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Authors' reply: Dr Cantor seems to have misconstrued the intended scope and content of our editorial. We did not set out to comment upon national suicide prevention strategies but, as the title suggested, we sought to discuss the role of psychiatrists specifically in attempting to prevent suicide among the patients we treat. We agree wholeheartedly that any strategy that focused exclusively on psychiatrists as the agents of suicide prevention would be absurd. Indeed, this was one of the main points we were trying to make.

Dr Cantor thinks that our ignorance of the epidemiological data makes us state that "all of our patients are at increased risk of suicide". This is in fact an epidemiological statement, which he interprets concretely. The fact that the lifetime risk of suicide among people with recurrent depression has been adjusted downwards actually renders statistical prediction of a rare event even more difficult. Largely for this reason we cannot predict which of our patients will commit suicide or when they might do so, and thus we must regard the entire cohort of patients we see as collectively at increased risk of dying by suicide and view their clinical management accordingly.

We take issue that it is "self-indulgent" to suggest that psychiatrists find the suicide of their patients to be traumatic. We know this to be the case from our survey in Scotland (Alexander *et al*, 2000) and from other, more qualitative accounts (Hendin *et al*, 2000). While valid comparisons among professional groups are difficult to make accurately, we in Aberdeen are more than a little interested in the impact of 'critical incidents' on colleagues in the caring and emergency services (e.g. Alexander, 1993; Alexander & Klein, 2001). One crucial difference between psychiatrists on the one hand and other doctors and other professionals on the other is the issue of blame. While, as we try to point out, it is often illogical for psychiatrists to take responsibility for the suicide of our patients, we frequently do, and this distinguishes it from the deaths that other professionals encounter. Finally, presumably we would wish our patients (and their families) to feel cared for and understood. Surely, as professionals in psychiatric services, we should accord the same opportunities to each other.

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Psychiatric training in developing countries

Jacob (2001) successfully highlights the problems of community care of people with mental disorders in developing countries. Both he and the *Journal* are to be commended for addressing the mental health issues of the vast populations of such countries, a topic generally overlooked in the literature. The author is right to point out that most programmes have failed to deliver and that the success of local model projects has not been repeated at a national level. From personal experience as both a trainee and a trainer and from discussion with colleagues in a similar situation, I believe the most important reason for this is the inappropriate training of psychiatrists in developing countries.

The suitability of the training in developed countries for psychiatrists who will ultimately work in developing countries is increasingly being questioned (Mubbashar & Humayun, 1999), but questions have rarely been asked about the training in their own countries. Unfortunately, the training in most developing countries is still based on models of psychiatric services and theories derived from developed nations. An obvious example is the concept of community psychiatry. This concept and its enactment, derived from the history of modern Western psychiatry, cannot be applied in developing countries (Farooq & Minhas, 2001). Young psychiatrists from developing nations who trained in this model of community psychiatry will find the realities of psychiatric services in their own countries totally different from what they have learnt in training.

Moreover, the training in many developing countries remains narrowly focused on acquiring clinical skills. This is despite the fact that a World Health Organization expert committee recommended long ago that trained mental health professionals should devote "only part of their working hours" to the clinical care of patients (World Health Organization, 1975). As Jacob points out, the realities of mental health care in the community in developing countries demand that training is broad-based and equips the psychiatrist to work effectively with other disciplines, particularly primary care. This, however, is rarely the case in many developing countries.

The training of psychiatrists in developing countries needs a total paradigm shift to address the problems raised by Jacob. Both the mental health professionals and the policy makers need to address this as a priority. If they do not, most of the mental health initiatives in these countries will fail.

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Vascular risk factors for stroke and depression

Stewart *et al* (2001) present an important study of the association between the vascular risk factors for stroke and depression. Although the non-participation rates and levels of physical morbidity were high in the sample, they did not find any association between risk factors for vascular disease and level of depression in the older

https://doi.org/10.1192/bjp.179.5.464-a Published online by Cambridge University Press

adult population (aged 55–75 years) studied. We have prospectively studied 45 stroke patients (aged 26 to 65 years) for psychiatric morbidity. The most common disorder was depression (in 78% of the patients), followed by generalised disorder (in 17%). Younger age, physical disability (resulting in occupational and social dysfunction) and past history of stroke were strongly correlated with depression. Vascular disease has been found to be associated with a more prolonged duration of depression (Hickie & Scott, 1998), but in our sample 52% of the patients with depression recovered within 3–6 months of treatment. However, two patients who were unemployed when they were disabled by stroke did have depression of prolonged duration. Uncontrolled hypertension (moderate to severe) was associated with the presence of generalised anxiety disorder. The role of medication (especially beta-blockers, calcium channel blockers and sedatives) in producing depression is an important variable and could not be ruled out in six patients. Although laterality of brain lesion (i.e. left hemispheric lesion) and risk of depression have been reported (Robinson & Price, 1982), the subject remains controversial and we did not find any such association. A detailed prospective study on a larger sample of patients from all age groups and different socio-demographic backgrounds is needed to establish the association of depression with various demographic and vascular risk factors for stroke.

