SIR: I think Dr Stein has been brave in tackling the controversial and emotive topic of drug treatment of personality disorders. However, he has not done justice to the psychological implications of drug treatment. Drug treatments, including low dose neuroleptics, like other psychiatric treatments share some common and powerful non-specific effects aptly described by Frank (1961). Some of these factors are: an emotionally charged relationship with a helping person, a plausible explanation of the causes of distress, and the use of therapists' personal qualities to strengthen the client's expectation of help.

Miller (1989) has considered in more detail some of the underlying issues which influence drug treatment of personality disorders. He states "Medication can represent substitute gratification for unmet interpersonal needs. The insatiable quality of these needs increases the risk of drug dependence and overdose. It may also be seen as a reward for regression thus encouraging the latter". However, a related concept is that medication can be used as a substitute form of dependence that is preferable to more destructive alternatives. Physical treatments may also increase the temptation of the physician to act in an authoritarian manner and for the patient to feel helpless and not responsible. Medication may be used to alleviate staff's own anxiety, as an indirect expression of anger, or even as a non-verbal method of controlling feelings. These issues need to be carefully considered when prescribing medication for patients. Lastly, it must be emphasised that drug treatments have a useful but limited role in the management of personality disorders.

FRANK, J. D. (1961) *Persuasion and Healing – A Comparative Study of Psychotherapy*. Baltimore: Johns Hopkins University Press.

MILLER, L. J. (1989) In-patient management of borderline personality disorder – a review and update. *Journal of Personality Disorders*, **3**, 122–134.

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AUTHOR'S REPLY: I am pleased that Drs Markovitz & Schultz have drawn the readers' attention to the beneficial effects that fluoxetine has in some cases of BPD as demonstrated in their study. The only reason these papers were omitted from my review was because, at the time of my initial submission (September, 1991), I was unaware of these publications, although subsequently I have become aware of these important studies.

In the concluding paragraph of my review, a plea was made for the development of good trial protocols for assessing new and old drugs in BPD, so that further controlled studies could be undertaken. Once there is an acceptable trial, protocol funding from drug companies and government agencies is likely to be more forthcoming. It would be a great shame to have to wait for 30 years as had been the case before a controlled trial of amytriptiline was undertaken. My plea for good trial protocols was made with five drugs in mind, fluoxetine and seroxat, as they are the serotonin reuptake inhibitors, moclobemide (a new monoamine oxidase inhibitor lacking the cheese effect), and clozapine and lithium.

With regard to Dr Souza-Faria's comments, I agree that the psychological effects of prescribing to BPD subjects are complex and poorly described in standard textbooks. In the review a brief section summarising these effects, how patients overvalue or devalue the effects of any prescribed drug, or act out by taking overdoses, as well as the large placebo effects, were described, and several references by leading authorities were included. For reasons of space, a more comprehensive description of the bizarre psychological reactions that subjects with BPD may have to prescribed drugs was just not possible.

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Suicide and Asian religions

SIR: Soni Raleigh & Balarajan (*Journal*, September 1992, **161**, 365–368) do not attempt to distinguish subgroups in their discussion of suicide among people in Britain born in the Indian sub-continent. Yet differences between subgroups may be more illuminating than overall rates: a study of psychiatric admissions in Newham, East London found significant differences between religious groups with Hindus higher than Sikhs, and Moslems highest of all. These differences would not have been apparent if all the groups had been considered together (Glover, 1990).

The salience of religious belief and practice on suicidal behaviour has been long acknowledged (Durkheim, 1952). Studies in Singapore have shown much higher rates for Hindus than Moslems, for both suicide and attempted suicide. Teachings of the two religions towards suicide provide explanations for such a difference (Ineichen, 1993). Soni Raleigh