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.

P. ABRAHAM.

Cambridge Military Hospital,
Aldershot,
Hants. GU11 2AN.

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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.

J. M. KELLETT.

The Maudsley Hospital,
Denmark Hill,
London SE3 8AZ.

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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'.