Brit. J. Psychiat. (1980), **136**, 311–316

Correspondence

DICHOTIC PERCEPTION IN AFFECTIVE PSYCHOSIS

DEAR SIR,

Yozawitz *et al* (*Journal*, 1979, **135**, 224–37) interpret findings as supporting the hypothesis of right hemisphere dysfunction in affective disorders. However, I note a few shortcomings in this paper.

Their method of arriving at a diagnosis leaves a lot to be desired. They chose 'selected items' from three different schedules and therefore must be using a new schedule which is probably not validated. Next, two raters (perhaps blind to each other's diagnosis) rated the patients as suffering from either schizophrenia or affective disorder. If the two raters disagreed then a third rater came to a diagnosis. Similar results could be obtained by having each of the raters toss a coin after the initial diagnosis had been made.

Unfortunately the authors do not state if their patients have had ECT, and if they had, as is likely in hospitalized patients with affective disorder, then this might well explain their finding of right hemisphere dysfunction (D'Elia *et al*, 1976; and Squire *et al*, 1978).

In view of the above problems I feel that at most this work lends little support to the hypothesis of right hemisphere dysfunction in affective disorders.

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References

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SQUIRE, L. R. & SLATER, P. C. (1978) Bilateral and unilateral ECT: effects on verbal and non-verbal memory. *American Journal of Psychiatry*, **135**, 1316–20.

DEAR SIR,

In reply to Dr Griffin, we take the opportunity to clarify procedural details not fully explained in our paper, which we believe to be central to the issues he has raised.

Dr Griffin's concern about the validity of our interview schedule was doubtless due to our less than complete description of its composition. Our protocol contained all of the items from the PSE (Wing *et al*, 1974) and only added those SADS items (Endicott and Spitzer, 1978) and those US–UK items (Cooper *et al*, 1969) which did not overlap with the PSE or with each other. Certainly, no single interview schedule could claim to demonstrate complete validity. The information elicited by any one of the three interview schedules would have been sufficient for clinical diagnosis. Our use of a combined interview schedule, however, permitted a comprehensive assessment with at least as much validity as any of the individual instruments from which it was constructed.

With respect to our procedure for arriving at diagnoses, we take exception to Dr Griffin's contention that similar results could have been achieved with the toss of a coin. Although one rater did initially screen patients to select those with affective or schizophrenic symptoms, the two other independent raters (project psychiatrists who were blind to each other's diagnoses) were not told to restrict their diagnosis to these two alternatives, and did, in fact, use other categories (e.g. unspecified psychosis and schizoid personality disorder). Accordingly, it is difficult to conceive that random probability could have done as well as these project psychiatrists, who had previously demonstrated satisfactory diagnostic reliability in an extensive study of cross-national psychiatric diagnosis (Cooper *et al*, 1972). [For a lark, we followed Dr Griffin's prescription for tossing a coin. The combined index of ear asymmetry for the resulting groups did not differ significantly on the first day ($P > .05$), while the affective and schizophrenic groups in our study did differ significantly on this measure].

In response to Dr Griffin's comment that our affective patients might have experienced ECT, we assure him that they had not. Although we were explicit in stating that histories of brain damage or epileptic seizure were part of our exclusion criteria, we neglected to report that histories of ECT had