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Correspondence

INTERVIEW GUIDES

DEAR SIR,

Dr. Michael Rutter's review (*Journal*, April, 1969, pp. 501–2) of my Systematic Interview Guides prompts me to justify my decision to make them available for publication.

When I began my studies of the aetiology of behaviour disturbance some 23 years ago, I found myself handicapped by the total lack of instruments for the systematic recording of either the behavioural data by which the conditions could be identified, the social circumstances which might predispose thereto, the prenatal antecedents in the form of maternal illness or mental stress, or collateral impairments in the child. A large part of my work has consequently been taken up with the development of such research tools. For the assessment of disturbed behaviour this has resulted in the compilation of the Bristol Social Adjustment Guides, which by positive correlation with independent assessments and early-life antecedents have gained a measure of validity (Stott and Sykes 1956, Stott 1966a).

My studies of the prenatal factors in mental retardation and behaviour disturbance (Stott 1957, 1959) similarly forced me to systematize the recording of data on pregnancy and early life. Doing so made me appreciate the complexity and above all the degree of interaction of the factors involved, to the extent that no field experiment could have aetiological validity which did not include *comprehensive* data. Owing to the phenomenon of multiple congenital impairment (Stott 1966b) significant results can often be obtained by correlating isolated pairs of variables, from which spurious conclusions may be drawn. The most blatant examples have been studies of institutionalized children without taking account of the reasons for institutionalization or failure to place for adoption (illegitimacy, infantile morbidity, suspected retardation, etc.). Comprehensive data are also required for studying the effects of cumulative insult.

Not only, in recent years, have many studies been published which failed to take account of any but the small number of variables of interest to the investigator, but also the techniques for obtaining even these data have been such as could vitiate the result. In one reported study, for example, the investigator merely asked the mothers: 'Did you have any emotional upsets during the pregnancy?' instead of eliciting the degree of situational stress to which she might have been subjected by such questions as, 'Did any dear relative die or contract a fatal illness during the pregnancy?' or 'Were you happily settled the whole time in a home of your own?'

Without any standard data schedule to use or consult, investigators (with limited time for a particular research) are forced more or less hurriedly to compile their own, not only without an opportunity to validate it, but often without experience of the possibly significant variables. Apart from the faulty methodology of lack of comprehensiveness, such 'off-the-cuff' schedules are likely to be seriously defective. Surely there is some advantage, in these circumstances, in having readily available schedules which have been the result of another worker's experiences, even though these have to be taken on trust for the time being. In this connection I make bold to add that for many years I was in close consultation with Dr. C. M. Drillien in Edinburgh, whose follow-up studies of premature children are widely known and unexceptionable. Although she did not wish to claim joint authorship of the Systematic Interview Guides, she allowed me to quote her endorsement of the medical and developmental parts of them.

Dr. Rutter's criticism of lack of normative and validating studies is well taken. Since he himself has undergone the travail of producing similar instruments—even though he has eschewed commercial publication—I am sure that he can testify to the practical difficulties by way of expense and the time needed for adequate validation. A matter of 20 years can elapse between the beginning of the compilation of such an instrument and a 'satisfactory' final and well-validated edition. By making it available a number of co-workers can participate in this task by the use of samples drawn from varying populations.

In effect, normative and validating studies are in progress. One is a follow-up study from birth of some 200 infants in the West of Scotland. Another covers 1,000 four-to-five-year old children in Ontario. The results of these will be available within a year. For those who would like to make use of them, computer ized automatic data-reading sheets are now available for both the Prenatal and Birth-to-Five Years Guides.

Finally, in reply to Dr. Rutter's jibe about the paucity of references to studies of the reliability of case-history data, I quoted the two that were avail-

able at the time of publication two years ago. Since then others, or references to reliability, have appeared, which I would be pleased to make available to anyone interested.

The value of the Systematic Interview Guides has been demonstrated in a small way from a recent study of 'Inconsequential' (minimally brain-damaged) children in Ontario. It gave highly significant correlations between the pregnancy stress scores derived from the above and, on the one hand, the indications of pre-school maladjustment recorded on the same instrument, and, on the other, the subjects' scores on the Bristol Social Adjustment Guides some twelve years later. This report has been submitted for publication, and duplicated copies of the article are available.

It seems to me, in short, that although Dr. Rutter is right in drawing attention to the lack of published norms, his indignation about these instruments being published is unjustified. Moreover, he gives no grounds for his verdict on them as 'unsatisfactory'.

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CLASSIFICATION AND GLOSSARY OF MENTAL DISORDERS

Dear Sir,

I refer to the letter from Dr. Peter Sainsbury (*Journal,* June, 1969, p. 743), in which he appeals to psychiatrists to use the new Revision of the Classification of Mental Disorders.

In July 1964 the Ministry of Health wrote to hospitals for the mentally subnormal and asked these hospitals to introduce the classification devised by Rick Heber in 1959 for the American Association on Mental Deficiency and to use it in completing Box 16 of the Mental Health Inquiry Hospital Index Card A. So far Heber's classification has generally proved to be more useful and acceptable to workers in mental retardation than the International Classifications. The American Classification has three parts 'Clinical', 'Behavioural' and 'Intelligence Levels', although only the clinical section is being widely applied in hospitals for the mentally retarded in this country at the present time.

For psychiatrists not immediately involved with mental retardation and who may be unfamiliar with Heber's Classification, the reference is: *A Manual in Terminology and Classification in Mental Retardation* by Rick Heber. Monograph Supplement to the American Journal of Mental Deficiency, September 1959. Published Albany, New York State, 1959.

In practice the expression of Heber's Classification in terms of an equivalent International Classification Code is not difficult and can be readily standardized, so that the two systems of classification can be regarded as complementary.

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PSYCHOTHERAPEUTIC STATUTORY INSTRUMENTS

Dear Sir,

In the past ten years in one locality, I have occasionally been struck, as must others similarly elsewhere, by remarkable degrees of failure to protect psychiatric patients (from the worst excesses of their lack of insight or loss of judgement) because of a reluctance to initiate compulsory admission to hospital. Thus, hypomanic patients have been allowed irrevocably to squander their livelihoods, and comparatively well-to-do schizophrenics to live for months or even years in conditions of unchecked squalor, before the psychiatric services were eventually brought sufficiently to bear to permit others to manage the patients' affairs and the latter to receive the modern effective treatments available.

Admittedly, it can be difficult at times even for the expert, on insufficient acquaintance in a busy out-patient department, to distinguish mild hypomania from the hail-fellow-well-met, or degrees of schizophrenia from eccentricity, especially if the family doctor or others whose acquaintance with the patient may be longer have themselves failed to