To the Editor:

Some current trends in the psychiatric handling of psychotic and postpsychotic conditions are taking on a disturbing cast. In the name of "therapy," the time spent by psychiatric patients in a protective environment is being reduced to a minimum and the phenothiazines are being relied upon increasingly to foster "recovery." Because patient turnover is rapid and the psychiatric resident is harassed, case histories become ever shorter and diagnostic labeling daily grows more categorical. The distressing impression that our field is being governed more by political-economic considerations than by properly psychological ones is difficult to countenance. Does this not represent an American cultural bias toward "efficiency"—covering the needs of the greatest number with the least cost?

In doing therapy with persons in the acute schizophrenic state, I have been impressed by the developmental potential in the process and by the subject's need to learn how to assimilate the fruits of the process into his life. In my experience of practice and of supervision of residents, I often find that patients feel a gulf between their felt need and their expectation of a meaningful response from our profession. Persons who are finding their way through and out of schizophrenic episodes experience more than anything else the need to be met by a therapist in a mutual relatedness of considerable intensity. Interviews held bimonthly to monitor medication, or group therapy in which there is equally little personal involvement, are appropriately interpreted by such persons as being held at arm's length, and as being looked upon as offering little promise for significant growth and development. However, if as psychotherapists we really engage with such persons at a significant level of involvement, dramatic and gratifying movement in development often takes place.

Is it not time to reconsider our criteria of "efficiency" in impersonal terms to include "effectiveness" in the personal dimension of emotional development?

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diabetes as a model

To the Editor:

Wyatt, Termini, and Davis, in your Fall 1971 issue, used obstructive jaundice as an analogy for schizophrenia. To me, a more likely model is diabetes mellitus, and I suggest this to clinical researchers investigating a biochemical mechanism for schizophrenia.

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To the Editor:

I agree with Donald Bannister's appeal (Schizophrenia Bulletin, Fall 1971) for research in schizophrenia to be "carried out within the language and assumptions of an overall theoretical framework." Allow me to suggest a somewhat different framework upon which to plan future research in this field.

Because disordered behavior (overt and covert) is the most flagrant sign of the schizophrenias, it has been the one upon which most research has been based. Historically, however, this approach has not been fruitful: The content of disordered behavior accompanying such states as syphilis and myxedema, for example, might best be understood by a science of psychology, but the process could only be grasped and then countered with a full understanding of the biology involved. The bufotenine experiments serve as excellent reminders of the poor correlation between a biological datum (bufotenine in the urine) and a behavioral one (symptoms of craziness). I would propose then, in schizophrenia research, to turn the matter around, beginning with disordered physiology in arriving at a diagnosis, rather than disordered behavior. We need to honestly face the fact that our behavioral measures are too imprecise to do justice to the concept of schizophrenia. Calling all bufotenine-positives "schizophrenics" might better help us search for the most appropriate treatment for "schizophrenia" and then to examine