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.

Haigh, R. & Stegen, G. (1996) In-patient psychotherapy (letter). *British Journal of Psychiatry*, **169**, 524.

Norton, K. & Hinshelwood, R. D. (1996) Severe personality disorder: Treatment issues and selection for in-patient psychotherapy. *British Journal of Psychiatry*, **168**, 723–731.

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Sir: I am writing to you in response to Haigh & Stegen (1996) concerning the clinical need for in-patient psychotherapy. While I would agree that day treatment is suitable for the majority of difficult patients, in my view there remains a core of very difficult patients who cannot be treated except on an in-patient basis. This is particularly true of the work on the unit where I work, which involves intensive treatment of seriously disordered families, most of whom have suffered severe child abuse. Clinicians in the community generally are unable to keep such families safe and thus rehabilitation cannot be attempted.

The advantage of an in-patient environment is that you can attend to the night-times and early mornings when children may be at most risk. This treatment is costly but so are protracted court cases, repeated foster placements and long-term special schooling, not to mention forensic units, which are very often needed when these families break down without appropriate treatment.

Haigh, R. & Stegen, G. (1996) In-patient psychotherapy (letter). *British Journal of Psychiatry*, **169**, 524.

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One hundred years ago

The Belfast Asylum

The report on the Belfast Asylum of Dr. O'Farrell, Inspector of Lunatics, has just been published. He says that all restraint appliances should be retained in the charge of the medical officers and used only by their direct instruction, and that there should be daily and accurate entries of every case in which restraint or seclusion has been employed. The condition of the auxiliary asylum at Purdysburn Dr. O'Farrell regards us [*sic*] most satisfactory. He thinks it the most beautiful site and surroundings for an asylum in the United Kingdom, and he refers to the announcement of the new asylum during 1897 as a charitable commemoration of Her Majesty's most glorious reign. When this new asylum is ready for the reception of patients he trusts the governors may be able through legislative action to convert the Purdysburn manor house into an asylum for the reception of private patients of the middle and lower classes. The necessity for such an institution will be at once apparent, he says, when the large sums annually diverted from this country for the maintenance elsewhere of the wealthier classes of the insane are considered, while there is a very large number of private patients of the lower middle class whose friends cannot afford to pay a rate of board above, or much above, the average cost of maintenance of pauper patients, yet who are unwilling to submit to the stigma of pauperism in order to obtain asylum treatment for them. The provision of accommodation for this class in an institution detached from, but under the same management as, the district asylum would, in the inspector's opinion, meet a most important and charitable want.

REFERENCE

Lancet, 16 January, 1897, 212.

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https://doi.org/10.1192/bjp.170.1.90c Published online by Cambridge University Press