowledge that a statistical association between suicidal behaviour and cruelty to children was demonstrated 13 years ago by McCulloch & Philip (1972). Their important painstaking study deserves wider recognition than it has received hitherto.

S. GREER

King's College Hospital,
London SE5 9RS

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Research into Non-Organic Physical Symptoms

DEAR SIR,

Further psychiatric research is needed into non-organic physical presentations and in this respect the study reported by Wilson-Barnett & Trimble (*Journal*, June 1985, **146**, 601–608) is welcome and interesting. There have been a number of similar studies lately in which psychiatric and psychological measures have been made in groups of patients with non-organic symptoms (for example, Bass *et al*, 1983; Blumer & Heilbronn, 1982; Macdonald & Bouchier, 1980; Gomez & Dally, 1977; Beard *et al*, 1977). In most of these studies comparison has been made between a non-organic group and a group with diagnosed organic disease, and the non-organic group has been found to have higher rates of psychiatric and psychological abnormalities. A conclusion common to most of the authors of these studies is that the physical symptoms represent unexpressed psychiatric disorder or unexpressed emotional distress.

In methodology all of these studies have limitations and the authors should perhaps have been more cautious in reaching their conclusions. All studies are cross-sectional in design and have generally investigated patients after they have been experiencing unexplained symptoms for several years. It therefore cannot be assumed that any abnormalities found are causal, whether these be in psychiatric health, personality inventories, history of childhood events, history of impaired sexual functioning, etc. That these abnormalities are effects of longstanding symptoms cannot be excluded. The organic comparison groups used in many of these studies have not been satisfactory. Severity of symptoms has never been matched, and it is possible that symptom severity has been less in the organic groups given that organic disease can often be treated and can sometimes remit. Furthermore, patients in these groups have known that an explanation for symptoms has been found and that treatment should follow.

Another criticism that can be made of the report by Wilson-Barnett & Trimble and of the other studies referred to, is that the non-organic group was analysed as a single one, and conclusions appear to refer to all patients. This group of patients may be very heterogeneous and subclassification may be helpful. Patients in whom psychiatric disorder, masked or unmasked, seems to be the explanation for symptoms could be analysed separately. The remainder could be subclassified in terms of physical symptom variables seldom described in detail in the above studies—duration, course, nature of onset, severity in terms of distress and disability, history of frequent non-organic consultations, presence of illness fears, among others.

The sort of research needed to answer my points would be formidable, but until it is done I do not think we can claim to understand non-organic physical symptomatology with any certainty.

DONALD I. MELVILLE

Royal South Hants Hospital,
Southampton SO9 4PE

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The PSE in Different Cultures

DEAR SIR,

Swartz, Ben-Arie and Teggin (*Journal*, April 1985, **146**, 391–394) provide a useful discussion of the rather exiguous opportunities in PSE9 for rating 'subcultural delusions or hallucinations'. I hope they will find the tenth edition, now under development, more satisfactory. The solution is indeed to provide local supplements and, if possible, also to translate these into English.

However, many apparently culture-specific