the elderly and this is presumably the reason for such 'nervous' prescribing, sometimes in marked contrast to the heroic doses of benzodiazepines prescribed to the same patient.

The appropriate course of action in a frail elderly person is to start with a very cautious dose and build up slowly over two or three weeks to the full adult dose. Obviously, careful monitoring is the key and an elderly patient should be assessed every few days. I fear it is the commitment to frequent assessment which deters the prescriber from increasing the dose to an effective level.

I would take issue with Dr Bridges on one point, however. He comments that "there is an excessive preoccupation with environmental causes for psychiatric illness" and consequently, he feels, an excessive emphasis on social and psychotherapeutic treatments. I would agree that 'causes' in medicine often have very little to do with 'cures' but would not wish to diminish the status of research into environmental and psychodynamic causes. The fact that depressive illnesses respond rather better to drugs than to psychotherapy does not imply that environmental and psychodynamic 'causes' are unimportant. Take as an example another hazard in old age—the old lady's fractured femur. The fracture is often the end result of osteoporotic bones, loose fitting threadbare carpet, poor lighting and Mogadon, but it is all irrelevant when it comes to putting in the right pin and plate. But what's more important in the long run—developing superior operative hip techniques or tackling the background of poor health and inadequate housing? By all means let us treat depression with adequate doses of efficacious drugs but I hope we won't be seduced by their efficacy into stopping the search for the social and intrapersonal causes.

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IMIPRAMINE AND AGORAPHOBIA

DEAR SIR,

Richard Stern states that "it might surprise readers in the U.K. to know that Klein advocates very small doses of imipramine, even as low as 10 mgs, to counteract panic attacks (*Journal*, May 1983, **142**, 545–46).

Unfortunately, this is not exact. As we stated clearly in our chapter that appeared in the book on agoraphobia edited by Chambless and Goldstein, we advocate starting with a dose as low as 25 mgs per day, but building up till the spontaneous panics are completely relieved. In our last study, the average dose was over 200 mgs per day, with a substantial number of patients requiring 300 mgs daily.

The reference to low dosage refer exclusively to a small subgroup who respond to imipramine with marked psychomotor stimulation and insomnia. Such patients do respond to apparently homeopathic doses, but this is the exception, not the rule.

The usual flaw in clinical practice is to undertreat with imipramine, and we would not want Stern's comments to support this error.

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Reference

CHAMBLESS, D. L. & GOLDSTEIN, A. J. eds. (1982) *Agoraphobia: Multiple Perspectives on Theory and Treatment.* Chichester: John Wiley.

KORO EPIDEMIC IN ASSAM

DEAR SIR,

J. A. Harrington (*Journal* 1982, **141**, 98–99) in his letter described his recent experience on a visit to Thailand where he came across three apparent outbreaks of epidemic psychosis. The report of the first outbreak occurring in North East Thailand, the so called 'Rok Loo' (genital shrinkage disease) is of great interest. Assam, in North Eastern India recently experienced a unique situation in the form of an epidemic of psychological origin. It started in early June, 1982 affecting four western districts of Assam, and lasted until the middle of September. Termed 'Jinjinia Bemar' indicating a disease characterised by tingling sensation of the body, this epidemic started with a rumour that a lethal disease had struck the people bringing instant death or making the person impotent. In the early part of the epidemic, the affected persons did not seek the help of medical men, but tried to combat the epidemic by various preventive measures of indigenous type. These were pouring copious cold water, drinking gallons of lemon water, smearing of chalk paste or lime paste over the ear lobules and also over the private parts, avoiding all outdoor activities. Along with these, religious rites were performed in the different places of religion. People were scared to pursue their outdoor activities. Towards the later part of July people came to consult medical experts and the Department of Psychiatry, Gauhati Medical College surveyed the epidemic in the district of Kamrup where the college is situated.

