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

https://doi.org/10.1192/S0007125000012952 Published online by Cambridge University Press

appropriate for different purposes, in relation to studies of different questions. While one may agree with the idea of Teasdale and his colleagues that workers in this field should all use the same scales, perhaps one should add 'if studying similar questions'. Further, it will also be important to ensure that all who say they are doing 'exposure *in vivo*' (for example) are doing the same sort of thing, and are equally good at it. It is possible that differences in results between Oxford, London and elsewhere are due to patient differences or, as discussed here, to scaling problems; but they can also be due to differential therapist abilities. *In vivo* treatments are not everyone's cup of tea. The Oxford workers would be welcome to see what we do at Guy's.

J. P. Watson

Department of Psychiatry,
Guy's Hospital Medical School,
London Bridge, SE1 9RT

References

Gelder, M. S. & Marks, I. M. (1966) Severe agoraphobia: a controlled prospective trial of behaviour therapy. *British Journal of Psychiatry*, **112**, 309–18.

Watson, J. P. & Marks, I. M. (1971) Relevant and irrelevant fear in flooding—a common study of phobic patients. *Behavior Therapy*, **2**, 275–92.

—— Mullett, G. E. & Pillay, H. (1973) The efforts of prolonged exposure to phobic situations upon agoraphobic patients treated in groups. *Behaviour Research and Therapy*, **11**, 521–45.

SALIVA LITHIUM ESTIMATION

Dear Sir,

Professor Verghese and his colleagues (*Journal*, February 1977, **130**, pp 148–50) describe the use of saliva lithium estimations, particularly from the standpoint of psychiatry in India. In the United Kingdom there may be patients in whom an alternative to venepuncture is helpful: where frequent monitoring is necessary (for example in renal disease); when the patients' veins are difficult to puncture; when the patient has a great fear of the procedure (for example, as in one of our cases, a delusion that her illness is caused by blood loss).

Professor Verghese and colleagues may be premature, however, in recommending that saliva lithium levels are *reliable* indicators in monitoring lithium treatment. Having found that the mean of the ratio of saliva Li to serum Li in 24 samples from 10 patients was 2·22, they suggest that 'this value can be used to adjust the dosage of lithium so that a therapeutic range of saliva lithium level between 1·5 and 3 mEq per litre can be maintained'.

The range of the means of the ratios in 10 patients was found to be 1·90–2·56. This variability is certain to be clinically important. For example, the patient whose mean ratio is 2·56 and whose saliva Li falls at the lower end of the range they suggest (1·5 mEq per litre) may have a serum Li of ·58 mEq per litre, i.e. below the therapeutic level. Conversely, the patient whose mean ratio is 1·90 and whose saliva Li falls at the upper end of the range they suggest (3 mEq per litre) may have a serum Li of 1·58 mEq per litre, i.e. above the level at which toxic symptoms begin to appear.

Until more is known of the variation in the saliva/serum ratio, both between individuals and within an individual over time and for a range of plasma lithium levels (a matter which we are studying), it would seem prudent to calculate a mean ratio for each individual from at least three pairs of samples at therapeutic levels and use that in subsequent monitoring via saliva levels.

We have a further reservation. Frequently, drugs are prescribed concurrently with lithium and could alter the ratio. It is possible that the tricyclics, by reducing saliva flow, might lead to increased lithium re-uptake in the salivary duct and thus decrease the saliva/serum Li ratio.

Jonathan Chick

MRC Unit for Epidemiological Studies in Psychiatry,
Royal Edinburgh Hospital,
Morningside Park, Edinburgh EH10 5HF

John Loudon
Helen Wilson

MRC Brain Metabolism Unit and Metabolic Unit,
Royal Edinburgh Hospital,
Morningside Park, Edinburgh EH10 5HF

A CORRECTION

On page 81 of Professor A. E. Maxwell's article 'Coefficients of Agreement between Observers and their Interpretation' in the January issue, pp 79–83, equation (4) should have read as follows:

$P_1 = (3a+d-1)/2$ and $P_0 = (3d+a-1)/2$.

https://doi.org/10.1192/S0007125000012952 Published online by Cambridge University Press