emotion and maybe less honesty is usually needed. In many ways, the therapeutic community then is a 'luxury', and very stimulating and perhaps therapeutic in its constant examination and analysis of one's own and other people's actions, motivation, and attitudes—but it is arguable whether residents are being conditioned to meet realistic situations. In a similar vein, the community is a source of understanding and support which is a strongly attractive force—especially for those without satisfactory homes—and I feel that many can become too dependent on it; which, of course, also makes rehabilitation difficult. Maybe 'a therapeutic community within the community' (rather than within the hospital), with a gradual tail-off of meetings for those who have left, might be an answer, rather than complete and immediate ending of support after discharge.

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THE CLINICAL DISTINCTION BETWEEN AFFECTIVE PSYCHOSES AND SCHIZOPHRENIA

Dear Sir,

In the September, 1970, issue of the *Journal* (p. 261) Kendell and Gourlay report no clinical distinction between affective psychoses and schizophrenia, and further imply that these conditions should be considered as opposite poles of a continuum and not as separate diseases. Their conclusions rest on a discriminant function analysis which demonstrates a trimodal distribution rather than the bimodal distribution characteristic of two distinct illness populations. I submit that these conclusions are based on methodological artifact and do not reflect clinical observation.

Patients described by Kendell and Gourlay were involved in a cross-national study and were given diagnoses by physicians associated respectively with a London and with a New York State mental hospital. The diagnostic criteria of these physicians are not described, but the authors suggest the use of 'inconsistent diagnostic criteria' by the New York group, with one of the New York physicians, 'by his broader concept of schizophrenia', effectively eliminating the concept of affective psychoses from his consideration. If diagnostic criteria are inconsistent, discriminant function analysis of patients selected by these inconsistent criteria could not possibly discriminate two relatively homogeneous groups.

Nevertheless, the authors state they attempted to maximize the possibility of bimodality, yet they include involutional paraphrenia with the schizophrenics, dismissing this inclusion as statistically insignificant. Most discussions include involutional paraphrenia among the affective disorders (Slater and Roth 1969), and I would have been more inclined to accept their maximizing had they too kept to this established classification. Also included among the schizophrenic group, and I suppose other examples of maximizing efforts, were: one acute schizophrenic (an illness clinically distinct from process schizophrenia (Robins and Guze, 1970), four latent schizophrenics (an illness based on highly questionable psychodynamic concepts), 17 schizo-affective schizophrenics (an illness demonstrated by Clayton *et al.*, (1968) to be a variant of the affective disorders), and four 'unspecified' schizophrenics (an illness with which I am unfamiliar, nor one to which I can find any reference). So we have 26 patients who perhaps should not be included among 'Kraepelinian' schizophrenics and whose inclusion may have resulted in the reported trimodal distribution.

Finally, if maximizing a bimodal distribution was their goal, why did the authors choose for analysis such statistically confounding and often irrelevant items as: loss of insight, difficulty in relaxing, insomnia, time in hospital, and 'schizophrenic speech' (is that like a criminal face)? Would not Schneiderian first-rank symptoms or other precise psychopathological terms have been more relevant and more likely to have resulted in a distribution reflecting homogeneous groups?

In summary, lack of rigid diagnostic criteria, the inclusion of questionable schizophrenic sub-categories and the choice of less than optimal items for analysis could explain the authors' result, perhaps statistically sound but too far removed from basic clinical observation.

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