Contemporary China furnishes a good example. Compared with the rapid development in big cities and in the commercial and industrial sectors of the coastal areas, a combination of adverse factors, including a low income growth rate, heavy tax burdens and surplus labour have hindered economic development, intensified poverty, and threatened social stability in rural China, which is inhabited by a staggering 900 million population (Liu, 1995). Along with gender inequalities and the one-child-per-couple policy adopted since 1980, these social forces have underprivileged rural women. Although the one child policy is responsible for China's remarkable success in population control and is relatively well accepted by urban couples, it drastically clashes with the entrenched value of *duo zi duo sun* ("having more sons and grandsons"), which is integral to agrarian subsistence and rural women's social status. Ethnographic studies revealed that women who gave birth to baby girls were fearful about not carrying on the lineage, the loss of extra labour power, and not having someone to provide for them in old age. They experienced a loss of face, alienation, and often physical abuse (Pearson, 1995). In such an oppressive context, depressive and anxiety disorders may also be understandable reactions to the brutality of everyday deprivation that will respond less to psychotropic agents than socially meaningful forms of empowerment.

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Lithium revisited

SIR: I am pleased that my editorial (Moncrieff, 1995) has provoked some discussion but I do not believe that I made any erroneous statements about Coppen *et al*'s (1971) trial (Coppen, 1996). The paper presented results for 65 patients but only 37 of these had bipolar disorder and the number of subjects who did not complete the first 16 weeks of treatment was not documented in the original report. I criticised the study for failing to do an "intention to treat" analysis as the comparability of the residual groups cannot be assumed. The presentation of results was also unsatisfactory with no information on the number or polarity of episodes and global assessment scores combined in various ways that were not specified *a priori*. In addition diagnosis of illness episodes and administration of additional treatments may have been influenced by unblinding effects, emphasised again by Double (1996). Meta-analysis with the trials I reviewed would only reflect and amplify previous problems.

The follow up study cited (Fieve *et al*, 1976), which concerned a mixed group of bipolar and unipolar patients taking lithium did not demonstrate unequivocal success. Fourteen per cent of patients were admitted during the course of one year, 20% were prescribed neuroleptics and 37% antidepressants and it is likely that rates of morbidity were higher in the bipolar group, which was not examined separately (Coppen & Abou-Saleh, 1988).

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Minor physical and factual anomalies

SIR: In their article on minor physical anomalies (MPAs) and schizophrenia, Murphy & Owen (1996) state

> "The majority of proponents of the neurodevelopmental model have focused on an environmental rather than a genetic explanation for the excess of MPAs seen in schizophrenia (Mednick *et al*, 1988; Murray *et al*, 1992)."

In fact, my views are not those Murphy & Owen attribute to me and the paper they quote contains no statement regarding the causes of MPAs. Elsewhere, in an article which was entitled "The genetics of schizophrenia is the genetics of neurodevelopment", we (Jones & Murray, 1991) wrote:

"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!

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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.

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