treatment-resistant psychotic patients almost invariably have unusual cognitive patterns on neuropsychological testing, most can be helped a great deal by the provision of a stress-free milieu (advocated by Murray), together with the careful provision of suitable occupations and recreations. Above all, they need appropriate supportive psychotherapy.

JOHN GUNN
PAMELA TAYLOR
JAMES MACKEITH
EDNA DOOLEY
TOM MCMILLAN

Bethlem Royal Hospital
Monks Orchard Road
Beckenham, Kent

References

MACMILLAN, J. F., CROW, T. J., JOHNSON, A. L. & JOHNSTONE, E. C. (1986) The Northwick Park study of first episodes of schizophrenia: III. Short-term outcome in trial entrants and trial eligible patients. *British Journal of Psychiatry*, **148**, 128–133.

WATT, D. C., KATZ, K. & SHEPHERD, M. (1983) The natural history of schizophrenia: a 5 year prospective follow-up of a representative sample of schizophrenics by means of a standardised clinical and social assessment. *Psychological Medicine*, **13**, 663–670.

SIR: I was astonished to read the Maudsley Grand Rounds case report (Roberts *et al*, *Journal*, December 1986, **149**, 789–793). Where is the data to support the view that all "acute symptoms of schizophrenia can be controlled pharmacologically"? Existing data suggests that a substantial proportion of cases show unremitting psychotic symptoms. The landmark Camberwell study of Brown *et al* (1972) included 29 patients who left hospital with persistent symptoms in the 101 consecutive admissions who were discharged to family households. The five patients who remained in hospital probably suffered persistent symptoms. Thus, it seems reasonable to conclude that at that time excellent treatment at the Maudsley Hospital was unable to induce a remission in one-third of cases.

Despite considerable recent advances in our understanding of the pharmacology of schizophrenia there is little evidence to suggest major advances in the efficacy of drug treatment. However, there have been developments in psychological interventions that appear to add to the efficacy achieved by drugs alone. These include a broad range of behavioural psychotherapy interventions (Hagen, 1975; Paul & Lentz, 1977; Falloon, 1985). Before advocating the low stress social environments offered by the long-stay asylum I would recommend pharmacologists to seek the assistance of a skilled behavioural psychotherapist in the comprehensive management of schizophrenia.

IAN R. H. FALLOON

Buckingham Mental Health Service
High Street
Buckingham MK18 1NU

References

BROWN, G. W., BIRLEY, J. L. T. & WING, J. K. (1972) Influence of family life on the course of schizophrenic disorders: a replication. *British Journal of Psychiatry*, **121**, 241–258.

FALLOON, I. R. H. (1985) *Family Management of Schizophrenia: A Study of Clinical, Social, Family and Economic Benefits*. Baltimore: Johns Hopkins University Press.

HAGEN, R. L. Behavioral therapies and the treatment of schizophrenics. *Schizophrenia Bulletin*, **13**, 70–96.

PAUL, G. L. & LENTZ, R. J. (1977) *Psychosocial Treatment of the Chronic Mental Patient*. Cambridge, MA: Harvard University Press.

Psychological Disorders in Obstetrics and Gynaecology

SIR: In her review of *Psychological Disorders in Obstetrics and Gynaecology*, Jequier (*Journal*, December 1986, **149**, 807) applauds the comprehensive coverage assembled by the editor of the book, R. G. Priest.

About one-fifth of all pregnancies end in spontaneous abortion or miscarriage, although estimates range from 10 to 43% (Miller *et al*, 1980; Llewellyn-Jones, 1982). This is comparable in frequency of occurrence to that of induced abortion, which Olley (1985) puts at about three in ten. Yet a complete chapter is given to the latter and the bare mention of the former is in a brief coverage of psychogenic factors in repeated abortion.

It is now being recognised in some of the literature (Raphael, 1984) that spontaneous abortion frequently has profound psychological effects and that these reactions are often missed or mishandled, partly because the event is dismissed as 'routine'. What a pity, then, that this "splendid contribution to the literature" has failed, like the reviewer, to give recognition to such a common and distressing, but often ignored, problem in obstetrics and gynaecology.

D. RIDLEY-SIEGERT

Greenwich District Hospital
Vanbrugh Hill
London SE10 9HE

References

MILLER, J. F., WILLIAMSON, E., GLUE, J., GORDON, Y. F., GRUDZINSKAS, J. G. & SYKES, A. (1980) Foetal loss after implantation: a prospective study. *The Lancet*, *ii*, 554–556.

