

## The Importance of the Role of the Patient in the Outcome of Schizophrenia

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The Family Interpersonal Perception Test (FIPT) was used to explore the relationships between schizophrenic patients and their parents, and how these related both to relapse in the year after discharge and to improvement in social functioning. Forty schizophrenic patients and their parents were tested during their first ever admission to hospital and again two years later. Parents' and patient's views of each other were more negative in those with worse outcome, but what most significantly distinguished groups with different outcomes was how patients expected their parents to see them. The FIPT, therefore, reveals patterns of interaction in which the patient's role in outcome is at least as important as that of the parents, and can aid the identification of specific features with which to work in therapy.

Since the early 1970s there has been much interest in the influence of key relatives on the outcome of schizophrenia. This issue has been extensively investigated through work on expressed emotion (EE) (Brown *et al*, 1972; Vaughn & Leff, 1976; Leff & Vaughn, 1981, 1985; Vaughn *et al*, 1984), and also through the rating of affective style (Doane *et al*, 1981, 1985; Miklowitz *et al*, 1984; Strachan *et al*, 1986). This work centres on a key relative's attitude to the patient and how this relates to relapse, or less commonly to the patient's social life (Doane *et al*, 1988).

By contrast there appear to have been only four studies that have taken into account patients' attitudes to their relatives. Hahlweg *et al* (1989) rated from videotapes the interaction between a schizophrenic patient and his/her parents engaged in trying to solve a problem involving conflict. They used a sophisticated rating system designed to rate communication, and designated the families as high EE (critical), high EE (emotionally overinvolved), and low EE. In the low-EE families, the parents and patient tried to solve the problem in a mutually supportive fashion, while the high-EE (critical) families were drawn into a prolonged, increasingly negative exchange. Outcome was not rated, but high EE was likely to be associated with relapse.

In another approach to scoring the attitude of the patient to parents, Parker *et al* (1982) developed the Parental Bonding Instrument (PBI), which enables patients to score how they remember their parents in the first 16 years of life in terms of care and protection. A score hypothesised as being of high risk was found to be associated with more severe illness (Warner & Atkinson, 1988).

Rea *et al* (1991) reported research into the schizophrenic patient's interactional style with parents and how this might be changed by family

treatment programmes, and also its relation to relapse. In a rating of coping style (developed by Strachan *et al* (1986)) three categories of behaviour were seen as likely to increase or diminish tension with the parents. No relation was found between the patient's coping style and relapse.

The work of Scott *et al* has shown that the part played by patients in the relationship between them and their parents is a key factor in outcome in terms of crises, social and work functioning (Scott *et al*, 1970; Scott & Montanez, 1972; Scott, 1973; Scott & Alwyn, 1978), and relapse (unpublished). These researches employed the Family Interpersonal Perception Test (FIPT), which is a self-rating test scored by both the patient and parents based on Laing's conception of viewpoints (Laing *et al*, 1966). In a three-year project it was found that although the parents' view of the patient was a significant predictor of outcome, the best predictor of poor outcome was the patient seeing parents more than 20% worse than they expected to be seen. This is termed a 'discordant score' (DS). A DS on first admission accurately predicted an untenable relation between parents and patient whereby, owing to crises, the patient would spend more than 50% of a two-year follow-up away from home, either in hospital, or in trouble in the community (Scott & Alwyn, 1978).

The present paper uses data from the above project to explore the association of the patient-parent relationship with outcome in terms of relapse and social and work functioning over a two-year follow-up. It also explores the association between aspects of the parents' relationship and relapse.

### Method

The sample comprised 40 schizophrenic patients (33 men, 7 women) admitted for the first time ever, from parental homes, to seven psychiatric hospitals in north-west London.

The sample was taken from consecutive admissions by selecting the next case which fell within the following criteria. (a) The patients must have been diagnosed schizophrenic by the hospital doctor, as well as having a diagnosis of schizophrenia in ICD terms (General Register Office, 1968). (b) Patients were only accepted subject to the agreement of the hospital, the patient, and the family.

### Procedures

The patient and parents were seen together during the first admission by two members of the research team in an interview lasting about three hours. They were introduced to the project, family patterns of interaction were mapped out, and the FIPT was administered ('test 1').

