strual exacerbation of symptoms occurring at other times may indicate a premenstrual component. Dr Dalton insists that these women are not premenstrual sufferers but it is not at all clear on what grounds, clinical, hormonal or therapeutic, she advances this distinction. She must surely know too that symptom ratings in the various cycle ratings repeatedly show high and significant correlations from phase to phase, (Moos, 1969; Halbreich and Kas, 1977; Taylor, 1979). There are significant correlations too between ratings of dysmenorrhoea and premenstrual affective symptoms, premenstrual somatic symptoms and premenstrual pain.

Dr Dalton herself is clearly aware of the difficulty, for elsewhere she has drawn our attention to those 'unlucky sufferers' whose symptoms 'start at ovulation, increase in severity during the premenstruum and resolve gradually during menstruation leaving only a few days in which good health is enjoyed' (Dalton, 1975). Indeed, one of the earliest papers on the subject, by herself and Dr Raymond Greene, (Greene and Dalton, 1953), so defined the syndrome as to include just such cases. Reproving Dr Sampson for using a definition which Dr Dalton herself provided over 20 years ago seems, if I may be permitted an indelicacy, a little below the belt.

However, Dr Dalton does raise an interesting point when she doubts the wisdom of equating reporting with complaining. She is right to be cautious. A recent study of over 500 women attending GPs found that 95 per cent reported some kind of somatic, affective or behavioural change premenstrually (Clare, in preparation). Such changes appear ubiquitous and merely eliciting their presence tells us nothing. Nor, however, can one simply rely on the fact that women present for treatment, without knowing more than is usually provided about how they come to identify themselves as 'ill' and how they differ, if they do differ, from women who do not come forward.

My one reservation concerning Dr Sampson's work relates to her use of sine curves in analysing the data from the diaries. Such a method presupposes a symmetry within the menstrual cycle such that the portion of the cycle in which the woman scores highly on individual symptoms is equal to the portion of the cycle in which she scores low, which is not necessarily so. It also presupposes a dip in symptom scores with a minimum score at some point in the cycle. A more appropriate approach, and one that fits the reality of symptom variation throughout the premenstrual sufferer's cycle, involves fitting polynomials to the scores obtained on individual symptoms or factors and examining for significance of the resulting fit using the F-test, as in fitting a regression line.

I doubt, however, if my reservation affects Dr Sampson's overall result. Dr Dalton may insist that 'progesterone is the specific treatment for premenstrual syndrome' but the fact remains that in the twenty years since this claim was first made, not a single properly controlled trial has shown it to be significantly superior to placebo nor to the many other treatments, such as pyridoxine, diuretics, monoamine oxidase inhibitors and bromocriptine, on whose behalf others argue as enthusiastically as Dr Dalton argues for progesterone.

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PSYCHIATRIC DISTURBANCE IN MENTALLY HANDICAPPED PATIENTS

DEAR SIR,

There are considerable objections to the study described by Craft and Schiff (*Journal*, September 1980, **137**, 250–5) of fluphenazine in mentally handicapped hospital patients.

Firstly, the 'behavioural disturbance ratings' described amount to no more than ordinary scales peculiar to each clinician and patient. Their summation, and the use of parametric statistics in their interpretation, is spurious, even had they been shown to be reliable (which they were not).

Secondly, it emerges that about 22 per cent of the original group of patients did not complete the study. The possibility that the 'behavioural disturbance rating' improvement of the whole group can be accounted for by the progressive removal of those with the highest 'scores' is not attended to.

Thirdly, and most seriously, the authors' abandonment of the traditional methods of attempting to minimize sources of bias in drug studies (double-blind methodology and the use of control groups) cannot be justified in the context of so complex and difficult a problem as mental handicap. They imply that this is the unfortunate result of the clinicians' inability to resolve ethical problems about the use of inert injections, but that this deficiency was unlikely to have affected the outcome because the clinicians were 'largely undecided, and occasionally sceptical'! By this intellectual décolletage, the authors expose exactly why control groups are used in drug studies, and why little credence of the type sought by the authors can be given to results obtained without stringent methodology.

It would appear, then, that the only piece of useful knowledge to emerge from this large study is that there were no deaths due to hyperpyrexia in a sample of 80 mentally handicapped patients given fluphenazine decanoate over twelve weeks.

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Book Reviews

Obesity. The Regulation of Weight. By PAULINE S. POWERS. Baltimore, Maryland: Williams and Wilkins. 1980. Pp 427. $31.25.

The aim of this book is to provide "a basic core of information about what is known and is not known about the etiology, effects, treatment and prevention of obesity" which the author regards as "a national problem that is reaching epidemic proportions". I believe that Dr Powers has achieved this aim and would thoroughly recommend this book to anyone who wants a comprehensive, accurate and fair summary of recent research in the obesity field.

Dr Powers has obviously read widely and gives about 50 original references at the end of her fourteen chapters. It is pleasing to note that these are international references of recent vintage (1978 being the most recent). The book is well illustrated with carefully chosen summary charts and diagrams which are always appreciated in this type of review.

There are two particular aspects of Dr Power's book which impress me because they are aspects which are frequently poor in other books on obesity. First, areas of controversial research are always covered fully and both sides of any argument are presented fairly. Secondly, animal experiments are referred to when appropriate, but priority is always given to studies in man. In the author's own words "animal models may well provide an initial understanding of basic biochemical and organic factors in human obesity, but elucidation of critical emotional, cognitive, and social factors which influence the onset and maintenance of obesity will require carefully designed studies of man".

Psychiatrists will not only find the excellent chapters on 'Psychiatric Considerations in Obesity' and 'Psychological Treatment Modalities' particularly illuminating, but they will also be grateful to Dr Powers for reproducing, as appendices, several useful questionnaires including one on 'Nutrition History' and one on 'Food Management'.

Perhaps the only strange thing about the book is its title—I have always considered obesity to represent the *non*-regulation of weight!

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Principles of Clinical Psychiatry. By ARNOLD M. LUDWIG. New York: The Free Press. 1980. Pp 438. $22.95.

There is a mind that loves lists, diagrams, models systems, acronyms and mnemonics. Here is a book on clinical psychiatry to attract it. What some would call psychoneurosis becomes A.P.O.D. complex disorder: that is, anxiety, phobia, obsession and depression. We are commended to remember the features of O-R-G-A-N-I-C memory impairment as orientation impaired, retrograde amnesia, gradient of learning impaired, anterograde amnesia, nonspecific for emotional events, inaccessible memories and confabulation. Idiosyncratic, if neat. However the many diagrams often clarify and the trainee will find useful concepts on which to hang his teaching. Dr Ludwig is confident and logical if overfond of the dependent abstract, (situation, basis, aspect, sphere). The text covers consulting room psychiatry comprehensively