people involved with the law without having a diagnosable mental illness, will also be a problem requiring clarification.

Professional alliances in the mental health field will be a necessity, aiming to work towards global aims and good practices. The sooner the psychiatry of our times adopts this approach the better for everyone, especially the people we serve.

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ECT seizure threshold and fluoxetine

SIR: We describe the case of a patient given electroconvulsive therapy, where resulting convulsions were either shortened or absent despite conventional measures to lower seizure threshold. This problem was overcome by the simultaneous prescription of fluoxetine.

A 50-year-old man with a severe depressive disorder and suicidal ideation failed to improve despite treatment with amitriptyline 300 mg/day augmented by lithium carbonate. Physical examination and laboratory investigations were unremarkable. A course of bilateral ECT (Ectron series 5) was commenced; however, the convulsions generated were either short (less than 25 seconds) or absent, even at the maximum output of the apparatus and despite attempts to lower the seizure threshold, including pretreatment with caffeine sodium benzoate (Abrams, 1992). After 14 treatments the patient showed only slight improvement and ECT was withheld. Mean and total seizure duration were 6 and 108 seconds respectively (range 0–30). The medication regime was reviewed and the antidepressant changed to fluoxetine, increased to a dose of 40 mg/day. After a five week interval the patients' mental state deteriorated, culminating in a serious suicide attempt. A second course of ECT was commenced, a total of eight treatments were given in the same way as previously described, however on each occasion convulsions were now in excess of 25 seconds duration (mean 31 seconds, range 26–45; total duration 220 seconds). At the end of eight treatments the patient was judged to be markedly improved, he denied depressed mood or suicidal ideation, showed an improvement in sleep and appetite, and began interacting with fellow patients and engaging in occupational therapy.

The effects of antidepressants on seizure threshold and duration are variable and unpredictable (Pritchett *et al*, 1993). Fluoxetine is reported to have been associated with prolonged seizures in patients receiving ECT (ABPI data sheet compendium), however Guitierrez-Estinou & Pope (1989) found no difference in seizure duration in patients given ECT plus fluoxetine compared with patients given ECT alone. In the case of our patient the addition to fluoxetine did appear to be associated with prolongation of seizure length and with outcome. This raises the possibility of an idiosyncratic effect of the drug on seizure threshold.

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Discrepancies on prescribing antipsychotics

SIR: Recently, much effort has been directed towards reaching a consensus on the use of antipsychotic medication in the United Kingdom (Thompson, 1994). Anecdotal evidence suggests, however, that any differences that may exist between practitioners in the UK are only minor in comparison to those between practitioners in the various countries in the European Union (Van Os *et al*, 1993). In this context, we investigated differences in antipsychotic prescribing practice among French and UK psychiatrists. Patients with an RDC or DSM–III–R diagnosis of schizophrenia were drawn from two British and French cohorts consisting of consecutive admissions. French patients (n=107) were much more likely to have been prescribed two or more oral antipsychotics than British ones (38.3% v. 1.4%; $P<0.0001$). British patients (n=70) were more likely to have received a single depot antipsychotic (35.7% v. 7.5%; $P<0.0001$), but there was also a slight excess in the number of patients who were prescribed a depot antipsychotic in combination with a different oral compound (24.3% v. 12.1%; NS). The same large and significant differences were present in men and women, in the under-30s and in the over-30s, in acute in-patients and in out-patients, and in recent onset and chronic patients alike. The discrepancy in prescribing habits presented in this study may also be relevant to the issue of high-dose antipsychotic

medication. For example, the 1994 VIDAL (the French equivalent of the British National Formulary) gives an advisory maximum daily dose of the oral antipsychotic fluphenazine of 800 mg, and an average daily dose of 25–300 mg, compared to a 20 mg maximum daily dose in the BNF (a 4000% difference). Further research into the relative merits of these divergent treatment approaches is clearly needed.

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Lithium in steroid-induced depression

SIR: In their report of two cases of successful lithium treatment of mood disorders associated with corticosteroid treatment, Terao *et al* (*BJP*, January 1994, **164**, 109–111) conclude that the effectiveness of lithium in these cases is a manifestation of its activity as a serotonergic antidepressant. This interpretation is tenable, but another interpretation must also be considered.

Mixed mood disturbances (referred to as agitated depression, dysphoric mania, or mixed manic-depressive states) can closely resemble other depressive states (McElroy *et al*, 1992). If these two patients were suffering from mixed mood disturbances, then their positive responses to lithium would be seen as responses to a mood-stabiliser. Note that each of these patients had anxiety and irritability as prominent symptoms.

The authors' interpretation would predict a positive response in these cases to serotonergic antidepressants. Although specific serotonergic drugs have not been systematically studied in these patients, reports on responses to older non-specific antidepressants (each of which has some serotonergic activity) have been very negative (Hall *et al*, 1978). Authors who had previously reported positive results of lithium treatment for steroid-induced mood disturbances had noted the high incidence of manic and mixed manic-depressive states in these patients as a reason for trying lithium (Siegal, 1978; Falk *et al*, 1979).

By the same token, an interpretation based on mood stabilisation would predict a positive response to other mood stabilisers, such as carbamazepine or valproate. Consider the following case. A 41-year-old female was being treated for Crohn's Disease of long duration with prednisone in doses as high as 60 mg per day. All other treatments had failed. She found that irritability, racing thoughts, emotional lability and dysphoria appeared whenever high-dose prednisone was used. I rejected lithium because it irritates the gastrointestinal tract. Carbamazepine, in a dose of 800 mg per day, brought about complete cessation of her mood disturbance even at the highest prednisone doses.

Steroids are frequently used in high doses. More research on the treatment of steroid-induced mood disturbances would be very useful.

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Language and psychiatry

SIR: While welcoming Thomas & Fraser's review of recent developments in linguistics (*BJP*, November 1994, **165**, 585–592), I am surprised that no mention of any psychoanalytic works was made, as psychoanalysis is above all a textual analysis. The French psychoanalyst Jacques Lacan said that "psychoanalysis has only one medium: the patient's speech", thus rehabilitating speech and language as the basis of Freudian analysis (Lacan, 1953).

Freud's command to his first patients (the hysterics for whom speech was so problematic) was to speak. It was through this speech that the unconscious text emerged. His example of the fort-da game (Freud, 1920) shows how the child uses language in order to cope with the mother's absence