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

LOTHAR B. KALINOWSKY

30 East 76th Street,
New York, N.Y. 10021

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.

GERALD SILVERMAN
MANGAL KATZ

St Bernard's Hospital,
Southall, Middlesex

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