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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References

CLOUSTON, T. S. (1881) *The Clinical Teaching of Psychiatric Medicine*. London: Kolckmann.

—— (1879) The study of mental disease, being the introductory lecture delivered in the University of Edinburgh on the institution of the Lectureship on Mental Diseases, May 1879. *Edinburgh Medical Journal*, **25**, 1–20.

DIGBY, A. (1987) Quantitative and qualitative perspectives on the asylum. In *Problems and Methods in The History of Medicine* (eds R. Porter & A. Wear). London: Croom Helm.

KLEINMANN, A. (1987) Anthropology and psychiatry. *British Journal of Psychiatry*, **151**, 447–454.

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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References

HOLDEN, T. J. (1987) Koro syndrome associated with alcohol-induced systemic disease in a Zulu. *British Journal of Psychiatry*, **151**, 695–697.

KENDALL, E. M. & JENKINS, P. L. (1987) Koro in an American man. *American Journal of Psychiatry*, **144**, 1691.

KRANZLER, H. R. & SHAW, P. J. (1988) Atypical koro. *British Journal of Psychiatry*, **152**, 579–580.

KUMAR, H. J. (1987) Koro in an Israeli man. *British Journal of Psychiatry*, **150**, 133.

MUKHERJEE, T. (1987) Koro-like states. *British Journal of Psychiatry*, **150**, 881.

A Capital Mistake?

SIR: In 'Sherlock Holmes: a suitable case for treatment?' (*Journal*, August 1988, **153**, 241–242) Dr Rollin argues that the detective showed signs of obsessional neuroticism with bouts of depression. Holmes' sexuality is considered and found wanting, and he is thought to use cocaine therapeutically to lift his mood. A glance at *A Scandal in Bohemia* (Doyle, 1981) reveals a Holmes who dismisses such speculations. He remarks that "It is a capital mistake to theorise before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts".

Not only does Dr Rollin make such a "capital mistake" in trying to adduce a diagnosis from a description, but in doing so there is a danger of bringing some slight discredit to the discipline of psychiatry. For if in our profession there are clinical skills, the application of which may lead to a diagnosis being made, then to suggest that the literary dissection of fictional or historical figures may also lead to a 'diagnosis' is to severely debase the term. When published in a scientific journal, these speculations then gain a respectability unwarranted by their content.

Lest anyone thinks I am unduly critical of a pleasant literary piece, the *Sunday Times* of 21 August commented on the article under the headline 'He was quite a case'. The *Journal* is mentioned by name and it is suggested with journalistic licence that the "great detective was a fruitcake", Conan Doyle's hero was "mentally ill", and that "if Holmes had walked into a GP's surgery today he would be put on drugs and sent for psychotherapy".

In the *Sign of Four* (Doyle, 1981) Holmes ascribed his powers to "observation, deduction and knowledge". He complained of no mental illness except lack of stimulation, and our appreciation and enjoyment of his exploits is not increased by psychiatric post-mortems.

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Reference

DOYLE, A. C. (1981) *The Complete Sherlock Holmes*. Harmondsworth: Penguin Books.

Sherlock Holmes – Would He Be a Good Psychoanalyst?

SIR: Rollin (*Journal*, August 1988, **153**, 241–242) speculates that Holmes would eventually use his inordinate capacity for deductive analysis to show up Freud, Jung, or whosoever and turn the analytic table on them. Can I add to the psychopathological lore and suggest that Holmes was actually suffering from a delusion, namely that if he only thought long and hard enough, using the few available clues, he could accurately reconstruct the motives and actions of the protagonists of his cases. As Shepherd (1985) implied, this delusion was shared by the first psychoanalysts and is propagated, I daresay, in the public media even today. It comes as a relief, therefore, that we have the example of a sane detective; Brother William from Umberto Eco's *The Name of the Rose*. Brother William understands that clues are signs (signifiers for the connoisseur), and in an explanatory dialogue with Adso (his 'Watson') he comments that "they are the only things man has with which to orient himself in the world." But he admits that he does not understand the relationship between the signs. He concedes that he successfully identified the villain by "pursuing the plan of a perverse and rational mind" but, really, the villain "was overcome by his own initial design, and there began a sequence of causes, and concauses, and of causes contradicting one another, which proceeded on their own, creating relations that did not stem from a plan". He concludes with the resigned observation that he was "stubbornly pursuing a semblance of order, when [he] should have known well that there is no order in the universe". Adso tries to console him in vain: "But in imagining an erroneous order, you still found something . . . " Dr Jaspers could not have put it better.

Holmes would, therefore, not have made a good psychoanalyst. If only more psychoanalysts were like Brother William, and if only more psychiatrists read *The Name of the Rose*!

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References

ECO, U. (1984) *The Name of the Rose*. London: Picador.

SHEPHERD, M. (1985) *Sherlock Holmes and the Case of Dr Freud*. London: Tavistock Publications.