treatment. Not one "endogenous" factor showed a significant association.

Using Column A (which is a more realistic and conservative estimate than Column B), diurnal variation is no longer significant, and psychomotor retardation is thus the only one of the six "endogenous" factors to be significant. However, the three "reactive features" which were significant in Column B remain so.

Perhaps the most significant aspect of Table II is the large number of "mixed" (really undiagnosable, according to our criteria) cases. When the more conservative method of distributing the patients was used, 32 per cent. of the patients did not fall into either the "reactive" or "endogenous" group.

To turn to Foulds's claim that the use of "adequate personality and steady course under endogenous, and their opposites under reactive", is inadmissible: These factors were originally studied as continuous variables, in which case the extremes might have validity. Furthermore, using "course of illness" as an example, if fluctuating course as reactive feature were removed, this would create a bias in the direction of making the diagnosis of "endogenous". To remove both is to ignore what may be significant components of the syndrome.

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DEAR SIR,

Professor Fish (*Journal*, January, 1966) says that I make the erroneous assumption that reactive and endogenous depressives are equivalent to my neurotic and psychotic depressives. But I criticized Carney, Roth and Garside for using terms from two different universes of discourse (endogenous and neurotic)! As the two dimensions (endogenous-exogenous and psychotic-neurotic) are used by psychiatrists, they are very far from being orthogonal. When I have been wanting to dichotomize depressives into psychotic and neurotic and some wayward psychiatrists have written endogenous or reactive, I have asked them to use psychotic: neurotic. Almost invariably endogenous and psychotic have been associated, and so have reactive and neurotic. I dislike endogenous: exogenous because it is an aetiological classification (without adequate basis and with less likelihood of inter-judge agreement than presence or absence of delusions) amidst surrounding phenomenological classes.

With regard to sleep, my more general point was that clinicians often confirm their hunches because they so arrange the situation that there is no possibility of disconfirmation. I could have made this point better had I said paranoid rather than reactive depressive.

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DEAR SIR,

Recent correspondence in the *Journal* on the nature of depressive illness is rather disturbing: it is especially a ground for despondency that controversy remains after so many years' discussion, although this is one of the occasions when clinical experience and more academic studies appear to be in agreement. One is bound to ask just what fundamental advances have been made in psychiatry for which administrators and the pharmaceutical industry are not responsible.

It is a part of human experience that some suffer changes in mood for which they can find no explanation, while others suffer from a change in mood for which an environmental cause is only too clear. Those who experience both types of mood change at one time or another can distinguish them not only by the presence or absence of an environmental cause, but also in the quality of the mood change. When they suffer reactive depression they have suffered a stress which they are, at least temporarily, unable to withstand; they lie awake thinking of the problem at night, and then sleep through the alarm clock; they forget the problem temporarily at a party and feel happier until they are again reminded of it.

These are also the symptoms of a neurotic depression, and when one moves from normal experience to experience of disease one finds neurotic depression affecting one sort of person, who experiences one set of symptoms and shows one type of response to treatment; and endogenous depression affecting another type of person, with different symptoms and a different response to treatment: and none of these differences looks like a merely different point along the same line. If neurotic depression and endogenous depression were merely quantitatively different one would have to place the endogenous depression at the more severe end of the scale; and yet we can find mild depressions which share the basic symptomatology of severe endogenous depression, which are milder than other depressions which share the symptomatology of a non-pathological reactive