

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 biased 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 Jaspersian 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.