mystery as rather to point out that there are difficulties attending the psychiatric practice of treating different types of psychiatric problems as all equally 'medical'. Kendell, in fact, lends strong support to my arguments, as expressed most recently in my Methuen pamphlet on *The Future of Psychiatry*, by concluding that the functional psychoses would, on his criterion, be 'diseases', while neuroses and 'the ill-defined territory of personality disorder' cannot (at least as yet) be so regarded. That, of course, was the basis of my argument in that pamphlet (and earlier in my *Handbook of Abnormal Psychology*); that psychiatry was in fact split in two parts, one medical, dealing with what might justifiably be called 'diseases', and the other behavioural, dealing with behavioural maladjustments and constituting a psychological-educational rather than a medical problem. The argument about 'lesions', although important, probably distracts attention from the major difference. Kendell's arguments would seem to support my position, although only implicitly.

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SUBJECTIVE AGE IN CHRONIC SCHIZOPHRENIA

DEAR SIR,

We read with interest the recent article by Crow and Mitchell (*Journal*, April 1975, **126**, p 360), and as we were in the process of testing a random sample of psychiatric in-patients in connection with another project we decided to obtain subjective ages on these patients as well. As a result, subjective ages were obtained from 144 patients in the various wards of Harlem Valley Psychiatric Center, Wingdale, New York. Responses from four of these patients were eliminated because of vagueness or extremeness (e.g. '30 to 40 years old', '1,000 years old').

The subjective age-distribution obtained is quite similar to that obtained by Crow and Mitchell (Table).

Crow and Mitchell conducted additional analyses on those patients who reported themselves to be five or more years younger than they really were. They found that 27 per cent of their sample fell in this category, with a mean true age for these patients of 59 years and a mean duration of stay of 26 years. Corresponding figures in our series were 28 per cent of the entire sample, with a mean true age of 53 years and a mean duration of stay of 18 years.

Among their patients whose subjective age was five or more years younger than their real age Crow and Mitchell attached particular diagnostic importance to those whose subjective age was within five years of their age upon admission. They found 26 patients (12 per cent) in this category, while we found 12 (9 per cent).

Our results are very similar to those of Crow and Mitchell, despite the fact that the composition of the two samples differed. Their sample consisted of only chronic, male schizophrenics, while ours consisted of males and females, schizophrenics and a few non-schizophrenics, and short-term and long-term patients. Interestingly, although our sample was more varied, of the 12 subjects in the critical group (i.e. those who reported their ages to be five or more years less than their actual age and within five years of their age at admission) 11 were diagnosed as schizophrenics and 10 of these were males.

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TABLE

Comparison of two subjective age studies

	Crow-Mitchell		Smith-Oswald	
Males	220		71	
Females	0		69	
Mean age (years)	54		49	
Mean length of stay (yrs)	19		15	
Distribution of subjective ages	N	%	N	%
I. Correctly reported age	80	36*	51	36
II. Subjective age within 5 years of actual age	74	34	39	28
III. Subjective age ⩾5 years below actual age	60	27	39	28
IV. Subjective age ⩾5 years above actual age	6	3	11	8

* Based on a sample of 220.

SCHIZOPHRENICS' FAMILIES

DEAR SIR,

The use of a controlled family study (Stephens *et al*, *Journal*, August 1975, **127**, pp 97–108) to investigate the schizophrenic 'spectrum' appears to have potential for clarifying the diagnostic boundaries of

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schizophrenia. However, the finding of more personality disorder in the families of the schizophrenics is one with which we wish to take issue.

Although the risk of schizophrenia in the parents of schizophrenics is usually less than that for siblings, the parental risk from the Stephens data is less than that seen in the general population, and much less than that seen in the siblings. It has been our experience that when both parents and siblings are interviewed their risks for schizophrenia are similar (Tsuang *et al*, 1974). An explanation for the Stephens results may lie in the frequent diagnosis of schizoid and paranoid personality disorders in the parents.

We take particular issue with the classification of the schizoid (ii) subgroup as a 'personality disorder'. The authors characterize people with this disorder as 'rambling, vague, unrealistic, . . . eccentric and solitary in their personal life'. Certainly there are difficulties in diagnosing schizophrenia in the absence of delusions, hallucinations or clear thought disorder; however, a suspicion of schizophrenia would appear justified in relatives with 'schizoid subgroup (ii)' characteristics. To us, it would appear appropriate to use the term 'suspected schizophrenia' for these relatives, and to include them in the analysis as 'schizophrenia'. In the long run, we feel that a rose by this name not only smells sweeter but is more precisely named.

Interestingly enough, even if the schizophrenic group is broadened along the above lines there may yet remain an excess of personality disorder and heavy drinking in the parents and siblings of schizophrenics.

Data from this Department suggest a possible explanation for such an excess. In an analysis of psychiatric illness in the parents and siblings of 260 process schizophrenics (Fowler *et al*, unpublished), psychiatric disorders in siblings—schizophrenia, alcoholism, affective disorder—were viewed according to the psychiatric disorders in the parents—no psychiatric illness, schizophrenia, alcoholism, other psychiatric illness. Only the following statistically significant associations were noted: (1) schizophrenia in siblings with schizophrenia in parents; (2) alcoholism in siblings with alcoholism in parents; (3) affective disorder in siblings with other psychiatric illness in parents (Table). These data suggest that alcoholism and probably affective disorder are transmitted independently of schizophrenia in these families.

In addition, 49 per cent of the parents with schizophrenia have psychiatrically ill spouses, alcoholism being the most common diagnosis. This reinforces a previous finding that schizophrenics frequently marry alcoholic and personality-disordered individuals (Fowler and Tsuang, 1975). Thus our data suggest that alcoholism and some personality disorders in the families of schizophrenics are more a function of the selective mating of the schizophrenic parent(s) than a biological variant of schizophrenia.

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TABLE

Parental illness and schizophrenia, alcoholism and affective disorder in the siblings of schizophrenics

Illness in parents	Illness in siblings: Schizophrenia +	Schizophrenia −	Alcoholism +	Alcoholism −	Affective disorder +	Affective disorder −
No illness . .	6	325	4	327	6	325
Schizophrenia	6**	27	1	32	2	31
Alcoholism . .	0	34	5**	29	2	32
Other psychiat.	4	118	3	119	9*	113
	16†	504	13	507	19	501

* $P < \cdot 05$.
** $P < \cdot 001$.
† Both parents of one sibling with schizophrenia are ill; therefore, the sibling is counted twice.

PERSONALITY AND DEPRESSIVE ILLNESS

DEAR SIR,

I wish to draw attention to a fundamental misconception in the paper by Serra and Pollitt (*Journal*, September 1975, **127**, p 211). It is an error which has underlain and largely negated the value of uncountable previous research reports and which will no doubt persist into the foreseeable future.

In their paper, the authors attempt to show that the psychic symptoms of depressive illness are largely determined by the underlying personality structure;