can be so devastating as to cause death. In lesser cases recent research has shown a significant increase in physical illness in the bereaved, especially cardiovascular disease.

Dr. Sunder Das suggests converting grief into suffering to mitigate its effect. Might this not also apply to converting unnecessary and unreal depression, anxiety, delusions, etc., into more adaptive reactions?

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REFERENCE

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THE N.A.M.H. 'GUIDELINES'

DEAR SIR,

In trying to justify his opinion that the N.A.M.H.'s 'Guidelines' will be of very little value, Dr. Alexander Walk says, amongst other things, that all textbooks on mental nursing have something to say about violence (this *Journal*, September, pp. 347-8). How satisfactory in this respect are the textbooks? Miss Altschul makes a few sensible points in her *Aids*. Brian Ackner's textbook skates quickly over the problem. Maddison, Day and Leabeater's describes a variety of procedures from sympathy to seclusion, and makes the suggestion: 'The very angry patient may be given rags and hessian to tear up or allowed to carry out violent hammering.' Boorer and Boorer's advises that 'the nurse should stay with the patient and encourage her to let off steam in an energetic way such as scrubbing floors or making a sponge cake'. Very little is said in any of the textbooks about the conditions in which violence occurs, with a notable exception. Noyes-Haydon and Van Siekel's contends that the aggressive patient may have 'heightened erotic drives and make vulgar and profane remarks'. It continues: 'If the patient uses obscene language, the nurse may suggest to him that there must be some reason why he needs to use such words.'

Perhaps these excerpts are unfair. Nurses will find in the textbooks some advice—not always good advice—on what to do, but will get little help in understanding why and when patients become violent. To be told that violence is a symptom of the illness is not helpful and may be seriously misleading. Even if they were fully satisfactory, textbooks, unhappily, are few and far between on the wards of psychiatric hospitals. Few of the staff have had the opportunity of following any of the syllabuses Dr. Walk has helped to draw up. The demand for N.A.M.H.'s booklet has been heavy and continues. It seems to be getting into the hands of the staff on the wards, both untrained and trained, for whom it was written.

Dr. Walk underestimates the concern felt by the staff of psychiatric hospitals about the problems of violence. We do not doubt the need for something like the 'Guidelines'. We hope, as many do, that N.A.M.H.'s booklet will soon be superseded by something much better.

The 'Guidelines' were written for nurses by nurses. Doctors gave some modest help. Dr. Walk's reference to 'the fashionable medical abdicationism' suggests to us that he has misunderstood—or is perhaps out of sympathy with—the kind of partnership it was.

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DEAR SIR,

Mr. Bury and Professor Russell Davis must have read my letter (*Journal*, September 1971, Vol. 119, p. 349), rather cursorily, for I did not contend that the 'Guidelines' were of little value in general, but that they would not be very helpful to nurses on the ward—referring, of course, to paragraphs 1 and 2; I added that the administrative sections contained much that was to be commended. The writers, taking an *illi quoque* line, disparage existing textbooks and make the very sound point that many of them do not explain why and when patients become violent. But this was precisely my criticism of the 'Guidelines', in which the nurse will find nothing but a few well-worn clichés about 'establishing a good relationship' and 'removing what the patient perceives as threatening', without even the sketchiest account of the widely ranging 'whys and whens' that may result in violence.

I am at a loss to understand what the writers can mean by the statement that 'few of the staff have had the opportunity of following any of the syllabuses" of the G.N.C. Something like 20,000 nurses have passed final examinations based on these syllabuses, and, as I have said, questions on the causes and prevention of violent incidents have been frequent and have been well answered.

I am glad that Mr. Bury and Prof. Davis agree that something much better is needed. I hope that the Joint Working Party will take the widest possible

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veiw of these problems, and will do nothing to suggest that 'violence'—still less 'restraint of violent patients'—can be considered in isolation from the whole art of mental nursing.

