play football locally are inadequate. It is the same for almost every other activity and interest that human beings are involved in.

To use the Eysenck Personality Inventory N scale and a modified California Q sort as the only assessments of personality is to miss most of the features of personality which distinguish those who cope well with life from those who do not. Unfortunately clinical assessments by experienced assessors do not produce information which can be easily dealt with statistically. This difficulty should not prevent us from viewing the interplay of personal and social factors realistically.

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CUSHING'S SYNDROME

DEAR SIR,

Dr Cohen's conclusion (*Journal*, February 1980, 13;, 120–24) is not justified. He writes "since the depressive symptoms are removed by removal of the adrenal glands, a substance produced by the adrenals must be responsible for them". But other major changes occur, including the psychological one that the patient is finally given the certain cure of his long distressing illness. Moreover, the patients do not all recover promptly: "twelve had bilateral adrenalectomy: in some of these the psychiatric symptoms began to abate within a few days, usually within a few weeks, but in some it was as long as a year before they had cleared completely". The factors must include hormones, possibly susceptibility to affective disorders as mentioned by the author, and how the situation seems to the patient.

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DEAR SIR,

Dr Cohen (*Journal*, 1980, **136**, 120–24) has presented an informative account of the psychiatric concomitants of Cushing's syndrome. However, his conclusions outreach his data on the question of the association between depression in patients with adrenal hyperplasia as opposed to those with tumours. He states categorically that if there are no psychiatric symptoms in a patient with Cushing's syndrome there is a three in four chance that they have a tumour. This is open to challenge on two counts. Firstly, it is not certain from Dr Cohen's account whether all of his psychiatric diagnoses were made blind to the results of endocrine investigation and surgery. Even the most careful and scrupulous investigator is not immune from observer bias and studies with a small sample size are particularly vulnerable to producing spurious results from this source. Secondly, the contingency table of patients with/without psychiatric symptoms X with/without tumour, contains two cells where the expected frequency is below five. Hence it is inappropriate to use the chi square test as he has done (Siegal, 1956). Re-analysing the table using Fisher's exact test gives a probability of obtaining these or more extreme results, of 0.0524 and therefore just fails to attain the conventional level of statistical significance.

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Reference

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MEDITATION

DEAR SIR,

Attempting to isolate transcendental meditation or any other form of meditation from its proper setting is to produce an artificial situation (see Review Article by M. West (*Journal*, November 1979, **135**, 457–67). One should note that meditation is to be practised in the context of a way of life extending far beyond the bounds of the 'sitting' period. Wherever it is practised there is likely to be some effect, whether attributable to placebo effect, relaxation or something else. What is important is to be wary of the effects, especially when meditating in isolation; in fact meditation alone is not likely to achieve very much, but it can lead to immense changes and it is the nature of such change with which we should be concerned. On the one hand it may be generally welcome, but on the other it could be catastrophic.

We in the West know next to nothing of meditation and related practices, and we are not likely to change this, except in a sadly naive way, by our objective attitudes. Our modern western mind is tuned in to a different wavelength from that of those who properly practise meditation. If we are seriously interested we should be prepared to undergo considerable changes ourselves which perhaps means leaving the security of the 'scientific-cum-logical' approach, with all its tenacious cultural accretions, if only for a while, as does the anthropologist who ventures out to live in a situation quite new to him. Meditation comes from

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and properly belongs with religion where it is practised, while at the same time all-important 'wisdom' is developed. This is what one is blindly 'measuring' in well seasoned monks.

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MENSTRUATION, MOOD AND MENTAL HANDICAP

DEAR SIR,

It is widely reported that the female menstrual cycle polarises certain events in women's lives so that they occur much more frequently in the paramenstruum (premenstrually and with menstruation). Katharina Dalton (1977) reports that schoolgirls' examination results, schoolgirls' offences, offences by women prisoners, accident proneness, admission to both general and psychiatric hospitals and suicide attempts occur more frequently in the paramenstruum than at other times of the cycle. Birtchnell and Floyd (1974) do not find a relationship between attempted suicide and the menstrual cycle and point out many of the statistical problems in relating events to menstruation, as the menstrual cycle is not itself a regular predictable event.

This is a report of a pilot study to assess the effect of menstruation on the behaviour and mood of female patients with mental handicap. Women with mental handicap were selected, as it was felt that they would be less able to conceal mood changes, and that the mood changes would be reflected in behavioural changes. Preliminary discussion of the study with medical and nursing staff suggested that we would find a clear cut relationship between behaviour and menstruation. A questionnaire was devised with five questions

(1) Has the patient shown any abnormal elation or depression today?
(2) Has the patient had an episode in the last 24 hours of shouting, being destructive, excessive overactivity, interfering or aggression?
(3) Has the patient been unusually either under- or overactive?
(4) Has the patient either complained of or indicated that she has abdominal (period) pain?
(5) Has the patient been more dependent upon nursing staff or more attention-seeking than usual?

These were scored on a 4-point scale—No; Just noticeable—Slight; Moderate; Very Marked. For 84 consecutive days all menstruating patients in a 60-bedded mental handicap hospital were studied. The questionnaires were completed every day, and a separate record was kept of menstruation, epilepsy and medication.

There were 60 patients in the hospital, and records were completed for 29 (48 per cent) of patients, although only 25 (42 per cent) menstruated during the three months of the study. Fifty-two menstrual cycles were recorded in 25 women. In 16 women no change in mood or behaviour was recorded at any time. In nine women there were changes in mood and behaviour, but in only two of these nine did changes occur in the paramenstruum. In one of these patients three menses were recorded but here mood and behaviour changed in the paramenstruum of only one mensis. The other patient had two menses recorded, she had paramenstrual symptoms with one mensis but none with the other, and she also had behavioural changes which were unrelated to menstruation.

So out of 52 menstrual cycles recorded, in only two were there noticeable changes in mood and behaviour in relation to menstruation. These findings are at variance with the results predicted by nursing and medical staff, and imply that the menstrual cycle is not an important variable in the control of mood and behaviour in female patients with mental handicap.

This was a pilot study and it might be valuable to assess a larger group of patients with mental handicap, including those living in hostels and the community.

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SCHOOL PHOBIC CHILDREN AT WORK

DEAR SIR,

The final sentence of the article by Baker and Wills (*Journal*, December 1979, **135**, 561–64) and its summary is a non-sequitur to all the preceding article. The authors present no evidence that there are any 'underlying conditions' to school phobia, nor that adequate treatment of these supposed conditions is beneficial, let alone being 'more important than returning the child to school'. In fact, the cynic might conclude that such treatment might indeed be counterproductive in view of their finding that significantly more children who received further psychiatric treatment after discharge later failed to reach their potential in work or further education. Of

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