not supported by the evidence. The authors acknowledged that evidence for a relationship between cataracts and specific antipsychotics is, unlike every other issue addressed, insufficient for them to assess the quality of the evidence. They acknowledge that only beagles—and not other species, including primates—had an increased risk of cataracts when they received four times the maximum recommended human dose of quetiapine. The United Kingdom epidemiological study that they cited (1) showed no increase in cataracts among a large population treated with antipsychotics, and they cited another naturalistic survey (2) in the United States that reported only 34 lens opacities in 620,000 patient exposures to quetiapine. Given the prevalence—at least 15%—of age-related cataracts in the adult population (3, 4), that study would suggest, if anything, a protective effect of quetiapine.

Although it would certainly be a good practice for psychiatrists to inquire about visual changes in this often-underserved population, requiring at least annual slit-lamp examinations seems ill founded. My informal survey of three sources (university clinic, private ophthalmologist, private optometrist) revealed costs ranging from $110 to $195 for an initial assessment, far more than the authors' estimate of $23 for an examination. And what is one to do when a lens opacity is found in a patient who may already, by virtue of diabetes, hypertension, nutrition, or age, be at a higher risk for cataracts? If the patient is otherwise responding well to a particular atypical antipsychotic medication, it would seem risky to change it. Despite the authors' disclaimer that their recommendations should not "subject [providers] to legal consequences," it is likely that enterprising attorneys will indeed seize upon the opportunity to sue psychiatrists for failure to have ensured one or two slit-lamp examinations per year in a schizophrenic patient who develops a cataract. Why make such a recommendation when the evidence for it is, as the authors acknowledge, absent?

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Dr. Marder and Colleagues Reply

TO THE EDITOR: Drs. Foulds and Williams make a valid point regarding our article: smoking makes a substantial contribution to the morbidity and mortality of individuals with schizophrenia. Although we decided at the onset of our consensus meeting that we would not include discussion of all of the factors that should be monitored in patients with schizophrenia, we agree with the writers that psychiatrists should inquire about smoking routinely. If patients are smokers, clinicians should review the health hazards associated with smoking and the available approaches for promoting smoking cessation. Whenever feasible, clinicians should engage in attempts to motivate patients to give up smoking, and they should refer them to a specialized smoking cessation program.

The letter from Dr. Steele provides an opportunity for us to underline the importance of mental health providers ensuring that their patients with schizophrenia receive adequate eye care. The recommendation for annual eye examinations for patients over 40 is a standard of care for all individuals rather than a special requirement for individuals with schizophrenia. The participants at the consensus meeting also recommended that psychiatrists inquire about the quality of vision on an annual basis and that they inquire specifically about changes in vision, the quality of distance vision, and the presence of blurry vision. Changes in vision should lead to a referral to an optometrist or an ophthalmologist. The additional requirement for slit-lamp examinations at 6-month intervals for patients receiving quetiapine is included in its package insert. As noted in the article, the meeting participants agreed that clinicians should follow the recommendations on the quetiapine package insert until there is more definitive evidence regarding the risk of cataracts. Because patients with schizophrenia often have risk factors for lens opacities, such as diabetes, hypertension, and poor nutrition, clinicians should inquire about visual changes and ensure that guidelines for visual monitoring are followed, independent of the antipsychotic prescribed. The article also noted that the level of evidence for an association of cataracts with specific antipsychotics could not be graded. As in several other areas, we hope that more definitive information will become available, resulting in updates to package inserts, whether those updates are more restrictive or more permissive.

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Alexithymia, Personality, and Psychopathology

TO THE EDITOR: We read with great interest the recent article by Hans Joergen Grabe, M.D., and colleagues (1) concerning alexithymic features as predictive factors of psychopathology in psychiatric patients. The article suggested the relevance of improving emotional awareness as a major issue of therapeutic interventions in patients with mental disorders. However, some methodological concerns should moderate the interpretation of these findings. Dr. Grabe and colleagues used a linear regression technique to calculate the relative magnitude of the prediction of psychopathology of several independent variables, such as Toronto Alexithymia Scale factors, Temperament and Character Inventory dimensions, age, and gender. However, they did not integrate in their analysis a dimensional assessment of depression. Now we know from several studies that alexithymia and depression, although not totally overlapping, are strongly associated, with depression acting as a strong mediator between alexithymic features and psychopathology (2). This is especially true for the difficulties identifying feelings subscale of the Toronto Alexithymia Scale,

