and as Chairman of the relevant Board of Examiners, both for a good many years, I know that candidates were expected to be able to discuss the causes of violence and the management of possibly violent patients; and moreover, the many thoughtful and intelligent answers to questions set on the subject showed that on the whole it was being adequately taught and understood. All textbooks on mental nursing have something to say about violence—perhaps the best discussion is that in Miss Altschule's *Aids*, which has been in widespread use.

It is hard to see how any nurses who have forgotten the instruction they have received, or who choose to ignore it, or who find it impossible to apply it in practice because of adverse circumstances, are going to be put back on the right road by the two or three paragraphs of the 'Guidelines' which are meant for them. These paragraphs are not even up to the standard of a nursing examination answer; for example, no distinction is made between the aimlessly violent low-grade defective, the unruly psychopathic girl, or the patient who is violent only because he comes from a milieu where violence is normal.

To put it briefly, good nurses do not need to be told what is in the Guide, and bad nurses will ignore it.

The 'Guidelines' are stated to have been drawn up in response to 'appeals from within the nursing profession', and more specifically to a letter addressed to the Committee of Enquiry into conditions at Farleigh Hospital by a group of nurses at that hospital. This letter purported to express the staff's anxieties and perplexities, but these related solely to the 'restraint' of violent patients. One wonders whether such a limited view of the problem could not have been dealt with more effectively by discussion on the spot—indeed it may have been—and whether it really called for the ponderous production of a code of almost equally limited scope. We all know that complaints at other hospitals have referred to old people who are not violent at all, but exceedingly trying to the patience of those attending to them; surely it is not intended that there should be a separate set of 'Guidelines' for these, and more for other types of patients? And if a really comprehensive code dealing with every eventuality is compiled by the proposed Joint Working Party, will not its scope not be co-extensive with the whole of psychiatric nursing, so as to be in effect just another textbook?

I should add that much of what is said in the paragraphs on administrative procedures is to be commended, though even here there is a certain amount of woolliness. If indeed there are any nurses who are prone to act 'other than in good faith' or to 'apply undue force' they will not refrain from such actions just because a patient's admission has been 'discussed with the Nursing Services'. The idea of policy being decided 'by discussion' (instead of 'after discussion') reflects the fashionable 'medical abdicationism'. Neither Conolly's 'non-restraint' nor T. P. Rees's 'open doors' could ever have been brought into being in this way.

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MECHANISM AND MEANING

DEAR SIR,

Dr. O. T. Phillipson's strictures (*Journal*, March 1971 pp. 377–8) on my Ernest Jones Lecture, an abbreviated version of which was published in the *Journal* recently (Hill, 1970), call for a reply. He quotes two passages of mine (although the second contained a reference from a paper by Mr. H. J. Home which he did not acknowledge) to elucidate what he thinks I mean by 'meaning'. He reaches the conclusion that what I am 'concerned with are questions which are outside the scope of scientific explanation, that is philosophy, metaphysics or what you will'. Dr. Phillipson then states that the difference I have described between mechanism and meaning is the 'difference between the objectivity of science (insofar as that is possible) and the subjectivity of metaphysical speculation'.

If I had believed in such a simple conclusion, I would not have undertaken the task of writing the lecture, which was an attempt to discuss again the position of psychoanalysis and its claims to be a deterministic science—but to do so in the context of different types of conceptual model. Having ignored my arguments Dr. Phillipson has made his own interpretation of the position, which is certainly not mine, and has then surprisingly stated: 'if this interpretation is correct, it shows a logical misunderstanding of psychoanalytical theory'.

There is only one other matter of fact in Dr. Phillipson's letter to which I wish to respond. He seems disturbed by my statement that for psychiatrists neither knowledge of how things happen in the nervous system, nor the full analysis of the outward forms of behaviour, if both were possible, will be *sufficient* for their purposes. This is a self-evident truth to most psychiatrists with any degree of clinical experience, but they would agree with Dr. Phillipson that knowledge of the nervous system and the analysis of behaviour are greatly to be desired, and that these 'approaches are essential'. But I think Dr. Phillipson has fallen into the common

https://doi.org/10.1192/bjp.119.550.348 Published online by Cambridge University Press

error, because he does not agree with me, of overstating his case and understating mine. What I wrote was: 'It can therefore be held that the objectives and aims and the methods of enquiry of those who study mechanism and those who study meaning are not antithetical, but rather they are complementary'.

