(*iii*) *The Symptom–Sign Inventory*

The results from the two scales drawn from the S.–S.I. (Foulds, 1965) do offer evidence of differences between the two groups of alcoholic patients. However, within the Foulds' system of conceptualization a symptomatic measure such as the S.–S.I. is viewed as being comparatively independent of personality structure and thus offers little supportive evidence for the author's basic hypothesis concerning personality and type of alcoholism.

(*iv*) *Conclusions*

The two types of alcoholism may well exist as clinical entities to the practising psychiatrist, and from the two S.–S.I. scales there is evidence that they affirm different patterns of symptomatology. There would, however, appear to be little or no evidence that these two types of alcoholic differ in personality structure in general or in hostility in particular. A total misclassification rate of 1 in 6 would appear excessively high if these two types of alcoholic are as clearly defined as the author suggests. In the present paper few of the author's conclusions are substantiated by the evidence he presents.

J. J. KEAR-COLWELL.

Crichton Royal, Dumfries.

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DEAR SIR,

I am grateful to Mr. Kear-Colwell for his interest in my paper. He has misunderstood it, however, at many points, which unfortunately vitiates his comment.

1. The 16 P.F.

(*i*) *First-order Factors.* He suggests that I "talk of two types of alcoholic" on the basis of two 16 P.F. profiles. He misunderstands the method used. The two types of alcoholic are clinically determined, the criteria for assigning a patient to either syndrome being defined on p. 761, and the procedure of assignment on p. 762.

I reported the difference in 16 P.F. profile briefly because the report as a whole was brief. Mr. A. Philip had, in fact, calculated profile coefficients for the two types of drinking syndrome (Table 1).

We knew that inability-to-abstain drinkers have similarities with both neurotics and patients with personality disorder, while loss-of-control addicts in 16 P.F. profile were more like neurotics.

TABLE 1

Comparison of Profile Coefficients of Alcoholics' First Order 16 P.F. Scores with Scores of McAllister's (1) *Three Criterion Groups*

	Normals	Personality Disorders	Neurotics
Inability-to-abstain alcoholics	·62	·76	·72
Loss-of-control alcoholics	·41	·50	·67

The conclusion Mr. Kear-Colwell arrives at after his own statistical analysis, that the total alcoholic group "proves" to be a typical group of psychiatric patients, is already stated in the paper. I say that the alcoholics differ from McAllister's patients with neurosis and personality disorder only on two of the 16 first-order factors (p. 763).

(*ii*) *Second-order Factors.* I stated myself (p. 764) that the difference in Extraversion score of the two types of alcoholic was not statistically significant. This is synonymous with "could well be due to chance variations".

There is an *erratum*, not noted by Mr. Kear-Colwell, which I am pleased he gives me the opportunity to correct. Loss-of-control addicts are (non-significantly) somewhat *less* extraverted.

2. The Hostility Scale Finding

Mr. Kear-Colwell says I have not reported statistically significant differences between the two types of alcoholic. What I do report is stated plainly: "an analysis of variance demonstrates a difference that almost approaches significance at the 5 per cent. level" (p. 765). I elect to pay further attention to this finding, advisedly. When the Hostility Scale scores of the 31 male alcoholics are separately analysed, the inability-to-abstain addicts have a mean score of 17·70, standard deviation 8·11; the loss-of-control addicts have a mean score of 24·91, standard deviation 8·11. The difference is statistically significant ($t = 2{\cdot}41$; $p < {\cdot}025$).

3. The Symptom–Sign Inventory

Mr. Kear-Colwell errs in his reading of the finding from "the two scales drawn from the Symptom–Sign Inventory." He says these scales offer evidences of differences between the two types of alcoholics. They do not. I show (p. 764) that one of them, the Personal Illness scale, does not differentiate between the two alcoholic syndromes.

He then essays an argument that the scale which does differentiate between the two types of alcoholic, the Personality Disorder Scale, is not a measure of

personality. In validation studies of the scale, people classified clinically as Personality Disorders were differentiated from people not so classified by the frequency with which they affirmed the presence of a certain cluster of symptoms. This cluster was called the Personality Disorder Scale. The defining characteristics of Personality Disorders used by clinicians are in terms of personality variables. Significantly more of the loss-of-control alcoholics, as reported in the paper, were classified by the scale as Personality Disorders. The mean Personality Disorder Scale score of the inability-to-abstain males in the sample was 3·35, standard deviation 1·74, and the mean score of the loss-of-control males was 6·09, standard deviation 2·28 ($t<3·62$; $p<·002$). Mr. Kear-Colwell may want to look up the references to the scale (2, 3), one of which I provided with the paper.

He is also wrong about "the Foulds' system of conceptualization". It proposes unequivocally (4): "All personality disorders are within the universe of discourse of personality" (p. 86).

In his last paragraph Mr. Kear-Colwell again misreports me and also misreads a section of the paper. I did not claim that the two types of alcoholics are "clearly defined". Indeed, at the top of p. 762 I go into detail that, among an earlier sample of alcoholics studied (5), classification of drinking pattern produced the following distribution: 34 per cent. were of loss-of-control type, and 22 per cent. of inability-to-abstain type; this left almost half with the addiction pattern not so clear-cut, 17 closer to the former and 27 closer to the latter clinical type. In this study, given the relative clinical atypicality of many cases, subjects were classified on an either/or basis to one of the two categories.

Also in the final paragraph, Mr. Kear-Colwell conveys an incomprehension, supposing that the "total misclassification rate" refers to this assignment to categories; as stated on p. 765, it refers to a multiple correlation between drinking pattern and a battery of nine tests, three of them clinical ratings and six personality tests. He will pardon my preference for the advice of the statistician with whom I collaborated that the misclassification rate was acceptably low.

H. J. WALTON.

Department of Psychiatry,
University of Edinburgh

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SUICIDE IN THE NORTHERN SUDAN

DEAR SIR,

In the Northern Sudan there are marked differences in both the epidemiology of suicide and in the methods used as compared with those in Britain and the Western world. The Northern Sudanese culture pattern has been summarized elsewhere in this *Journal*, "Psychiatry in the Northern Sudan: a study in Comparative Psychiatry" (this issue, pp. 945–958), and it is assumed that the manifestations of suicide are influenced by this pattern.

The overall incidence of suicide in the Northern Sudan is very low indeed; it is estimated that it is just under 1:100,000 of the population. Even among the mentally ill and those with abnormal personalities the incidence is much lower than in the West. This may be because family ties are powerful, and because the people live with common beliefs and purposes and under the restraint of a common religion (Islam) which expressly prohibits suicide. Clinical impressions suggest that suicide, whether attempted or consummated, is virtually unknown among elderly people. It is the custom in the Sudan for three generations of a family to live in the same household, and consequently the old people do not suffer from loneliness but are sheltered from want, and are positively made to feel needed, important, and indispensable; their wisdom and their advice are sought to solve inter-family problems. It must be remembered also that relatively few Northern Sudanese reach the senium; the average expectation of life is still under 40 years.

Attempted and consummated suicides occur mainly among single young women between the ages of 17 and 30, and seem to be committed impulsively and for apparently trivial reasons. A typical example was the girl who was prevented by her parents or older brother from attending a neighbour's wedding and made to stay at home instead. Women in the Northern Sudan live in subjection, so it is possible that many of them suffer from a chronic state of despair, and that only a little additional stress is needed to tip the balance in favour of suicide. Of course, there are more serious causes of suicide: illegitimate pregnancy