source of data on past treatments and reasons why treatments had been used" and "poor recording of clinical data made it difficult to assess the rationale for, or efficacy of, treatment initiated by other doctors". As it seems unlikely that patients' information regarding their past treatment would be any more reliable, we must conclude that the authors' judgements are based on highly unreliable data. It should be added that if case notes fail to record treatment details, this does not indicate inappropriate treatment but poor record-keeping.

I have recently completed a study of prescribing to lithium clinic attenders, comparing prescriptions in the clinic with those issued to these patients at the time of their last in-patient discharge. This shows a highly significant reduction in polypharmacy, frequency of dosage, and use of neuroleptic and anticholinergic drugs in the clinic, suggesting that in-patient prescribing habits do not inevitably carry over into the clinic setting and mitigating against the notion that clinicians habitually indulge in uninformed, irrational polypharmacy.

I contest the assertion that Muijen & Silverstone (1987) produced evidence that an academic psychopharmacology service produces more rational prescribing. Their three-hospital survey was not controlled, the authors confirming differences between the patient populations and hospitals, and as a result they have only shown that the hospital with the least polypharmacy also had a psychopharmacology department. This no more establishes a causal relationship than the presence of a neurosurgical unit only in this hospital would imply a meaningful association between neurosurgical units and low polypharmacy. Similarly, it cannot be accepted that Diamond *et al* (1976) have shown that peer group review in out-patients induced more rational prescribing, as they too omitted a control group. My own lithium clinic findings show that considerable changes occurred over time without intervention, and these would also be considered more rational.

Dr Holloway's suggestion for agreed criteria of good prescribing practice was undertaken by an APA Task Force (Dorsey *et al*, 1979), and the limitations of this procedure were, perhaps, highlighted by their need to emphasise that these should be subject to adaptation based on "differences in populations, clinical practices, resources, and professional judgement". Furthermore, they acknowledged the appropriateness of a wide range of psychopharmacological practices, including drug combinations, and this eminent group of experts were unable to reach a unanimous opinion on the correct use of anticholinergic drugs for patients receiving neuroleptics.

To date, prescribing surveys have not provided a suitable data base on which to judge the appropriateness of prescribing. If clinicians' practices are to be evaluated, this must be on the basis of reliable and valid information, and although the medication review sheet provides a useful recording tool it does not help to address the fundamental problem of obtaining suitable data.

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Schizophrenic Thought Disorder

SIR: Cutting & Murphy (*Journal*, March 1988, **152**, 310–319) have rightly emphasised the need to investigate the difficult and little-understood area of thought disorder in schizophrenic patients. They have also illustrated an attempt to define and operationalise possible components of thought disorder for study.

The speculative proposal and subsequent conclusion of a component of deficiency in social and practical knowledge of the real world is debatable. The examples quoted of a patient regarding a thermometer as the cause of his 27-year pneumonia and of another patient planning to audition for a star part in a film already made illustrate the use of primitive modes of thinking in wakeful life in schizophrenic patients (Lehmann, 1980). These modes of thinking are closely related to the primary process thinking that is at work in normal dreaming and allow for various psychological mechanisms, including displacement of feelings from one object to another and a disregard for time sequence (Freud, 1976).

Now and then I come across patients telling me stories about themselves which could not have been true nor logical, just as in the examples quoted. In accordance with the technique recommended in conducting an interview with the schizophrenic patient

(Mackinnon and Michels, 1971), in these situations I tell them of my willingness to understand them but of my difficulty in following what they have just stated. Sometimes patients are able to remake their statements to allow you to know what they mean. At other times they may just laugh without either correcting their own statements or insisting on them. I doubt very much that they are actually deficient in real world knowledge and that they are totally ignorant of the illogicality in producing the statements.

Alternative explanations include the possibilities that they do have the relevant real world knowledge but have not checked or cannot check the logicality of their statements according to their knowledge, or that they have checked with their knowledge but do not see the need to follow the logicality, or use the illogicality intentionally. The latter could be interpreted as meaning that they want to avoid understanding, or that they have some complex thoughts that can only be expressed in this way.

As seen from the examples mentioned in the article for the practical and social knowledge tests, we need to know whether the tests are truly measuring knowledge or just eliciting judgement or response, like a thematic apperception test. Payne (1970) has discussed some schizophrenic patients' unusual responses to various situations including different tests. The tests used could have elicited unusual responses which might or might not have been related to the use of primitive modes of thinking. The findings of abnormally low scores in the schizophrenic subjects studied cannot be used as evidence to support the hypothesis of deficient real world knowledge in the schizophrenic.

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SIR: Cutting & Murphy (*Journal*, March 1988, **152**, 310–319) highlight and explore a dormant aspect of the psychopathology of psychosis which they have construed as a component of thought disorder, namely a disorder of the way a subject thinks about or judges events in the real world. This is further designated a deficiency of "real-world knowledge" or "a lack of common-sense". The phenomenon is very closely related to the notion of 'schizophrenic dementia', one of the fundamental symptoms of Eugen Bleuler (1911). Bleuler distinguished this form of 'dementia' from the organic variety, and viewed it as a complex and mercurial phenomenon which was really a derivative of other fundamental symptoms, especially the disturbance of associations and affectivity, and autism. The following quotations may help to further convey his views on its nature: "The severe schizophrenic dementia is characterised by the fact that in all thinking and acting there occur a large number of mistakes [*Fehlleistungen*]; the relative dificulty of the task is of secondary importance. Conversely, in the mildest cases the dementia is characterised by the fact that, although these people are usually quite sensible, they are also capable of every possible stupidity and foolishness." "The actual amount of knowledge remains preserved on the whole but it is not always available or it is employed in the wrong way." "The anomaly called schizophrenic dementia consists of the effects of association disturbance, indifference and irritability in the affective sphere and the autistic exclusion from the influences of the outside world."

Bleuler devotes nearly 19 pages of his original monograph to depicting this phenomenon. It is puzzling, therefore, that Dr Cutting, a respected scholar of the history and concept of schizophrenia, fails to acknowledge this, particularly since he also seems to regard the phenomenon as a dimension, albeit an orthogonal one, of schizophrenic thought disorder. Jaspers (1959) also discussed the phenomenon, relating it, as did Bleuler, to the concept of autism. Minkowski's elaboration of the idea (1927) *is* appropriately emphasised by the authors; however, they have chosen not to take up his suggested term, 'pragmatic deficit', for the phenomenon. This is a pity, since it is a less cumbersome and perjorative term than 'deficient real-world knowledge or lack of common-sense'.

The next step will necessarily involve an exploration of the boundaries and causes of the impairment. The authors have considered the possibility that prolonged institutionalisation could contribute to the phenomenon; however, data on duration of illness and degree of isolation in the community prior to admission are not presented. Socially withdrawn or isolated patients living in the community might also conceivably develop such a disability in a secondary manner. Control groups of people with schizoid and schizotypal personality traits, frank