am doubtful, however, about their proposed distinction between body image preoccupation, by which they say the therapist should not be 'distracted', and the underlying disturbance upon which he is encouraged to concentrate. It does not appear that their intervention supports this conclusion. Laufer & Laufer (1984) argue that adolescent breakdown is almost always linked with disturbance of the body image and that therapeutic approaches that neglect this aspect are likely to be ineffective. The key interpretation which turned this therapy round was the comment: "Which of your eyebrows do you find most repulsive?' Why was this unusual and creative comment so potently mutative? Was it the lightening of the burden of the patient's misery by humour? Did it enable the patient, by a form of desensitisation, to be less threatened by the feared object by encouraging perceptual discrimination? Was it an acknowledgement of the intensity of the patient's self-disgust by the use of the word 'repulsive'? Or was the 'other', singular, eyebrow to which the therapist tactfully and perhaps unconsciously drew attention not her pubic hair, thus linking her presenting problem with the underlying disturbance of her sexuality? In this counter-transferential comment, her male therapist offered a playful and tacit acceptance of her body to which she could respond and so make the move from mother to father that is such a vital part of adolescent development (Holmes, 1986).

Psychotherapists need to adjust their concepts and techniques to the particular stage of the 'seven ages' of the life cycle at which their patients find themselves. This girl was terrified by the prospect of a "lover/ sighing like a furnace, with a woeful ballad/ made to his mistress' eyebrow . . . ". When the therapist used an implicit metaphor to link the patients bodily distress *with* the 'underlying disturbance' she could begin to recover.

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ECT for Depression in Dementia

SIR: I was interested to read Liang *et al's* description of two women with depressive illness and dementia, whose depressive symptomatology responded to ECT (*Journal*, February 1988, **152**, 281–284). In a series of 122 patients treated with ECT at the University Hospital of South Manchester, 4% (5 patients) had depressive illnesses complicated by dementia (Benbow, 1987). Two patients did not respond to ECT, one had two courses during the study period and was well on completion of each, one improved, and the last recovered completely. Four of the five patients were discharged to live in their own homes in the community after treatment and the fifth (who had failed to respond) died following transfer to a medical ward.

There is a single case report in the literature of a man in his 50s with depression and Huntington's chorea who responded to ECT, which concludes that ECT is often useful in treating depression in the presence of dementia (Perry, 1983), as have other authors (Salzmann, 1982; Benbow, 1985). Unfortunately, the literature on cognitive changes in the demented treated with ECT is very limited. Most studies of ECT and memory exclude patients with organic brain disease. A recent paper describes the successful use of ECT for 12 of 14 people with post-stroke depressions (Murray *et al*, 1986).

There is no reason to withhold ECT from elderly people who have severe depressive illnesses, solely because they have an established dementing illness.

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Dangerous Delusions: Violence and the Misidentification Syndromes

SIR: De Pauw & Szulecka (*Journal*, January 1988, **152**, 91–96) describe several patients who manifested delusional misidentification and as a result either attacked their 'false' persecutors or threatened to do so, or were themselves assaulted as a direct result of acting on their beliefs. I agree with their observations, which appear to support my own. In a one-year period, of 8400 patient presentations to a

psychiatric emergency service, six patients manifested a Capgras delusion; four of these patients presented with the chief complaint of violence towards a family member (Fishbain, 1987). Only on inquiry as to the reason for the attack did the Capgras delusion become evident. Such observations indicate that unless specific inquiry is undertaken for a misidentification syndrome, the diagnosis could be missed, especially if the patient manifests additional delusional material. Violence or threatened violence towards family members is a relatively common psychotic presentation (Benezech *et al*, 1980). These findings and observations have led me to postulate the following: misidentification syndromes could be responsible for a much greater percentage of psychotic violent acts towards significant others and/or family members than once thought, but this diagnosis is routinely missed (Fishbain, 1987). I have therefore suggested that a chief complaint of violence towards a significant other and/or family member in a psychotic patient should alert the examining psychiatrist to the possibility of a misidentification syndrome.

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The Need to Compare the Effectiveness of Antidepressant Drugs: In Which Patient Populations?

SIR: The analysis of the present state of knowledge and its inherent limits in the field of antidepressant agents made by Garattini (*Journal*, January 1988, **152**, 140–141) is realistic and has important consequences. In this therapeutic area, old and new compounds can be satisfactorily described in terms of their pharmacological activities (more than in terms of their mechanisms of action), but our understanding of the clinical relevance of their properties as to their efficacy is nonexistent.

The *ex-juvantibus* approach utilised to try to understand and describe the biological basis of depressive disorders through psychopharmacology has favoured the growth of scientific knowledge, but seems now to have come to a standstill: at present, it seems highly unlikely that any abnormality of a single biochemical system possibly detected in this way could be related to a nosological entity (van Praag, 1986).

As we know, hypotheses can only be disproved, and we should search for differences; Dr Garattini suggests seeking differences by increasing the sample size of comparative clinical trials or by focusing on non-responders. On the other hand, differences within the patient populations studied as to their diagnostic classification, the clinical prerequisite (Ban, 1987), could be similarly important.

Acquisition of new knowledge in pharmacological research depends upon a process that "symmetrically relates diagnosis, treatment and outcome" (Joyce, 1986). The available diagnostic instruments have been shown to be able, at the most, to discriminate therapeutically more responsive patient populations from therapeutically less responsive ones, thus providing sufficiently homogeneous samples for establishing the efficacy of antidepressant drugs; the use of diagnostic instruments adequate to identify diagnostically distinct patient sub-populations would allow a more efficient detection of the differences between drugs. Identification and validation of more sensitive diagnostic approaches would provide reliable methods to collect the information needed for new and, perhaps, more productive efforts of pharmacological research. Proposals are already available (Ban, 1987).

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Barking mad

SIR: Recently I was asked to see an 86-year-old lady who had developed a paranoid illness for the first time following a prolonged hospital stay. Ward staff were bewildered by her occasional barking at night and, I am afraid, I was unable to enlighten them in relation to this matter. As the patient did have a delusional persecutory system, I suggested that she be started on thioridazine.