It would seem that in cases of dementia with abnormal DST, the duration was long, the clinical state variable and a disproportionate number of cases actually displayed mild and moderate dementia. It is thus possible that an abnormal DST may well be a marker of a less malignant course, at least in some cases of dementia.

It has been claimed that the abnormal DST may also reflect abnormality in central monoaminergic neurotransmission in relation to hypothalamo-limbic system dysfunction, but Carroll *et al* (1978) have speculated that the abnormal DST in depression may well be the result of muscarinic cholinergic hyperfunction in the limbic system. As hypofunction in cholinergic activity is the widely accepted view of Alzheimer disease pathology, it is also possible, in the light of these recent studies, that there is a more complex disturbance in cholinergic transmission (with the suggestion that prognosis depends on the direction of cholinergic dysfunction), than we have been led to believe.

B. MAHENDRA

Department of Neurological Sciences,
St Bartholomew's Hospital,
West Smithfield,
London EC1A 7BE

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USE AND MISUSE OF THE PSE

DEAR SIR,

Wing in his lecture "Use and Misuse of the PSE" (*Journal*, August 1983, **143**, 111–17) is responding to Berner and Küfferle's comments (*Journal*, 1982, **140**, 558–65) on the failings of what they call "British Psychiatry", a generalization which would hardly survive for long a closer acquaintance with the wide range of opinions in Britain. This indeed is what one would find in any other country where the subject is alive, and debate is free. But be that as it may, Berner *et al* made a number of interesting points, which they present as those of "The Viennese School", quoting as their main authority Janczarik from Heidelberg.

I wish here to concern myself only with one point which was also dealt with by Wing, namely the proper place in the PSE of 'hypochondriasis'. The PSE lists this as item 9, as a worrying preoccupation with possible disease or bodily malfunction. Berner *et al* for the sake of 'increased categorical thinking in psychopathology' suggest that it should be ranged among what they call "fact phobias" which are more or less what Fish called 'fears restricted (or linked) to an idea'. Wing accepts Berner's point and announces that "fears of illness" will be included in the next edition of the PSE in the section on phobias.

The literature on 'hypochondriasis' has often been flawed by a lack of appreciation that it refers to the *content* rather than the *form* of an experience. It is in that respect comparable to jealousy, persecution or any of the other great themes of human existence. A few examples may illustrate this:—

1. A patient after an heart attack is taken by a strong fear of a repetition brought on by any activity. This fear makes it impossible for him to cooperate with efforts at rehabilitation.—Form: anxiety state.
2. A patient becomes a health-food buff, talks of little else, and makes life for his family and others difficult with his insistence on excluding all kinds of food from the diet to prevent diseases.—Form: overvalued idea.
3. A patient is constantly afraid of picking up germs when touching doorknobs, and goes to great length in avoiding this. He says he often realizes the absurdity of his fears has doubts about them, but is unable to resist these thoughts.—Form: obsession.
4. A melancholic patient is convinced he has cancer and is doomed to die.—Form: delusionlike idea.
5. A patient is convinced that rays are being directed from aeroplanes onto his genitals in order to bring about impotency and sterility.—Form: delusion.
6. A patient hears voices repeating over and over that he is riddled with VD.—Form: hallucination.

In all these diverse experiences the content reveals a fearful preoccupation with health. The list of the forms this might take can of course be extended. But if one conceives of a phobia as an avoidance of an overwhelming fear which the patient knows is triggered by objects such as for instance insects or certain ideas, although this strikes the patient himself as senseless but nevertheless irresistible, then it is difficult to think of clinical examples of phobias where the content would be hypochondriacal. It is therefore surprising

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that Berner *et al* classify hypochondriasis as such as, of all things, a phobia.

The PSE is designed as a multipurpose instrument and may of course include items of form, as well as items of content, but it is essential not to compound the two.

J. HOENIG

Memorial University of Newfoundland,
St John's, Newfoundland,
Canada A1B 3V6

THE TWO-WAY TRADE—PSYCHIATRY AND NEUROSCIENCE

DEAR SIR,

McHugh and Robinson's review (*Journal,* September 1983, **143,** 303–5) confirms that new transmitter pathways constitute a new neuroanatomy. However, it is questionable whether they provide for "conceptualizing new relationships of neuropathology to psychopathology" or merely corroborate Hughlings Jackson's (1884) notions of uniform and local dissolutions in the nervous system. In addition, Jackson already provided a conceptual framework for such states as hemiplegias, epileptiform seizures, choreas etc, as well as the mental phenomena of 'non-cerebral disease'.

An additional 'two-way trade' for psychiatry and neuroscience would therefore be the apparently forgotten contributions from the past to the present. In keeping with Dewhurst's (1982) sentiments, if Jackson's fertile ideas are given a second chance in psychiatry today perhaps the trade would be complete.

GEORGE HALASZ

The Bethlem Royal Hospital,
Monks Orchard Road,
Beckenham, Kent BR3 3BX

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IMIPRAMINE AND AGORAPHOBIA

DEAR SIR,

Donald Klein implies that I incorrectly cited from the chapter in *Agoraphobia* edited by Chambless and Goldstein (*Journal,* September 1983, **143,** 309). To make matters clear I would like to cite verbatim a sentence from the chapter:

"Even those patients who show stimulant side effects can most often be treated effectively by lowering the dose and then increasing very gradually, sometime to a maximum tolerated level of 10 mg per day (Zitrin *et al,* 1978)."

I am grateful to Dr Klein, however, for pointing out that the more recent studies he has carried out advocate doses in the range of 200 to 300 mg daily.

RICHARD STERN

St George's and Springfield Hospitals,
London SW17

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SUGGESTION AND SUICIDE BY PLASTIC BAG ASPHYXIA

DEAR SIR,

Of some six hundred suicides recorded in Kingston-upon-Hull by the city coroner between 1960, by when (according to local firms) plastic bags had become widely available to the general public, and 1980 inclusive, only nine were by this means. Their dates were 12:7:71, 18:9:72, 25:10:72, 4:12:72, 7:1:78, 15:3:78, 30:4:78, 5:5:80 and 5:9:80, giving an impression of tight clustering with long intervening gaps, heightened by the fact that all occurred in the last ten years of the series.

If the ten years are slightly shifted so as to begin on 1:2:71 and end on 31:1:81, and divided into consecutive two-month segments, then there are 51 such segments without a plastic bag suicide, and 9 with exactly one each, in the sequence

$$0^2\,1\,0^6\,1^3\,0^{29}\,1^3\,0^5\,1\,0\,1\,0^8$$

(where 0 represents a segment without a plastic bag suicide, 0^n n consecutive such segments, 1 a segment with one, etc). There are 11 runs (16.3 expected), with an exact probability (by the Wald-Wolfovitz test) of 0.0142469, confirming the impression of clustering. Alternatively, a non-plastic bag suicide (npbs) segment has estimated probability 5/50 = 0.1 of being followed by a plastic-bag suicide (pbs) segment, whereas a pbs segment has estimated probability 4/9 = 0.4 of being so followed; thus a plastic bag suicide in a segment appears to increase the probability of another in the next segment. In fact, the lag 1 autocorrelation is 0 = 0.34, with exact probability (by the Fister-Yates test) of 0.023689. Either way, there is a modest but significant clustering effect or dependency.

Since the city is served by a local newspaper and, from 1971, local radio, for the reporting of proceedings in the Coroner's Court, the most likely explanation seems to be that a process of suggestion or imitation has affected the choice of means of suicide. (Our evidence cannot go so far as does Phillips (1974), who points to a direct effect in increasing the suicide rate).

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