

the implication being that it is not a measure of anxiety but probably is a measure of neuroticism.

A legitimate distinction can be made between anxiety as a personality "trait" and anxiety as a psychiatric "state". A person of marked anxious personality disposition need not necessarily be suffering from an anxiety state in the neurotic sense; conversely a person could suffer from an anxiety state who normally is not of an anxious disposition. Therefore any degree of correlation between a test that measures anxiety as a trait (which the IPAT Anxiety Scale mainly does) and a test that measures anxiety as a state (which the Modified Hamilton Anxiety Scale probably does) need not be expected. Of course, where there was both a marked anxiety state and a normally high anxious disposition a degree of correlation would occur; but I would suggest, since these two features are relatively independent, that few people would fit into that category.

To lend some force to this suggestion I would like to quote some slight work of my own. Using the Foulds' Symptom Sign Inventory (which measures, *inter alia*, anxiety states) I found that on a ten-point scale the mean number of symptoms was only 3.91 with a definite skew towards the lower end of the scale; on the other hand anxiety scores derived from the 16 Personality Factor Questionnaire (which is the same scale as the IPAT Anxiety Scale) were fairly normally distributed, but with a slight skew towards the higher end of the scale. On a small sample of the same patients who were seen after treatment the anxiety symptoms had almost completely disappeared, whereas the anxiety scores had not altered very much—a mean decrease of 0.7 (sten) in fact. Although Cattell and his associates claim that the anxiety scale could be used as a "temperature chart", this is not meant in the sense that a dramatic change in the anxiety level must be expected after treatment, rather as Cattell himself says, "we all experience higher and lower states with changing circumstances, but there is also evidence that some people vary about levels which are typically different for them from the central tendency in others. We then speak of 'characterological anxiety', i.e. a trait" (*The Scientific Analysis of Personality*). Thus a complete remission of anxiety symptoms might well be expected after treatment, but there would be a limited decrease in trait anxiety, probably only down to the characteristic level. If this is so, lack of correlation between the Modified Hamilton Anxiety Scale and the IPAT Anxiety Scale is not surprising.

The high correlation between the EPI Neuroticism Factor and the IPAT Anxiety Scale is not a very

valid indication that the IPAT is not measuring anxiety. Two scales correlating highly does not necessarily mean that they are measuring the same thing, e.g. a colleague of mine (J. J. Kear-Colwell) found a high correlation, $r = 0.68$, between hostility (as measured on the Foulds' Hostility Scale) and anxiety (as measured by the IPAT Anxiety Scale). It would be more rational to say that hostility and anxiety are related, a fact confirmed by extensive clinical observation also, than to say these are both measures of the same thing and then rely on being very partisan to decide which test is best. Incidentally, the Taylor Manifest Anxiety Scale was also accorded the same treatment because it correlated with the MPI Neuroticism Factor. Also there is some query whether there is an anxiety component in the EPI Neuroticism Factor. But without embarking upon a lengthy discussion about factorial composition it is reasonable to say that psychological entities can be correlated but separate.

In conclusion, I would like to state that I have not wittingly tried to uphold that the IPAT Anxiety Scale is a valid measure of anxiety, only that the conclusion of the authors that it did not "appear to be" is not warranted by their results, or the interpretation of their results. The question of the validity of the IPAT Anxiety Scale is a matter of very precise experimentation related to that problem alone. At the risk of appearing partisan, I would suggest that the work of Cattell and his co-workers has been too thorough to be dismissed in a cavalier fashion.

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WORK OF A PSYCHIATRIC EMERGENCY CLINIC

DEAR SIR,

Dr. John Brothwood in his paper on "The Work of a Psychiatric Emergency Clinic" states: "It is pertinent to ask what part might be played by a Psychiatric Emergency Clinic in an integrated service."

The question might be answered from the experience at St. Clement's Hospital, E.3, where integration was made possible by the transfer of statutory obligation for Mental Health from the London County Council to the London Borough of Tower Hamlets.

