therefore lead to surprise at our report. As for the second reason, Singh *et al* (1985) did not elaborate on or discuss the brief sentence noted above, and actually stated in the beginning of their paper that "water does not alter perception" (this speaks against an ASC which characteristically causes perceptual distortions and body image change (Ludwig, 1966)). Besides, it was not clear whether depression (the patient's diagnosis) with an accompanying self-harming motive or an enjoyable ASC was the primary aetiological factor. It will take a meticulous reader to spot that sentence and think about it in the perspective of ASC. Incidentally, we have quoted even earlier and more likely mentions of ASC ("a feeling of unreality" and hysterical fugue in patient 2 (Barlow & De Wardener, 1959)) in our paper, but again ASC was not specifically discussed. A more recent review does not include ASC or allied factors in its discussion of possible aetiological factors in polydipsia (Illowsky & Kirch, 1988). Hence, we consider that it is still worthwhile to highlight ASC in our case report. Concerning the third reason, Ripley *et al*'s paper was published several months after our report was submitted and accepted for publication, and aims to show an association (they suggested both genetic and psychological reasons) between alcohol abuse and water intoxication in schizophrenic male patients. No specific discussion was made on ASC, which in my opinion may provide a valuable link between drunkenness from alcohol abuse and "pleasurable polydipsia" as hinted at by the author. Incidentally, a pleasurable experience, such as eating good food, may or may not constitute an ASC as it is usually described – Ludwig (1966) listed nine general characteristics. Viewing compulsive water drinking as "maladaptive ASC" (Ludwig, 1966) also carries treatment implications because, if verified, it will be possible to replace this potentially dangerous habit by methods of developing "adaptive ASC", as by self-hypnosis or Qigong, a popular Chinese breathing and physical exercise.

There is also some misunderstanding about water drinking in traditional Chinese medicine. A large amount of cool water does achieve a mildly 'cooling' effect, but an intake of 20 litres/day is exceptional, apparently because of the physical discomfort that ensues. Besides, most Chinese would prefer to take a smaller amount of a more potent 'cold' remedy (e.g. bitter tea or melon) rather than water (Koo, 1984), so that our patient's adverse complications are still very unusual. Cigarette smoking and the list of aetiological factors cited by Dr Cooney are all irrelevant to our case. Finally, I would be interested to learn, with regard to the "many patients with excess fluid intake who present as drunk" to Dr Cooney, what kinds of patients they are and whether it is feasible to investigate their drunkenness using an ASC scale.

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Better to be depressed in the sun

SIR: Further to the correspondence following the papers by Lee & Murray (*Journal*, December 1988, **153**, 741–751) and Kiloh *et al* (*Journal*, December 1988, **153**, 752–757), may I be permitted to suggest an alternative explanation to the apparent difference in outcome between London and Sydney depressives? It is now accepted that phototherapy is an effective treatment for the seasonal affective subgroup of endogenous depression. It is highly likely that representatives of this subgroup were included in both the London and Sydney cohorts. With, I gather, the exception of this year, the climatic differences between foggy London and sunny Sydney are well accepted. Might not therefore the Sydney group have unwittingly been practising autophototherapy as they disported on Bondi Beach and its environs?

Rather than suggest the drastic step of emigration to the Antipodes, might not Drs Lee & Murray advise their depressive patients to take a long sea voyage around the West Indies, thus proving what our Victorian forebears knew well?

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