in age and sex structure and in terms of the form of the EPI taken would have been desirable.

G. K. SHAW.

Bexley Hospital,
Bexley, Kent.

E. H. HARE.

The Bethlem Royal Hospital,
Beckenham, Kent.

REFERENCES

BARTHOLOMEW, A. A., and MARLEY, E. (1959). "The temporal reliability of the Maudsley Personality Inventory." *J. ment. Sci.*, **105**, 238–40.

COPPEN, ALEC, and METCALFE, M. (1965). "Effect of a depressive illness on MPI scores." *Brit. J. Psychiat.*, **111**, 236–9.

EYSENCK, H. J., and EYSENCK, S. B. G. (1964). *Manual of the Eysenck Personality Inventory*. London: University of London Press.

LEVINSON, F., and MEYER, V. (1965). "Personality changes in relation to psychiatric status following orbital cortex undercutting." *Brit. J. Psychiat.*, **111**, 207–18.

SHAW, G. K., and HARE, E. H. (1965). "The Maudsley Personality Inventory (short form) distribution of scores and test–retest reliability in an urban population." *Brit. J. Psychiat.*, **111**, 226–35.

DEAR SIR,

Dr. Shaw and Dr. Hare suggest that the changes in N and E scores we obtained in depressed patients were due, not to the additional sentence we added to the test instructions, or, subsequently, to recovery from the illness, but to the fact that people always obtain lower N and higher E scores on retesting.

Their letter conveys the impression that there is clear evidence in the literature that N scores fall and E scores rise when people are given the MPI or EPI a second time, but this is not so. They reproach us for "failure to take cognizance of the implications of earlier studies", yet they themselves, rather curiously, fail to take cognizance of Knowles' (1960) study of the temporal stability of the MPI. Knowles gave this test to a group of ninety-two neurotics and normals on two occasions a year or more apart. Their mean N score was 25·2 on the first occasion and 25·5 on the second; their mean E score 23·1 on the first occasion and 22·5 on the second. The percentage change in N score is +1·2 per cent and that in E score =2·9 per cent. Both changes are trivial but are, of course, in the opposite direction to those required by Shaw and Hare's hypothesis. Of the studies which they quote in support of their hypothesis, Levinson and Meyer's patients were tested before and after a leucotomy, Coppen and Metcalfe's before and after recovery from a severe depressive illness, and many of Bartholomew and Marley's subjects were neurotics who at the time of retesting regarded themselves as "markedly improved as compared with the first testing in hospital". There may be no logical absurdity in attributing the changes in score that took place in these patients simply to increasing test familiarity, but, as in the whisky and water, rum and water, gin and water argument, there is a certain commonsense absurdity. Certainly none of these authors themselves interpreted their results in this way. Moreover, we understand that Coppen and Metcalfe have recently found that when patients become depressed a second time their N scores rise again and their E scores fall again, in spite of their increasing familiarity with the test.

The only work which does suggest that MPI or EPI scores change independently of any change in clinical state is Shaw and Hare's own study of 239 adults, randomly chosen from an electoral register, who were given the short form of the MPI on two occasions a few weeks apart. In this group the mean E score was almost identical on retest (7·22 compared with 7·19) and the mean N score fell from 5·39 to 4·79. Two comments seem pertinent to these findings. In the first place Dr. Hare and Dr. Shaw seem to be confusing statistical significance with practical importance. Their fall in N score is statistically significant because their sample is large, but it could be produced by less than one patient in three answering Yes to one more question. The changes in N and E score we obtained, on the other hand, require, on average, every patient to change his answer to five different questions. Secondly, Dr. Hare and Dr. Shaw's subjects were, as we understand it, tested by someone they had never seen before who arrived at their homes to ask them a lot of questions whose purpose and relevance must have been difficult for them to grasp. It is easy to visualize how such a situation might produce anxiety, and how this anxiety would be less on the second occasion. Our patients were in quite a different situation. They were in hospital, and even before the first administration of the EPI most would already have been required to complete a Cornell Health Questionnaire, a Mill Hill Vocabulary Test and Raven's Matrices, and so would have been only too familiar with the questionnaire situation. In many cases the test administrator was already well known to them, and the two forms of the test were given, not several weeks apart, but always on the same day and usually at the same sitting.

