heat by noting differences in labelling of various types of depression, which create havoc with the percentages labelled as "good to excellent results", as well as the opposite pole of "poor to fair".

It is apparent that current classifications of depression hardly do justice to the facts of the individual patient. For example, how long does a "reactive" depression remain reactive before it becomes classified as "endogenous"? All depressions must have precipitating causes which are stress-related (perhaps biochemical) but it must be admitted that precipitating events may become quite blurred in the older age groups. Perhaps both Dr. Hoenig and Dr. Browne (Vol. 10, pp. 100–101, July, 1964) can reach some compromise if they could substitute "depression with severe anxiety or agitation" as the type that is helped by amitriptyline. In the U.S.A. this category is often labelled as Involutional Psychosis provided they are in the right age group. These patients obtain both the anti-depressant as well as the tranquillizing properties of amitriptyline. Patients with "retarded" depression, with little to no anxiety, do not do as well with amitriptyline. In addition in "our neurotics", where the need to keep alert (especially in New York) is not only desirable but highly commendable, amitriptyline is usually rejected by the "normal neurotic" because it produces sluggishness, sleepiness or a loss of the "neurotic" drive when the usual dose of 25 mg. tablet is given. I have found that many of these do better with 10 mg. tablets t.i.d. (occasionally with a little Dexedrine added); they then take 50 mg. at night, since amitriptyline is of extreme value in combating their insomnia.

Yours faithfully,

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References

Dorfman, W. (1963). "Current concepts of depression." *Psychosomatics*, **4**, 5, 6.

—— (1964). *Ibid.*, **5**, 1.

SYNDROMES OF PSYCHOSIS

Dear Sir,

In his review of "Syndromes of Psychosis" by Lorr, Klett and McNair (July, 1964, p. 605), your reviewer, Dr. J. Hoenig, raises wide questions concerning the reliability of psychiatric diagnosis. Since he was kind enough to mention the study by my colleagues and myself, perhaps I might take up some of his points.

Dr. Hoenig poses a question "What is at fault—the diagnostic scheme or the diagnostician?" As it stands the question is philosophically unwholesome; there can be no schemes outside the minds of the people who use them. But from his remarks attributing the supposedly low levels of concordance to scholastic ignorance on the part of psychiatrists, it would appear that Dr. Hoenig is suggesting that knowledgeable psychiatrists would reach higher levels of agreement than the less erudite. Up to a certain point this may well be correct, in that laymen would presumably achieve lower levels than psychiatrists, and beginners in psychiatry do less well than the more experienced. But beyond a certain point, it is by no means obvious that reliability would continue to increase with increasing knowledge, even if it were possible to say precisely where such "knowledge" is to be found. The belief that "sound men" (those like oneself?) would do better than the generality is of course very seductive, but is quite lacking in proof. There is scope for an interesting, though possibly chastening, investigation.

Secondly, I would suggest that though reliability is undoubtedly important, concern with it can easily be exaggerated. It is perfectly possible to reach high reliability with a quite meaningless system, for all we know the phrenologists (especially the knowledgeable ones) might have agreed to the last man about the presence of the bumps. Validity of diagnosis is surely our major concern, and if this could be achieved, reliability would automatically follow.

Thirdly, I do not accept that the inter-diagnostician levels are as low as everyone seems to assume. To interpret reliability figures correctly one must always bear in mind not only the conditions under which they were obtained, but also whether any particular study aimed to describe a concrete situation or to show what might be achieved under ideal conditions. It is also worth noting that the percentage of agreement can be very simply altered by using different formulae, according to whether one is concerned with agreement regarding the presence of a disorder, or agreement regarding both its presence and its absence. In the following table, for example, agreement could be scored as 33 per cent., or 80 per cent., depending on which definition was used.

		Doctor 1	
		Condition A	Not Condition A
Doctor 2	Condition A ..	10	15
	Not condition A	5	70

Beyond this, it is worth mentioning that at some levels the psychiatrist does considerably better than his colleague in general medicine, where reliability is less of a bogey. If one uses comparable methods of calculation, then it appears that depression as a symptom can be diagnosed with greater agreement by psychiatrists than can a cough by physicians, and certainly much better than the presence of a cardiac murmur.

Lastly, having said all this, it still remains true that the main interest of reliability studies in future must be to elicit the causes of disagreement between clinicians. We made one attempt to do this, but a rather different approach has recently been used by Beck *et al.* (1962) and by Ward *et al.* (1962). The former concluded that in about two-thirds of instances where clinicians recorded discrepant diagnoses, the difference was one of emphasis rather than of substance. Similarly, the second study showed that only about a third of disagreements could be attributed to fundamental differences of assessment, and that the remaining cases could be laid at the door of the APA Diagnostic Manual. Perhaps these studies provide some answer to the question Dr. Hoenig no doubt intended.

Yours faithfully,

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References

Beck, A. T., *et al.* (1962). *Amer. J. Psychiat.*, **119**, 353.
Kreitman, N., *et al.* (1961). *J. Ment. Sci.*, **107**, 887.
Ward, —., *et al.* (1962). *Arch. Gen. Psychiat.*, **7**, 198.