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.

PATRICK MCGORRY

Royal Park Hospital
Parkville
Victoria
Australia 3052

References

MINKOWSKI, E. (1927) The essential disorder underlying schizophrenia and schizophrenic thought. In *The Clinical Roots of the Schizophrenia Concept* (eds J. Cutting & M. Shepherd), 1986. Cambridge: Cambridge University Press.

BLEULER, E. (1911) *Dementia Praecox or the Group of Schizophrenias*. (Translated by J. Zinkin, 1950). New York: International Universities Press.

JASPERS, K. (1959) *General Psychopathology* (7th edn). (Translated by J. Hoenig & M. W. Hamilton, 1962). Manchester: Manchester University Press.

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?

MAXWELL G. CHAPMAN

P.O. Box 67
Ettalong Beach
New South Wales 2257
Australia

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.

ANTHONY J. PELOSI

General Practice Research Unit
Institute of Psychiatry
London SE5 8AF