The unrepresentative nature of the pre-senile vascular dementia group is acknowledged by the authors, and patients with mixed Alzheimer's and vascular pathology are also likely to be included in this vascular category. To date it is unclear as to the degree to which the two conditions coexist. As it is apparent that the Alzheimer's disease group may also be unrepresentative, the question begs to be asked, what groups are actually being compared? The overall suggestion that pre-senile Alzheimer's disease and vascular dementia have a similar prognosis needs to be taken in the context of these limitations and highlights the need for neuropathological studies in this area.

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M. C. Dale Old Age Psychiatry, Fleetwood Hospital, Pharos Street, Fleetwood FY7 6BE

Psychotherapy and developmental disability

I welcome Holmes' (2000) editorial outlining the application of psychotherapies in psychiatry and across the sub-specialities. He advocates the inclusion of the broad range of psychotherapeutic treatments in all psychiatric practice and the development of a research and evidence base for the work. It is of concern, however, that in spite of his reference to learning disability as a psychiatric speciality in his introduction, he has effectively excluded people with learning disability by failing to include those with a developmental disability in his list of those benefiting from psychotherapeutic techniques.

On account of the neglect of developmental disability by psychotherapy, the Institute for Disability and Psychotherapy has been founded in order to provide, train in and research effective treatments for people with developmental disability and thus include them in health care. Each method of therapy cited in the editorial from analytic to family therapy is relevant and applicable to the patient group in my practice. Common themes in the experience of their lives are abuse and rejection (Sinason, 1992). The behavioural and psychological manifestations and the effects on personality of these problems in a person with developmental disability have the potential to give invaluable insights into the development of personality and the treatment of personality disorders in the population without developmental disability.

I hope that practitioners of the psychotherapies will have the courage to embrace all that working with people with developmental disability has to offer and to include rather than further compound the exclusion of people from the provision of effective care and treatment.

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K. P. Courtenay Department of Psychiatry of Disability, St George's Hospital Medical School, Jenner Wing, Cranmer Terrace, London SW17 0RE

Ethnic differences in forensic hospitalisation

It is sobering to note that Coid *et al* (2000) have once again found that variations in compulsory hospitalisation cannot be entirely attributed to racial bias, as some would lead us to believe. This was a large multi-centre study that did not limit itself to inner-city areas. The authors must be congratulated on their courage in challenging a popular and attractive myth and at the same time suggesting that services should be culture-sensitive.

Regarding their question of whether (predominantly White) forensic psychiatrists actively select White people with personality disorders as more suitable for treatments such as psychotherapy in secure setting, the answer may lie in the fact that maybe White people do have a greater chance of having a personality disorder (and thus meriting treatment) than the Black or Asian population. There is a study currently taking place at the Institute of Psychiatry and Broadmoor Hospital which is looking at Black patients with personality disorders, and the results should be most interesting. The Asian people in this study show a less than expected degree of morbidity, personality disorder, substance use and previous conviction, in spite of sharing the same socio-economic disadvantage, which is consistent with current knowledge. To paraphrase Freud, maybe a cigar is just a cigar.

Coid, J., Kahtan, N., Gault, S., *et al* (2000) Ethnic differences in admissions to secure forensic psychiatry services. *British Journal of Psychiatry*, **177**, 241–247.

S. P. Sarkar Broadmoor Hospital, Crowthorne, Berkshire RG45 7EG

Stigmatisation: classifying drug and alcohol misuse as mental illness

Crisp *et al*'s (2000) article aims "to determine opinions of the British adult population concerning those with mental illnesses as baseline data for a campaign to combat stigmatisation". Specifically, the authors go on to list the disorders investigated: severe depression, panic attacks, schizophrenia, dementia, eating disorders, alcoholism and drug addiction.

I was surprised by the way in which alcoholism and drug addiction were grouped under the label of mental illness as if this was a commonly accepted truth within the scientific community.

The literature on drug and alcohol use and addiction suggests that these phenomena have to be seen as a complex interaction between a variety of factors, including psychosocial ones (McMurran, 1994). Similarly, views on drug use (and also mental illness) may change over time and are also the result of socio-political and historical contexts (Foucault, 1967; Levine, 1979). Treating drug and alcohol addiction as mental illness is an indication of the way mental illnesses are currently defined by the American Psychiatric Association (Cooksey & Brown, 1998) and should perhaps not be accepted all too readily as truth.

I recognise the psychiatric community's need to categorise mental illnesses. However, by classifying drug and alcohol users as suffering from mental illness, a

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