Table 1: Self-esteem scale by age and gender

Age	Total Mean (CI) (n)	Boys Mean (CI) (n)	Girls Mean (CI) (n)
10-13 yrs	85.4 (84.7-86.2) (1146)	85.6 (84.6-86.7) (523)	85.3 (84.2-86.3) (623)
10 yrs	87.6 (85.0-90.1) (73)	88.2 (83.7-92.8) (24)	87.2 (84.1-90.4) (49)
11 yrs	85.9 (84.7-87.1) (488)	86.6 (85.1-88.1) (217)	85.3 (83.6-87.0) (271)
12 yrs	84.7 (83.5-85.8) (499)	84.3 (82.6-86.0) (229)	85.0 (83.4-86.6) (270)
13 yrs	85.1 (82.8-87.5) (84)	85.7 (82.7-88.7) (51)	84.3 (80.4-88.1) (33)

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Psychiatric morbidity in prisoners

Dear Editor - I read with interest the large scale study by Linehan *et al* on Psychiatric Morbidity in Prisoners. This is a very important study because of the large numbers involved and because a structured demographic interview was used. I was looking for information on very important psychiatric diagnosis among prisoners, Pervasive Development Disorders/Asperger's syndrome, and Pervasive Developmental Disorder Not Otherwise Specified as well as Attention Deficit Hyperactivity Disorder. I was surprised not to find any comment on these diagnosis which are so important in modern Forensic Psychiatry.

Scragg and Shah found the rate of Asperger's syndrome in a Secure Hospital between 1.5% - 2.3%. This is higher than in the general population. In a pilot study by Curran and Fitzgerald found increased rates of Attention Deficit Hyperactivity Disorder in Mountjoy Prison compared to the general population. As it was a pilot study it needs to be done using larger numbers. It is critical that a study now to be done in an Irish prison population of the Pervasive Developmental Disorders including Asperger's syndrome, Autism, Pervasive Developmental Disorder Not Otherwise Specified, as well as Attention Deficit Hyperactivity Disorder as it is my impression that there are significant numbers of these in prison population who are undiagnosed and of course then by definition not treated.

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Pimozide treatment for body dysmorphic disorder

Dear Editor - McWilliams *et al* are to be commended on their interesting and informative case report on body dysmorphic disorder published in the *Irish Journal of Psychological Medicine*.[1] We have recently treated an outpatient with body dysmorphic disorder and we wish to make some points that may be of interest to your readers, relating to both the phenomenology and pharmacolotherapy of this condition.

In summary, the case is that of a 46 year old married man, newly referred to our outpatient department with no previous contact with the psychiatric services. The initial diagnosis made was that of a major depressive episode with associated obsessional ruminations regarding acne rosacea, subsequently revised to major depression and body dysmorphic disorder. Symptoms of acne rosacea had been present to a varying degree for the previous seventeen years, despite little objective evidence of any skin problems on examination. He had consulted dermatologists and had numerous courses of antibiotic treatment but was never satisfied with the outcome.

The phenomenology was interesting, involving obsessional ruminations regarding the acne rosacea, mirror-checking and social avoidance with associated low self-esteem and depressed mood. Analogous to the phenomenology seen in anorexia nervosa, it was sometimes difficult to establish if the patient's beliefs could be defined as overvalued ideas or delusional in nature.

He was initially treated with sertraline (up to 150mg per day) and risperidone (up to 6mg per day) but did not respond. His mood became more depressed and he took an

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