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