

Ms. A, a 25-year-old woman, reported that she had been unable to reach orgasm in sexual intercourse throughout treatment with amoxapine, 150 mg/day. She had been orgasmic after the onset of her depression and before the chemotherapy.

After an initial 2 months of amoxapine treatment, Ms. A presented the complaint of orgasmic inhibition to another psychiatrist, who replaced the amoxapine with imipramine, 150 mg/day. She regained her sexual functioning in 2 days. However, her depressive symptoms, such as feeling "blue" and having crying spells, sleeping difficulties, and loss of appetite, returned. Thus, 4 weeks later her psychiatrist put her back on amoxapine, 150 mg/day. She remained on this regimen for 7 more months. Amoxapine was able to rid her of all the depressive symptoms, but it also removed her ability to experience orgasm. Ms. A's husband confirmed her difficulty to be "turned on" while she was taking amoxapine. After amoxapine treatment was discontinued, Ms. A returned to her normal sexual function in 2 days.

Because of its similarity to a crossover design, this case report indicates that Ms. A's orgasmic inhibition was due to amoxapine instead of the symptoms or signs of clinical depression itself. Partial or complete female sexual inhibition has been noted to be associated with other psychotropics, such as thioridazine (1 and unpublished data of W.W. Shen and S. Park) and phenelzine (2, 3). On the basis of this case and other publications (1-3), I suggest that a psychotropic drug might cause orgasmic inhibition in women if the drug is reported to produce ejaculatory side effects in men.

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## Memory and Electroconvulsive Therapy

SIR: Although electroconvulsive therapy (ECT) is considered to be a safe and useful treatment for depressive illness, there is continuing concern regarding its effects on memory. Follow-up studies involving formal testing report that memory functions substantially recover during the months after treatment (1, 2), and it has seemed reasonable to suppose that memory for past events and new learning capacity have largely if not fully recovered by several months after a typical course of treatment. However, interviews of former patients and results with self-rating instruments find persisting memory complaints long after ECT (3, 4). Moreover, the self-rating data (3) indicate that the memory complaints reflect an experience of amnesia rather than an experience of depression.

We have completed a prospective 3-year follow-up of 35 individuals who had been prescribed a single course of bilateral ECT (mean=10.9 treatments, range=5-21) for relief of depressive illness. Of 31 persons available for follow-up (25 women, 6 men; mean age=45 years, range=28-68), 18 (58%) answered in the negative the question "Do you think your memory now is as good as it is for most people your age?" Of these 18, 17 attributed their memory difficulties to ECT. Each person also filled out a "time line" showing the time periods before and since ECT, up to the present time, that were associated with memory problems. The median group response was the 6 months that preceded ECT and the 2 months that followed ECT.

The 2-month period after ECT indicates the perceived period of anterograde amnesia and corresponds to published estimates based on formal memory testing (1). The 6-month period before ECT indicates the perceived period of persisting retrograde amnesia. This

estimate may reflect in part diminished learning ability due to depressive illness during the before-ECT period. The pattern of anterograde and retrograde amnesia is similar to the known temporal characteristics of amnesia (5).

Persisting memory complaints after bilateral ECT may in large part refer to a gap in memory that surrounds the time of treatment. It is also possible that the measurable memory impairment that occurs during the first weeks after bilateral ECT could lead persons to become more critical of their memory abilities and to attribute normal failures of memory to ECT. Finally, it should be emphasized that these conclusions pertain only to bilateral ECT. Right unilateral ECT is associated with strikingly less memory impairment and less memory complaint than bilateral ECT (1). These findings provide additional reason to favor right unilateral over bilateral treatment.

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## "Idiot Savants" or Special Skills?

SIR: In the article "Idiot Savant with Unusual Mechanical Ability: An Organic Explanation" (February 1980 issue), T.L. Brink, Ph.D., argued that a behavioral explanation of the skills displayed by the so-called "idiot savants" is insufficient and offered an explanation in terms of the superiority of the right hemisphere for these individuals. My study (1) of a calendar calculator was cited as supporting evidence for this hypothesis. Brink stated that this skill "is not adherence to a conceptual algorithm but eidetic imagery." Although the study cited did investigate eidetic imagery as one possible mechanism for the ability to calendar calculate, the individual tested did not have eidetic imagery. In a recent review of the literature on "idiot savants" (2) I reported on two unpublished studies that also tested eidetic imagery. Among a total sample of 35 "idiot savants," only 2 subjects were found to have any eidetic abilities. Also reviewed were the reported results of a neurological examination, a neuropsychological battery, EEGs, and autopsy reports of "idiot savants." None of these evaluations produced supportive evidence for right hemispheric superiority.

The paucity of supportive evidence for any organic explanation for the skills displayed by "idiot savants" should not suggest that Brink's arguments against a behavioral hypothesis are invalid. However, approximately .06% of institutionalized mentally retarded have developed special skills (3), and this low incidence argues strongly against such an explanation as the complete answer.

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