

research, where comorbidity with other Axis I diagnoses, particularly depression and anxiety disorders, is extremely common. The authors do not specify their diagnostic criteria (even for PTSD); however, none of their cases would appear to have a diagnosis of PTSD alone. All seem to have a depressive disorder and cases 1, 2 and 4 probable panic disorder. Case 3 may have generalised anxiety disorder. It seems to make little sense to study treatment outcome in PTSD using measures specific to other disorders which may well be present at the same time.

I would therefore suggest that, before worrying whether *in vivo* or imaginal exposure is more effective, future research should use more appropriate outcome measures for PTSD and carefully define what combination of disorder is present initially.

M. R. BAGGALEY

Psychiatric Department  
BMH Iserlohn  
BFPO 24

#### Admission rates, detention rates and socioeconomic deprivation

**SIR:** It is now recognised there is a strong relationship between psychiatric admission rates and social deprivation, and that psychiatric admission rates tend to be higher in urban than in rural areas (Hirsch, 1988; Thornicroft, 1991). We report the relationship not only between deprivation and admission rates, but also compulsory detention rates, by comparing and contrasting in Scotland a largely rural (Dumfries and Galloway Region) with a largely urban (Renfrew District) area.

Data on the total number of admissions and compulsory detentions by postcode sector for the years 1987, 1988 and 1989 were obtained for the two hospitals that serve the areas, namely Crichton Royal, Dumfries, and Dykebar, Paisley. Detention rates refer to patients admitted from the community and do not include those admitted informally and subsequently detained. For each postcode sector, yearly rates of admission and detention were determined, and the level of correlation with both Jarman (JI) (Jarman, 1984) and Carstairs (CI) (Carstairs & Morris, 1989) indices of socioeconomic deprivation calculated; the latter index is more indicative of material deprivation.

The trend was that postcode areas served by Crichton Royal were less deprived than those served by Dykebar; this reached statistical significance using Carstairs ( $P < 0.05$ ) but not Jarman scores. Correlations between rates of admission and deprivation varied between hospitals, being high

and statistically significant at Dykebar (JI+0.66,  $P < 0.001$ ; CI+0.56,  $P < 0.001$ ) but low at Crichton Royal (JI+0.20, NS; CI+0.16, NS). Correlations between rates of detention and deprivation indices were broadly similar for both Crichton Royal (JI+0.51,  $P < 0.01$ ; CI+0.31, NS) and Dykebar (JI+0.54,  $P < 0.01$ ; CI+0.45,  $P < 0.01$ ). As rates of compulsory detention might simply reflect rates of admission, a partial correlation was calculated between rates of detention and the Jarman and Carstairs scores, holding rates of admission steady. The partial correlations at Crichton Royal were higher (JI+0.48,  $P < 0.01$ ; CI+0.27, NS) than in Dykebar (JI+0.27, NS; CI+0.19, NS).

The Dykebar results pertaining to admission rates and deprivation are in line with findings in English urban hospitals. It has also been shown in Scotland that there are strong gradients in admission rates by deprivation category for all psychiatric admissions and specific psychiatric illnesses (Carstairs & Morris, 1990). At Crichton Royal, therefore, there must be other factors which swamp the effect social deprivation has on admission rates. Although there are various possibilities, two deserve mention. Firstly, Crichton Royal serves a somewhat less deprived area than Dykebar. Perhaps general practitioners working in such an area are influenced less by social deprivation when requesting admission for the mentally ill. Secondly, and probably more importantly, geographical accessibility to Crichton Royal is difficult, with some parts of the catchment area 80 miles from the hospital. Rapid access to out-patient and domiciliary assessment in some areas is difficult; admission to in-patient care may be the only answer.

Partial correlations showed that rates of detention were more strongly associated with social deprivation at Crichton Royal than at Dykebar. Perhaps in the former's catchment area, general practitioners avoid the need for detention in many cases by using the better support systems. Where such support systems are especially poor, that is, in the areas of greater social deprivation, detention will be more likely. The weaker association at Dykebar between rates of detention and social deprivation is hard to explain.

When compared with the Jarman index, the associations between the Carstairs index and rates of admission and detention were much weaker. However, Jarman and Carstairs indices measure different things. The Jarman index probably reflects poorer social support (for example, single parent households) than the Carstairs index which is more indicative of economic deprivation (for example, people with no car). It is likely that levels of support rather than material wealth influence rates of

admission and compulsory detention to a psychiatric hospital.

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LESLEY J. ROBERTSON  
ROBIN G. MCCREADIE

*Department of Clinical Research  
Crichton Royal Hospital  
Dumfries  
Scotland*

#### Depression and polycythaemia

SIR: The article by Murray & Hodgson (*Journal*, June 1991, **158**, 842–844), regarding a patient with depression and polycythaemia, emphasises the potential for cerebral ischaemia in this disease which we have noted can cause psychiatric symptoms (Aker *et al*, 1990). This is brought about by the mechanism of blood sludging which can be reversed or prevented by anticoagulant therapy (Knisely, 1968).

We have found the use of anticoagulant therapy very useful for dementia due to arteriosclerosis (Walsh *et al*, 1972), and see no reason why it would not work well in polycythaemia patients who do not respond to venesection. It would be well worth a trial before resorting to electroconvulsive therapy. Since this approach focuses on relieving the primary cause of the mental upset, cerebral ischaemia, the results could be far superior to ECT.

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ARTHUR C. WALSH

*161 N. Dithridge Street  
Pittsburgh  
Pennsylvania 15213  
USA*

#### What's in a name?

SIR: Power-Smith (*Journal*, August 1991, **159**, 296) was bemused with the term 'Consultant Physician (Mental Health)' and canvassed for other appellations. The following are lists (Walter, 1991) of formal and slang terms which have, at various times, been used to designate members of our profession:

- (a) *Formal appellations*: clerical mad doctor, psychopathic practitioner, alienist, mental hygienist, psychiatrist, psychotherapist, therapist, psychoanalyst, analyst, nerve specialist, mental specialist.
- (b) *Slang appellations*: mad-doctor, nut-doctor, looney-doctor, crazy-doctor, bug-doctor, squirrel-doctor, psycho, psyche, psych, sickey-ackey, sky-high-atrist, headpeeper, couch-doctor, trick-cyclist, headshrinker, shrinker, shrink, straightener.

The number, range and nature of such designations attest historical changes in the treatment of mental illness, euphemistic influences and the ambivalent attitude displayed towards those who manage mental illness. Other factors may also play a part. It may not be coincidental that the word 'psychotherapist' became fragmented into 'psycho, the rapist' (Mackay, 1990) in Australia at a time when there was a much publicised case of therapist–patient sexual contact. The relevance to our profession is that the maintenance of moral and ethical standards of care may not prevent the introduction of unsavoury appellations but will also not actively encourage them.

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GARRY WALTER

*The Northside Clinic  
Sydney, NSW  
Australia*

#### Monozygotic male triplets discordant for psychosis

SIR: Differences in brain morphology between monozygotic twins discordant for schizophrenia suggest brain damage as a cause of the psychosis. I report a rare occurrence, a persisting schizoaffective psychosis in one of monozygotic male triplets with MRI findings suggesting abnormality in the unaffected siblings. The diagnoses were made with the Schedule for Affective Disorders and Schizophrenia (SADS).

The triplets were born of a healthy 19-year-old married woman. The normal pregnancy ended at 36