Correspondence

EDITED BY LOUISE HOWARD

Behavioural ecological approach to depression

Sir: For many years we have been advocating a behavioural ecological approach to psychiatric disorders (Price, 1969; Stevens & Price, 1996). We therefore welcome Justin Williams' (Williams, 1998) suggestion that behavioural ecology should become a basic science for psychiatry. There are, however, glaring omissions from what purports to be a review of the contribution that behavioural ecology can make to our understanding of depression. There is, for example, no mention of the rank theory of depression first announced in the pages of the *Journal* 30 years ago (Price, 1969) and which has proved to be a fruitful source of discourse and research among evolutionary psychiatrists (Sloman *et al*, 1994). Nor is there any acknowledgement of John Bowlby, who was the first psychiatrist to use the findings of behavioural ecology to elucidate the "nature of the child's tie to his mother" (Bowlby, 1958) and the depressive reaction that occurs when that tie is broken either by forced separation or by loss.

In approaching the aetiology and clinical consequences of manic depression, evolutionary psychiatrists have focused on the fulfilment and frustration of two basic biosocial goals: (a) the need for affectional bonds, and (b) the need for social rank or status. The adaptive function of elevated or depressed mood is to enable an individual to adjust to his circumstances when he is convinced that either one or both of these needs has been decisively fulfilled or irrevocably frustrated.

On the whole, we are sceptical of Williams' conjecture that the depressive reaction has parallels with an animal's response to threat from a predator. We would maintain that attachment and rank theory provides a more economical explanation of the evolutionary origins of bipolar disorder. This does not mean to say that all depressive or manic reactions should be regarded as adaptive, only that they exist, *in potentia*, as evolved mechanisms which can be triggered by perceptions of loss or gain. In psychiatric practice, these reactions can manifest in certain individuals in ways that are so clearly maladaptive that they may result in gross incapacity, suicide, or social and financial ruin. The roots of these reactions are nevertheless susceptible to an evolutionary biological explanation.

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Scientific attitude to 'difficult' patients

Sir: The impact of the psychiatrist's scientific attitude on the therapeutic relationship is carefully considered by Hinshelwood (1999). Examination of these issues at a more institutional level can explain the antithetical responses of psychiatry to the two types of 'difficult patients' presented.

Patients with personality disorder are often referred to as having no 'formal' mental illness and thus fall outwith the remit of psychiatrists. Whatever the validity of the mental illness construct, it cannot be questioned that it lies at the heart of the medically oriented approach to mental disorder, which is currently predominant in Western cultures. Application of the principles underlying the definition of illness in physical medicine (such as absence of health, presence of suffering, and pathological process) to mental disorder cannot account for the view that personality disorder is not a mental illness. The attempt to circumvent this problem by proposing the idea that illness can be defined according to its response to treatment is flawed by its circularity.

The tendency to distinguish personality disorder and mental illness is often based on their respective temporal and qualitative relationship with normality. However, there is increasing evidence that symptoms of many major psychiatric illnesses lie on a continuum with normality (Bentall, 1996). Furthermore, many disorders accepted as illnesses, such as schizophrenia, are not always preceded by the absence of psychological abnormality (Malmberg *et al*, 1998).

Although the medical approach claims to be scientific, the distinction between personality disorder and mental illness does not seem to rely on universal laws which are central to the scientific paradigm. If not scientific, then what is the rationale for this distinction? In the context of the dominance of physical treatment in psychiatry, the apparent resistance of severe personality disorder to medical intervention evokes hopelessness and powerlessness in the medical therapist. Given this countertransference, features central to the construct of personality disorder often elicit retaliation (Travin & Protter, 1982). The rejection of the individual with a personality disorder by the psychiatric profession, in my opinion, reflects institutionalised retaliation in the face of a challenge to the scientific basis of this medical speciality.

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