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

adequately recognize the large areas of interest that we share with other professions and disciplines (education is especially ignored) and to accept that these disciplines may have more productive theoretical models and more practical experience in some of these areas. Where groups are concerned, the tenacity with which we hang on to the hallowed doctor/patient relationship may well have a bearing on this.

Nothing of this is intended to indicate that psychiatry has little to offer in the development of Training Groups. In the areas of selection, protection and follow-up it is reasonable to assume that psychiatric experience would be particularly valuable. Such a 'responsible' contribution however, is probably best made from within the organization, and it could be argued that in these circumstances psychiatry has as much to gain as it has to offer. It is certainly not enough, to suggest that 'the way in which Training Groups are conceived bears some relationship to cults which have developed in the past'. The very fact of the popularity of Training Groups and other group activities in education, industry and other institutions surely indicates a 'need' that may have relevance both to the aetiology and the management of large areas of emotional disturbance.

The fact is that we live and work in a complex matrix of groups, and, H. Osmond (*Journal*, November 1970, p. 607) notwithstanding, mental hospitals provide one and many types of group. Understanding of the abnormal proceeds from understanding of the normal. At very least, if we are to further the understanding and practice of mental health we must be to able show that we can distinguish between unbiased scientific enquiry and professional 'group maintenance'.

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PRISONERS OF XYY CONSTITUTION

Dear Sir,

In a recent paper, Griffiths (1971) reports on the questionnaire scores of prisoners of XYY constitution and controls equated for height; he concludes that of the three variables measured (P = psychoticism, E = extraversion, N = neuroticism), the only significant difference occurred with respect to E, XYY karyotypes being more introverted. The scoring key used by Griffiths has been supplanted by a different key based on a number of factor-analytic investigations on various groups of prisoners and controls, and hence it may be of interest to see whether similar differences are apparent when the new key is used. In searching for an appropriate control group it seemed undesirable to confine ourselves to that used by Griffiths; although he tried to equate this group with the XYY group for height, there was a difference between the two groups significant at the 1 per cent level, which may rule out the possibility of regarding this group as matched for height with the experimental group. Fortunately the very small control group did not differ significantly from our large prison standardization sample of 603 with respect to P, E or N, and consequently we have compared the experimental group with this much larger group (Eysenck and Eysenck, 1970). Of the original 12 subjects, records for rescoring were made available by Mr. H. Marriage, senior prison psychologist at Wandsworth, for 10; their mean scores and SDs and those of the control group, are given below

XYY:	N = 10	P = 8·40 ± 3.86	E = 9.40 ± 3.53	N = 12.2 ± 5.65
Controls:	N = 603	P = 6.25 ± 3.01	E = 12.75 ± 3.52	N = 11.04 ± 4.75

Significant differences were observed for E ($t = 2{\cdot}98$, $p < {\cdot}005$), and for P ($t = 2{\cdot}23$, $p < {\cdot}05$). XYY karyotypes are significantly more introverted and higher on psychoticism than the normal controls; there are no differences on N. It is the addition of P to the previously noted difference on E which caused us to write this letter; this additional difference is very much in line with prediction (Eysenck, 1971). The number of cases on which this difference is based is of course small; it is to be hoped that future studies will make it clearer just how much confidence can be had in these relationships.

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SCHIZOPHRENIA AND SEASON OF BIRTH

Dear Sir,

We should like to reply to Dr. James' letter (*Journal*, August 1971, Vol. 119, page 229). There seemed to us good reasons for not comparing the season of birth of our Maudsley patients with those of the general population given by the Registrar