

References

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SIR: Dr Waring *et al* raise a number of questions about our attempts to help the families of schizophrenic patients. We have not followed up our two trials beyond two years. Although we recognise the importance of a longer perspective, it is difficult to maintain control over the interventions received beyond two years. For the same reason, it is rare for trials of maintenance drugs to exceed this period. Uncontrolled follow-ups are of doubtful value; however, we did maintain contact with a number of families for three years or more and did not learn of any further suicides. Moreover, there were no suicides in our second trial, which may reflect improved intervention techniques, or merely better luck. With regard to the demand on professional resources, this is maximal during the first year of intervention for most families. Beyond that, families appreciate having access to professional help from time to time, but in many cases a phone call or letter once a month or less is sufficient.

Our difficulty in accumulating sufficient families was not due to their reluctance to accept the help offered, but to our stringent entry criteria for the trials. We focused on the highest risk families; those in which patients were in high face-to-face contact (more than 35 hours per week in the *same room* as the relative) with high EE relatives. These constitute no more than 1 in 6 of all schizophrenic admissions. We recognize the limitation this imposes on generalising our findings to “the vast majority of outpatient schizophrenics seen in day-to-day clinical practice”, and have never claimed that our recommendations extend to all patients living with families. Indeed, the study of the Scottish Schizophrenia Research Group (1987) reveals that for patients living with relatives in a rural community, the prognosis for schizophrenia is remarkably good, only 19% being readmitted in the course of a year.

Our recommendations apply, not to these fortunate individuals, but to the high-profile patients who are frequently readmitted despite receiving drug therapy. We are therefore less concerned with the first onset patients that Dr Waring *et al* are attempting to help, although we do attempt to engage their

families if they are high EE, high contact. We have not experienced any insuperable obstacles to this, perhaps because we begin the process of engagement by offering knowledge about the illness, for which relatives are eager, and follow on by attempting “to help the family to help the patient”. We never target the family as the object of “therapy”. An additional factor which facilitates engagement is our readiness to make home visits to those families who are unwilling or unable to come to us.

It is our view that reduction in high-EE attitudes does represent an increase in tolerance and understanding for the sufferer. However, this is also accompanied by significant changes in the coping behaviour employed by relatives. We are in the process of studying these in more detail.

Finally, we share the concern of Dr Waring *et al* that our intervention techniques may be perceived as beyond the capability of ordinary clinical teams. This has impelled us to study whether the techniques can be learned and effectively applied by psychiatric nurses in a routine clinical service. We shall report on this research in the fullness of time.

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Better to be depressed in Australia . . .

SIR: Kiloh *et al* (*Journal*, December 1988, **153**, 752–757) describe better outcome after 18 years among New South Wales depressives than among our Maudsley patients (Lee & Murray, 1988). They suggest that the poorer outcome in London may have been due to the mis-inclusion of schizophrenic and schizoaffective cases, and are inclined to dismiss our findings concerning the predictive power of the neurotic-psychotic continuum on similar grounds.

We have re-analysed our data after excluding all those patients who developed schizophrenia and schizoaffective disorder: 25% of the remainder still fell into the operationally defined poor-outcome group. We further examined whether the presence of delusion, hallucinations, or mood incongruent features during the index admission predicted poor outcome. None of these indicators of possible “mis-inclusion” were correlated with poor outcome. Finally, and most surprisingly, we found that the development of schizophrenia or schizoaffective