Psychotherapy Guidebook

Lithium Therapy

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DEFINITION

Lithium, a naturally occurring salt, is the first agent in psychiatry to be specifically effective against a major mental illness. In manic-depressive disorder it calms psychotic manic excitement, usually within five to ten days. When taken on a maintenance regimen it prevents the recurrence of major highs and, to a lesser extent, lows, thus being the first truly prophylactic psychiatric drug. Lithium is of little value in the treatment of acute depression. The ion's mechanism of action is not known.

HISTORY

Lithium's effect in mania was discovered serendipitously by the Australian psychiatrist John F. J. Cade in 1949. Studies that confirmed his results were soon under way in Europe. However, recognition of the value of lithium treatment was slow in the United States because lithium chloride, used as a salt substitute in the 1940s, had caused a number of deaths and serious poisonings among patients with heart and kidney disease, conditions in which it is now known that lithium is dangerous. The FDA ban on lithium

was not lifted until 1970, when it became available for treatment of mania. In the past twenty years numerous studies have established beyond doubt lithium's effectiveness in mania. More recently, several investigators have shown its prophylactic effect in the depressed as well as the manic phase of manic depression, and in recurrent depression. (Fieve, 1978).

TECHNIQUE

Lithium carbonate is given orally in tablet form. In acute mania, dosage is 1500 to 1800 mg daily in divided doses. Maintenance dosage is 900 to 1200 mg. Blood lithium levels must be maintained in the therapeutic range of 0.8 to 1.5 mEq/Liter. The amount of lithium in the blood is measured by flame photometry, a relatively simple office procedure. Monitoring is done weekly for the first month of treatment and monthly thereafter.

Since lithium easily can become toxic, it is essential that it be administered by an experienced clinician. Diuretics, diet pills, and crash diets are contraindicated, as these upset the electrolyte balance on which safe lithium treatment depends. Patients with heart or kidney disease are usually not recommended for treatment.

Side effects may include hand tremor, weight gain, muscle weakness, diarrhea, gastrointestinal upsets, polydipsia and polyuria, goiter and hypothyroidism, maculo-papular cutaneous lesions, leucocytosis, and mild

EKG changes. Most of these subside within the first few weeks of treatment. Patients on lithium report no dulling effect as occurs with the major tranquilizers. They are able to lead relatively normal lives as long as they continue to take the medication. In most cases they find additional psychotherapy unnecessary once their mood swings have been stabilized.

Many patients on lithium also require periodic antidepressant medication, which can be discontinued once their depression subsides.

APPLICATIONS

Once stabilized on lithium, even the most severe cases of manic depression can be treated on an out-patient basis. Lengthy hospitalization, shock treatments, and extensive psychotherapy are rarely needed. The implications for future mental health care in this country are great. Lithium clinics, based on a medical model, can dispense lithium and other drugs to a large number of severely ill patients. Utilizing paramedical personnel and a few psychiatrists, such clinics can treat patients safely, inexpensively, and effectively (Fieve, 1975). This type of clinic is beginning to appear. Unfortunately, many major hospital centers still lack facilities for dispensing lithium as well as personnel trained in lithium administration. In addition, manic depression and recurrent depression are often misdiagnosed by clinicians (often as schizophrenia), and consequently improperly treated

(Cooper, et al., 1972). With increasing knowledge of diagnosis and treatment of affective disorders (of mood and emotion) the outlook for this major mental illness is bright.