

imagination. Subjects who understood their experience in religious terms found it comforting and inspiring, while those who believed that they had heard a ghost were frightened. All subjects firmly denied any possibility that they might have been falling asleep. Indeed, some of the subjects had experienced their 'voices' while walking.

Such phenomena appear similar to the auditory hallucinations described by Spivak *et al.* It is implausible that all these experiences are hypnagogic in origin. Because they are transient and usually understood in terms of religious and supernatural beliefs, they are rarely reported to psychiatrists. But unless we recognise the diversity of hallucinatory experiences we will make little progress in understanding the mechanisms underlying these phenomena.

FRANCES KLEMPERER

York Clinic
Guy's Hospital
London SE1 9RT

Koro and Capgraw Syndrome in a non-Chinese Subject

SIR: Smyth & Dean's report (*Journal*, July 1992, 161, 121–123) of the coexistence of 'koro' and Capgraw syndrome in a non-Chinese subject with a manic illness makes fascinating reading. Their conclusion that this report provides 'a further challenge to the specificity of both as nosological entities' requires some qualification.

Koro as a culturally determined *syndrome* is clearly a different entity to the *symptom* of genital retraction occurring in patients with major psychotic illnesses. This problem was approached systematically by Bernstein & Gaw (1990) who in proposing a classification for DSM-IV distinguish between the symptom in the setting of another, axis I, diagnosis and the syndrome occurring in a culturally sanctioned setting, reserving the term 'koro' for the latter.

This distinction is valid since koro in South East Asia and China, cannot, by definition, be delusional. It is not so much the symptoms of the individual but the culturally held beliefs surrounding their significance which define koro here, and it is the belief in those in close proximity to the individual that he will suffer death as the result of the retraction of his genitalia which makes the syndrome 'culture bound'. So whereas in these societies koro may occur in an epidemic form and in otherwise healthy people, this is less likely to be the case in Westerners with the symptom of penile retraction. It would therefore be misguided to use a sporadic case-report from the Western literature to challenge the basis for koro as a distinct nosological entity in the Far East.

BERNSTEIN, R. L. & GAW, C. G. (1990) Koro: proposed classification for DSM-IV. *American Journal of Psychiatry*, 147, 1670–1674.

MATTHEW HOTOFF
RICHARD MULLEN

The Maudsley Hospital
Denmark Hill
London SE5 8AZ

Postnatal depression and antenatal morbidity

SIR: I read with interest the article by Hannah *et al.* (*Journal*, June 1992, 160, 777) on links between early postpartum mood and postnatal depression. Their results showed a significant association between Edinburgh Postnatal Depression Scale (EPDS) scores at five days and six weeks postpartum. They also found that various obstetric factors were significantly associated with the EPDS score at five days postpartum but that only bottle feeding and delivery by Caesarean section continued as significant predictors of high EPDS scores at six weeks postpartum.

We followed a group of 100 pregnant women from the 36th week of pregnancy to two months postpartum to investigate the role of psychosocial and biological factors in the genesis of postnatal psychological morbidity. The GHQ 28 (Goldberg, 1978) was administered antenatally and at two months postpartum and the EPDS at two months postpartum. Mood change in the first postnatal week was assessed at interview and with the Maternity Blues Questionnaire (Kennerley & Gath, 1989). We failed to find significant associations between any social or obstetric factor (e.g. housing, financial status, employment, social support, type of delivery, complications, and bottle feeding) and post-natal morbidity. However, in agreement with Hannah *et al.*, Kennerley & Gath blues ratings were significantly predictive of GHQ and EPDS scores at two months postpartum ($r=0.21$ and $r=0.24$, $P<0.05$ respectively) – more, remarkably. However, antepartum GHQ scores were also significantly predictive of postnatal GHQ scores ($r=0.43$, $P<0.01$) and EPDS score ($r=0.39$, $P<0.01$).

These results suggest that a significant proportion of early postnatal depression is a continuation of antenatal psychological morbidity, a conclusion suggested by some earlier studies (Tod, 1964; Watson, 1984). The lack of association with psychosocial variables suggests trait abnormalities may be more important mechanisms of postnatal psychological morbidity.

The results reinforce the importance of monitoring the emotional state during pregnancy as well

as in the postnatal period to mobilise preventative interventions.

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TOD, E. D. M. (1964) Puerperal depression: a prospective epidemiological study. *Lancet*, *ii*, 1264–1266.

WATSON, J. P., ELLIOT, S. A., RUGG, A. J., *et al* (1984) Psychiatric disorder in pregnancy and the first postnatal year. *British Journal of Psychiatry*, **144**, 453–462.

ALISON KELLY
BILL DEAKIN

*Department of Psychological Medicine
Hope Hospital
Eccles Old Road
Salford M6 8HD*

A HUNDRED YEARS AGO

The Increase of Insanity

SIR: The article in the *British Medical Journal* of October 22nd upon this subject was calculated to afford much interest to those engaged in the treatment of the insane. Little consideration is needed to convince us that the increase referred to is to be checked by legal, rather than by medical, means. The measures adopted to check the transmission of insanity can only be advised medically, whilst legally they can be enforced. What such advice is worth in the case of a contemplated marriage, based on affection, an elementary acquaintance with human nature will teach us. A legal remedy for the increase of insanity by propagation to the effect would be that the law might “forbid the banns” in case one of the contracting parties had been insane. I venture to think such a measure too severe for a preliminary one, and suggest that immunity from further attack for a certain number of years (to be decided by experts) might warrant us in giving the quondam patient a clean bill, so far as mental health was concerned. If experience showed that this modified measure failed to meet the case, then we should have more justification in enforcing the stricter course suggested in your article. This criticism, of course, leaves unimpaired the main contention – that the law should have authority in the matter. There is perhaps an even more difficult problem to decide than that just considered – namely the course best to pursue with persons already married, who are discharged from the asylum as “cured” or “improved.” “The

results are, of course, often deplorable. And it is a very common occurrence for such persons to be re-admitted to the asylum, having meantime begotten insanity. The resources of the asylum are then employed in bringing them once more into a fit condition for discharge, and all its potentialities. I think this is a humiliating reflection.

Your suggestion regarding the creation of special hospitals in connection (I presume) with the existing asylums, to be devoted to the treatment of recent and curable cases, will, I feel sure, meet with cordial welcome from all asylum physicians who have at heart the welfare of the insane, and, I would add, their own reputation. The finger of scorn has too long been pointed at alienists. At least, they should have an opportunity of trying, unhampered by the care of demented in their hundreds, all the resources of our art, all the means with which medical science has endowed us, upon recent and curable cases, in order to determine whether cure can be hastened or obtained in larger measure. We need a consensus of alienistic opinion on this matter, and it is to be hoped that your suggestive article will be the means of furnishing us with such. Already, as is well known, some of the leading and most respected superintendents of asylums are in favour of separation and special treatment of the recent and curable cases.— I am, etc.,

Oct. 24th

ALIENIST

Reference

British Medical Journal, 29 October 1892, 973.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey