Mentally handicapped epileptic patients: psychiatric illness and personality disorder

SIR: I read with interest the articles by Deb & Hunter (*Journal*, December 1991, **159,** 822–834). Although the articles were concerned with comparing epileptic with non-epileptic mentally handicapped patients in terms of maladaptive behaviour, and diagnoses of psychiatric illness and personality disorders, I feel that a more integrated comparison would have been useful. Since the study population was the same for all the comparisons it would be interesting to know the overlap between maladaptive behaviour, psychiatric illness and personality disorder diagnoses. I wonder if closer approximations between the three would not occur. It would be surprising that after diagnosing severe maladaptive behaviour some patients would not be diagnosed as having psychiatric illness or even personality disorders. It seems that all three studies have measured similar variables and have, not surprisingly, arrived at similar conclusions.

Although the authors acknowledge that the diagnosis of personality disorder is difficult in mental handicap, it is surprising that the DSM–III criteria were used to diagnose psychiatric illness but not personality disorder. The personality disorder most commonly diagnosed in the study, the aggressive type, does not correspond to any of the categories currently in use; it must also be difficult to diagnose persistent aggressive behaviour associated with mental handicap and epilepsy as a manifestation of an abnormal personality independent of the associated conditions. The authors should have attempted to address these issues.

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SIR: We were impressed with the industry of Deb & Hunter (*Journal*, December 1991, **159,** 822–834) in their study examining the behaviour, extent of psychiatric illness and personality disorder in mentally handicapped epileptic patients. Arising from their study is support for a persistent, perseverative epileptic personality in these patients living outside hospital.

However, we were concerned about the authors' interpretation of their finding that patients receiving carbamazepine therapy alone were less likely to be affectively and behaviourally disturbed and that this may be due to the mood-stabilising effects of this drug. In a naturalistic survey like the one they have presented, it is not possible to determine cause and effect. Mentally handicapped epileptic patients often receive more than one epileptic drug to control their fits (Fishbacher, 1987; Thinn *et al*, 1990) and this is usually because their secondary epilepsy is difficult to control. In a recent study carried out in mentally handicapped epileptic in-patients, only 7% of those receiving one drug for epilepsy had more than one fit a month whereas 43% of those in the polypharmacy group had fits of this degree of frequency (Thomson *et al*, unpublished).

Drs Deb & Hunter have shown in their papers that patients with frequent and multiple fits are significantly more likely to exhibit maladaptive behaviour than epileptics with less frequent seizures and than a matched sample of non-epileptic patients. The patients receiving monotherapy for epilepsy are consequently better behaved, but this may well be due to less cerebral damage in this group and other factors affecting fit frequency, not to the prescription of carbamazepine.

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AUTHOR'S REPLY: Dr Bhandari has raised an important point regarding the overlap among the diagnostic categories (i.e. maladaptive behaviour, psychiatric illness, and personality disorder) in our study population. Further analysis of the data has shown that those adults with a mental handicap who had a diagnosis of psychiatric illness had a significantly higher rate of severe maladaptive behaviour than those who did not have such a diagnosis. Similarly, those adults who had a diagnosis of personality disorder, particularly the aggressive type, showed a significantly higher rate of severe maladaptive behaviour than those who did not have such a diagnosis. We intend to report these results in a separate paper. It was not possible to report all our study findings in this publication (*Journal*, December 1991, **159,** 822–834) because of lack of space. On the second point of the choice of the diagnostic criteria for personality disorder, we explained in our papers why we used that Standardised Assessment of Personality (SAP) and T-L Personal Behaviour Inventory. SAP is an

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observer-rated personality questionnaire with a high reliability score in both normal and mentally handicapped populations (Mann *et al*, 1981; Reid & Ballinger, 1987). As the diagnosis of personality disorder in the mentally handicapped population remains difficult and controversial, it seems important to use an observer-rated questionnaire which has a good tested reliability on mentally handicapped populations. Neither DSM–III nor DSM–III–R has that advantage. The T-L scale, however, was used by Bear & Fedio (1977) to detect the personality characters which they claimed to be specifically associated with epilepsy.

It is true, as Drs Tyrer & Moore have pointed out, that we found the epileptic patients living in the community to have a significantly higher T-L personality abnormality, particularly 'persistence and repetitive' type than those without epilepsy. However, such behaviour is not uncommon in people with a mental handicap, the numbers in each group were very small and in the context of a high number of statistical tests these few positive findings may have been obtained by chance. On the question of the protective effect of carbamazepine on maladaptive behaviour, we agree that in a cross-sectional survey it is difficult to ascertain cause and effect relationships; however to overcome that difficulty we used a carefully matched control population and compared the effect of each monopharmacy group separately to avoid contamination effect. Analysis of our data does not support their assumption that behavioural effects may have been due to the associated factors (e.g. less severe brain damage, less frequent seizures, etc.) rather than the influence of carbamazepine monopharmacy *per se*. When the combined subgroups of epileptic patients (both from hospital and from the community) with evidence of severe brain damage (e.g. those who had multiple types of seizure and also frequent seizures) were compared with their counterpart of non-epileptic adults, no significant difference in the maladaptive behaviour was observed. On the contrary, the severely mentally handicapped adults with epilepsy showed significantly less maladaptive behaviour when compared with the adults without epilepsy. Although as a group those who received monopharmacy had shown significantly less aggressive behaviour, this did not prove true for any monopharmacy group other than carbamazepine, whereas associated brain damage factors should have remained the same in all monopharmacy groups.

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Ethical problems in genetic linkage studies

SIR: We were most interested to read Alexander *et al*'s contribution to the long-overdue discussion of the ethical issues and problems inherent in genetic linkage studies of psychiatric disorders (*Journal*, January 1992, **160**, 98–102). We applaud the thoughtful nature and general thrust of their approach, but feel it might be useful to share our experience in the method of making the all-important initial contact with the proband's relatives.

Dr Alexander *et al* state that family members "are often taken aback" by "the initial contact [which] is usually by telephone". While we are aware that there may well be considerable cultural differences in the way telephone communications are offered and received in different countries, such a response to an unexpected call by a member of a psychiatric research team should perhaps not come as a surprise to the caller; it is for this reason that our policy in Scotland is to make initial contact by means of a brief letter explaining in general terms the nature and purpose of our research, which is then followed up within a week by a telephone call and a request to meet personally. In this way, family members have the opportunity to think over the issues before any demands are made on them, and consider any questions they may wish to ask. In our experience the procedure may be marginally more time-consuming than a straightforward telephone call, but the extra effort is repaid in terms of less anxiety for future participants in our studies and very high degree of cooperation and goodwill in the longer term.

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Western psychotherapy and non-Western populations

SIR: It was interesting to read about the difficulties our Saudi Arabian colleagues experienced (*Journal*,

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