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Somatoform disorders: a topic for education

Bass *et al* (2001) believe that somatoform disorders are ignored by psychiatrists and health service planners because of the nature of diagnostic practice, a current preoccupation with only "serious mental illness", limited experience of patients with medically unexplained symptoms in general hospital settings, and stigma. They do not mention whether they have found an increasing fear of litigation to be another contributing factor. Currently, it appears to play a part in delaying referral to psychological services while the patient is exhaustively investigated for any physical pathology. Any comment they might make regarding this practice would be of interest.

Certainly, as they mention, a lack of training of non-psychiatric practitioners in this area contributes greatly to non-referral within the general hospital setting. We would, however, dispute their comment that psychiatrists working in this area find that patients with somatoform disorders "comprise between one-third and one-half of all referrals to the liaison psychiatry service". A review carried out several years ago of the nature of referrals to the consultation–liaison services of two general hospitals in Dublin City (Cullivan *et al*, 1997) suggests a much smaller number of such referrals. Over a 6-month period 491 patients were referred and patients with diagnoses falling into categories F40–F48 of ICD–10 (neurotic, stress-related and somatoform disorders) accounted for only 12% of referrals in one hospital and 15% in the other. As a significant number of the patients in these categories were suffering from adjustment disorders, the numbers diagnosed with somatoform disorders, formed an even smaller percentage of all referrals.

It is worth noting that these were the diagnostic categories provided by the psychiatrists who assessed these patients. The reason for the referrals given by the medical/surgical teams was "no organic cause for symptoms found" in just 1.7% of cases in one hospital and 10.2% in the other. Perhaps somatoform disorders are even more neglected than previously thought? Education of both psychiatric and non-psychiatric personnel regarding these disorders would appear to be in need of urgent review.

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We read with interest Bass *et al*'s (2001) review on somatoform disorders. Although the authors usefully pointed out that these disorders are common and cause severe disability, we were dismayed to find that, ironically, they neglected to mention one of the more common somatoform disorders: body dysmorphic disorder (BDD; also known as dysmorphophobia). A distressing or impairing preoccupation with an imagined or slight defect in appearance, BDD has reported rates in the community of 0.7–2.3% (Phillips, 2001). People with this disorder commonly present to psychiatrists, dermatologists, cosmetic surgeons and other physicians (Phillips & Castle, 2001).

Body dysmorphic disorder causes severe distress and marked impairment in functioning (Veale *et al*, 1996; Phillips, 2001). A high proportion of patients require hospitalisation, become housebound and/or attempt suicide. Completed suicide has been reported in both psychiatric and dermatology settings. Mental-health-related quality of life is poorer than that reported for patients with depression, obsessive–compulsive disorder and a variety of physical illnesses, including recent myocardial infarction and type II diabetes.

Like the other somatoform disorders, BDD is often neglected by psychiatrists. The diagnosis is usually missed in mental health settings (Phillips & Castle, 2001). This is unfortunate, because a majority of these patients request and receive non-psychiatric treatments, such as dermatological treatment and surgery, which are usually ineffective. Many patients consult numerous physicians, request extensive work-ups, and pressure dermatologists and surgeons to provide unsuitable and ineffective remedies. Some patients, in desperation, even perform their own surgery. As one dermatologist stated, "The author knows of no more difficult patients to treat than those with body dysmorphic disorder" (Cotterill, 1996).

The good news is that emerging data indicate that a majority of these patients can be successfully treated with selective serotonin reuptake inhibitors or cognitive–behavioural therapy (Phillips, 2001). It is important that psychiatrists and other physicians screen patients for this disorder so that effective treatment can be provided. Body dysmorphic disorder is a severe psychiatric illness that we cannot afford to neglect.

Bass, C., Peveler, R. & House, A. (2001) Somatoform disorders: severe psychiatric illnesses neglected by psychiatrists. *British Journal of Psychiatry*, **179**, 11–14.

https://doi.org/10.1192/bjp.179.5.464-a Published online by Cambridge University Press