that this 'metamorphosis' has taken place in clinicians' assumptions, in treatments, and in the quality of follow-up studies, rather than in the disorder itself. We concluded, however, that '*a move away from self-fulfilling prophecies regarding the inevitable deterioration of this condition augurs well for the innovative care of patients, and should stimulate further research into modifying the preventive strategies*', which is in keeping with the sentiments expressed by Murthy.

In our current paper we have attempted to give a clear cross-sectional account of outcome at 13 years in schizophrenia. We are surprised at Murthy's suggestion that there is a 'bias' towards chronicity in the reporting of our data, since the percentages quoted in our concluding remarks, and the abstract refer to those subjects without symptoms and without disability at follow-up. The finding that only 17% of the sample were alive at follow-up, without symptoms and disability, and receiving no treatment, should not be taken out of context. When this finding is viewed with the results as a whole, it suggests that we have cause to be optimistic about the 'treated' outcome of schizophrenia.

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Accepting voices

SIR: Max Birchwood makes reference to Karl Jasper's use of the term 'abyss' to describe the discontinuity between normal and psychotic experience (Book review: Accepting Voices, December 1995). During my years (seven) as a schizophrenic I have been examined by 18 psychiatrists, and the impression one gets is that they all have a very good *objective* understanding of the illness, but (obviously) they lack *subjective* knowledge. In my view, this is because the psychiatrist concerns himself with dissecting the statements a patient makes, in order to promote the patient's insight and reach an objective understanding of the cause of their symptoms. Psychiatrists always ask 'Why do you say that?' In order to understand the illness from a *subjective* viewpoint, he must ask 'How does that make you feel?' The questions a schizophrenic asks of his beliefs are not concerned with aetiology, but implication. The psychiatrist looks back into the belief to promote insight, whereas the sufferer looks forward, to gain pleasure. Thus, dissective questioning begets objective understanding, whereas implicative questioning instils subjective understanding (in the psychiatrist). The truth of the psychotic experience is like a rat, in one respect only. To find out how a rat functions, we put it on a slab and cut it up, but in doing so, the rat loses something vital. Similarly, dissective questioning fails to uncover something vital i.e. what the belief means to the patient. Empathy is a valuable asset in psychiatry, and by promoting subjective as well as objective questioning, we can allow the sufferer to express his feelings more clearly. Learning can then become a two way process.

BIRCHWOOD M. (1995) Book review: Accepting Voices. *British Journal of Psychiatry*, **167**, 843–844.

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CORRIGENDUM

MASON, P. & WILKINSON, G. (1996) The prevalence of psychiatric morbidity. OPCS survey of psychiatric morbidity in Great Britain. *BJP*, **168**, 1–3. The following reference should have been included in the reference list:

MELTZER, H., GILL, B., PETTICREW, M., *et al* (1995) *OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 1. The Prevalence of Psychiatric Morbidity among Adults Living in Private Households*. London: HMSO.