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Synopses of Papers Awaiting Publication

Overinclusive Thought Disorder and Symptomatology. D. V. HAWKS and R. W. PAYNE.

It has been assumed that the standard tests of overinclusive thinking (Payne and Friedlander, 1962) provide an objective and reliable measure of the overinclusiveness manifest by some acute schizophrenics. In addition there is some evidence that overinclusion as assessed by these tests may be causally related to the development of paranoid delusions. That performance on these tests may also be related to verbal responsiveness has been suggested in a number of sources but never directly investigated.

Psychiatric in-patients were assessed clinically for evidence of over-inclusive thinking and assigned to one of three groups; clinically over-inclusive schizophrenics, clinically non-overinclusive schizophrenics, and clinically non-overinclusive non-schizophrenics. The method of selection ensured that the three groups were matched in terms of age, intelligence, education and length of hospitalization. These three groups together with a normal control group were given the three standard tests of overinclusion by an independent examiner and the testing repeated after four days. The patients were also independently assessed on a standard symptom rating scale by two people assumed to be equally familiar with them.

The three tests were significantly intercorrelated and highly reliable in the present population. Performance on them was also highly correlated with the clinical assessment of overinclusive thinking. Contrary to prediction, however, there was no tendency for patients getting high scores on the tests of overinclusive thinking to display more delusions; there was however, a significant tendency for them to be more responsive.

It is suggested that the standard tests of overinclusive thinking, all of which employ the number of responses made as their measure of overinclusion, are markedly affected by the responsiveness of the patient and that the tendency for acute schizophrenics to get higher scores on these tests than chronic schizophrenics may merely reflect the greater responsiveness of acute patients.

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Differences in Usage of Diagnostic Labels amongst Psychiatrists in the British Isles. J. R. M. COPELAND, J. E. COOPER, R. E. KENDELL and A. J. GOURLAY.

Differences in diagnostic practice and rating behaviour between groups of psychiatrists trained in different centres in the British Isles are examined, using their observations on three video-taped psychiatric interviews.

Some 200 psychiatrists participated, and viewing sessions were held in London, Birmingham, Edinburgh, Glasgow, Manchester, Belfast and Dublin.

Diagnostic agreement was reasonably high, and only Glasgow-trained psychiatrists stood out as a group, being more prone than the rest to make a diagnosis of affective illness rather than schizophrenia. Compared to the large differences known to exist between the diagnoses of American and British psychiatrists on two of these same tapes, these differences within the British Isles are quite small.

On the ratings of symptoms and behaviour (made using Lorr's I.M.P.S.) there was a striking and general tendency for Maudsley-trained psychiatrists to rate at a lower level than the rest. An age effect was also demonstrated, older psychiatrists rating higher than younger, irrespective of their place of training. In addition, psychiatrists with psychotherapeutic training and experience rated higher than those without.

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These differences in rating habits are discussed, but no obvious explanations emerge. The present lack of knowledge about these important components of the diagnostic process is emphasized, and a plea is made for more work in this field, which is of fundamental importance for both clinical and research work.

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Criminality and Violence in Epileptic Prisoners. JOHN GUNN and JOHN BONN.

There is a longstanding belief that the phenomena of 'epilepsy' and of 'crime' are associated. A census of prison and borstal receptions in England and Wales conducted in 1966 showed more epileptic males being taken into custody than would be expected by chance. A later survey suggested a prevalence of at least 7·1/1,000 epileptic men in prisons and borstals. The possibility that these epileptic men commit more violent offences than other prisoners is examined in this paper. Four features of a group of epileptic prisoners and of a matched control group are studied: (i) the nature of the current offence, (ii) the degree of violence involved in the current offence, (iii) the degree of impulsivity involved in the current offence, (iv) the nature of any previous offences.

The current offence was a violent one in 15 per cent of the epileptic men and 22 per cent of the non-epileptic controls. This difference is not statistically significant. No differences were found between the groups on a specially constructed scale measuring the 'degree of violence' exhibited in the current offence. The degree of impulsivity scale, also specially constructed for this survey, rated the epileptic men as slightly more impulsive than the controls. No differences were found between the groups in the number of violent convictions previously recorded against them. The temporal lobe cases were found to have a higher previous conviction rate, but it was the idiopathic group who received disproportionately more previous convictions for violence.

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Regression from a Biological Standpoint. THOMAS D. POWER.