Detailed information was obtained as to what the parents and the patient individually saw as the first sign of illness, and when this occurred. A history of symptoms and disturbance was obtained conjointly from the patient and parents, and ratings of the patient's social life were made for the two to three years preceding the first sign of illness. A rating was also made of symptoms present at the interview or reported as having been present in the previous one to two months. Interview 1 was usually conducted in hospital during first admission, an average of nine weeks from admission. The peak frequency for testing was 30–40 days after admission. Test 1 was always given after the acute disturbance had subsided because it was found that during the acute phase patients see their parents more negatively.

Approximately two years after first admission, the patients and their parents were again seen in a joint interview, usually in their homes. The FIPT was administered again ('test 2'). Ratings were made of the patient's social life and work performance during the follow-up, and of the patient's current clinical symptoms. Detailed information was obtained about contacts with hospital services, general practitioners and social services, noting drug regimes and social help received. A record was kept of time spent away from home by the patient and whether this was in hospital or not.

### The Family Interpersonal Perception Test (FIPT)

The family, normally the mother, father and patient, sits down together in such a way that they cannot see each other's scoring. They complete the form by themselves, without discussion during the actual scoring. On separate forms, they score the following viewpoints: how they see themselves, how they see each other, and how they think each of the others sees them (five viewpoints in all for each person). It should be noticed that the scoring, as well as involving the patient and parents, can also reflect the relation between the parents. The test itself takes three people around 60 minutes. The discussion which follows is optional, but can be revealing of subtle features of

interaction and identity and can take another one to two hours (Scott *et al.*, 1970).

On the score form there are 16 positive or 'S' (for strong) terms, such as self-confident, mixes well out, secure, responsible, and 28 negative terms, such as emotionally inadequate, secretive, obstinate, interfering. The most negative are the 'I' terms, which are commonly used to attribute illness, and the less negative are the 'N' terms, which are commonly used to attribute nervousness not amounting to illness. There are 11 'I' terms and 17 'N' terms, and four terms not used in this paper. The terms were derived from lists made in shorthand during family meetings of the most common types of attributions family members made about themselves and each other. The classification is based on how family members used and understood the attributions (see Scott *et al.*, 1970, for the FIPT terms).

The test results are analysed in terms of the amounts of 'positivity' and 'negativity' expressed in one person's view of another. Ratios measure this. The total number of 'S' terms divided by the number of 'I' terms scored in a viewpoint gives the S:I ratio. Similarly, there is an S:N ratio. Thus, the ratios are a balance between the positive and negative: the higher the ratio the more positive the view being expressed. Since the FIPT is self-rated, the ratio will express how family members see themselves and each other.

The predictive validity of the FIPT concordance score (CS) (a measure of the agreement between the patient's view of parents and their expectations, and also their self-views) was shown by Scott & Alwyn (1978), who also showed the test-retest reliability of the CS over two years (Kendall  $t = 0.52$ ,  $z = 4.05$ ,  $P < 0.001$ ), coupled with sensitivity of the CS to changes in family dynamics over follow-up.

### Measures of outcome

Three measures were used.

(a) *Social functioning.* For these patients, the key issue was whether they could lead an independent life. Thus, social contacts outside the families of origin were rated from two to three years preceding the disturbance which led to admission to the two-year follow-up point. The ratings (number of social contacts and whether they were friends or merely acquaintances) were on a six-point scale: (1) no social relationships outside the family; (2) very tenuous connections outside the family (one or two individuals of the same sex seen occasionally); (3) a few acquaintances but no real friends; (4) a number of acquaintances, usually in the context of an activity such as sport, but no real friends or lasting relationships; (5) acquaintances and one or two friends, including one of the opposite sex; (6) acquaintances and friends, including a lasting relationship with a friend of the opposite sex.

It should be noted that the scale is heterosexually orientated because in the pilot survey for the project we had not found any patients having lasting homosexual relationships. This also proved to be the case in the project itself.

(b) *Work performance.* This was operationally defined as percentage of the period from first admission to follow-up in paid employment.

