and my own long-continued clinical observation, are not mentioned by Dr. Claridge, and I am left wondering whether they come under the heading of the 'immature nature of theorizing in the field' (p. 2) or, more hopefully, as 'creativity variously described as the ability to take conceptual leaps in the face of minimal information, the ability to see remote connections between apparently unrelated items, and the ability to retain a flexible approach to problem-solving in order to seek a solution whether one is possible or not' (p. 5). I suppose only time will tell!

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THOUGHT DISORDER IN MANICS AND SCHIZOPHRENICS

DEAR SIR,

We were interested in the paper 'Thought Disorder in Manics and Schizophrenics Evaluated by Bannister's Grid Test for Schizophrenic Thought Disorder', by W. R. Breakey and Helen Goodell (*Journal*, April 1972, *120*, 391–5), particularly as the greater part of their discussion was concerned with a critique of our own work (*Brit. J. Psychiat.*, *118*, 671–3 (1971).

Breakey and Goodell imply that our finding that schizophrenic and manic patients score significantly differently on Bannister's Grid Test for Schizophrenic Thought Disorder was due to the fact that we selected schizophrenics with, and manics without, thought disorder. This was not so.

Certainly we selected schizophrenic patients with thought disorder, but the manic patients also had thought disorder, as the investigation we were concerned with was to see whether a test of schizophrenic thought disorder could help with the clinical problem of the psychotic patient who presents with 'overactivity, pressure of talk, loose association of ideas . . .'. He might be schizophrenic or manic.

One of our criteria for the selection of manic patients was that each should have a clinical picture consistent with mania as described by Slater and Roth (1969), and part of their description is of a disturbance in the stream of thought, of varying degrees. Our manic patients showed such a disturbance. An additional assessment using a 'proverbs test' to assess thought disorder, carried out on the schizophrenic and manic groups in question at the time of completing the Grid Test, has recently been published (Harrison, Spelman and Mellsop, 1972) and highlights the presence of clinical thought disorder in both groups.

We feel it is not surprising that Breakey and Goodell did not find the test useful in discriminating persons with mania from persons with schizophrenia when the exhibition of thought disorder was not a necessary diagnostic point for inclusion in either group. As they point out, albeit indirectly, a test of thought disorder is not likely to distinguish non-thought-disordered patients from other non-thought-disordered patients.

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AFFECTIVE DISORDERS

DEAR SIR,

I wonder if I might make a few comments on present trends in the psychiatry of states featured by anxiety, depression of mood or both, with special reference to the symposium on anxiety provided by the College this July?

The prevailing attitude seems to be to regard patients whose symptoms include anxiety or depression, and even more so those in whom such is the leading symptom, as though these disorders were primarily disorders of affect. Attempts are then made to evolve rating scales, and other instruments, so that the degree of anxiety or depression may be measured and compared from patient to patient. In the same way, the physiological concomitants of mental anxiety are arrayed and measured, and work is done on the central nervous system to find which structures subserve the various affective reactions.

I am far from suggesting that such work is unimportant or valueless. What disturbs me, however,

is that we seem to be acquiring a mental set—or displaying a set acquired in our medical schools and subsequent quest for 'higher qualifications' before we settled down to adapt to the special needs of psychiatry—so that when we come to discuss treatment for people suffering from neuroses this is very largely conducted in terms of what is the best (or latest) anxiolytic thymoleptic with which to block the patient's emotional responses. It is as though a group of physicians were to discuss the treatment of malaria, phthisis, pneumonia and other febrile conditions in terms mainly of the best available antipyretic.

There is a great deal more to the nature of an anxious or depressive neurosis than merely the affective reaction. It is not impossible, though I doubt it, that there are people who suffer from anxiety purely because of a disorder of the physiological anxiety mechanism, and of course we meet the occasional case of hyperthyroidism presenting with 'nervous' symptoms, but the great majority of patients presenting with such symptoms show anxiety as a response to stresses involved in disturbed inter-personal relationships past and present—always provided they are given time and skilled help to show what it is all about.

Admittedly an adequate theory of the development and vicissitudes of interpersonal relationships is a complicated and difficult matter. However, a vast amount of work has been done upon it during this century. A great deal is known and established. The general structure of dynamic psychopathology is perspicuous in some parts, obscure in others, nowhere complete, final and inalterable, and in general hard to grasp. One may have all sorts of legitimate doubts, reservations, or disagreements about particular parts of the large body of psychoanalytic theory and practice, but surely today it should not be acceptable for anyone working in the field of the neuroses simply to ignore it.

One of the considerations that led many of us to press for the foundation of our own Royal College of Psychiatrists was precisely that we recognized the disorders we are called upon to study and to treat as being essentially different from those met with in internal medicine. Nowhere, perhaps, is this more strikingly the case than in the field of the psychoneuroses. It is therefore especially disappointing to find the College discussing the problem of anxiety on the basis of such a predominantly 'Medical Model'.

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KOHUT'S 'ANALYSIS OF THE SELF'

DEAR SIR,

I wish to draw your readers' attention to this work, which I feel has received inadequate notice in your recent book reviews (*Journal*, March 1972, *120*, 350). I have personally found it to be the most stimulating, informative and helpful psychoanalytic publication of the past decade—one which should be reaching all serious psychotherapists.

Kohut is primarily concerned with the development of the psychic structure 'self' which though experientially close and vitally important in the experience of human existence has only lately come to the centre of psychoanalytic theory. He makes strikingly original contributions to the theory of the normal development of the self, deriving his theories from the reconstructions obtained in adult analysis. His case material is from persons whose disturbances in personality development do not seem severe and who do not display strikingly obvious psychopathology until the analysis is under way. Then the patient's characteristic transference pattern is that of the 'narcissistic transference' which enables therapeutic activation of archaic structures, viz. the 'grandiose self' and the 'idealising transference'. Already these terms, for the experienced clinician, will indicate and illuminate the types of experiences Kohut is discussing. He asserts that these two archaic structures are the normal way-stations in the passage from the early primary narcissism of the infant when, under the impact of developing awareness and unavoidable shortcomings of material care, the narcissistic equilibrium is disturbed. The infant attempts to salvage the earlier experience of 'perfection' (akin to Freud's 'purified pleasure-ego') by the elaboration of psychic structures, involving the fantasy of either possessing all the capacity for satisfying its own needs for love and care—the grandiose self—which enables it to turn away from the disappointing mother; alternatively the 'idealised parental image' is elaborated; an omnipotent object whose perfection is shared by the infant. Kohut terms this object, in fact, discrete and independent, but in experience felt as part of the self, in 'self-object'. This object is cathected with narcissistic libido, not with object libido and the infant therefore expects a similar control over the 'self-object' that it expects of its own self and body and it is felt to be essential for the maintenance of comfort and safety, the narcissistic equilibrium. When this transference emerges the analyst can feel oppressed and 'engulfed' by the patient—he is in fact treated as a part of the patient and his environment, not as a separate person. Experienced psychotherapists will be acutely and uncomfortably aware of this type of experience and of the patients who