Brit. J. Psychiat. (1974), **124**, 314–6

Correspondence

Letters for publication in the Correspondence columns should be addressed to:
The Editor, British Journal of Psychiatry, Chandos House, 2 Queen Anne Street, London, W1M 9LE

PSEUDO-HALLUCINATIONS

DEAR SIR,

I am surprised that to date Dr. Hare's 'A short note on Pseudo-Hallucinations' (*Journal*, 1973, **122**, 469–76) has not provoked a reply in these columns, either from a phenomenologist or from an angry examination candidate agreeing with him that the question on this topic in the Membership examination was difficult—even unfair.

It was a challenging article implying that the concept of pseudo-hallucination was nowadays largely superfluous, although it 'won't yet lie down'. This opinion was supported by a strangely perfunctory and unhelpful search of the literature. For instance Hare says that apart from Slater and Roth 'the only other commonly available English language text-books which mention pseudo-hallucinations are those of Fish'. Yet a similarly perfunctory search of the literature (my own book-shelf) brought to light two further standard text-books (Anderson and Trethowan, and Granville-Grossman) that not only mention pseudo-hallucinations but discuss the concept in reasonable detail.

Similarly, although there may well be 'only three papers dealing with pseudo-hallucinations in British psychiatric journals over the last ten years', these articles (all Sedman's) are key papers, greatly detailed and include a historical survey of the literature as well as illustrative cases. I would not have thought it unreasonable to expect an examination candidate to have read these articles or to have looked at the books by Fish, Granville-Grossman, Slater and Roth, and Anderson and Trethowan. I would concede that Jaspers appears muddled when writing on pseudo-hallucination, but Sedman's review is surely clear enough.

The question of the everyday clinical importance of the concept is a separate issue, but I would feel, contrary to Hare, that the concept has a pragmatic value. One needs to distinguish initially between phenomena occurring in clear or in clouded consciousness. Having done that, hallucinatory phenomena in clear consciousness can usually be divided into 'true' hallucinations (or hallucinations proper) and various forms of imagery and pseudo-hallucination. The latter phenomena indeed appear to lie on a continuum, which is why Sedman refers at times to pseudo-hallucinations as 'a special form of imagery'. The subject experiencing a pseudo-hallucination recognizes it is not a veridical perception. The experience has a subjective quality which the patient realizes, and occurs in inner subjective space—'the mind's eye' or 'the mind's ear'. The content is nearly always 'ego bound' and psychologically meaningful—words of advice and comfort are proferred and so on.

This differentiation is not merely a pedantic academic exercise, but can be relevant diagnostically. Unlike Hare, I do not read Fish as being sceptical of the clinical importance of pseudo-hallucination; he was surely pointing out that true auditory hallucinations in clear consciousness are of more ominous import with regard to a possible diagnosis of schizophrenia. Too often a patient is said to be 'hallucinated', with all that that implies, without an adequate investigation of the symptom. Phenomenology is admittedly not a sharp tool, but at least let us not blunt it further.

G. G. HAY.

Department of Psychiatry,
University Hospital of South Manchester,
West Didsbury,
Manchester, M20 8LR.

REFERENCES

ANDERSON, E. W. & TRETHOWAN, W. H. (1973) *Psychiatry*, 3rd ed. London: Baillière, Tindall.

GRANVILLE-GROSSMAN, K. (1971) *Recent Advances in Clinical Psychiatry*. London: J. & A. Churchill.

THE CAPGRAS SYNDROME

DEAR SIR,

We would refer to two papers in the December 1973 issue of the *Journal* discussing the Capgras syndrome which you published under the general heading 'Organic Conditions'. We have seen a patient with pseudo-hypoparathyroidism who developed two brief episodes of a schizophrenia-like psychosis following courses of electro-convulsive treatment. The illness occurred in clear consciousness and included the Capgras symptom. We suggest that

the effect of ECT in our patient, acting on a previously abnormal central nervous system, was sufficient to produce the schizophrenia-like psycho-syndrome.

