that Berner *et al* classify hypochondriasis as such as, of all things, a phobia.

The PSE is designed as a multipurpose instrument and may of course include items of form, as well as items of content, but it is essential not to compound the two.

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THE TWO-WAY TRADE—PSYCHIATRY AND NEUROSCIENCE

DEAR SIR,

McHugh and Robinson's review (*Journal,* September 1983, **143,** 303–5) confirms that new transmitter pathways constitute a new neuroanatomy. However, it is questionable whether they provide for "conceptualizing new relationships of neuropathology to psychopathology" or merely corroborate Hughlings Jackson's (1884) notions of uniform and local dissolutions in the nervous system. In addition, Jackson already provided a conceptual framework for such states as hemiplegias, epileptiform seizures, choreas etc, as well as the mental phenomena of 'non-cerebral disease'.

An additional 'two-way trade' for psychiatry and neuroscience would therefore be the apparently forgotten contributions from the past to the present. In keeping with Dewhurst's (1982) sentiments, if Jackson's fertile ideas are given a second chance in psychiatry today perhaps the trade would be complete.

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JACKSON, J. H. (1884) Evolution and dissolution of the nervous system. *British Medical Journal,* 591–3.

IMIPRAMINE AND AGORAPHOBIA

DEAR SIR,

Donald Klein implies that I incorrectly cited from the chapter in *Agoraphobia* edited by Chambless and Goldstein (*Journal,* September 1983, **143,** 309). To make matters clear I would like to cite verbatim a sentence from the chapter:

"Even those patients who show stimulant side effects can most often be treated effectively by lowering the dose and then increasing very gradually, sometime to a maximum tolerated level of 10 mg per day (Zitrin *et al,* 1978)."

I am grateful to Dr Klein, however, for pointing out that the more recent studies he has carried out advocate doses in the range of 200 to 300 mg daily.

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Reference

CHAMBLESS, D. L. & GOLDSTEIN, A. J. (EDS.) (1982) *Agoraphobia: Multiple Perspectives on Theory and Treatment.* Chichester: John Wiley.

SUGGESTION AND SUICIDE BY PLASTIC BAG ASPHYXIA

DEAR SIR,

Of some six hundred suicides recorded in Kingston-upon-Hull by the city coroner between 1960, by when (according to local firms) plastic bags had become widely available to the general public, and 1980 inclusive, only nine were by this means. Their dates were 12:7:71, 18:9:72, 25:10:72, 4:12:72, 7:1:78, 15:3:78, 30:4:78, 5:5:80 and 5:9:80, giving an impression of tight clustering with long intervening gaps, heightened by the fact that all occurred in the last ten years of the series.

If the ten years are slightly shifted so as to begin on 1:2:71 and end on 31:1:81, and divided into consecutive two-month segments, then there are 51 such segments without a plastic bag suicide, and 9 with exactly one each, in the sequence

$$0^2\,1\,0^6\,1^3\,0^{29}\,1^3\,0^5\,1\,0\,1\,0^8$$

(where 0 represents a segment without a plastic bag suicide, 0^n n consecutive such segments, 1 a segment with one, etc). There are 11 runs (16.3 expected), with an exact probability (by the Wald-Wolfovitz test) of 0.0142469, confirming the impression of clustering. Alternatively, a non-plastic bag suicide (npbs) segment has estimated probability 5/50 = 0.1 of being followed by a plastic-bag suicide (pbs) segment, whereas a pbs segment has estimated probability 4/9 = 0.4 of being so followed; thus a plastic bag suicide in a segment appears to increase the probability of another in the next segment. In fact, the lag 1 autocorrelation is 0 = 0.34, with exact probability (by the Fister-Yates test) of 0.023689. Either way, there is a modest but significant clustering effect or dependency.

Since the city is served by a local newspaper and, from 1971, local radio, for the reporting of proceedings in the Coroner's Court, the most likely explanation seems to be that a process of suggestion or imitation has affected the choice of means of suicide. (Our evidence cannot go so far as does Phillips (1974), who points to a direct effect in increasing the suicide rate).

The results therefore provide a new instance of an already observed phenomenon (Phillips, 1974; Surtees, 1982).

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SOMATIC SYMPTOMS OF ANXIETY MOULDED BY EARLY EXPERIENCES

DEAR SIR,

Two patients who had spent some of their childhood in German concentration camps, presented with depressive disorders which responded to tricyclic medication. Both initially complained of burning sensations; one, a lady in her fifties, had severe burning sensations in her arms and the other, a man in his forties, burning sensations and pains in his legs. In both cases the symptom was quickly relieved with benzodiazepine anxiolytics. The similarity in the constellation of the features was striking and suggested that the horrifying early experiences had moulded the anxiety symptoms.

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RE: THE DIAGNOSIS OF DEPRESSION IN OLD AGE

DEAR SIR,

The paper by Dr Elaine Murphy (*Journal,* February 1983, **142,** 111–19) would appear to be an excellent example of a study in prognosis. There is one important omission. There is no detailed account of the treatment of these patients and yet treatment is a very major factor in prognosis. Treatment of depression is not constant and there are effective and ineffective treatments. Electro-convulsive therapy is the most effective measure in the treatment of the severely depressed, particularly in those with delusional features. Even then, the administration of a course of ECT is not constant, for the number and frequency of treatments can influence the prognosis.

It is also likely that a number with severe physical illness would be excluded from having ECT because of potential hazard and so it is not surprising that a poor prognosis was associated with severe physical illness. As 30 out of the 124 died, and only one from suicide, within the first year, it would suggest that these physical illnesses were very severe and that there must have been among those that did not die a number who were also seriously ill. While death cannot be regarded as a good outcome, it is wrong to attribute death from physical causes to the depression, especially as depression is a common feature of organic disease both cerebral and systemic.

Dr Murphy herself in her comments on age and sex (p. 113) states that, "Age did not affect prognosis: older patients were just as likely to make a full recovery as younger ones." Yet the paper concludes that prognosis of depression in the elderly is poor. It would be fairer to say that if the patient has a serious and fatal illness and is probably considered unsuitable for an adequate course of ECT the outcome is unfavourable.

Even the administration of tricyclic anti-depressants can be a hazard in the elderly because of their vulnerability to the anti-cholinergic action of these drugs and it would be of interest to know what dosage of drug was tolerated and how many had to have the drug discontinued.

I stress these points, for in my long experience of treating psychotic depression, I consider the prognosis still to be excellent, regardless of age. In this I agree with Dr Murphy. My concern is that her general conclusions are not supported by her data and that effective treatment of a recoverable illness may be denied people merely on the grounds of age. Dr Murphy's paper does emphasize the importance of a thorough physical screening of the elderly because a number of physical conditions which may well be precipitating the depression are treatable and anti-depressant measures for these conditions would be entirely inappropriate.

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BRIEF PSYCHOTHERAPY IN FAMILY PRACTICE

DEAR SIR,

The study by Brodaty and Andrews ("brief psycho