At St. Clement's Hospital the observation ward was converted into an Early Treatment Unit (Benady and Denham, 1963). Emergency referrals

are accepted from general hospitals, general practitioners, mental welfare officers, health visitors, social workers employed by the Local Authorities in the welfare, housing and children's departments, probation officers and citizens' advice bureaux. Self-referrals by patients with or without their families, friends or neighbours' assistance constitute a major share. New patients are seen by the duty doctor in the out-patient department, while old patients go straight to the ward where they had previously been treated. There they are received by the nursing staff whose knowledge of the case enables them to deal rapidly and satisfactorily with any behaviour disturbance of the patients, and with the anxiety of the accompanying relatives or friends. Psychiatric assessment is carried out and disposal is entirely within the local Mental Health Services, i.e. admission to in-patient or day-care, or referral to home and/or community care. Day care and treatment is preferably undertaken on the wards, or alternatively in day centres provided by the Local Authority and the Psychiatric Rehabilitation Association.

After 1 April 1965—the date of coming into force of the Greater London Act—St. Clement's Hospital took on half of the London Borough of Tower Hamlets as a catchment area, and the Emergency Psychiatric Services for the whole borough were concentrated at the hospital. Emergency calls after 5 p.m. on weekdays and for the whole of Saturday and Sunday are taken by the duty doctor, who will advise as regards emergency treatment at home, or referral to St. Clement's Hospital. Alternatively, he will visit, accompanied by a nurse, the patient at home to assess the situation and arrange admission or institute domiciliary treatment. In exceptional cases he could call on a Mental Welfare Officer for statutory assistance. These emergency provisions were officially notified to the general practitioners by the Medical Officer of Health, with a cautionary note about abuse of Section 29 of the Mental Health Act, 1959. The expected increase of emergency referrals during and after duty hours never happened. After-hours emergencies during April, 1965, were at the previous level of 12, during May they fell to 6, and in June there were only 4. The emergencies during duty hours remained at their usual level.

Integration of the Emergency Services proceeded by the following steps:

- (i) Observation ward becomes an Early Treatment Unit.
- (ii) The Emergency Unit accepts also day-patients and out-patient referrals.
- (iii) The out-patient department copes with day-time emergencies, while all the wards deal with acute and threatened relapses.

- (iv) After assessment patients are also accepted by the growing community services.
- (v) The hospital undertakes the emergency function of the Local Authority and begins to institute domiciliary treatment in addition to hospital and community care.
- (vi) More effective and co-ordinated services lead to a reduction of emergencies.

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REFERENCE

- BENADY, D. R., and DENHAM, J. (1963). "Development of an early treatment unit from an observation ward." *Brit. med. J.*, ii, 1569–1572.

FOREARM BLOOD FLOW IN NORMAL SUBJECTS AND PATIENTS WITH PHOBIC ANXIETY STATES

DEAR SIR,

I was most interested in the recent paper by Harper, Gurney, Savage and Roth (*Journal*, August 1965, p. 723), since I have been investigating the forearm blood flow of normal subjects and psychiatric patients for the past 2½ years. My findings were similar in that patients suffering from specific situational phobic anxiety had resting forearm blood flows which were not significantly higher than those of normal controls. Harper and his co-workers made blood flow measurements on their 10 phobic anxiety states, 8 of whom were also suffering from free-floating anxiety, when they were actually receiving drugs to reduce anxiety, such as amylobarbitone. I found that chronic anxiety states in whom free-floating anxiety was the main feature had a significantly higher resting forearm blood flow than controls, and that treatment with amylobarbitone was sufficient to reduce high resting forearm blood flows to normal levels in certain cases ("Measurement of Anxiety by Forearm Blood Flow", awaiting publication in the *Journal*). Harper *et al.* might have found higher resting forearm blood flows in the patients suffering from free floating anxiety if these had not been receiving drugs at the time of the physiological measurements.

The authors made a comparison between a patient group with a mean age of 40·4 years and a normal group with a corresponding age of 26·4 years, but considered age to be an unimportant factor because they found a negative correlation between age and initial forearm blood flow. They then say "This supports the work of Hellon and