Correspondence

Contents: 'Audible thoughts' and 'speech defect'/Tricyclics and SSRIs/Cross-cultural studies/Lithium and weight gain/Influenza and schizophrenia/No evidence for association between CNTF null mutant allele and schizophrenia/Should the administration of ECT during clozapine therapy be contraindicated?/Train of thought continued.

'Audible thoughts' and 'speech defect'

Sir: Szasz (1996) equates auditory hallucinations with "thoughts becoming loud" (Gedankenlautwerden), which, he suggests, is much the same as talking to oneself, which in turn is what thinking really is. Ergo: auditory hallucinations are in fact part of normal cognition. Put this way, his conclusion sounds absurd — which it is. (Szasz's arguments have, by the way, nothing to do with so-called output theories of auditory hallucinations, according to which patients talk to themselves, but perceive the voices as coming from somewhere or someone else — a phenomenon which is clearly pathological.)

Let us examine more closely what at first sight appears to be the least tenuous link in the exceedingly rusty chain of Szaszian arguments. Szasz quotes Plato's view in the 'Theaetetus' that thinking is an inward dialogue carried on by the mind with itself and Kant's statement that "thinking is talking to oneself". Although Szasz asserts that this idea is "self-evident", after a moment's reflection it becomes self-evident that thinking is not always talking to oneself. Many of us are familiar with the experience of having a thought and not knowing how to put it into words or even knowing that it cannot be put into words at all. Thinking is clearly possible without words. If I am thinking of my next move in a game of chess, I am not usually talking to myself (after all, my opponent might overhear me), or thinking in words, but imagining how the position will change if I attack my opponent's knight with my bishop and what the most likely responses are. Similarly, if I am thinking about how to arrange some pictures on my living-room wall, words are not required. The verb "to think" can even be used in contexts in which there is no conscious thought, e.g. in a chess tournament I may fail to complete my first 40 moves within the time allocated and then say to the referee "I thought I had more time", although at no time during the game was I aware of having this thought. While thought and language are obviously connected in complex and varied ways, and talking to oneself can be one criterion of thought, the two are not at all the same thing.

Szasz misconstrues two of the key German terms in his paper. Sprachfehler is any linguistic error, not merely one of speech or articulation (Sprache = language, as well as speech). In the context of schizophrenia, the wider sense is more appropriate than Szasz's translation ("faulty speech" or "faulty speaking"). Secondly, he interprets Gedankenlautwerden ("thoughts becoming loud") to be something very like "talking to oneself aloud". Here he turns what in German is an experience ("thoughts becoming loud") into an action. Unfortunately, the Italian motto which Szasz installs at the beginning of his piece, "Traduttori traditori — Translators are traitors", can be applied to Szasz himself.


P. CRICHTON

Guy's Hospital
London SE1

Sir: I am sure that many people will agree with Szasz (1996) that elucidating the meaning of psychotic experiences is an important although complex task. Rather than suggesting that these experiences are not abnormal, I think the value of this approach lies in its emphasis on the possibility of gaining insight into psychosis in terms of ordinary experience.

However, in contrast to Kerr & Howarth (1996), I think that the attribution of meaning to the activities and expressions of psychotic conditions does present problems for the concept of mental	
illness. Abnormality as a criterion is not sufficient to
distinguish illness from other forms of deviance.
The meaning of the terms illness and disease is
derived from the context of physical, bodily condi-
tions and implies more than deviation from the
norm. These concepts characterise processes which
are discrete from the subject's will or intention-
ality and whose course is biologically determined.
To suggest that behaviours and utterances are
"symptoms" of illness is therefore to classify them
as events that have no relation to the voluntary
activity and purposes of the individual and are
therefore devoid of meaning. This seems to me to be
an impoverished approach to the myriad of com-
plex human behaviours that comprise psychiatric
problems and is likely to hamper the process of
finding imaginative solutions.

Characterising mental disorders as existential
conditions rather than as illnesses does not mean
that medical techniques have no place in helping
people to manage or survive them. A different
emphasis in psychiatry might liberate psychiatrists
and patients alike from the shackles of the "illness"
paradigm.

toughs' and 'speech defect' in schizophrenia". British Journal
of Psychiatry, 168, 538-539.

SZASZ, T. (1996) 'Audible thoughts' and 'speech defect' in schizo-
phrenia. A note on reading and translating Bleuler. British

J. MONCRIEFF

Institute of Psychiatry
London SE5 8AF

Sir: Szasz (1996) has provided us with another
example of his inimitable linguistic legerdemain,
this time concerning the phenomenology of
schizophrenic thought disorder and auditory
hallucinations.

Firstly, contra Szasz, there is a clear difference
between hearing one's own thoughts spoken aloud,
as if they were coming from outside oneself, by a
(stranger's) voice at the same time as one is thinking
them (Gedankenlautwerden) and "hearing" one's
own inner voice or even thinking aloud. There is no
collision between these two distinct phenomena in
psychopathology.

The comparison between schizophrenic thought
insertion and "projection" is a typical Szaszian
disanalogy. The belief that others are somehow
beaming their thoughts into one's head is catego-
rically different from accusing others of having
feelings that one is unwilling to recognise in oneself.
Again the psychopathologies are unmistakably
distinct, and certainly not applied post hoc after
deciding whether the patient is sane or insane.

Finally, how can he assert that "ordinary medical
maladies are not diagnosed by making inferences
from the way the patient speaks"? We routinely do
so in terms of both the form and the content of the
patient's speech; the former is utilised to diagnose
cerebellar staccato speech and Parkinsonian speech;
the latter whenever we reach any diagnosis from the
history alone; perhaps a mixture of the two with the
aphasias. These 'speech defects' certainly do not
arise from "incorrect use of the muscles of [the]
mouth and tongue" as Szasz would have it, but
from brain diseases. It also seems particularly wil-
sful to suggest that schizophrenic speech is "deviant" in
the way that a thick Yorkshire accent deviates from
Received Pronunciation.

Perhaps the only worthwhile point I could draw
from this paper was that we should more properly
speak of schizophrenic speech disorder and inferred
thought disorder since we do not have direct access
to the thoughts of others.

SZASZ, T. (1996) 'Audible thoughts' and 'speech defect' in schizo-
phrenia. A note on reading and translating Bleuler. British

S. WILSON

Friargate Hospital
Northallerton
North Yorkshire DL6 1JG

Tricyclics and SSRIs

Sir: Taylor & Lader (1996) usefully point out the
typical dangers of combining tricyclic antidepress-
ants with selective serotonin reuptake inhibitors.
The tertiary referrals received at this unit, which
specialises in treatment-resistant depression, indi-
cate that this practice is becoming increasingly
common and usually occurs without the monitoring
of serum tricyclic antidepressant concentrations.
We would like to extend their clinical recommenda-
tions by suggesting that this combination should
not be routinely used. It is difficult to justify theo-
retically as adequate doses of tertiary amine tricyclic
antidepressants would produce the same effect on
cerebral amines as combinations of tricycles and
selective serotonin reuptake inhibitors. If adequate
dooses of tricyclic antidepressants are not tolerated
then perhaps venlafaxine would be the next logical
step because of its effect on both serotonin and
noradrenaline neurotransmitters.

A clinically important cytochrome-mediated
interaction that Taylor & Lader do not mention is