THE EDITORIAL COMMITTEE welcomes original papers, which should be addressed to the Editor, Journal of Neurology, Neurosurgery, and Psychiatry, BMA House, Tavistock Square, London WC1H 9JR. Papers are accepted on the understanding that the subject matter has not been and will not be published in any other journal. Papers should deal with original matter and the discussion should be closely relevant to this. Manuscripts should be typewritten in double spacing on one side of the paper only. Two copies (including figures and tables) should be submitted of which only one need be a top copy. A summary of about 50 words should appear at the beginning of each paper. The name(s) of the hospital or laboratory should also appear. Full postal address for correspondence and reprints should be supplied. Receipt of manuscripts will be acknowledged.

The Editor will welcome Short Reports or Preliminary Communications limited to about 1000 words and with no more than one figure and one table. Also welcome are Letters to the Editor.

ETHICS Ethical considerations will be taken into account in the assessment of papers (see the Medical Research Council’s publications on the ethics of human experimentation, and the World Medical Association’s code of ethics, known as the Declaration of Helsinki (see British Medical Journal 1964:2:177)).


ILLUSTRATIONS Photographs Unmounted photographs on glossy paper should be provided together with magnification scales when appropriate. Diagrams will be reduced to 2¾ inches (68 mm) wide, occasionally to 5¼ inches (145 mm). Lettering should be in either Letraset or stencil and care should be taken that lettering and symbols are of comparable size. Illustrations should not be inserted in the text. They should be marked on the back with figure numbers, title of paper, and name of author. All photographs, graphs and diagrams should be referred to as figures and should be numbered consecutively in the text in Arabic numerals. The legends for illustrations should be typed on a separate sheet. Tables should be numbered consecutively in the text in Arabic numerals and each typed on a separate sheet. The format used in this issue of the Journal should be noted. Vertical lines will not be printed and usually there are only three horizontal lines in each table.

REFERENCES should be in the Vancouver style as in this issue. They should appear in the text by number only in the order in which they occur and should be listed on a separate sheet in the same order. Punctuation must be correct and journal titles should be in full or abbreviated in accordance with the Index Medicus. Thus:


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During the course of a one month stay, he learnt and used spontaneously the names of two staff members, and learnt about half of the geography of the unit. His behaviour was frequently disrupted by three things: his memory disorder, his obsessional rituals (dominated by his need to record in his "diary" every little event "before I forget"), and explosive outburst, mostly but not exclusively, in response to frustration.

On admission, chlorpromazine was stopped, carbamazepine was increased to 400 mg bd, and eplim stopped. He was also given clobazam 20 mg on. During his first week, his behaviour was actively uncooperative, aggressive and "depressed" (as was his wont at home, he frequently asked for "suicide pills"). All episodes of outburst behaviour led contingent to five-minute periods of "time out" (in a Time Out Room). Interruption of sessions by ritual was prevented. All inappropriate utterances ("suicide pill", and also "All I need is a driving licence") were timed on the spot (in other words, ignored).

During the remaining three weeks, all of his behaviours improved, and his apparent mood became one of cheerfulness for the most part, with evidence of his enjoying many activities. He could be argumentative at times, but only briefly, and responded to prompting. He was generally very active, and his physically perfect state was exemplified by his extreme skill in swimming. To be more specific on the behavioural side, explosive outburst occurred with the following frequencies during the four weeks:

37, 4, 1, 0.

(These weekly figures obscure an initial increase over the first few days, and a brief upsurge of three in one day at the end of the second week, and the daily graph is very typical for an extinction process.) Although actual counts were not made, there was not one single request for "suicide pills" during the second two weeks, and only one mention of "driving licence" (on the direct question "What problems do you see yourself having?")

Certainly, this patient has shown solid evidence of good response to behaviour modification. A one-month period is extremely unlikely to be sufficient for these behaviour changes to endure. Nevertheless, the exercise makes it virtually certain that sufficiently prolonged treatment would lead to lasting improvements in behaviour control. The fact that the changes took place in a setting in which he was under very considerable pressure to co-operate in rehabilitative therapies demonstrates, we believe, that "attempts at rehabilitating him further need not be frustrated by uncontrollable outbursts of rage and aggression".

PETER EAMES,
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St. Andrew's Hospital,
Northampton NN1 5DG, UK

Greenwood replies:
Dr Eames' comments regarding a good response to behaviour modification in our case 1 (JBR) are well taken. If these techniques are as successful as is claimed there lack of general availability to patients with more or less diffuse brain injury is unfortunate.

Notice

World Society for Stereotactic and Functional Neurosurgery

The Ninth meeting will be held 4–7 July, 1985 in Toronto, Canada. Further information may be received from:

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