must be present to constitute a 'rebound': abrupt withdrawal of the drug; a relatively long period of treatment before withdrawal; an increase in the frequency and/or intensity of the episodes; a brief interval between withdrawal and relapse.

Several studies have found relapses after lithium discontinuation. The older studies (Baastrup *et al*, 1970) examined the efficacy of lithium in the prophylaxis of manic–depressive psychosis and therefore the temporal relationship between drug withdrawal and onset of illness was not closely examined. More recently there has been evidence to suggest that abrupt withdrawal of lithium can lead to a rapid recurrence of affective symptoms, especially mania (Mander & Loudon, 1988). These studies have shown that many patients relapse within two weeks of drug withdrawal, that these relapses warrant urgent hospital treatment, and that these patients have received lithium for an average of over three years – all evidence in keeping with the above criteria and strongly in favour of a rebound phenomenon, contrary to the views expressed by Professor Schou.

An abstinence phenomenon with lithium withdrawal is to be expected given the effect this drug has on various systems in the body. Therefore, it is somewhat surprising that no somatic or physiological symptoms have been described in relation to its withdrawal (Balon *et al*, 1988). Moreover, the symptoms of nervousness, irritability, insomnia and labile mood which have been observed after lithium withdrawal are unlikely to be abstinence phenomena, as Professor Schou has pointed out. It is also interesting to note that Christodoulou & Lykouras (1982) demonstrated a reduction in symptoms such as hand tremor, fatigue and increased tendon reflexes, which are commonly associated with withdrawal states following lithium discontinuation.

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SIR: The article by Professor Schou opens up the discussion on the possible drawbacks of lithium treatment. His suggestion that the data from the pooled analysis by Suppes *et al* (1991) be plotted on a semilog scale is a good one, and when I did this it appeared that there are two slopes, indicating a steeper withdrawal phase over the first three months.

An interesting study that Professor Schou did not consider is that of Coxhead *et al* (1992), in which half the patients (randomly and blindly) were suddenly switched from lithium to carbamazepine. As carbamazepine has been shown to be as effective a prophylactic as lithium, one might expect that there would be a similar rate of recurrence. On the other hand, if lithium withdrawal markedly increased the vulnerability to recurrence, then one would expect that, immediately after the switch, considerably more of the patients who were switched would experience a recurrence. The results pointed to the latter conclusion, with 7 of the 15 patients switched to carbamazepine relapsing within two months, compared with only 2 of the 16 patients who remained on lithium. At 12 months the drugs appeared to be equivalent in efficacy: eight of the carbamazepine group and nine of the lithium group had relapsed. This suggests that it is the most vulnerable patients who are 'picked off' by lithium withdrawal.

I think that it is not only possible that lithium withdrawal is a cause of recurrence in bipolar disorder, but that it may be a common cause. Along with two colleagues, I reported an observational study of bipolar patients, selected by consecutive admission, looking at the relationship of life events to recurrence (Hunt *et al*, 1992). In the course of this two-year study, 9 of the 18 who were on lithium (but not on carbamazepine or antipsychotics) suffered a recurrence; four became ill within six weeks of stopping lithium, suggesting that a significant proportion of recurrences might be due to rebound mania on withdrawal of lithium.

It would seem likely that if this effect does occur with lithium it would also occur with other drugs which are effective in the prophylaxis of bipolar disorder. I know of no well conducted trial that has examined this possibility, but have seen one case in which the withdrawal of carbamazepine was associated on two consecutive occasions with rapid recurrence and an overall marked shortening of cycle length.

In my view, given the current state of knowledge, it would appear to be advisable only to start treatment with lithium (or carbamazepine) if both the patient and doctor understand that though long-term treatment is likely to improve outcome,

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short-term treatment may worsen the course of manic–depressive illness.

COXHEAD, N., SILVERSTONE, T. & COOKSON, J. (1992) Carbamezepine versus lithium in the prophylaxis of bipolar affective disorder. *Acta Psychiatrica Scandinavica*, **85**, 114–118.

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SUPPES, T., BALDESSARINI, R., FAEDDA, G., *et al* (1991) Risk of recurrence following discontinuation of lithium treatment in bipolar disorder. *Archives of General Psychiatry*, **48**, 1082–1088.

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Ethnic nomenclature

SIR: May we endorse Dr Callan's timely protest about the vagaries of ethnic nomenclature (*BJP*, October 1993, **163**, 551)? An earlier objection to the use of the pseudoscientific term 'Caucasian' for White Europeans and the then Editor's subsequent note on this (*BJP*, October 1991, **159**, 588–599) seem to have had only little effect. Now that Caucasian speakers have established a provisional government, with Caucasian forces engaged against the Transcaucasians, and with Caucasians expelled from Moscow on the basis that they are 'black' (as reported in *The Times*), this racial term, derived from 18th-century speculations about Noah's Ark (Blumenbach, 1795), seems even more absurd.

BLUMENBACH, J.F. (1795) *De Generis Varietate Nativa* (3rd edn). Göttingen, Germany.

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Morbidity among social phobics

SIR: Social phobia (SP) has a lifetime prevalence in the order of 2.8%. Moreover, 70% of patients with SP develop a comorbid psychiatric disorder during their lifetime (usually after the onset of SP). It has also been associated with lower socio-economic status and being single (Schneier *et al*, 1992). Over the last 10 years, efficacious psychological and pharmacological treatments have been developed (Gelernter *et al*, 1991). Despite its high prevalence and morbidity, and effective treatment, relatively little attention is given to SP in many standard textbooks on psychiatry.

We recruited 27 SP patients (13 women and 14 men) through notices in local newspapers; 45 responses were received in total, and 34 patients attended for interview. For the 27 subjects meeting DSM–III–R criteria for SP, ages ranged between 25 and 68 years, with a mean of 36 years for both sexes. Onset was usually in childhood or adolescence and started after the age of 25 in only two patients.

Social impairment was significantly higher among the men: only five of the men had married or entered a significant long-term relationship, whereas 11 of the women had done so ($P < 0.05$, χ^2 test). Most men attributed their single status to their SP.

Occupational impairment among those with SP was marked: five men and one woman reported being unable to work because of their SP. Most of those in employment were in skilled or semiskilled jobs, and two held degrees, although all but two of the men and three of the women reported impairment of their functioning at work. There were many examples of turning down promotions, moving jobs to areas where they were not known, and avoiding training courses because of the social interaction demanded. Gender differences in occupational impairment did not reach statistical significance.

Over half of both sexes (9 men, 7 women) had received some form of psychological or psychopharmacological treatment. However, treatment had usually been directed at comorbid disorders rather than the SP. Any treatment directed at the SP had been either pharmacological or psychological, with no patient having received both. Six of the 27 subjects had current DSM–III–R comorbid disorders (excluding personality disorders), with three cases of depression, two of panic disorder, and one of amphetamine abuse. Many men reported using alcohol to relax before social functions. Although none currently had features of alcohol addiction, two had previously.

Theses findings appear in line with those from studies in the USA and Canada (Swinson *et al*, 1992).

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