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THE IMPACT OF AN ABNORMAL CHILD UPON THE PARENTS

DEAR SIR,

In the April 1977 issue of this *Journal* (**130**, pp 405–10), Dr Gath comments upon the impaired 'quality of the marital relationship' of the parents of mongols, as evidence by their admissions of 'severe tension, high hostility or marked lack of warmth' at interview.

May I suggest that Dr Gath has fallen into the same trap as did Singer and Wynne (1963) in their study of parents of schizophrenics? It will be recalled that the latter were found to give more pathological descriptions of ink-blots, but careful studies by Hirsh and Leff (1975) later revealed that the difference resulted simply from the increased willingness to talk at interview on the part of parents with problem children.

In Dr Gath's study, parents of mongols confessed more frequently to *all* the measures assessed, whether constructive or destructive to the marriage, while control parents related more moderate feelings. This may reflect the anxiety of the former to enlist help, rather than supporting Dr Gath's hypothesis.

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THE HIERARCHICAL MODEL OF DEPRESSION

DEAR SIR,

It is comforting to have one's work replicated (Bagshaw, 1977) and to see this twice in one Journal issue suggests something more than 'sheer carelessness'. I wish to point out, however, that the author also comes close inadvertantly to replicating the error of Kendell (1976). Within the hierarchical model of personal illness the 'two types of depression' are not differentiated simply by the presence of delusions of contrition in one group. We most recently concluded (Foulds and Bedford, 1976a) that '(1) those with a preponderance of delusions of contrition over delusions of grandeur or of persecution may, in the absence of delusions of disintegration be regarded as virtually synonymous with Psychotic Depressives; (2) dCs (or Psychotic Depressives) almost invariably suffer from neurotic symptoms (with ruminations the commonest); (3) all dCs (or Psychotic Depressives) suffer from either a state of anxiety or of depression and usually both; (4) a state of depression, *as a diagnosis*, can only be identified in the absence of neurotic symptoms (phobic, hysterical, or obsessional) and of delusions.' In other words, dCs are members of Classes 3, 2, and 1, sDs are only members of Class 1. There are, therefore, differentiae at two class levels.

Bagshaw found that 42% of her 'psychiatrically diagnosed depressed sample obtained a DSSI diagnosis of psychotic (dC) or neurotic (sD) depression'. A further twenty-two cases (29%) fell into one of the neurotic symptoms groups. This is precisely the area of confusion we commented upon when we made a case for separating out the dysthymic states from the neurotic symptoms (Foulds and Bedford, 1976b). As 92% of her patients fitted the hierarchy model it would seem plausible that the agreement in her study between the clinical and DSSI 'diagnoses' could be as high as 71%.

Finally, unpublished data from a pilot study of self-reinforcement in depression has been made available to me by Mr R J Wycherley. 93% of his 40 in-patients have DSSI patterns which fit the hierarchy model. Of the 28 scoring sD 16 are also dC (57%); of the 19 scoring dC 16 are also sD (84%). Again the relationship between these two sets might reasonably be described as inclusive and non-reflexive.

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