children who show the behavioural disorders but who have never had a fit.

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Delusional Infestation in Late Life

SIR: Renvoize *et al* (*Journal*, March 1987, **150**, 403–405) provide a useful review of the literature, including the German literature, in reporting their interesting patient whose delusions of infestation occurred during the course of a dementing illness. We have been interested to find that delusions of infestation are seen quite commonly among the patients referred to our psychiatric services for the elderly and we recently reviewed seven cases that presented between 1983 and 1986. There were two men and five women. Their ages ranged from 69 to 76 – a little above the boundary of 'late middle age', the age-group from which patients are most frequently reported, but not very old (patients aged 75 and above constitute about three quarters of our referrals).

All seven were found to be depressed. None were seriously demented, although in three there was clear evidence of some organic cerebral impairment and in only one could we be sure that there was no such pathology. In two patients the delusions of infestation developed in the context of guilt at not maintaining cleanliness in the home after the death of a spouse. In three, previous neurotic preoccupation with cleanliness or 'phobia' of 'creepy-crawlies' had become delusional in the setting of severe depression, and in the last two the delusion was part of a systematic belief that the body was changed and degenerating.

In most of our patients the delusions appeared when powerful change of affect occurred with mild organic change. This is a potent combination in the genesis of delusions (Hay *et al*, 1974). Successful treatment of the mood disorder has led to resolution of the delusions of infestation in the six cases we have known longest. Thus, in this age group delusions of infestation may be less persistent and pernicious than those of the monosymptomatic psychoses that are reported more commonly in younger middle-aged patients. The presence of some organic impairment should not detract from the treatability of the condition through an appreciation of the mood disorder.

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Reference

HAY, G. G., JOLLEY, D. J. & JONES, R. G. (1974) A case of the Capgras syndrome in association with pseudo-hypoparathyroidism. *Acta Psychiatrica Scandinavica*, **50**, 73–77.

Hysterical Personality Disorder

SIR: Thompson & Goldberg (*Journal*, February 1987, **150**, 241–245) question the validity, reliability, and utility of the diagnosis of hysterical personality disorder. Though such issues are properly raised about a vexing construct, I believe the authors' gloomy conclusions may not be wholly warranted.

Based on a retrospective review of case notes, Thompson & Goldberg observe that the diagnosis "is frequently made without the core features being present". Their finding may tell us less about the construct, hysterical personality disorder, than it does about diagnostic practice and documentation at Withington Hospital in 1975. Had the authors tabulated the "core features" present in the case notes of patients with another diagnosis we would be better able to judge where the problem lay.

This matter is of considerable importance because the authors fear that the diagnosis of hysterical personality disorder may be used "to label those patients who are perceived as hostile, difficult, and uncooperative, with the result that the doctor is distracted from recognising an underlying diagnosis". Prominent among such proposed underlying conditions is 'primary affective disorder', which the authors claim that McHugh and I found (Slavney & McHugh, 1974) in a sample of patients with the diagnosis of hysterical personality disorder. I feel constrained to point out that what we noted was not 'primary' affective disorder, but rather the frequent occurrence of depressed mood and self-injury, phenomena which we interpreted as the responses of self-dramatising and emotionally labile people to stressful circumstances (i.e. as 'secondary' to events such as romantic disappointment). What was 'underlying', then, was the personality disorder, the recognition of which a psychiatrist should not be distracted from by the presence of affective symptoms. The validation of the trait of self-dramatisation has yet to be accomplished, but there is some support (Slavney & Rich, 1980) for the existence of emotional lability as an actual attribute of patients who receive the diagnosis of hysterical personality disorder.

Finally, the authors observed low inter-rater reliability in the assessment of hysterical traits based on brief videotaped interviews. The diagnosis of personality disorders in the clinical setting, however, depends to a great extent on the description of