seems a pity that he did not take this opportunity to define more closely the classes of patient likely to benefit and those unlikely to do so.

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REFERENCE

CARNEY, M. W. P., FERGUSON, R. S., and SHEFFIELD, B. F. (1970). Psychiatric day hospital and community. *Lancet*, *i*, 1218–1220.

PSYCHIATRIC DIAGNOSES

DEAR SIR,

Dr. Kendell's paper 'Psychiatric Diagnoses: A Study of How They Are Made' (*Journal*, April 1973, **122**, 437–45) made fascinating and illuminating reading. I would very much like to comment on just a few points which I think are of considerable importance to future psychiatric research and teaching in this country. If indeed the visual information is virtually non-contributive to the majority of diagnostic situations, and we accept that accurate or at least concordant diagnosis should be one of the first aims of psychiatric teaching, then the very heavy investment in video-tape hardware for teaching psychiatry should be seriously reviewed. My belief is that the 'sound only' results might well have been even higher in Dr. Kendell's study had the recording been of a higher quality, and it is conceded in the paper that this quality was often quite poor. A problem with video-tape apparatus is that sound quality often turns out to be poor. If indeed the auditory information *is* the crucial information, then this points to an even more urgent requirement for research into speech and language in psychiatric patients. Speech conveys not just the semantic intention of a patient but a great deal else; subtle changes in syntax, word distribution, etc. may well, in many instances, be substantially more important than the semantic content in making diagnoses. Perhaps it also points to a reorientation in the future in which good quality sound cassettes of interviews with patients might be used with relatively inexpensive tape reproducers in teaching, allowing students to use these individually and at will (which is virtually impossible with video-tapes), with the opportunity for replay as often and wherever they like. In terms of expense there would almost certainly be a great saving. I am reluctant to raise any criticism about such an excellent paper, but I feel that the choice of words 'behavioural' and 'non-behavioural' was unfortunate. Speech is certainly behavioural in many aspects quite unconnected with actual meaning (speech rate, vocabulary diversity; syntactic complexity, etc.), all of which reflect fundamental brain processes which are well labelled *behavioural*. Thus to see the 'transcript only' described as 100 per cent non-behavioural is, I think, misleading It is certainly to be hoped that the paper will act as an antidote against those who teach that a diagnostic interview should be the passive reception of 50 minutes of spontaneous autobiography, and that it may temper recent enthusiasms for video-tape in psychiatric teaching. A more appropriate combination would seem to consist of witnessing the live interview between psychiatrist and patient together with the opportunity to consult purely audio recordings, perhaps with transcripts and comments.

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PSEUDO-HALLUCINATIONS

DEAR SIR,

In the *Journal* for April 1973 (**122**, 469–76), Dr. E. H. Hare reviewed papers dealing with pseudo-hallucinations in British psychiatric journals over the last ten years. He was able to find only three papers dealing with this topic, all by Sedman. I should like to draw his attention to my own paper (1) in which I discussed the definition of the term pseudo-hallucination as applied to the perceptual experiences of normal subjects exposed to sensory deprivation conditions. The visual experiences of these subjects seemed to fit into the definition of pseudo-hallucinations proposed by William James (2), in that although they appeared to exist external to the subject they usually had a cartoon-like quality and were considered to be unreal. However, the degree of insight evinced by these subjects varied: one subject believed that the experimenter was projecting images on to the translucent goggles he was wearing as part of the experiment. In addition, to these qualities, the visual experiences sometimes showed the feature of being closely related to the subject's affective state at the time. It was also possible to categorize some of the auditory and somaesthetic experiences of these subjects as pseudo-hallucinations.

A significant association was found between schizoid personality traits in these subjects and the reporting of perceptual experiences during sensory deprivation. This link alone suggests that the term pseudo-hallucination is worth retaining and that