

The students replied that they almost never crossed their fingers to bring themselves luck or "knocked on wood", with assessments of 2.7 and 3.5, respectively. The symmetrical distribution of answers to the question about walking under ladders, with an average score of 10.3, may reflect an ambiguity in the wording of the question, although it could also reflect a cultural habit.

Thus a sizable fraction of the well educated students under study do not reject beliefs in supernatural explanations, though the scientists tend to be somewhat more sceptical. The overall level of superstition is sometimes substantial among Harvard students. At the University of Ghana, where Jahoda<sup>1</sup> found "mean belief scores" between 5 and 8 out of 20, his data showed that the science students did not differ from the overall sample, as they tended to at Harvard. Of course, we asked different specific questions and evaluated replies in a different manner, so our study cannot be used to provide an American baseline for his work.

We thank the master and senior tutor of Kirkland House, Harvard College, for their cooperation, and Professor Owen Gingerich and the Smithsonian Astrophysical Observatory for their assistance with computing facilities.

JAY M. PASACHOFF

Harvard College Observatory, and  
Kirkland House, Harvard College,  
Cambridge, Massachusetts 02138.

RICHARD J. COHEN

Adams House, Harvard College,  
Cambridge, Massachusetts 02138.

NANCY W. PASACHOFF

Barnard College,  
New York City 10027.

Received June 22, 1970.

<sup>1</sup> Jahoda, G., *Nature*, **220**, 1356 (1968).

## "Put Away"—For How Long?

MORRIS<sup>1</sup> has stated that "In subnormality hospitals . . . most patients, once admitted, will never leave." In the past this was true, but the present trend is for subnormal individuals to remain at home, adequately supported by appropriate services, for as long as possible. Moreover, it has been shown that 10 per cent or less<sup>2</sup> of populations of subnormality hospitals require "detailed specialist day to day diagnosis, care and treatment"<sup>3</sup>. 80 per cent of severely subnormal children now remain at home<sup>4</sup>. One of the services which can extend the time for which families can tolerate a mentally handicapped dependant at home is periodic short term care in hospital. Of all admissions to mental subnormality hospitals and units in England and Wales, 48 per cent in 1964 and 60 per cent in 1966 were for informal short term care, usually for eight weeks or less<sup>5</sup>. We present here a short account of a study aimed at discovering whether the same factors determine short term and long term care for children and fulfil the same needs.

In this hospital during 1964-66 it was possible to offer either short term or permanent care almost equally readily; of 373 admissions, 58 per cent were for short term care. Subsequently, there has been almost no option for long term care, irrespective of the need. After exclusions (such as multiple admissions), 285 records were studied, and the results analysed by computer.

Of the 164 short term care children, only 9 per cent remained in longer than eight weeks; of the long term admissions, 5 per cent remained in for less than eight weeks, and 89 per cent remained over a year. Although more boys than girls were admitted, as has been observed elsewhere<sup>6,7</sup> the same proportion of each sex came in both for short or long term care. Penrose<sup>8</sup> thought that probably society was less able to tolerate inadequate role performance among males; fortunately it seems that, if so, the in-

tolerance is as likely to be temporary as permanent. Similarly, there was no significant difference in the age on admission of the children who came in for long term or short term admissions; 46 per cent of the short term and 41 per cent of the long term care patients were between 1 and 4 years, and 21 per cent of each type of care were between 4 and 7 years old.

110 of the children, 43 per cent of those formally psychologically assessed, were profoundly retarded (IQ below 20) and a further 127 (49 per cent) were severely or moderately retarded (IQ 20-51), but as the age on admission increased, so did the proportion who were profoundly retarded: 62 per cent of 37 children admitted under the age of 1 year, 67 per cent of 116 admitted between 1 and 4 years; 89 per cent of 54 between 4 and 7 years; and 85 per cent between 7 and 10 and 10 and 13 years were profoundly retarded according to tests.

When the reasons for which hospital care had been requested were considered, significantly fewer of the short term care children were reported to be illegitimate or to present difficulties of management in the home, or to have serious physical disabilities (excluding spastic cerebral palsy or epilepsy, which occurred in approximately one third of both groups). An assessment of the parents' health indicated that maternal physical illness was associated with 42 per cent of the short term admissions, but with only 24 per cent of long term admissions.

Physically, approximately three quarters of both groups were in good general condition, requiring no active medical treatment. Of those measured<sup>9</sup>, four fifths of the children were below the average for their age in height, and three quarters were below average in weight, in both groups. The most commonly seen physical defect was squint, which in varying severity was noted in one quarter of both groups, although the general population incidence has been estimated as 1-2 per cent<sup>10</sup>. Emotionally, in both groups less than a tenth of the children were overactive, destructive, aggressive, self-mutilating or excessively attention-seeking.

We conclude that at the present time over half the patients admitted to subnormality hospitals will leave again within a few weeks. Objectively, there is little to distinguish those who leave from those who do not. It therefore seems that community care, backed where necessary by short term residential care, will increasingly become a superior alternative to long term residential care for severely mentally handicapped children, and few indeed will "never leave".

We thank Mr Eisenberg, Mr Duckor and Miss Meredith for their help; the Institute of Computer Science for the use of the Atlas Computer of the University of London; and the South West Metropolitan Regional Hospital Board for their research grant which enabled us to secure the help of Mrs Edlin.

E. C. DONOGHUE  
K. A. ABBAS

Queen Mary's Hospital for Children,  
Carshalton, Surrey.

E. GAL

Institute of Computer Science,  
University of London.

Received March 19; revised June 19, 1970.

<sup>1</sup> Morris, P., *Put Away*, ch. 13, 294 (Routledge and Kegan Paul, London, 1968).

<sup>2</sup> McKeown, T., and Leck, I., *Brit. Med. J.*, **3**, 573 (1967).

<sup>3</sup> Pilkington, T. L., in *Rep. Ann. Conf. Nat. Assoc. Mental Health*, 50 (Nat. Assoc. Mental Health, London, 1966).

<sup>4</sup> Kuschlick, A., in *Residential Care for the Mentally Retarded* (edit. by Stephen, E.), 1 (Pergamon, Oxford, 1970).

<sup>5</sup> Worters, A. R., in *Modern Trends in Mental Health and Subnormality* (edit. by O'Gorman, G.), 1, ch. 2, 26 (Butterworths, London, 1968).

<sup>6</sup> Pitt, D., and Roboz, P., *J. Ment. Defic. Res.*, **9**, 4 (1965).

<sup>7</sup> *Ann. Rep. Ministry of Health, 1967*, 191, Table 77 (HMSO, London, 1968).

<sup>8</sup> Penrose, L. S., *Spec. Res. Ser. MRC*, No. 229 (HMSO, London, 1938).

<sup>9</sup> Tanner, J. M., and Whitehouse, R. H., *Height and Weight Standard Charts* (Collard, London, 1959).

<sup>10</sup> Trevor-Roper, P. D., *Ophthalmology*, ch. 18, 270 (Lloyd-Luke, London, 1955).