skin in trivial injury will have an alerting effect in the C.N.S., while those released in vascular injury will have a sedative effect. The survival value of a flight reaction to trivial injury, and lying still in vascular injury, will be obvious.

I worked out this idea some years ago; since then an alerting C.N.S. function of histamine in the hypothalamus (Monnier, 1969), and a sleep-producing function of serotonin in the median raphe nuclei (Jouvet, 1972) have been proposed. I think further research will further support this hypothesis.

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GENERAL HEALTH QUESTIONNAIRE

DEAR SIR,

The doubts expressed by Drs Corser and Philip (*Journal*, February 1978, **132,** 172) as to the psychiatric nature of the emotional upset measured by the General Health Questionnaire (GHQ) are clearly of concern to those of us who are using the instrument in epidemiological studies of psychiatric illness. However, the data in Table VI show that 14 of the 15 GHQ-probable patients who consulted partly or wholly with psychological problems were found to have a well defined psychiatric disorder, whereas only 3 out of the 17 GHQ-normals who consulted could be allocated a clear psychiatric diagnosis. This seems to suggest that the GHQ is effective in differentiating 'transient situational disorders' from 'true' psychiatric illness, i.e. anxiety state and reactive depression.

The survey also indicates that the GHQ produced significantly more false positives than false negatives (9 out of 24 as against 3 out of 95: $\chi^2 = 21.28$, $P < 0.001$).

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DEAR SIR,

Thank you for giving us an opportunity to reply to Dr Schiff. We submit the following for your editorial consideration.

Dr Schiff's comments about 'well defined' and 'true' psychiatric illness imply a certainty of diagnosis which would seldom be found in a primary care consultation. Subsequent work in the same general practice (Corser and Ryce, 1977) describes the use of a problem orientated approach which avoids the use of terms such as anxiety state and reactive depression when all the criteria for the syndromes of the same names are not met. Wing (1976) and Foulds (1976) in their different ways provide structural approaches to the classification of psychiatric illness which are well suited to epidemiological studies, in particular, by being quite precise about what they include as illness.

We do not deny the value of the General Health Questionnaire as a preliminary screening instrument. However, too many of its items are 'part symptom—part personality state' measures to lead us to accept that all the emotional upset reflected in high scores is psychiatric in nature without seriously discrediting the illness model which Dr Schiff clearly accepts.

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CONTRACEPTION

DEAR SIR,

Drs Fleming and Seager rightly state that there is controversy regarding psychological side effects of the contraceptive pill (*Journal*, May 1978, **132,** 431–40). Their own study, however, does little to clarify this state of affairs, for although they consider 'The majority of these papers deal with uncontrolled samples selected without defined criteria for measuring depression' they themselves are open to the same criticisms.

In the absence of data on why past-takers stopped and non-takers never started taking the contraceptive pill, the value of these groups as controls is suspect, as a major factor in this may be existing depression or a potential to develop it as perceived by the prescriber. One is unable to assess the normality of controls in the absence of validity data for the depression rating scale used. Further, data on marital status are not pre-

sented, and none collected for age of children, both of which factors are known to correlate with depressive symptoms, and both of which might be expected to differ between the groups studied. Throughout the paper the authors refer to the *incidence* of depression, although the data reported are concerned exclusively with prevalence. If they were concerned with incidence they should have amplified the last question in Appendix 1.

One hopes the study does not befall the fate attributed by Drs Fleming and Seager to previous work, of being 'quoted uncritically by subsequent authors'.

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SCHIZOPHRENIA IN FICTION

DEAR SIR,

Surely it is unwise to suppose that a novelist of Charlotte Brontë's stature would rely on lay concepts rather than personal experience in describing the behaviour of a character essential to the plot. Although the description of the mad Mrs Rochester might defy diagnosis in terms of present-day psychiatry in Britain, Dr Robinson (*Journal*, **132,** 525) would appear to have overlooked the fact that diseases tend to change in their manifestations over the years. But some 50 years after Charlotte Brontë's description, it was still recognizable to British alienists, for Sir Thomas Clouston (1892), describing his experiences of a patient with chronic mania, says 'I have never seen anything so completely parallel to the famous maniac scene in Charlotte Brontë's Jane Eyre'. Before the Kraepelinian revolution, the term mania was generally used to cover all states of mental excitement not associated with fever, and from the descriptions in textbooks and from Kraepelin's own remarks (1913) it is clear that 'mania' in the 19th century included the now rather rare (but then, it would seem, much commoner) condition which today we call schizophrenic excitement.

It is perhaps worth noting that a present-day diagnosis of the case of Don Quixote might seem problematic. Yet the diagnosis was plain to Esquirol, who states (1838) that 'in Don Quixote we have an admirable description of monomania'. We can't today form a very clear idea of what Esquirol meant by monomania, but this again is probably because of changes in the manifestations of psychiatric disease which have occurred in Europe during the past 100 years.

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