whose correlations with depression vary between 0.42 and 0.65 (3). It is not surprising that this factor was found to be the strongest predictor of psychopathology in the study by Dr. Grabe and colleagues. The authors should have included in the linear regression analysis a dimensional measure of depression, or they should have measured with a hierarchical regression analysis the additional part of the variance of psychopathology explained by alexithymic features beyond the variance accounted for by depression, as was done by Luminet and colleagues (4). These procedures would have strengthened their results and would have allowed a comparison with previous published studies that have shown that alexithymia is truly associated with higher levels of psychopathology and acts as a negative predictor of outcome beyond the influence of depression (5).

These limitations aside, we agree with Dr. Grabe and colleagues on the relevance of the alexithymia construct in mental disorders and on the need for developing specific psychotherapeutic techniques to improve affect identification and differentiation for emotionally dysregulated subjects.

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Dr. Grabe and Colleagues Reply

TO THE EDITOR: We want to reply to the important comments of Dr. Speranza et al., who suggest including a dimensional measurement of depression as an additional independent variable in regression analyses predicting the psychopathological dimensions of the SCL-90-R. They argue that the "difficulties identifying feelings" subscale of the Toronto Alexithymia Scale and the ratings of depression have especially been shown to be correlated with each other alexithymic features and psychopathology." First, because alexithymia is conceptualized as a personality construct demonstrating a high relative stability (Luminet et al., 2001), our intention was to assess the association between alexithymia and psychopathology, with adjustment for personality dimensions (the Temperament and Character Inventory) that have been shown to explain up to 45% of the variance in alexithymia (1). Second, our data show that depression (beta=0.32) is not only associated with alexithymia but also with a broad range of psychopathologic dimensions, including anxiety (beta=0.41) and somatization (beta=0.44). Thus, anxiety or somatization could also act "as a strong mediator between alexithymia and psychopathology." Third, one has to decide a priori whether actual psychopathology is the dependent variable or a confounder within the model.

Ignoring these three statements, we followed the statistical recommendation of Dr. Speranza et al. Unfortunately, we do not have dimensional information on depression other than the depression subscale of the SCL-90-R. Given the high internal consistency of the SCL-90-R, each subscale, e.g., depression, entered as a confounder will show major statistical effects on the dependent variable, which is also an SCL-90-R subscale in our model. Thus, when we entered depression, the three Toronto Alexithymia Scale factors, the Temperament and Character Inventory, age, and gender as independent variables and the SCL-90-R global severity index (without items assessing depression) as an dependent variable into a hierarchical linear regression model, SCL-90-R depression resulted in R^2=0.785 and difficulties identifying feelings added an additional R^2_{chg}=0.030 (F_{chg}=41.3, p<0.001) to the variance. However, it is important to consider that the correlation (Pearson) between SCL-90-R global severity index (without depression) and the depression subscale was r=0.89! Thus, the adjustment of a statistical model for, e.g., depression is more reasonable if the confounder variable is not as highly correlated with the dependent variable. This was done by Luminet et al. (2001) in predicting posttreatment scores for alexithymia with pretreatment scores of alexithymia with adjustment for scores for depression or by Grabe et al. (1) when they predicted alexithymia with Temperament and Character Inventory dimensions with adjustment for the SCL-90-R global severity index.

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Refining the Personality Disorder Diagnosis

TO THE EDITOR: The article by Jonathan Shedler, Ph.D., and Drew Westen, Ph.D. (1), provides an excellent overview of the need to refine personality disorder diagnostic criteria. We would like to add some additional data about the complex diagnostic relationships between borderline and histrionic personality disorders in clinical practice.

Andalusia is the most highly populated region in Spain (7,606,848 inhabitants) (2). The health care network in Andalusia, which serves the region's entire population, comprises 17 psychiatric units for acutely ill patients in general hospitals.

As part of a wider study, we have been working with the Minimum Basic Data Set at Discharge From Hospitals (3), a system of hospital record-keeping that records all patient discharges taking place at Andalusian hospitals.