We have listed these considerations because we felt we ought to make a formal reply to Dr. Shaw and Dr. Hare's criticisms. But at the time our most

important reason for interpreting our results as we did was much simpler. It was clear to us, from the spontaneous comments of our patients, that they were misinterpreting the standard test instructions and that the sentence we later added altered the meaning of these for them. Time and again the standard form would be handed back with some such comment as "Of course, I didn't use to be like this" and our amended form would be received with "Oh, I see, now you want to know how I used to be before this depression came on. Is that it?" Nor do we remember anyone, on receiving the amended form, telling us that he had already discounted the symptoms of his illness on the first occasion.

One final point. Dr. Shaw and Dr. Hare suggest that our results may have been distorted by unequal numbers of patients receiving the A and B parallel forms of the test on recovery. A more careful study of our description of our results will make it clear that this possibility was both foreseen and allowed for.

R. E. KENDELL.

Institute of Psychiatry,
London, S.E.5.

W. J. DISCIPIO.

Bronx State Hospital,
New York City.

USE OF SECTION 26, MENTAL HEALTH ACT

DEAR SIR,

Dr. Alarcon's letter (*Journal*, January 1969, p. 126) raises points which need critical evaluation.

The Act rightly recognizes that patients are not either mentally ill or mentally well, and as the Mental Health Act is now constituted treatment under Section 26 includes out-patient treatment. It is possible to commence treatment without even disturbing the patient's residence and employment, and this can be valuable when the patient lives a long way from the hospital. In principle full hospital review at not less than six monthly intervals seems a small imposition if the Order's continuation is in fact necessary. The trial leave period would be better extended to coincide with the normal expiry of the Order.

We have found that the major difficulty is in administration. This is caused by the patients not complying with the Order because they have been notified too late of their appointment time. This also allows them, if they wish, to evade the Order.

The residential requirement is particularly necessary with the addicts and psychopaths. These patients require the stability of the hospital until they have finally established themselves. The residential requirement ensures that they also meet the nurses and social workers, upon whom are based many of their relationships and profit from their new environmental experiences. These meetings are particularly valuable in view of the medical staff shortage and the large numbers of patients that have to be treated. The majority of these residential requirements are fulfilled during the week-end, thereby avoiding disruption of the patient's working life.

Patients who have travelled across country would, I believe, resent only a short out-patient review of their achievements, especially if this were conducted by a member of the medical staff with whom they were not acquainted. Some of the patients welcome the feeling of security provided by the Order, and a number have asked for the Order to be extended, even when it was not felt to be clinically necessary.

I would doubt if guardianship could give the continuity and quality of care needed by psychopaths and addicts, even if suitable guardians could be found. The physician certainly needs more resources than those normally available to guardians when dealing with these groups of patients.

I would accept Dr. Alarcon's viewpoint so far as most of the psychotic mental illnesses are concerned, but in these cases it is usually possible to discharge the patient to the care of the general practitioner or the industrial medical officer as soon as he is stabilized.

These changes would, however, entail either recognizing addiction as primarily a psychopathic disorder, whereas we now regard it as a mental illness with the social aftermath and psychopathy as directly following the addiction; alternatively, it would be better to recognize addiction as a separate legal entity for the purposes of Section 26 (2) (a) (ii).

The security which the various sections of the Mental Health Act give the employer and the patient's family as well as to the patient are important factors in using the Act for the patient's treatment.

JOHN HARDING PRICE.

St. John's Hospital,
London Road,
Lincoln.

THE BRITISH SOCIETY FOR PHENOMENOLOGY

DEAR SIR,

The British Society for Phenomenology will begin publication of a new journal in the autumn of 1969 under the editorship of the undersigned. It will