By a strange sleight-of-hand my mention of 'medical abdicationism', which referred to the 'formulation of a policy for each patient *by* discussion', has been transferred to something quite different, the drafting of the 'Guidelines' themselves. I could not have remained a member of the G.N.C. for fifteen years had I been out of sympathy with 'this kind of partnership'. But policy-making *by* discussion is only possible if there is agreement on fundamentals, and this is why I think the doctor should retain the final responsibility—i.e. take a decision *after* discussion. There are many nurses of whom I can truly say that I would unhesitatingly accept their policy. But I once knew a matron who held that our young unruly psychopathic patients ought to be treated by the operation of smackbottomy. Fortunately she was not in a position to put this into practice. In these circumstances, formulating a policy *by* discussion might have resulted in a (? Rhodesian-type) compromise on unilateral smackbottomy.

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TRAINING GROUPS

DEAR SIR,

In discussing the growth of interest in Training Groups in Britain, J. R. Marshall (*Journal*, July 1971, Vol. 119, p. 117) expresses 'uneasiness concerning the methods employed and the assumptions made by those involved in the organization of these groups'. The argument developed is commonly heard, but since most of it applies far more widely than just to Training Groups it seems relevant to question the motivation behind it. In Australia, as in Britain, comparatively few psychiatrists are significantly involved in such group activity, and the fact that these methods have been more extensively and systematically used in non-medical institutions might equally be argued as a cause for concern.

There is an Australian Institute of Human Relations, and it is precisely the aim of this organization to provide training and to set 'normative standards, rules and codes of behaviour'. It does not however, reduce the amount of suspicion and disquiet with which groups and laboratories are viewed, any more than associations and training schemes reduce the same attitudes to psychoanalysis and the psychotherapies. The recent contribution of Melitta Schmideberg (*Journal*, January 1971, Vol. 118, p. 61–68) indicates that a well-established professional body does not necessarily prevent 'very tragic happenings . . . strange intrigues, and . . . incredible incidents'. Recent research in the United States on the outcome of psychotherapy would also tend to support the argument that professional acceptability and conformity is no guarantee of therapeutic results (or safety). Furthermore, if, as is often stated, 'psychotherapy is the treatment peculiar to psychiatry', it must be accepted that there are still many practising this art who have neither had formal training nor subject themselves to critical evaluation, whether by themselves or their peers or anybody else.

That 'leaders may use the groups for their own aggrandizement or neurotic needs' and that they may be 'incompetent—either accomplishing little or allowing unnecessary and destructive group activity' is an argument that might be directed equally well at any leaders. Nor do anecdotal descriptions of cases of emotional disturbance aggravated by sensitivity training, nor any of the other arguments indicating the dangerous possibilities of Training Groups, do anything more than highlight the uncertainty which bedevils all attempts at interfering in human behaviour. That some people get hurt certainly justifies constructive criticism, but it must be remembered that there are no human situations involving stress in which vulnerable individuals may not be damaged, whether they enter them voluntarily or under orders.

There are of course more specific criticisms that can be directed at Training Groups, but most of the problems that confront them are in fact essentially the same as those that arise in naturally occurring or more formally established groups—wherein lies their training value.

One is led to the conclusion that much of the criticism directed by the profession against the practice and assumptions of Training Groups is derived from professional defensiveness (and, incidentally, no group is more defensive than one composed of 'professionals'). The correspondence in the *Journal* last year, engendered by the Seebohm Report (*Journal*, April 1970, p. 457; July, p. 126; November, p. 607), is evidence enough of the territorial rivalry that exists between us and our neighbouring disciplines. Not that this is surprising or unnatural. After all it only indicates that professional bodies behave much like any other human groups. It is, however, probably true that the failure of the profession as a whole to accept in partnership sociology and psychology has resulted in many of our institutions remaining antiquated in their approach to the management of human behaviour. There is a tendency to deny the blurred boundaries between normality and psychiatric disorder. In consequence there is a failure to

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