now virtually unknown in the Anglophone literature except for his eponymous syndrome. Unaware of de Clérambault's tragic suicide in 1934 and that his collected papers were published *posthumously* in 1942, Goldstein (1986) concluded that "a new (*sic*) psychiatric syndrome [had] been . . discovered . . in a work of literary fiction before (or perhaps concurrently with) its official 'discovery' by psychiatry" and, in an "effort to assign scientific credits and priorities fairly", suggested that erotomania be renamed "Simenon's syndrome"! Surely proof that truth can be at least as strange as fiction . . .

KAREL DE PAUW

Doncaster Royal Infirmary
Armthorpe Road
Doncaster DN2 5LT

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Words of wisdom

DEAR SIRS

The first instalment of Larry Culliford's series (*Psychiatric Bulletin*, December 1990, **14**, 734) makes interesting reading. I look forward to the rest of what promises to be a very worthwhile contribution. I also commend the *Psychiatric Bulletin* for encouraging an interest in philosophy.

Dr Culliford concludes this first instalment with, "Here is the chicken: wisdom. Here is the egg: a free and discerning mind. Which shall we choose to put first?", and refers this as a *paradox*.

A paradox is a situation that arises when, on the basis of valid deductions from generally accepted premises, a conclusion is reached which appears absurd or self-contradictory, or conflicts with other generally accepted beliefs.

There are basically two types of paradoxes: the *logical* (for example, Cantor's paradox, Burali-Forti's paradox, Russell's paradox), and the *semantic* (for example Zeno's famous Paradoxes and the Liar Paradox – the statement "I am lying" is true if it is false and false if it is true). The Clock Paradox in Einstein's Special Theory of Relativity is in a class of its own, for it is a *prediction* of the theory itself, much as the theory predicts the existence of black holes.

Temple (1981) is of the view that paradoxes "may well be due to faulty ideas concerning thought and language and not to faulty logic or mathematics"; while Russell (1908), himself the discoverer of an important paradox, dismisses them as the results of a vicious circle of thinking.

Paradoxes are supposed to force us to re-examine our ideas. However, all they actually achieve is our frustration and perplexity. None has been of any use, or been demonstrated, with the single exception of the Clock Paradox, which states that, when observed from a stationary frame of reference, clocks run more slowly in a frame of reference moving at speeds close to the speed of light.

Returning to Dr Culliford's short piece, it is not clear what he means when he speaks of putting one or the other first – wisdom superior to, exists prior to, or is more desirable than, a free and discerning mind, or vice versa? Based on the discussion above, you can see that what he has there is definitely *not* a paradox. It is simply a question, at best an unfathomable enigma.

If Dr Culliford is contemplating using paradoxes in his series may I be allowed space to share this note with him: paradoxes are *not* the best way of learning or teaching. They take up too much mental energy for which there is very little reward. Try *parables* instead. Parables once heard are never forgotten and their meaning continues to unfold to us for the rest of our lives. An excellent example is the parable with which he introduces the short essay referred to in this response.

If you heard Aesop's fables or Christ's parables as a child I bet you could remember them in full detail today, even if you had never heard them repeated since then, and the wisdom they contain grows as your own consciousness unfolds.

IKECHUKWU O. AZUONYE

The Royal London Hospital (St Clement's)
Bow Road, London E3 4LL

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Odious correspondence

DEAR SIRS

There is more than a whiff of sanctimonious self-righteousness in the letters of Seager, Drummond and Young (*Psychiatric Bulletin*, November 1990, **14**, 679).

When I was preparing myself for a working life devoted to the elderly mentally ill I visited and worked with a number of services both in psychogeriatric and geriatric medicine which were of good repute and very active. It was notable that the environment of wards was often spoiled and dominated by the smell of urine and/or faeces. Where this lingered it was always traceable to carpets, pseudo-carpets or (less often) inappropriate chairs.