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REFERENCE

HILL, D. (1970). On the Contributions of Psychoanalysis to Psychiatry: Mechanism and Meaning, *Brit. J. Psychiat.*, **117**, 609–15.

PREPARATION OF THE TRAINEE IN PSYCHIATRY IN MANAGEMENT

DEAR SIR,

It is surprising that the Memorandum on Educational Programmes for Trainees in Psychiatry (*Journal*, June 1971, pp. 693–5), excellent as it is, makes little reference to the administrative and managerial role which the trainee in psychiatry is being prepared to fulfil.

The specialist, to be successful, must be more than a highly paid technician. In the day to day treatment of his patients in hospital, the consultant is dependent on nurses, occupational therapists, social workers, psychologists and other members of the staff, whose functions have to be co-ordinated and whose attitudes may have to be modified if effective therapy is to be realized.

In few centres are optimal facilities and conditions obtainable. Hospitals are short of staff, and the demands for services nearly always exceed the resources. Hence the consultant needs to evolve strategies to utilize what is available to the fullest extent and to determine priorities. No specialist can work in isolation, and a willingness and ability to co-operate with colleagues, professional and lay, on a flexible basis is essential.

In the psychiatric hospital all influences which impinge on the patient have therapeutic or non-therapeutic effects. If the consultant is to be finally responsible and accountable for his patients' treatments he must know how to play an effective part in the overall administration and management of the hospital as an institution, the *raison d'être* of which is treatment of the patient.

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SMALL HANDWRITING IN SOME PATIENTS WITH ANOREXIA NERVOSA

DEAR SIR,

The syndrome of anorexia nervosa was defined by Gull in 1868. It occurs predominantly in adolescent girls and young women and is characterized by weight loss, food refusal and amenorrhoea. Russell (1970) has discussed the identity of this syndrome as an illness with its own peculiar psychopathology, and others such as Bruch (1966), Selvini (1965), and Crisp (1967) have drawn attention to characteristic psychological disturbances in these patients. Bruch stresses in particular that they frequently have a distorted body image, believing themselves to be obese when in fact they are emaciated.

We have observed peculiarities in the handwriting of patients suffering from anorexia nervosa. The handwriting in some cases is extremely small and neat. This is demonstrated in examples (a), (b) and (d) in Fig. 1. In each instance the handwriting is that of a girl with anorexia nervosa during the phase of her emaciation. Example (d) is of particular interest, as a specimen of the patient's writing before the onset of her illness is available (c), and the change which has occurred is well demonstrated. All the examples of handwriting are reproduced at their natural size.

It is suggested that in some patients with anorexia nervosa the handwriting is extremely small. This observation is perhaps of interest in view of what is known of the characteristic psychopathology of the condition.

ACKNOWLEDGEMENT

I wish to express my gratitude to Dr. G. F. M. Russell of the Institute of Psychiatry and Metabolic Ward, Maudsley Hospital, for permission to represent data concerning his patients.

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REFERENCES

BRUCH, H. (1966). 'Anorexia nervosa and its differential diagnosis.' *J. nerv. ment. Dis.*, **141**, 555.

CRISP, A. H. (1967). 'The possible significance of some behavioural correlates of weight and carbohydrate intake.' *J. psychosom. Res. II.* 141.

GULL, W. W. (1868). 'The Address in Medicine delivered before the Annual Meeting of the British Medical Association at Oxford.' *Lancet*, *ii*, 171.

RUSSELL, G. F. M. (1970). 'Anorexia nervosa: its identity as an illness and its treatment.' In *Modern Trends in Psychological Medicine*, edited by J. H. Price, Butterworth.

https://doi.org/10.1192/bjp.119.550.348 Published online by Cambridge University Press