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Correspondence

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IMPROVED HOSPITAL ENVIRONMENT ON BEHAVIOUR PATTERNS OF MENTALLY HANDICAPPED PATIENTS

DEAR SIR,

A previous communication (James, Spencer and Hamilton) (*Journal*, 1975, **126**, pp 577–81) described a new hospital and the immediate effect of patients' behaviour when transferred from three old hospitals. This further communication deals with the longer-term effects on the patients' behaviour, most of whom would be classed as severely subnormal.

The investigation was on the same patients as in the previous study and the method of assessment was unchanged. The patients were divided into disturbed and non-disturbed groups. The former were rated on a modified form of the questionnaire of Moore, Thulin and Capes (1968) which was adapted by giving a numerical value to each behaviour trait listed. The number 2 was assigned if the trait 'certainly applies', number 1 for 'somewhat applies' and zero for 'does not apply'. The non-disturbed patients were rated on the NOSIE scale (Honigfield and Klett, 1965). To ensure unity of scoring by the nurses group discussions were held on the interpretation of the individual items. Since the start of the first study forty patients have been lost to the survey by reason of death, transfer to other hospitals or discharge to hostel or home, and of these 16 patients were in the disturbed group. Because the disproportionate loss of disturbed patients may lead to bias, the original data has been recalculated for those remaining. Numbers of patients rated and found disturbed at six weeks and two years are as follows:

Patients	No. rated 6 wks before transfer	No. disturbed	No. re-rated 2 yrs after transfer	No. disturbed
Adult males	226	82	199	74
Adult females	45	25	33	20
Children (male and female)	24	9	23	6
Total	295	116	255	110

In the initial survey six weeks after transfer to the new hospital, disturbed women and, to a lesser extent, men improved in their behaviour but the disturbed children did not improve. After two years the women showed a further improvement from 3·51 to 5·10 points, this further improvement being highly significant ($P < \cdot001$). In the previous paper improvement for disturbed women was given as 2·56 points but the figure of 3·51 points is the improvement recalculated with reference to the twenty disturbed women who remained for the final analysis at two years. The corresponding figures for the men was in the original paper from 0·96 points but recalculating this figure on the remaining 74 patients it is 1·36 points; their further gain after two years was to 3·76 points, which is also highly significant ($P < \cdot005$). The six disturbed children who remained in the survey had shown no significant change at six weeks and this was still true at two years but the number is too small for any useful conclusions.

The immediate effects of age and epilepsy which appeared at six weeks to be factors related to improvement were not seen when the two year results were analysed.

The non-disturbed patients had originally shown some improvement but their scores were re-examined after two years and this improvement had disappeared.

Patients did not always remain in the same category; disturbed patients may become non-disturbed and *vice versa*. Although there has been some improvement in the average behaviour with better physical environment 60 per cent of the originally disturbed patients remained disturbed at the end of two years while of non-disturbed patients 87 per cent remained non-disturbed at the end of two years. Undoubtedly the original period of six weeks was too short a time to judge the final outcome as patients needed time to adjust to their new environment.

From our findings it is evident that with a new purpose-built environment (which was not ideal in many ways) many patients may remain constantly or intermittently disturbed. The nature of this disturbance is varied, in some cases there is a recognizable mental illness but in other instances there

are unexplained affective outbursts. There is no doubt that mentally handicapped patients require a standard of accommodation that provides a good and suitable permanent home. Nevertheless it would appear that the physical environment alone may not play a dominant part in determining behaviour. Number and attitudes of staff, 'esprit de corps', personal relationships and psychiatric treatment may well be of much greater significance.

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References

HONIGFIELD, G. & KLETT, J. (1965) The Nurses Observation Scale for In-patient Evaluation: a new scale for measuring improvement in chronic schizophrenics. *J. Clin. Psychol.*, **21**, 65.

JAMES, F. E., SPENCER, D. A. & HAMILTON, MAX (1975) Immediate effects of improved hospital environment on behaviour patterns of mentally handicapped patients. *Brit. J. Psychiat.*, **126**, 577–81.

MOORE, B. C., THULINE, H. C. & CAPES, L. (1968) Mongoloid and non-mongoloid retardates—a behavioral comparison. *Am. J. Mental Defic.*, **73**, 433.

SEX OFFENDER THERAPY

DEAR SIR,

There are comparatively few therapeutic settings in which it is possible to conduct small group psychotherapy with sex offenders (of either sex) and members of the opposite sex. Most penal establishments are run on a one-sex basis. The literature on various forms of psychotherapeutic approaches in treating the sex offender is copious, *except* with reference to the small mixed group.

At this hospital we have been conducting such groups for the past five years and I would like to invite interested colleagues to communicate with me. Within the field of offender therapy there are relatively few openings for mixed small group psychotherapy. To be able to observe and monitor the behaviour of the man with a history of multiple rapes, in addition to the progressive disclosure of his inner world phenomena, in a small group where half the members are girls can provide vital clinical information. Such groups therefore provide the opportunity for enhancing a diagnostic dynamic formulation of the patient's psychopathology at the same time as furnishing the matrix for the sequential phases of the therapeutic process itself.

I am keen to collate data and pool the experience of those working in this field and would be grateful if they would kindly write to me at this hospital.

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PSYCHIATRY: MEANING AND PURPOSE: AN ANSWER TO DR BEBBINGTON

DEAR SIR,

Dr Bebbington's paper (*Journal*, March 1977, **130**, pp 222–8) raises a number of issues having different importance. The first and less important is whether the arguments he raises against those who make the distinction between causal explanation and meaningful understanding in examining the theory of psychoanalysis can bear the weight that he puts upon them. The contention is that physical reality can be observed and explained in terms of causal connections, whereas psychic reality can only be 'understood' by meaningful connections. In themselves these arguments are academic in the pejorative sense, and they can be answered fairly easily by saying that he has misunderstood the authors he has criticized, and indeed be accused of misquoting them. Whether this is correct must be an individual opinion, only reached by those sufficiently interested to read the works of those he criticizes. To me the philosophical hardware which Dr Bebbington throws at us, if I have not misunderstood him, has a soft impact. I do not wish to try to answer him blow for blow. He is, however, very concerned that psychiatrists should be scientists, because he thinks reasonably enough that this will influence what they do in the clinical situation. His main conclusion is that he would like to see the principle of Popperian refutability applied to psychoanalytical theory even though this 'would involve major change in the form of the theory'. But surely the 'theory', as put forward by Freud, has been subject to change and revision again and again, and who can tell now what the main tenets of psychoanalytic theory are? To quote Seeley (1967):

> 'The words were hardly cool on Freud's lips, the ink hardly dry on his pen, before "revisionism"—or as he looked upon it apostasy—set in, even in Europe. Unlike Christ, eleven-twelfths of whose disciples remained formally firm in the faith, Freud lived to see proportions almost reversed—Jung, Adler, Ferenczi, Reik, Rank and Stekel to mention only the most eminent.'

In the US there were the revisions of Sullivan, Horney and Fromm, and in the UK that of Klein. In Europe existential theory has flourished. But there