(c) *Relapse*. In this case, the follow-up was one year after discharge from first admission, since by the time the patient with the longest first admission was discharged, there was just over a year between leaving hospital and the two-year follow-up. Relapse was defined as the further involvement of clinical services as a result of exacerbation of symptoms, but not as a result of social stress only. Data on crises and relapses were obtained through weekly telephone contacts with relevant medical and nursing staff in each of the seven hospitals involved in the research, and by periodic contacts with general practitioners, by examination of hospital notes, and at the 'test 2' follow-up interview with the family. In some cases the team were able to be present at a crisis. Owing to the variety of sources of information about recurrence of symptoms, it was not possible for raters to have no contact with the FIPT scores. However, at the time of conducting the project, no predictions were made concerning the relationship between FIPT scores and relapse.

### Symptoms

Symptoms present or present in the previous one to two months at both test 1 and test 2 interviews were assessed, together with those reported by the patient's doctor, the patient and his/her family as having been present during and since the acute disturbance had subsided.

Symptoms were classified with a scheme based on ICD-8 (General Register Office, 1968), allowing ranking of the categories in order of decreasing severity, as follows:

- (a) symptoms of nuclear schizophrenia: voices discussing the patient in the third person, thought insertion, delusions of being controlled, auditory hallucinations, and marked thought disorder; also included were other symptoms listed in the glossary under the hebephrenic type, the paranoid type, and the acute schizophrenic episode
- (b) schizoaffective psychosis, characterised by delusions which were often persecutory, ideas of reference, and associated typical manic or depressive features, often marked by elation and grandiose ideas
- (c) negative schizophrenic symptoms without manifest active psychosis (e.g. flatness of affect, relative muteness, withdrawal, tangential replies, and the 'schizophrenic feel'); also included were other symptoms listed in the glossary under the simple type, the latent type, and residual schizophrenia
- (d) severe neurotic symptoms only; these might be of any type - anxiety, depression, obsessions, or personality disorder
- (e) mild neurotic symptoms only, again of any type
- (f) no symptoms of mental illness.

### Results

Two patients failed to complete the FIPT, and the responses of one patient to the test were unscorable.

Age distribution was 16-34 years, with a peak at 17-18 years. All but one of the patients had never been married. Social class was rated according to the father's occupation except where the father was permanently away from home,

in which case the mother's occupation was rated. The distribution corresponds fairly closely to the Office of Population Census and Survey's (1975) data for the boroughs in which the parents lived: 4 families were social class I, 9 social class II, 18 social class III, 6 social class IV, and 3 social class V.

Of the 21 (52.5% of the sample) patients who relapsed, 15 (71%) deteriorated from a non-psychotic to a psychotic state, one had an increase of neurotic symptoms, and six (29%) suffered a definite exacerbation of persistent psychotic symptoms, moving from a state of having residual or negative symptoms to acute psychosis. In 16 cases relapse was associated with readmission, and in five the disturbance could be contained in the community.

Six patients from the relapse group and five from the no-relapse group had three or more out-patient appointments, and three from the no-relapse group attended day hospital. Six from the no-relapse and one from the relapse group had individual or family therapy from special centres. All patients were at one time or another on neuroleptics. When not in hospital, these were mainly prescribed by their general practitioners. Thirteen had intramuscular fluphenazine decanoate, but only three of these, all from the relapse group, received injections for more than 50% of the follow-up year. Concerning oral neuroleptics, the following is our best estimate: of the 21 in the relapse group, 12 were on regular or probably regular treatment, three were irregular, three stopped after discharge, three were uncertain; for the 19 in the no-relapse group, the figures are ten, five, one and three, respectively. Thus, there is no great difference between the groups in the proportion who were definitely not on medication or for whom this was uncertain.

### Relationship between test 1 FIPT data and relapse

The FIPT scores of the mothers and fathers are combined and termed 'parent'.

Table 1 shows that both the S:I and S:N ratios of how the parents saw the patient distinguish relapse, with the group means two to twelve times higher (i.e. more positive) for those who did not relapse. This parallels the basic finding of studies of expressed emotion, that the relatives' attitude to the patient is associated with relapse.

