

and deserves more research, I would predict that after a couple of days in our unit in South East London, he would soon run out of inverted commas.

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DEAR SIRs

I agree with Dr David that the nosological status of "cannabis psychosis" is unclear. Psychotic reactions to cannabis are uncommon in Western societies despite the drugs widespread use (ARF, 1981). I am intrigued by the suggestion that the number of cases seen in Camberwell is so overwhelming – perhaps this provides a setting for the research Dr David advocates to clarify the issue. In the meantime the hard-pressed doctors of King's College could perhaps save on the use of inverted commas by applying appropriate ICD or DSM diagnoses.

As for my own interest in the subject, this stems from time spent working with the Mid-Glamorgan Community Drug Team, whose catchment area includes three of the poorest local authority districts in England and Wales and draws clients from socially disadvantaged communities whose streets are as mean as any in South-East London.

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Reference

ADDICTION RESEARCH FOUNDATION (1981) Report of an ARF/WHO scientific meeting on adverse health and behavioural consequences of cannabis use. Toronto.

The portable computer in psychiatry: tips on buying one

DEAR SIRs

We read with interest Dr Littlejohns' article (*Psychiatric Bulletin*, August 1991, 15, 493–495) but were disappointed that no distinction was made between "palm top" (mostly personal organisers the size of a small paperback), "notebook" (usually the size of A4 paper and often weighing less than 10 lbs) and "laptop" computers (almost anything that can be lugged around in a small bag: some weigh more than "desk top" computers).

Additionally, describing the Cambridge Z88 in such detail, a rather archaic machine by today's standards, does not accurately represent the current trend in portable computers: the user is confined to miniscule memory, truly basic wordprocessing,

having to learn "Basic" (a programming language), incompatibility with so-called IBM clones and no practical way of running important software such as statistical packages. The modem set-up is fiddly.

Anyone considering portable computing should think about an IBM compatible "notebook" with a battery life of more than one and a half hours, a well lit screen and preferably an internal modem. Hard disk space would be a bonus and a working memory (loosely termed RAM) of one megabyte is usually adequate. Furthermore, most portable computers nowadays can serve quite adequately as the user's only machine. Toshiba's T1000 range, or the Sanyo MBC-17NB are rather good, and the cost can be kept down by asking for an educational discount which can be as much as 35% below the list price. Really smart buyers get their goods in the United States and still make a saving after paying their fare and accommodation: a budget of £800 would not be unrealistic. For those who really need computing, a 286 (a type of micro-processor) based machine is the best choice. Those wishing to use a Graphical Interface such as "Windows" (which makes an IBM based machine run like an Apple Mackintosh) should think hard about a 386SX (another type of micro-processor) machine. In the near future, "notebooks" will have Cellular Telephone communication facilities instead of, or in addition to, a modem fax.

Market leaders in portable computing include Toshiba, Compaq, Dell, Tandon, Zeos, NEC and Viglen: there appears to be a direct correlation between reliability (which is poorer with "notebooks" compared with "desktops") and the buyer should be cautious of very "cheap" products.

We applaud Dr Littlejohns for raising the profile of portable computing in psychiatry.

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DEAR SIRs

I attempted in this article, to state my personal requirements and show the decision process that produced a best fit solution, for me. It was not my aim to formally review portable computing.

Much computer terminology is sales talk. 'Palm-top' must be a new one, but I understood 'laptop' and 'notebook' to be synonymous, and very recent, terms. Most computers called merely 'portable' as I think Johnson and Wells sought to infer, are often quite big, with a handle on them. I, however, used the word conventionally.

The small memory of the Z88 can now be expanded to 1500k, which is reasonably excessive bearing in

mind that simpler machines have reduced memory requirements. I frequently use the Z88 with a modem (and an additional amateur radio 'packet' modem from the car) without undue trouble, although for heavy use a set of rechargeable pencil batteries has usefully added approximately 10 hours of operation.

When considering compatibility, remember that simple text can be transferred between any type of computer. IBM clone compatibility is measured in percentage terms, often scoring less than 100. The current explosion of faster computer processors gives the software writers a choice, either write programs that ignore the newer, expensive features, or cut out most of your potential customer market, and pass on the costs to those that have the faster machines.

If it is your hobby, buy computer potential. If it is for your work, you should buy only the computer power you need. It will all be archaic soon. A lesser machine that is demonstrated, has local service arrangements and some telephone support can still be a better deal overall.

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Cigarettes and psychiatric patients

DEAR SIRS

I read with interest Dr Brown's paper on cigarette smoking among psychiatric out-patients (*Psychiatric Bulletin*, July 1991, 15, 413–414) in which he reported a prevalence of "about one and a half times that of the general public" for both sexes. He states that their residency in the community at the time of the study rules out the effects of institutionalisation. How can we judge this for ourselves when he does not tell us if and for how long these people had been in-patients in the past. I found that 24% of psychiatric in-patients started their smoking careers as in-patients. In-patients also have very high consumption of tobacco (Masterson & O'Shea, 1984).

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Reference

MASTERSON, R. & O'SHEA, B. (1984) Smoking and malignancy in schizophrenia. *British Journal of Psychiatry*, 145, 429–432.

DEAR SIRS

I accept Dr O'Shea's point that current residence in the community does not exclude previous institutional experience as an aetiological factor in cigarette smoking. A number of patients in the study had been in-patients in the past; however all were

living independently in the community at the time of the study. None were from the group who have recently moved into the community as a result of the closure of long stay hospital beds, as these patients came under the care of a different service. I therefore feel that institutionalisation in a narrow sense cannot explain the high levels of smoking.

Dr O'Shea's figure of the number of patients who start smoking as in-patients is surely cause for embarrassment, at least. We have a degree of responsibility for the physical health of our patients, smokers and non-smokers alike, especially those involuntary patients who may be unable to leave a smoky environment. The risks of passive smoking are now recognised. Perhaps self-interest may prompt a re-examination of our attitudes to smoking.

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The meaning of 'psychosis'

DEAR SIRS

The term 'psychosis' is in widespread use yet little is known about what it means to health workers. A study was performed among 96 members of various professional groups working within Exeter Health Authority (all 41 psychiatric medical staff, eight District General Hospital (DGH) consultants in acute specialities, 36 psychiatric nurses, five occupational therapists and six approved social workers). Each was sent an unstructured questionnaire asking them to write their understanding of the term psychosis. All replies were anonymous and varied in length from 300–500 words. From each it was possible to identify a definition, often with several items, which could be listed, as well as a variable length of commentary. Many definitions contained items expressed in so similar a fashion that they could be grouped together with "disturbance of contact with reality" the most frequent, appearing in 25 replies and "loss of insight" the next commonest feature (in 15 definitions). Thirteen respondents included "disorders of thinking, experience or perception". Half the respondents (26) had only one item in their definition and a further 19 had only two items.

Historically the term 'psychosis' is imprecise, from its appearance early in the 19th century distinguishing mental disorder from neurosis or a functional disease of nerves to the view of Gelder *et al* (1989) of psychosis as meaning broadly the more severe forms of mental illness. DSM-III-R regards psychotic as gross impairment in reality testing and a creation of a new reality while the ICD-9 definition contains three elements – gross interference with insight, with ability