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Correspondence

Letters for publication in the Correspondence columns should not ordinarily be more than 500 words and should be addressed to:
The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

WHAT BRAND OF TRICYCLIC DO YOU PRESCRIBE?

DEAR SIR,

The spreading legalization of the substitution of generic for brand name drugs, including psychotropics, is responsible for an escalating number of patients being given by dispensing pharmacists a generic instead of a prescribed brand name product. In the case of tricyclic antidepressants this practice can be hazardous because, as the Food and Drug Administration has stated (Federal Register, Vol. 43, No. 34—February 17, 1978), 'available data suggest that the various marketed brands of the same oral tricyclic antidepressant may not have comparable therapeutic effects' (due to bioequivalence differences), and 'the substitution of a poorly bioavailable form in the regimen of a patient controlled on a fully available form would result in reversion to the depressed state'.

I am gathering instances of: (1) depressed patients who did not respond to initial treatment with a generic tricyclic antidepressant but did respond to a subsequently administered brand name tricyclic antidepressant; or (2) depressed patients who responded to a brand name tricyclic and relapsed when a generic form was substituted. I would be grateful if my fellow psychiatrists who have had patients adversely affected by treatment with a generic tricyclic antidepressant would share their data with me.

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CLASSIFICATION: INTUITION OR STATISTICS?

DEAR SIR,

Garside and Roth (*Journal*, July 1978, **133**, 53–67) diagnose psychiatry as intuitive genius confirmed by questionable multivariate statistics. They seem anxious to reassure us that with some developments in statistics we can hope for much greater objectivity.

One fears, however, that their views could make less informed research workers too rigid about the groups compared, and therapists inflexible; further idiographic approaches by either may be undervalued. Classifying objectively by intuition and/or multivariate statistics may be demonstrably impossible. This is really a central intellectual debate between nominalists, conceptualists and realists. The difficulty may not be because our statistical logic is incomplete. Ours could be epistemological difficulties about objectivity. The relation between knower and known could be involved. The 'truth' of our classes depends on their value for various purposes and people.

One is doomed in psychiatry in part to choose one's language, way of acting and believing, and one is necessarily parochial even in intention. Surely there is a considerable need to emphasize the inevitable, though often defensible, projection involved.

This is not to propose that psychiatrists should adopt a thoroughgoing nominalism, believing things have no more in common than their names. That too is a complex position and demonstrably untenable. It is merely to emphasize that the ontological status of abstract entities, like mental diseases, is beyond our ken. As long as the outcome of our treatments remains complicatedly related to our categories, and multivariate statistics only respond to and act on our own prior assumptions and language, we have difficulties we seem likely to have to continue to tolerate.

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VALIDITY OF THE ZUNG SELF-RATING SCALE

DEAR SIR,

In their article on the validity of Zung Self-Rating Depression Scale (*Journal*, April 1978, **132**, 381), Drs Biggs, Wylie, and Ziegler presented some data of their own and made some comments about our previous examination of the Zung scale (1). It seems to me that their report is misleading on both issues.

To hoist the authors by their own petard, they are handicapped by (an) 'isolated view of psycho-