"It is quite possible that some of the minor physical abnormalities (MPAs) common in schizophrenia are due to processes involving abnormal ectodermal expression of CAMs. If this is so, then they may have some genetic aetiology in common with the perturbed neurodevelopmental processes we believe to be fundamental to schizophrenia; that MPAs are more common in familial than non-familial schizophrenia (Waddington *et al*, 1990) lends some support to this notion."

More recently, we reported on the occurrence of MPAs in 157 psychotic patients (McGrath *et al*, 1995). There was no evidence that MPAs were related to pregnancy and birth complications, but there was a weak association between MPAs and a positive history of major psychiatric disorder in males.

I was going to complain about being misquoted. However, the attitude of grant giving bodies and university authorities to a researcher is now much influenced by his/her citation and publication rates. Let me, therefore, thank Murphy & Owen for misquoting me and for both increasing my citation rate and allowing me to extend my CV by this letter. It's much better to be misquoted than not quoted at all!

JONES, P. & MURRAY, R. M. (1991) The genetics of schizophrenia is the genetics of neurodevelopment. *British Journal of Psychiatry*, **158**, 615–623.

MCGRATH, J. J., VAN OS, J., HOYOS, C., *et al* (1995) Minor physical anomalies in psychosis. *Schizophrenia Research*, **18**, 9–20.

MURPHY, K. C. & OWEN , M. J. (1996) Minor physical anomalies and their relationship to the aetiology of schizophrenia. *British Journal of Psychiatry*, **168**, 139–142.

WADDINGTON, J. L., O'CALLAGHAN, E. & LARKIN, C. (1990) Physical anomalies and neurodevelopmental abnormality in schizophrenia. *Schizophrenia Research*, **3**, 90.

R. M. MURRAY

Institute of Psychiatry
London SE5 8AF

Reporting of psychosocial distress

SIR: We read with interest Weich *et al* (1996) on the effect of early life experiences and personality on the reporting of psychosocial distress in general practice. Their paper has many characteristics in common with the Zaragoza Somatisation study (Lobo *et al*, 1996; Garcia-Campayo *et al*, 1996).

One of the most important clinical implications of these authors' paper is that psychological presenters find it more difficult to form close personal relationships compared with somatic presenters. Weich *et al*'s interpretation is that the reason why psychological presenters disclose psychological symptoms to the general practitioner, is because they feel insecure about discussing these with anyone else. This conclusion is quite unexpected and barely consistent with everyday clinical experience with these kind of patients. In fact, Weich *et al*'s hypothesis was just the opposite: somatic presenters would report more difficulties with intimate relationships than psychological presenters.

The authors suggest as a minor drawback of the study a recall bias of the patients but fail to mention the possibility that the final results of the research might be affected. On the contrary, we would suggest that the recall bias of psychological presenters might affect the whole study and, in fact, this seems to be the most logical explanation for such clinically unexpected data. We have demonstrated that, despite similar global severity rates of psychiatric illness, psychologisers show significantly higher levels of reported depression and feelings of hopelessness, inferiority and guilt compared with somatisers (Garcia-Campayo *et al*, 1996). Similar findings were previously documented by Goldberg and his group (Bridges *et al*, 1991) who considered low depression as one of the key features of somatisation and blame avoidance its main adaptive advantage (Goldberg & Bridges, 1988). For this reason, it seems reasonable that psychological presenters, with higher levels of depression and depressive thoughts, should give a more unfavourable report than somatic presenters about their interpersonal relationships, early life experiences or any other component of their inner world. To ensure the reliability of the data, the quality of the interpersonal relationships of both psychological and somatic presenters should be assessed by an external rater to avoid recall bias of the patients.

BRIDGES, K. W., GOLDBERG, D. P., EVANS, B., *et al* (1991) Determinants of somatization in primary care. *Psychological Medicine*, **21**, 473–483.

GARCIA-CAMPAYO, J., CAMPOS, R., MARCO, G., *et al* (1996) Somatisation in primary care in Spain. II: Differences between somatisers and psychologisers. *British Journal of Psychiatry*, **168**, 348–353.

GOLDBERG, D. & BRIDGES, K. (1988) Somatic presentation of psychiatric illness in primary care settings. *Journal of Psychosomatic Research*, **32**, 137–144.

LOBO, A., GARCIA-CAMPAYO, J., CAMPOS, R., *et al* (1996) Somatisation in primary care in Spain. I: Estimates of prevalence and clinical characteristics. *British Journal of Psychiatry*, **168**, 344–347.

WEICH, S., LEWIS, G. & MANN, A. (1996) Effect of early life experiences and personality on the reporting of psychosocial distress in general practice: a preliminary investigation. *British Journal of Psychiatry*, **168**, 116–120.

J. GARCIA-CAMPAYO

Avda. Cesáreo Alierta 47, 2°B
50.008 Zaragoza, Spain

C. SANZ CARRILLO

Hospital San Jorge
Huesco, Spain