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PUERPERAL DEPRESSION

DEAR SIR,

I was very pleased to read Dr. Katherina Dalton's prospective study in your June issue (vol. 118, pp. 689–92). Dr Dalton quotes my work (*Lancet*, 1964, *ii*, 1264) as suggesting that I assume a psychological explanation for the illness; this is in fact not entirely correct. What I said was:

'Dramatic deterioration in the depressive state a few days or weeks after parturition was very noticeable. Possibly pregnancy, with its hormonal and electrolytic changes, has a beneficial effect, and it is the disappearance of this effect after parturition that precipitates the final breakdown. Perhaps, therefore, the oestrogen production of normal pregnancy forms a built-in protection mechanism accounting for the well-being commonly enjoyed; and the depressive reaction results from the sudden fall in oestrogen levels at parturition.'

There appears little doubt that changes in hormone production during monthly cycle are associated with psychological disturbances when women take oral contraceptives. These disturbances are not entirely explained by psychological mechanisms.

At the International Conference of Psychosomatic Medicine in Obstetrics and Gynaecology held earlier this year, puerperal depression was one of the subjects discussed, and I suggested in a paper that there had been a fall in the incidence of puerperal depression since folic acid administration during pregnancy became routine. This suggests that alterations in the metabolic pathways are involved in aeteology of puerperal depression.

Dr. Dalton confirms my findings that anxiety in early pregnancy indicates the possibility of puerperal depression. She also confirms that some women were in the best of physical and mental health and if anything elated. I would agree with her suggestion that the women who are elated may well experience some difficulties in adjusting to their hormonal levels in the puerperium and thus become even more depressed.

The value of Dr. Dalton's study is that the triad of mood change—anxiety, elation and depression—during the pregnancy and the puerperium are established. It is now much easier for us to understand why in the past various workers in the field differed from one another in their publications and conclusions.

I hope that now all obstetricians, psychiatrists and general practitioners will take note that anxiety and/or elation symptoms during pregnancy cannot be ignored, and that as a result fewer women will be allowed to become depressed in the puerperium.

E. D. M. TOD.

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CHLORIMIPRAMINE IN THE TREATMENT OF SEVERE DEPRESSION

DEAR SIR,

In your August issue (vol. 119, p. 230) there is a letter from Dr. Abenson commenting on the severe extra-pyramidal reaction experienced by a female patient after a course of intravenous infusions of chlorimipramine.

Since my original paper, Vol. 117, pp. 211–2, we have now given intravenous chlorimipramine by drip infusion to over 60 patients. No severe reaction of the type described has been encountered, but a number of patients have complained of tremor, which has usually responded to a reduction in dosage, or if necessary by the use of anti-parkinsonian drugs. In no case has it proved necessary to discontinue treatment on account of these side effects.

G. H. COLLINS.

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Stockport, Cheshire SK3 8BL.

AMALGAMATION OF PSYCHIATRIC AND GENERAL HOSPITAL GROUPS

DEAR SIR,

We, the undersigned, have been asked to send you the views of 21 consultants employed in twelve hospital groups in the South West Metropolitan Region in the hope that publication of this information in your Correspondence columns will stimulate interest in what is now a national problem. The criticisms are as follows:

1. *Delay:* There is evidence of increased delay in communicating with the R.H.B. Similarly, there is an increased delay in the transmission of official information from the R.H.B. to consultants.

2. *Lack of Representation:* Specialists in psychiatry and mental subnormality are under-represented on Group H.M.C.s and Group M.A.C.s.

3. *Decisions affecting patients are made by administrators:* These are made at Group level without consultation with appropriate medical experts at local hospital level. The majority of Group Secretaries are not aware of the special needs of psychiatric hospitals.

4. *Over-centralization of administration:* This often causes delays over obtaining items from Supplies Department.

5. *Loss of clinical facilities:* The transfer from psychiatric hospital to general hospital of departments such as X-ray, pathology and EEG causes an increased delay in obtaining results.

6. *Lack of finance:* This is felt most under the following headings:

(a) Ancillary staff, e.g. psychologists.
(b) Housing.
(c) Essential repairs.
(d) In general, serious doubts were expressed as to whether psychiatric hospitals are getting a fair proportion of the financial resources available to the Group.

7. *Deterioration in relationships with medical and surgical colleagues:* This arises through having to compete with them in spending the Group budget.

8. *Lack of improvement in psychiatric facilities at general hospital:* In spite of amalgamation, psychiatrists are usually offered inconvenient and the most unattractive parts of the general hospital.

9. *Increased demands on psychiatric man-power:* The general hospital expects immediate psychiatric cover for attempted suicides, etc., and refers many psychosomatic problems. There is no compensatory increase in psychiatric establishments.

10. *Standardization:* There is a failure to appreciate that psychiatric hospitals do not fit easily into a philosophy of standardization.

11. *Poor professional relationships:* Some senior consultants at psychiatric hospital level have never met the Chairman or the Secretary of the Group.

To summarize: It seems to be clear that the attempt to graft general hospital administration on to psychiatric hospitals has not been successful. If amalgamated psychiatric and general hospital groups are to be formed it is essential to devise a new type of group hospital administration which will understand the differing needs of psychiatric and general hospital patients.

J. M. W. Fisher.

Warlingham Park Hospital,
Warlingham, Surrey.

John T. Hutchinson.

Cane Hill Hospital,
Coulsdon, Surrey.

'BEHAVIOUR THERAPY IN THE 1970's'

Dear Sir,

With reference to N. L. Gittleson's review of the book *Behaviour Therapy in the 1970's* (edited by L. E. Burns and J. L. Worsley. John Wright and Sons, 1971), which appeared in the August 1971 issue of the *Journal*, pp. 221–2, may we point out that the symposium was held under the auspices of the British Psychological Society (not Association) and that the book consists of six papers, not eight, that were presented at the symposium, the other two papers being specially written for the book.

With regard to the reviewer's fourth paragraph in which he endorses Professor H. G. Jones's remark that behaviour therapy has not yet become successfully involved with polysymptomatic personality disorders including the full-blown obsessional, your readers might like to consider evidence presented elsewhere in the book which suggests that considerable progress, derived from therapeutic techniques based on learning theory, has in fact been made in treating these conditions.

L. E. Burns.
J. L. Worsley.

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Birch Hill Hospital,
Rochdale, Lancs.

PROCEEDINGS OF CONFERENCE OF CLINICAL TUTORS

Dear Sir,

In September 1970 the Clinical Tutors' Sub-Committee of the Royal Medico-Psychological Association held a Conference at Merton College, Oxford. Selected papers presented there have now been edited and published as the Proceedings of the Conference. The papers contain interesting and useful information about various aspects of Clinical Tutors' work, including training facilities, the organizing of libraries, and some new approaches to teaching.

Copies of the Proceedings have been sent to participants in the Conference and to psychiatric hospitals and University Departments of Psychiatry, but spare copies may be obtained from Mrs. V. J. Kewell, MRC Clinical Psychiatry Unit, Graylingwell Hospital, Chichester, Sussex, by sending 75p, together with a stamped addressed envelope, 9 in. × 7 in. Cheques should be made payable to the Royal College of Psychiatrists.

D. C. Watt.
B. M. Barraclough.

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