

LANGUAGE LATERALIZATION AND UNILATERAL ECT

DEAR SIR,

Dr Allen's suggestion of applying Levy and Reid's method for determining cerebral lateralization of speech to the choice of hemisphere for unilateral ECT (*Journal*, March 1980, 136, 316) would seem premature.

Discrepant findings, Herron *et al* (1979) and McKeever and Van Deventer (1980) question the validity of the relationship between handwriting posture and cerebral localization of speech. In view of results such as these, it would be prudent not to incorporate this procedure into routine clinical practice, despite its attractiveness of speed and simplicity, until the relationship between hand posture and speech localization is further clarified.

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LITHIUM AND PLATELETS

DEAR SIR,

The paper by Coppen *et al* (*Journal*, March 1980, 136, 235-238) provides interesting results but it is difficult to see that the declamatory title 'Lithium Restores Abnormal Platelet 5-HT Transport in Patients with Affective Disorders' is entirely justified.

The main cause for doubt is that results which are taken to demonstrate the effects of Lithium (e.g. $V_{max} = 19.5$ in recovered depressives; $V_{max} = 27.8$ with Lithium therapy—Table I) are similar in magnitude to the apparent variability of the results of measurements in comparable groups (e.g. V_{max} in controls, Table I = 30.6; V_{max} in controls, Table II = 24.8). Several examples of this variability, which receives no attention in the discussion, are apparent, hence it is difficult to know whether any weight can be attached to the conclusions.

A second factor which obscures evaluation of the paper is that the groups of patients studied are not clearly defined. Though recovered depressives and Lithium-maintained patients are well described two

other groups of patients on lithium are introduced without discussion of their characteristics.

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THE DISABILITIES OF CHRONIC SCHIZOPHRENIA

DEAR SIR,

Drs Cunningham Owens and Johnstone in their article on the disabilities of chronic schizophrenia (*Journal*, April 1980, 136, 384-395) confirmed clinical impressions that the deficits are multiple. It was unjustified, however, to comment that "... these deficits result from a disease process and are unlikely to be cured by rehabilitative measures". The article made no reference whatever to whether these patients have had rehabilitative treatment or not and the authors simply, with a single stroke, brushed away any possible benefit from rehabilitation. It is interesting to note that their own earlier study had shown that social and behavioural performance need not necessarily be related to the features of the mental state. Rehabilitation aims to improve social and behavioural performance and never to 'cure'.

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SCHIZOPHRENIA: THE EFFECT OF TELLING THE PATIENT AND RELATIVES

DEAR SIR,

I have avoided for many years giving a diagnosis of schizophrenia to patients and their relatives. I have used, perhaps naively, 'depression' or 'anxiety' with emphasis on the normal aspects of the individual and the potential for rehabilitation. It was, therefore, with relief and satisfaction that I read Professor Ciompi's article in this *Journal* (May 1980, 136, 413-20) confirming that schizophrenia is a non-entity as a diagnosis and has no significant therapeutic or prognostic value. I wonder how many practising psychiatrists have felt the same way.

I believe a diagnosis of schizophrenia, which in the lay mind is no less devastating than that of multiple sclerosis, could inflict a lot of avoidable

suffering and mental damage. Is it still too early to start repairing this damage for which psychiatrists are specifically responsible? Perhaps the diagnosis should be reserved to the small hard core of severe and irreversible cases, still with emphasis on the normal aspects and the potential for rehabilitation.

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SEASON OF BIRTH AND FAMILY HISTORY

DEAR SIR,

Professor Kety quotes the work of his colleagues, Kinney and Jacobsen (*Journal*, May 1980, 136, 421-436), who propose that if schizophrenia is a heterogeneous disorder then, in each individual, genetic and environmental factors should be inversely related in the aetiology of schizophrenia (5).

Taking up this idea, I have examined the date of birth of all schizophrenics admitted to The Maudsley Hospital during the triennium 1967-1969. By comparing date of birth of patients with and without a history of psychiatric illness in close biological relatives, I hoped to gain clues as to the factors responsible for the observed unusual seasonality of birth of schizophrenics (1, 2, 3, 4, 6, 7).

There were 160 cases of whom 106 had no family history of psychiatric illness, and in 14 cases the family history was unknown, leaving 40 cases with 'high genetic risk'. There was no difference between the groups with respect to decade of birth.

The patients as a whole, as in Kinney and Jacobsen's sample, do not show unusual seasonality of birth, but when they are separated according to family history, differences emerge. There is a significant excess of 'high genetic risk' schizophrenics born in the second quarter of the year, with a corresponding deficit in the third quarter of the year (Table).

These results are in contrast to those of Kinney and Jacobsen, who found an excess of low genetic cases born in January to April. My results may suggest that genetic factors (e.g. unusual conception patterns in parents of schizophrenics (3, 6) rather than environmental ones are responsible for the unusual pattern of birth observed in schizophrenic patients.

I am currently studying a much larger group to exclude the possibility that these findings are due to chance.

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Season of birth	Proportion of patients born in that season with:		χ^2 with Yates correction	P
	High genetic risk	Low genetic risk		
Jan.-March	6/40	27/106	1.271	N.S.
Apr.-June	20/40	27/106	6.920	<0.01
July-Sep.	3/40	30/106	6.044	<0.02
Oct.-Dec.	11/40	22/106	0.418	N.S.