Regression may be defined as the re-living by an individual of his past, or part of it, in the present. Viewed in this way it can be seen as an adaptive defence mechanism, if at times an abortive one, operating in widely differing biological fields far removed from psychiatry. Instances of it are given (1) in the psychological field in association with organic cerebral disturbance, (2) in the neuro-muscular sphere in neurological disease, (3) in the sphere of animal behaviour in the face of stress, (4) at the cellular level in association with regeneration after injury.

Regression in man does not involve a clear-cut return to the past, but a merging of the present into the past—a 'telescoping' of experience. In the course of this backward journey there takes place a de-differentiation and unification of function in the dimensions of Time and Space. This applies in both mental and neuro-muscular fields.

Attention is called to the resemblance between ontogenetic regression and the phenomenon of 'paedomorphosis' in phylogenesis.

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Psycho-Analysis and The Treatment of the Psychoses. THOMAS FREEMAN.

Following a brief introduction an outline of the psycho-analytic theory of psychosis is presented in which emphasis is laid on its psycho-biological and developmental orientation. This is followed by a description of Anna Freud's Metapsychological Profile suitably adapted for cases of psychosis. The completion of a profile for a case of psychosis provides the basis for the formulation of an explanatory psychopathology. This can be used first, as a means of differentiating patients who present

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similar symptom complexes and second, as a guide for the management and treatment of the patient while in hospital and after discharge. This use of psycho-analysis has as its aim the perpetuation of the beneficial effects of drug therapy and the prevention of relapse.

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Comparative Effect of Lithium and Chlorpromazine in the Treatment of Acute Manic States. GORDON JOHNSON, SAMUEL GERSHON, EUGENE BURDOCK, ARTHUR FLOYD and LEON HEKIMIAN.

A controlled double blind evaluation of the effects of lithium and chlorpromazine in acute manic states is reported. Patients diagnosed as either manic-depressive, manic phase or schizophrenia, schizo-affective excited phase were selected for the study. Three psychiatrists participated in the initial selection of each subject and complete agreement on diagnosis was necessary for inclusion in the study. The diagnostic criteria took into account longitudinal developmental aspects of the illness as well as the cross-sectional presenting symptomatology. The major features on which these differential diagnoses were based are tabulated. The patients were assigned to one of four treatment groups. First, manic-depressive, manic phase treated with lithium. 2. Manic-depressive, manic phase treated with chlorpromazine. 3. Schizo-affective, excited phase treated with lithium. 4. Schizo-affective, excited phase treated with chlorpromazine. Comprehensive, quantitative behavioural assessment was made during baseline period and at intervals throughout the study treatment which was continued for a period of at least 21 days. Lithium was administered in doses ranging from 1·5 gm. to 3·5 gm. per day. Serum levels attained ranged from 1·0 meq./l. to 2·5 meq./l. Chlorpromazine was administered in identical capsules containing 50 mg. Doses ranged from 0·2 gm. to 2 gm. per day. Treatment outcome was analyzed from baseline to termination within each treatment group, and a comparative analysis was made between lithium and chlorpromazine treatment within each diagnostic group. Analysis of baseline to termination data showed that chlorpromazine produced significant improvement in both groups whereas lithium produced a significant improvement in the manic-depressives only. A comparison of the difference of the changes between lithium and chlorpromazine showed that the changes in the manic-depressive group were greater with lithium than with chlorpromazine, while in contrast, the changes in the schizo-affective group were greater with chlorpromazine than with lithium. However, these changes did not reach statistical significance. Clinical profiles obtained by separate independent raters showed evidence of consensual validity in that the greatest improvement was shown by the manic patients treated with lithium. Also, analysis of subjects suggested that lithium had a specific impact on the pattern of mania but not on that of schizo-affective disorder; chlorpromazine in contrast affecting the pattern of schizo-affective disorder, but doing little to that of mania.

An unusual effect of lithium was produced in some schizo-affective patients. Symptoms of a toxic confusional state were seen after ten to fourteen days of treatment. Serum levels of lithium were within the therapeutic range from 1·1 meq./l. to 1·9 meq./l. No laboratory abnormalities were found in relation to these toxic effects which disappeared when lithium was discontinued. The role of lithium in the treatment of mania is discussed, the major conclusions reached being the following: Firstly, that lithium can and does effectively control the majority of patients with acute mania. Secondly, evidence has been presented which shows that lithium has both quantitative and qualitative differences when compared to chlorpromazine which would tend to favour lithium in most circumstances as the drug of choice in acute mania. If precautions such as hospitalization with careful clinical observation and laboratory control are observed, unwanted effects can be minimized.

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