are a stigma of abuse then we feel that their removal should be readily available.

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Simple schizophrenia – a forgotten diagnosis

SIR: Vostanis & Dean (*Journal*, August 1992, **161**, 265–267) reported two adult patients with self-neglect and found them interesting for the following reasons: (a) onset in young adulthood (age 35 and 38 at referral) rather than old age; (b) no psychiatric diagnosis was possible in the DSM–III–R in view of "the long history of generally stable behaviour and no confirmed psychotic symptoms" which precluded schizophrenia; (c) depot neuroleptic was ineffective and patients declined psychiatric treatment.

In our view, the case histories are typical of 'simple schizophrenia', an uncommon condition first described by Eugen Bleuler, later accepted by Emil Kraepelin, and recently reviewed by Black & Boffeli (1989). Although ICD–9 advised that the diagnosis should be made 'sparingly', it is retained (F20.6) in ICD–10 because of its 'continued use in some countries'. The essence of this condition is insidious psychosocial deterioration without obvious psychotic symptoms. Associated features include neglect of hygiene, social isolation, loss of initiative, oddities of conduct, hoarding useless items, vague digressive speech, and overvalued ideas. As the case histories provided by Vostanis & Dean include virtually all the above features, we do not agree that no psychiatric diagnosis is possible. Further, as few positive symptoms were present, the relative lack of response to neuroleptic treatment is expected. Even though the DSM–III–R deleted simple schizophrenia and has attempted to fill the vacuum by creating the entity of schizotypal personality disorder, there is conceptual problem in applying the latter diagnosis to the two cases because of the marked avolition, functional deterioration and self-neglect.

Simple schizophrenia remains of heuristic interest and a clinically useful differential of self-neglect in young adulthood. Bleuler suggested that outside of hospitals, it might be as common as other forms of schizophrenia (Black & Boffeli, 1989). More research on its validity is warranted.

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Phenomenology and schizophrenia

SIR: I read Dr Mortimer's article on phenomenology in schizophrenia research with enjoyment (*Journal*, September 1992, **161**, 293–297). Her three-level model of schizophrenia covers the fact that natural phenomena can be observed on multiple levels, providing a framework for understanding complex causes of disease that are not simple 'lesions' on any one level.

She omitted, however, any level relating to 'mind', or intersubjective reality, the organisational level at which schizophrenia most clearly manifests as a problem. For example, by wishing good morning to a person with schizophrenia, that something is radically wrong is apparent; and, as she points out, such information is at least as reliable as sophisticated instrumentation.

Models of mind are often said to be 'unscientific', because they are difficult to test in traditionally accepted ways: complex philosophical questions are raised, which by their nature may have to remain unresolved. Yet in practice, it seems to be assumed that they have been resolved. The concept of mind is largely ignored by modern psychiatry, which appears mistrustful of abstract ideas.

It was, perhaps, the tendency of the psychoanalytical establishment to reject insights and advances from outside its own world view, particularly the revolutionary (and serendipitous) pharmacological discoveries in the mid-20th century, that led to the decline in the influence of its ideas. However, as usual, a new orthodoxy simply took the place of the old. The historical perspective allows us now to see

that many of their ideas were simply displaced, rather than rigorously discredited, and that the baby, as it were, might well have been thrown out with the bathwater. Much in the current psychiatric world view is by no means empirically proven, and research activity may often be driven by reasons other than the pure pursuit of knowledge.

Schizophrenia is a disease of the person, and the bewildering variety of manifestations of what appears to be the same disorder finds a parallel in the paradox of human personality – how can we all be in one sense so very different, and yet at the same time so similar? There is a challenging tradition of psychoanalytic personality theory, often very rigorously formulated (e.g. Bion, 1962). It seems rarely drawn on, or even read, by schizophrenia researchers – the result of a psychiatric orthodoxy imposed most tangibly on trainees by the MRCPsych examination.

Extension of models such as Dr Mortimer's to include a level of mind which can accommodate psychodynamic insight, and its own particular methods of research, and allow interaction with the other approaches, are vital for a creative integration within our profession as a whole. Already there are other dialogues taking place, such as between psychoanalysis and artificial intelligence work (Dahl *et al*, 1988); it is regrettable that there is a lack of such communication between the psychiatric and psychodynamic thinkers. We need to actively prepare the soil in which a new generation of theories might grow.

It may be that current approaches are sufficient, but, as suggested in Mortimer's article, evidence for this hypothesis is lacking. Indeed, using clinical utility as an outcome measure for research, it might be said that psychodynamic ideas have contributed more to the humane management of people with schizophrenia than X-rays of their heads, no matter how exciting it is to see the pictures.

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Suicide prevention: fact or fiction

SIR: We read the pessimistic letter of Michael *et al* (*Journal*, June 1992, **160**, 867–868) in connection with the efficacy of suicide prevention. The importance of the question, especially in Hungary, forced us to think over this problem. To speak about suicide prevention in general terms is counterproductive. Being psychiatrists we cannot speak about the prevention of suicide of a person who has never been seen by a psychiatrist. The question is whether in everyday care we are able to treat high risk patients successfully or not. Primary depression, especially bipolar disorder, represents the highest suicide risk. Previously we demonstrated that under-referral and underdiagnosis of depression is the main cause of suicide in Hungary, since we found a significant negative correlation between suicide rate and the rate of treated depression across the 20 different regions of Hungary (Rihmer *et al*, 1990). On the other hand, it has been demonstrated that after an intensive postgraduate training programme for GPs on the diagnosis and treatment of depression, the suicide rate in the area served by trained GPs dropped significantly (Rutz *et al*, 1989). However, adequate antidepressant treatment can prevent only the suicide risk connected with the given depressive episode, while only adequate prophylactic treatment can provide long-term results in patients with recurrent mood disorders. Since more than 50% of those who kill themselves have primary, mostly recurrent, depressive illness (Arató *et al*, 1988) the correct acute and prophylactic treatment of these patients has particular relevance in suicide prevention.

At least six studies have proved the significant reduction in suicidal behaviour of bipolar depressive patients on prophylactic lithium therapy (see Goodwin & Jamison, 1990, pp. 237–239 for review).

Investigating retrospectively the suicide behaviour of 36 (30 women and 6 men) out-patients with bipolar I ($n=19$) and bipolar II ($n=17$) affective disorder who were on prophylactic lithium therapy for at least two years (maximum: 18 years, mean: 7.2 years) we supported the role of prophylactic lithium therapy in preventing suicide in this patient population. Compared with the pre-lithium period (mean: 7.6 years, range: 0.3–18 years), during the lithium period (mean: 7.2 years, range: 2–18 years) there was a significant reduction not only in the number of suicidal patients, but also in the number of suicide attempts (15 patients and 25 attempts v. 1 patient and 2 attempts, $P<0.001$).

We hope that lithium therapy is not just delaying the suicidal behaviour, so that patients who have not made an attempt for the past 18 years will not make one in the next 18 years either.

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