What their interesting investigation demonstrates, is again the poor therapeutic effectiveness of unilateral ECT.

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CHANGES IN SELF-RATING OF SYMPTOMS

DEAR SIR,

Bedford, Edington and Kellner (*Journal*, January 1979, **134,** 108–10) assume that response set 'is likely to make a test more stable, i.e. less sensitive and therefore less suitable for the measurement of changes related to treatment'. Though agreeing with the latter point, our own experimental work leads us to disagree totally concerning the assumption of greater stability. We have conducted a number of experiments to examine behaviour of response set with re-testing. A wide variety of subjects have been asked to rate photographs of faces for a number of items, some connected with psychiatric symptoms, especially mood and anxiety. Where *unipolar* item scales have been used (5 and 7 point and 100 mm line) they were perceived invariably though unwittingly as *bipolar* scales with an assumed opposite pole and mid-point. We have found that the sum of all scores lying above the mid-point initially falls dramatically on a subsequent occasion a week later. Similarly all scores below the mid-point move upwards.

In one experiment ten subjects were tested on four weekly occasions and the effect was seen even up to the fourth week. Calculations were made using both the *explicit* mid-point (i.e. 3 for 5, or 50 mm for the 100 mm line) and the *implicit* mid-point (grand mean of all scores). Some differences between the two methods are evident, but the picture overall is the same regardless, and changes in scores followed this way are significant beyond the 0.001 level. An implication arising is that rating scales containing items scaled for severity in the same direction, giving a simple total score, could show a drop in severity with re-testing alone (the photographs do not change).

We have conducted a *post hoc* test for this by extracting an eight item scale (from 18 items) equivalent to a depression/anxiety rating scale for two of our experiments. Where subjects initially rated high (one standard deviation or above), then on re-testing there was a fall significant beyond the 0.05 level thus confirming our prediction. Further research is being conducted with recorded speech and for the effect of drugs on change in response set with re-testing.

We do not suggest, of course, that the patients in the study by Bedford *et al* did not benefit from treatment but we think another explanation is available. Their sentence 'after affirming an item the patient then rates the intensity or frequency of occurrence of that item' is in our terms *those scores which initially fall above the mid-point*. We hope soon to publish our preliminary data in full and regard this 'Heracleitean Phenomenon' as an alternative explanation for the so-called placebo effect and a hitherto unrecognised serious source of error variance in treatment studies.

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CONVERSATIONS WITH SCHIZOPHRENICS

DEAR SIR,

Dr Morgan's account of his conversations with a group of chronic schizophrenic patients (*Journal*, February, 1979, **134,** 187–94) is of considerable interest to those working with similar patients, and compels admiration for his persistence, compassion and humour.

However, we have recently completed a study of 'old long-stay' patients which suggests it may be easy to form a misleadingly simple picture of their behaviour and overlook aspects which show it in a more complex light. Their shrewd understanding of what mattered to them day-to-day emerged clearly in our study, as indeed it does from Dr Morgan's conversations, and it is difficult to understand why he gives this little weight in comparison to interest in fields such as politics, from which they will have been excluded for most of their lives.

However, it is clear that his patients are severely disabled, having been selected by failure to respond to a sustained programme of social and occupational rehabilitation. Uncertainty about the precise effect of their disabilities is less important than doubts about the fundamental conclusions he draws from them about the course of schizophrenia. Dr Morgan assumes that the current levels of disability are due to continuing progression of schizophrenic illnesses, and that therefore 'the current community-orientated style of managing such illnesses will result in such chronic schizophrenic patients becoming no less disabled outside hospital after a similar length of illness'.

But he offers no evidence that his patients are undergoing a continuing process of deterioration. What he describes are intractable rather than progressive disabilities: a crucial distinction. Amongst a sample of the most disabled long-stay patients in

Goodmayes we did not find a single example of the progressively deteriorating course which is the traditional stereotype of chronic schizophrenia. All the patients had either been maximally disabled at the time of first admission to hospital, or their deterioration had ceased to progress at least ten years previously; the end-state described by Bleuler (1972) in *Die schizophrenen Geistesstorungen im Lichte langjahriger Kranken- und Familiegeschichte.*

This evidence that chronic schizophrenia tends to stabilize is supported by a number of long-term studies, including Bleuler's own personal follow-up of over 200 patients and Daum, Brooke and Albee's 20 year follow-up of 253 patients, and accords well with clinical experience.

This is not, of course, to suggest there will be no chronic schizophrenics in the community, but taken in conjunction with evidence that the most severe and crippling forms of the illness are less common than in the past (Hogarty, 1977, *Schizophrenia Bulletin*, **3**, 587–99) it predicts a more hopeful future than the tenacious myth of inevitable, progressive deterioration.

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Reference

DAUM, C. M., BROOKS, G. W. & ALBEE, G. W. (1977) Twenty year follow-up of 253 schizophrenic patients originally selected for chronic disability. *The Psychiatric Journal of the University of Ottawa*, **2**, 129–32.

NO LUNG CANCER IN SCHIZOPHRENICS?

DEAR SIR,

I was prompted by the letter from Dr D. Rice (*Journal*, January 1979, **134**, 128) and by the recent death of one of my chronic schizophrenic patients to look at post-mortem records at Rainhill Hospital—made available to me by Dr A. S. Woodcock, F.R.C.Path. In the past five years post-mortem examination has confirmed the presence of lung cancer in eight patients. Three with no previous psychiatric history had an acute psychotic episode of the type familiar in this condition; two had long-standing recurrent depressive illnesses; three were typical chronic schizophrenic patients of at least twenty years duration before the terminal illness. Two of them had been continuously in hospital (since 1953 in one case and 1956 in the other), while the third had been maintained at home, thanks partly to a supportive family. Histologically the tumours were: oat cell, poorly differentiated squamous, and a well differentiated papillary adenocarcinoma.

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BRITISH POLICY ON OPIOID MISUSE

DEAR SIR,

Professor G. Edwards (January, 1979, **134**, 1–13) refers to a paper of mine (1) by the wrong title, date and page, and misquotes some figures from it. He has made the mistake of combining results from my study with those of a previous one by Bewley *et al* (2), though he lacks the necessary data. The passage in his article should have read: 'of 112 opioid users whose deaths were reported in the United Kingdom, 24 were not known to the Home Office before they died'. These deaths deserve more attention than Edwards has given them because they represent some of the price paid for the present British policy.

The prescribing of NHS heroin or methadone—whether this is done by general practitioners or by specially licensed doctors—does not protect against the high morbidity, mortality and infectious nature of opioid misuse (1, 4). There is, therefore, an alternative option to the ones Edwards has proposed. This is to stop the prescribing of opioids for self-administration altogether, and for medical personnel to administer them to patients considered suitable for maintenance treatment. The advantages of this approach are that it would diminish the above risks, officially acknowledge that the medical risks are too great to justify using medical means (prescribing opioids) for social ends ('keeping the Mafia out') and enable different maintenance schedules to be tested. Certain problems would remain such as when to start maintenance treatment (5) for a 'new case' or for one who has relapsed, and when to stop because, say, a patient is misusing illicit drugs. The disadvantages would include the logistics of implementing this scheme and the possibility of stimulating a criminally organised black market.

Although it may have been justifiable in 1967 to be so fearful of what might happen, Edwards shows that there is less cause for alarm today and that the present policy should be reviewed.

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References

(1) GARDNER, R. (1970) Deaths in United Kingdom opioid users 1965–69. *The Lancet*, **2**, 650–3.