a mentally retarded man she met at a mental health clinic. She believed that she was secretly married to the rock star, David Bowie, after supposedly meeting in a church camp several years previously. She described seeing him "waiting for her" outside her hospital window. The onset of this delusion coincided with a local tour by Bowie.

Premorbid lifestyle featured an intense, infantilizing but covertly eroticized relationship with her father (a clergyman), and a distant and unrewarding attachment to her mother. She was raised in an overprotected environment, from which she escaped at an early age into the first of two ill-fated marriages, necessitated by an unplanned pregnancy.

She responded to anti-psychotic treatment by slowly and reluctantly relinquishing her delusions. The diagnosis was chronic paranoid schizophrenia with dependent personality traits.

The similarities in the delusions of these two female patients are noteworthy. Their delusions may be contemporary counterparts of De Clerambault's syndrome (paranoid erotomania), reflecting the high status popular musicians acquire in Western culture. These are celebrities with overt sexual symbolism, representing to each patient a fantasied wish-fulfillment of social and sexual success, in distinct contrast to the paucity of such rewarding experiences in their real lives.

Investigating the incidence and content of rock and roll delusions might be illuminating, and provide insights into the cultural determinants of psychotic symptomatology.

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FATE OF PSYCHOGERIATRIC PATIENTS

DEAR SIR,

I was interested to read the article by Drs Eagles and Gilliard (*Journal*, March, 1984, **144**, 314–6) describing the trends in the admissions to the Psycho-geriatric Assessment Unit at the Royal Victoria Hospital, Edinburgh from 1977–82. They point out that more of the patients are going on to long term hospital care and fewer are being discharged to either their own homes or to local authority Old Peoples' Homes.

I have looked at the sixty admissions in 1983 to psycho-geriatric beds at the Parc Hospital Bridgend for assessment from an area covering two of the industrial valleys in South Wales, with a population of 127,000 of whom 19,000 are over the age of sixty-five years. Eleven died, thirteen required long-stay psychiatric beds, and three were discharged to Old Peoples' Homes.

None of the patients were discharged to a long-stay geriatric bed. Just over half (33) of our patients were discharged home, more than in either of Dr Eagles' two groups; but our figures contain many cases where great pressure had to be put on reluctant relatives to accept the old people back from the hospital. However, like Dr Eagles we had only a few patients discharged to Old Peoples' Homes. The relevant local authority has specialized homes for the confused elderly but has no apparent plans to increase the number of places in its Old Peoples' Homes. Grundy & Arie (1982) pointed out that the number of places in the Old Peoples' Homes has failed to keep pace with the growth in the elderly population. If this trend continues, which seems likely particularly if the local authorities are forced to make reductions in their Social Services budgets, the psychiatric hospital will be asked to take even more demented people who require residential care.

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Reference

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MONOAMINES AND MADNESS

DEAR SIR,

With the development of biological psychiatry we have seen, in recent years, an immense investment of time and resources in the study of monoamines. This concentrated effort is justified because of the supposed malfunctioning of these systems in psychiatric illness. It is postulated that schizophrenia, depression, anxiety and other disorders are due to abnormalities within catecholamine or serotonergic systems. In fact the only consistent concrete evidence we have linking monoamines with biological brain dysfunction, is of a pharmacological type. Drugs useful in the treatment of depression and schizophrenia do alter monoamine systems. There is, however, little logic in assuming that a drug which produces a therapeutic effect must do so, by a direct action on the dysfunctional brain area.

Many research papers give one the impression that the brain contains a large majority of monoamine neurones. This is far from the truth, as the overall number of monoamine-containing neurones in the mammalian brain is probably considerably less than

1% (Ungerstedt, 1971). Many researchers counter this argument by pointing out that these systems are highly arborized and have a wide sphere of influence. That these neurones arborize widely is true, but their influence is probably no more widespread than that of cholinergic or other putative neurotransmitter systems (Aston-Jones *et al,* 1983).

Is it not reasonable to suggest that disorders of higher cognitive functioning such as schizophrenia, must primarily involve neurones at the highest cortical level? Yet at present we concentrate our energies on monoamine neurones in the medulla, pons and mesencephalon. Whatever the sphere of influence of these neurones there can be little doubt that they are relatively small in number and anatomically vary little from the rat to man.

Surely the time has come to look at these systems realistically and focus our attention on neurones at a higher level. In this regard psychiatrists are obviously dependent on advances in neurophysiology and neurochemistry. Whilst waiting for such advances, let us not delude ourselves into believing, we have found the root of madness.

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BRIEF PSYCHOTHERAPY IN FAMILY PRACTICE

DEAR SIR,

In response to Dr Williams' letter (*Journal,* January 1984, **143,** 101–2), the points made had indeed been covered in the original article (*Journal* 1983, **143,** 11–19), and we acknowledged the high probability of a type two error. The figures provided by Dr Williams are quite correct, but one would expect there to be a differential effect between treatment groups for a larger number of subjects to demonstrate an effect. In fact, a reverse trend was found in that the control group improved more than either of the treatment groups.

Secondly the problems of finding patients suitable for controlled therapeutic trials of psychotherapy were discussed, and Dr Williams has merely emphasised those issues. He goes on to point out that "The results of such a study are applicable to only seven per cent of those patients with significant psychiatric morbidity who present to general practitioners, and thus of limited relevance to the practical management of psychiatric disorder in general practice". What he appears to have failed to appreciate is that it is in fact only these patients with persistent psychiatric morbidity in whom we were interested. The vast majority of psychiatric disorders presented by patients in general practice remit (Johnstone & Goldberg, 1976). There were 128 patients who were persistently symptomatic for at least six months of whom 27 were allocated to the control group. Of the remaining 101 persistently psychologically symptomatic patients, 35 refused interview, 25 declined treatment and 12 dropped out of therapy leaving 36 patients who completed psychotherapy. A more realistic appraisal then is that 36 out of 101 patients with the type of disorder specified, persistent psychological morbidity for at least six months, might be suitable for dynamic psychotherapy.

We look forward with interest to the results of the studies by workers at the General Practice Research Unit with regards to social casework in the primary care setting as until now only anecdotal evidence of its efficacy exists.

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Reference

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MIANSERIN AND WARFARIN

DEAR SIR,

I refer to the letters of Warwick and Mindham (*Journal,* September, 1983, **143,** 308) and Ancill and Pinkerton (*Journal,* February, 1984, **144,** 213–4) concerning a case of concomitant administration of warfarin and mianserin which resulted in an abnormally high prothrombin time. I would like to report a case where such an interaction did not occur.

An otherwise healthy 53 year old female developed cardiac arrhythmias and pulmonary oedema while on tricyclic antidepressant therapy for a severe depressive phase of a manic-depressive psychosis (ICD 9, 296.1). On recovery she was stabilised on digoxin and anticoagulant therapy with warfarin 8 mgs. daily, a dose she has remained on since. A month after commencing warfarin she was prescribed mianserin on the grounds that it is non-cardiotoxic. She responded to a dose of mianserin built up to 120 mgs./day, but