effective treatments are applied. There is no paradox in this statement. Coppen and Metcalfe's own data give some demonstration that the M.P.I. has both properties.

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TRIAL OF OXYPERTINE FOR ANXIETY NEUROSIS

DEAR SIR,

In the October issue of this *Journal*, McAllister takes us to task for concluding on the basis of intercorrelations of approximately 0·20 or less between scores on Cattell's I.P.A.T. Anxiety Scale and independent clinical ratings of anxiety that "The I.P.A.T. Anxiety Scale does not appear to be a valid technique for the assessment of anxiety states". He does so on the grounds that the I.P.A.T. Anxiety Scale is mainly a measure of anxiety as a personality trait and that it may be valid for this purpose without necessarily having any significant correlation with ratings of anxiety as a state. We wish to make four points in reply.

First, we doubt whether it was improper of us to assess the validity of the scale by comparing test scores and clinical ratings of anxiety. Indeed, this procedure is explicitly recognized by Cattell, who on p. 9 of the *Manual* describes the intercorrelation between test scores and psychiatric assessments of anxiety as being one of the three "most conclusive ways possible" of determining the scale's external validity. It would thus appear that McAllister's views are at variance with those of the author of the scale.

Secondly, while agreeing that in general it is quite legitimate to draw a conceptual distinction between measures of personality traits and of clinical states, we doubt whether such a distinction can be applied unambiguously in the present case. In particular, it is difficult to reconcile McAllister's views with Cattell's description of the "overt symptomatic" score which is distinguished precisely to provide "*a record of actual symptoms*" (p. 6, our italics).

Thirdly, even if McAllister were right to draw this distinction with respect to the I.P.A.T. Anxiety Scale, this has no relevance to our conclusion, since at no time did we question the scale's validity as a *personality* measure.

Fourthly, we question McAllister's interpretation of the scale's purpose, which he maintains is to measure predisposition to anxiety. We, on the basis of the evidence cited in our article, suggest that the scale measures neuroticism. Since our study was not specifically designed to adjudicate between these rival interpretations, we do not wish to be dogmatic on this point. We may note, however, that our interpretation is consistent with the findings of Bendig (1960), who on the basis of an extensive factor-analytic study of anxiety and neuroticism inventories (which included the Cattell Scale) suggested that "Anxiety and Neuroticism are both manifestations of a more general emotionality factor and are not separate dimensions within commonly used inventories . . ." (p. 167).

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PHENOTHIAZINE TREATMENT IN SCHIZOPHRENIA

DEAR SIR,

To test the hypothesis that phenothiazine treatment in schizophrenia loses much of its effectiveness if its initiation is delayed, we recently studied the records of 109 schizophrenic patients.

All these patients had a well-confirmed diagnosis of schizophrenia (made independently by at least two psychiatrists), were less than 45 years old, had graduated high school, and had been in-patients in this hospital at some time more than three years prior to the study.

Our basic assumptions were that all these patients must have begun their schizophrenic illness at around the same age, and that those who had first received phenothiazines at early ages would, therefore, tend to have received them at an earlier stage in their illness than those who first received them at later ages.

As an index of how well or badly the patients did, we used the percentage of lifetime after the first psychiatric consultation spent in mental hospitals.

A Pearson correlation coefficient was calculated between the ages at which phenothiazines were first given, and the following index:

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