(2005): 'the clinical treatment of young people identified as being at high risk of developing a psychotic disorder, particularly the use of neuroleptics, should be provided only in the context of a research trial, where standards of informed consent and monitoring are highest'.

Nevertheless, there remain worries about trials in poorer countries. Ethical committees often do not have the same level of independence as they do elsewhere, financial inducements may lead to covert or overt pressures, and there is even sometimes a nationalistic element (e.g. if country X can recruit 100 patients, we must not recruit fewer than 200). This somewhat macho mentality may be behind comments such as that by Khanna *et al* (2005) that the symptoms of mania in the patients seen were 'substantially more severe than those of patients with bipolar disorder participating in trials elsewhere', implying that only countries that can be successful in persuading these 'difficult' patients to take part should be chosen.

We note that the Indian Council of Medical Research has now decided to audit clinical trials systematically to ensure that national recommendations are followed (Mudur, 2005) and the outcome of this will be followed closely. For our part, we have made changes to our refereeing procedure, and have been asking assessors to examine more closely the ethical aspects of papers that are submitted. We shall also be using our new group of international editors (in the case of India this will be Dr Vikram Patel) to advise on ethics both generally and with regard to specific papers, attempting as much as possible to take account of the need for 'autonomy, beneficence, non-maleficence and justice . . . and care ethics' summarised by Bloch & Green's (2006) recent paper.

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Antiparkinsonian prescription and extrapyramidal symptoms

Park *et al* (2005) cite the results of clinical trials as evidence supporting their hypothesis that the use of antiparkinsonian drugs in schizophrenia is an indication of extrapyramidal symptoms (EPS). This may be true for clinical trials (most of which include young adults with no comorbidity) but may not hold true for their observational study, in which other factors such as prescribing habits and comorbidity may affect the reason for prescription of antiparkinsonian drugs. As the mean age of their sample was 48.6 years, which falls within the range in which Parkinson's disease often develops, some patients could have been receiving antiparkinsonian drugs for the illness *per se*. Although this is mentioned as a limitation of the study, it has an adverse impact on the central hypothesis. Since decrements and increments in antiparkinsonian medication followed expectations from changes in antipsychotics (Tran *et al*, 1997), the results could well reflect the prescribing pattern of the general practitioners (GPs) rather than be true evidence for the presence of EPS.

One of the main limitations of the study is the lack of data regarding the reason for switching antipsychotics. As it is mandatory to submit data of all major illnesses (presumably including Parkinson's disease), any indication for prescribing or altering medication and any adverse drug reaction to the General Practice Research Database (GPRD; Walley & Mantgani, 1997), the data could have been provided and would have helped in the interpretation of the results. Furthermore, during the period studied more than 400 GPs provided data to GPRD but data from only 266 were analysed. It is not clear why the data from some GPs were excluded.

Park *et al* (2005) classified their study population as those switched from typical to atypical antipsychotics (TA group) and those switched from typical to different typical antipsychotics (TT group). However, when we add up the total figures provided (3% and 99% were receiving atypicals and typicals respectively in 1992, which changed to 47% and 70% in 2000), it appears that some patients were receiving a combination of both classes of antipsychotics. This could have influenced the trend for prescribing antiparkinsonian drugs.

Park, S., Ross-Degnan, D., Adams, A. S., *et al* (2005) Effect of switching antipsychotics on antiparkinsonian medication use in schizophrenia: population-based study. *British Journal of Psychiatry*, **187**, 137–142.

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Authors' reply: We agree with the comments of Grover & Kulhara on the lack of information about the specific reasons for the prescription of antiparkinsonian drugs in our observational study. We have stated that such prescribing might have been influenced by factors other than the occurrence of EPS. However, previous naturalistic studies have shown that the use of antiparkinsonian medication was highly correlated with clinical indices of EPS when patients were prescribed antipsychotics (Barak *et al*, 2002; Bobes *et al*, 2003; Montes *et al*, 2003). In addition, the sudden change in the incidence of antiparkinsonian drug use following introduction of atypical antipsychotics in the entire population (not just among patients who switched type of antipsychotic therapy) makes it unlikely that physician prescribing habits were a strong alternative explanation for our findings.

Since we observed the same patients over time in the analysis of drug switching, changes in antiparkinsonian drug prescribing following the switch could be explained by the differential effects of antipsychotics on EPS.

