Trautner *et al.* (1957) used oral doses of barbiturate containing 12 to 23 per cent. bemegride, and found that up to a barbiturate intake of 750 mg. there was no effect on onset, depth or duration of sleep. The mixture acted exactly as the same amount of the barbiturate alone. At a barbiturate intake of between 1 and 1·5 grammes, however, the duration and depth of sleep were greatly reduced as compared with the effect of the same amount of barbiturate. At a barbiturate intake of between 1·5 and 3 grammes subjects either slept or were merely somnolent for a few hours.

Orwin *et al.* also fail to mention that there have been no fatalities reported with the combination tablets containing amylobarbitone 100 mg. and bemegride 10 mg. in each (Mylomide) since their introduction.

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REFERENCE

TRAUTNER, E. M., MURRAY, T., and NOACK, C. H. (1957). *Brit. med. J.*, *ii*, 1514-1518.

DEAR SIR,

We were familiar with the paper by Trautner *et al.* (1957) which is quoted by Dr. Neville, but did not see fit to take it into account in our study. Superficially, this work does suggest that bemegride is relatively more effective in larger doses, but Dr. Neville does not point out that the authors were studying the value of bemegrated barbiturate as a hypnotic in disturbed and chronic schizophrenic patients. The assessment of sedative effect was a subjective one in the control group, while in the patient group the criteria were clinical, namely, the dose required to render a disturbed patient tranquil and asleep. Our study used the objective evidence of the inflection point in the EEG graph, which in turn was matched with slurring when the patient was used as his own control.

The schizophrenic patients who comprised the major study had a 2–5 years' history and had been subjected to a variety of treatments, "several" having had continuous narcosis with barbiturates. None had responded to the ordinary doses of sedation, having had continuous narcosis with barbiturates. and the authors were searching for a method whereby they could prescribe even larger doses without the risk of severe poisoning.

Our criticisms of this work are:

(1) Many of the patients had had barbiturates over the years and in heavy doses with probable development of tolerance. This could have rendered them relatively more sensitive to the bemegride.

(2) The response of chronic and disturbed schizophrenic patients to barbiturates is notoriously difficult to assess. For example, a catatonic patient may respond to 0·5 grammes of intravenous barbiturate with remission of the psychotic features but little drowsiness. The authors did not demonstrate whether the sleep their patients enjoyed was due to the sedative effect of the barbiturate or to the amelioration of the psychotic process.

(3) Subjective tests and clinical observations are not as reliable as EEG studies. We tried to assess the duration of sedation on the patient's return to the ward, but had to abandon it because of the many variables involved, one being observer error.

(4) The authors used oral preparations, while we used the intravenous route. The latter does ensure that the drugs are in the blood stream, which we felt was important in a scientific study. It also eliminates the possibility of uneven absorption and produces a speed of reaction which is more readily observed, and the blood concentration of barbiturate approaches that of the toxic doses used by Trautner *et al.* (1957).

(5) The patient's mental state can influence the amount of barbiturate required to produce sedation, and with disturbed schizophrenics a constant baseline would be very difficult to obtain.

While Trautner *et al.* (1957) indicate that their selected patients were less drowsy with bemegride, we frankly do not know what conclusions can be drawn from this work. The absence of a report of suicide with bemegrated barbiturate is of interest, but must be correlated with the population at risk, which is probably small, and with the type of patient who has the drug prescribed, who may be addicted. The suggestion that the dose response curve does not run parallel throughout the range is an interesting one which still awaits proof.

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THE COUVADE SYNDROME

DEAR SIR,

Couvade, though recognized by the psychiatrist, is less well known to the general practitioner, who

tends to pass it off as a joke. Apropos of the article by Trethowan and Conlan in the January number of the *British Journal of Psychiatry*, attention may be drawn to a report of my own (*Armed Forces Med. J.*, Vol. 20) on 20 cases, with a follow-up of 6 to 10 years. These patients were all Indians, comprising clerks, office superintendents, medical men, and senior civil servants; all were socially and economically comfortable. The marriages were generally of the arranged type, common in India, and all were sanctified by formal rituals, and socially accepted.

The clinical features of couvade were of five types: (*a*) "neurasthenic" (8); (*b*) gastro-intestinal (8); (*c*) headache (2); (*d*) bad dreams; and (*e*) localized pains. These appeared from the tenth week of the wife's pregnancy in the earliest case, but generally from the fifth month, and lasted till the confinement was over (all successfully), when the "couvade" syndrome disappeared. The neurasthenic features were fatigue, mistakes in the office, sense of depression, "anxiety states", and hypochondriasis. The gastro-intestinal features were anorexia, gastralgia, heart-burn, vomiting, constipation, and epigastric distress.

All the men were "normal" in the social aspect in the usual sense of the word. No effect was noticed of "service away from home", age, income, education, office status, parity of the wife, general health, except in one man with allergy and in another with gross nervousness due to chronic indebtedness.

Progress was uneventful and the condition was rarely disabling; treatment was essentially psychological with holding drugs in some instances. Full clinical investigations were done on the medical and air force officers, a surgeon and a senior civil servant —more to assuage their feelings than to achieve a diagnosis.

The prognosis was excellent. Indeed, the unpleasant experiences of first fathering were no deterrent to further efforts.

"Couvade"—hatching, really refers to the woman, etymologically. But the man does not really hatch, though it is his seed. An appellation such as "fathering syndrome" will give him status, and recognition and dignity to his prowess.

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ACEDIA

DEAR SIR,

I am pleased that Dr. Altschule agrees with me "in the main" and sorry that he finds most of what he agrees with (i.e. all but the last paragraph) to be irrelevant. The charge of irrelevancy is precisely what I am criticizing and such an opinion implies a judgment, despite any disclaimers.

Perhaps the word "automatism" was ill-chosen. It was intended to convey the contrary of free choice, voluntariness, responsibility and similar attributes which are usually agreed to characterize the normal or non-psychiatric subject, and which are variably diminished or lacking in psychiatric syndromes. The point I made was that the mental attitudes discussed under "acedia" are not necessarily outside the scope of personal responsibility, as is the case with psychiatric syndromes.

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NATURE OF PSYCHOTHERAPY

DEAR SIR,

Miss Hamilton's defence of her author does her credit (correspondence column, *Journal*, July 1965).

Jaspers (and Sir Aubrey Lewis) no doubt felt the book was a good guide to what psychotherapy was. My point was that it was detached, not based on inner experience, and defined the word tautologically. Dated, because in the 30 years much new thinking had gone into our approach to the whole subject, which the "student" might thus ignore.

It is evidently not permissible to criticize patristic writings, as Miss Hamilton assumes that I, whom she mistakes for a dyed-in-the-wool Freudian, would not dare question Freud! In fact I have often done so.

I did not fail to praise what was of permanent significance. Here she and I agree. But I remain convinced that this booklet is for those "inside", who can truly understand what is involved.

I can only repeat my slightly different conclusion, as a devoted *practising* psychotherapist, who has paid the price of training and experience, by my doubt about the general utility of making this booklet into a sacred text. What psychotherapy is about is vividly discussed in clinicians' books, illustrated by cases, and experienced in one's own and one's patients' realities.

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