Table 1  
Mean S:I and S:N ratios of four viewpoints and relapse

	Relapse (n = 21)		No relapse (n = 19)		Relapse v. no relapse <sup>1</sup> : P	
	S:I	S:N	S:I	S:N	S:I	S:N
Parent-patient <sup>2</sup>	2.07	0.98	5.19	1.98	0.018	0.022
Patient-parent <sup>3</sup>	6.1	2.25	8.45	5.22	0.05	0.012
Patient expectation <sup>4</sup>	2.06	0.85	3.39	1.46	0.005	0.005
Parent expectation <sup>5</sup>	8.95	3.05	10.94	3.19	0.33	0.20

1. Mann-Whitney U; values of P are one-tailed.
2. Parent's view of patient.
3. Patient's view of parents.
4. How patient expects parents to see him/her.
5. How parents expect patient to see them.

**Table 2**  
Correlation (Spearman's *r*) of patient's view of parents to parents' expectation,<sup>1</sup> and parents' view of patient to patient's expectation<sup>2</sup>

	No-relapse group (n = 19)		Relapse group (n = 20) <sup>1</sup>	
	S:I	S:N	S:I	S:N
Patient's view, parents' expectation	0.35	0.25	0.08	-0.4
Parents' view, patient's expectation	-0.26	0.07	0.58*	0.56*

1. One patient did not score this.  
2. Two patients did not score this.  
\**P* < 0.02 (two-tailed).

Table 1 also shows that how patients see their parents also distinguishes those who relapsed. The patients in the no-relapse group saw their parents more positively.

The patients' expectations of how their parents would see them again distinguishes relapse, with the more positive expectations in the no-relapse group (Table 1). Patients' expectations of how they are seen by parents gives the best distinction between the groups, but Table 1 also shows that the reverse is not the case in the total sample: the parents' expectation has no relation to relapse. This intimates that some parents are out of touch in some way.

Table 2 shows that the parents' expectation in the no-relapse group is positively, although not significantly, correlated with how they are seen; there is a mutually positive relationship between parents and patients, of which the parents may have some specific awareness.

In the relapse group, the parents and patients take a more negative view of each other, and Table 2 shows that the patients are quite accurately aware of this - their expectation being correlated with how they are seen, but the parents' expectations have no correlation, or even a negative correlation, with how they are seen. In the case of the S:N ratios of the parents' expectations, the difference between the correlations for the relapse and no-relapse groups was statistically significant (*z* = 2.00, *P* < 0.05).

Mutual negativity characterises the relation between patients and parents in the relapse group, the patients being more accurate while the parents are quite adrift as to how the patient sees them. An examination of scoring shows that there are two subgroups: in the larger, 12 sets of parents place their expectations too high (they are seen negatively but do not expect this) while the other nine expect a more negative evaluation. The former is composed of the most crisis-prone families in the sample.

**The relationship between the parents and relapse**

When testing a family with two parents (eight were single-parent families), the couple were asked to score their perceptions of each other as well as of the patient. Their patterns of scoring allowed their relationship to be classified as 'concurrent' or 'discrepant'.

There were quite clear cut-off points defining the two groups. Using S:I ratios, if one parent saw the other 35% worse than the other saw themselves, or 35% worse than this other parent expected to be seen (or both), this was

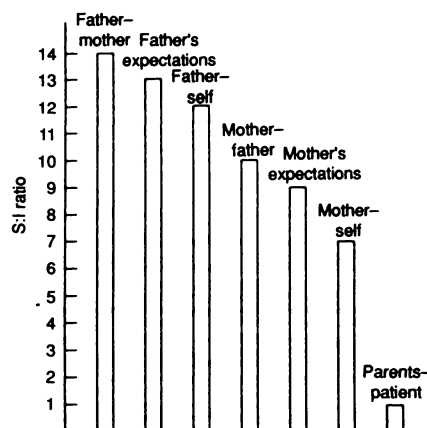


Fig. 1 An example of the parents' 'concurrent' relationship in the no-relapse group, as S:I ratios of different viewpoints.

defined as a discrepant score. On this basis, of the 32 two-parent families who scored test 1, 20 were concurrent, and 12 discrepant.

*The concurrent profile.* Eleven were in the no-relapse group and nine in the relapse group. In this profile the parents take a positive view of themselves and each other and correctly expect it to be reciprocated. Figure 1, a family representative of the no-relapse group, shows how the parents saw themselves, each other, and the patient in terms of the S:I ratios. The vertical axis is the S:I ratio scale (the higher the more positive). The histogram shows that the father sees the mother more positively than she sees herself, and she correctly expects this. The mother sees the father similarly to how he sees himself and expects to be seen. At follow-up (test 2), they placed the patient nearer themselves. There were no relapses and the outcome was quite good for the patient and the family.

