

1990). The site of bleeding was assessed by computerised tomography (CT) scanning (41 patients) and intracerebral arteriography (38 patients).

The presence of depression was assessed by means of the Montgomery-Åsberg Depression Rating Scale (Montgomery & Åsberg, 1979), which was modified to decrease the bias involved when using somatic systems to diagnose depression in the medically ill. The modified scale excluded scores on the items for sleep disturbance, poor appetite, lethargy, and poor concentration. Those who scored above seven on this modified depression rating scale during their first week of admission to a regional neurosurgical unit, on average some seven days following the development of their haemorrhage, were categorised as depressed. Using this method, 11 patients were identified as being depressed, and the sites of the arterial haemorrhage in these patients were as follows: anterior communicating artery ($n=3$), right internal carotid artery ($n=4$), basilar or vertebral artery ($n=3$), with no bleeding site being identified in one patient. In the 30 non-depressed patients (some of whom had multiple aneurysms) the site of arterial haemorrhage was anterior communicating artery ($n=13$), right internal carotid artery ($n=1$), left internal carotid artery ($n=5$), right middle cerebral artery ($n=4$), left posterior communicating artery ($n=3$), basilar or vertebral artery ($n=3$), and no site identified ($n=3$). Thus, of the 11 patients who were depressed, 5 had haemorrhages in the right hemisphere and only 2 had a haemorrhage in the left hemisphere.

These results, which do not support the suggestion by Cutting that left hemisphere dysfunction increases the risk of depression, are consistent with studies regarding the incidence of depression following other forms of brain insult. For example, Flor-Henry (1969) suggested that it was right hemispheric dysfunction that may be important in the genesis of depression among patients with epilepsy. Achte *et al* (1969) in a study of cases of affective disorder following brain injury found no relationship between the location of brain damage and the development of depression. More recently, Sharpe *et al* (1990) have found no link between the incidence of depression and the site of cerebrovascular haemorrhage identified using CT-scanning. Thus, at present I do not feel that the balance of evidence supports the suggestion by Cutting that there is a link between depression and changes in left hemisphere function. Instead it is more likely that the incidence of depression is increased following any brain insult, but that damage to one hemisphere rather than the other does not further increase the risk of depression developing.

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The first psychiatric use of lithium

SIR: Scott (*Journal*, May 1992, **160**, 709–710) wrote about S. Weir Mitchell's treatment of epilepsy with lithium bromide and wondered whether this was the first use of lithium in psychiatry. Epilepsy is hardly a psychiatric illness, but Mitchell also gave lithium bromide for emotional lability, hypervigilance, fatigue, reduced appetite, and poor sleep (Mitchell, 1877), thus continuing its use as a tonic (Gibb, 1865) and a sedative (Lévy, 1874). Garrod (1859) had recommended lithium salts for "uric acid diathesis", which included "gouty mania", and Hammond (1871) used lithium bromide for "acute mania with depression". A lithium salt not containing bromine, lithium carbonate, was used on a psychiatric indication by Carl Lange (1886), who gave it to patients with periodic depressions, and by Frederik Lange (1894), who used it for the acute treatment of depression. The early authors based their claims of therapeutic efficacy on theoretical arguments and clinical impressions illustrated by case histories; they did not provide any quantitative documentation. Lithium went out of psychiatry and did not re-enter it until 1949.

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women will tend to disappear once they are well enough to recommence their self-care routines.

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Women and scientific thought

SIR: Stephen M. Lawrie (*Journal*, April 1992, 160, 569–570) suggests that, “To my mind our male-dominated, scientific, mechanistic view of mental illness needs to include a more feminine, subjective and sensitive aspect”. The notion that scientific thought is a male dominion is damning to women. Even more objectionable (if possible) is the belief that being subjective and sensitive is incompatible with being scientific and objective.

At the same time, we agree wholeheartedly with Dr Lawrie that there exist problems in psychiatry in the way research is undertaken as a result of academic and funding policies. It is unfortunate that the solution he proposes is both off the point and derogatory to women.

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Hypertrichosis in mentally ill women

SIR: Regarding hypertrichosis in insane females (A Hundred Years Ago, *Journal*, May 1992, 160, 721) the situation remains much the same today as it was in 1892.

The underlying reason for this is that hirsutism is common, especially in dark-haired women over 30 years of age. The ideal female is not only excessively thin but also prepubertally hairless: hence Ruskin's horror and incredulity on first facing the reality of pubic hair.

Impressive amounts of time and money are devoted by women to depilation. These activities are carried out in secret because of the perceived unattractiveness of hirsutism.

Small wonder that when women become mentally ill, such activities cease and nature takes its course. I think much of the hypertrichosis seen in insane

Descriptions of psychiatric conditions in literature

SIR: Sno *et al* (*Journal*, April 1992, 160, 511–518) give several examples of descriptions of the *déjà vu* experience in prose and poetry, and indicate that psychiatrists should read more widely than the psychiatric literature.

A good piece of descriptive writing can help in the understanding of what sufferers might be experiencing when undergoing experiences that would be interpreted by a psychiatrist as a psychiatric condition, and in literature the psychiatric condition, being only a part of the overall piece, is set in the wider context of the person undergoing it, just as psychiatrists attempt to do, albeit in far less detail, when they set a few symptoms against the background of a full Maudsley-type psychiatric history.

If reading more widely from the general literature might help those with less experience of psychiatry gain a feel for some of the conditions that they wish to treat, may I offer a selection of books that might help in the understanding of the more common psychiatric conditions, which might be purchased by a psychiatric library without excessive cost.

Nikolai Gogol provides an account of the development of an acute psychosis in *Diary of a Madman* (all the foreign books in this selection can be found in the Penguin Classics series), and Evelyn Waugh describes a bromide-induced psychosis for a man on board ship in *The Ordeal of Gilbert Pinfold* (Penguin, 1962). Anton Chekhov's *Black Monk* is a short story about a man with manic-depressive psychosis. The central character of Paul Sayer's *Comforts of Madness* (Sceptre, 1988) has catatonia. The heroine of Sylvia Plath's *The Bell Jar* (Faber, 1966) experiences a severe neurotic depression, and the central character of J. Bernlef's *Out of Mind* (tr. A Dixon, Faber & Faber, 1988) suffers from a dementing process. Emile Zola graphically presents life for the poor in 19th century Paris, the slide into alcohol abuse, and an account of delirium tremens in his book *L'assommoir*. Henrik Ibsen's play *The Wild Duck* deals with how relationships work, the basis for good family dynamics and the strains that lead one member to commit suicide; the suicide of Dido in Vergil's *Aeneid Book IV* arises from anger at being deserted by her lover Aeneas, and Freud's descrip-