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

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Clarke (1959) on the effect of age on forearm blood flow." Hellon and Clarke did not find a negative correlation between age and forearm blood flow, but in fact found that in a group of 50 men with ages ranging from 18 to 73 years there was a significant increase in forearm blood flow with age ($p < 0 \cdot 01$). This was also my experience.

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Reference

Hellon, R. F., and Clarke, R. S. T. (1959). "Changes in forearm blood flow with age." *Clin. Sci.*, **18**, 1–7.

PIN-UP FETISHISM

Dear Sir,

In their recent article (*Journal*, July 1965, pp. 579–581), Drs. Raymond and O'Keeffe are apparently unhappy with older theories of the formation of sexual deviations. Elsewhere (1) we have tried to provide an alternative explanation using a learning theory view of these disorders. Your authors' interesting case corresponds well with our hypothesis, if the photographs in question are taken—as the title implies—not as aids to sexual behaviour (as is usually the case) but as sexual objects—i.e. fetishes—in themselves. So it happened that the initial "seduction experience" (looking at photographs) was exciting and produced guilt, but only later was the deviation learned and shaped through masturbation, and this at a time when our hypothesized factor negative to ordinary heterosexual behaviour—his sister's illegitimate pregnancy—came into effect.

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Department of Psychiatry,
University of Leeds,
Leeds.

Reference

1. McGuire, R. J., Carlisle, J. M., and Young, B. G. (1965). "Sexual deviations as conditioned behaviour: a hypothesis." *Behaviour Research and Therapy*, **2**, 185–190.

TREATMENT OF TRAFFIC PHOBIA

Dear Sir,

For a period of 18 months we have been following up the case of traffic phobia, reported in the March 1965 number of the *British Journal of Psychiatry* (pp. 277–279). Throughout this period the patient has remained completely symptom-free, and there has been no evidence of symptom substitution. His wife, however, has contacted us complaining of anxiety and phobic symptoms. She found that she could not tolerate his new level of adjustment and wished that he might have another accident. In fact, she became so desperate that she thought very seriously of separation.

Although the wife's complaints may well be related to her own background, it is surprising that the appearance of her symptoms should coincide so closely with the successful treatment of her husband. There is also a striking similarity between wife and husband's symptoms—her fear of travelling alone seems to closely parallel his fear of riding a bicycle in traffic. As symptomatic treatment is relatively short, and induces rapid changes in the patient's behaviour, this may well have important repercussions in the patient's social environment. In the present case, it is quite possible that the wife had adjusted to her husband's phobic symptoms by being sympathetic and protective towards him, but cure of the husband may well have brought about a breakdown in her adjustment. A brief course of behaviour therapy with the wife of the patient, at St. Clement's Hospital, has removed her phobic symptoms in 8 treatment sessions. It would appear that although behaviour therapy brings relief to the patient, by eliminating his symptoms, behaviour therapists might well be advised to take the patient's whole social situation into consideration when embarking on a course of treatment, and to take action accordingly.

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THE NEED FOR BETTER OUT-PATIENT FACILITIES

Dear Sir,

Dr. Kingsley Jones's "Suicide and the Hospital Service" (*Journal*, July 1965, p. 625) makes a cogent point for increasing and improving out-patient facilities. Another argument is that if out-patient facilities are poor and hospital services good, more patients are liable to be sent to hospital or be more ready to return, which is neither economic nor in the interest of the patient.

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