Brit. J. Psychiat. (1976), **129**, 93–6

Correspondence

Letters for publication in the Correspondence columns should be addressed to:

The Editor, British Journal of Psychiatry, 17 Belgrave Square, London SW1X 8PG

GRID TEST OF SCHIZOPHRENIC THOUGHT DISORDER

DEAR SIR,

A. B. Hill's cogent paper on the validity and clinical utility of the Grid Test of Schizophrenic Thought Disorder (*Journal*, March 1976, **128**, p 251) fairly argues that statistical validity does not necessarily imply clinical utility. But then does 'clinical judgement' necessarily have any 'clinical utility' if it is accepted that clinical utility refers to the capacity of a procedure to be helpful to patients? Does it help patients to designate them 'thought disordered schizophrenics' whether we do this by clinical judgement or by grid test? I suggest that it probably does not—certainly A. B. Hill has not sought to find out which kind of judgemental procedure is most helpful to the patient. He has arbitrarily assumed that clinical judgement is to be *criterion* 'because it is difficult to find an alternative' and the grid test is to be *predictor* and be evaluated purely in terms of its correlation with clinical judgement.

The only virtue in the grid is that it has what Hill refers to as a 'clear and appealing rationale', whereas clinical judgement has little by way of rationale, it is a descriptive response which says nothing as to the 'why' or the 'how' or the 'what do we do about' of schizophrenic thought disorder.

Till the day when either grid or clinical judgement provides us with an argument from which we can derive a way of helping the so-called thought-disordered schizophrenic (such as was attempted by Bannister *et al*, 1975), neither grid nor clinical judgement has 'clinical utility'. They both do no more than provide bases for exploration.

D. BANNISTER

Bexley Hospital,
Old Bexley Lane,
Bexley, Kent DA5 2BW.

REFERENCE

BANNISTER, D. *et al* (1975) Reversing the process of thought disorder: a serial validation experiment. *British Journal of Social and Clinical Psychology*, **14**, 169–80.

PSYCHOSIS DUE TO NASAL DECONGESTANT ABUSE

DEAR SIR,

The schizophrenia-like reactions caused by abuse of amphetamines and related substances are well known. In 1964 amphetamine sulphate ('Benzedrine') was withdrawn as a constituent of nasal decongestant preparations because of these effects. It was replaced by propylhexedrine, a sympathomimetic agent with similar chemical structure and vasoconstrictor properties but with little stimulant action on the central nervous system. I wish to report a psychotic reaction due to abuse of the propylhexedrine inhaler, 'Benzedrex'.

A 24-year-old single female student had for a year found increasing difficulty in concentrating on her course and had failed to sit class examinations. She felt continually tired. Her parents found her withdrawn and depressed. She presented to the psychiatric department on 9 October 1975 shortly after becoming delusionally convinced that she was radioactive and that radio and television were 'bugged' and were watching her. There was blunting of affect but no evidence of visual or auditory hallucinations. She had no insight into her condition. She had a successful record at art school and no history of psychiatric illness. However, both an elder sister and a maternal uncle are schizophrenic.

An initial diagnosis of schizophrenia was reconsidered when the patient admitted later to having taken one or two 'Benzedrex' inhalers (each 250 mg) a day for much of the previous two years, removing and chewing the contained propylhexedrine-impregnated strip. This gave her 'a lift' with the impression of more efficient studying. When the effect wore off she was left tired and lethargic. She had occasionally experimented with cannabis, but never for any length of time.

Following admission to hospital the symptoms at first persisted despite chlorpromazine therapy. However, an illicit source of inhalers was discovered, and when this was finally stemmed she made a gradual