et al's earlier research (1990) showed UK Hindus had higher rates than Moslems. It would be interesting to know if their later work finds this pattern repeated.

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AUTHOR'S REPLY: Dr Ineichen raises a valid issue. Aggregation of groups originating from the Indian subcontinent conceals the significant epidemiological differences that exist between them, and our preference would have been to disaggregate into the different national, religious and regional subgroups. We have always adopted this approach where possible, as for instance in an earlier paper in which we were able to examine religious differences in suicide rates (Soni Raleigh *et al*, 1990). Some disaggregation was feasible on that occasion because we were in the unusually fortunate position of working directly from death certificates, and hence could distinguish between Hindu and Muslim names.

Unfortunately, much of the epidemiological research relating to ethnic minorities has been constrained because the data more typically available (on mortality and population size) do not permit such disaggregation. We did not have access to the death certificates for this later period. Instead, we used the OPCS national mortality data relating to persons born in the Indian subcontinent. These cannot be disaggregated into the component country groups (India, Pakistan, Bangladesh, Sri Lanka) without some bias – the reason for the bias is that India is sometimes referred to as undivided, pre-partition India in recording country of birth at the time of death registration. Thus, deaths registered as Indian-born include some people born in Pakistan. It is for this reason that OPCS have followed the practice of aggregating the groups from the Indian subcontinent (Marmot *et al*, 1984) and the subject is discussed in greater detail in these publications. Hence, in this paper, we were not able to examine any subgroups, whether national, regional or religious, and I am conscious that we thereby lose an important dimension to the work. In the circumstances, it was unavoidable. I have little doubt (although this is no more than an informed hunch) that the pattern *vis-à-vis* Hindu and Muslim suicide rates would be similar to what other studies have shown, because, as Dr Ineichen points out, the two religions have very different positions on suicide.

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What is the incidence of conversion pseudodementia?

SIR: Copeland *et al* (*Journal*, August 1992, **161**, 230–239) presented a three-year follow-up study designed to confirm the prevalence and incidence of dementia, depression, and pseudodementia identified in a sample of 1070 elderly persons living in Liverpool. The results from this detailed and rigorous research have major implications for cross-cultural studies. However, we are, once again, surprised to see that cases of 'conversion pseudodementia' (McEvoy & Wells, 1979) were not detected by an epidemiological investigation. At the end of the second year of a follow-up study still in progress we confirm the diagnosis of cases of conversion pseudodementia identified at year 0.

Briefly, our study involved review of the clinical charts of all 467 patients (228 men, 239 women; median age 49 years, range 18–93) admitted to our department of psychiatry from April 1989 to March 1990. We encountered an unexpectedly high number (six) of cases of cognitive impairment probably related to hysterical conversion reaction. This preliminary diagnosis was established using a standardised protocol based on existing sets of clinical criteria (Grant, 1989). Patient assessment followed a step-by-step algorithm: (a) recognition and measurement of the cognitive deficit by Mini-Mental State (Folstein *et al*, 1975) and Blessed-Roth information-memory-concentration test (modified by Hodkinson (1972)); (b) exclusion of organic dementing disorders by medical history, physical-neurological examination, laboratory tests, neurophysiological and brain-imaging evaluation and by

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