an attempt to reach agreement on its definition would also be worth while.

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CLASSIFICATION OF THE FUNCTIONAL PSYCHOSES

Dear Sir,

I have just obtained some results of a study of psychotic patients which have a bearing on Dr. Ollerenshaw's article in your May 1973, issue (**122**, 517–30).

Thirty-eight male patients diagnosed clinically as suffering from a schizophrenic illness were assessed at the end of their stay in hospital, at which time they had largely recovered from their acute illnesses. The eighth edition of the Present State Examination (PSE) was used (Wing *et al.*, 1967). Twenty-seven patients had, at the time of the PSE examination, definite depressive symptoms, and these were quite marked in 14 cases. In fact 6 patients were categorized by the computer programme devised for use with the PSE as having a depressive illness. However, this was in no sense a new illness which they had 'developed' or 'slipped into' because *in every case* the patient had exhibited a greater range and/or severity of depressive symptoms when he was assessed by the same method soon after admission. Of 46 patients examined during the acute stage of their illness (including 8 patients who were not re-assessed later), all but one had some depressive symptoms, and in 41 patients these were quite marked. However, only one was classified as depressive by the computer programme, because, in common with the practice of most clinicians, if definite schizophrenic symptoms were also present that diagnosis was preferred.

The depressive symptoms could not be attributed to treatment, since the initial assessments, when the patients were more depressed, were made *before any treatment had begun.* The effect of treatment between the two assessments could only have been to reduce the depressive symptomatology. Incidentally, more detailed analysis of the treatment given, while perhaps indicating the benefit of ECT in diminishing depressive symptoms, further exonerates the depot phenothiazines from blame for *causing* them, as the following Table shows.

Table

Treatment	Depressive Symptoms at end of stay in hospital			
	Absent	Minimal	Marked	Total
Nil	1	1	–	2
Phenothiazines only	–	–	2	2
Phenothiazines only including Depot Phenothiazines	–	2	2	4
ECT and Phenothiazines	8	7	9	24
ECT and Phenothiazines including Depot Phenothiazines	2	2	1	5
ECT only	–	1	–	1
	11	13	14	38

It looks, therefore, as if, instead of the consecutive appearance of schizophrenic and depressive illnesses, these two are in a sense concurrent, but, because pride of place is given to schizophrenic symptoms in arriving at a diagnosis, depressive ones are under-recognized (How many clinicians inquire into depressive symptoms at all when confronted with florid and clear-cut schizophrehnic illness?). The effect of treatment, far from inducing depression, is to remove the masking schizophrenic picture, revealing whatever residual depression exists after ECT and other therapy. An important objection raised by the author to the 'possibility that schizophrenic and affective psychoses are two independent dimensions rather than separate categorical disease entities' is thus removed.

A somewhat similar picture emerged when hypomanic symptoms were considered. In the acute phase before treatment 8 of the 46 patients had some hypomanic symptoms and in 16 others these symptoms were numerous. On recovery, 13 out of 38 had *some* hypomanic symptoms and in only 4 were they numerous. Two of the 4 and one of the 13 had not previously had such symptoms, but in all other cases they were more marked in the acute phase. However, 14 'recovered' patients were classified with a category indicating a definite element of mania. Only 6 were so classified initially, not, as we have just seen, because they lacked relevant symptoms but because once again precedence was given to florid schizophrenic

symptoms, e.g. Schneider symptoms, in arriving at the final classification.

There seems to be no need for the author to postulate 'that much of what is currently classed as "acute schizophrenia" is really what might be termed a "manic equivalent" in a manic-depressive illness.' His two-dimensional model is sufficient to account for the facts. In other words, in the acute phase of the illness in the subjects studied manic (and depressive) symptoms were present but were outweighed in the majority of cases by schizophrenic symptoms. The patients were treated accordingly, and in most cases the symptoms of the schizophrenic dimension remitted more completely, leaving those of the effective dimension relatively more prominent. Attention to the affective component of a psychotic illness, in the initial as well as subsequent stages of the illness, might, as the author suggests, be of prognostic value, but to do this there is no need to squeeze a schizophrenic patient into a manic-depressive mould. Both components can be evaluated separately.

I would like to thank members of the UK/US Diagnostic Project for their guidance in the use of the Present State Examination and help in processing the data.

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DEAR SIR,

Dr. Ollerenshaw (*Journal*, May 1973, 517–30), has produced a carefully argued case for restricting the use of the term schizophrenia to patients who fail to recover from functional psychotic illness. The test, however, of a diagnostic classification is its value to those who use it, and examined in this light the proposed changes are by no means an advantage.

Basically, we hope that diagnosis reflects a common aetiology, a concept which is difficult in psychiatry where so many factors are operating. Since diagnosis is most commonly used to predict the most effective physical treatment, presumably reflecting a common biochemical change, the current classification distinguishes neuroleptic responders from tricyclic-lithium responders, which is of more value than distinguishing poor responders from good responders to psychotropic drugs as a whole. Other means of isolating a clinical entity, such as genetic, only partly support Dr. Ollerenshaw. For example, a recent twin study has confirmed genetic loading for schizophrenia but shown none for outcome (Margit Fischer, 1973).

Diagnosis is also used to standardize research, for which purpose it is essential that psychiatrists use it reliably. Although there is ample evidence that psychiatrists do not agree cross-nationally on the concept of schizophrenia, the agreement within Britain seems close (Copeland, 1971). Despite the ability of Vaillant to predict outcome successfully in 82 per cent of cases, I doubt that other psychiatrists would agree on such factors as schizoid personality, insidious onset, and affective colouring. While outcome can provide a simple validation, it would take too long to be established as useful in research, and differential drug response is quicker.

In one area at least the change might be of value, this being the prediction of outcome, However, in practice psychiatrists are reluctant to commit a patient to a poor outcome and so would underuse the diagnosis. On the other hand, when used, the diagnosis becomes self-fulfilling by inducing therapeutic apathy. These tendencies would further reduce the value of the diagnosis for research. Thus despite its inadequacies I think we do better to stick to our current concept of schizophrenia, while recognizing a subcategory with poor prognosis.

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DEAR SIR,

Several recent papers have reflected an upsurge of interest in the 'depressive phase' which frequently seems to follow the 'acute schizophrenic phase' in patients originally diagnosed as suffering from 'acute schizophrenia'.