

LETTERS TO THE EDITOR

Sir,

Interactions between Nursing Staff and Profoundly Retarded Children

This study in the June 1974 issue of the British Journal of Mental Subnormality appears to have been designed to produce evidence supporting previously held convictions (indeed, prejudices) rather than to add to the body of knowledge concerning a difficult subject, i.e., the proper care of the mentally handicapped. The scope of the study is so narrow and so many variables are totally ignored that it would normally not be admitted as evidence at all by any bona fide researcher, yet the authors claim that their findings support the very sweeping suggestions made at the end of their report.

A useful way of illustrating my point would be, perhaps, to take each of their suggestions in turn and to ascertain how far, if at all, their figures support those suggestions.

Suggestion (a). This contains, in actual fact, two suggestions, so I will take these separately.

(a) **"To revise the training of nurses who care for the mentally retarded in favour of a child care or 'nursery nurse' approach."**

The authors do not demonstrate that the nurses observed are, in fact, trained or in training, nor do they mention the types of qualifications held (there are at least seven different forms of nurse training). Nor do they produce any evidence that a child care or nursery nurse approach would produce better interaction results bearing in mind that these are **not** normal children, and some have a chronological age of 18 years, e.g., no syllabus content, no other surveys.

(a) (ii) **... to remove their multiple housekeeping duties.** This is the only mention of these duties in the survey, yet the length of time the nurses are involved in these surely governs to some extent the amount of time available for interaction with the residents.

(b) **... to consider the employment of staff with other types of training.**

As the authors have not demonstrated that faulty training is indeed the reason for lack of interaction, the suggestion that staff with other forms of training should be used appears unwarranted. (Indeed, are there types of training in existence which would produce better results in the circumstances?) In fact they indicate that other factors could be involved, i.e., staff—patient ratio—multiple housekeeping duties.

(c) **To consider other forms of long-term care, e.g., small residential hostel care.**

What is meant by the term "small"? Many hostels currently in existence have approximately the same number of residents as the wards in the survey, i.e., 20. Is there any evidence that given the same staffing ratio resident care would be any better?

(d) **To consider the numerical adequacy of staffing of wards for severely retarded children.**

This should surely have been considered before any of the other suggestions were made! But from the survey no real estimate of the relevance of this suggestion could be made.

It is stated that there were three members of nursing staff to 20 residents, but it was not made clear whether—

- (i) The staff were available all the time to care for the residents, e.g., was the Charge Nurse who would have other duties to perform included in these numbers?
- (ii) The twenty residents were present on the ward during the whole of the observed period or whether some were attending other departments, e.g., School or Occupational Therapy.

Certain other criticisms can also be made concerning the overall planning of this survey. One of the more important is subdivision of staff/patient interaction into three categories. How realistic is it to expect a significant degree of "positive" interaction in situations such as these where the mental ages of the residents are 24 months or lower despite their much greater chronological ages?

The choice of terms, "positive, negative and neutral," could also be said to introduce a degree of "value judgement" concerning the types of interaction—can one really describe cuddling a child as a form of "neutral" interaction?

One further factor which seems to have been ignored, and this, to me, is a crucial one. Were the staff on each shift the same for the major part of the time observation was taking place, or was there a constantly changing staff? This would surely influence the amount of interaction, particularly that which was child-initiated.

In short, it would seem to me that many factors clouding the main issue (that of appropriate staff training) have to be removed before any observation can be made in the adequacy of training or recommendations made as to alterations in training. The main ones are:—

(1) Administrative

- (a) Numerical adequacy of staff.
- (b) Staff constancy.
- (c) Other duties required of staff which remove them from the vicinity of the resident.
- (d) Pressures from other disciplines, e.g., the demand that residents be delivered to school or occupational therapy at a particular time, even if this does not allow adequate time for residents to practise self-help skills such as feeding themselves.

(2) Relevance of criteria

- (i) Making certain that it is realistic to expect certain behaviours in a given situation.
- (ii) Ensuring that, in this particular instance, staff observed have the qualification under discussion, i.e., are trained in the care of the mentally subnormal and not in the care of the physically ill adult, or child, or the mentally disturbed.

It seems a pity that studies such as this which stop short as soon as the observers have proved (to their own satisfaction at least) some "trendy" theory are published at all. Researchers in the social sciences sphere could imitate, with profit, the integrity and precision of researchers in the natural sciences—no journal concerned with which would, I am sure, publish such an inadequately researched study.

Yours sincerely,

Tatchbury Mount Hospital,
Calmore,
Southampton.

MISS J. COOMBES,
Senior Nursing Officer (Teaching).

