abduction by Russian soldiers was quite common among this group of immigrants and might in fact be realistic.

Management of his blood pressure was continued, replacing propranolol by atenolol, a beta-blocker which penetrates the blood-brain barrier poorly.

He remains well one year later, without further incident.

Case 2

A violinist aged 50 was admitted with accelerated hypertension (230/145) and was given minoxidil, frusemide and propranolol (up to 320 mg thrice daily). After two days on propranolol he became psychotic. He believed the patients were planning to shoot him and the nurses, and heard a group of patients loudly singing a song designed to warn him of his fate. (The ward was in fact quiet at this time.) Logical arguments were of no avail. He spoke under pressure in great agitation and attempted to escape from the ward. At that time he was alert but disorientated.

Propranolol was replaced by atenolol and the symptoms all remitted during the succeeding week, without specific treatment. The patient had no previous psychiatric history and has remained well.

Inspection of blood pressure charts showed that psychosis was not associated with hypotension in either patient, occurring during stable or rising pressure phases. The patients recovered despite continuance of the other drugs used. Propranolol is known to accumulate in the brain in concentrations up to ten times the plasma level (5), and it seems to have been the sole cause of paranoid delusions and hallucinations in these patients.

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RATIONING OUT-PATIENTS

Dear Sir,

I was greatly interested by Dr Robin's article (*Journal*, August 1976, p 138) 'Rationing Out-Patients', in which he finds that an eleven week increase in waiting time produced a 10 per cent decrease in new referrals seen, and this with no apparent detriment to his clients. When I worked in the field of child psychiatry I too experienced this very general problem of an ever-increasing number of new referrals. The clinic team employed a variety of devices—none wholly successful—to keep this waiting period down to around six weeks. It is ironic to realize that if Dr Robin's thesis is correct our efforts were worse than useless.

Perhaps my experience of some years ago may be helpful, in that it both goes some way to substantiate Dr Robin's theories and also underlines some possible snags. At that time I had been set to work in a child psychiatric clinic which had accumulated a long waiting-list. On it were about sixty children who, on average, had been waiting around fifteen months. However, when we made personal inquiry, we found that only some fifteen parents still wanted treatment. Our waiting-list had shrunk to a quarter of its original size. But despite this bonus we had our problems.

Most important, these children, though presenting with a mixed bag of symptoms, proved extremely difficult to treat. Time, of course, had eliminated all the children who would have made a quick spontaneous recovery—as also families 'poorly motivated'. But it seemed to us that time had also sieved out most of the children for whom it could be hoped that psychotherapy could tip the balance in favour of mental health. It is a possibility that some children would have been more readily treatable in the early days of their disorder but with time had become 'fixed' in their patterns of maladjustment. And though the parents of these remaining children had shown dogged persistence in waiting for psychiatric help, they were not very regular in attendance once this help was offered.

Another difficulty, not unexpected, was the anger with which many parents greeted our long-delayed offer of help. Some parents declared that their child was no better but that they had become used to its disturbance. Some, we felt, even when the child was genuinely improved, would have been most reluctant to seek our help again.

The example I cite is, admittedly, an extreme one. All the same, before we become too complacent about long waiting-lists (let alone contrive them) we should remember that the object of psychiatry is not simply to assess patients but, as far as possible, to cure them. We must thus be reasonably sure that a long wait will not result just in more treatment sessions for fewer patients—and possibly a poorer therapeutic result. It would also be interesting to

know whether patients who 'fell by the wayside' during their long wait were deterred from seeking psychiatric help on later occasions.

I feel we should be circumspect before we too eagerly accept long waiting-lists as blessings in disguise.

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THE CLASSIFICATION OF DEPRESSIONS

DEAR SIR,

Professor Kendell's review (1) of the current state of the controversy surrounding the classification of depressions was extremely welcome. I should like to add one point concerning the dimensional/categorical part of the argument and suggest that the pattern of aetiology should not be assumed identical to that derived from studies concerned largely with clinical presentation. If we consider the clinical picture in depression, while a dimensional hypothesis is plausible for some of the features, notably mood disturbance, it is much less so for others, such as nihilistic delusions or auditory hallucinations, which seem to have no equivalents in normal states, or for the rapid changes in mental state that occur with acute onset or with swings from depression to hypomania. These 'discontinuous' features tend to occur in those whom Kendell designates Type A depressives, and it is noteworthy that in cluster analyses, where a substantial proportion of variables are related to clinical features, such a group of patients tends to be reliably identified (e.g. 2, 3), whereas Type B patients either fail to 'cluster' or appear as more than one group. It has been suggested that Type B depressions may be dimensional and continuous with normal states, while Type A are categorical and represent a pathological form with a separate and presumably discrete causation. Yet relevant studies reveal little evidence of major differences in the aetiology of the different forms of depression. It is plausible to suppose that in all depressions, one or more constitutional factors are implicated, together with stressful environmental features, and that all these are continuously distributed. It will be noted that in those studies in which a relatively large proportion of variables concerned with aetiology were included—notably Kendall's own (4, 5)—the separation of Type A depression has been less easy to demonstrate.

Can we then suppose that similar and continuously distributed causal factors can lead to either a continuous or a discontinuous symptom pattern? This is theoretically possible, as can be seen if one considers the analogy of the electric switch; and there are many instances in biology where continuous forces normally have continuous effect but at extreme intensities demonstrate a new and discontinuous effect. This model has recently received more prominence with the provision of a mathematics to deal with it (6), and is rather unfortunately known as 'catastrophy theory', The evidence for such a model of depression is limited; but it seems worthwhile to bear in mind that classification based on patterns of symptoms may be of limited value in the description of aetiology.

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LONG-TERM EFFECTS OF BEHAVIOUR THERAPY

DEAR SIR,

The introduction of behavioural techniques has led to a wave of therapeutic enthusiasm, but there are few long-term follow-up studies, and it is for this reason that I would like to report on two patients whom I treated ten years ago, using the method of systematic desensitization.

1. A 30-year old married woman who had been treated for her frigidity and housebound features (Kraft, 1967) was delighted with the treatment outcome; she was very much more cheerful, no longer moody, and could cope adequately with main roads and crowded places. Further she was pleased to report that during these ten years there had been a great improvement in her relationship with her husband. However, she was only prepared to speak to me on the telephone and refused to come and see me, because she felt that this might lead to a recurrence of her