and my own long-continued clinical observation, are not mentioned by Dr. Claridge, and I am left wondering whether they come under the heading of the 'immature nature of theorizing in the field' (p. 2) or, more hopefully, as 'creativity variously described as the ability to take conceptual leaps in the face of minimal information, the ability to see remote connections between apparently unrelated items, and the ability to retain a flexible approach to problem-solving in order to seek a solution whether one is possible or not' (p. 5). I suppose only time will tell!

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THOUGHT DISORDER IN MANICS AND SCHIZOPHRENICS

DEAR SIR,

We were interested in the paper 'Thought Disorder in Manics and Schizophrenics Evaluated by Bannister's Grid Test for Schizophrenic Thought Disorder', by W. R. Breakey and Helen Goodell (*Journal*, April 1972, *120*, 391–5), particularly as the greater part of their discussion was concerned with a critique of our own work (*Brit. J. Psychiat.*, *118*, 671–3 (1971).

Breakey and Goodell imply that our finding that schizophrenic and manic patients score significantly differently on Bannister's Grid Test for Schizophrenic Thought Disorder was due to the fact that we selected schizophrenics with, and manics without, thought disorder. This was not so.

Certainly we selected schizophrenic patients with thought disorder, but the manic patients also had thought disorder, as the investigation we were concerned with was to see whether a test of schizophrenic thought disorder could help with the clinical problem of the psychotic patient who presents with 'overactivity, pressure of talk, loose association of ideas . . .'. He might be schizophrenic or manic.

One of our criteria for the selection of manic patients was that each should have a clinical picture consistent with mania as described by Slater and Roth (1969), and part of their description is of a disturbance in the stream of thought, of varying degrees. Our manic patients showed such a disturbance. An additional assessment using a 'proverbs test' to assess thought disorder, carried out on the schizophrenic and manic groups in question at the time of completing the Grid Test, has recently been published (Harrison, Spelman and Mellsop, 1972) and highlights the presence of clinical thought disorder in both groups.

We feel it is not surprising that Breakey and Goodell did not find the test useful in discriminating persons with mania from persons with schizophrenia when the exhibition of thought disorder was not a necessary diagnostic point for inclusion in either group. As they point out, albeit indirectly, a test of thought disorder is not likely to distinguish non-thought-disordered patients from other non-thought-disordered patients.

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AFFECTIVE DISORDERS

DEAR SIR,

I wonder if I might make a few comments on present trends in the psychiatry of states featured by anxiety, depression of mood or both, with special reference to the symposium on anxiety provided by the College this July?

The prevailing attitude seems to be to regard patients whose symptoms include anxiety or depression, and even more so those in whom such is the leading symptom, as though these disorders were primarily disorders of affect. Attempts are then made to evolve rating scales, and other instruments, so that the degree of anxiety or depression may be measured and compared from patient to patient. In the same way, the physiological concomitants of mental anxiety are arrayed and measured, and work is done on the central nervous system to find which structures subserve the various affective reactions.

I am far from suggesting that such work is unimportant or valueless. What disturbs me, however,