whatever may be lost in 'completeness' is more than compensated for by its reliability and validity, and that it gives a *minimal* estimate of the importance of life changes and crises in precipitating major psychiatric disorders. Our findings suggest that such events are of considerable importance (Birley and Brown, 1970; Brown and Birley, 1970). We have discussed in detail our reasons for concluding that these events could not have been brought about by the insidious onset of the patient's disorder.

We must leave readers to judge whether this difference is due to different and more precise methodology, as we believe, or merely to a different bias. But we freely confess to a different bias. Like Dr. Hudgens and his colleagues we are biologists, but we believe that the biology of 'biological psychiatrists' is altogether too simple. When we consider the remarkable waywardness of the spirochaete of syphilis, the epileptic discharge, and the schizophrenic gene in 'causing established mental disorders', we feel that it is biologically respectable to investigate the hypothesis that external circumstances, such as an occurrence which may make adaptive demands upon the person, may also contribute to the development of mental disorder, but we would avoid the words 'causing' and 'established' as begging too many biological questions.

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NEUROTIC SYMPTOMS, PERSONALITY AND PERSONAL CONSTRUCTS

DEAR SIR,

May I comment on Dr. D. J. Smail's stimulating paper, 'Neurotic Symptoms, Personality and Personal Constructs' in your December issue (pp. 645–8)? It is important because it adds fresh substance to our knowledge that personality factors influence the form in which emotional disturbances are presented by people in trouble, and alerts us to the way (therapeutic or anti-therapeutic) in which they are responded to by the people they come to for help. There are individuals whose avoidance of awareness of the inner subjective realities of themselves and others is so great that objectification is used as a substitute and defence rather than as a way of validating and modifying them. Their feelings and imagination are pushed away as unmanageable threats. Some become patients, some become professional helpers, including psychiatrists. Both groups pose practical problems, and Dr. Smail does a great service in pointing to them, and showing us one sophisticated way of studying them.

With regard to patients, it might not be out of place to mention the relevance of his work to psychosomatic disorders, partly in the hope that he or others will extend it into this field. A short time ago, in a study of some eighty patients with eczema (Brown, 1967; 1970), I found a similar dichotomy between two-thirds who were fairly obviously emotionally disturbed (almost always *before* the onset of the rash) and admitted spontaneously or on questioning to newly emerging psychological symptoms, and one-third who denied such symptoms. The two groups were validated clinically and with psychological tests, and I used the terms Unstable and Superstable to denote them. The Superstable patients appeared not to be more psychologically normal than the others, but abnormal in a different way; in fact in some ways they were more abnormal, and it was the Unstable group that resembled control groups in the balance of psychological and physical complaints. The Superstable group approximate to Smail's neurotic group who tend to produce somatic symptoms and in being relative 'thinking extraverts', and to the similar group described by Foulds (1965) in being unaware of aggression and tending to blame others.

From our data it seems likely that the undoubted personality factors interact with social factors too. The Superstable group showed a borderline tendency to be male and in the lower social classes, and it seems likely that in addition to the individual's defence structure, social pressures encourage somatic rather than psychological/symptom formation. A reduction in the need to maintain self-esteem in the face of such pressures, as the lower class men get older, perhaps explains the finding of a reversal in the eczema patients (but not dental and psychiatric groups) of the expected negative correlation between age and evidence of emotional instability and symptomatology (on the Eysenck Personality In-

ventory and Cornell Medical Index). This reversal was largely confined to men in the Unstable group, suggesting that social factors leading to somatization are relatively more important in this group, whilst in the Superstable group internal factors are relatively more important. It might be that some such interaction between social and personality factors (including 'interview defensiveness') explains Dr. Smail's unexpected finding in relation to the effect of age.

With regard to psychiatrists, one thing the eczema study underlined was the importance of fitting the treatment to the patient. A controlled trial of psychiatric treatment (to be reported) indicated that the eczema of patients with overt emotional disturbance tended to respond well to short term psychiatric treatment, that of the Superstable type (in whom psychogenesis was considered as important) did not, and might even have been worsened initially in some cases. As one would imagine, the Superstable patients were less accepting of psychiatric referral, and their motivation for psychiatric treatment tended to be low. To some extent any scientific study of people must be a Procrustean bed, and the dangers of this are greatest when therapy is involved. Some psychiatrists tend to be more immediately in tune with Unstable patients, tend to be 'thinking introverts' themselves and to see patients' problems as psychologically rather than somatically determined, and to prefer *them* to. Others are relieved when physical factors can be incriminated, including 'constitutional' and 'endogenous' ones. A more Superstable doctor than I am *might* have had better therapeutic results with Superstable patients, might have been more supportive and reassuring, less inclined to question their defences; he might also have been less helpful to the Unstable ones who wanted to talk about and explore and try to resolve some of their emotional problems rather than be given ointments or just psychotropic drugs (most were given a combination of drugs and psychotherapy). At present this is speculation, but it is the sort of notion that Dr. Smail's paper provokes. How can we fit the psychiatrist to the patient, or at least help him to fit himself to the patient's needs?

The hospitable academy of psychiatry, with space for all types of psychiatrist, can be a confusing and perhaps dangerous place for some patients. How fair is it that people in distress are seen by a psychiatrist who might not be able to see and offer help for their problems in a way that is most acceptable, makes most sense to them, and is therefore most efficacious?

If I may be allowed a final fantasy, perhaps we could all be examined, and rather than coming out with D.P.M.s and Memberships, be clearly labelled like our patients as SSI (psychological or somatic), DIQ (introvert or extravert), Construct Diversity (large or small). Then the first step in psychiatric referral would be something like computer dating. The problem behind the fantasy is a real one. Let us hope that as a profession we can find a less bleak solution, and thank Dr. Smail for alerting us to it.

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THOUGHT DISORDER IN THE PARENTS OF THOUGHT DISORDERED SCHIZOPHRENICS

DEAR SIR,

Muntz and Power (1970) are correct in assuming that not all the schizophrenics' relatives I tested in my study (Romney, 1969) were related to schizophrenics showing clinical signs of thought disorder: in fact, 3 out of 51 schizophrenics' relatives were related to schizophrenics judged by a psychiatrist to be totally free of thought disorder (Romney, 1967, p. 258–9).

I feel, however, that these relatives constituted such a small minority that Muntz and Power's criticism of my sample of schizophrenics' relatives on those grounds is not damaging. Nevertheless, I agree my sample was by no means perfect (Romney, 1967, p. 191).

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