LLEWELLYN-JONES, D. (1982) *Fundamentals of Obstetrics and Gynaecology Vol. 1*. London: Faber and Faber.

OLLEY, P. C. (1985) Termination of pregnancy. In *Psychological Disorders in Obstetrics and Gynaecology* (ed. R. G. Priest). London: Butterworths.

RAPHAEL, B. (1984) *The Anatomy of Bereavement*. London: Hutchinson.

Comprehensive Psychiatric Community Services for the Severely Disabled

SIR: I was interested in Wing & Furlong's plans for a "haven community" to serve the future needs of West Haringey's chronically mentally ill (*Journal*, October 1986, **149**, 449–457), as their proposals have much in common with the developments which have taken place within Oxford's Department of Rehabilitation and Community Care. They rightly stress that disability in one aspect of life does not necessarily imply an equal disability in all areas; any one patient should be able to obtain a unique combination of residential, occupational, and recreational services (Gan & Pullen, 1984).

In 1980 a service was started at Littlemore Hospital to meet the needs of Oxfordshire's 'new long-stay', although patients are accepted on the basis of clinical criteria rather than length of previous admission. This has evolved into the Young Adult Unit, based on a 24-bedded ward, The Eric Burden Community (EBC), on the edge of the Littlemore site (Pullen, 1986). The same building also houses the Unit's out-patient department and is the administrative centre of a developing network of hostels and group homes specifically for the young adult chronically mentally ill. Day care for this group includes a centre, based in an Oxford church, run by the Oxford branch of MIND (Hope & Pullen, 1985).

Our experiences confirm the necessity of providing continuity of care for the severely 'socially disabled' by a single team. A sense of 'haven' can also be created by the knowledge that wherever one happens to be living at the time one still 'belongs' (once accepted, patients remain on the case register of the department indefinitely).

One anxiety I have after reading about the Friern plans concerns the capacity of the proposed 12-bedded mother house to re-admit patients during their inevitable relapses. We have retained the EBC as a hospital ward (albeit one run as a therapeutic community in which, for example, the residents are responsible for the provision of most meals) because we feel that it is at times of crisis that long-term patients most need the care of those who know them well. The psychiatric hospital bed is an essential component of community care.

The Friern Haven appears to be an exciting and imaginative response to the present needs of some of the hospital's existing long-stay patients and to the future needs of Haringey. Elsewhere, other patterns of service will be more appropriate, but in every case there will need to be an integrated network of varied services. I join Wing & Furlong, however, in arguing "that responsibility for the most severely disabled and disturbed group... should be given high priority rather than left as a residual group to be provided for only when all other services are in place".

G. P. PULLEN
Department of Rehabilitation & Community Care
Littlemore Hospital
Oxford OX4 4XN

References

GAN, S. & PULLEN, G. P. (1984) The unicentre: an activity centre for the mentally ill. *British Journal of Occupational Therapy*, **47**, 216–218.

HOPE, J. & PULLEN, G. P. (1985) 'The Mill': a community centre for the young chronically mentally ill – an experiment in partnership. *British Journal of Occupational Therapy*, **48**, 142–144.

PULLEN, G. P. (1986) Community study: The Eric Burden Community. *International Journal of Therapeutic Communities*, **7**, 191–200.

Delineating Social Phobia

SIR: Solyom *et al* (*Journal*, October 1986, **149**, 464–470) state that "the problem of overlap may also arise because both agoraphobia and social phobia may be based on fear of having a panic attack, i.e. both may suffer from panic disorder."

DSM–III and DSM–III–R (8/1/86 draft) attempt to distinguish social phobia from panic disorder and agoraphobia. Social phobics in DSM–III and DSM–III–R are defined by the occurrence of intense anxiety specifically in response to feeling scrutinised or evaluated by other people (or in anticipation of this). This differs from the panic attack associated with Panic Disorder or Agoraphobia. To meet the DSM–III–R definition of Panic Disorder, an individual has to experience intense anxiety episodes occurring at times when the patient is not the focus of others' attention.

Soylom *et al* appear to be questioning this diagnostic convention. The reasonable question to ask is: does the convention make sense? Specifically, is there a meaningful basis to distinguish between the anxiety experience of Social Phobia and the panic attacks associated with Panic Disorder or Agoraphobia with Panic Attacks?

Several lines of evidence suggest qualitative differences between the anxiety experience of social phobic and panic disorder or agoraphobic patients. Aimes *et al* (1983) noted differences in the symptom pattern.