symptoms, e.g. Schneider symptoms, in arriving at the final classification.

There seems to be no need for the author to postulate 'that much of what is currently classed as "acute schizophrenia" is really what might be termed a "manic equivalent" in a manic-depressive illness.' His two-dimensional model is sufficient to account for the facts. In other words, in the acute phase of the illness in the subjects studied manic (and depressive) symptoms were present but were outweighed in the majority of cases by schizophrenic symptoms. The patients were treated accordingly, and in most cases the symptoms of the schizophrenic dimension remitted more completely, leaving those of the effective dimension relatively more prominent. Attention to the affective component of a psychotic illness, in the initial as well as subsequent stages of the illness, might, as the author suggests, be of prognostic value, but to do this there is no need to squeeze a schizophrenic patient into a manic-depressive mould. Both components can be evaluated separately.

I would like to thank members of the UK/US Diagnostic Project for their guidance in the use of the Present State Examination and help in processing the data.

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DEAR SIR,

Dr. Ollerenshaw (*Journal*, May 1973, 517–30), has produced a carefully argued case for restricting the use of the term schizophrenia to patients who fail to recover from functional psychotic illness. The test, however, of a diagnostic classification is its value to those who use it, and examined in this light the proposed changes are by no means an advantage.

Basically, we hope that diagnosis reflects a common aetiology, a concept which is difficult in psychiatry where so many factors are operating. Since diagnosis is most commonly used to predict the most effective physical treatment, presumably reflecting a common biochemical change, the current classification distinguishes neuroleptic responders from tricyclic-lithium responders, which is of more value than distinguishing poor responders from good responders to psychotropic drugs as a whole. Other means of isolating a clinical entity, such as genetic, only partly support Dr. Ollerenshaw. For example, a recent twin study has confirmed genetic loading for schizophrenia but shown none for outcome (Margit Fischer, 1973).

Diagnosis is also used to standardize research, for which purpose it is essential that psychiatrists use it reliably. Although there is ample evidence that psychiatrists do not agree cross-nationally on the concept of schizophrenia, the agreement within Britain seems close (Copeland, 1971). Despite the ability of Vaillant to predict outcome successfully in 82 per cent of cases, I doubt that other psychiatrists would agree on such factors as schizoid personality, insidious onset, and affective colouring. While outcome can provide a simple validation, it would take too long to be established as useful in research, and differential drug response is quicker.

In one area at least the change might be of value, this being the prediction of outcome, However, in practice psychiatrists are reluctant to commit a patient to a poor outcome and so would underuse the diagnosis. On the other hand, when used, the diagnosis becomes self-fulfilling by inducing therapeutic apathy. These tendencies would further reduce the value of the diagnosis for research. Thus despite its inadequacies I think we do better to stick to our current concept of schizophrenia, while recognizing a subcategory with poor prognosis.

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DEAR SIR,

Several recent papers have reflected an upsurge of interest in the 'depressive phase' which frequently seems to follow the 'acute schizophrenic phase' in patients originally diagnosed as suffering from 'acute schizophrenia'.

Ollerenshaw's paper in the May 1973 issue of this Journal contains a discussion of recent thinking on this phenomenon. The 'depressive phase' is usually regarded as following a resolution of the disorder. Some writers state explicitly that they regard this as progress towards health; most others imply that this is so.

The controversial attempts of Melanie Klein to link the normal successive development phases in children, usually described as 'paranoid-schizoid' and 'depressive', to psychoses developing later were not discussed by Ollerenshaw. Nevertheless, modern analysts using the same disputed model of human development do work through the 'paranoid-schizoid' phase followed by the 'depressive phase'. In the 'paranoid phase' such defences as omnipotence, projection and manic flight are present. Onset of the 'depressive phase', in which a melancholy reality is pervasive, is always considered to be a therapeutic victory (1). It would, indeed, be unscientific to ignore the observations of such individuals.

Vaillant (2), Ziskind *et al.* (3), and Ollerenshaw, in his recent paper, have discussed the observed fact that some patients originally diagnosed as suffering from 'schizophrenia' do present in their subsequent clinical history with symptoms which are exclusively affective in nature; these may be either manic or depressive. I believe it to be a common experience to encounter this type of history. It is not uncommon to find that there is a gradual progress from an 'acute schizophrenic' phase through phases presenting dominantly as 'depression' and sometimes 'mania', to a situation in which the patient is relatively symptom-free.

Many writers have commented on the maturational potentials inherent in certain psychotic episodes; these include Sullivan (4), Mayer-Gross (5), Bateson (6), Jackson and Watzlawick (7), and Levene (8). Autobiographical accounts by individuals who have suffered such disorders have described how the episodes become learning experiences. Bateson (6) quotes extracts from two such autobiographies.

Both Ollerenshaw and Hoenig, who writes a critical review of Bleuler (9) in the same issue of this *Journal*, exhort us, following Schneider, to consider both the 'form' and the 'content' of the psychoses. Both writers suggest that this will enhance our understanding of the disorder.

Of course, 'form' and 'content' thinking has been with us since antiquity. The anthropologist Levi-Strauss (10), in his analysis of totemism, has shown that such dichotomies are part of the basic nature of human thinking. However, the point is that such dichotomies become an obstacle to understanding unless an attempt is made at synthesis. The evolution of understanding proceeds by the synthesizing of such opposites, later to be superseded by new dichotomies. For example, Paul Dirac, who has recently somewhat belatedly been admitted to the Order of Merit, received the Nobel Prize as a young man for achieving such a synthesis in the realm of physics. I would maintain that to think of an 'acute schizophrenia' in terms of 'form' and 'content' is likely to hinder understanding.

