Brit. J. Psychiat. (1984), **144,** 326–333

Correspondence

Correspondents should note that space is limited and shorter letters have a greater chance of publication. The Editors reserve the right to cut letters and also to eliminate multitudinous references. Please try to be concise, strictly relevant and interesting to the reader, and check the accuracy of all **references in Journal style.**

STORR AND SNAITH ON DEPRESSION

DEAR SIR,

In his essay 'A Psychotherapist Looks At Depression' (*Journal,* 1983, **143,** 431–5) Dr. Storr confidently confirms the view that 'depression' is a loss of self-esteem and results from stress acting on a vulnerable personality; the stress is usually loss in some guise and the vulnerability most often results from an early distortion of the relationship with the mother. In his view depression "varies in degree but not in kind" and if the stress is sufficiently severe, such as loss of liberty under a totalitarian regime, then the 'depression' may be of a psychotic intensity. Dr Storr laments distinctions between types of depressive disorder and abhors the concept of 'endogenous depression', a notion which he considers "discourages research and should be forbidden to psychiatry".

Dr Storr's adopted viewpoint is, of course, an extreme statement of Meyerian position, a well respected and enlightened approach to some forms of emotional disorder; but what is not acceptable, and far more stultifying to understanding and research than the use of the word endogenous, is Dr Storr's bland disregard of the varying psychic phenomena and his assumption that the word 'depression' denotes a single form of emotional disorder characterized by "loss of self-esteem". As an aside it may be noted that it was Meyer (1905) who introduced the term depression into psychiatry in the hope of "distinguishing our cases according to etiology, the symptom complex, the course of the disease and the results". Lewis (1938) an eminent teacher at the Maudsley Hospital, where Dr Storr studied, stressed the need for careful description of mental states and warned of the idiosyncratic and personal uses of terms such as depression.

Dr Storr says he "blushes for psychiatry" in that it took a sociologist, (George Brown) "to discover the cause of depression". My own blush for psychiatry is that we continue to use the word 'depression' as if it had some defined meaning understood by all. Certainly there is a loss of self-esteem which may be called 'depression' but the same term is variously used to cover such a motley of states as frustration at failed aspiration, the gloom of despair, accidie of disillusion and the cynical outlook of the born pessimist. A prolonged tendency to blame oneself, or pity oneself, may at times be called 'depression', so may states of indisputable psychosis and the less fearful experience of failure of all pleasure response or anhedonia. And Leff (1978) reminds us that patients use descriptive words for mood states in a different way to their doctors so that the most useless question in the whole field of clinical practice is "Are you feeling depressed?"

Some time ago an advance was made when psychiatrists discovered that the word 'schizophrenia' was applied in different ways in different countries and even by different psychiatrists within those countries; it was agreed that no useful communication or scientific advance could be made until the definitions were agreed. Considering the extent of morbid states of 'depression' and the enormous cost in suffering and cost of treatment, I believe that the most urgent task now facing psychiatry is a wide agreement in the definition of those states at present labelled 'depression'. Until this comes about we will continue to use our therapeutic resources in a random and frequently ineffective manner. Dr Storr appears to find comfort in the patient's "realization . . . . . that even the worst attack usually comes to an end". He should not do so; the end is frequently suicide.

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PSYCHOTHERAPY WITH THE BORDERLINE PERSONALITY

DEAR SIR,

I would like to respond to Dr Sidney Crown's article "Contraindications and Dangers of Psychotherapy", (*Journal*, November 1983, **143**, 436–41). I do so as a general psychiatrist with some experience of psychotherapy, particularly in a University City, where we seem to see an over-representation of the so-called borderline personality disorder.

Dr Crown, in his article, suggests that working with borderline people is quite difficult and can lead to negative effects in psychotherapy. This touches on a particular dilemma for myself which I have not yet been able to resolve.

It seems to me that such individuals, in terms of Anthony Storr's article published in the same edition of the *Journal*, are suffering from early profound loss and rejection to such an extent they form as adults an anxious attachment when they believe they have found someone who may be able to help them. The very qualities of empathy, warmth and genuineness which are now held to be desirable qualities in a therapist, are the ones to which such borderline individuals respond with an anxious clinging. My experience is that even in the very first assessment interview such borderline individuals may perceive the therapist as transparent rather than opaque, as accessible rather than distant, and genuinely concerned with the "real person" which the patient feels is locked up inside themselves, to such an extent that sadly there is little room for the tactical manoeuvre Dr Crown suggests, of setting up a number of trial interviews to see whether they are really going to be able to work in therapy. I find that these people can form such an anxious attachment, even during the first interview and that any attempts to structure further contracts along the lines Dr Crown suggests are liable to be experienced by them as lack of caring or as rejection. As a result, they do put considerable pressure on the therapist to continue to be available to them, and almost at once the transference begins to develop.

The subsequent management and resolution of the transference is vital to the therapy with such patients, and as Anthony Storr points out, therapeutic work with such borderline individuals often takes a considerable period of time until they are able to incorporate the "good" aspects of the therapist, and so begin to build up their own internal self esteem. I would be interested to hear if colleagues find themselves faced with the same dilemma and if so, how they feel the dilemma might be resolved.

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EUGEN BLEULER AND SCHIZOPHRENIA

DEAR SIR,

I would like to comment on the interesting article by Professor Hoenig (*Journal*, June 1983, **142**, 547–56).

Eugen Bleuler (my father) never thought that he had a better conception of the diagnostic criteria for schizophrenia than Emil Kraepelin, for whom he had the highest respect. Bleuler also agreed with Kurt Schneider in so far as he considered Schneider's main symptoms to be important and frequent schizophrenic symptoms. Bleuler, however, stressed the importance of a basic clinical experience more than Schneider: the experience that not a single psychopathological symptom exists which is present in every schizophrenic—and that there is no symptom in schizophrenics which might not also occur in other psychoses. Decisive for the diagnosis of schizophrenia were for Eugen Bleuler never one or several individual symptoms but the whole psychopathological picture together with the circumstances under which the syndrome had developed. To characterize the schizophrenic psychopathology in brief, Bleuler would formulate:

the dissociation the splitting the disharmony the overwhelming ambitendence	in	speaking thinking feeling and acting

If Bleuler did not differ essentially from Kraepelin in regard to the diagnosis of schizophrenia—in what other way did he develop Kraepelin's great concept? The mere introduction of another name for the disease was certainly not important for Bleuler as some have speculated. The main contribution of Eugen Bleuler to the problem of schizophrenia was to favour the study of what was going on psychodynamically in a schizophrenic patient. He helped to introduce psychodynamics in research on schizophrenic psychoses, and therefore created a basis for a psychotherapeutic and psychosocial approach. This endeavour had its roots in a mission given to him as a boy by the simple country people around him, including his parents. They cherished the idea that some young man with their own background would be more successful in understanding the mentally sick, and feeling with them, staying with them—and helping them—than the aristocratic doctors of their time.

Eugen Bleuler's main conclusion from his experience with schizophrenics was that it was possible to