

Act 1990, and these should be utilised to undertake to examine the future provision of the mental health services. I believe that the clinicians who have an intimate and close understanding of the services are the most appropriate professionals to do this.

KING, D. (1991) *Moving on from Mental Hospitals to Community Care. A Case Study of Change in Exeter*. London: Nuffield Provincial Hospital Trust.

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Reporting predictable negative results

SIR: Korczyn *et al* (*Journal*, July 1992, 161, 132) report the negative results of their search for a mutation in the PRNP gene in six patients with bipolar affective illness. If I have understood their letter correctly, their justification for this search was based upon the following logical steps: mutations in this gene have been linked with a familial form of Creutzfeldt-Jakob disease; this has been demonstrated in Libyan Jews; some patients with Creutzfeldt-Jakob disease have affective symptoms; therefore, Libyan Jews with familial affective disorder should have the PRNP gene mutation.

Studies with negative results are of course scientifically as interesting as those with positive results and sometimes more so. This, however, is more likely when negative results are not as glaringly expected as in this case. The authors do not seem to have been discouraged by their findings and recommend that studies for mutant DNA sequences be performed in sporadic and familial forms of psychosis. I earnestly hope that they will not be testing for all known DNA mutations at random in psychotic patients. If they do, goodness knows how much more journal space will be filled with their negative results!

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Hypnotising lobsters, etc.

SIR: I was very surprised that the idea of hypnotising lobsters was thought to be evidence of gullibility requiring further photographic proof (Brooks, *Journal*, July 1992, 161, 134).

As a young child in rural Ireland I was taught to 'hypnotise' various animals by my mother. My particular expertise was in hypnotising turkeys and geese, for which I gained immense kudos as most of my peers were afraid of them. The technique involved stroking them firmly on the back of the neck, until the head rested on the ground at which point a white line was drawn in front of their heads. I often had dozens of them all over the yard, immobile until either they were moved or a loud noise disturbed them.

One recognised technique for hypnotising young children involves gentle, firm massage as this produces the relaxation and narrowing of attention required for induction.

My interest in hypnosis has continued although I confine my practice to people and my cat, Martha, when she requires calming at the vet's.

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Stress-induced hallucinations

SIR: Spivak *et al* (*Journal*, March 1992, 160, 412-414) describe stress-induced hallucinations, apparently experienced in clear consciousness, in army recruits who exhibited no other gross psychopathology. Cohen (*Journal*, July 1992, 161, 130) proposes that these experiences are most likely hypnagogic, a common and familiar source of isolated hallucinations. But I think that it may be a mistake to dismiss these unusual stress-induced experiences in this way.

In a recently completed series of retrospective interviews with 200 healthy subjects, 3% ($n=6$) described a single isolated experience of a brief second-person auditory hallucination, in which they heard a voice speaking to them, in clear consciousness. (No subjects in my series described stress-induced *visual* hallucinations, except in circumstances suggesting they were in a state of clouded consciousness.) These auditory hallucinations had occurred when the subjects had been faced with stress they regarded as 'severe', for example, life-threatening illness in their child. The words heard related to the concurrent stress. Most subjects described hearing comforting words, for example, "it's going to be all right", but some experienced threatening words such as "you're going to die". None of the subjects had experienced any associated psychopathology except distress in proportion to the perceived stress. None had consulted a psychiatrist around the time of the experience. The 'voices' were variously attributed to communication from God, to ghosts, or to

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.

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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 Capgras 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.

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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