personality disorder and primary major depressive illness. Our patients were carefully and reliably diagnosed by traditional clinical methods as well as by structured diagnostic schedules at baseline and at follow-up.

We perceive their final suggestion that Irish panic-disordered patients are somehow ethnically anancastic as a racist joke in poor taste.

Finally, we note that our data on Axis I comorbidity are consistent with the arguments for a general vulnerability factor in the aetiology of panic disorder, so ably rehearsed by Andrews (1996): he showed that patients themselves discriminate between primary disorder (e.g. panic disorder) and secondary or derivative disorders (e.g. depression, substance abuse, etc.), which may complicate the long-term course of the primary illness. This return to clinical common sense may clarify the reasons why 'different' Axis I disorders have appeared in recent surveys to cluster together in individual patients.

Andrews, G. (1996) Comorbidity and the general neurotic syndrome. *British Journal of Psychiatry*, **168** (suppl. 30), 76–84.

Argyle, N. & Roth, M. (1990) The phenomenological study of 90 patients with panic disorder. *Psychiatric Developments*, **7**, 187–209.

Fahy, T. J., O'Rourke, D., Brophy, J., *et al* (1992) The Galway study of panic disorder. I: Clomipramine and lofepramine in DSM–III–R panic disorder: A placebo controlled trial. *Journal of Affective Disorders*, **25**, 63–76.

O'Rourke, D., Fahy, T. J., Brophy, J., *et al* (1996) The Galway study of panic disorder. III: Outcome at 5 to 6 years. *British Journal of Psychiatry*, **168**, 462–469.

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Body dysmorphic disorder

Sir: We read with interest the paper by Veale *et al* (1996) on body dysmorphic disorder. In the field of orthodontics and maxillofacial surgery we also encounter a number of patients suffering from body dysmorphic disorder. In contrast to Veale *et al* we have not found a higher proportion of female patients to be affected. Phillips (1991) stated that the ratio of women to men in reported cases was approximately 1.3:1, and in a later paper (Phillips *et al*, 1994) this ratio was quoted as approximately 1:1. A study in Japan by Fukuda (1977) found 62% of affected patients were male, although this may reflect ethnic variations.

It would appear that the large female component in the study by Veale *et al* is almost certainly due to the self-referral pattern, with females having higher figures for self-referral and consulting doctors generally. This ratio may also be heavily influenced by the authors having advertised in a women's magazine (*Cosmopolitan*).

Fukuda, O. (1977) Statistical analysis of dysmorphophobia in out-patient clinic. *Japanese Journal of Plastic and Reconstructive Surgery*, **20**, 569–577.

Phillips, K. A. (1991) Body dysmorphic disorder: The distress of imagined ugliness. *American Journal of Psychiatry*, **148**, 1138–1149.

—, McElroy, S. L., Keck, P. E., *et al* (1994) A comparison of delusional and nondelusional body dysmorphic disorder in 100 cases. *Psychopharmocology Bulletin*, **30**, 179–186.

Veale, D., Boocock, A., Gournay, K., *et al* (1996) Body dysmorphic disorder. A survey of fifty cases. *British Journal of Psychiatry*, **169**, 196–201.

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Steroid-induced prepartum psychosis

Sir: We were interested to read Johnson's letter (1996) on steroid-induced prepartum psychosis. We have encountered two similar patients.

A 25-year-old primigravida was treated with dexamethasone at 31 weeks' gestation, because of intrauterine growth retardation of one twin, necessitating very early delivery. She promptly developed delusional mania. One week later she gave birth to twins, one of whom proved to have Down syndrome. Her illness continued into the puerperium.

A 29-year-old primigravida, with insulin-dependent diabetes, was delivered by caesarian section at 36 weeks' gestation. She developed laryngeal spasm and was thought to have angioneurotic oedema as a reaction to the anaesthetic. She was given dexamethasone and developed a delusional psychosis within 36 hours of the birth.

Johnson kindly refers to previous Birmingham work on the association of prepartum and puerperal psychosis, but we were not the first to report it: there are at least seven earlier reports making (with Johnson's case) 15 in all – quite a strong association. There are also several other reports of puerperal and steroid-induced psychoses occurring in the same women (five in all). Johnson may be right in suggesting that adrenal steroids *predispose* to postpartum psychosis. Another view is that late pregnancy, the puerperium and exposure to excessive adrenal steroids are independent triggers of manic–depressive psychosis, i.e. the predisposition is inborn. The association of pregnancy-related and steroid-induced psychosis could be a clue to their shared aetiology, because progesterone is a precursor of adrenal steroids as well as oestrogen.

Johnson, I. (1996) Steroid-induced prepartum psychosis (letter). *British Journal of Psychiatry*, **169**, 522.

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In-patient psychotherapy

Sir: We write in support of in-patient psychotherapy units (Norton & Hinshelwood, 1996). Although Haigh & Stegen (1996) are right to point out that day units provide an important service, there will always be patients desperately in need of psychotherapy who can only be contained in in-patient settings.

At Francis Dixon Lodge the majority of patients are admitted directly from general psychiatry wards, many of them having recently been detained under the Mental Health Act. They often exhibit active suicidal behaviour, on-going serious self-harm, and are on a variety of neuroleptics, antidepressants, mood stabilisers and benzodiazepines when first admitted. By providing 24 hour support, in an environment where a crisis meeting can be called at any hour of the day or night, massive levels of anxiety can be more contained, and residents gradually encouraged to find more constructive ways of coping with distress.

The day unit Haigh & Stegen describe has very different admission criteria: patients have to stop psychotropic medication; survive out of hospital for three months; and self-harm is a dischargeable offence. It is unlikely, therefore, that they are talking about the same clinical population as Norton & Hinshelwood (1996) or Francis Dixon Lodge.

It is ironic that at a time when services for the mentally ill are being prioritised that psychotherapy is being pushed in the opposite direction. There is enormous pressure to offer brief therapies and see as many patients as quickly as possible. In many areas there is nothing for the patient with personality disorder between brief therapies and secure units for severe forensic cases.