1963) do not "recommend 600–800 mg. and up to 3,000". They say, "300 mg. or more of chlorpromazine a day in three divided doses is given initially and increased progressively until symptoms respond or side-effects become too troublesome. Doses of up to 3,000 mg. a day *have been reported*, but we have rarely had to give more than 1,200 mg. a day. *Seriously disturbed* patients should be started on 600–800 mg. a day." For maintenance therapy they advise "between 150 and 300 mg. a day", although "larger doses are sometimes needed". (Our italics.)

Henderson and Gillespie (*Textbook of Psychiatry*, 9th ed., revised by Henderson and Batchelor, 1962) say that "chlorpromazine is prescribed usually in doses of 150 to 400 mg. daily by mouth, and as much as 800 mg. daily has been given". Noyes and Kolb (*Modern Clinical Psychiatry*, 6th ed., 1963) say that "there is no standard dose of the drug; this must be individualized", the reference to approximately 600–800 mg. a day is in relation to the chronically *disturbed* patient.

The N.I.H. study to which Dr. Kline refers (presumably "Phenothiazine Treatment in Acute Schizophrenia", *Arch. gen. Psychiat.*, **10**, 246–262, 1964) is concerned with the treatment of *acute* schizophrenia. It covers a range of doses from 200 to 1,600 mg. a day, with a mean of 654·8 mg. No conclusion is drawn about the value of doses below 300 mg., nor is it stated that doses of 500–600 mg. constitute a "practical working minimum".

We have not checked on the doses given on "the package inserts in the United States" (nor on the manufacturer's recommendations in this country). Dr. Kline may well be right on this point.

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INFANTILE PSYCHOSIS

Dear Sir,

In their very interesting paper (*Journal*, November 1967, p. 1169) Michael Rutter and Linda Lockyer include a most valuable table of the "behavioural characteristics of psychotic and control children", which verifies that many of the signs are (quantitatively) shared by the two groups. It is common experience and practice among child psychiatrists, however, to recognize a *qualitative* element in the diagnosis of either "psychosis" or "organic" brain damage in children. This is bound to elude any tabulation, and I am sure that, although it carries the danger of inaccuracy due to unchecked clinical "impressions", it is nonetheless the very essence of the clinician's ability to utilize the non-measurable elements that many an illness offers for diagnosis.

Having worked as Dr. James Anthony's Registrar in the Children's Department of the Maudsley Hospital during the period that Michael Rutter and Linda Lockyer cover in their stimulating paper, it is most likely that I have examined several of the psychotic children mentioned in their report, and I feel I could make the following point: the label of "autism" given to some of the "control" patients (Table IV, p. 1173) raises the question that these might approximate to either cases of "organic brain damage" (a term that I remember the late Dr. Cameron often using in case-conferences) showing psychotic behaviour, or, possibly so-called "psychotic-defectives". In any event, even if these terms are not in preference today, the label of autism in some of the *control* patients indicates a certain heterogeneity which, if somewhat awkward methodologically, is a very interesting finding with regard to the psychopathology of these patients. It would be interesting to know if the "autistic" controls had achieved communicative speech or not, and what was their final "diagnosis". It is also a pity that the authors did not provide a table about the presence of brain damage in the control children, corresponding to their Table X. Finally, one might remark that "brain damage" (i.e. organic dysfunction) cannot be equated with "brain disease" (p. 1178), and that developmental delays in brain maturation are sufficiently "organic" in origin to be placed together with "organic brain dysfunction". This would substantially alter the analysis of results of Table X, and might explain the greater incidence of fits which the investigators found in the follow-up during adolescence.

Whatever the answers to these minor queries may be, Dr. Rutter and Miss Lockyer are to be most warmly thanked and congratulated for a very useful description of the clinical status and of the follow-up of psychotic children, and also for showing us that this can be done with the use of a control design.

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COGNITIVE DISORDER IN THE SCHIZOPHRENIAS

Dear Sir,

The findings of Foulds *et al.* (*Journal*, December 1967, pp. 1361–1374) are of considerable interest, but it is a pity that they were unable to obtain a more useful clinical rating of thought disorder. In an unpublished study (Costello, 1966) I showed that when

patients were ranked in order of clinically assessed thought disorder the correlation with Bannister and Fransella's measures was quite high (N=17, Spearman's rho for consistency with clinical rating=·57, P<·05, and for intensity rho=·79, P<·01).

The contrast between these relatively high correlations and the rather low ones found by Foulds *et al.* points, I believe, to a weakness in the clinical concept of thought disorder. As these authors comment, the difference between thought content disorder and thought process disorder is often ignored. Another distinction which is implicit in the psychiatric literature, but not clearly defined, is that between disorder of thought manifest in speech and disorders of speech not dependent on thought disorder. This distinction becomes most troublesome when one attempts to make operational definitions of the components of schizophrenic thought disorder. Moreover, many of these components, such as misuse of words or unimportant detail, are almost impossible to define in such a way that the phenomenon is specific to the schizophrenic, without introducing circularities of argument.

It is hardly surprising that several different psychiatrists failed to produce a consistent clinical scale of thought disorder. And might not the low correlation of test results with clinical rating found amongst chronic patients be due to the reduced attention and less frequent interviews which psychiatrists are compelled to give their chronic patients? Inevitably, clinical ratings would be more erratic and clouded by the psychiatrist's recall of the patient's state on previous occasions.

There is one other aspect of the assessment of thought disorder which I hope Dr. Foulds and his colleagues may cover in further studies.

It is not clear from Bannister's work whether thought-process-disordered schizophrenics have an abnormal concept structure which they use normally as an intermediary in the performance of tasks, or if whilst retaining normal concept structure they are unable to use it effectively. In my experience of the test the most thought-disordered schizophrenics frequently tackle the sorting of the photographs in a manner quite different from normals. The non-thought-disordered subject takes as much trouble over the selection of the fourth and fifth ranking photograph as he will over the first—sometimes he takes longer. The thought-disordered subject, on the other hand, may select the first one, two or three with care—and amongst the first few selections his consistency is quite high; subsequent decisions are then taken at random. One subject made this process explicit: asked to select "the person who looks the most kind" she said "God, I couldn't tell you . . . as I am a woman I observe the woman first . . . it is very difficult, I'll give a woman a chance first, they have softer sentiments (selecting a woman) . . . then her (selecting another woman) (after a pause) then all the rest can take its chance", and she picked up the photographs in order from left to right, rapidly, and handed them to me. It would be of interest to measure the decision time for the selection of each rank for normal and schizophrenic subjects, including the thought-disordered.

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REFERENCE

COSTELLO, A. J. (1966). *Curiosity and Schizophrenia.* Unpublished dissertation submitted for the Academic Post-Graduate Diploma in Psychological Medicine of the University of London.

DEAR SIR,

I should be grateful if I might bring to your readers' attention the fact that the World Psychiatric Association has recently formed a number of Sections, dealing with specialist fields of psychiatry. In some cases Section committees have actually been formed, in others there is, as yet, only a small convening body. Those who are interested in any of the subjects covered, and who wish to foster international collaboration in a particular field of psychiatry, are invited to communicate with the Sections Adviser. Sections so far in the course of formation are as follows:

Biological Psychiatry
Child Psychiatry
Drug Dependency
Epidemiology and Community Psychiatry
Forensic Psychiatry
Geriatric Psychiatry
Higher Nervous Activity
Psychiatric Education
Transcultural Psychiatry.

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