stopped. I hope to repeat this work on a larger series to see if a mild pyrexia is common in patients receiving neuroleptics and showing extra-pyramidal side-effects.

Finally, I should like to retract my statement that neuroleptic malignant syndrome is not mentioned in any British textbook (see O'Shea & Falvey, 1985).

ALEX M. P. KELLAM

University Hospital of Wales
Heath Park
Cardiff CF4 4XW

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Edinburgh Post-natal Depression Scale

SIR: Cox *et al* (*Journal*, June 1987, **150**, 782–786) have produced a concise instrument for detecting post-natal depression. I would question the inclusion of question seven in its present format. Probably the majority of new mothers experience sleepless nights for many weeks, because neonates generally take some time learning to sleep through the night. For such people, it might prove difficult to answer this question, which implies that unhappiness is the only cause for their insomnia. Rephrasing the question as follows might help:

"I have been so unhappy that I have had difficulty sleeping, even when my baby has been quiet and the opportunity for sleep was there. . .".

G. E. VINCENTI

The Duchess of Kent's Military Hospital
Catterick Garrison
North Yorkshire DL9 4DF

SIR: Vincenti has drawn attention to the central dilemma of the validity of established self-report mood questionnaires when administered to pregnant or puerperal women and to our attempt to overcome these difficulties.

The main problem which was discussed in our paper (*Journal*, June 1987, **150**, 782–786) is that certain somatic symptoms, such as weight loss or palpitations, may be caused by the physiological changes of childbearing as well as by a mood disturbance. The wording of the questionnaire items may also need to take into account the particular social circumstances of the mother and the incessant demands that may be made on her. The Edinburgh Post-natal Depression Scale (EPDS) was developed to reduce these ambiguities as far as possible.

Because many mothers experience sleepless nights for many weeks after childbirth, the sleep item (item 7), "I have been so unhappy that I have had difficulty sleeping", was worded to detect those mothers whose sleep difficulty was secondary to a mood disturbance and not caused *directly* by a noisy baby or by a restless partner.

The correlation matrix (available on request) between the 10 items on the EPDS confirmed that we had been successful in this endeavour. The sleep item had its highest correlations ($r = 0.52$) with item 3 ("I have blamed myself unnecessarily when things went wrong") and item 8 ("I have been feeling sad or miserable"), which would indicate that this item is detecting women whose sleep difficulties relate to their depression.

The modification suggested by Vincenti is, in our opinion, unlikely to be an improvement and might cause yet further problems; for example, what *are* the requirements for "the opportunity to sleep" – a comfortable bed, or perhaps a quiet partner?

JOHN COX

Department of Postgraduate Medicine
University of Keele
Stoke-on-Trent ST4 7QB

Predictions of Outcome in Depressive Illness

SIR: Eagles (*Journal*, May 1987, **150**, 715) appears to claim that we were unjustified in assuming that patients presenting for admission to hospital on clinical grounds were more likely to be depressed than those who remained in the community (*Journal*, January 1987, **150**, 43–48). We would like to hear the evidence supporting his rather idiosyncratic view.

We will answer Eagles' points seriatim. He observes that the sample was not "normally distributed" on the Newcastle Scale. However, elsewhere in the article, we clearly showed that there was evidence of discontinuity in the distribution.

He questioned the representative nature of the sample. However, we made no claim that the sample was representative of anything other than severely depressed patients. We made this clear on p. 46, second column: "we were probably not looking at a random sample of the general population, sources of potential bias being the mode of referral to hospital and the criteria of selection for the trials". Moreover, this was confirmed by the use of the Newcastle Scale worked out for use with similar in-patients.

We accept that there is a distinction between treatment response and outcome, and this may become

important in the remoter outcome period. However, in the short term the two are virtually identical. Differences might arise in the longer term, and outcome measures could provide further criteria for determining whether there is a binary distribution of outcome or, whatever the follow-up measures employed, this had a unimodal distribution. However, this was outside the modest remit of our own study, although it could be looked at in the future. Thus the inference drawn by Eagles that "these findings provide no convincing evidence for the dualist theory of the classification of depressive illness' is clearly not supported by the evidence and is therefore inappropriate.

M. W. P. CARNEY
Northwick Park Hospital & Clinical Research Centre
Watford Road
Harrow, Middlesex

E. H. REYNOLDS
B. TOONE
Kings College Hospital, London SE5

The Hungerford Massacre and its Aftermath

SIR: The above hypereredic* episode has received world-wide publicity. The unanticipated consequences of such attention seem worthy of closer observation, as does the possibility of prevention in some instances of this type of explosive behaviour.

During the 1950s and 1960s I examined hypereredic individuals categorised in this area as 'amok runners'. They came from among peoples of three grades of technological development: the Melanesians of Papua New Guinea, the Chinese in Singapore, and the Europeans resident in Australasia (Burton-Bradley, 1968, 1972). Since that time further instances have surfaced in this area at the rate of approximately one every 18 months. Although culturally variable, there is a hard-core symptomatology in all of them, based on the self-defined unrelieved insult. There are four discrete periods: (a) a prodromal brooding, during which a resolution may be effected if circumstances permit; (b) explosive homicidal outburst; (c) continuing homicidal drive; and (d) a retrospective claim of amnesia by the ones who survive.

Case Reports: (i) A 35-year-old Caucasian public servant had received no promotion for 10 years. He wrote me a letter in 1967 outlining his claim of differential treatment. He stated that he had been continually overlooked, that colleagues with the same or lesser qualifications had been promoted, and that he had been railroaded into a dead-end position. He declared his empathy with, and total acceptance of, the solution adopted by a laboratory technician in remote Pennsylvania, USA, who had recently ran amok killing six people and wounding six others. This had been reported in great detail in the weekly newspaper. The victims were people in authority over him. I asked the public servant to come and see me, and during the course of interview I detected oversensitivity coupled with anxiety and anger. I formed the opinion that he had a diminished capacity to select and control alternative forms of behaviour. There was, I felt, a serious risk that he would act out the Pennsylvania model. I conferred with his superiors, and it transpired that his promotion was in fact being processed, but at a slow bureaucratic rate. This was speeded up, and the would-be amok runner informed, with dramatic effect in eliminating his brooding. When examined again two years later he was free of all symptoms.

(ii) Another Caucasian amok runner, who was killed during the period of his episode, left behind a letter showing how he had modelled his plans on a similar tragedy which took place in remote Canada one month earlier. He had read about it in the newspaper. He had been rated by his victims as a "humbug". He acted out the Canadian model.

These brief observations show that the physician, close acquaintance, or other person in contact with an adult male (usually living alone) who outlines his disaffections in the above fashion should be alerted. The proposed ban on certain classes of firearms, admirable as it may well be, is based on a response to public expectation and not necessarily on fact. It will do little to eliminate such episodes, and gives the impression of seeking a solution merely by closing the door after the horse has bolted. Also, it is unlikely that much help will, or could be, obtained from the media, but such bodies should be adequately informed. But is psychiatric expertise being fully utilised?

BURTON G. BURTON-BRADLEY
The Maho Place Clinic,
PO Box 111, Port Moresby
Papua New Guinea

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**Hypereredism:* a morbid state of hostile tension, following provocation, sometimes leading to explosive behaviour out of proportion to the circumstances.

Behaviour Disorder in Childhood Re-assessed

SIR: We have completed a pilot study of one year's intake of 207 children as new out-patients to a hospital-based department of child and adolescent