empirically verify whether an attempted suicide had been committed in the passive voice or the future tense.

However, in pointing out that non-verbal behaviour is not syntactical one is not thereby denying that attempted suicide may for some people be a means of drawing attention to their plight. Rather is one suggesting that the suicidal behaviour is not a form of 'See *what* I mean' but 'See *that* I mean (what I say)'.

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ACTUARIAL V. CLINICAL PREDICTION

DEAR SIR,

I have recently pleaded (McConaghy, 1969), that editorial responsibility should include seeing that if the conclusions reached in articles are not the only ones which are consistent with the relevant data, the alternative ones are at least presented. Otherwise the majority of readers who do not have time to read articles carefully will accept the only conclusions put forward as established. Can I extend this responsibility to requiring, at least of review-type articles, that when the research work of others is quoted at some length this is so done that it is not necessary to refer to the original reports to ensure they support the reviewer's conclusions.

I am confident Professor Sines (*Journal*, February, 1970, p. 129–44) is aware that it would grossly favour actuarial v. clinical prediction if the data were analysed after a study was completed, the items selected which best accorded with the feature to be predicted, and the correlation of these items with the feature accepted as a measure of actuarial prediction. I therefore presume that all the studies he quoted applied predictive relationships determined prior to the study being carried out, not only those few where he stated this was so. Without consulting the original article it is difficult to see how this could be so from his description of Lindzey's study, which suggests that the 85 per cent actuarial prediction was made with a formula developed in the course of the study. As Professor Sines points out the disfavour done to actuarial prediction when a predictive formula is tested on a different population from that from which it was derived, it would seem not unreasonable that he should warn against this opposite and unfortunately still too common error of accepting unpredicted relationships found after a study is completed, before they are tested on a similar population.

Basically I am in agreement with his in fact extremely modest claims, pointing out as he does the limited relevance of actuarial predictions, at least at present. On *a priori* grounds one would expect clinical impressions to be most valuable when they are based directly on the interview. In this situation the clinician is able to form hypotheses as he goes along, and obtains data to support or refute these by suitable direction. When, as in the majority of studies he quotes, this flexibility is lost by limiting the clinician to making his judgements from the protocol of an MMPI or a TAT, most psychiatrists would, I think, expect that better predictions would result from actuarial methods.

This point that clinical impressions may be more valuable in some situations, actuarial in others does, I think, need stressing. The previously widely promulgated belief that improvement in patients in clinical trials should be measured by rating scales rather than by a clinical estimation of global improvements is rarely refuted, despite the evidence that the clinical estimate is as good as any rating scale measure and considerably better than many. (Lipman *et al.*, 1965; Rickels *et al.*, 1965). I consider the abandonment of the clinician's judgement and the complete reliance on rating scales in this situation probably responsible for such bizarre findings as that thioridazine is as effective an anti-depressant as imipramine (Overall *et al.*, 1964); as well as negative findings as to the value of the anti-depressants themselves (Ashby and Collins, 1961; Hare *et al.*, 1964). These results, so much at variance with clinical experience, seem to have produced a loss of interest in carrying out controlled trials, so that for some years now such important questions have been left unanswered as whether some depressed patients would respond better to tricyclic anti-depressants, others to MAO-inhibitors; and whether those who fail to respond to drugs from one of these groups would respond to one from the other.

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FOLLOW-UP OF DAY PATIENTS

Dear Sir,

In an article published two years ago, R. S. Ferguson (1) refers to the absence in the literature of follow-up studies, controlled or otherwise, of day-patients in this country, nor do recent publications mention any such study (2, 3). I am glad to hear that Dr. Ferguson (4) has undertaken further researches and look forward to seeing it in print.

In the Psychiatric Day Department at Crumpsall Hospital, Manchester, out-patients are also seen by the two psychiatrists responsible for the day-patients. These out-patients constituted a control group, as the decision whether to admit as day-patients frequently rested on practical rather than clinical considerations; though it must be said that younger patients currently off work because of their psychiatric illness usually became day-patients, indicating perhaps a somewhat greater degree of illness in the latter, who comprised one-third of all the day-patients followed up. We sent questionnaires to all day-patients and out-patients discharged in the past four years. The questionnaires were identical except for the word 'day-patient' or 'out-patient' respectively, and a second form was included on which the nearest relative was asked to make an independent assessment. No name was to be entered on the questionnaires, which were thus returned anonymously. Patients and relatives were asked to tick on a five-point scale: (1) clinical improvement; (2) residual handicap at work caused by the psychiatric complaint for which they were treated; (3) handicap in patients' social life, and (4) in their family relationships. Further, patients and relatives were asked to assess on a three-point scale the treatment received in our department as day or out-patient, compared to other treatment they might have undergone for the same complaint elsewhere, before or since. Breakdown for age, sex and diagnosis for the two groups circularized showed that there was no significant difference in their composition. Organic psychosyndromes and psychogeriatric day-patients were excluded.

There was a marked discrepancy in the proportion of completed forms returned, the day-patients enabling us to analyse 66·5 per cent of questionnaires sent out, but the corresponding figure for out-patients was only 40·9 per cent. This is partly explained by urban clearance in North Manchester having reached its maximum by the time out-patients were circularized.

There was no significant difference in the percentage of true defaulters, but the percentage of those who returned inadequately completed forms (4·6 per cent of day-patients and 12·5 per cent of out-patients) was significantly greater ($p = 0·05$) in out-patients.

Scrutiny of completed questionnaires revealed that answers given by patients and their relatives differed so little that it was assumed they co-operated in most instances, and we felt justified in averaging the small discrepancies where they did occur. The table shows percentage of patients recovered plus those greatly improved:

	Recovered plus greatly improved	
	Day-patients	Out-patients
In their clinical condition ..	68%	70%
In their work (including housework)	64%	71%
In their social life	54%	64%
In their family relationships ..	60%	64%
Numbers analysed	115	72

There was no significant difference between the two groups, and equally the 'slightly improved', 'just the same' and 'worse' categories formed very similar proportions.

The replies in the three point preference scale again did not differ statistically, two-thirds of each group recording treatment 'more satisfactory' than elsewhere.

No definite conclusions can be drawn from the results of this pilot study, as the proportion of forms analysed were so unequal for the two groups, thus diminishing the validity of any comparison. It is interesting that for both out-patients and day-patients the universally expected proportion of two-thirds was recovered or much improved, but this decreased slightly in respect to social and family relationships. Though not reaching statistical significance, the smaller proportion of day-patients