KING, D. J., BURKE, M. & LUCAS, R. A. (1995) Antipsychotic drug-induced dysphoria. *British Journal of Psychiatry*, **167**, 480–482.

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AUTHOR'S REPLY: Gray *et al* make a number of criticisms which would, of course, be valid had ours been a prospective study. It was, however, submitted as a *Brief Report* and was an account of clinical observations made in the course of two pharmacokinetic studies. It was reported because it was probably the largest single series in healthy volunteers (51 subjects) to be published, and because of the high and consistent incidence of dysphoria (an unpleasant and subjective mood state characterised by irritability, hostility, fear, tension, panic, impatience or vaguely described distress) on the two study days (40%).

The aims of the report were to remind clinicians not to miss or dismiss this symptom in their patients, to illustrate that dysphoria can occur independently from akathisia and to note that the "neuroleptic threshold" is unlikely to be any different in patients and volunteers after acute dosing (McEvoy *et al*, 1991).

MCEVOY, J. P., HOGARTY, G. E. & STEINGARD, S. (1991) Optimal dose of neuroleptic in acute schizophrenia. A controlled study of the neuroleptic threshold and higher haloperidol dose. *Archives of General Psychiatry*, **48**, 739–745.

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Bias towards chronicity in schizophrenia?

SIR: The conclusions of 13 years follow-up study by Mason *et al* (1995) raise important questions as much about the course of schizophrenia as to the 'bias' of the professionals. The conclusion "only 17% . . . achieve complete recovery over the longer term" appears biased for the following reasons. It appears that mental health professionals are not willing to consider the illness of schizophrenia in a manner that general medicine considers illnesses like hypertension, diabetes, arthritis. The above three illnesses and many others with 'no cure' do not lead to 'complete recovery'. However, doctors working with non-psychiatric illnesses emphasise and focus on abilities rather than disabilities. The diabetic with food restriction among other limitations, the hypertensive with activity restriction, do not consider themselves as 'disabled' and learn to live near normal lives. All of them need help and care but they are not seen as 'Chronic' in the way we present the course of schizophrenia.

There are three implications for a revision of the 'non-recovery' approach to schizophrenia. Firstly, a medical approach to describe course would draw greater support for patients, research and professional work. Secondly, there is need to embark on a series of new studies with first episode patients to delineate how far chronicity is a function of events occurring after the onset of illness (early recognition, early treatment, adequate family and community support, rehabilitation in the community, lack of stigma etc.) rather than an essential part of the illness. Thirdly, for those of us working in developing countries, the difference in the approach of 'treatability' could prove decisive in terms of support from the planners and people for mental health programmes. This is especially true for the acceptance of the integration of mental health with primary health care which is the current focus of mental health care in developing countries. A shift in 'bias' of mental health professionals may be timely?

MASON, P., HARRISON, G., GLAZABROOK, C., *et al* (1995) Characteristics of outcome in schizophrenia at 13 years. *British Journal of Psychiatry*, **167**, 596–603.

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AUTHORS' REPLY: We agree with Murthy's point that 'disability and chronicity' have been overemphasised in describing the outcome in schizophrenia, and that this pessimistic outlook is unlikely to be in the best interests of our patients. However, there are many authors who share a more optimistic view about the outcome of schizophrenia. Zubin *et al* (1983) suggested that the course of schizophrenia has undergone a 'benign metamorphosis' over the second half of this century, and Harding *et al* (1987) demonstrated good symptomatic outcome (no further signs or symptoms of schizophrenia) in 68% of their 20–25 year follow-up of 'chronic hopeless' cases of DSM–III schizophrenia. In a previous paper (Harrison & Mason, 1993) we commented on the hypothesis that outcome in schizophrenia has undergone a 'benign metamorphosis'. We suggested

that this 'metamorphosis' has taken place in clinicians' assumptions, in treatments, and in the quality of follow-up studies, rather than in the disorder itself. We concluded, however, that '*a move away from self-fulfilling prophecies regarding the inevitable deterioration of this condition augurs well for the innovative care of patients, and should stimulate further research into modifying the preventive strategies*', which is in keeping with the sentiments expressed by Murthy.

In our current paper we have attempted to give a clear cross-sectional account of outcome at 13 years in schizophrenia. We are surprised at Murthy's suggestion that there is a 'bias' towards chronicity in the reporting of our data, since the percentages quoted in our concluding remarks, and the abstract refer to those subjects without symptoms and without disability at follow-up. The finding that only 17% of the sample were alive at follow-up, without symptoms and disability, and receiving no treatment, should not be taken out of context. When this finding is viewed with the results as a whole, it suggests that we have cause to be optimistic about the 'treated' outcome of schizophrenia.

HARDING, C. M., BROOKS, G. W., ASHIKAGA, T., *et al* (1987) The Vermont longitudinal study of persons with severe mental illness. II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *American Journal of Psychiatry*, **144**, 727–735.

HARRISON, G. & MASON, P. (1993) Schizophrenia – falling incidence and better outcome? *British Journal of Psychiatry*, **163**, 535–541.

ZUBIN, J., MAGAZINER, J. & STEINHAUER, S. R. (1983) The metamorphosis of schizophrenia: from chronicity to vulnerability. *Psychological Medicine*, **13**, 551–571.

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Accepting voices

SIR: Max Birchwood makes reference to Karl Jasper's use of the term 'abyss' to describe the discontinuity between normal and psychotic experience (Book review: Accepting Voices, December 1995). During my years (seven) as a schizophrenic I have been examined by 18 psychiatrists, and the impression one gets is that they all have a very good *objective* understanding of the illness, but (obviously) they lack *subjective* knowledge. In my view, this is because the psychiatrist concerns himself with dissecting the statements a patient makes, in order to promote the patient's insight and reach an objective understanding of the cause of their symptoms. Psychiatrists always ask 'Why do you say that?' In order to understand the illness from a *subjective* viewpoint, he must ask 'How does that make you feel?' The questions a schizophrenic asks of his beliefs are not concerned with aetiology, but implication. The psychiatrist looks back into the belief to promote insight, whereas the sufferer looks forward, to gain pleasure. Thus, dissective questioning begets objective understanding, whereas implicative questioning instils subjective understanding (in the psychiatrist). The truth of the psychotic experience is like a rat, in one respect only. To find out how a rat functions, we put it on a slab and cut it up, but in doing so, the rat loses something vital. Similarly, dissective questioning fails to uncover something vital i.e. what the belief means to the patient. Empathy is a valuable asset in psychiatry, and by promoting subjective as well as objective questioning, we can allow the sufferer to express his feelings more clearly. Learning can then become a two way process.

BIRCHWOOD M. (1995) Book review: Accepting Voices. *British Journal of Psychiatry*, **167**, 843–844.

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CORRIGENDUM

MASON, P. & WILKINSON, G. (1996) The prevalence of psychiatric morbidity. OPCS survey of psychiatric morbidity in Great Britain. *BJP*, **168**, 1–3. The following reference should have been included in the reference list:

MELTZER, H., GILL, B., PETTICREW, M., *et al* (1995) *OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 1. The Prevalence of Psychiatric Morbidity among Adults Living in Private Households*. London: HMSO.