Both sexes were found to be affected. Often the affected person came for help tying his penis securely with broad ribbons or elastic bands or simply grasping it by hand. The amount of panic generated by the epidemic was stupendous. To start with the diagnosis was a baffling problem for many of our physician

colleagues working in the primary health centres of the State. The local term 'Jinjinia' means only the tingling sensation arising out of extreme anxiety and does not cover the almost delusional conviction of shrinkage of the genitals. The clinical picture of this epidemic conformed to the classical description of epidemics of Koro—a psychological disorder which is produced and is cured by suggestion. Koro is known to be a culture-bound syndrome occurring exclusively amongst people of South East Asia in sporadic or epidemic form. For the first time this disease has affected people of the Indian sub-continent. Once the diagnosis, symptomatology and benignity of the disease were focussed through various mass communication media, the intensity of the panic faded away. Only a few sporadic fresh cases were recorded after the epidemic subsided in the middle of September 1982.

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Reference

DUTTA, D., PHOOKAN, H. R. & DAS, P. D. (1982) The Koro epidemic in Lower Assam. *Indian Journal of Psychiatry*, **24**, 370–4.

CONFIDENTIALITY AND PUBLICITY: A TECHNIQUE

DEAR SIR,

One of the great handicaps suffered by psychiatry is that it is very difficult to publicise psychiatric problems and illnesses without breaking confidentiality. Obviously general issues can be aired and drama can take the place of reality. However an increasingly sophisticated public will want to understand the details of psychiatric disorder before it lends full hearted support to our discipline. What does a mentally ill patient look like? What do they say ? How do they behave? What does the psychiatrist say to the patient? What is thought disorder? What are delusions and hallucinations? These and many others are legitimate questions. They are difficult to answer without clinical illustrations. Sometimes clinical illustrations can be provided via patients who understand the issues of public display and consent to it. Frequently however our patients are not really able to grasp all the issues concerning publicity. How then can we illustrate their problems?

Recently we have developed a technique which we believe partially solves this problem, although it is expensive. The clinical point to be demonstrated is made by an ordinary interview using a standard video tape technique. This tape is then transcribed. Identifying statements and features are omitted or changed. An actor or actress is then employed to play the part of the patient in a tape replay opposite the psychiatrist who plays him or herself. Both "actors" stick strictly to the script and copy the the verbal cadences, the gestures, mannerisms, and other behaviour of the original tape as far as possible. In this way a wide audience gets a realistic look at a psychiatric interview whilst the patient's anonymity is preserved. We have used this technique, successfully we believe, for teaching material within the University of London, and for public broadcasting.

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FATHER–SON RESEMBLANCES IN AGGRESSIVE AND ANTISOCIAL BEHAVIOR

DEAR SIR,

In our paper (*Journal*, January 1983, **142**, 78–84) we reported that boys whose fathers had left the home did not resemble their fathers on either aggressiveness or antisocial behavior, in marked contrast to the boys whose fathers were still in the home. We have now analyzed the data further and found that this conclusion was wrong.

We considered three possible explanations for the lack of significant correlations between the boys' traits and those of their absent fathers: the information on the father might be invalid, the range of variation in their traits might be too narrow, and the absent fathers might divide into subgroups with differing results. The first possibility arose from the fact that the information on the absent fathers came from interviews with the boys' mothers. The second and third came from the finding that 72 per cent of the fathers who had left the home had antisocial personality or alcoholism.

We cannot prove the validity of the information on absent fathers, but we showed in the paper that the absent fathers had significantly higher scores on aggressiveness and antisocial behavior than fathers still in the home. This was to be expected since these traits in men commonly go with inability to maintain a marriage. Further analysis showed that antisocial or alcoholic men who were gone from the home ($N = 46$) had scores on aggressiveness equal to those of the corresponding men still in the home ($N = 14$) and significantly higher on antisocial behavior (mean scores: 3.24 ± 1.39 vs. 1.93 ± 1.59; $P < .01$). These results argue that the mothers might have exaggerated the behavior of their ex-husbands, but they did not underestimate it.

The range of variation was apparently not restricted by the high proportion of deviants among the absent fathers. Even when we correlated the traits of the 60 fathers who were antisocial or alcoholic with their son's traits we found significant resemblance on aggressivess and a correlation between boys' noncompliance and fathers' antisocial behavior.