varied from three to 10 treatments, most subjects receiving from six to eight shocks. As a side-line to the main study I looked at the clinical features which were associated with a good or bad response to ECT.

Subjects unable to cry were significantly more likely to respond well to ECT, whatever the placement, than were those who could cry ($P < 0.05$), whereas those with early waking, diurnal variation, or weight loss were no more likely to respond well than those without these features. The presence of depressive delusions was associated with a good response where bilateral ECT was administered, but the response to unilateral ECT was inconsistent. Unfortunately the numbers studied were too small for definite conclusions to be drawn.

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¹ Clyma, E A, unpublished MD dissertation. University of Cambridge, 1976.
² Snaith, R P, *et al*, *Psychological Medicine*, 1971, 1, 143.

What the public wants to know

SIR,—I was recently involved in a Capital Radio Helpline special day. This is a service seeking to provide information to listeners on any topic, and on this particular day was featuring "medicines." After a short interview over the air, people phoned me confidentially for the rest of the day about any problems they had encountered with their medicines. The interview set the scene with such points as side-effects, interactions, compliance, pregnancy, and disposal of old medicines.

I was surprised at the number of people who were worried about the long-term effects of drugs and the possibility of their becoming "addicted," particularly as the drugs most mentioned were minor tranquillisers and analgesics. More disturbing was the fact that many patients had no idea why they should still be having to get repeat prescriptions for these items after several months, if not years. The overwhelming flood of response I received was an indication not only of the interest the subject provoked but also of what appears to be a genuine gap in patient care somewhere along the line.

Callers were generally shy to go back to their GP and not always able to get to the retail chemist. It does seem a shame that there is nobody to give a few minutes' advice or reassurance that could make all the difference between a successful recovery or a worrying course of treatment.

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"The Dignity of Labour?"

SIR,—Your reviewer of Ann Cartwright's important new book *The Dignity of Labour? A Study of Childbearing and Induction* (19 May, p 1343) assumes that "consultants, registrars, general practitioners or medical students" will not wish to read it. If it were true it would certainly be a tragedy for it would imply that the medical profession is uninterested in its own practices and their effect on the attitudes and preferences of their patients.

Happily, there is plenty of evidence that most doctors are sensitive to their patients' feelings. They want to know what mothers

feel about such elective procedures as induction, to take but one example. They will find the book an invaluable source of information on the experiences and opinions of the providers and recipients of maternity services. Unlike your reviewer I feel that the book should be available in every obstetric unit and postgraduate centre. It should provide all those concerned with the care of the mother and child during pregnancy and childbirth considerable food for thought.

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Self-injection of veterinary oil-emulsion vaccines

SIR,—When using an oil emulsion vaccine to immunise a flock of chickens, the vaccinator may inadvertently inject some of the vaccine into his own thumb or finger. A number of such incidents have been reported and all cases appear to have exhibited local symptoms only. These symptoms are pain and inflammation at the injection site, sometimes apparently associated with vasospasm in the blood vessels of the finger that has been accidentally injected. Where there has been delay in seeking medical advice, amputation of a phalanx has been necessary in some cases.

Three main factors contribute to this situation. (1) Any adjuvant vaccine will cause some swelling. In a finger, which has little connective tissue, pain and tension will follow. (2) In some cases the vaccinator has injected himself more than once. This may lead to sensitisation and thus increase the severity of the local reaction. (3) The needle will never be either free of protein or sterile. Non-sterile injections into the hand, even with organisms of low virulence, often cause unpleasant pulp infections.

Our advice to vaccinators is that, in the event of such an accident, the vaccine should be expressed if possible and medical attention sought urgently, certainly within six hours, with an explanation of what has occurred. The sequence of the pathological process appears to follow the line described for grease-gun injuries,¹ although the much smaller volume of vaccine inoculated and the lesser force of injection cause less extensive and less horrifying results. Nevertheless, in the light of the physical distension leading to swelling, numbness, and vascular embarrassment, we consider that early exploration is of prime importance, with incision, irrigation, and drainage of the affected area. Prolonged delay of adequate treatment may result in gangrene and the consequent need for amputation.

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Marriage matters

SIR,—Your correspondence occasioned by the leading article (5 May, p 1164) of "Marriage Matters" included a letter by Dr Joan Coombs (2 June, p 1486), in which she states that referral of patients requiring psychosexual counselling to an outside agency seems "a terribly retrograde step for the medical profession" and suggests that such counselling

should be undertaken by the general practitioner entrusted by the patient with the problem.

No doubt this represents an ideal solution. In the realities of NHS general practice, however, it is rather impractical, except when psychosexual counselling represents a special interest of the particular general practitioner. Another possible solution is the attachment of trained counsellors to individual practices. This solves the problem not only of psychosexual counselling, when the counsellor has had training in sexual dysfunction, but of counselling in the wider sense of the word. In surgery counselling the counsellor becomes a member of the primary care team and the patient's feeling of rejection by his general practitioner is greatly reduced. This was clearly borne out in a recently completed study of nine practices with counsellor attachments in north London.

At present a number of pilot schemes of this kind are operative in various parts of the country, whereby a Marriage Guidance Council attaches a counsellor to an individual general practice team. The bulk of the counsellor's work consists of sexual, marital, and relationship problems and the results recorded so far are very encouraging.

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Obsessionalism and response to lithium

SIR,—We were interested to read (27 January, p 230) that Drs R J Kerry and J E Orme found psychiatric patients with positive responses to prophylactic lithium treatment to have psychological profiles more like those of the normal controls than those of other psychiatric patients in the study—with the single exception of a scale measure of obsessionalism, on which the lithium responders and other patients were indistinguishable. We have previously reported that bipolar patients, who tend to show more antidepressant responses to lithium than other depressed patients, have more nearly normal psychological test profiles than do unipolar depressed patients.¹ We have also recently described a psychological test subscale which, in a replication test, successfully predicted lithium responders.²

When we re-examined psychological data from this latter study of 53 patients in regard to the question of possible associations between obsessional features and lithium response, we found that 23 of 31 patients (74%) who were responders to lithium had T scores ≥ 70 ($\chi^2 = 7.26$, $P < 0.005$, one-tailed) on the Pt scale of the Minnesota Multiphasic Personality Inventory (MMPI), which had been administered prior to treatment. As the MMPI Pt scale has been shown to provide an index of obsessive-compulsive behaviour,³ elevations on this scale suggest that a significant number of lithium responders in our sample have obsessional features.

In a previous study, House and Martin⁴ reported that 21 of 36 responders to the antidepressant effects of lithium had a high (T score ≥ 70) depression (scale 2) and psychasthenia (scale 7) MMPI pattern and five non-responders had a low (T score < 70) pattern on scales 2 and 7; Donnelly *et al* also found a similar trend with a depressed population.² Although this pattern on scales 2 and 7 is most frequently found in studies of hospitalised