I determined that there would be no carpets in units within my service. There was immense resistance to this suggestion from nursing officers, administrators and others who knew very well that the provision of carpets was a sign of a good and sound caring attitude to the elderly. They were not themselves going to work with them. Often they had never worked with them. But they knew that good souls provided carpets.

I have visited a number of units which claim to have succeeded with carpeting or similar coverings in geriatric/psychogeriatric wards. In all instances there were explanations for their 'success': a patient mix that included few severely demented, restriction of use of the carpeted areas to able and continent patients; recourse to rigid and restrictive use of incontinence devices. These are not for me – we must provide for the most severely disabled and behaviourally disordered. They must have freedom to use the territory to the full and not be restricted in movement, nor be required to wear catheters or other similar intrusive devices.

We have no carpets. There are none in staff rooms either – thus confirming equality for all and ridding anyone of the need to eject wandering patients for fear of an 'accident'. Our wards are recognised to be more pleasant than general psychiatry wards within the same units. Carpeted they are, and smell they do.

There are no carpets nor carpetlike materials that can cope with the heavy repeated wear expected in a day room for twenty mobile incontinent elderly adults without retaining a uriniferous smell – it suits manufacturers to claim otherwise and we would all wish their claims were true. They are not.

Speedily available cleaning systems and domestic staff cannot always be to hand. For heaven's sake, the funding of my service requires that letters are two weeks or more on from dictation before they are typed for lack of secretarial time. Who would dare to suggest that there will be an inappropriatedly equipped and highly motivated domestic cleaner behind every pillar on Sunday afternoon, and Monday morning and Wednesday noon etc.!

Of course Greater Persons than we will tell us that carpets are good and reflect well on everyone. If they smell, then it is not their fault, nor the manufacturers faults. It is our fault – we who toil day by day. We have failed and so we and our patients and their relatives suffer.

Dr Azuonye is right. For a tough child you buy a Tonka toy. Psychogeriatric wards: use vinyl throughout.

Attention to the design and distribution of furnishings, wallcoverings and other equipment and, most of all, the behaviour and attitudes of staff are the main factors in ensuring homeliness.

DAVID J. JOLLEY

Withington Hospital
West Didsbury
Manchester M20 8LR

DEAR SIRS

I read the letters from the NHS Health & Scottish Hospital Advisory Services on 'Stinking Wards' (*Psychiatric Bulletin*, November 1990, **14,** 67) supporting carpet-like fabrics for psychogeriatric wards instead of the lino advocated by Dr Azuounye (*Psychiatric Bulletin*, July 1990, **14,** 431).

I feel the reason for "carpet-like" surfaces in hospitals is the claim by those individuals who check cost efficiency and budget control that these are "more efficient" as less staff are required to "clean" the area.

I cannot accept that the matrix of "carpet" damp from the cleaning and warm from the heating will not offer a culture medium for bacteria and possibly mould and spores which may affect the chests, skin and digestion of the ageing population.

In case this reason for *not* carpeting hospitals with their changing clientele is not accepted, the Environmental Protection Agency in the United States of America describes people at work in certain buildings who have sore throats, running noses, headaches and difficulty in concentrating as a result of the adhesives used to fix the pile and carpet to the floor. There are other factors in 'Tight Building Syndrome' but carpets are one.

I also feel that many wards benefit from modern synthetic surfaces that are softer underfoot, easy to clean properly and which have a wide choice of 'homely' colours. There is an escape of solvents for a while, although nothing is perfect for the variety of clients and patients.

DAVID G. MAYNE

Craigavon Area Hospital
Craigavon, Co. Armagh BT63 5QQ

Liaison psychiatry in general practice

DEAR SIRS

I have read the paper by C. Darling & P. Tyrer (*Psychiatric Bulletin*, October 1990, **14,** 592–594) with great interest. It highlights the value of liaison services provided through psychiatric clinics in primary care settings.

I would like to share my own experience of working with the general practitioners (GPs) and other