subsequent postpartum depression, the case for specificity is rather more compelling. Indeed, the respective age of those with a previous psychiatric history and those without such a history becomes irrelevant when the critical comparison being made is the relative risk at postpartum and non-postpartum periods. Indeed, if those with a previous history do represent a more severe group, as Bell and colleagues suggest, it is of even more note that they are not at risk for subsequent postpartum depressive episodes.

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Personality features in chronic depressive episodes

SIR: It is unfortunate that Brown *et al* (*BJP*, October 1994, **165**, 447–56 and 457–65) did not examine the role of personality disorder more exhaustively in their report and studies of chronic depressive episodes. Personality status no longer needs to be assessed by 'a crude rating of predominant personality disorder backed up by inter-rater reliability' of unspecified information. There are several instruments that can be used to record the presence of DSM personality disorders more satisfactorily and, although we acknowledge their imperfections, they are undoubtedly superior to the techniques used in this study. It is also accepted that there is often particular difficulty in disentangling the effects of personality from those of chronic illness and even more care with assessments is needed under such conditions. The absence of satisfactory information about personality status is doubly unfortunate when so many other measures are recorded that are often associated with personality disorder. These include life events and early experiences such as sexual abuse, parental separation and delinquency.

The finding of only a marginal association of personality disorder with chronicity in depression is also at variance with most other studies. Although we acknowledge the methodological problems of assessing personality status when there is co-existing mental illness, it is only when workers of stature such as George Brown address these issues squarely that the complex inter-relationship between related life events, childhood adversity and current interpersonal difficulties will be resolved. It is hoped that other investigators will examine personality status in more detail in further studies. Our suspicion is that a careful recording of early childhood experiences and that of current personality status would identify remarkably similar groups of people.

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Chinese whispers and the prophylactic effect of cognitive therapy

SIR: In *Psychotherapy in the maintenance treatment of depression* (*BJP*, December 1994, **165**(suppl), 42–50), Weissman summarises evidence for the maintenance and prophylactic effects of cognitive therapy (CT). She states that "results of follow-up studies in patients who have received CT have been mixed". Results have indeed varied in terms of whether they were (Evans *et al*, 1992) or were not (Shea *et al*, 1992) significant. However, they have not varied in the direction of effects which have consistently favoured CT over treatment with medication alone.

In addition, when considering evidence suggesting prophylactic effects of CT, Weissman reiterates a conclusion from Shea *et al* (p. 786) that "The possibility that CT selects healthier patients with a lower latent risk of relapse compared with those recovering with tricyclic antidepressants is an equally plausible explanation". In neither the NIMH study (Shea *et al*) nor that of Evans *et al* was there any evidence that differential retention of patients during acute treatment biased the comparison of outcomes over follow-up. Differential retention is particularly unlikely to explain the difference in relapse between patients treated with combined cognitive therapy and pharmacotherapy versus patients treated with pharmacotherapy alone in the Evans *et al* study. Furthermore, in both of these studies, patients initially treated with cognitive therapy were found to have received less further treatment during follow-up than patients in the other treatment groups. This would be likely to result in an underestimate of any advantage of CT over pharmacotherapy in the prevention of symptomatic relapse without such further treatment. Thus, it could be argued that there is no evidence that the studies overestimate, and some evidence that they may underestimate, the prophylactic effects of cognitive therapy.

That CT prevents relapse of depression beyond termination of therapy has yet to be proved conclusively. However it is important that encouraging

findings are not obscured by the reiteration of overcautious conclusions for which there is no evidence.

EVANS, M. D., HOLLON, S. D., DE RUBEIS, R. J., *et al* (1992) Differential relapse following cognitive therapy and pharmacotherapy for depression. *Archives of General Psychiatry*, **49**, 802–808.

SHEA, M. T., ELKIN, I., IMBER, S. D., *et al* (1992) Course of depressive symptoms over follow-up: findings from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Archives of General Psychiatry*, **49**, 782–787.

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A HUNDRED YEARS AGO

The mental aspect of some traumatic neuroses

Mr. Herbert Page (London) read a paper on this subject. Having defined a traumatic neurosis as a disorder of the nervous system following injury, functional or dynamic in character, and independent or gross structural or as yet known lesion in the nervous centres, he pointed out that the evolution and elaborated structure of the nervous system in man seemed to predispose it to instability of equilibrium. The close relationship of distant parts of the body through the nervous system made it unavoidable that prolonged physical pain should cause mental anxiety and derangement of the general health. He showed how trifling physical injury to the peripheral nerves might lead in time to considerable mental disturbance, while psychical shock, acting on the cerebral cortex, might bring about serious impairment of health by causing functional derangement of the organic processes of life; as instances of the former effects, he cited cases of injury to extraspinal structures. Railway collisions and kindred accidents, accompanied by great terror, provided examples of the neuroses beginning in cerebral disturbance. It was a mistake to look on the symptoms in these cases as either imaginary or feigned, nor could treatment be successful if this were the view entertained of them. The close relationship of mind and body must not be forgotten and due regard to the psychical element in all these nervous disturbances was essential for success in treatment. It was all-important, moreover, that diagnosis should be prompt, so that the patient might be saved from lines of treatment likely to perpetuate his ailments by reason of continued apprehension and introspection. The various determining factors in the traumatic neurosis were specially alluded to, and it was shown how suggestion might play a part in originating new phenomena and prolonging those which had arisen directly from the accident.

Drs. and Messrs. Puzey, Banks, A. Wiglesworth, Barr, Carter, Sheldon, Paul, and Davidson took part in the discussion.

Reference

British Medical Journal, April 1895, 759.

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