endeavours – talking about a loss (and other losses) may elicit avoidance reactions and seeming lack of progress in therapy. Exploring Mrs A's automatic thoughts (Beck *et al*, 1979) when she experienced relief may have helped her uncover dysfunctional thinking.

We believe it is too simplistic to consider only psychodynamic factors. These can be proposed as 'fundamental mechanisms' to understanding. However, they are filtered through the executive and cognitive functions of the ego. Therefore previous learned cognitive attributional sets and conditioned responses must also be considered. All three mechanisms operate together in any case of grief and therapeutic work.

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References

AMERICAN PSYCHIATRIC ASSOCIATION (1987) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) (3rd edn, revised). Washington, DC: APA.

AMICK-MCMULLAN, A., KILPATRICK, D. G. & VERONEN, L. J. (1989) Family survivors of homicide victims: a behavioral analysis. *The Behavior Therapist*, **12**, 75–79.

BECK, A. P., RUSH, A. J., SHAW, B. F. *et al.* (1979) *Cognitive Therapy of Depression*. New York: Guilford Press.

BANDURA, A. (1969) *Principles of Behavior Modification*. New York: Holt Rinehart & Winston.

SIR: Fisher & Murdoch have reformulated the case material I presented (*Journal*, December 1989, **155**, 862–864) and the mechanism of the patient's recovery using explanations drawn from cognitive and learning theory. I am grateful to them for their interest and in most respects I regard their theorising as compatible with my own. However, I would like to take issue over two points where our thinking diverges.

Firstly, they suggest that, as a result of her (earlier) experience of the disapproval of a powerful authority figure (a priest) at her seeming failure to mourn her daughter, Mrs A developed an approach–avoidance conflict regarding her grief whereby she believed that to experience relief she must endorse the belief that she was a bad person, which she wished to avoid. They go on to suggest that resolution of this conflict occurred with a cognitive shift (reinforced by the therapist) that the previous belief was erroneous. This explanation fails to take into account the importance of the patient's guilt over her aggressive feelings towards both her husband and daughter. Exploration of this, in psychodynamic psychotherapy, allowed her to express these feelings to the therapist and to face her fantasy that she was indeed a bad person. Interpretation to her of her *unconscious* fantasy that she was *continuing* to harm her husband (by triumphing over him) each time she experienced relief from her grief, allowed her to free herself from the vicious circle.

Secondly, I would wish to emphasise that the significance of authority figures in this patient's mental life lay in the way in which they interacted with her own internal world, that is with her internal objects. Exploration and interpretation of this was important in helping her to establish a less harsh view of herself and in freeing her from the need for self-punishment.

In summary then, I disagree with Drs Fisher & Murdoch over their failure to consider the unconscious meaning of the patient's symptom pattern and the importance of the interaction between real external figures and the patient's internal objects.

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Long-stay psychogeriatric patients

SIR: Hilton *et al* (*Journal*, December 1989, **155**, 782–786) provide useful cross-sectional data revealing very high levels of dependency among long-stay psychogeriatric patients compared with residents of a local authority home. However, another perspective can be provided by asking whether changes in levels of dependency have occurred over time.

In 1985, Norman, then of the Centre for Policy on Ageing, performed a survey in 14 facilities offering long-stay psychogeriatric care, including our own September ward (Norman, 1987). Dependency was rated using a subsection of the Crichton Royal Behaviour Rating Scale which has been found to correlate well with clinical assessment (Evans *et al*, 1981). The ratings were repeated in December 1989.

In the 1985 survey of our ward, before it was fully open, 15 patients attained a mean score of 8.5 (range 5–11). One patient scored the maximum dependency score (11). Furthermore, Norman reported that 'several' had difficulties with speech, no-one was totally chair-bound and four (27%) required physical help with feeding. The mean score in December 1989 for 18 patients (the maximum number of beds was 20 but two deaths had occurred just before the ratings) was 9.6 (again, range 5–11). However, this

time, eight patients scored the maximum of 11, only two had any conversant language, eight were chair-bound and 12 (67%) needed help with feeding. Although not documented, our nurses were convinced that disturbance as well as dependence had increased since 1985.

