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CONTROLLED TRIALS OF IMIPRAMINE

Dear Sir,

Drs Rogers and Clay (*Journal*, December 1975, **127**, 599) suggest that further drug-placebo trials in endogenous depression are not justified as imipramine is of indisputable benefit in such patients who have not become institutionalized. The data presented are open to other interpretations, and the effectiveness of imipramine for the treatment of depression has still not been established beyond doubt. A suitably designed trial comparing antidepressants with placebo might still help to clarify the problem. Many psychiatrists would expect most patients (certainly over 50 per cent) with endogenous depression to get better in due course without treatment because of the natural history of the disorder. There is no indication of the length of time for which any of the patients were treated. We think the distinction between endogenous and other depressions is not so readily made as implied in the table. The great variation in percentage improvement rates in both imipramine and placebo groups of endogenous depressions needs some explanation. The criteria for rating improvement are not mentioned, and the sample sizes vary from 6 in one trial to 140 in another.

The trials analysed by Rogers and Clay form only a small proportion of the published trials on antidepressants. The method of statistical analysis does not allow for all trials to be tabulated. There are many trials in which placebo has achieved a better result than an antidepressant, and these have not been included. Also, only two trials carried out since 1966 are mentioned and it is in the first years of a drug's commercial life that favourable reports tend to be published. Some of these points concerning antidepressants have been made previously by Leyburn (1967) and by Porter (1971). It would be unfortunate if the results of this particular statistical review were accepted uncritically as evidence that imipramine is in fact so therapeutically effective.

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A MARRIAGE THAT OUGHT TO ENDURE

Dear Sir,

In his pamphlet *The Future of Psychiatry* Professor Eysenck advocates an amicable divorce between the disciplines of Psychiatry and Clinical Psychology. It is our opinion that this would not be in the best interest of the psychoneurotic patient. By arguing that psychoneurosis is behaviour largely determined by conditioning, deconditioning or failure to learn or condition, Eysenck (p 6) is stretching his stimulus-response theories just as far as he claims many psychiatrists are stretching the disease model. Recent work (Beech, H. R. and Perigault, J., 1974; Crowe, M. J. *et al*, 1972) suggests that both acquisition and extinction of morbid fears and obsessions constitute a very complex process—'it is obvious that multiple conditions are involved which interact with one another, so a satisfactory model cannot be simple', comments Marks (1975). 'Unusual states of arousal' and 'right cognitive set' are postulated, but elude precise qualitative definition. Thus the door once again opens to concepts such as idiosyncratic meaning and conflict. Many behaviour therapists, contrary to Eysenck's view, emphasize the role of cognitive factors in the cause and treatment of psychoneurosis. At this point there is a great deal of overlap between behaviour therapy and psychotherapy.

A significant proportion of our patients resist exploration so that basic drives remain unrevealed: the obstacles of denial, dissociation, projection and displacement of feeling can be formidable, and it is the psychotherapist's often slow and arduous task to evaluate and disentangle them. Such obstacles do not necessarily constitute complexes in the classical sense (Eysenck, p 17), but may represent interpersonal emotions or phobias hidden from conscious awareness and therefore not accessible to treatment until the patient can be brought into direct contact with the phobic object or situation: but if the latter remains unrevealed, unrecognized or unknown, what precisely do we help the patient to confront?

The danger of neglecting covert factors is not so much symptom replacement as resistance to treatment or only very partial improvement. In a series of agoraphobic patients, psychological gain appeared to have prevented success with deconditioning therapies in 56 per cent of cases (Shafar, 1975); psychodynamic gains operated, but many were relinquished with