know whether patients who 'fell by the wayside' during their long wait were deterred from seeking psychiatric help on later occasions.

I feel we should be circumspect before we too eagerly accept long waiting-lists as blessings in disguise.

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THE CLASSIFICATION OF DEPRESSIONS

DEAR SIR,

Professor Kendell's review (1) of the current state of the controversy surrounding the classification of depressions was extremely welcome. I should like to add one point concerning the dimensional/categorical part of the argument and suggest that the pattern of aetiology should not be assumed identical to that derived from studies concerned largely with clinical presentation. If we consider the clinical picture in depression, while a dimensional hypothesis is plausible for some of the features, notably mood disturbance, it is much less so for others, such as nihilistic delusions or auditory hallucinations, which seem to have no equivalents in normal states, or for the rapid changes in mental state that occur with acute onset or with swings from depression to hypomania. These 'discontinuous' features tend to occur in those whom Kendell designates Type A depressives, and it is noteworthy that in cluster analyses, where a substantial proportion of variables are related to clinical features, such a group of patients tends to be reliably identified (e.g. 2, 3), whereas Type B patients either fail to 'cluster' or appear as more than one group. It has been suggested that Type B depressions may be dimensional and continuous with normal states, while Type A are categorical and represent a pathological form with a separate and presumably discrete causation. Yet relevant studies reveal little evidence of major differences in the aetiology of the different forms of depression. It is plausible to suppose that in all depressions, one or more constitutional factors are implicated, together with stressful environmental features, and that all these are continuously distributed. It will be noted that in those studies in which a relatively large proportion of variables concerned with aetiology were included—notably Kendall's own (4, 5)—the separation of Type A depression has been less easy to demonstrate.

Can we then suppose that similar and continuously distributed causal factors can lead to either a continuous or a discontinuous symptom pattern? This is theoretically possible, as can be seen if one considers the analogy of the electric switch; and there are many instances in biology where continuous forces normally have continuous effect but at extreme intensities demonstrate a new and discontinuous effect. This model has recently received more prominence with the provision of a mathematics to deal with it (6), and is rather unfortunately known as 'catastrophy theory', The evidence for such a model of depression is limited; but it seems worthwhile to bear in mind that classification based on patterns of symptoms may be of limited value in the description of aetiology.

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LONG-TERM EFFECTS OF BEHAVIOUR THERAPY

DEAR SIR,

The introduction of behavioural techniques has led to a wave of therapeutic enthusiasm, but there are few long-term follow-up studies, and it is for this reason that I would like to report on two patients whom I treated ten years ago, using the method of systematic desensitization.

1. A 30-year old married woman who had been treated for her frigidity and housebound features (Kraft, 1967) was delighted with the treatment outcome; she was very much more cheerful, no longer moody, and could cope adequately with main roads and crowded places. Further she was pleased to report that during these ten years there had been a great improvement in her relationship with her husband. However, she was only prepared to speak to me on the telephone and refused to come and see me, because she felt that this might lead to a recurrence of her

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