In his paper Ollerenshaw seeks to account for the observed facts. He properly rejects the logical absurdity of 'schizo-affective disease' and suggests that 'the schizophrenic syndrome is a non-specific clinical entity, which can be symptomatic not only of organic cerebral dysfunction but also of manic-depressive psychosis—particularly the manic phase as well as schizophrenia'. He feels that such a theory would 'make comprehensible those frequent cases where the patient has an acute 'schizophrenic' illness on one occasion and an 'affective illness' on another, and those cases where an 'acute schizophrenic' illness is followed *on recovery* almost immediately by typical endogenous/psychotic depressive symptoms'. Ollerenshaw also suggests that Eysenck's (11) proposal for the resolution of the unitary/binary controversy in the field of depressive illness could not explain the consecutive appearance of the two syndromes in the same patient. This would seem to be correct.

It is my belief, however, that Ollerenshaw's speculative suggestions cannot account for the observed phenomenon in a satisfactory manner. He does not explain either the frequency with which two conditions occur together, or the cardinal point that there is a dynamic of growth from the 'acute schizophrenic phase' to the 'depressive phase' and towards health. Most writers have commented on the progress from relative ill-health to the relative health of the 'depressive phase'. There is a theory, however, which can account for the observed data with more precision and elegance. It is not new, and has been the subject of controversy for many years. It is a theory which is implicit in Bleuler's ideas on 'schizophrenia'. It is that, in the case histories discussed, the slow resolution of maturational conflicts occurs within the constraints of the unchangeable. It is a mistake to consider such developmental theories as postulating the 'psychogenic' origin of psychoses. Psychogenic v. organic dichotomies are as sterile to new thought as the old nature/nurture dichotomies were in the past.

In addition to determining the nature of action of the drugs which cause depression following 'acute schizophrenia', we should also look at the therapeutic potential of such a phase. However, it would be unwise to assume that the majority of patients diagnosed as 'acute schizophrenia' will deteriorate.

Better understanding of the stages of such disorders should aid therapeutic procedures.

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AN OBSESSIONAL PATIENT TREATED WITH CLOMIPRAMINE

DEAR SIR,

Following a recent description of phenomenological differences in patients with obsessional symptoms treated with Clomipramine (Capstick, N., and Seldrup, J., *Brit. J. Psychiat.*, 1973, 122, 719–20), I should like to present the following case history:

A 45-year-old married male ex-teacher has had a variety of obsessional symptoms since the age of 18, comprising obsessional thoughts of harming others, particularly relatives. The thoughts had a bizarre quality, though insight was retained, For example, when passing a tree he could not avoid thinking that evil would flow from him into the tree, to spring out and harm the next passer-by. He had a repertoire of compulsions to avoid harming others, and numerous other checking rituals. He was incapacitated for up to two hours each morning with cleaning after defaecation, and handwashing. His symptoms were accompanied by subjective tension and irritability. He also possessed a well-developed visual memory which contributed to rumination over memory images of past activities.

He is a highly intelligent man, with traits of meticulousness and high morality, who nevertheless has an ability to make relatively deep relations. He has had seven separate breakdowns with exacerbation of obsessional symptoms. During one of these, which was accompanied by depressive shift, he took 100 Parstelin tablets.

He had been treated with major and minor tranquillizers, monoamine oxidase inhibitors, and, during the depressive shift, ECT, all with minimal success for the obsessional symptoms. For two years he was in psychanalytically orientated psychotherapy, which produced a lessening of his tension but little improvement in the obsessional symptoms.

He was referred because of a worsening of his obsessional symptoms and guilt about not working. It was planned to explore his symptomatology with a view to behaviour therapy. He received behaviour therapy and supportive psychotherapy for some months, but there was improvement only in the tension. The obsessional symptoms finally increased to incapacitating levels, together with tension and fatigue, during a frustrating work situation. He showed no features of endogenous depression, though he did show some depressive ideation and affect in response to the obsessional symptoms. He was put on to haloperidol 0·5 mg. t.d.s., with little effect on tension, then started on oral Clomipramine 75 mg. daily, rising to 150 mg. daily. It was explained to him that the purpose of the drug was to decrease his tension and depression, and he was warned that the obsessive-compulsive phenomena would not be substantially affected, though he might feel more adequate to deal with them.

Within ten days to two weeks he was reporting almost complete freedom from obsessional thoughts and compulsions, though he remained rather fatigued. An unsolicited letter from his wife, previously resigned to his condition, commented on his remarkable improvement and freedom from symptoms for the first time in many years. The behaviour therapy involving relaxation practice and thought-stopping became more effective.

He was subsequently employed on an equally frustrating job involving exacting work at high speed under conditions of isolation and darkness (photo-finishing). Previously, during a similar task, he had experienced elaborate obsessions, including the thought that calamity would befall the photographed figures unless the work was carried out to perfection. In the present job, however, he was unable to continue because of tension and fatigue, but at no time did he experience obsessional thoughts.

Although the value of the single, impressionistic study is limited, this case would seem to be an example of obsessional phenomena alone responding to Clomipramine, in a long-standing history of pure obsessive-compulsive neurosis, with absence of endogenous mood change. From the expectations given, placebo effect is unlikely.

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