gastrointestinal transit times and renal function, and the results cannot be explained by changes in the patients' medication. The fact that three patients with chronic schizophrenia developed abnormal intestinal permeability over time argues powerfully against the latter's role as an aetiological factor. The questions remain as to what the mechanism of abnormal intestinal permeability is, and what influence it has on both the disease process and the efficacy of medication.

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'New long-stay' patients and social deprivation

SIR: Abbott (*Journal*, January 1990, **156**, 133) makes the point that a detailed analysis of the socio-demographic characteristics of catchment areas may reveal associations between accumulation rates of 'new long-stay' patients (admission duration of more than one year) and indices of social deprivation. At present, the Team for the Assessment of Psychiatric Services (TAPS) is evaluating the reprovision of services for patients leaving Friern and Claybury Hospitals. Furthermore, such an analysis has already been performed (Jones & Margolius, 1989) in which the Spearman rank correlation coefficient between the annual rate of accumulation of new long-stay patients and the Jarman-8 index (Jarman, 1983) of social deprivation for their nine districts of residence was 0.82 ($P < 0.01$).

Although this association has not been previously reported, it is not surprising. The association between residential area and incidence of schizophrenia was described in Chicago over 50 years ago by Faris & Dunham (1939) and has been replicated more recently in Bristol and Nottingham (Ineichen *et al*, 1984; Giggs & Cooper, 1987). The Royal College study (Hirsch, 1988) found a correlation of 0.76 between district psychiatric admission rates and Jarman-8 indices in North West Thames. Indeed, a number of other combined deprivation scores such as ACORN, Unit 9, and the Department of the Environment Social Index (but not Standard Mortality Rate (SMR)) correlate equally highly with admission rates (Thornicroft, 1989). The strength of these associations support Hirsch's proposals that the service norms used in planning psychiatric services should be weighted to take explicit account of the extent of local social and economic deprivation.

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Platelet MAO and 5-HT uptake in agoraphobics

SIR: The hypothesised association between neurotransmitter abnormalities and the anxiety-states panic disorder and agoraphobia with and without panic attacks has been the focus of renewed attention since the introduction of the concept with DSM–III (American Psychiatric Association, 1978). The recent report by Flaskos *et al* (*Journal*, November 1989, **155**, 680–685) describes studies of platelet monoamine oxidase activity (MAO) and serotonin (5-HT) uptake in patients with agoraphobia and neurotic depression compared with a control group. Both measurements are relevant to the neurotransmitter hypotheses of these disorders. The findings of elevated MAO activity in agoraphobia are supported by some

studies in the literature but not all. While several studies have demonstrated elevated MAO activity in agoraphobia with panic attacks (DSM-III criteria) there are methodological shortcomings with these studies (Norman *et al*, 1988). Furthermore, in the largest study undertaken to date (Khan *et al*, 1986) no difference was found between panic disorder, agoraphobia or generalised anxiety disorder (GAD) and a control group. More recently, Norman *et al* (1988) found no differences in either K_m (affinity constant) or V_{max} (maximum uptake velocity) of platelet MAO between patients with panic disorder or agoraphobia with panic attacks (DSM–III criteria) and normal controls. These conflicting results are difficult to explain but clearly studies in small numbers of patients using diverse methodological refinements correctly require circumspect interpretation.

The finding of increased platelet 5-HT uptake in 'neurotic' depression is of interest in the context of a hypothesised decreased 5-HT availability in depressive illness. Most reports find decreased 5-HT uptake in endogenous depression but no difference from controls in non-endogenous (neurotic (*sic*)) depression (Langer *et al*, 1987). This is again a finding which requires cautious interpretation given the small number of patients involved. In the agoraphobic group it was stated that there was "no association between the 5-HT uptake kinetics and the central symptoms of agoraphobia". It would have been interesting to have known the relationship with panic attacks, particularly as a significant negative correlation between V_{max} of uptake and the tense-panicky dimension of the fear questionnaire was reported ($r = -0.44$; $P < 0.05$). We have previously reported an elevated V_{max} of platelet serotonin uptake in panic disorder and agoraphobia with panic attacks (Norman *et al*, 1989). Certainly, these studies have implications for a serotonin-overactivity hypothesis of panic disorders, which is supported by some neuroendocrine challenge tests (Khan *et al*, 1988). It does not necessarily follow that unchanged ^{3}H-imipramine binding in panic disorder supports the unchanged platelet serotonin kinetics. It is notable that dissociation of 5-HT uptake and ^{3}H-imipramine binding sites has been observed. The more likely association between 5-HT uptake and ^{3}H-imipramine binding site is that of an allosteric control exerted by the latter over the 5-HT transporter (see Langer *et al*, 1987). While ^{3}H-imipramine binding may be normal, 5-HT uptake can be altered, a finding we noted in patients with panic attacks (Norman *et al*, 1989).

It is unusual that in the group of agoraphobic patients studied by Dr Flaskos *et al* (1989) the presence or absence of panic attacks is neither commented on nor quantified. This additional information would facilitate the comparison of their results with those that already exist in the literature.

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'Le Suicide'

SIR: I would like to thank Berrios & Mohanna (*Journal*, January 1990, **156**, 1–9) for their cogent and illuminating critique of Durkheim's use of psychiatric texts in *Le Suicide*. The main thrust of their argument is that Durkheim is both 'selective' and 'idiosyncratic' in his choice of psychiatric material and terminology. I am left wondering, however, just how many contemporary articles would stand up to so rigorous an appraisal, as I am sure it cannot be only late 19th century social scientists who are selective and idiosyncratic in their choice of material. For example (and not because of particular dismerit), many World Health Organisation (WHO) transcultural studies play down or de-emphasise anthropological explanations or accounts of the phenomena they study (Kleinman, 1987).

Drs Berrios & Mohanna have themselves been selective, if not idiosyncratic, in choosing "not to deal, in any way, with Durkheim's sociological views", explaining instead that they will do this in a separate publication. Durkheim's undoubted methodological sleights-of-hand become more understandable when seen in the broader context of his other works. I would suggest that *Le Suicide* can be seen as an,