This is not so: the hypothesis of inconsistency was advanced by us to explain, not schizophrenic thought disorder, but simply Dr. Bannister's experimental results—a rather different matter.

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EYE-CONTACT AND DEPRESSION

DEAR SIR,

I was interested to read Derek Rutter's criticism of our study of Eye Contact in Depression in his review article 'Visual Interaction in Psychiatric Patients' (*Journal*, August 1973, 193–202).

I agree with him, there are major problems in controlling for interviewer behaviour and interview content without stylising the interview to such a degree to render its content artificial and useless. We were aware of these snags and indicated that we had found significant trends in our results. I agree that a more detailed breakdown of looking while listening and speaking are desirable. Another point that he raised was the effect of admission to a mental hospital on Eye Contact levels. In fact our depressed patients had been admitted to the psychiatric ward of a general hospital and were interviewed during the first week of their admission. Many were first admissions for psychiatric illness. Thus we avoided the stigma of admission to a large mental hospital, a point frequently mentioned with relief by the patients.

We also found wide variation in results between patient and control group, with some overlap in results. I would not attribute this so much to 'differences in aetiology and symptomatology' but to personality differences well known to influence levels of eye contact, such as dominance-dependency, introversion-extraversion, as well as sex differences. In our studies we encountered two female patients with total gaze avoidance. I attributed this to hostile defiant behaviour in hysterical personalities.

My overall impression of depressed psychiatric patients is that there is a marked and obvious reduction in eye-contact when intimate and painful topics are being discussed, that there is a general slowness of responsiveness in the eye-contact patterning compared with controls, but that this correlates with their psychomotor retardation.

We are also looking at eye-contact in the free discussion situation in order to avoid a discussion of symptoms. We are taking videotape recordings of depressed patients and their spouses in discussion and comparing eye-contact levels with those that the patient makes when talking to a normal stranger of the opposite sex. It seems that the anxious spouses are looking more than their depressed partners. The depressed patients become considerably more reactive and socially aware with the stranger and increase eye-contact.

In response to Rutter and Stephenson's results which indicate a similar level of reduced eye-contact in both schizophrenic and depressive groups I would suggest that there may be a minimum optimum level of eye-contact to which the emotionally disturbed individual retreats and that this protects him from a troublesome degree of social interaction and yet provides him with enough information about his interactant.

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