

References

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FAMILY AND SOCIAL FACTORS IN THE COURSE OF SCHIZOPHRENIA

DEAR SIR,

In their letter (*Journal*, April 1977, **130**, p 417) in response to an earlier letter from ourselves in which we criticized certain aspects of their work concerning the influence of relatives on relapse in schizophrenia, Dr Leff and Professor Brown have cleared up some of the issues which troubled us.

It is true that in the 1972 paper by Brown *et al*, we had taken first episodes as meaning first admissions, a thing it is easy to do in reading an account of a study which uses 'key admission' as the base for research design and analysis. In fact, no mention is made in the 1972 paper, or in Vaughan and Leff's 1976 paper, as to what proportion of their sample were first admissions. The authors have now pooled their data and analysed first and readmissions separately, and have found that High Expressed Emotion (EE) in relatives towards the patient is predictive of relapse in both cases.

However, the matter is not entirely resolved, because the authors have missed the central point of our criticism, which is that the raters were, in the case of readmissions, probably rating factors (those composing EE) used to predict outcome (relapse in the nine months after discharge) in the knowledge of outcome. This conclusion is based on the fact that in the 1972 study relapse led to readmission in 83 per cent of cases, and the analysis of correlations between the variables showed that previous admissions were highly correlated with relapse, ranking second to high EE. The raters can hardly have been unaware of the pattern of previous admissions.

Thus the authors have established the important fact that their findings concerning EE apply to first admissions, but there must remain a reservation about the ratings of EE for readmissions.

Professor Brown and Dr Leff evidently do not think much of a pencil-and-paper test compared to their painstaking ratings of the components of EE. However, now that we know that high EE predicts relapse in first admissions and, as indicated in our letter (*Journal*, January 1977, p 102), that our self-rating interpersonal perception technique have some power to predict relapse during the nine months after discharge in a sample of 40 first admissions, it seems likely that our test was measuring some of the same factors as contributed to the rating of expressed emotion. In our test, the patients and parents score the test at the same time in the same room, and this generates considerable feeling and emotional commitment in the great majority of cases. In this situation, we have found that both patient and parents will score on paper terms about themselves and each other which it can be difficult to get them to express in words. This probably accounts for our test giving significant results in several realms, and it looks promising in the present context. The advantage of a technique which does not require a trained rater and which can be administered in about 30 minutes, is obvious.

R. D. SCOTT
T. FAREWELL
D. PARIENTE

*Napsbury Family Research Unit,
Napsbury Hospital,
Nr St Albans, Herts*

DEAR SIR,

Dr Scott and his colleagues are fighting a rearguard action against logic. They agree that we have demonstrated that high Expressed Emotion is predictive of relapse *within* the group of patients who have had previous admissions. Yet they maintain that knowledge that the patients were readmissions enabled us to predict outcome and hence biased our assessment of Expressed Emotion. Knowledge that a patient has had previous admissions enables one to predict a worse outcome than in the case of a first admission. But *within* a group of readmitted patients it does not help one to determine who will do well in the subsequent nine months and who will relapse. This is exactly what the measure of Expressed Emotion does enable one to do.

It is worth emphasizing that we built into the design of our studies a precaution against any extraneous factors biasing the assessment of Expressed Emotion. Checks were made on the reliability of the ratings by having another rater assess the taped interviews blindly. In the most recent study, Leff rated a random selection of Vaughan's audio tape recordings without knowing which families they

pertained to. There was no indication on the tapes whether the patients were first admissions or readmissions. As reported in our 1976 paper, the interrater reliability was 0.86 (product moment correlation). We hope this finally puts to rest the qualms of Dr Scott's group.

With regard to their second point that their test may measure some of the same factors as ratings of Expressed Emotion, we consider that this is entirely possible but needs to be demonstrated by the simultaneous use of both instruments in the same families. Our Family Interview has gone through a long process of refinement and streamlining. We have recently shown that for ratings of Expressed Emotion the original 4- to 6-hour interview can be legitimately reduced to one hour. We are concerned to continue this process and are currently experimenting with further modifications with a view to producing a practical clinical tool.

JULIAN LEFF

*Institute of Psychiatry,
De Crespigny Park,
Denmark Hill,
London SE5*

GEORGE BROWN

*Department of Sociology,
Bedford College,
Regent's Park,
London NW1*

ALCOHOLISM AND PSYCHIATRIC DISORDER: SOME FURTHER DATA

DEAR SIR,

Theories which suggest a possible relationship between psychiatric disorders and alcoholism alternatively hypothesize that alcoholism is (1) a *secondary* symptom which through chronic abuse or attempts at self-medication acts to mask an underlying psychiatric disorder, or (2) a *primary* disorder equivalent in relation to another psychiatric disorder in the sense of being a pleiotropic expression of the same etiological process (1-3).

In a recent study of the effects of the repeal of alcohol regulation laws in Sweden in 1955 on the rates of psychiatric hospital admissions and treatment for alcohol addiction and abuse over several subsequent years, Herner (4) reported data which bear on the validity of these theories. From the Table comprising Appendix I in Herner's publication we subtracted the male admissions for alcoholic disorders from the total number of admissions, and reanalysed the data in terms of the effect of repeal on both alcoholism and other psychiatric disorders separately.

In his original evaluation, Herner accounted for the extraneous effects of increased population, the enlargement of treatment facilities and available beds, and the rates of alcohol consumption following repeal, all of which were consistent with natural and expected increases in the total rate of admissions. The data represented admissions to all but a few treatment facilities in Sweden for the period evaluated. We deleted data for rates beyond 1961 due to spurious increases attributable to change in the reporting method and because these data were well removed from the period of interest.

The above theories predict that an increase in admissions for alcoholism will reveal a compensatory reduction in admissions for psychiatric disorder. As shown by the Figure below, repeal more than doubled the proportion of admissions for alcoholism from 1954 baselines, while the rate of admissions for psychiatric disorders remained constant and within expectancy for the period. The respective increases in admissions for alcoholism and psychiatric disorder between 1954 and 1955 were 555 and 325 cases, the 1955-56 increases were 1,234 and 356 cases, and the 1956-57 increases were 156 and 270 cases. Proportionately, admissions for alcoholism which comprised 19 per cent of all admissions in 1954 increased to 32 per cent by 1956. This proportion was thence maintained for the remainder of the assessed period.

At face value, these data tend *not* to confirm general explanations of alcoholism as a phenomenon secondary to an underlying psychiatric disorder or as a primary disorder equivalent. Reservations regarding this conclusion include the possibilities that (1) some cases of alcoholism had been misclassified as psychiatric disorder and thus masked the reduction and (2) that alcohol precipitated admission to hospital of persons predisposed to psychiatric disorder misclassified alcoholic. The applicability of these explanations to the non-observed expectancy, however, appears somewhat remote in the face of the large increase in admissions for alcoholism which resulted. Alcoholism in the study was defined as WHO classifications 307 and 322 (5).

JOE GALDI
ROLAND BONATO

*Biometric Laboratory,
The George Washington University,
11501 Huff Court,
Kensington, Maryland 20795, USA*

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