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Correspondence

Letters for publication in the Correspondence columns should not ordinarily be more than 500 words and should be addressed to:
The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

SELF-INJURY IN THE SEVERELY DEFECTIVE

DEAR SIR,

Most mental deficiency hospitals have a few patients who habitually hit, bite, scratch or otherwise injure themselves and for whom satisfactory treatment is exceedingly difficult. Aversion therapy with electric shocks has been tried, but there are difficult ethical considerations in using this form of treatment.

We have recently had significant improvement in some of these patients by treating them with Baclofen, a drug which is a chlorophenyl derivative of the neurotransmitter GABA. The first change noted has been one of mood, when the patients are observed to be quieter and happier. Subsequently there has been a diminution in the amount of self-injury. Dosage has usually had to be increased, and in some improvement has now been maintained for more than a month. A few patients have not shown any improvement.

Some of the patients having treatment are known epileptics. The only possible side-effect so far noted has been enuresis in a youth who had previously been toilet-trained.

It will take a prolonged trial to assess this form of treatment, but the results so far seem to justify a preliminary report.

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AN OPEN LETTER ON WARD ROUNDS

DEAR SIR,

I was glad to see 'An Ex-Patient's' letter in your correspondence column (*Journal*, January 1978, **132**, 111). Just such a protest was badly needed. My out-patient work nowadays brings me only tangentially in contact with those in-patient situations, and as an onlooker I have been astonished at this—as it seems to me—uncomprehending, even unfeeling practice.

Psychiatric patients, by and large, are more sensitive to invasion of privacy than is the average person. Psychotherapy and, one would hope, other forms of psychiatric treatment pay tribute to the individuality of the person, and to the privileged position of communication between patient and doctor and within the therapeutic group. If those meetings, where less involved members of the Staff also attend, are considered necessary for teaching purposes, this ought to be discussed with patients beforehand, and their consent obtained.

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CAPGRAS' SYNDROME AND PROSOPAGNOSIA

DEAR SIR,

Drs Hayman and Abrams, in their stimulating article (*Journal*, January 1977, **130**, 68–71), have suggested that 'prosopagnosia (face non-recognition) may be the primary expression of a specific cerebral dysfunction which forms the basis for a delusional elaboration resulting in Capgras' syndrome'. We too have considered the possibility of contribution of a prosopagnostic mechanism in the pathogenesis of some other kinds of delusional misidentifications (3). We investigated eleven patients with delusional misidentifications (seven with Capgras' syndrome, three with the syndrome of Frégoli and one with the syndrome of subjective doubles) for prosopagnosia. The patients were matched for age, sex and educational level to a group of healthy controls, and for age, sex, educational level and basic illness to a group of psychotic patients. The test for prosopagnosia by Tzavaras *et al* (4) was utilized. The patients with delusional misidentifications took a longer time to accomplish the test in comparison to the healthy controls ($P < 0.01$) but not in comparison to the psychotic controls. With respect to the number of errors, the performance of the patients was (surprisingly) better than that of the psychotic controls ($P < 0.01$) and did not differ from that of the