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Correspondence

Letters for publication in the Correspondence columns should be addressed to:
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PSYCHIATRIC CASE-WRITING

DEAR SIR,

Kiernan, McCreadie and Flanagan (*Journal*, August 1976, **129**, 167), believe that the 'essence of healing is the detailed and intimate knowledge of psychopathology' and consequently they are saddened by the poor quality of case-history taking by junior medical staff. I was not previously aware that *knowledge* was the essence of healing. It would seem to me that it is not the possession of this knowledge of psychopathology but what the healer does with it when he has obtained it that is important to the essence of healing.

Consultants who insist on complete and detailed case-histories have ward rounds which may develop into inquests. The luckless junior doctor fears the embarrassment of being seen to have failed to gather some piece of information. Consequently his working day is spent in information-gathering so that when the weekly round comes about he can sit comfortably at ease. He finds his professional week becomes a matter of being one jump ahead of the consultant rather than spending the time with the patients letting them talk.

I have gained the impression that the consultant, although requiring detailed knowledge of the psychopathology, is no more able to make use of it psychotherapeutically when he has gained it than are his juniors. Could it be that his insistence on detailed knowledge is a smoke-screen to hide this inadequacy? For after all, if the case presentations are long enough, there is not much time left to discuss treatment.

Are Drs Kiernan, McCreadie and Flanagan concerned about the ongoing *outcome* of the patients, whose detailed case-histories they so laboriously require from their juniors? Have they performed any outcome studies on their patients? If so, have they been able to show that the improvement was due to a detailed knowledge of their psychopathology rather than to the Valium, the Modecate, the lithium, the ECT, etc? Or maybe, it was due to the healing essence of a junior doctor who was more concerned about, say, conjoint psychotherapy with married couples or developing a therapeutic peer-relationship with a disturbed adolescent? This activity takes much time and interferes with information gathering.

I feel that Drs Kiernan, McCreadie and Flanagan 'tithe mint rue and cummin' in their psychopathology information-gathering and 'neglect the weightier matters of the law' in the assessment of therapeutic outcome for different patients and for different psychotherapeutic techniques.

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RESEARCH IN PSYCHOTHERAPY

DEAR SIR,

The Medical Research Council's Neurosciences Board wish to encourage more research into the various forms of treatment of the neuroses, with special emphasis on psychotherapy. They invite applications for research in this area. The submission of proposals in short draft form (1 to 2 pages) is requested in the first place. Scientifically promising proposals will then be singled out and the applicants invited, without commitment, to submit a formal programme or project grant application for full scientific assessment in the usual way.

The scope of the term 'psychotherapy' is wide, and for this purpose is intended to exclude proposals limited purely to behaviour therapy, because a good deal of work on this aspect is already being supported by the Council. While the main concern should be with forms of psychotherapy (group or individual) as practised within the NHS, the field need not be so narrowly confined as to exclude other proposals. Applications may cover work by non-medically qualified or medically qualified personnel.

The following suggestions are intended as a guide only, and applicants need not be deterred if their proposals do not fall within the following areas of research:

1. Decision-making by GPs and others as regards referral of patients for psychotherapy. This covers both the social networks involved and the psychosocial changes within patients that may occur during the process of referral.
2. Studies of the 'process' (in its wider sense) of psychotherapy and of the outcome of such intervention.

3. Interactions between psychotherapy and other treatments having a different theoretical and empirical basis, including the use of drugs and social measures.

Applications are likely to be more favourably received if they refer not to ill-defined conditions like 'personality disorder' but to groups of patients diagnosed as suffering from a neurotic disorder with identifiable or definable symptoms or associated conditions such as attempted suicide, phobias, situational crises like bereavement, or reactions to chronic medical or psychological disabilities. The methods of treatment proposed for study should, as far as possible, be described in specific terms.

Applicants may ask for whatever is needed to carry out the study to evaluate methods of treatment, though it should be noted that salary support for psychotherapists actually carrying out the treatments would need careful scientific justification and that no administrative overheads can be provided.

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FAMILY AND SOCIAL FACTORS AND THE COURSE OF SCHIZOPHRENIA

DEAR SIR,

The studies of Brown, Birley and Wing on the influence of family relationships on outcome in schizophrenia, reported in their replication study (*Journal*, September 1972, 121, p 241) and replicated again by Vaughn and Leff (*Journal*, August 1976, 129, p 125), are gaining general acceptance in the United Kingdom and therefore require to be carefully assessed in the light of other work done in this field. Their studies, showing that high Expressed Emotion (EE) by a key relative towards the patient, independently of other events, predicts relapse have two main points of weakness. These arise from the composition of the samples. The sample used in the 1972 paper is composed of 27 per cent first admissions, the remainder of the patients being divided about equally between those with a history of less than five years, and those with a history of more than five years, since first breakdown. The pattern of outcome in schizophrenia is usually quite apparent by two years and often by one year after first breakdown. Thus Brown and his co-workers are, in the majority of cases, rating EE in key relatives and using this as the key predictor of relapse when the pattern of outcome is already known. For instance, in the table showing correlations between the variables, previous admissions are significantly related to relapse and rank only second to high EE (p 258, 1972 paper).

Secondly, in using readmissions these workers are depriving themselves of direct access to the question of how high EE arises and when. For this purpose they have to use inferences derived from partial correlation coefficients and retrospective ratings. These weaknesses could be avoided by using a sample of first admission patients. The Napsbury Family Research Unit has recently completed a four year study of 40 first admission schizophrenics from parental homes. Using a self-rating interpersonal perception technique (1970), patient and parents were tested shortly after the first admission and again 2½ years later. In this study, Brown's concepts were not used, but the test scoring available from this study is easily adapted to score a number of critical comments made by parents about the patient, as well as to provide some measure of degree of parental involvement with the patient (two central features of EE). We therefore scored the test material in this way and found that the test given soon after first admission had some power to predict good and poor outcomes 2½ years later, these being rated in terms of a patient's capacity to function socially and at work. It also gave some distinction between those who relapsed and those who did not during the nine months after first admission ($P < \cdot 04$ Mann Whitney). The second test given at follow-up showed that the association between the test score and these two measures of outcome had increased enormously ($P < \cdot 0002$).

If we accept the thesis that high EE as an independent factor is a cause of relapse, and that the test scoring indicated above provides some measure of EE, then our findings may be summarised as: (a) high EE is likely to have been present in 20–30 per cent of parents long before the first breakdown and to have been a factor leading to it; (b) in patients with good outcomes, the test score thought to be associated with EE decreases dramatically during the follow-up period; (c) in patients with poor outcomes, high EE develops very early on (probably quite abruptly) and thenceforth shows no significant change; it becomes encapsulated, thus rendering the parents' attitude unrelated to other events, including how well or ill the patient is; this in turn causes relapse and maintains the illness; and (d) whether (b) or (c) occurs is, in about 75 per cent of cases, closely related to the patient's attitudes to his parents (1975).

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