patients by those who know them well, and recent developments in the standardised assessment of traits as rated by informants gives hope that diagnostic reliability can be improved. Using the scale devised by Mann *et al* (1981), for example, Ballinger (1987) has recently shown acceptable inter-rater reliability in the rating of traits (including hysterical ones) for a sample of patients with mental handicap. As well as this, there is evidence to suggest that judgements about the central trait in the hysterical cluster – self-dramatisation – are not greatly influenced by the sex of the rater or by the sex of the patient (Slavney & Chase, 1985).

Thompson & Goldberg call our attention to important matters, but not to lost causes.

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SIR: Our conclusions are far from gloomy. We draw attention to a group of patients whose response to illness, whether physical or psychiatric, is characterised by difficult, demanding, and aggressive behaviours. Our findings should encourage clinicians to properly examine such patients for underlying illness and not attribute their behaviours and symptoms exclusively to personality disorder. We contend that the recognition of such underlying illnesses in patients affords a greater opportunity for effective treatment than would be the case if they were to be managed simply as 'personality disorders'.

We concede that our data reflects the clinical practices at Withington Hospital, but we have worked in a variety of hospitals in the UK and would describe the practices at Withington Hospital as similar and certainly no worse than those in other hospitals. One author (DG) has also worked in several hospitals in the United States and observes that the particular clinical practices there are comparable. In Slavney & McHugh's (1974) paper comparing hysterical personality disorder with control patients, the only criteria that referred to the mental state and significantly distinguished between the two groups were the items "dramatic" and "change of therapist". The latter suggests those same behaviours that characterised our index group. Core features such as provocativeness, seductiveness, and lability of mood were not significantly different.

The theme which we consider central is the relative role of illness and personality. The evidence suggests that personality traits may be exagerated by major stress, and that may include an underlying physical or psychiatric illness. The personality disorder simply colours (or sometimes clouds) the presentation as seen by the doctor. To say otherwise ignores evidence amassed from follow-up studies in a variety of hospitals, almost all of which demonstrate a high level of unrecognised illness at the index episode (Slater, 1965; Reed, 1975).

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Capgras' Syndrome in a Patient with Dementia

SIR: I describe a further patient (Kumar, *Journal*, February 1987, **150**, 251), with the additional feature of prominent visual hallucinations.

Case report: An 86-year-old man was referred with a six-month history of believing his wife was replaced by an imposter every afternoon – during which time his real wife (78 years old) was soliciting young men in local pubs. At the same time he regularly saw up to four young women in the house. He varied between being annoyed by their intrusion and being friendly towards them when he believed they had come to help with the house-work. On his wife's 'return' he would express anger at her behaviour. After some weeks he began making sexual demands of his wife, stating that he

was entitled to his 'share'. He was then distressed by his failure to achieve an erection. Since the couple's sex life has been in abeyance for years his wife made clear her fears for his physical health, which made him even angrier. He threatened her with a stick on a number of occasions. One night he tried to cut off her pyjamas with a pair of scissors, and this led to his referral.

His wife described a three-year gradual decline in memory. Premorbidly, he was said to be a self-contained suspicious man, particularly distrustful of women. There was no psychiatric history. Two months prior to the onset of this episode he suffered a chest infection during which he suspected his daughter of trying to poison him. These beliefs resolved completely following antibiotic treatment. On mental state examination, the features were delusional misidentification, delusions of jealousy, visual hallucinations, and impairment of short-term memory without impairment of consciousness. He had no insight, and expressed anger towards the "imposter". He was quite deaf, but otherwise physical examination was normal. Routine blood tests were normal. A diagnosis was made of a paranoid syndrome secondary to dementia, probably of Alzheimer type. He was treated with thioridazine, up to 100 mg/day, with resolution of the Capgras syndrome and visual hallucinations.

This patient is of interest for several reasons. Firstly, he illustrates Enoch's (1979) theory of ambivalence towards the loved object revealing itself in the Capgras syndrome, but differs in that the sexual demands followed the onset of the Capgras syndrome rather than that the rebuffed demands contributed to the development of the syndrome. One could speculate that a lesion in the right occipito-parietal area might result in both visual hallucinations and Capgras syndrome following the suggestion (Haymans & Abrams, 1977) that facial non-recognition causes the Capgras syndrome. However, I would agree with the observation (Weston & Whitlock, 1971) that the Capgras syndrome is the exact antithesis of facial non-recognition, there being no difficulty in the patient recognising the imposter as a replica of the person concerned. Sensory deprivation (Gluckman, 1968) has been mentioned as relevant; and this man's deafness, in conjunction with living close to a noisy girls' school, might be important aetiological factors.

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Trazodone-induced Mania

SIR: Knobler *et al* (*Journal*, December 1986, **149**, 787–789) report on three cases of trazodone-induced mania. Two of their patients had DSM–III mixed bipolar disorder, and the other had DSM–III recurrent major depression. I would like to report a case of trazodone-induced mania in a patient with a single episode of major depression.

Case report: A 58-year-old female widow met DSM–III criteria for major depression with melancholia (296.23) (single episode). She had suffered from depression for two years. Examination revealed depressed mood and affect, hopelessness, anhedonia, transient suicidal ideation, loss of energy and interests, loss of appetite and weight, and insomnia. She had no previous affective or other mental disorders. Her brother was a schizophrenic and committed suicide. Treatment (out-patient) with trazodone (50 mg t.i.d.) was started. In two or three days her mood was less depressed, and she felt better. But after one week of treatment, she became very talkative, quarrelsome, sleepless, hyperactive, and restless. She was spending money uncritically and frequently changed her clothes. She also thought that her grand-daughter had been poisoned by her son-in-law. She was admitted to hospital.

On admission she showed pressure of speech, psychomotor agitation, and mood-incongruent delusions. Trazodone was stopped, and treatment with haloperidol (1.5 mg t.i.d.) was started. After one day, her delusions completely disappeared and her mood was less elated. On the next day she was transferred to a general hospital because of paroxysmal tachycardia. There she was found to have hyperthyroidism and ischemic cardiomyopathy. She was seen after one month as an out-patient: her mood was stable and haloperidol treatment was stopped. After three weeks she was seen again, and she was in remission.

A causal connection between trazodone treatment and the manic state in this patient seems obvious. Her manic episode started only a week after trazodone was prescribed, and this was her first manic episode. She received trazodone without any other psychotropic medication. After the discontinuation of trazodone the manic episode remitted in less than ten days.

The mood-incongruent delusions in this patient are confusing. They were of short duration (about three days), but represent a difference between the patients described by Knobler *et al* and this patient. The patient's family history of schizophrenia may be relevant. The patient's hyperthyroidism could have