This timely publication may help to remind psychiatrists of the limitations of any approach to the understanding and treatment of psychotic disorders that ignores the inner life and psychodynamics of the individual. It may also remind psychoanalysts and psychoanalytic psychotherapists working in the health service of the urgency of the need to find ways to increase their input to the treatment of psychotic patients, and to improve cooperation with those of their colleagues who adopt a more exclusively biological approach to the task at the expense of psychodynamics.

HANSEN, J. B. (ed.) (1993) *Crossing the Borders: Psychotherapy of Schizophrenia*. Ludvika, Sweden: Dualis Forlag.

MURRAY JACKSON

le Pous
St Andre de Roquepertuis
30630 France

Long-term antidepressant treatment in the elderly

SIR: The Old Age Depression Interest Group (OADIG) (*Journal*, February 1993, **162,** 175–182) reported the results of their important study of continuation and maintenance of antidepressant treatment in depressed elderly subjects. Compared to placebo, dothiepin reduced the risk of a recurrence of depression by two-and-a-half times during the two-year study. The authors concluded that "elderly patients who recover from a major depressive illness should continue with antidepressant medication for at least two years". While most clinicians would agree with this recommendation for patients with recurrent depression, it is more controversial for the elderly patient with a first episode of depression. Indeed, the recently published NIH Consensus Development conference statement on the diagnosis and treatment of depression in late life recommends only six months of treatment after remission from a first episode of major depression in old age (NIH Consensus Development Panel, 1992).

Sixty per cent of patients in the OADIG study were experiencing their first depressive episode. The authors found that age at first onset of affective disorder did not predict outcome. However, they did not specifically report on the rate of recurrence in the group of patients suffering their first depression. This piece of information would be of particular interest and value. There is evidence from other studies that elderly persons with a first episode of depression are at the same risk of recurrence, within two years of the index episode, as those with recurrent depression (Flint, 1992). A similar finding from the OADIG study would further support the contention that *all* patients over the age of 60 years with major depression should continue with treatment for a minimum of two years following recovery.

FLINT, A. J. (1992) The optimum duration of antidepressant treatment in the elderly. *International Journal of Geriatric Psychiatry*, **7**, 617–619.

NIH CONSENSUS DEVELOPMENT PANEL (1992) Diagnosis and treatment of depression in late life. *Journal of the American Medical Association*, **268**, 1018–1024.

ALASTAIR FLINT

Department of Psychiatry
Toronto General Hospital
Toronto, Canada M5G 2C4

Child psychiatric syndromes with a somatic presentation

SIR: Garralda's useful review (*Journal*, December 1992, **161,** 759–773) missed one important series of papers in the literature on conversion disorder. Seltzer's papers in *Family Systems Medicine* (Seltzer, 1985*a*,*b*) give detailed accounts of the family and cultural background of such patients with a conversion disorder, and offers some helpful therapeutic advice. Nowhere else have I seen a discussion of the personality and environment of childrens' hysteria in such depth, and I recommend these papers to your readers.

SELTZER, W. J. (1985*a*) Conversion disorder in childhood and adolescence: a familial/cultural approach, part I. *Family Systems Medicine*, **3**, 261–280.

— (1985*b*) Conversion disorder in childhood and adolescence, part II. Therapeutic issues. *Family Systems Medicine*, **3**, 397–416.

SEBASTIAN KRAEMER

Child and Family Psychiatric Service
The Whittington Hospital
Highgate Hill
London N19 5NF

Distribution of adipose tissue in patients receiving psychotropic drugs

SIR: Stedman & Welham (*Journal*, February 1993, **162,** 249–250) investigated the problem of obesity in long-term female in-patients on psychotropic medication. They found similar levels of obesity to those reported in other studies. Within this context they demonstrated a previously unrecognised problem with central obesity, and they argue for the importance of this finding.