*The discrepant profile.* Of the 12 discrepant profiles, 10 were in the relapse group. The family from the relapse group in Fig. 2. is representative. It shows that the mother and father score themselves high, but the mother scores the

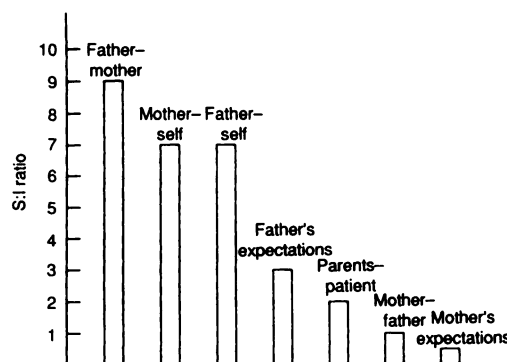


Fig. 2 An example of the parents' 'discrepant' relationship in the relapse group, as S:I ratios of different viewpoints.

father nearer to the patient and the father more or less expects this. However, the father takes a very positive view of the mother, although she thinks he sees her negatively. A look at the score form showed that the mother sees many of the negative things she expected from the father in her view of him. This is certainly an indicator of conflict – ‘If he sees me as bad, I’ll see him the same’. This profile corresponded to the situation found in interaction during the meeting with the parents and the patient. Despite severe conflict, the father was also prepared to show his qualities by holding the family together and, as the scoring shows, being supportive of the mother. There were relapses in the year after first admission but the outcome was not the worst. At the two-year follow-up the situation was still liable to crises.

Comparing the concurrent and discrepant family patterns for relapse, there are more families with discrepant profiles in the relapse group (Fisher’s exact probability,  $P=0.04$ ).

#### The relation between relapse and social and work functioning

Relapse as a measure of outcome might not reflect quality of life. Its relationship to the measures of social and work functioning was therefore examined. Dividing the sample into those who spent 50% of the two-year follow-up working and those who had not, significantly more of the relapse group were not working ( $\chi^2=24.43$ ,  $P<0.001$ , one-tailed). Similarly, dividing them into those who had expanded their social life or remained at a social rating above 1, and those whose social life had contracted or remained at a rating of 1, significantly more of the relapse group had a restricted social life ( $\chi^2=11.83$ ,  $P<0.001$ , one-tailed).

#### Changes between tests 1 and 2

At test 2 there was a more significant distinction between the relapse and no-relapse groups for all viewpoints for the S:I or S:N ratio, or both. In the relapse group the S:I ratio of the parents’ view of the patient remains at the same level at test 2 as it was at test 1 (S:I of parent–patient = 2.07 at test 1 and 1.58 at test 2, Wilcoxon  $T=58$ , NS) while in the no-relapse group the parents saw the patient more positively at test 2 (S:I of parent–patient = 5.19 at test 1 and 8.94 at test 2, Wilcoxon  $T=14$ ,  $P=0.025$ , one-tailed).

#### Cut-off points for relapse

The best cut-off points for the three viewpoints which distinguish relapse – patient expectation, parent–patient, and patient–parent – are respectively for the S:I and S:N ratios: 1.8 and 1.1, 2.3 and 1.1, 4.4 and 1.4 at test 1, and for test 2, 1.5 and 1.65, 4.5 and 1.3, 3.7 and 2.7. In test 1 the combined scores for the three viewpoints distinguish 83% of patients in the relapse and no-relapse groups, and 87% in the case of test 2.

### Discussion

The results of this study need to be seen in the light of our previous research on tenability (Scott *et al*,

1970; Scott & Montanez, 1972; Scott & Alwyn, 1978).

