psychogeriatric assessment units, we find that in Cornwall (1) 9 per cent of discharges were to a psychiatric hospital and 33·5 per cent to geriatric and general wards (*total to 'hospital' 42·5 per cent*) and in Nottingham (2) 7·5 per cent of discharges went to a psychiatric hospital and 21·5 per cent to other wards (total to 'hospital' 29 per cent). In the former unit the agreed policy was to admit a higher percentage of patients with dementia than in the latter, thus explaining the discharge differences between the units. The Gloucestershire discharge figures, which are so much at variance with others published, also suggest a high degree of admission selectivity, which in our view make the conclusions misleading. The total picture of admission policies and description of the relevant services in Gloucestershire are unfortunately not included in this paper, and we question most seriously the suggestion that the number of beds for severely demented patients recommended by the DHSS may be excessive. At least we do not believe that evidence to support this conclusion has been presented. We hope that the DHSS planners will also consider the paper by Drs Early and Nicholas in the same journal which comes to very different conclusions and makes recommendations which we would (strongly) support.

E. V. B. Morton
T. S. Wilson
I. E. I. Williams
J. F. Donovan

Cornwall Geriatric Unit,
Barncoose Hospital,
Redruth

References

1. Donovan, J. F., Williams, I. E. I. & Wilson, T. S. (1971) *Recent Developments in Psychogeriatrics. Brit. J. Psychiat.* Special Publication No. 6.
2. Morton, E. V. B. & Tyndall, R. M. (1971) *Geront. Clin.*, **13**, 145.
3. Andrews *et al* (1972) Planning of psychogeriatric care. *Geront. Clin.*, **14**, 100.
4. Early, D. F. & Nicholas, M. *Brit. J. Psychiat.* **130**, 117.

Dear Sir,

Drs Baker and Byrne offer us 'Another Style of Psychogeriatric Service'.

They present the account of a mere six months, presumably not long after the service had been established, and yet claim to have demonstrated the permissibility of far-reaching generalized conclusions.

Psychogeriatric services are intimately linked with and dependent on the success and level of provision of geriatric services and Local Authority residential care. Perhaps Drs Baker and Byrne ought also to pay tribute to the humble and unacknowledged geriatric physicians, matrons and care attendants of Gloucestershire when they claim such success in the care of elderly people with organic psychiatric disorder.

The burden of proof is on Dr Baker to refute Professor Adams' statement: 'The geriatric physician with a high turnover and no long-stay problem is (equally) suspect as a gerontological spiv. Somebody, somehwere, must carry the can for him' (Adams, 1974).

Many a new service, run with enthusiasm and hard work, makes a startling impact and is reported on before the chickens come home to roost. We should view Dr Baker's activities with interest but await a more extensive and comprehensive report and react with caution and perhaps alarm to the dangerous and unsubstantiated claims made in this paper. Claims such as these may hinder the provision of resources in under-endowed areas of the country, especially in these times of financial stringency.

Let us hope that the elderly, their hard-pressed families and all of us who are concerned with the care of the elderly are not made to suffer on the basis of Drs Baker's and Byrne's inadequate analysis.

Klaus Bergmann

Newcastle General Hospital,
Westgate Road,
Newcastle upon Tyne NE4 6BE

Reference

Adams, G. F. (1974) Eld Health. *British Medical Journal, iii*, 789–91.

Dear Sir,

As the three Consultant Physicians in Geriatric Medicine working in the same clinical area as Drs A. A. Baker and R. J. F. Byrne, we would like to comment on 'Another Style of Psychogeriatric Service'.

We have personal experience of the benefit that has been derived from improved community services and increased day hospital provision, but we are seriously concerned with other aspects of the policy. We note in particular the statement that it is felt the 'number of beds for this type of patient recommended by DHSS may be excessive', and that a further bed reduction seems likely as only 5 per cent of admissions appear to become long-stay. This figure is in considerable contrast to that found by other workers (1, 2) and we feel our experience may help to explain the difference.

