

of less neonatal trauma in the vacuum group when the fetal position was occipitoanterior.

We recognised that major adverse neonatal outcome was too infrequent to allow a precise estimate of the relative merits of the two instruments. For this reason, as many as possible (77%) of the infants born in the trial were reviewed at about 9 months of age.² Other than strengthening the association between mild neonatal jaundice and vacuum extraction, this showed no clear differences between the two cohorts. As Rydén says, this mild jaundice is probably due to the increased incidence of scalp trauma associated with vacuum extraction. He did not mention that both trauma and jaundice might be reduced by the newer types of vacuum cup. Bird's latest modification (the new generation cup), for example, aims to reduce cup detachment, but in another randomised controlled trial³ we found no evidence of fewer detachments or reduced trauma and jaundice. The more flexible soft cups may be an improvement in these respects,⁴ but further randomised trials are needed.

Rydén makes no mention of women's views of vacuum extraction and forceps delivery. In the only study which has examined this methodically⁵ women allocated to receive vacuum extraction reported less pain at delivery but had more worries about their babies; this finding reflected the association of vacuum extraction with neonatal jaundice.

The relative merits of the two instruments for babies remain uncertain. Much larger, multicentre trials are required to assess these precisely. Centres where operators are familiar with both instruments may like to contact each other through this unit.

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The hospital anxiety and depression scale

SIR,—Minerva's comment (4 January, p 63) on mood rating scales and the implication that these are liable to overreport depression in medical and surgical patients leads us to draw to the attention of your readers our recent self assessment mood scale: the hospital anxiety and depression scale.¹

This instrument was devised after a request from one of our colleagues for a simple device to separate depressive disorder that can be treated with antidepressant drugs from sadness, demoralisation, and grief in patients attending a general medical clinic. As depression is a concept with a multitude of meanings we first had to decide which clinical symptoms were the test markers of the mild biogenic mood disorder; certainly the loss of pleasure response (anhedonia) ranks high and so may retardation. However, retardation is likely to be prevalent in physical illness without necessarily indicating mood disorder; the other mandatory symptom of the DSM III system for diagnosis of major depression is dysphoria (sadness) but this is too broad a concept to be useful for distinguishing

between biogenic (antidepressant responsive) and psychogenic mood disorder. After careful item analysis in a general medical clinic we devised the HAD scale, the depression subscale of which is largely (five of seven items) an anhedonia scale.

The advantages of the HAD scale are that it is short (14 items), acceptable to patients, and easily completed in a hospital waiting room. All symptoms of mood disorder which are also likely to be present in patients with physical illnesses such as insomnia and anorexia have been excluded, and a subsequent validation study² shows that the scale distinguishes clearly between the concepts of depression and anxiety. A further advantage is that users in the UK may obtain the pads of scales, with an inbuilt scoring device, free on application to: Medical Sciences Liaison Division, Upjohn Limited, Fleming Way, Crawley, West Sussex RH10 2NJ.

The HAD has been translated into all major European languages and many oriental languages, and copies of translations are available on application to us.

The HAD scale is still fairly recent and as yet few results of completed projects have been published, but a report from a cardiology department reprinted the full scale for readers to judge its usefulness.³ Many uncompleted studies have come to our attention and these show that, as intended, the incidence of depression is not overreported. An unpublished dissertation validates its use in the elderly but, even so, many elderly and partially sighted people may be unable to complete a questionnaire so a study is in progress to adapt the HAD scale so that clinicians can administer it.

We hope that researchers and clinicians who decide to use the HAD scale will inform us of their experience in order that we may build up a reference guide of use to other inquirers.

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Doctors and overpopulation

SIR,—As doctors involved in the specialty of reproduction and supporters of the Doctors and Overpopulation Group we write concerning the world population problems and our government's action.

The Doctors and Overpopulation Group was formed in January 1972 as a result of a letter written by a number of doctors to the *British Medical Journal* and the *Lancet*. The aims of the group remain as they were at the outset: to call on the government to admit that a population problem exists in Britain as well as overseas; to press for a comprehensive service for contraceptive counselling and supplies, male and female sterilisation, and legal abortions; to urge a reappraisal of laws and policies relating to women in society; and to be in the vanguard of a campaign for population education.

In his speech on behalf of the government to the World Population Conference in Mexico one year ago Lord Glenarthur welcomed the low birth rate here in the United Kingdom. We feel it would be helpful not only if more money were given in development aid, which was earmarked specifically for population activities, but also if that

fact were explicit and made widely known. The current, tragic famine in Ethiopia is primarily caused by the increase in population there, from 13 million in 1940 to 32 million in 1984. This clearly makes it more difficult to feed the population when there are adverse climatic conditions. In addition, desertification associated with the drought has been exacerbated by tree cutting in the Ethiopian highlands—on too large a scale for the environment to withstand, largely because there are now too many tree cutters.

Although Africa has enough land to feed two and a half times its population, countries like Kenya are doubling their population in only a little over 15 years. Thus however efficiently the land were to be farmed, and the resulting food distributed, there would be too many people for the carrying capacity within considerably less than 50 years. Attempts to alleviate poverty and hunger are swamped by sheer weight of numbers and the destruction of the land.

The reaction of the UK public and the UK government to the problem of famine in Africa has been admirable. However, as usual it tends to be a reaction to a crisis, and there is far too little awareness of the trends that produced this, and will produce further crises in the future. The problem with population is its enormous momentum: with at least 40% of the population of so many Third World countries being under the age of 15, at least a further doubling of their populations is inevitable (unless drastic one child type solutions are brought in, as in China).

There are those who accuse us of overemphasising the family planning component of aid. We believe in the well known slogan, "Take care of the people and the population will take care of itself," but we will accept this slogan only if it includes effective family planning services, available as a human right to all people including those in the rural areas and slums. Assistance with birth control should not be considered as an extra to follow after development but as an integral component of such development. We invite correspondence from any who share the opinions of the Doctors and Overpopulation Group.

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Learned pain behaviour

SIR,—I was interested to read Dr S P Tyrer's leading article (4 January, p 1) and in the same issue an article by Dr T C O'Dowd and others on the irritable urethral syndrome (p 30); there is an unmentioned common theme.

It might be helpful to introduce the concept of the somatiform disorder,¹ an ugly neologism which, however, describes a group of conditions that probably includes the subject of both articles. "Learned pain" seems to fall in the DSM III category of psychogenic pain,² and irritable urethral syndrome is one of the many symptoms of the rubric, "somatising disorders." These two categories are grouped together with conversion disorder and hyperchondriasis and have many common features.

The advantage of recognising this classification is that research has illustrated something about the characteristic individual and family histories, the