ventory and Cornell Medical Index). This reversal was largely confined to men in the Unstable group, suggesting that social factors leading to somatization are relatively more important in this group, whilst in the Superstable group internal factors are relatively more important. It might be that some such interaction between social and personality factors (including 'interview defensiveness') explains Dr. Smail's unexpected finding in relation to the effect of age.

With regard to psychiatrists, one thing the eczema study underlined was the importance of fitting the treatment to the patient. A controlled trial of psychiatric treatment (to be reported) indicated that the eczema of patients with overt emotional disturbance tended to respond well to short term psychiatric treatment, that of the Superstable type (in whom psychogenesis was considered as important) did not, and might even have been worsened initially in some cases. As one would imagine, the Superstable patients were less accepting of psychiatric referral, and their motivation for psychiatric treatment tended to be low. To some extent any scientific study of people must be a Procrustean bed, and the dangers of this are greatest when therapy is involved. Some psychiatrists tend to be more immediately in tune with Unstable patients, tend to be 'thinking introverts' themselves and to see patients' problems as psychologically rather than somatically determined, and to prefer *them* to. Others are relieved when physical factors can be incriminated, including 'constitutional' and 'endogenous' ones. A more Superstable doctor than I am *might* have had better therapeutic results with Superstable patients, might have been more supportive and reassuring, less inclined to question their defences; he might also have been less helpful to the Unstable ones who wanted to talk about and explore and try to resolve some of their emotional problems rather than be given ointments or just psychotropic drugs (most were given a combination of drugs and psychotherapy). At present this is speculation, but it is the sort of notion that Dr. Smail's paper provokes. How can we fit the psychiatrist to the patient, or at least help him to fit himself to the patient's needs?

The hospitable academy of psychiatry, with space for all types of psychiatrist, can be a confusing and perhaps dangerous place for some patients. How fair is it that people in distress are seen by a psychiatrist who might not be able to see and offer help for their problems in a way that is most acceptable, makes most sense to them, and is therefore most efficacious?

If I may be allowed a final fantasy, perhaps we could all be examined, and rather than coming out with D.P.M.s and Memberships, be clearly labelled like our patients as SSI (psychological or somatic), DIQ (introvert or extravert), Construct Diversity (large or small). Then the first step in psychiatric referral would be something like computer dating. The problem behind the fantasy is a real one. Let us hope that as a profession we can find a less bleak solution, and thank Dr. Smail for alerting us to it.

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THOUGHT DISORDER IN THE PARENTS OF THOUGHT DISORDERED SCHIZOPHRENICS

DEAR SIR,

Muntz and Power (1970) are correct in assuming that not all the schizophrenics' relatives I tested in my study (Romney, 1969) were related to schizophrenics showing clinical signs of thought disorder: in fact, 3 out of 51 schizophrenics' relatives were related to schizophrenics judged by a psychiatrist to be totally free of thought disorder (Romney, 1967, p. 258–9).

I feel, however, that these relatives constituted such a small minority that Muntz and Power's criticism of my sample of schizophrenics' relatives on those grounds is not damaging. Nevertheless, I agree my sample was by no means perfect (Romney, 1967, p. 191).

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