used in endocrine, cardiovascular and many other disorders, where drug treatment aims to restore and preserve the patient's functional adequacy.

Lithium does not abolish the clinical and psychosocial evidences of recurrent affective disorders. It diminishes the severity of symptoms to varying degrees and reduces the amplitude of mood swings to a point where hospitalization can be avoided. Actually, most of the reported statistics concerned with prophylactic effects concern reduction of frequency or length of hospitalization. While hospitalization may be taken as a global measurement of the severity of affective episodes, clinical evaluation must also take into account the less severe mood fluctuations which continue during lithium therapy.

It is well known that lithium is frequently combined with antidepressant drugs during depressive cycles to maintain patients' ambulatory status. Similarly, neuroleptic drugs may have to be added to control rapidly emerging manic disturbances to maintain the patients' functional balance. Neither clinical nor psychosocial patterns indicate that lithium prevents affective disorders to the point where evidence of illness disappears.

Whatever the pharmacological action of lithium may turn out to be, it appears to interact effectively with an ongoing biochemical disorder, counteracting its socially and clinically disruptive manifestations. I believe that this is best conceived of as compensatory therapy rather than as prophylaxis.

F. A. FREYHAN.

St. Vincent's Hospital and Medical Center of New York,
153 West 11th Street,
New York, N.Y. 10011, U.S.A.

REFERENCES

1. FREYHAN, F. A., MAYO, J. A., and O'CONNELL, R. 'Clinical evaluation of the treatment of recurrent affective disorders with lithium carbonate.' *International Pharmacopsychiatry*. Karger, Basel. In press.
2. —— F. A. 'The evolution of compensatory therapy with drugs in modern psychiatric practice.' (In *Neuropsychopharmacology*. Elsevier Publishing Company, Amsterdam, 1959.)

CRIMINALITY AND VIOLENCE IN EPILEPTIC PRISONERS

DEAR SIR,

Once again, by use of a biased sample, a paper has been published purporting to show that, 'it is clearly incorrect to think of epileptic prisoners as being especially violent' (*Journal*, March 1971, p. 337). Although reference is made to the possibility of the sample being unrepresentative in not including patients in Special Hospitals, broad conclusions have been drawn which, while strictly true for the sample chosen, do nothing to elucidate the problems of epilepsy and violence.

The definition of the Hospital Order (M.H.A., Section 60) includes the terms 'A patient convicted . . . of an offence punishable on summary conviction with imprisonment . . . etc.' Thus the Mental and Subnormality Hospitals, as well as the Special Hospitals, must contain many individuals who, but for the Hospital Order, would be in prisons.

In Rampton in 1968 there were 138 known male epileptics, representing 20% of the males in that institution. Of these, 11 committed property offences chiefly and 127 were violently aggressive and assaultive, leading to deaths on four occasions. It was apparent in reading the records that in many cases deaths had only narrowly been averted.

N. F. HILLS.

Prisons Department,
'Willmar House',
606 Murray Street,
West Perth, W.A. 6005.

CLASSIFICATION OF DEPRESSED PATIENTS: A CLUSTER-ANALYSIS-DERIVED GROUPING

DEAR SIR,

In his paper (*Journal*, March 1971, page 275) describing cluster-analysis-derived groups of depressed patients, Dr. Paykel rightly observes that few studies using factor analysis have seriously explored the possibility of more than two groups. He also comments that previous factor-analytic studies suggested a simple division of depressives into two polar types rather than more complex classifications.

Since the implications for methodology could be considerable, I wish to point out that at least one previous factor-analytic study went further than a simple dichotomy and proposed a multiple-group classification. In a factor-analytic study of 126 depressed patients seen in general practice (1), two clear-cut groups of patients, one endogenous and one non-endogenous, were found when the patients were distributed on one factor; on another, virtually independent, factor there were *three* patient groups: phobic-anxious, (non-phobic) anxious, and non-anxious. Two other factors, identifying reactive depression and general severity respectively, did not serve to distinguish patient groups. These results acknowledge a diversity of neurotic sub-groups independent of a primary division of patients into endogenous (or psychotic) and non-endogenous.

This multiple-group classification was obtained by factor-analytic methods (including calculation of factor scores) only when the number of variables