Brit. J. Psychiat. (1966), 112, 743–745

Correspondence

PARENTAL LOSS AND ATTEMPTED SUICIDE

DEAR SIR,

I should be grateful for the opportunity to correct a misprint which appeared in my paper in the May issue of the *Journal*. The discussion on causes of parental loss (p. 468, col. 2) should read:

> "Miscellaneous causes other than illegitimacy, parental death and divorce appear to be somewhat less frequent among suicidal patients than among non-suicidal controls, but surveys of much larger samples would be required to determine the significance of this finding."

This point is of some interest, because a more extensive study which has just been completed (1) shows significant differences between attempted suicides and matched non-suicidal controls in respect of causes of parental loss, the suicidal group being more often deprived as a result of irreversible causes such as parental death and divorce, whereas among controls parental loss is more commonly due to temporary exigencies such as war service. These results confirm the trend shown in the previous study.

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REFERENCE

GREER, S., GUNN, J., and KOLLER, K. M. (1966). *Aetiological Factors in Attempted Suicide*. To be published.

BEHAVIOUR THERAPY

DEAR SIR,

In the February, 1966, issue of the *Journal* there were printed both my letter regarding the article by Marks and Gelder published in July, 1965 and a rejoinder by these authors. I am writing now in an attempt to clear up the confusion.

Drs. Marks and Gelder allege that I missed the point regarding their matching patients for treatment outside of "behaviour therapy" (i.e., practical retraining); they say that patients were, in fact, successfully matched on all treatment variables other than practical retraining. However, a close examination of their article fails to confirm this. I have taken the liberty of constructing a little table which ought to make clear my argument that there was, in fact, absolutely no control in terms of treatment beyond retraining:

Agoraphobics

	"Behaviour" Therapy" (N=21)	"Controls" (N=21?)
Relaxation-hypnosis	8	0
Systematic desensitization ..	6	0
Sedatives	13	9
ECT	2	0
Abreaction	1	2
Leucotomy	1	1
Anti-depressants ..	0	5
LSD	0	1
Intensive psychotherapy ..	0	7
General encouragement	0	7

Examining just this group of phobics, we see that (*a*) it is not clear how many patients received various combinations of other-than-retraining ministrations. Obviously *some* such combinations had to occur, for otherwise we would have 31 patients in a group of N=21. What, then, is the interaction between, for example, systematic desensitization and ECT? In addition, there is no information as to the actual drugs used or their dosages. Furthermore, what is "intensive psychotherapy?" (*b*) it is also very clear that, contrary to the authors' rejoinder, satisfactory matching was *not* achieved *vis-à-vis* treatment, e.g., where is the LSD patient in the "behaviour therapy" group of agoraphobics?

Even if patients had been matched for treatment, one would still have to raise serious questions. For example, do we know the effects of leucotomy on the presumed conditioning during practical retraining? In fact, do we know what happens in the brain during *any sort* of learning? We do not, so that simply adding practical retraining to leucotomy entails a dangerous assumption as to the nature of the interaction between just these two variables.

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A word on the second point in their rejoinder, practical retraining as behaviour therapy. It was not my intent to exclude this technique from what is generally considered "behaviour therapy"; rather it was to discourage the *equation* of this single technique with "behaviour therapy"; this is the implication both of the title of their paper and of the manner in which the article (and their letter) was written. Behaviour therapy includes a *number* of techniques (*vide* new book on behaviour therapy techniques by Wolpe and Lazarus, Pergamon Press); it would, therefore, seem wise to specify the procedure being followed rather than to refer globally to "behaviour therapy".

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DEAR SIR,

We do not equate behaviour therapy with practical retraining. We used the former term in our paper as a convenient way of referring collectively to desensitization whether by practice or in imagination or both.

Dr. Davison's Table purports to show that none of our behaviour therapy patients were given antidepressants; in fact 9 were so treated. We noted in our paper (p. 564) that more patients in the behaviour therapy group had additional treatment: if this biassed the result it should have favoured behaviour therapy.

The findings of this paper have been broadly confirmed by two prospective studies (*Journal*, February, 1966, p. 309, and to be published). These show that desensitization by practice and in imagination is more useful for the simpler phobias than for severe agoraphobia with multiple other symptoms.

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DEPRESSION: PSYCHOTIC/NEUROTIC: ENDOGENOUS-EXOGENOUS

DEAR SIR,

I have read the letter by B. H. Fookes (April, 1966), and agree in the main with him, but I do not find it disturbing that the Depression controversy is still open. It may well be that each generation of psychiatrists must argue it out for themselves in the light of accumulating academic and clinical knowledge.

I would not wish to aggravate the controversy further, but I should like to offer a classification of Depression which I find useful in clinical work, and which may serve to answer some of the points raised by Dr. Fookes.

Depressive reaction: this is an extension in degree and quality of the emotional response, known to all, which is the response to frustration and loss of a prized object. It will be expected to occur more commonly in those personalities, described as vulnerable or inadequate, that are generally at risk in a biological sense. This is a pattern of reaction rather than an illness as such (unless illness be defined solely in terms of severity of symptoms).

Psychotic depression: so called because of the non-comprehensible nature of the symptoms in a Jasperian sense. Here are found the delusions of guilt, hallucinations, psychomotor retardation, etc., commonly subsumed under the heading of "endogenous" depression. This latter term is rejected because it implies that the aetiology is purely constitutional, whereas in clinical experience many "endogenous depressions" can be environmentally provoked. Thus, Psychotic Depression can occur along a continuum based on the presence or absence of environmental provocation, and is independent and different from the Depressive reaction. Munro (April, 1966) concludes "it is suggested once more that depressive illness—(Psychotic Depression in the classification of this writer)—is basically due to a genetic abnormality, but that the expression of this abnormality may be greatly modified by a multiplicity of environmental factors."

Thus— I Depressive reaction (psychological response),

II Psychotic depression (genetic substrate):

(*a*) largely situationally provoked,

(*b*) admixture of situational/constitutional factors,

(*c*) apparently totally "endogenous".

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REFERENCE

MUNRO, A. (1966). Some familial and social factors in depressive illness. *Brit. J. Psychiat.*, 112, 429–441.

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