the psychiatric and associated services in follow-up studies (Tyrer & Seivewright, 1988).

The debate between the dimensionalists and categorists in relation to the classification of personality is on-going. For ease of communication, a categorical approach is used clinically. The PAS, an instrument derived from clinical practice rather than theory, conforms to this, and offers the option of both categorical and dimensional diagnoses.

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Is diazepam an antidepressant?

SIR: Regarding the points raised by Douzenis *et al* and O'Shea (*Journal*, February 1990, **156**, 279), atypical depression in our study was operationally defined, as in studies by other research groups, and was a diagnostic category in DSM–III. The Hamilton Depression Rating Scale (HDRS) was not used as a diagnostic instrument but was used to rate depression after diagnosis. The analysis of individual items from the HDRS was effected to try and separate items which reflect depression change from those that may reflect only anxiety change. The surprise was the persistent significant improvement with diazepam in HDRS items related to depression only.

It was not suggested in our paper that all depressions will respond to benzodiazepines. It may well be that some disorders which are currently referred to as 'depressions' may be more appropriately classified as anxiety disorders, despite prominent lowered mood.

It was noted in the paper that moclobemide had been an effective antidepressant in a variety of studies. When the study was initiated it was expected that diazepam would not produce sustained reduction in the HDRS, especially not in items that are unrelated to anxiety. Following these unexpected results we made a further literature search which showed that, contrary to the common understanding, benzodiazepines, especially in higher doses, may help some depressions. The trial was unable to distinguish if both moclobemide and diazepam were effective or not, hence the speculative nature of the title. These results highlight the problems of not having a true placebo in such studies.

The report was not intended to exhort clinicians to prescribe benzodiazepines for depression. Rather, the report was to discuss the possibility that benzodiazepines, in adequate doses, may relieve some depressions, and to open that as an area for further objective investigation.

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Suicide in Hindu women

SIR: Soni Raleigh *et al* (*Journal*, January 1990, **156**, 46–50) suggested that suicide by burning is common in Hindu women in India, deriving possibly from the medieval practice of suttee in parts of India. Although suicide by burning and suttee are related in India, the authors did not mention how this is so.

If we consider women in India in their real cultural and physical context, factors other than suttee appear to have greater influence on the choice of method for committing suicide. Most people in India, either because of their level of education or general knowledge, are not aware that an overdose of tablets would kill a person. The general attitude is that only a poison can kill someone and this is why there are many incidents of self-poisoning by pesticides and insecticides. Furthermore, looking at the home environment shows that most people in India still use kerosine for cooking and lighting purposes, making its presence ubiquitous. Most of the suicides by burning use kerosine. In addition to this, the exposure in society to the news that someone has committed suicide by burning herself reinforces or validates the method for others.

I should also mention one more point. When Indians emigrate, they tend to stay segregated as a group, not mixing much with the natives for several reasons. One of these is that, although they live in a foreign country physically, they tend to live in India psychologically. This is how ideas regarding suicide

by burning (just as many others) are carried to Britain and maintained. This factor, together with those described above, provides a better explanation of burning as a method of suicide than suttee.

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The first case of battle hysteria?

SIR: Patton (*Journal*, February 1981, **138**, 180–181) described an early case of battle hysteria which occurred during the Peninsular War (1808–1814) in a soldier who was the author's great grandfather.

I would like to report an earlier case, recorded well before the advent of modern explosives, which occurred in 490 BC at the Battle of Marathon, and was reported by the Greek historian Herodotus (1954): "Epizelus, the son of Cuphagorus, an Athenian soldier, was fighting bravely when he suddenly lost the sight of both eyes, though nothing had touched him anywhere – neither sword, spear, nor missile. From that moment he continued blinded as long as he lived. I am told that in speaking about what happened to him he used to say that he fancied he was opposed by a man of great stature in heavy armour, whose beard overshadowed his shield, but the phantom passed him by and killed the man at his side." Herodotus does not tell us whether Epizelus had post-traumatic stress disorder as defined in the DSM–III–R (American Psychiatric Association, 1987), but he does give a life-time follow-up by indicating that Epizelus was blind for the remainder of his life.

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Multiple personality disorder

SIR: I would like to comment on two recent letters regarding multiple personality disorder (MPD). Coons (*Journal*, March 1990, **156**, 448–449) states that "over 700 scientific articles, chapters, books, etc, have appeared on MPD, and that it was first recognised as a diagnosis in the DSM–III". Unfortunately, in a field like psychiatry, what is scientific to one may not be so to another. Furthermore, with all due respect to DSM–III, it tries to accommodate all kinds of psychiatric diagnosis and theories around the world, and as far as I am concerned, just because MPD is listed in the DSM–III, it does not necessarily become a scientific clinical entity.

Ross (*Journal*, March 1990, **156**, 449) states that: "if all individuals admitted to an acute care adult psychiatric in-patient unit in Britain or South Africa were screened with the Dissociative Experiences Scale, I predict that about 15% would score above 30. Of these individuals one-third would meet DSM–III–R criteria for MPD on the Dissociative Disorders Interview Schedule and one-third would have another dissociative disorder." Thus, according to him we can deduce that 5% of all psychiatric admissions in Britain or South Africa will carry DSM–III–R diagnoses of MPD and another 5% would have "another dissociative disorder". Considering the fact that the majority of psychiatrists have never seen or diagnosed a case of MPD on both sides of the Atlantic, I find these figures and predictions incredible.

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Accurate description of ethnic minorities

SIR: It is disappointing that in a special cross-cultural edition of the Journal, Milner & Hayes (*Journal*, March 1990, **156**, 438–440) employ the term 'second generation Jamaican' to describe the subject of their case report. This description implies that either the subject is a second generation immigrant in Britain or that three generations ago the family were not Jamaican.

Clearly this is an inaccurate description. Perhaps it is now time to describe as accurately as possible members of various ethnic minorities when writing scientific reports. May I suggest the term British Afro-Caribbean to describe people born in Britain of Afro-Caribbean ethnic origin. A Jamaican Afro-Caribbean would describe a Jamaican immigrant in Britain.

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