Surprisingly, only three patients (3·1 per cent) were classified on the discriminate function analysis, compared with 14 per cent in Kendell and Gourlay's group. This improvement shows that a single investigator using consistent criteria can achieve good clinical separation between the two types of depression. However, in spite of this improved clinical distinction, the analysis itself, like that performed by Kendell and Gourlay, produced a unimodal curve which did not differ significantly from a normal distribution (see accompanying table).

Score on the Discriminate Function Analysis	Total N = 94	Psychotics N = 55	Neurotics N = 39
−8.99 — −8.00	7	7	
−7.99 — −7.00	10	10	
−6.99 — −6.00	15	15	
−5.99 — −5.00	12	12	
−4.99 — −4.00	12	10 minimum 2	
−3.99 — −3.00	8	overlap	8
−2.99 — −2.00	12		12
−1.99 — −1.00	7	1	6
− .99 — −.00	4		4
.01 — .99	6		6
1.00 — 1.99	1		1

Distribution of Weighted Scores on the Discriminate Function Analysis.

That one may distinguish two groups of patients clinically does not necessarily imply that they represent separate disease entities. By analogy it should be possible, using suitably refined criteria, to distinguish clinically between the characteristics of persons aged, say, under 40 years and over 40 years, but on placing the two groups together they would still be found to lie on a continuum.

J. R. M. Copeland.

Institute of Psychiatry,
De Crespigny Park,
Denmark Hill, London, S.E.5.

PSYCHOTHERAPY WITH FAILURES OF PSYCHOANALYSIS

Dear Sir,

In the May, 1970, issue of the *Journal* (p. 574) Dr. Hilda Abraham was outspokenly disparaging about Dr. Melitta Schmideberg's article, 'Psychotherapy with Failures of Psychoanalysis' (*Journal*, February 1970, pp. 195–200). She says of Dr. Schmideberg that 'it is very obvious that she has no knowledge of developments during' presumably the last 20 years.

I should like to ask Dr. Abraham to tell us just how the majority of medical analysts and analytically trained psychologists in the Health Service were provided with the medical and other schooling which enabled them to become 'skilled in choosing the method of treatment most likely to benefit a specific case'. Further, as Dr. Abraham contends that it is no longer true that little research has been carried out by analysts, will she give the extract reference(s) to such psychoanalytic research work, and for a rigorous assessment of the quality of those studies.

So far as Dr. Schmideberg's article is concerned I am in steadfast agreement with her. Negative suggestions put forth authoritatively by the analyst discourage the patient. He must be helped to face reality and learn how to tolerate or cope with true-to-fact anxieties.

Any therapy that isolates the patient from ordinary life and over-protects him against it produces undesirable consequences. The psychoanalytic relationship will tend to be self-perpetuating when realistic anxiety is attributed to irrational factors which are interpreted as deep-seated abnormalities that can be cured only by further analysis. It appears to me that the analytic schools gloss over generally accepted methods of handling difficult situations, and give inordinate emphasis to irrational material. Direction is avoided, positive suggestions are not given, reassurance is denied and encouragement withheld. No efforts are made to build up self-esteem or to encourage step-by-step improvement or to induce praiseworthy undertakings.

I too have long since discarded the training I received at the Boston Psychoanalytic Institute. As a clinical neurophysiologist who is also a Director of Research and Program Development, I have found it much more rewarding to myself, and much more gratifying to my patients, to upgrade the quality of the results by adopting the lines advocated, and avoiding the snares counselled against, by Dr. Melitta Schmideberg in her very fine, practical, realistic, sensible and rational paper.

Ernst Schmidhofer, M.D.

Assistant Commissioner,
Research and Program Development,
Division of Psychiatric Criminology,
Ohio Department of Mental Hygiene and Correction,
P.O. Box 5500,
Chillicothe, Ohio 45601, U.S.A.

