Brit. J. Psychiat. (1969), 115, 629–31

Correspondence

UNILATERAL E.C.T.

DEAR SIR,

I agree with Dr. Levy (*Journal*, January 1969, p. 121) that unilateral E.C.T. is a method of treatment that 'would repay further systematic and objective study'. We need to know much more about it: e.g. how often it should best be given; if or how it may be given to left-handed and ambidextrous patients; if it is as effective as bilateral E.C.T. in the treatment of conditions other than depression. Reports of investigations published so far have thrown little light on these questions. However, I would also like to echo the views of Dr. Cannicott and Dr. Armin (*Journal*, November 1968, p. 1483) that unilateral is as effective as bilateral E.C.T. in relieving depression, and that unilateral E.C.T. is much less upsetting to the patient, causing earlier and more comfortable recovery and fewer side-effects after each treatment. The most recent reports (1, 2, 3) on this subject in this Journal all offer evidence in support of these points. When one also bears in mind that the risk of more lasting memory impairment may be reduced by unilateral electrode placement over the non-dominant hemisphere, a useful case can be made for preferring this technique. After a double-blind trial at this hospital (4), unilateral E.C.T. is now our treatment of choice for right-handed depressed patients.

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PUERPERAL PSYCHOSIS AND THERAPEUTIC ABORTION

DEAR SIR,

I was interested in Dr. Protheroe's article (*Journal*, January 1969, p. 9) and was impressed by the information he has managed to extract from his retrospective enquiry. Although he states that his own findings do not 'have much relevance to the question of termination of pregnancy' (p. 28) he does not hesitate to reject my statement that 'there are no psychiatric grounds for termination of pregnancy'. He calls this a 'general prejudgement'. Yet, while conceding that a second puerperal schizophrenic illness cannot be predicted, he regards the results of his 1947–61 survey, which showed the risk as being one in five, as being sufficient grounds for seriously considering termination.

An important result of Dr. Protheroe's enquiry is his confirmation that the prognosis of puerperal psychosis has continued to improve, and to give point to this he divided his patients into two groups: 1927–41 and 1942–61. It would have been even more helpful if he had subdivided the second group into two: 1942–53 and 1954–61, in order to assess the contribution of tranquillizers, though there have been other advances in treatment which are less easily defined. These include trained staff, a better appreciation of relevant social factors, and the provision of better facilities in terms of social support and rehabilitation.

I wish to point out that my statement in my paper on abortion (Sim, 1963) was not a 'prejudgement' as Dr. Protheroe claims, but a conclusion based on a personal study of a very large series of puerperal psychoses as well as on a retrospective study of admissions to several mental hospitals. It was also based on the supervision and treatment of a number of schizophrenic women who became pregnant. These studies have continued, and, to date, my original conclusions have been reinforced.

I find myself in general agreement with Ekblad (1955), who pointed out that the greater degree of psychiatric handicap the greater the psychiatric risks of abortion. I can assure Dr. Protheroe that very serious consideration is given to the decision not to abort in these cases, for I accept the responsibility of supervising them during and after their pregnancy and, if necessary, undertaking their treatment.

M. SIM.

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Sim, M. (1963). 'Abortion and the psychiatrist.' *Brit. med. J.*, *ii*, 145–8.

Dear Sir,

Dr. Sim sees an inconsistency in that, in my paper on puerperal psychoses (*Journal*, January 1969, page 9), I state that I do not consider my findings 'to have much relevance to the question of termination of pregnancy' and yet criticize a conclusion of his 'there are no psychiatric grounds for termination of pregnancy' (Sim 1963). However, in the paper I did continue to point out that I did not assume, as did Sim 'that the main issue facing the psychiatrist is whether the mother is likely to develop a puerperal psychosis and the effects of such on her future health'. Because I have never accepted this view, I cannot accept a study concerned mainly with puerperal psychoses, my own or his, as having much relevance to the question.

There is no doubt that the outlook for women developing schizophrenia in the puerperium has improved with more recent treatments. Dr. Sim may not consider that a risk of one in five of a woman developing a further schizophrenic illness with a further pregnancy is sufficient for seriously considering termination of pregnancy. This is a figure obtained from a group study, and we know that individuals differ in their predisposition towards further illnesses, as they differ in their social circumstances and their likelihood of accepting the treatments we have to offer. I do not wish to argue an extreme opposite view to Dr. Sim's, but consider that every woman who presents to us as psychiatrists requires individual consideration as to whether in her case termination of pregnancy is the best treatment we can advise.

I do not claim in my paper that Dr. Sim's statement 'there are no psychiatric grounds for termination of pregnancy' was a prejudgement prior to his study, but those who accept the conclusion are certainly prejudging the issue thereafter.

C. Protheroe.

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Sim, M. (1963). 'Abortion and the psychiatrist.' *Brit. med. J.*, *ii*, 145–8.

MANIC-DEPRESSIVE PSYCHOSIS

Dear Sir,

I read T. H. Court's recent paper 'Manic-depressive psychosis. An alternative conceptual model' (*Journal*, December 1968, p. 1523), with considerable interest. In a recent review of studies bearing upon the neurophysiology of affective illness, Joe Mendels and I have reached very similar conclusions regarding the difficulties of a bipolar model for manic-depressive illness (1).

It appeared to us, however, that a third model having advantages over that of a continuum might also be entertained. Here, depression, mania and normality of mental state may be seen as occupying the three corners of a triangle. The clinically observed 'mixed' affective state then falls along the continuum between mania and depression, but either state may revert to normality without necessarily passing through the affective tones of the other. This is in keeping with clinical experience, and bypasses the difficulty, noted by Dr. Court, that the continuum model does not easily account for those individuals who move directly from normality to mania and vice versa. The evidence he presents supports such a model equally well.

Also of note is that preliminary sleep E.E.G. studies give further support to close similarity between manic and depressive states, at least from a neurophysiological standpoint. The disturbance in sleep pattern of one manic patient (2) was essentially the same as that found in severely depressed patients (3), with a gross reduction of stage 4 sleep and a very low arousal threshold.

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[This correspondence is now closed.]

TRAINING OF PSYCHIATRISTS

Dear Sir,

In view of the very inadequate experience and training in Subnormality shown in the Report on