Unfortunately, the information regarding current neuroleptic medication was not helpful as the authors failed to supply the formula for conversion to chlorpromazine equivalents. Of the formulae in common use, there is reasonable agreement on the relative potencies of the oral neuroleptics, except for haloperidol. There are, however, large discrepancies between their recommendations for depot neuroleptics (Foster, 1989). The advantage of expressing the current medication in mean chlorpromazine equivalents is that some comparison can be made between clinical practices. The disadvantage is that, without additional information, such a cross-sectional measure has limited value in identifying patients at risk of developing obesity (Silverstone *et al*, *Journal*, August 1988, **153,** 214–217), which is a medium to long-term complication.

FOSTER, P. (1989) Neuroleptic equivalence. *Pharmaceutical Journal*, 30 September, 431–432.

JUSTIN HAY

The Stonebridge Research Centre
Cardiff Street
Carlton Road
Nottingham NG3 2FH

Parental bonding

SIR: Dr Birtchnell's inference (*Journal*, March 1993, **162,** 335–344) that a poor early relationship with parents may extend into adult life cannot be supported by the data presented. To use a single measure from an already reductionistic and simple questionnaire (Parker, 1990) does not allow a generalisation to the total parental relationship. Greater support for Bowlby's hypothesis may have been offered if both dimensions of the Parental Bonding Instrument, that is care and overprotection, were used and if subjects were assigned quadrants of bonding (Parker, 1989). A comparable three-dimensional model of current relationships has already been well described in this population (Birtchnell, *Journal*, May 1991, **158,** 648–657).

PARKER, G. (1989) The parental bonding instrument: psychometric properties reviewed. *Psychiatric Developments*, **4,** 317–335.
— (1990) The parental bonding instrument. A decade of research. *Social Psychiatry and Psychiatric Epidemiology*, **25,** 281–282.

T. MORRIS

Ashworth Hospital North
Park Lane
Maghull
Liverpool L31 1HW

The influence of ethnicity and family structure on relapse in first-episode schizophrenia

SIR: We read with great interest the article by Birchwood *et al* (*Journal*, December 1992, **161,** 783–790) on family support systems within different ethnic populations. In a retrospective study, that we are currently undertaking, on patients of Asian background (i.e. immigrants from south-east Asia) we found a lower recidivism rate of readmission in the Asian patients, compared with a matched Caucasian sample. This is similar to Birchwood *et al*'s findings.

An interesting finding in our study was that 47% of the Asian sample were on depot antipsychotics. A lower relapse rate was noted among Asian immigrants who were on depot antipsychotics, who had follow up from doctors and mental health workers of the same or similar ethnic backgrounds, and who had a strong family support system. These factors also contributed to better patient compliance with oral medications.

We concur with the conclusion by Birchwood *et al* with regard to language factors and diagnostic caution. Of the 30 patients in our sample, 15 had a poor command, or no knowledge of English. The frequency of a diagnosis of schizophrenia in these 15 patients was over 60%. We feel that language factors in assessing these patients could have affected diagnostic validity. We agree that prospective studies and comparisons with samples from the country of origin would contribute to a better understanding of mental illness within an immigrant population.

HARI N. GARBHARRAN
TERRY ZIBIN

Alberta Hospital Ponoka
Box 1000
Ponoka, Alberta T4J 1R6

Tattooed female psychiatric patients

AUTHORS' REPLY: We read with interest the response to our letter (Inch & Huws, *Journal*, January 1993, **162,** 128–129). Sexual abuse in childhood has been shown to be positively correlated with symptoms and diagnosis of borderline personality disorder (Sheldon, *Journal*, January 1988, **152,** 107–111), and there is a recognised association between tattoos and borderline personality disorder (Virkunen, 1976). This could suggest a correlation between childhood sexual abuse and tattoos.

We agree with the comment that on the basis of our four cases it is not possible at present to substantiate this hypothesis, and further work with a larger number of tattooed females with different psychiatric diagnoses should be undertaken. We feel that if