

blockade, perhaps exacerbated by cholinergic overactivity during withdrawal, (Gardos *et al*, 1978) and relieved by an anti-cholinergic drug.

E. D. D. FREED

*St Vincent's Hospital,  
Darlinghurst, N.S.W. 2010, Australia*

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#### SOCIAL PHOBIA

DEAR SIR,

We were interested to read the paper by Amies *et al* (*Journal*, February 1983, **142**, 174–79) that presents the distinguishing features of social phobia and agoraphobia and implies a heterogeneity within the term phobic neurosis in ICD-9 (WHO, 1978). Social

phobia has a specific definition in the DSM III (APA, 1980), consisting of a fear of criticism and scrutiny in situations of public eating, speaking, writing or urination, with consequent avoidance. The definition used by Amies *et al*, however, was more general, viz. “anxiety experienced in the company of other people . . . increased with formality and the extent to which the person feels under scrutiny”. Following this wider definition, they found that the situation feared mostly by their group was that of being introduced to other people.

We recently surveyed forty-six patients referred to the Maudsley Hospital, London, whose main complaint was a difficulty in initiating and maintaining conversations, especially with strangers of the opposite sex, at parties and other social gatherings. Like Amies *et al*, we found that the majority were single men, whose problem began in their second decade of life, although over 60 per cent of our group reported having no friends in childhood. Agoraphobics and social phobics defined by the DSM III were not included. Considering the very early development of the problem, we concluded that this group could be subsumed under the DSM-III term, “avoidant personality disorder” viz difficulty in relating comfortably to others, with social withdrawal, and a fear of rejection and humiliation. Unlike schizoid personality disorder, this group wishes to be able to socialize, and all our patients approached the clinic with this as their main problem.

We suspect that many patients of Amies *et al* would be better classified as having an avoidant personality disorder. The therapeutic implication of such a division may well prove to be that social phobia, like other phobias, responds to anxiety-reducing methods such as exposure (Marks, 1981), while avoidant personality disorder requires social skills training, which includes instructions and role-play of improved social performance in addition to exposure (Stravynski *et al*, 1982).

DAVID GREENBERG

*Jerusalem Mental Health Center-Ezrath Nashim,  
P.O.B. 140, Jerusalem,  
Israel*

ARIEL STRAVYNSKI

*Psychiatric Research Center,  
Louis H. Lafontaine Hospital,  
7401 Hochlage St.,  
Montreal, Quebec,  
Canada*

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#### THE PROGNOSIS OF DEPRESSION IN OLD AGE: THE CASE FOR LITHIUM THERAPY

DEAR SIR,

The elegant study by Murphy (*Journal*, 1983, **142**, 111–13) is another confirmation of the poor prognosis of depressive illness in late life. The study, primarily an investigation of the 'importance of social factors in influencing outcome', could not—by reason of its design—determine the contribution of physical treatment to this outcome. Murphy rightly concluded that the case for maintenance treatment with antidepressant medication or for lithium prophylaxis remains an open one: 'a prospective study of the role of maintenance therapy in these patients would be very valuable'.

We would like to provide evidence for the efficacy of lithium prophylaxis in depressions of late life.

Forty-four male and 104 female patients with recurrent affective disorders were studied. Patients had been attending the lithium clinic for periods varying from 1 to 14.5 years (mean 4.9 years). All patients had received lithium carbonate in the form of sustained release tablets (Priadel). Lithium was given once daily, at night, to achieve plasma levels of 0.8–1.2 mmol/l, 12 hours later. Affective morbidity over time was measured by the Affective Morbidity Index (AMI), a composite index of the severity and duration of both manic and depressive episodes each patient had suffered during the period studied (Coppen *et al.*, 1973). Among these patients there were 47 who had started lithium prophylaxis in late life (at the age of sixty or above). Table I shows comparisons between this group and groups who had started lithium prophylaxis at earlier ages. There were no significant differences between these groups in terms of their previous morbidity and their AMI. The elderly group, however, had a significantly shorter duration of lithium therapy than the other younger groups. There was no significant correlation between duration of lithium therapy and AMI in the whole group.

TABLE I

General details of patients, and relationship between age and morbidity during lithium therapy (results expressed as mean  $\pm$  SEM)

Age when lithium started (yrs)	n		Polarity		Episodes prior to lithium	Years on lithium	AMI*
	M	F	Unip.	Bip.			
60 and above	4	43	42	5	4.9 $\pm$ 0.6	3.8* $\pm$ 0.4	0.18 $\pm$ 0.03
40–60	31	48	58	21	4.2 $\pm$ 0.3	5.5 $\pm$ 0.4	0.17 $\pm$ 0.02
Less than 40	9	13	17	5	4.4 $\pm$ 0.6	5.3 $\pm$ 0.7	0.14 $\pm$ 0.03

\* Significantly lower than (40–60 yrs) group  $P < 0.01$  and (less than 40 yrs) group  $P < 0.05$ .

\* Affective Morbidity Index (Coppen *et al.*, 1973).

TABLE II

Morbidity and plasma lithium level in 22 elderly patients before and during trial period (results expressed as mean  $\pm$  SEM)

Plasma lithium level (mmol/l)	n		Polarity		AMI	
	M	F	Unip.	Bip.	Before trial	During trial
Above 0.8	0	8	6	2	0.16 $\pm$ 0.08	0.17 $\pm$ 0.06
0.60–0.79	2	4	5	1	0.40 $\pm$ 0.17	0.36 $\pm$ 0.12
0.45–0.59	0	8	7	1	0.22 $\pm$ 0.15	0.36 $\pm$ 0.20