TREATMENT OF PHOBIC PATIENTS WITH ANTIDEPRESSANTS

Dear Sir,

Dr. Mawson's letter (July, 1970, *Journal*, page 117) illustrates the intellectual arrogance, coupled with

the neglect of practical and humane considerations, which are unfortunate by-products of the development of academic psychiatry. Like many clinicians who actually treat patients, I am deeply indebted to Dr. Sargant and his colleagues for their demonstration of the value of MAOI's in phobic states, which has enabled me to help many people who had suffered severe distress over long periods. I am also grateful to them for their courage in pursuing the continued development of combined anti-depressant therapy, in the face of much misguided and irrelevant alarm; this again has brought relief to numerous patients with previously untreatable illnesses.

The pursuit of methodological purity in itself is no guarantee that information of value will result. Some ten years ago, a monumental MRC trial comparing ECT with anti-depressants was a total flop in spite of (or perhaps because of) the weight of scientific sophistication that had gone into its design. About the same time, a study from the Maudsley Hospital 'proved' that phenelzine had no anti-depressant action, a finding which anyone who has had clinical experience of it will find very difficult to accept. At present, we in this area are trying to get the results of four years' experience with long-acting fluphenazine for vulnerable schizophrenics into a form that will be acceptable to academic assessors. Yet this cannot in any way convey the transformation for the better that has been clinically observed in many cases who had previously been subject to continual relapse outside hospital. The day-to-day responsibility for large numbers of severely ill and handicapped people, in ill-equipped and understaffed conditions, is a very different matter from armchair reflections on chi-squares, as Dr. Mawson will discover if he ever leaves the academic womb.

HUGH FREEMAN.

Adelphi Clinic,
Salford Royal Hospital,
Chapel Street, Salford 3.

DEPRESSION AND CARCINOMA

DEAR SIR,

In reply to Dr. Judelsohn's letter (*Journal*, July 1970, p. 119), which we read with interest, we should like to make the following observations.

The fact that her survey did not bring to light evidence that depressive illness in male patients may be the presenting symptom of carcinoma does nothing to invalidate the observations we made or the conclusions drawn from them. The patients we investigated suffered from a depressive illness that was sufficiently severe to require admission to a psychiatric hospital. The exclusion of relatively mild depressions was unavoidable under these circumstances, but it is irrelevant to the questions at issue.

If Dr. Judelsohn had wished to obtain further evidence bearing on our findings it would have been more appropriate to differentiate between mild and severe depressions in her patients; on the basis of our findings, a prevalence of carcinoma beyond normal expectation would have been predicted only among the severe depressions. Presumably the factual information about the affective states of the patients in her study was not sufficiently detailed to permit such differentiation.

The finding that male patients diagnosed as suffering from carcinoma in a general hospital clinic had a significantly lower prevalence of depression than the control subjects with other types of physical illness suggests interesting possibilities. Those suffering from a malignant disease complicated by severe depression are possibly to be found elsewhere; perhaps in psychiatric hospitals. It is of interest in this connection that two of five patients with carcinoma in our sample had not attended a general hospital clinic, the diagnosis of malignant disease being established only at post-mortem examination.

It cannot be assumed that Dr. Judelsohn's retrospective postal enquiry provides a reliable picture of psychiatric disorder in any selected population. The rate of referral to psychiatric departments of patients with psychiatric disorders from family practice has been shown to vary widely, and differences in prevalence appear unlikely to be the explanation; the amount of interest in, and the degree of alertness to psychiatric disorders are more likely to be involved (Rawnsley and Loudon, 1962). Retrospective studies of psychiatric disorders, even under the most favourable conditions, can provide only an incomplete picture.

T. A. KERR, KURT SCHAPIRA, and MARTIN ROTH.

Department of Psychological Medicine,
Queen Victoria Road,
Newcastle upon Tyne, 1.

REFERENCE

RAWNSLEY, K., and LOUDON, J. B. (1962). Sociology Review. Monograph No. 5, University of Keele, 1962.

DIAGNOSIS AND DRUG TREATMENT OF PSYCHIATRIC DISORDERS

DEAR SIR,

Dr. Blackwell's review (1) of our work (5) states '. . . the author's opinion (is) that diagnosis is the key to treatment. There is nothing in the content of the book to support this view.' If true, this judgment