present a relatively objective scientific study, rather than making the much needed plea for action to be taken about this population—a plea that I have already endorsed more informally elsewhere (Priest, 1973, 1975). It is in these reviews that I have covered some of the more recent literature (which tends to be of this action-demanding kind rather than being relevant surveys of representative samples).

I should like to try to follow up Beresford's suggestion and carry out a similar study in the general population—comparing the background prevalence of psychiatric symptoms there with rates found in the sample that presents to the psychiatric services. It would be a rather more expensive project, and so far I have been unable to get the money to fund it.

Finally, the NAB publication *Homeless Single Persons* did give the results on a survey of a representative sample of roughly 30,000 dwellers in common lodging houses, etc. Whether the title refers to this (as I assume) or a sub-section of the population (as Beresford suggests) is probably a matter of opinion. I think that we would both agree that the residents have a roof rather than a home.

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MONOSYMPTOMATIC HYPOCHONDRIASIS, ABNORMAL ILLNESS BEHAVIOUR AND SUICIDE

DEAR SIR,

I enjoyed Dr Bebbington's well-documented paper on the above topic (*Journal*, May 1976, **128**, pp 475–8) and I would agree with his statement that 'the treatment of hypochondriasis is difficult'. In fact, so far as psychotic cases are concerned, treatment has conventionally been regarded as well-nigh hopeless.

Dr Bebbington's paper went to press just before the appearance of a paper on monosymptomatic hypochondriasis published by Dr Joyce Riding and myself (1) in which we describe the striking response in five cases of this disorder to treatment with pimozide. There are, so far as we know, no previous reports of pimozide being used in this way.

Since coming to Canada, I have seen one other case which has responded just as convincingly to the same drug:

A man aged 49 was admitted to the Psychiatric Department, Toronto General Hospital on 25 February 1976, complaining that he smelled unpleasantly because of a leakage of urine. He was convinced that his perineum and legs were soaked in urine, although there was no objective evidence of this or of any unpleasant odour. The symptoms had developed gradually over the previous six months and he was very distressed by them. He could not be convinced that he was mistaken, and he wanted physical treatment, though he accepted admission to the psychiatric unit. He was not clinically depressed and showed no evidence of thought disorder or of significant personality deterioration. Physical examination was essentially negative.

Three days after admission, pimozide 4 mg in the morning was commenced, and during the ensuing seven days his symptoms gradually abated. He was discharged home two days later and returned to work after a short period of convalescence. He has remained well since, except that when he drinks heavily he becomes convinced for a time that he is again leaking urine, though he does not complain of any smell.

I would therefore temper Dr Bebbington's hitherto-justifiable therapeutic pessimism by suggesting that cases of monosymptomatic hypochondriasis of psychotic degree should certainly be given a trial of pimozide.

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1. RIDING, J. & MUNRO, A. (1975) Pimozide in the treatment of monosymptomatic hypochondriacal psychosis. *Acta Psychiatrica Scandinavica*, **52**, 23–30.

NEW LONG-STAY PATIENTS IN A HOSPITAL FOR MENTAL HANDICAP

DEAR SIR,

Dr Spencer (*Journal*, May 1976, **128**, pp 467–70) concludes his paper '. . . hospital is the only place with staff and resources to receive and help many mentally handicapped persons whose management is beyond the capability of their families and the local facilities of the Social Service Department . . .'.

The data presented in his paper only demonstrate that, at present, the existing hospitals *receive* clients, i.e. that consultants *transfer* clients into existing hospitals. What is missing is data relating to:

A. The current problems of:

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(i) the clients
—their behavioural deficits and excesses;
(ii) the clients' relatives
—their behavioural deficits and excesses with respect to the client;
(iii) the direct-care staff in local facilities of the Social Service Department
—their behavioural deficits and excesses with respect to the clients.

B. The behavioural targets set by consultants for the clients, their relatives and the Social Service staff which, when attained, will constitute 'solutions' to the problems specified in A.

C. (i) the interventions (treatments) which enable the above people to move from A to B;
(ii) *who* carries out the interventions?
(iii) the *criteria* of 'good' and 'bad' practice.

D. The relationship of interventions currently undertaken in hospitals to patients' attaining behavioural objectives.

E. The conditions in existing hospitals, not found elsewhere, which allow interventions specified in C to attain the outcomes demonstrated in D.

To be sure, severe disruptive behaviour, which is apparent only in a small minority of clients (biting, scratching, pushing, self-mutilation or screaming) is aversive to family members with a person at home, or to clients and staff in conspicuously sited Social Service or Health Service establishments. They will be thankful for the relief which the transfer of the client to a hospital may offer; but this is not to say that the conditions within the hospital are such that an improved educative programme will be initiated to develop alternative acceptable skills in the place of the problematic disruptive behaviour. Not only may the client not directly benefit, but, as is often the case, skills which were maintained in the relatively rich environment from which they came begin to weaken. This may lead to a worsening of the original problem behaviours.

We have evidence that the frequency of disruptive behaviour may increase in the less conspicuous but often more barren environments to which such clients are transferred (Kushlick, 1975a; Felce and Powell, unpublished). This is often reflected in the frequency with which injury forms must be completed on other clients who are victims, or on the disruptive client, now a victim of some counter-violence from others in the new shared environment.

Similarly, in the less conspicuous environment there may be a higher frequency of the unpleasant and ineffective practices by which staff attempt to control disruptive client behaviour. These practices include major degrees of restriction, restraint, as well as unsystematic punishments, both positive and negative (Kushlick, 1975b).

In addition, studies which have investigated the rates at which direct-care staff contact and interact with individual clients in existing hospital settings show that these rates can frequently be very low indeed (Durward and Whatmore, 1976; Wright *et al*, 1974).

Dr Spencer's conclusion will become useful to the extent that he is able also to provide at least some of the missing data.

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