Dear Sir,

A Study of the Interactions between Nursing Staff and Profoundly Mentally Retarded Children

Miss Coombes appears to require our study to answer questions which it never posed. The scope of the study was deliberately narrowed down in order to bring into sharp focus one particular observable variable, and no others (i.e., the nurse-patient interactions). Obviously many variables were ignored or, more accurately, intentionally excluded; this is so of every study in which the results are not to be obscured by a cloud of distracting detail. We set out to study one situation and to state as simply as possible what we could measure. We have both worked with severely or profoundly mentally handicapped children in hospitals for more than a decade, so it would be remarkable if we had not formulated some convictions during that time, though the implication that we held negative prejudices is false. We were not at all happy when we worked out the data obtained with our Research Assistant, Miss Meredith, and hesitated for a considerable time before preparing a paper for publication. Ultimately, we concluded that this was a statement of observable facts, as honest as we could make it, and as such worthy of consideration, if only to stimulate thoughts such as "Have we also this problem?" and "What can we do to improve our staff-patient interaction?"

In our suggestions to improve the quantity and quality of the interactions we drew heavily on the work of Professor Tizard and his team to which we referred in our paper. To replicate their work would have been beyond our resources and, in any case, unnecessary as no one, to our knowledge, has called into question the validity of their work. We cannot surmise Miss Coombes' concept of a *bona fide* researcher, but we feel that few would deny Professor Tizard this status.

This time we quote chapter and verse from King, Raynes and Tizard ("Patterns of Residential Care." London: Routledge and Kegan Paul, 1971) in support of each suggestion we made:

(a) To revise the training of nurses who care for the mentally retarded in favour of a child care or "nursery nurse" approach.

Page 197: "When we examined the training of the head of the unit we found considerable support for our hypothesis that high rates of interaction with the children are associated with training in child care, whereas low rates of interaction were associated with a nursing training."

(a) (ii) to remove their multiple housekeeping duties.

Page 196: "When they were engaged in domestic or administrative activities, the heads of child-oriented units tended to undertake them in the presence of children, whereas the heads of institutionally-oriented units did so in isolation from the children."

(b) to consider the employment of staff with other types of training.

To us this seems to follow from the first suggestion. If high rates of interaction with children are associated with training in child care (and if interactions are important) then consideration should be given to employing staff with training in child care.

(c) To consider other forms of long-term care, e.g., small residential hostel care.

Our suggestion clearly related not to the size of the living unit but to the total size of the whole institution.

(d) **To consider the numerical adequacy of staffing of wards for severely retarded children.**

We seem in principle in agreement over this suggestion. However, we could not consider this before anything else, as is suggested, because we had no control over it.

- (i) The Charge Nurse was included in these numbers.
- (ii) The twenty residents were present throughout each of the eight half-hour periods of observation. No child under M.A. 2 years then went to school (though all children now do so) and there is no Occupational Therapy Department. It is entirely realistic to expect "positive" interaction between patients with mental ages of 12—24 months, as any appropriate behaviour modification programme can demonstrate (v. Kiernan, C. C. and Wright, E. C., 1973. Proc. Roy. Soc. Med. 66, 1137-1140).

"Neutral" was defined as promoting neither independent nor dependent behaviour. Does Miss Coombes wish to suggest that cuddling is either positive or negative in relation to independence? (Granted, it is positive in relation to other factors.)

No, the staff were not "constantly changing," since the whole of the observations were conducted during a four-week period.

We trust these replies answer the questions raised.

We reject the allegation that our studies are "inadequately researched," and, apropos Miss Coombes' suggestion that natural science journals would not have published our work as they have a higher research standard, might point out that a very much less precise study of variables affecting long-term or short-term care was published by us in an extremely reputable natural science journal (v. Donoghue and Abbas, 1970. Nature 227, 5261, 972).

Finally, our study stopped short when it had made its point because we prefer precision. Our work, however, has not at any time stopped, and if Miss Coombes would care to visit us we would be delighted to welcome her and demonstrate our on-going studies which would, we trust and believe, convince her that whether or not precision is always possible in the field of mental handicap, integrity is not lacking either in our hospital or in our work.

E. C. WRIGHT.

K. A. ABBAS.

St. Ebba's Hospital,
Epsom,
Surrey.

Dear Sir,

Burden Research Medal and Prize

Entry for the Burden Research Medal and Prize is open to all registered medical practitioners who are working in the field of mental subnormality in the United Kingdom or Republic of Ireland.

The award for 1975, total value £250, may be presented at Stoke Park Hospital on or about the 1st April, 1975, for outstanding research work which has been published, accepted for publication or presented as a paper to a learned society during the three-year period ending 31st December, 1974.

Five copies of the paper or papers, with application form, should be submitted to the Secretary of the Burden Trust by the 10th January, 1975.

Further information and application forms are available from the Secretary, Burden Trust, 16 Orchard Street, Bristol BS1 5EA.

Yours sincerely,

Stoke Park Hospital,
Stapleton,
Bristol BS16 1QV.

W. A. HEATON-WARD,
Secretary to the Awards Committee.

THE PHYSICAL ENVIRONMENT OF THE MENTALLY HANDICAPPED

The Editor regrets that this series of articles had to be interrupted to make room for the publication of papers which had accumulated in recent months. The series will be continued as soon as possible.