quite different. The 19th and early 20th century psychiatrist was faced with two common conditions which caused a great deal of work – general paresis (GPI) and epilepsy – stimulating clinical observation and research. It was noted that: (a) some psychotics improved when they had a fever; (b) some psychotics improved after a spontaneous epileptic fit; and (c) at post-mortem, epileptic brains and schizophrenic brains differed greatly, suggesting some antagonism between the schizophrenic and the epileptic process. The first point led Wagner-Jauregg, a Viennese contemporary of Freud, on a long search for artificial fever therapy; in 1917 he found that malarial infection would cure GPI, and he received a Nobel prize in 1927. The second and third led Meduna in Budapest in 1935 to induce fits with metrazol, with therapeutic success. But his method was unpleasant for patients and difficult to control. Cerletti had been studying experimental epilepsy in dogs using an electrical stimulus; with Bini, he adapted the stimulus for man and so produced a painless and easily controllable variant of Meduna's treatment. ECT is part of the history of epileptic studies, and its understanding and that of epilepsy march together.

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Is Castration Too "Barbarous" for Rapists?

SIR: I fear that Salzman (*Journal*, August 1988, **153**, 270) is suffering from the illusion that motivation for recurrent sexual offending and rape is purely sexual. Often the apparently sexually motivated acts, which he attributes to "psychosexual malignancy", are in fact expressions of a deeper, more complex and less obvious psychopathology. Indeed, such pathology may still be expressed as serious aggression after libido has been artificially reduced.

Furthermore, even individuals whose main problem is deemed to be hypersexuality, and perhaps therefore those he believes most likely to respond to surgical castration, are probably those least likely to agree to such treatment. Indeed, individuals who might agree to voluntary sacrificial surgical castration to justify their liberation from detention may be those least helped by it and most in need of rather wider and more subtle treatments.

However, when libidinal suppression is required, the currently available, equally dependable, but reversible 'chemical castration' using hormonal implants already has an accepted role as an adjunct to the overall treatment of certain sexual offenders. Indeed, there is carefully controlled provision for such treatment under Section 57 of the Mental Health Act 1983.

Surely the use of presently available treatments rather than radical, but not magical, surgical castration will result in the continuation of a more considered overall approach to our patients and also less iatrogenic psychological morbidity in those whose ongoing mental stability is, after all, critical to both their success and the safety of others beyond conditions of detention.

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Females and Caring

SIR: I read with interest the recent review article by Morris (*Journal*, August 1988, **153**, 147–156) concerning factors affecting the emotional wellbeing of the caregivers of dementia sufferers. The different approach and strategies that men have to caring is described by Zarit *et al* (1986).

However, the evidence at present reveals that females receive less statutory help than males when caring for an elderly relative. A study of carers found that 4% of mothers, 20% of wives and 24% of daughters received home help support, while 95% of caring sons and 68% of husbands received this service (Equal Opportunities Commission, 1982). It could be said that these figures simply reflect the fact that men are more willing to organise and accept help, but my concern is that they are a reflection of society's basic assumption that women can cope with caring whatever the burden. Do we as professionals become more aware of the burdens of caring when the carer is male?

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Delusional Depression in Nineteenth Century Scotland

SIR: It is encouraging to find two serious studies of the history of psychiatry in the August edition of the British Journal of Psychiatry. It is surely a sign of the present health of psychiatry as a specialty that it is

able to examine its origins critically. However, there is a necessity for caution in the interpretation of such studies. Robinson (*Journal*, August 1988, **153**, 163–167) makes too large a claim in his assertion that the finding of a statistically significant decline in the prevalence of delusional depressive illness among inpatients from South West Scotland reflects a change in the phenomenology of affective illness since the last century.

Dr Robinson needs to justify his use of Feighner criteria to determine diagnosis and of the Present State Examination classification of delusions. While these methods are validated in contemporary studies, their use in the analysis of 19th century case-book material may be regarded as a 'category fallacy' analogous to that which Kleinmann (1987) has described with regard to cross-cultural comparisons.

Furthermore, it is necessary to be quite certain of the reliability of the data in the asylum records. Dr Robinson notes that nineteenth century doctors had a concept of "delusions" which included the idea that it was possible "by judicious reasoning to convince the patient of the absurdity of his belief". It is clear that this is a more inclusive concept than currently used, and it is thus to be expected that "delusions" will be more frequently recorded in 19th century case records than in contemporary mental state examinations.

The reliability of 19th century observation is further shaken by a consideration of the limited training in psychological medicine available at that time. In 1881 the first University lecturer in Mental Diseases in Scotland, Dr Clouston, was still arguing for general availability of such a training so that all doctors would, at least, have the ability to sign a lunacy certificate (Clouston, 1881).

Of those few doctors who had attended lectures in the field of mental diseases, some might have heard Clouston (1879) assert, "If you can treat a case out of an asylum and he recovers satisfactorily, it is better for you and for him". This highlights a further problem for the interpretation of Dr Robinson's findings. Scottish Lunacy Legislation specifically allowed up to six months home treatment for the insane, and it is especially likely that the quieter cases of melancholia would avoid the stigma of the asylum until a progression of their disorder compelled admission. Modern developments in the management of affective disorders must surely have some impact on similar cases in the later sample period, and Dr Robinson's study cannot allow for this difference.

These difficulties do not diminish the value of 19th century case records as source material, but they do emphasise the need for caution in the use of quantitative methods in historical studies. Anne Digby's recent chapter on 'Quantitative and qualitative perspectives on the asylum' (Digby, 1987) provides a helpful summary of the issues that must be addressed.

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Koro Secondary to a Tumour of the Corpus Callosum

SIR: We read with interest Durst & Rebaudengo's article (*Journal*, August 1988, **153**, 251–254). We are of the opinion that the title was not appropriate, as there was no evidence to show that the tumour was responsible for the koro-like symptoms. The patient seems to have had a fear of sexual inadequacy at the age of 17, whereas the tumour became apparent when he was around 24. Disappearance of his koro-like symptoms with ECT suggests the possibility of its coincidence with the tumour, rather than a cause and effect. This argument is further supported by the finding of tumour enlargement one year after discharge, with no exacerbation of psychological symptoms. Hence, there is no evidence to support the authors' suggestion that the sexual manifestations resulted from pressure of the tumour on thalamic and hypothalamic structures. It is interesting to find the disappearance of koro-like symptoms with ECT. However, this could be due to the improvement in the patient's depressive illness, with the koro manifesting as a symptom of depression.

Kumar (1987) found 22 cases in the literature where koro-like symptoms were found among non-Chinese subjects. Since then, five more cases have been reported (Holden, 1987; Kendall & Jenkins, 1987; Mukherjee, 1987; Kranzler & Shaw, 1988; and the authors' case) making a total of 27.

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