(Mackinnon and Michels, 1971), in these situations I tell them of my willingness to understand them but of my difficulty in following what they have just stated. Sometimes patients are able to remake their statements to allow you to know what they mean. At other times they may just laugh without either correcting their own statements or insisting on them. I doubt very much that they are actually deficient in real world knowledge and that they are totally ignorant of the illogicality in producing the statements.

Alternative explanations include the possibilities that they do have the relevant real world knowledge but have not checked or cannot check the logicality of their statements according to their knowledge, or that they have checked with their knowledge but do not see the need to follow the logicality, or use the illogicality intentionally. The latter could be interpreted as meaning that they want to avoid understanding, or that they have some complex thoughts that can only be expressed in this way.

As seen from the examples mentioned in the article for the practical and social knowledge tests, we need to know whether the tests are truly measuring knowledge or just eliciting judgement or response, like a thematic apperception test. Payne (1970) has discussed some schizophrenic patients' unusual responses to various situations including different tests. The tests used could have elicited unusual responses which might or might not have been related to the use of primitive modes of thinking. The findings of abnormally low scores in the schizophrenic subjects studied cannot be used as evidence to support the hypothesis of deficient real world knowledge in the schizophrenic.

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SIR: Cutting & Murphy (*Journal*, March 1988, **152**, 310–319) highlight and explore a dormant aspect of the psychopathology of psychosis which they have construed as a component of thought disorder, namely a disorder of the way a subject thinks about or judges events in the real world. This is further designated a deficiency of "real-world knowledge" or "a lack of common-sense". The phenomenon is very closely related to the notion of 'schizophrenic dementia', one of the fundamental symptoms of Eugen Bleuler (1911). Bleuler distinguished this form of 'dementia' from the organic variety, and viewed it as a complex and mercurial phenomenon which was really a derivative of other fundamental symptoms, especially the disturbance of associations and affectivity, and autism. The following quotations may help to further convey his views on its nature: "The severe schizophrenic dementia is characterised by the fact that in all thinking and acting there occur a large number of mistakes [*Fehlleistungen*]; the relative dificulty of the task is of secondary importance. Conversely, in the mildest cases the dementia is characterised by the fact that, although these people are usually quite sensible, they are also capable of every possible stupidity and foolishness." "The actual amount of knowledge remains preserved on the whole but it is not always available or it is employed in the wrong way." "The anomaly called schizophrenic dementia consists of the effects of association disturbance, indifference and irritability in the affective sphere and the autistic exclusion from the influences of the outside world."

Bleuler devotes nearly 19 pages of his original monograph to depicting this phenomenon. It is puzzling, therefore, that Dr Cutting, a respected scholar of the history and concept of schizophrenia, fails to acknowledge this, particularly since he also seems to regard the phenomenon as a dimension, albeit an orthogonal one, of schizophrenic thought disorder. Jaspers (1959) also discussed the phenomenon, relating it, as did Bleuler, to the concept of autism. Minkowski's elaboration of the idea (1927) *is* appropriately emphasised by the authors; however, they have chosen not to take up his suggested term, 'pragmatic deficit', for the phenomenon. This is a pity, since it is a less cumbersome and perjorative term than 'deficient real-world knowledge or lack of common-sense'.

The next step will necessarily involve an exploration of the boundaries and causes of the impairment. The authors have considered the possibility that prolonged institutionalisation could contribute to the phenomenon; however, data on duration of illness and degree of isolation in the community prior to admission are not presented. Socially withdrawn or isolated patients living in the community might also conceivably develop such a disability in a secondary manner. Control groups of people with schizoid and schizotypal personality traits, frank

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personality disorder, and creative individuals would also be worth studying from the standpoint of the 'pragmatic deficit'.

This concept is an elusive one and is not easy to study, notwithstanding its significant face validity. Minkowski recognised this, warning that such difficult-to-define phenomena should not be sacrificed to "the spirit of precision". Drs Cutting & Murphy have clearly heeded this warning, and deserve credit for attempting to breathe new life into an old idea.

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Supportive Psychotherapy: A Contradiction in Terms?

SIR: Crown (*Journal*, February 1988, **152**, 266–269) raises a number of cogent points in his most interesting paper on supportive psychotherapy. My comments are offered not necessarily with the intention of clarifying the issue but rather to add to the discussion.

Firstly, despite a good explanation contrasting dynamic psychotherapy with supportive psychotherapy, principles with which I would broadly agree, I suspect that such a clear distinction is not always obvious in practice. Although I personally set out to practice each in pure culture, I doubt very much whether the end result is always as 'pure' as I would have intended.

My second point is on the question of the length of treatment in dynamic psychotherapy. In my experience it takes anything up to six months (i.e. once weekly) for the therapist's bona fides to be satisfactorily evaluated by the patient to the extent that the patient decides that the pace of therapy will be "full ahead". That is not to say that therapy may not have been proceding in the interim.

I also feel obliged to challenge the concept that the raising of a 'negative' emotion necessarily dictates that that particular psychotherapy could not be of the supportive type.

I find difficulty in accepting the conclusion that if it is supportive it cannot be psychotherapy; if it is psychotherapy it cannot be supportive. I suspect this has something to do with what I perceive to be the use of the word psychotherapy as if it were to imply dynamic psychotherapy.

Over the years I have expended considerable energy in attempting to dissuade trainees from the idea that there is something not quite respectable about supportive psychotherapy; it is in some ways the Cinderella of the psychotherapies. While it seems to me that dynamic psychotherapy is a luxury that relatively few people can afford, and I don't mean financially, surely supportive psychotherapy should be regarded as the 'bread and butter' of the psychotherapies.

What if supportive psychotherapy, and psychoanalysis were the opposite ends of a spectrum?

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Mystical-Ecstatic and Trance States

SIR: Signer (*Journal*, February 1988, **152**, 296–297) reports the case of a former Cistercian monk who experienced mystical states, which unfortunately led to panic attacks and mild depression. A diagnosis of depersonalisation disorder/intellectual-obsessive depersonalisation with endless ruminative self-scrutiny was made, leading to treatment with alprazolam and, later, with phenelzine.

I feel obliged to place on record my view that religious phenomena such as these are not the legitimate concern of psychiatrists. They most definitely cannot be categorised using DSM–III or any similar classification. Mysticism is a vital part of the Christian tradition and many people would consider Dr Signer's patient privileged to have undergone these experiences. The greatest ever Cistercian, St Bernard of Clairvaux, was himself a mystic. It has always been acknowledged that the pursuit of such states may lead to emotional distress at certain stages and that a religious supervisor is required. I therefore urge Dr Signer to discontinue the monoamine oxidase inhibitor, and I suggest that he should advise his patient to seek more appropriate assistance from a spiritual mentor.

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