Nevertheless, antiparkinsonian drug prescribing is only a marker of EPS and

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cannot perfectly reflect the incidence of EPS. Owing to the limitation of our dataset (which did not include indications for prescriptions), we cannot exclude the possibility that some patients may have been prescribed antiparkinsonian medication because they had Parkinson's disease, not because they had EPS caused by antipsychotics.

Grover & Kulhara question why we included only 266 GPs in this study. We selected from the GPRD only those patients who had been diagnosed with schizophrenia and prescribed antipsychotics between 1992 and 2000. Therefore 6356 patients who met those requirements and their 266 general practices were included in the study.

Grover & Kulhara raise the possibility that patients might have taken both classes of antipsychotics simultaneously. We examined the effects of switching antipsychotics on antiparkinsonian drug prescribing by classifying patients into two groups. We defined the TA group as patients who had been prescribed typical antipsychotics with no atypical antipsychotic use before the switch, completely stopped typical antipsychotics and subsequently switched to atypical antipsychotics, with no typical antipsychotic use for at least 2 years after the switch. The TT group included patients who were prescribed one typical antipsychotic (e.g. chlorpromazine) then switched to a different typical antipsychotic (e.g. haloperidol), and who never received an atypical antipsychotic during the study period. Therefore, by definition, no patients in our study were receiving a combination of both classes of antipsychotics.

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Treatment of borderline personality disorder

Fonagy & Bateman (2006) hypothesise that a more benign course of borderline personality disorder may partially result from a reduction in iatrogenic harm. They describe people with borderline personality disorder as having 'hyperactive attachment systems' which interfere with the therapeutic relationship and treatment. They describe 'treatment' as being psychosocial treatment or psychotherapy, and attachment figures as therapists.

Many people with borderline personality disorder do not receive psychotherapy but do have contact with psychiatric services – casualty assessments, out-patient contact with generic services, brief crisis admissions and sometimes even prolonged admissions. I am curious as to Fonagy & Bateman's view on the nature of attachments that people with borderline personality disorder have with psychiatric *institutions*, especially when contact with individual workers may be inconsistent. Fonagy & Batemen give advice about how to encourage 'mentalisation' in the context of psychotherapy in order to avoid potential iatrogenic damage but give no advice for other clinical settings.

Clinical teams are well aware of how people with borderline personality disorder may unconsciously 'engineer' situations to re-enact disturbed early life experiences. Now Fonagy & Bateman suggest that although teams are aware of this situation further damage may be done. A 'helpful' intervention may deprive the patient of using or developing other more useful strategies. Fonagy & Bateman suggest that an 'inquisitive and flexible' approach may be useful. The challenge is therefore how this approach should be applied to how clinical teams within *institutions* respond to people with borderline personality disorder.

Fonagy, P. & Bateman, A. (2006) Progress in the treatment of borderline personality disorder. *British Journal of Psychiatry*, **188**, 1–3.

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Authors' reply: We share Dr Mountain's concern that this group of patients is often inadequately managed. Our primary aim in pointing to the iatrogenic consequences of psychotherapy was to illustrate the dangers of intensive interventions or those with poorly defined boundaries. The same concerns for iatrogenic consequences apply to institutional involvement because this is often disrupted by frequent staff changes. Separations and losses of this kind are also iatrogenic. They activate patients' attachment systems, leading them to make unproductive attempts to restabilise their sense of self. Moreover, interactions with institutions often occur at times of personal crisis when the attachment system is already stimulated. Concerns about the patient's state of panic and about reduced mentalising may lead to hospital admission. However, this can become iatrogenic in itself because emotionally charged interactions with staff and other patients may further destabilise the patient, leading them to self-harm or threaten suicide, prolonging hospital admission. We and others (Paris, 2004) recommend that the level of risk for self-harm of patients admitted to hospital should be assessed and documented daily. If there is no reduction in risk, alternative management of the patient in the community should be implemented.

Although patients may seem to be enacting past experiences in their interactions with clinical teams, in our view it is not useful to consider these as hapless repetition of past patterns or as acts that respond to or compensate for past hurts; rather they should be viewed as the only solution available to restore a sense of integrity, continuity and coherence. The provision of a highly integrated model of psychiatric care in a structured institutional environment that aims to offer consistent, coherent and thoughtful psychological care with a relationship focus, organised in a patient-oriented flexible manner with individualised care plans, is likely to be most helpful. Out-patient treatment, discharge from an in-patient unit or referral following a casualty visit should be considered in

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