

Our findings, therefore, are different from those of Kumar and Robson, who found a peak incidence of depressive neurosis in the first trimester. Some of the symptoms elicited in our population undoubtedly reflect physical changes of pregnancy, particularly in the late stages. Nevertheless, we feel that these observations merit further consideration, as depressive symptoms in pregnancy may be important and underdiagnosed.

We are following these women for one year postnatally, in order to explore further the relationship, if any, between antenatal depressive symptoms and postnatal depressive illness.

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DEPRESSION AND AFFECT-LADEN WORDS

DEAR SIR,

There appears to be a serious flaw in the design of the interesting study of Dunbar and Lishman (*Journal* April 1984 **144**, 376–382). “Depression, Recognition-Memory and Hedonic Tone”, from which the authors drew the conclusion that depressives showed a preferred recognition for unpleasant material.

Dunbar and Lishman, using Broadbent’s word list, found that depressed subjects were as likely to recognize ‘bad’ words as controls, but were less likely to recognize ‘good’ and ‘neutral’ words. Inspection of the word list used however, shows that unfortunately affect type and intensity are linked in it, with all of the strongly stimulating words in the ‘bad’ group:

<i>BAD</i>	<i>GOOD</i>	<i>NEUTRAL</i>
bleed	cheese	crow
starve	bride	chest
dread	mirth	brass
scream	cruise	flake
crash	ripe	flock
cruel	tune	sixth
groan	peach	plough
brute	hymn	mode
mock	cash	holt
pinch	plum	moist
snake	soup	barn
mob	lawn	glove

Fig. 1 Broadbent’s list rearranged

Consequently, the results of the study can be accounted for equally by the “intensity of affect hypothesis” as by the “type of affect hypothesis”. To distinguish them, matching for intensity in the word list would be required.

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MITRAL VALVE PROLAPSE AND ANXIETY DISORDERS: NO LONGER AN ENIGMA

DEAR SIR,

As Chan *et al* correctly point out (*Journal*, August, 1984 **145**, 216) most of the literature linking mitral valve prolapse (MVP) and anxiety disorders stemmed from the United States in the late 1970’s. However, there is no justification in continuing to refer to the relationship between the two disorders as “an enigma”.

Wooley (1976) was the first to draw attention to the fact that the symptoms reported by patients with MVP were strikingly similar to those with various “cardio-anxiety” disorders described in the past, including Da Costa’s syndrome and neurocirculatory asthenia. Demographically, MVP resembles anxiety neurosis (or panic disorder of DSM III). Both are common diseases occurring in 5–10% of the population, both affect women almost twice as frequently as men, and both are familial (Marks and Lader, 1973; Devereux *et al*, 1976). Wooley’s suggestion that many patients previously designated as cardiac neurotics were in fact undiagnosed examples of MVP had important implications. Subsequent case reports and a number of methodologically flawed studies appeared to confirm this view.

Unfortunately we had to wait until 1982 for these early claims to be seriously challenged (Hartman *et al*,

1982). In 141 patients with MVP Hartman *et al* found that 22 (16%) had panic disorder (PD). However, the prevalence of PD among the *relatives* of these patients (a population with minimal selection bias) was much lower: only 3% of relatives with or without MVP had evidence of PD. This is similar to the figure reported in the general population, and suggests that the high prevalence of PD in hospital populations is due to the selection of highly symptomatic individuals.

Two cardiologists (Leatham and Brigden, 1980) also criticized the ill-considered attempts to ascribe all sorts of properties to the prolapsing mitral valve. They were impressed by the absence of symptoms in those patients seen for the first time who were unaware of the existence of disease. In an attempt to explore the apparent association between clinical findings and reported complaints, Procacci *et al* (1976) identified all women on an air force base with an auscultatory click, murmur, or both and found that the symptoms of palpitations, dizziness, weakness and chest pains were as common in the group with as in those without the auscultatory abnormalities. These results, taken together with those of Hickey *et al* (1983), suggest that the underlying mechanism that causes MVP is not additionally responsible for psychological symptoms. Eight years after Wooley's editorial we are in a position to say that the association of MVP and anxiety disorders is no longer an enigma: it merely reflects the chance association of two exceedingly common conditions.

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DREAMS AFTER AMPUTATION

DEAR SIR,

I enjoyed reading the article by Frank *et al* (*Journal*, May, 1984, **144**, 493-497) on psychological response to

amputation as a function of age and time since amputation. I was particularly interested in their discussion of the importance of change in body image following amputation. It had come to my attention, in talking with persons who have had amputations, that a potentially useful measure of psychological response may be body image during dreams.

A 37 year old farm worker was sawing logs when one of the logs became caught in the saw. In an attempt to free it he became entangled in the log and had both arms amputated, one near the shoulder and the other just above the elbow. After several weeks of rehabilitation, physical therapy and occupational therapy he was fitted with two artificial arms and hook hands. He was then discharged home. In follow-up visits he continued to report difficulties in adjustment and acceptance of his amputations. Particularly, he observed difficulties in expressing physical affection to his children, his wife and in taking care of his toileting needs. As follow-up continued he continued to make excellent progress. He then reported that he knew the time when he had accepted his amputations because he began to dream of himself with hook hands.

This has been reported in a number of other patients I have seen who have suffered amputations. Many will no longer dream of themselves as running or walking but rather wheeling along in their wheelchairs or see themselves in their dreams with an artificial limb, these patients appear particularly well adjusted. To my knowledge, investigations in this specific area have not been completed. I think it is a particularly fruitful area to pursue from a research standpoint. From a clinical standpoint, it may also be useful in the ascertainment of individual acceptance of amputation and physical handicap. Finally, it would appear that, to a degree, this change in body image is a function of time since amputation.

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DEXAMETHASONE SUPPRESSION TEST AND RESPONSE TO ANTIDEPRESSANT DRUGS

DEAR SIR,

Beckmann *et al* (*Journal*, April 1984, **144**, 440-441) claim that in their study comparing response to amitriptyline and nomifensine, there was a preferential response of DST positive depressives to amitriptyline and of DST negative depressives to nomifensine.

In order to refute the null hypothesis that there is no difference in the distribution of treatment response to either drug among DST suppressors or non-suppress-