The great discrepancy between the old traditions and the modern Western way of life as disseminated by television, magazines, tourism and rapidly increasing education (with mixed sexes) is increasing tension among the young. They do not know how to behave. Even religious faith is weakening.

We observed that those who are educated are more prone to the 'cry for help' (68 per cent). They appear to be vulnerable to the conflict between old and new cultures, whereas simple people, especially those outside big cities, are more satisfied and content. The strong faith and cohesion of the traditional society are stabilizing factors. Another stress is the new law of compulsory education for those between 6 and 45 years of age, which has brought to notice those who cannot cope with the demands of schooling. The sick role can exempt from education on medical grounds.

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OILY INJECTIONS THAT OOZE

DEAR SIR,

Some observations of an experienced nurse on the technique and results of giving depot injections for schizophrenia might help patients, nurses and doctors. I have noticed, and you can easily confirm this, that some of the oily injection frequently leaks out of the puncture in the skin, soiling clothes or sticking plaster. Put plasters on injection punctures and you will see what I mean. Sometimes these leaks must be a significant proportion of the volume of drug originally injected, and I strongly suspect that this is the explanation of the comment frequently heard in psychiatric wards, "the injection never touched her".

Years ago, leaking and staining was a common problem with intramuscular injections of iron. Many nurses nowadays have forgotten, or never been taught, the technique used then of sliding the skin to one side before the injection and then back afterwards, sealing the track of the needle. It works.

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NORADRENERGIC OVER-ACTIVITY IN CHRONIC SCHIZOPHRENIA

DEAR SIR,

U. C. R. Gomes and colleagues (*Journal*, October 1980, **137**, 346–51) claim that statistical analyses eliminated the possibility that their finding of increased noradrenaline and cycle AMP in the cerebrospinal fluid of chronic schizophrenics was related to neuroleptic medication. They explained that the Wilcoxon test was applied to patients receiving medication who were matched for (*inter alia*) diagnosis, with patients not receiving medication.

How was this possible, given that Table I showed that all their chronic schizophrenic patients were receiving medication?

A. A. SCHIFF

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DEAR SIR,

Dr Schiff has quite correctly pointed out that all the chronic schizophrenic patients in our study were on neuroleptic medication. It was therefore not possible to make direct comparisons of medicated and unmedicated patients in this category, nor did we claim to have done so.

Consequently, we were compelled to examine the effects of medication on CSF noradrenaline and cyclic AMP concentration in the other three groups of psychiatric patients, i.e. those with acute schizophrenia, psycho-organic disorders and personality disorders. Our findings clearly showed that neuroleptic medication made no significant difference to any of the parameters studied. We therefore feel fully justified in our interpretation that ". . . neither the elevated noradrenaline nor cyclic AMP concentrations in the chronic schizophrenics were attributable to drug effects".

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IDENTIFICATION OF DISEASE ENTITIES

DEAR SIR,

Even Kendell and Brockington's paper (*Journal*, **137**, 324–31), which doesn't go far enough, makes us pose the question of when is it appropriate to discuss whether psychiatric terms refer to dimensions or categories. The idea that a mathematical technique could resolve it is a philosophical mistake, one which will obscure rather than clarify real issues. Any two

things are alike and different, depending on the purpose for the comparison. If the similarity can be said to be slight, moderate or marked, a dimension and measure can be used. As mathematics serves but does not produce purposes, statistical techniques cannot classify objectively, nor discover dimensions.

Kendell and Brockington talk about valid boundaries; we would prefer useful boundaries within a language and an attitude, because then one is led to ask about the origin of the language and attitude and the usefulness for whom? They talk about small changes in symptoms causing big changes in outcome, but here small and big are also difficult words, depending on the units.

There is nothing to be gained except coherence within a linguistic convention by any answer they can obtain. In their language it is difficult to produce evidence for schizophrenia and manic-depressive illness as distinct entities, but they fail to see they are defining when an entity or dimension shall be declared to exist in psychiatry.

Perhaps the oft-discussed distinction between bushes and trees in English might illustrate some of our points. What, for example, would a linear variable from discriminant function analysis on the abscissa mean, and what difference would there be between a categorical and a dimensional approach? The distinction was presumably made for reasons related to our lives, especially perhaps in farming, but it doesn't help much in collecting firewood. The response of schizophrenics to phenothiazines, and of manic-depressives to lithium, seem to be among reasons for maintaining the words, but the traditional use of the words may have affected the psychopharmacological view we now take. The danger of a portmanteau approach could be being restrictive. Such an approach is fostered by a belief in the possibility of objective nosologies based on mathematics. That could even induce a new alchemy of searching for the 'philosopher's stone', it could make us too content that our language of discourse is almost correct and suppress alternative more idiographic approaches to the mental miseries of our patients (other men). They may after all not be ill in any simple sense. The ideological rejection by some of them of our common sense, for example, may in the ensuing mêlée be producing much which we are 'mathematically objectifying' as psychopathology. Our struggle for a pseudo-objectivity, inevitable labelling and distancing etc., are all part of that mêlée, and they force our common sense back onto life's comparative chaos, as others ought to be like us. But it might be difficult for them, hence Babel may be intellectually more honest, fertile and true than a universalized language partly arising from mathematics, of which the foundations themselves are currently receiving scrutiny from thoroughgoing pragmatists. For every n clearly defined items there are 2^n-1 clearly definable things; which do we want, when and for what?

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LUNG CANCER AND SCHIZOPHRENIA

DEAR SIR,

May I refer again to the idea of other correspondents (e.g. Jancar (1978)) that heavy-smoking, long-term schizophrenics suffer much less lung cancer than is statistically expected? If it is true it is a very considerable fact and calls for verification or dismissal.

I was surprised that no mention was made of Kissen's (1967) investigation of psychosocial factors, personality and lung cancer in men aged 55–64 (average 59), studying random thoracic department patients before diagnosis. Of 366, it transpired that 218 had lung cancer and 148 did not. Marital or domestic status, position in the family, religion, and county of birth of patients or parents, had no cancer significance. The slight excess in classes 4 and 5 was not important, but unhappy childhood homes, early orphanage and stress in life situations, especially long-standing interpersonal ones and those developing over time at work, did seem significant. Kissen found silence and denial among lung cancer patients who "tend to repress significant emotional events", with an unconscious containment of conflict. Patients themselves often sensed a poor outlet for emotional discharge.

Of thousands of hospitalized long-term, heavy-smoking schizophrenics seen by me over the last three decades, their greatest blessing has been freedom to spend their substantial cash allowances on cigarettes, at the hospital shop or outside the hospital. For patients who had run out of cigarettes and money, the commonest effective calming medicine, producing immediate satisfaction, was absorbed from cigarettes.

The Records Officer at St Crispin Hospital, Northampton, provided the figures that over the last 23 years, of 2,363 patient deaths 22 were due to lung cancer. I examined the notes of the 22 and only one, an ageing woman who had lived effectively and unsupported in the community for most of her life, was schizophrenic.

Assuming for the sake of argument that Kissen and I are reporting facts, then it is a reasonable hypothesis that long-term schizophrenics, outwardly calm like Kissen's patients, have no capacity for the