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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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STATISTICS IN THE JOURNAL

DEAR SIR,

Alas! Every issue of your journal becomes harder to read, as research articles become more and more studded with numbers. Statistics is a valuable science but seems to be infiltrating every paragraph of medical text these days. May I make some suggestions to assist authors to pass on information in a memorable manner?

First let us agree to a simple method of reporting significance. I suggest the following:

'Significant' improvement (or difference)—means $p < \cdot 01$ (i.e. the chance of a fluke result is remote).

'Fairly significant' improvement—means $\cdot 05 > p > \cdot 01$.

This is neater and may help to avoid the trap of equating high significance with therapeutic importance.

Second, perhaps we could avoid the continental habit of unnecessary precision. To mention '8 out of 22 patients (36·4 per cent)' is absurd when the 0·4 per cent represents a small portion of one patient, less than one leg in fact! Why not omit the head count and say '35 per cent of patients'? Being so much simpler it allows readers to concentrate on the psychiatric findings without distraction, and facilitates quick comparisons.

Of course the full figures must be available for research and reference purposes, but these can profitably be confined to the tables. The less critical or more hurried reader can then assimilate the essential information from the text, quickly and in greater comfort.

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[Dr. Carr is perfectly right. We hope contributors will adopt these very sensible suggestions.—EDS.]

THE SCHIZOPHRENIAS AS NERVOUS TYPES

DEAR SIR,

Dr. Claridge (*Journal*, July 1972, pp. 1–17) rejects the traditional view of the schizophrenias as qualitatively distinct diseases, and suggests that they represent in an exaggerated form cognitive and personality characteristics found distributed among the general population.

The fact that certain characteristics, e.g. height or I.Q., are distributed among the general population does not preclude there being entities related to an exaggerated form of these characteristics, such as dwarfism and mongolism.

We have been taught that schizophrenia, unlike dementia, is a disintegration of personality without equivalent intellectual and cognitive deterioration, and that disturbance of attention (clouding of consciousness) is characteristic of delirious and confusional states, including the effect of LSD.

If we are to accept Dr. Claridge's suggestions that there is a qualitative disturbance of arousal and attention in schizophrenia, ought he not to include dementias, confusional and delirious states in his definition?

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DEAR SIR,

In reading Dr. Claridge's 'The Schizophrenias as Nervous Types', given pride of place in your issue of July 1972, my thoughts returned to the days of my youth when I first made the acquaintance of Pavlov's great works on the nervous system. It seemed to me then, as it does now, that his purely scientific discoveries of the positive and negative conditioned reflexes, and the complex dynamic processes governing their action physiologically and patho-physiologically which he elucidated, must provide the key to the mysteries of neurotic and psychotic illness.

It seems that I was mistaken, however, judging by the efforts expended on developing Pavlov's speculations on so-called typology both in the West and in the U.S.S.R. In what other branch of science would the speculations of a great scientist be given such prominence and attention to the detriment of his scientific discoveries?

My own humble contributions to a causal theory of psychiatric states, using Pavlov's basic scientific work

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,