

the Tower Hamlets population in these age groups that were of Asian origin, and compared Asian and non-Asian self-poisoners. We found no significant difference in the proportion of male Asians in the age group 10–24 who made parasuicide attempts; nor did we find an excess of Asian female patients in the age groups 10–14 and 20–24. However, of the 156 women aged 15–19 who presented with self-poisoning, 25 (16%) were Asian. Asians constituted only 7% of the female population in this age range, so this represents a significant excess ($P < 0.005$).

Merrill & Owens (1986) suggested that unmarried adolescent girls face culture conflict around family discord over Asian versus Western lifestyles. Dr Manium draws attention to parents' disapproval of marriage in the predominantly Muslim population of his study, which can lead to conflicts in both these areas.

In contrast to the Malay study, where there was a high rate of suicide, there were no reported suicides of Asians aged 10–24 from North East London between 1980 and 1984.

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Reference

- MERRILL, J. & OWENS, J. (1986) Ethnic differences in self-poisoning: a comparison of Asian and white groups. *British Journal of Psychiatry*, **148**, 708–712.

Castration and the Sexual Offender

SIR: Salzmann (*Journal*, August 1988, **153**, 270) recommends castration (orchidectomy) of persistent sexual offenders. His paradigm is "the Danish approach". He writes that "castration [is] voluntarily accepted by many inmates in Herstedvester as the price of release from indefinite detention". In that Dr Salzmann is wrong.

Due to fierce opposition within the public and the Danish Medico-Forensic Council, orchidectomy was abandoned in 1968. This procedure is an absolutely unthinkable approach to the sexual offender in Denmark today!

Currently, castration is only performed on a small number of transsexuals (2–3 men a year), this being a completely different issue.

On another note, we should add that the legal sanction "indefinite detention" within a treatment

and rehabilitation perspective as epitomised by the Herstedvester model was rescinded in 1973.

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Melatonin and Sulphatoxymelatonin in Eating Disorder Patients

SIR: We read with interest the report by Bearn *et al* (*Journal*, March 1988, **152**, 372–376), in which urinary sulphatoxymelatonin (aMT6s) excretion was compared in underweight and weight-restored patients with anorexia nervosa and in age-matched female controls. No significant differences were found between groups at any time, and the authors concluded that melatonin output, as assessed by aMT6s, was not influenced by changes in weight, although they did not directly assess plasma melatonin levels, or consider the relative influence of depression within the patient group.

We have recently completed a comparative study involving both nocturnal serum melatonin and urinary aMT6s in female patients with anorexia nervosa ($n = 15$), bulimia nervosa ($n = 9$) and in control women ($n = 10$) of similar age. All groups were compared according to weight and mood variables. Patients with anorexia nervosa had a significantly lower percentage of ideal body weight ($76.4\% \pm 9.9\%$) than bulimia nervosa patients ($102.1\% \pm 12.3\%$) and controls ($105.2\% \pm 14.2\%$) ($F = 22.2$, d.f. = 33, $P < 0.001$). Both patient groups had significantly higher depression scores on the Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1967) (for anorexia nervosa patients 19.8 ± 9.6 ; for bulimia nervosa patients 16.4 ± 8.4) compared with the control group (2.7 ± 2.6) ($F = 14.9$, d.f. = 33, $P < 0.001$).

There were no differences between patient groups and controls in night-time values of urinary aMT6s or serum melatonin values. A two-way analysis of variance for both urinary and serum results was carried out to examine the effects of weight and depression as independent variables among patients. Although weight did not influence either of these measures, a significant effect was found for depression. Patients who met DSM-III-R diagnostic criteria for major depression (American Psychiatric Association, 1987) and had HRSD scores equal to or higher than 17 had significantly lower melatonin output than the non-depressed group for both serum melatonin ($F = 4.22$, d.f. = 1, $P < 0.05$), and urinary aMT6s ($F = 6.51$, d.f. = 1, $P < 0.02$).