Weston and Whitlock (1971) described a case of the Capgras syndrome following severe head injury, and Whitlock (1967) also described cases of the Ganser syndrome occurring on an organic basis, thus emphasizing the fact that these conditions are non-specific and can occur in a wide variety of psychiatric settings. It may, therefore, be preferable to talk of the Capgras symptoms and Ganser symptoms rather than use the word 'syndrome'. Sir Aubrey Lewis (1966) has pointed out the difficulties that arise from arguments over the use of such terms as 'syndrome', 'illness' and 'clinical entity'. However, it is important that the significance of the above contributions does not get overlooked in what may become an argument over the meaning of words. What must be emphasized is the need to search carefully for a possible underlying cause in these cases.

G. G. Hay.
D. J. Jolley.

Department of Psychiatry,
University Hospital of South Manchester,
West Didsbury,
Manchester, M20 8LR.

References

Weston, M. J. & Whitlock, F. A. (1971) The Capgras syndrome following head injury. *Brit. J. Psychiat.*, **119**, 25–31.

Whitlock, F. A. (1967) The Ganser syndrome. *Brit. J. Psychiat.*, **113**, 19–29.

Lewis, A. J. (1966) Survivance de l'hystérie. *L'Evolut. Psychiat.*, **2**, 159.

DEPRESSIVE ILLNESSES IN LATE LIFE

Dear Sir,

May I register my surprise that Sir Martin Roth and Dr. Garside could advance the naïve notion (letter, *Journal*, 1973, **123**, 373–5), that researchers' biases in collecting data on symptoms would necessarily be a direct reflection of their views?

In patients over 40 I regularly find the early morning wakening, guilt, feeling worse in the morning and so on, the symptoms which characterize endogenous depression. However, when students fuss about whether a patient of under 30 suffers from this or a neurotic depression I am conscious of a growing irritation. Why, I feel, do they not merely ask, does the patient have a condition which is likely to respond to an anti-depressant? And, instead of attempting to find the list of symptoms which characterize neurotic or endogenous depression, why do they not focus on whether the patient has shown for some months a clear-cut depression or loss of interest with sleep disturbance and possible loss of appetite etc., which is different from their lifelong pattern? Again I ask myself: can endogenous depression be a clinically significant entity when so few of the symptoms which characterize it correlate with a good response to physical treatment? (Kiloh *et al.*, 1962; Mendels, 1965; McConaghy, 1968).

Clearly I am biased against the concept that these two illnesses exist as entities. Yet when I interview a patient I regularly ask whether he has difficulty in going to sleep or does he wake early; does he feel worse in the morning or at night; and so through the questions which tend to polarize the patient's symptoms to match one of these two postulated illnesses.

Roth and Garside underestimate the effect on clinicians, whether believers or non-believers, of a theory which is clear-cut and easy to grasp, particularly when there are no alternative theories available with these advantages. Yet how often must they have seen even the bitterest opponents of Freudian theory use large chunks of it when attempting to explain aspects of human behaviour. Equally I have heard the term 'double-bind' frequently used clinically by psychiatrists who in intellectual discussion obviously regard it as a meaningless cliché. Back to the drawing board?

N. McConaghy.

School of Psychiatry,
Prince Henry Hospital,
Little Bay, Sydney,
Australia.

References

Kiloh, L. G., Ball, J. R. B. & Garside, R. F. (1962) Prognostic factors in treatment of depressive states with imipramine. *Brit. Med. J.*, *i*, 1225–7.

Mendels, J. (1965) Electroconvulsive therapy and depression: II. Significance of endogenous and reactive depression. *Brit. J. Psychiat.*, **111**, 682–6.

McConaghy, N. & Joffe, A. D. (1968) Correlation of clinical features of depressed out-patients with response to amitriptyline and protriptyline. *Brit. J. Psychiat.*, **114**, 103–106.

[This letter was shown to Sir Martin Roth, who comments:

'The point we were making was that a man's bias will not necessarily distort his perception and falsify his findings. Sometimes a clinical psychiatrist subscribes to one theory, yet his own observations may establish the opposite. In the case to which we referred, the investigators were not themselves aware that this had in fact happened.

McConaghy's point is quite different. It is that man will not necessarily practise in the clinic what he preaches in