suppose that the four quarters of the year yield not ·25, ·25, ·25 and ·25 each of the schizophrenic births, but ·27, ·25, ·23 and ·25 of them. (The fact that control births also occur seasonally does not materially affect the argument.) Then

$$e = \frac{(\cdot 02)^2}{\cdot 25} + \frac{(\cdot 02)^2}{\cdot 25} = \cdot 0032.$$

Using Cohen's formula 7.4.1 (p 262) in conjunction with his Table 7.4.6, we find that the desired sample size is $\cdot 05 \times 218/\cdot 0032 = 3406$. Workers wishing to use other levels of significance, other levels of test power or other effect sizes may use Cohen's tables to derive the appropriate sample sizes. Table I gives illustrative values.

TABLE I

The sample sizes required to detect (at given levels of significance and at given levels of test power) an effect of the size described in the text

Test power	Significance level	
	·05	·01
·5	1,797	2,909
·7	2,562	3,875
·8	3,406	4,828
·9	4,423	6,016

If one were wishing to test seasonality, one might be unclear which null hypothesis to attack. Different sample sizes are needed to achieve the same test power against various closely similar hypotheses. Suppose, for instance, it is hypothesized that schizophrenic births occur disproportionately often in one half of the year; or suppose one wished to see whether there was a raised incidence of schizophrenic births in 4 months as contrasted with the remaining 8. Using Cohen's tables, one can estimate the sample size required in each case. Adjustments would have to be made if one were prepared to specify beforehand *which* months were to be associated with affected births.

In general the χ^2 test is a weak one for testing seasonality, especially when it is used with 11 degrees of freedom to test monthly values. However, as far as I know, the power of other tests of seasonality has not been investigated.

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THE DE CLÉRAMBAULT AND CAPGRAS SYNDROMES: A CASE HISTORY

DEAR SIR,

De Clérambault (1942) delineated a form of erotomania in which the patient holds a delusional belief that a man is in love with her. Capgras and Reboul-Lachaux (1923) described 'l'illusion des sosies', in which the patient believes that a person, usually closely related, has been replaced by an exact double. In 1973 Sims and White described a case in which these two syndromes coexisted and it was considered that they were descriptions of specific types of delusional content and not distinct diagnoses. A further case has now been observed in which these two conditions coexist.

Mrs J., aged 42, was admitted to the John Conolly Hospital, Birmingham, complaining of intermittent depression for the last two years, associated with marital disharmony, loss of libido and suicidal thoughts. She felt that people were watching her all the time, and she heard 'voices in my head', of people she knew. She would talk to these voices. She lived with her husband (a car assembly worker) and two teenage sons.

During treatment she was encouraged to attend a small psychotherapeutic group with a female doctor and a male charge nurse (B). The patient started to make amorous advances to B in the ward. She followed him about, declared that she loved him and that he loved her too, and asked him to have sexual intercourse with her. When she was asked about her behaviour she insisted that the man loved her, and that he was not a nurse but her husband, John Conolly. She referred to him sometimes as 'the man who is in love with me, John Conolly' and sometimes by his own first name (as was common in the hospital).

At this time she became distant and hostile in her attitude towards her husband during his visits, refusing to meet him. She believed that he was not her husband at all but merely posing as such, although she agreed that perceptually he was like her husband. Her evidence for this belief was obscure. 'He isn't my husband. Yes, he is like him, but he cannot be my husband as B is my husband.' Interestingly. Mr J. and B were not similar. Both the misidentification of

her husband and the belief that B was in love with her gradually became less prominent on treatment with trifluoperazine, and ten months later she was at home, well and without auditory hallucinations, or ascertainable delusions.

The distinctive features of the two syndromes were intricately, delusionally interwoven. The explanation given by the patient for the misidentification of her husband was that he could not be her husband as the victim of her erotomania was her husband. These two syndromes are not discrete entities but part of a more generalized psychotic process in which multiple misinterpretations occur, and the eponyms used are more significant historically than nosologically.

We are grateful to Dr J. C. Tibbits for permission to report this case.

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THE BATTERED HUSBAND

DEAR SIR,

In recent psychiatric literature from all over the world we read repeatedly about baby battering, wife battering, and even granny battering, but no one to my knowledge has touched upon the topic of the battered husband. Husband battering is not necessarily physical, and one tends to imagine that most cruelty to husbands is verbal, but I would like to draw attention to the fact that this is not always the case.

Within the last year, while working in psychiatric out-patient clinics and making many domiciliary visits, I have come across three instances of battered wives, and two of battered husbands. Of the battered wives, two were alcoholic, and the third guilty of marital infidelity. The wives of the men who claimed to have suffered physical cruelty had no similar complaints to make. One of these men went to the extent of making a serious suicide attempt as a result of his wife's physical cruelty to him. When I was visiting the other man in his home he begged me, having sent his wife out of the room on the pretext of fetching a glass of water, to take him into hospital, as he could no longer tolerate his wife's cruelty. He even had bruises to show me.

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