TABLE

Product movement correlations of boys' and their absent fathers' scores divided on fathers' deviance

	Boys whose fathers were antisocial or alcoholic (N = 46)		
Fathers	Aggressive	Antisocial	Noncompliant
Aggressive	.20	−.07	.12
Antisocial	.18	.19	.30*
	Boys whose fathers were neither antisocial nor alcoholic (N = 18)		
	Aggressive	Antisocial	Noncompliant
Aggressive	−.40	−.24	−.24
Antisocial	−.06	.07	.21

*P <.05

The figures shown in the table suggest that the third alternative is the true explanation. The majority of fathers who were absent, namely those who were antisocial or alcoholic, resembled their sons to an appreciable extent on aggressiveness and antisocial behavior. These resemblances followed the pattern that held through most of the analyses. On the other hand the correlations for the remaining absent fathers and their sons were either strongly negative or close to zero, with one exception. We cannot explain this odd result, but it seems that the matrices for the two subgroups cancel each other. Taken as one group the absent fathers seem unlike their sons. When they were divided into two, the majority of these fathers did resemble their sons, though to a lesser degree than the fathers and sons who were still living together.

In sum we have found that there were modest but robust similarities between our boy patients and their natural fathers on aggressiveness and antisocial behavior. The boys' noncompliance was also correlated with fathers' antisocial behavior. These relationships were strongest between boys and the fathers who were still in the home, but they persisted among boys and fathers who had left the home if the latter were antisocial or alcoholic.

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PLASMA AND RED CELL LITHIUM IN AFFECTIVE DISORDERS

DEAR SIR,

In 1980 we reported in this *Journal* the possibility of differentiating unipolar from bipolar patients with an objective parameter: The correlation between the plasma and erythrocyte lithium. We have now studied a large series.

A total of 48 patients were studied, all diagnosed as major affective disorders according to the DSM–III criteria, 15 suffering recurrent major depression and 33 bipolar disorders. All treatments were applied to outpatients and lithium was indicated as a prophylactic agent according to Coppen *et al*'s criteria (1971), all patients showing at least a 6 month remission. Lithium carbonate was given in 3 daily intakes, regulating the plasma levels to 0.80 to 1.2 mmol/L. The plasma and erythrocyte lithium concentrations were determined 12 hours after the last intake, following the method of T. B. Cooper *et al* (1974).

There was no difference, in the lithium ratio, between the two diagnostic groups (major depression, N = 15, ratio 0–350, bipolars, N = 33, ratio 0–377, N.S.). On the contrary when Spearman's correlation coefficient was applied, a statistically significant correlation ($P < 0.01$) between plasma and erythrocyte lithium was observed in the bipolar group whilst in the major recurrent depressions it was not significant, confirming the results previously communicated.

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LIVER CROSS-SENSITIVITY TO ANTIPSYCHOTIC DRUGS

DEAR SIR,

Two points on management arise from this nearly fatal case.

A 26-year-old man admitted with acute schizophrenia sometimes accepted chlorpromazine but mostly he refused. Control of the psychosis was urgent because he would disappear into the freezing night in minimal clothing impelled by 'supernatural influence'. Over the next two weeks he accepted three injections of modecate which settled the psychosis.

Seventeen days after his first dose of phenothiazine, jaundice was noticed. For the next four months he was physically very ill. Serum bilirubin peaked at 252 (normal 0–17 umol/l), alkaline phosphatase reached 294 (normal 0–50 IU/L), GPT reached 240 (normal 0–40 IU/L), γGT reached 1675 (normal 0–50 IU/L).

A second psychotic episode settled in hospital without medication. The third episode in the same year was very severe and did not settle after compulsory admission. A literature search and drug company enquiry indicated that no antipsychotic drug is without risk to liver. Nothing was gleaned about relative risks of cross-sensitivity.

Arbitrarily it was decided to try in succession the best known drug derivative of each class of antipsychotic other than phenothiazine i.e. haloperidol, flupenthixol, pimozide. The shorter acting preparations would be given for at least two weeks before risking transfer to a long-acting depot preparation.

With regular liver funtion tests oral haloperidol was given for fourteen days when a sharp rise in SGPT and γGT occurred. Oral flupenthixol was then given for three weeks when it was considered safe to establish him on the long-acting depot prearation, Depixol, on which he has now been quite well for five months.

Point one In patients found to be sensitive to one antipsychotic drug, at least two weeks on short-acting preparations of the alternative drug is required before transferring to its long-acting depot preparation. The risks of inadequate control of a non-compliant psychotic patient have to be very great indeed to justify earlier depot injections which might damage the liver for many months.

Point two A register of alternative drugs tried in patients who have developed such liver reactions might eventually permit choices to be made which are better than arbitrary.

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A CORRECTION: ALZHEIMER'S CLASSIC PAPER

DEAR SIR,

Contrary to Dr Robin Jacoby's view (Reading About the Psychiatry of Old Age, May 1983) a full English translation of Alzheimer's paper 'On a Peculiar Disease of the Cerebral Cortex' (1907) exists. It is by R. H. Wilkins and I. A. Brody (1969) *Archives of Neurology,* **21,** 109–10.

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