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".

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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.

Social phobics reported more blushing and muscle twitching, and less limb weakness, breathing difficulty, dizziness or faintness, actual fainting, and buzzing or ringing in the ears than did agoraphobics.

Analogue studies and open clinical trial suggest greater beta-blocker efficacy in social phobia than agoraphobia (Gorman *et al*, 1985). Tricyclics are quite helpful for blocking panic attacks. Clinically they seem less useful in social phobia. Controlled trials to confirm these impressions, however, are needed. MAO inhibitors appear useful in both conditions.

Plasma epinephrine does not appear to be elevated during *in vivo* or lactate induced panic attacks (Liebowitz *et al*, 1985). A study in progress is demonstrating that at least a subset of social phobics (perhaps 50%) demonstrate plasma epinephrine elevations of 50% or more during performance challenge. Studies in medical house officers suggest two to three-fold epinephrine rise during more stressful real life public speaking (Dimsdale & Moss, 1980). Social phobics are significantly less likely to panic with sodium lactate infusion than are agoraphobics (Liebowitz *et al*, 1985).

Onset and offset seem to differ as well. Social or performance anxiety is triggered only when the individual is faced with interpersonal evaluation or scrutiny, and is probably induced by cognitions that one will perform badly, look foolish, etc. Panic attacks related to panic disorder often occur unexpectedly, especially early on, without obvious cognitive precursors. When feeling anxious, social phobics prefer to be alone to recover their equilibrium; agoraphobics are less likely to panic, and more readily recover, in the presence of a trusted person.

Both agoraphobics and social phobics do fear the onset of severe anxiety experience. Available evidence, however, suggests important differences in pathophysiology, which Solyom's statement obscures.

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References

AIMES, P. L., GELDER, M. G. & SHAW, P. M. (1983) Social phobia: a comparative clinical study. *British Journal of Psychiatry*, **142**, 174–179.

DIMSDALE, J. E. & MOSS, J. (1980) Short-term catecholamine response to psychological stress. *Psychosomatic Medicine*, **42**, 493–497.

GORMAN, J. M., LIEBOWITZ, M. R., FYER, A. J., CAMPEAS, R. & KLEIN, D. F. (1985) Treatment of social phobia with atenonol. *Journal of Clinical Psychopharmacology*, **5**, 298–301.

LIEBOWITZ, M. R., FYER, A. J., GORMAN, J. M., DILLON, D., DAVIES, S. O., STEIN, J. M., COHEN, B. S. & KLEIN, D. F. (1985) Specificity of lactate infusions in social phobia vs panic disorders. *American Journal of Psychiatry*, **142**, 947–949.

——, GORMAN, J. M., FYER, A. J., LEVITT, M., DILLON, D., LEVY, G., APPLEBY, I. L., ANDERSON, S., PALU, M., DAVIES, S. O. & KLEIN, D. F. (1985) Lactate provocation of panic attacks: II. Biochemical and physiological findings. *Archives of General Psychiatry*, **42**, 709–719.

Clinical Tests of Memory as Sensitive and Specific Signs of Dementia

SIR: Psychogeriatricians could make greater use of Kopelman's evaluation of clinical tests of memory (*Journal*, October 1986, **148**, 517–525) if his organic and non-organic groups are sub-divided to allow the analysis of Alzheimer and depressed groups. This would extend the validity of several tests of memory, comprehension, and orientation as contributors to the common and problematic differential diagnosis of depressed versus Alzheimer patients. Using the number of subjects failing to score at cut-off point for each test (his Table III), the relative discrimination between these groups was assessed with the two-tail Fisher exact probability test (Armsen, 1955). The Gresham memory and orientation questionnaire, Wechsler logical memory, paired associates, name and address, and anomalous sentences tests all show significant discrimination beyond the 0.05 level of probability. Although test cut-off points were chosen to maximise the discrimination between organic (Korsakoff and Alzheimer) and non-organic (healthy controls and depressed), some show sensitivity exceeding 80% to Alzheimer's disease and specificity exceeding 80% relative to depression and healthy controls: logical memory with 45 minute retention below 50% of immediate retention; paired associates total score less than 14: name and address learnt in more than two trials. This is sufficiently promising to be worth cross-validating. A table of discrimination, sensitivity, and specificity is available from the author.

The publication of revised cut-off points chosen to maximise the discrimination of Alzheimer's disease from depression and normal controls, taking into account the base-rates for these pathologies, would greatly assist the selection and monitoring of cases in clinical trials. The availability of sensitivity, specificity, and misclassification rates as a function of test score (Anthony *et al*, 1982) would permit the selection of a cut-off point with high sensitivity for a