We have found that since the introduction of this service an increasing number of mentally-disabled

elderly patients have been denied admission or have been admitted for short periods and discharged little changed, thereby straining their families beyond endurance. General practitioners have subsequently called us out to see such cases, and we are not unused to having a daughter or other relative begging for help. Inevitably the closure of psychogeriatric beds has resulted in increased pressure on the Department of Geriatric Medicine, thus preventing admission of physically handicapped patients whose right it is surely to occupy the beds specifically allocated to them.

Psychogeriatric, geriatric and community services are obviously complementary in their function. To give the best overall service to the elderly community and their families a close working relationship is necessary, and one service should not be run in isolation to the detriment of the others and the patients they serve. In our opinion the paper by Drs Baker and Byrne makes no attempt to analyse the implications of their 'style of psychogeriatric service' for other branches of health and community services, and we cannot support the conclusions they draw. In short, the task of caring for these patients is falling into other hands.

J. M. Loudon
F. D. Honneyman
M. Bannerjee

Departments of Geriatric Medicine,
Gloucester and Cheltenham,
Delancy Hospital,
Charlton Lane,
Cheltenham GI53 9DU

References

1. Morton, E. V. B., Barker, M. E. & Macmillan, D. (1968) *Geront. Clin.*, 10, 65.
2. Andrews *et al* (1972) Planning of psychogeriatric care. *Geront. Clin.*, 14, 100.

THE MEASUREMENT OF PHOBIAS

Dear Sir,

Teasdale and his colleagues (*Journal*, February 1977, 130, pp 186–93) report on a comparison of the phobia rating scales of Gelder and Marks (1966) and Watson and Marks (1977). They suggest (p 192) that it is possible for someone with only moderately severe agoraphobia to obtain 'maximum score by the Watson and Marks method' by the assessor selecting suitable situations. There is a distasteful imputation of possible chicanery in the authors' phraseology; but, this apart, the reader might be interested to know why it was thought worthwhile to modify the Gelder and Marks scales which had apparently been useful in several Maudsley studies of phobic patients.

The main reason for change was that the anchor points on the Gelder and Marks phobia scales referred to both subjective anxiety and avoidance behaviour, giving rise to anxiety. Hence, separate scales for avoidance and anxiety were devised. The use of separate scales in group studies seems, interestingly enough, to have been of little benefit.

The measurement of phobias is a complex matter that cannot appropriately be dealt with comprehensively in a letter of this kind. One point is worth mentioning, however. The original Gelder and Marks scales required the identification by the investigator(s) of a 'main phobia' and of 'subsidiary phobias' for each patient. In group studies of phobic patients, ratings for different patient's 'main phobias' have been pooled and subjected to analysis of variance, covariance, etc. The 'main phobias' analysed as a single category have sometimes included very different things, such as 'travelling by train', 'eating in public', and, when specific and agoraphobic subjects have been studied together—'spiders', 'cats', etc. It is arguable that such varied material is not rendered analysable by parametric techniques by the semantic sleight of hand which calls it all 'main phobia'.

This problem is less important as one's study population becomes less heterogeneous, when it is easier to rate people for similar 'phobias', but it should be remembered that even 'agoraphobia' is too heterogenous for group studies of it to generate easily generatizable results. Problems associated with rating 'main phobias' are overcome, in agoraphobics at least, by using the same situations with them all. The data indicate that clearly defined situations related to streets, buses, trains, shops and walking away from home can be usefully rated (Watson *et al*, 1973). The assessor does not 'select suitable situations' (in the sense in which this phrase is used by Teasdale *et al*) if he uses this scaling method, although he may do if he uses the Gelder and Marks scales. The situations rated are very difficult—rather than merely mildly difficult—for most phobics to cope with *in vivo*. (For example, ratings for 'Travelling alone in a crowded tube train' will usually indicate greater anxiety than ratings for 'travelling accompanied on an empty tube train'.) 'Very difficult' situations normally respond to treatment less well than 'mildly difficult' ones.

There is no purpose in asking if the Gelder and Marks scales are better than the Watson and Marks ones. They rate different things and are therefore