Correspondence

EDITED BY LOUISE HOWARD

Contents ■ Meditation and anxiety ■ Unconsciousness and post-traumatic stress disorder ■ Mental health among Irish people living in Britain

Meditation and anxiety

Sir: In his editorial Snaith (1998) considers the use of meditation in the treatment of anxiety. I would like to draw attention to another strand of research on meditation. Kabat-Zinn *et al* (1987) have used mindfulness meditation extensively in the treatment of chronic pain, but also to help individuals with anxiety (Miller *et al*, 1995). Snaith's use of meditation appears to involve essentially a relaxation response. In mindfulness meditation rather than trying to distract oneself through calming imagery, the object is to pay more attention to one's experience. The awareness that may be developed allows the subject to view their experiences more fully for what they really are. Thus, fearful thoughts are just thoughts; bodily symptoms such as sweating and palpitations are just sensations. This can enable the separation of raw experience from catastrophic predictions about reality.

Mindfulness meditation appears to be a different means of helping anxiety disorders from Snaith's use of meditation. It may be closer to a cognitive–behavioural approach, with the advantage of being a tool to identify and work on unhelpful cognitions directly.

Kabat-Zinn, J., Lipworth, L. A., Burney, R., *et al* (1987) Four-year follow-up of a meditation-based program for the self-regulation of chronic pain: treatment outcomes and compliance. *Clinical Journal of Pain*, **2**, 159–173.

Miller, J. J., Fletcher, K. & Kabat-Zinn, J. (1995) Three-year follow-up and clinical implications of a mindfulness meditation-based stress reduction intervention in the treatment of anxiety disorders. *General Hospital Psychiatry*, **17**, 192–200.

Snaith, P. (1998) Meditation and psychotherapy. *British Journal of Psychiatry*, **173**, 193–195.

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Unconsciousness and post-traumatic stress disorder

Sir: I would like to support the proposal of O'Brien & Nutt (1998) for further investigations into the effects of unconsciousness on the later development of post-traumatic stress disorder (PTSD).

I have examined hundreds of people suffering from PTSD and related ill-effects from accidents. An almost universal element in their accounts of the traumatic experience is that the first 24–72 hours were the worst.

Very often, they were then in severe pain, only partially relieved by the analgesics they were given, could not sleep and – most significantly – were in a state of shock, distress and agitation. No treatment of any kind would have been given for these latter symptoms.

Quite apart from the humanitarian need to relieve suffering, it seems very likely on common-sense grounds that effective control of these acute sequelae of the accident could prevent much later disability. One of the main reasons that relief is not given is medical prejudice against the use of benzodiazepines on an acute basis, which is a total misunderstanding of their long-term risks (this point has been emphasised by Williams & McBride (1988)). There are even absurd, and completely unfounded, views that it is 'bad' for people to have their acute post-traumatic symptoms suppressed. Many doctors share this idea.

In addition to giving us important new information on the effects of unconsciousness, implementation of the proposal made by O'Brien & Nutt might lead to the more rational and humane management of accident victims.

O'Brien, M. & Nutt, D. (1998) Loss of consciousness and post-traumatic stress disorder. A clue to aetiology and treatment. *British Journal of Psychiatry*, **173**, 102–104.

Williams, D. D. R. & McBride, A. (1998) Benzodiazepines: time for reassessment. *British Journal of Psychiatry*, **173**, 361–362.

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Mental health among Irish people living in Britain

Sir: My attention has been drawn to Bracken *et al*'s (1998) editorial on the mental health of the Irish in Britain, in which hospital admission data of 20 to 30 years ago are used to infer substantially higher psychiatric morbidity in the British Irish compared with the indigenous population. However, admission data tell us more about how a community used in-patient facilities than about psychiatric morbidity and this has been nowhere better exemplified than in Ireland itself (Ni Nuallain *et al*, 1987). One of the most glaring examples of how misleading admission data are in relation to community morbidity relates to alcohol-related problems which, in the data presented by Bracken *et al* (1998), show the Irish to have admission rates that are 10 times higher than those of the indigenous population. Similar discrepancies in admission rates for this condition were observed between England and Scotland in the face of very similar alcohol consumptions between the two groups. However, when Latcham & Kreitman (1984) surveyed all treatment contact sources in the two communities, morbidity equalised; it was simply that the Scots were bringing their alcohol problems to psychiatric hospitals but the English were taking them elsewhere.

A further difficulty with admission data of the type presented by Bracken *et al* relates to social class or socio-economic grouping, which is not controlled for in the crude rates presented. It is likely that the Irish in Britain are over-represented in lower socio-economic groupings. That this is relevant is evident from hospital admission data from Ireland itself where a fourfold differential exists between employers and managers and unskilled manual workers (Keogh & Walsh, 1998), for example.

Bracken, P. J., Greenslade, L., Griffin, B., *et al* (1998) Mental health and ethnicity: an Irish dimension. *British Journal of Psychiatry*, **172**, 103–105.

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