The relapse group can be subdivided into two subgroups. In the first, comprising 11 of the 21 who relapsed, the patients had developed an untenable relationship with their parents after the first breakdown. An untenable situation was defined as one in which the patient through crises spent more than 50% of the two-year follow-up away from home. A discordant score (DS) on the FIPT gave a highly significant prediction of untenability. The 11 in this subgroup all had a DS on test 1 and test 2 (except in two cases in which test 2 was not obtained, but the situation remained clearly untenable throughout follow-up). All these 11 had more than one relapse and had poor outcomes socially and at work. The key viewpoint in a DS is the patient’s view of the parents that is much worse than the parents expected. The patients in this subgroup often saw their parents as negatively as patients were seen by their parents. In nine of the other ten families, the parents tended to expect a more negative view from the patient and to take an unnecessarily disastrous view of the situation.

The role of the patient in outcome is based on the vulnerability of some parents, especially in the untenable situation, in which one or occasionally both parents are profoundly unsure of their identities as parents and have a need to be seen by the patient as good parents. For example, one mother said at the time of her son’s psychotic breakdown, “[his] breakdown was a terrifying experience. I used to be dogmatic but now I don’t know if I’m coming or going.” She had become profoundly doubtful of herself as a mother. She needed the patient to see her as a good mother, but in the test he saw her quite negatively, and she received little support from her husband. The latter reflects the effect of parental conflict on outcome.

The finding that parents in the relapse group were not in touch with how the patient saw them, whereas patients were quite sensitively aware of how they were seen, probably stems from the vulnerability and liability to psychotic decompensation of these patients having led them to have tuned in to parental negativity for their survival. This puts these patients in a position to threaten parents who are not well in touch with the reality of their relationship with them. They have an awareness that parents do not have. By contrast, in the no-relapse group the patient and parents are mutually supportive, a position which has improved further at follow-up. The patient’s quality of life was significantly better in the no-relapse group.

The discrepancy between our findings and those of Rea *et al* (1991), who found no relation

between a coping style (CS) rating of the patient's attitude to parents and relapse, may have arisen from the characteristics of their sample. This consisted of patients living with their biological parents or who saw them daily. This would have excluded the untenable group, in which the patient's role shows up so sharply, who in our sample spent more than 50% of the time away from home. The discrepancy could also have arisen through the instruments used. CS is rated by observers of interaction between patient and parents. Our experience has shown that schizophrenic patients find it easier to express themselves in a questionnaire than in face-to-face interaction. A patient will frequently score on the FIPT things which it can be hard to get in words. This might also account for the patient not being rated in the studies of EE or affective style.

By contrast, in the other work in which the patient's part in interaction has been rated, Hahlweg *et al* (1989) found that in high-EE critical families (as opposed to emotionally over involved high-EE families), when patients and relatives were in conflict there was a prolonged and escalating 'mutual' negativity. It made no difference whether the patient or the relative started a negative sequence. Furthermore, in contrast to work on EE or affective style, they stressed that in low-EE families there was an actively supportive attitude to the patient. This parallels the present study for the parents in the no-relapse group, but our findings also stress the need for patients to be supporting of their parents, while in the case of the relapse group both studies show that the patient and relatives play at least an equal part in the negative interaction associated with relapse.

We may note that the lack of attention paid to the patient's view in previous research can be indicative of a tendency, apparent too in research on quality of life, to consider the schizophrenic predicament from the observer's perspective while ignoring the patient's construing of events (Winter *et al*, 1992).

A comparison of tests 1 and 2 shows that in the relapse group the parents' view of the patient remained at the same negative level in test 2 (two-year follow-up) as in test 1, most frequently given 30–40 days after first admission. Previous research indicates that such negative attitudes are likely to have abruptly occurred around the time of first admission and to have remained fixed (Scott & Ashworth, 1967). Likewise, the untenable situation, which is largely dependent on the patient's view of the parents, has a similar pattern, but about 25% changed over to tenability during the two years after admission.

Our research has the methodological weaknesses noted above. However, the findings regarding both

the role of the patient, and the relation between the parents, in outcome are clear cut and merit further research in this area which, in the case of the patient, appears from the literature to have been little investigated. Overall, our research points to a balance in which both the patient's and parents' views of each other are related to outcome. The patient's contribution shows, especially in the relapse group, the vulnerability of parents to what the patient thinks of them. Family work should first, therefore, sensitively and firmly support and validate the qualities of the parents, especially at times of crisis. This can create a space safe enough for the patient to emerge from the psychosis. An appreciation of how the patient may well be an unrecognised agent in outcome will bring to view his/her strengths as a person, who has often been rendered invisible by the illness.

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