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

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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

an attempt to reach agreement on its definition would also be worth while.

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2. JAMES, W. (1891). 'The perception of things'. In: *The Principles of Psychology*. London, Macmillan.

CLASSIFICATION OF THE FUNCTIONAL PSYCHOSES

DEAR SIR,

I have just obtained some results of a study of psychotic patients which have a bearing on Dr. Ollerenshaw's article in your May 1973, issue (**122**, 517–30).

Thirty-eight male patients diagnosed clinically as suffering from a schizophrenic illness were assessed at the end of their stay in hospital, at which time they had largely recovered from their acute illnesses. The eighth edition of the Present State Examination (PSE) was used (Wing *et al.*, 1967). Twenty-seven patients had, at the time of the PSE examination, definite depressive symptoms, and these were quite marked in 14 cases. In fact 6 patients were categorized by the computer programme devised for use with the PSE as having a depressive illness. However, this was in no sense a new illness which they had 'developed' or 'slipped into' because *in every case* the patient had exhibited a greater range and/or severity of depressive symptoms when he was assessed by the same method soon after admission. Of 46 patients examined during the acute stage of their illness (including 8 patients who were not re-assessed later), all but one had some depressive symptoms, and in 41 patients these were quite marked. However, only one was classified as depressive by the computer programme, because, in common with the practice of most clinicians, if definite schizophrenic symptoms were also present that diagnosis was preferred.

The depressive symptoms could not be attributed to treatment, since the initial assessments, when the patients were more depressed, were made *before any treatment had begun.* The effect of treatment between the two assessments could only have been to reduce the depressive symptomatology. Incidentally, more detailed analysis of the treatment given, while perhaps indicating the benefit of ECT in diminishing depressive symptoms, further exonerates the depot phenothiazines from blame for *causing* them, as the following Table shows.

TABLE

Treatment	Depressive Symptoms at end of stay in hospital			
	Absent	Minimal	Marked	Total
Nil	1	1	–	2
Phenothiazines only	–	–	2	2
Phenothiazines only including Depot Phenothiazines	–	2	2	4
ECT and Phenothiazines	8	7	9	24
ECT and Phenothiazines including Depot Phenothiazines	2	2	1	5
ECT only	–	1	–	1
	11	13	14	38

It looks, therefore, as if, instead of the consecutive appearance of schizophrenic and depressive illnesses, these two are in a sense concurrent, but, because pride of place is given to schizophrenic symptoms in arriving at a diagnosis, depressive ones are under-recognized (How many clinicians inquire into depressive symptoms at all when confronted with florid and clear-cut schizophrehnic illness?). The effect of treatment, far from inducing depression, is to remove the masking schizophrenic picture, revealing whatever residual depression exists after ECT and other therapy. An important objection raised by the author to the 'possibility that schizophrenic and affective psychoses are two independent dimensions rather than separate categorical disease entities' is thus removed.

A somewhat similar picture emerged when hypomanic symptoms were considered. In the acute phase before treatment 8 of the 46 patients had some hypomanic symptoms and in 16 others these symptoms were numerous. On recovery, 13 out of 38 had *some* hypomanic symptoms and in only 4 were they numerous. Two of the 4 and one of the 13 had not previously had such symptoms, but in all other cases they were more marked in the acute phase. However, 14 'recovered' patients were classified with a category indicating a definite element of mania. Only 6 were so classified initially, not, as we have just seen, because they lacked relevant symptoms but because once again precedence was given to florid schizophrenic