

Correspondence

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Social order/mental disorder

SIR: Scull (*Journal*, December 1990, 157, 937) complains his views on psychiatry have been caricatured by Dr Rollin in a recent book review (*Journal*, March 1990, 156, 454), and asks us to read his extended analysis of lunacy reform in the Victorian age in his monograph *Museums of Madness* (quotations from Penguin edition, 1982). This book sets out "to establish how and why insanity came to be exclusively defined as an illness . . . within the sole jurisdiction of the medical profession" which (he says) successfully captured the insane; and tells us "the substantial involvement of the state, and the emergence of a highly rationalised centrally administered and directed social control apparatus" – "a state-supported asylum system" – "a handy place to which to consign the awkward and unwanted, the useless and potentially troublesome" (i.e. those with "inability or refusal to abide by ordinary social conventions") (see pp. 16, 17, 240). Insanity became "a condition which could only be authoritatively diagnosed, certified and dealt with by a group of legally recognised experts" and "the asylum the sole officially approved response to the problems posed by mental illness". In it moral treatment was a mechanism for enforcing conformity, and became a repressive instrument for controlling large numbers of people (pp. 49, 50, 121).

All these statements are mistaken, either ignorant or grossly careless in expression, and coloured by Professor Scull's anti-psychiatric, anti-doctor, anti-establishment views. He claims no one knows what insanity was or is, and that it is simply a form of

deviance (social non-conformity), which he says modern experts (us) are spectacularly unsuccessful at 'curing'.

If you look at those who were actually sent to asylums in Victorian and Edwardian times you will find not social rebels, but cases of epilepsy, general paralysis of the insane (GPI), suicidal melancholia, severe mental handicap, dementia in the elderly and paraphrenia, among others. Insanity was a word covering diverse conditions, some of which are now curable (where are the epileptics and GPIs of the past?). These patients were never certified by experts: they were ordered into asylums by magistrates, whatever asylum doctors thought, and if a medical certificate was required it was written by any doctor in the country, who usually knew nothing about psychiatry.

The public asylums did not get a penny from the state, nor were they controlled by the state. Each asylum was independent, controlled by local magistrates (later, county councillors), who raised the capital required through a local rate and charged the running costs to the parishes from which the patients came. The state, through the Lunacy Commission or Board of Control, advised and inspected but could not compel. The magistrates did whatever they liked.

There was nothing to stop a family keeping a mentally ill (mad, insane) relative at home. If they were poor enough they might get financial aid from the parish. But if the family could not cope and gave up, the patient might be sent to the workhouse, or to a private madhouse or public asylum, for each of which the parish had to pay. Public asylum was not the sole response. Incidentally, about 30% of those sent to asylums by the magistrates were home again, much improved or recovered, in about six months. A recently published book (Crammer, 1990) enlarges on these basic facts.

Professor Scull quite obviously knows little about psychiatric practice past and present and his book, with its errors and misunderstandings, is a caricature of the truth. He has helped to mislead a generation of historians, and done his bit to discourage the mentally ill from seeking medical aid. It is not Whiggish prejudice, but fact, that medicine has increasingly

helped the mentally disabled over the past 150 years.

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Reference

CRAMMER, JOHN (1990) *Asylum History: the Buckinghamshire County Pauper Lunatic Asylum – St Johns*. London: Gaskell.

Who was Jellinek?

SIR: Hore (*Journal*, 1990, 157, 786–789) has provided a fair-minded reappraisal of Jellinek's *The Disease Concept of Alcoholism* (Jellinek, 1960). There are three issues on which he might perhaps be able to give us some further thoughts.

The first question is simply "Who was E. M. Jellinek?" Amazingly, the answer to that query remains obscure. Jellinek has been described as a biostatistician, but his understanding of statistical inference was limited, on the evidence of his published research (Jellinek, 1952). He held no medical or psychological qualifications, and *The Disease Concept* suggests that he was not well versed in issues relating to psychiatric taxonomy. At the same time, Jellinek's professional influence and the personal impact of his warmth and enthusiasm, are beyond doubt – we all stand in his debt.

Secondly, there is a question to be explored in relation to the historical antecedents of Jellinek's ideas. There is little in *The Disease Concept* which is not to be found in 19th-century authorities. Anyone who has, for instance, read Kerr (1888) or Crothers (1893) is likely to find in Jellinek a sense of *déjà vu*. Alcoholism was as much a 'disease' to those earlier writers as to Yale in the 1960s, and Kerr and Crothers had their typologies. Furthermore, and just as with Jellinek, the 19th-century activists confused 'disease' as a campaigning slogan, with disease as scientific formulation.

Thirdly, one might question whether Dr Hore is right in suggesting that the dependence syndrome (Edwards & Gross, 1976) "incorporates" Jellinek's views. It would, of course, have been impossible to write anything on alcoholism in the 1970s without an awareness of Jellinek, but those who put forward the syndrome formulation were also influenced by many other currents in the flow of contemporary science – learning theory formulations for instance (Edwards, 1986), and the epidemiological research which pointed to the shifting and multifarious nature of drinking problems within the community (Room,

1977). To suggest that the dependence syndrome was the disease concept reincarnate would be ahistorical.

On a more minor note, one might wish to correct the record as to the year of the *British Journal of Addiction*'s first publication under one of its several earlier titles – 1884, not 1892.

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Depression and the menopause

SIR: Neither the letter from Studd *et al* (*Journal*, 1990, 157, 931–932), nor the original review paper by Ballinger (*Journal*, 1990, 156, 773–787) considers another important aspect of depression and hormone replacement therapy (HRT), namely progesterone-induced depression.

The majority of menopausal women have intact uteri and so require additional treatment with progesterone to protect against putative endometrial cancer. Progesterone-induced depression is a well recognised complication of such treatment (Holst *et al*, 1989). The symptoms may be severe, including suicidal ideation, and specific antidepressant drugs then become necessary.

Gath & Iles (1990) have made a distinction between "depressed mood" and "depressive disorder" suggesting that the former will respond to oestrogen replacement but not the latter. They further state that, "if the diagnosis is depressive disorder the primary treatment is not oestrogen but standard psychiatric treatment, whether pharmacological or psychological, or both". Dr Ballinger's review refers to the treatment of "depressive illnesses" and so perhaps the argument should be confined to the illness rather than the emotion.