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INAYAT KHAN

10 Chemin des Burgnons
1217 Meyrin
Geneva, Switzerland

Affect logic

SIR: The current resurgence of interest in mental mechanisms and in unconscious mental processes is a healthy development in modern clinical psychiatry. It should help to redress the balance between the biological and psychological exploration of mental illness and to facilitate the correlation of psychopathology and the pathophysiology of the brain. Ciompi's erudite paper on affect and the psyche (*Journal*, July 1991, **159**, 97–105) is a heartening addition to the literature.

The author proposes a possible basis for a new, inclusive, three-level, functional model of the psyche. Most psychiatrists would agree that human behaviour is produced by some underlying psychological structure. It is impossible, however, to infer the complete details of this mechanism and we must content ourselves with formulating more general hypotheses (Deutsch, 1962), and reconstructing the more important, albeit more abstract, design of the mechanism whose external behaviour we observe. Ciompi succeeds admirably in finding the middle road between the absurdities of the pseudo-psychologist and the sterility of positivism run wild.

I was disappointed with the discussion of developmental issues and their considerable influence on the functioning of the psyche. The inner life of the mind can only be understood as a development from something more primitive in every man's behaviour. The valuable contribution of psychodynamic theory received only scant recognition despite the fact that the author was stalking mutual hunting grounds (Gottschalk, 1990). Furthermore, little was said of the role of language in general. Human beings are from the beginning recognised as potential language-users, and as potential observers of social conventions which they will later learn to formulate. The conditions of application of the vocabulary of feelings to human beings are determined by the fact that two capacities – the capacity to control their inclinations, and the capacity to identify their inclinations, and their circumstances, in words – are gradually developed together (Clark & Clark, 1977).

Ciompi's 'new' psychosocial/biological model bears a striking resemblance to the ideas and theories expounded by the 19th-century French psychiatrist Pierre Janet (1889) and the German psychiatrist Albert Eulenberg (1878). Janet was the first to systematically study dissociation as the crucial psychological process with which the organism reacts to overwhelming experiences and show that traumatic memories may be expressed as sensory perceptions, affect states, and behavioural re-enactments. Janet provided a broad framework that unifies into a larger perspective the various approaches to psychological functioning which have developed along independent lines in this century. Eulenberg believed that 'psychic shock', in the form of sudden vehement emotions such as terror or anger, could better be called psychic trauma. He regarded this 'sudden action of vehement emotions' as an actual molecular concussion of the brain, which he likened to the *commotio cerebri* postulated in physical trauma. Ciompi's formulation should be welcomed not as a new theory but as a rediscovery and improvement of these 19th-century contributions.

Finally, concerning the psychiatric applications of the proposed model, the author confines his discussion to possible uses in the psychoses. Potential applications in the study of the dissociation disorders, post-traumatic stress disorder and personality disorders, especially borderline states, go unmentioned. Hopefully this will be addressed in future contributions!

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RAY TRAVERS

Department of Psychological Medicine
Alder Hey Children's Hospital
Eaton Road
Liverpool L12 2AP

Exposure therapy for PTSD

SIR: Richards & Rose (*Journal*, June 1991, **158**, 836–839) describe a treatment programme for post-traumatic stress disorder (PTSD), but use outcome measures for depression, phobic anxiety and social adjustment. This is clearly a problem in PTSD

research, where comorbidity with other Axis 1 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 whch 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 somewhet 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