These changes were not merely the effects of a new unit opening with 'easy' patients who subsequently all grew frail together, since only two patients survived from the 1985 cohort. Like Dr Hilton *et al*, our colleagues also believe that their local authority homes have been taking ever more dependent clients. It may be then that this trend, if it is indeed a widespread phenomenon, has led to all but the most behaviourally difficult demented individuals being placed in residential homes. The hospital services then have to cope with an ever more disturbed and disturbing group that cannot (and perhaps should not, given the skilled interventions required) be placed elsewhere.

Secular trends are clearly important for planning, and it would be interesting to know whether or not our experience is purely local. If not, then it must add to the concerns raised by Dr Hilton *et al* concerning the closure of hospital beds for demented patients. The White Paper *Caring for People* (HMSO, 1989) states that "there will be others, in particular elderly and seriously mentally-ill people ... whose combination of health and social care needs is best met by care in a hospital setting. There will be a continuing need for this form of care". Doctors with a proper training in old-age psychiatry develop skills in managing these patients and in supporting those who care for them, both nurses and involved relatives. Wholesale re-location into the 'community', away from specialist supervision, for reasons of financial expediency could lead to deteriorating standards of care for these vulnerable patients.

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References

NORMAN, A. (1987) *Severe Dementia: the Provision of Long-stay Care* (Centre for Policy on Ageing). Dorchester: Dorset Press.

EVANS, G., HUGHES, B., WILKIN, D. *et al* (1981) *The Management of Mental and Physical Impairment in Non-specialist Residential Homes for the Elderly* (research report no. 4). Manchester: Psychogeriatric Unit, University Hospital of South Manchester.

HMSO (1989) *Caring for People: Community Care in the Next Decade and Beyond*. London: HMSO.

SIR: We were very interested to read the report by Hilton *et al* (*Journal*, December 1989, **155**, 782–786) since it is indeed the case, as the authors state, that there is a paucity of literature in this area.

We are able to confirm Dr Hilton *et al*'s results since we have recently completed a detailed observational study of two long-stay psychogeriatric wards which included the Clifton Assessment Procedures for the Elderly Behaviour Rating Scale (CAPEBRS) (Pattie & Gilleard, 1979). We also obtained scores typically higher than those reported by Pattie & Gilleard for a sample of long-stay psychogeriatric patients. Since the long-term aim of our research is facilitating collaborative ventures with neuroscientists, we also collected in-depth observational and reliability data. From this we make the following points.

We found the social disturbance scale of the CAPEBRS to be unreliable when rated by nursing staff, in contrast to Pattie & Gilleard. Dr Hilton *et al* report that the CAPEBRS was completed by the researcher, which may make this subscale more suspect. We feel this is an important point since it is this subscale which details objectionable behaviours so frequently reported in the literature. This unreliability may be due to the low frequency with which such behaviours occur in this setting, which is supported by Dr Hilton *et al*'s finding of an average score of 2.42 from a possible 10 on this subscale, and further supported by our own observational data.

We would suggest that the picture emerging of long-stay psychogeriatric patients is one of gross physical incapacity and dependency and agree with Dr Hilton *et al* on the need for appropriate staff support. However, the role of disturbed behaviour, typically wandering and aggression (e.g. Mann *et al*, 1984) is in our opinion less important in this setting than in earlier stages of the disease process.

Finally, we take issue with Dr Hilton *et al*'s last assertion, that the problems they have identified may describe any London borough. This may or may not be true, but is likely to depend on local availability of resources and, in the light of our comments above, we fail to see why this should make the authors wonder about the appropriateness of general plans for provision in the community.

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References

MANN, A. H., GRAHAM, N. & ASHBY, D. (1984) Psychiatric illness in residential homes for the elderly: a survey in one London borough. *Age and Ageing*, **5**, 257–265.