value on the opportunity to learn about themselves through their observation of others' experience (vicarious learning). This more passive form of psychological work then shifts to a more active form if work continues in out-patient group therapy.

It also seems to us that there is a greater complexity in attempting to compare in-patient and out-patient reactions to a group experience than is evident in Dr Kapur *et al's* study. A sample of out-patients who have been specially selected for long-term therapy is likely to differ from a sample of in-patients on a number of important dimensions. For example, our own current work suggests that the level of functioning and the duration of the therapy experience are particularly important variables to consider.

Much remains to be clarified about the interrelationships between patient characteristics and response to group therapy. We hope that more British researchers will be exploring this difficult area.

GRAHAM S. WHALAN

County Hospital
North Road
Durham DH1 4ST

GRETA L. MUSHET

Claremont House
Newcastle-on-Tyne

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Assaults on Staff by Psychiatric In-patients

SIR: The paper by Haller & Deluty (*Journal*, February 1988, 174–179) is non-contentious in that it suggests the benefits of predicting the likelihood of patients' dispositions towards violence. However, it is also important that such information is not escalative towards promoting the very behaviour which is not desired.

Professors Haller and Deluty do not stress the importance of support and training for staff, especially when predictive tests need to be interpreted. In addition, anxiety levels are always a key factor in understanding violence. Thus it is essential that where patients are being treated in situations which increase the potential for violent acting-out, every opportunity is taken to assess and understand overt and covert anxieties. At these times it is also important to distinguish between verbal and actual physical aggression, because they are not the same. This is not made clear in the paper.

Means of prediction are important, but can be no substitute for the sensitivity and perceptiveness of staff. Furthermore, applications of these skills by staff can never be made safely without adequate training, supervision, and support.

PHILIP HEWITT

City University
Northampton Square, London EC1V 0HB

SIR: Dr Hewitt makes a number of interesting assertions in his letter, some of which I feel are correct, some incorrect, and some puzzling.

It is unclear to me how knowledge or information concerning *who* is likely to assault *whom* under *what* conditions could be escalatory or could promote "the very behaviour which is not desired". I agree with Dr Hewitt that predictors of assaultiveness derived from actuarial techniques cannot substitute for sensitivity and perceptiveness of staff. However, relying primarily on the sensitivity and perceptiveness of individual clinicians has been shown to be highly problematical. For example, Werner *et al* (1983) found that while psychologists and psychiatrists agreed among themselves as to which patients would be violent and what the critical predictor variables were, empirical correlations of violence with these variables indicated that the judges' predictions were rarely accurate.

Dr Hewitt writes that "anxiety levels are always a key factor in understanding violence", yet he provides no empirical evidence to support this assertion. On the contrary, our literature review revealed that no single variable is "always a key factor" in explaining or predicting violent behaviour.

I concur with Dr Hewitt that it is very important to distinguish between verbal and actual physical aggression. I am very puzzled, though, by his comment that, "This is not made clear in the paper". Throughout our paper, we criticise researchers in the field for not making this critical distinction.

ROBERT H. DELUTY

University of Maryland
Baltimore County, Catonsville
Maryland, USA 21228

Reference

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Psychotherapy and Dysmorphophobia

SIR: The paper by Bloch & Glue (*Journal*, February 1988, **152**, 270–274) was enjoyable and stimulating. I

am doubtful, however, about their proposed distinction between body image preoccupation, by which they say the therapist should not be 'distracted', and the underlying disturbance upon which he is encouraged to concentrate. It does not appear that their intervention supports this conclusion. Laufer & Laufer (1984) argue that adolescent breakdown is almost always linked with disturbance of the body image and that therapeutic approaches that neglect this aspect are likely to be ineffective. The key interpretation which turned this therapy round was the comment: "Which of your eyebrows do you find most repulsive?' Why was this unusual and creative comment so potently mutative? Was it the lightening of the burden of the patient's misery by humour? Did it enable the patient, by a form of desensitisation, to be less threatened by the feared object by encouraging perceptual discrimination? Was it an acknowledgement of the intensity of the patient's self-disgust by the use of the word 'repulsive'? Or was the 'other', singular, eyebrow to which the therapist tactfully and perhaps unconsciously drew attention not her pubic hair, thus linking her presenting problem with the underlying disturbance of her sexuality? In this counter-transferential comment, her male therapist offered a playful and tacit acceptance of her body to which she could respond and so make the move from mother to father that is such a vital part of adolescent development (Holmes, 1986).

Psychotherapists need to adjust their concepts and techniques to the particular stage of the 'seven ages' of the life cycle at which their patients find themselves. This girl was terrified by the prospect of a "lover/ sighing like a furnace, with a woeful ballad/ made to his mistress' eyebrow . . . ". When the therapist used an implicit metaphor to link the patients bodily distress *with* the 'underlying disturbance' she could begin to recover.

JEREMY HOLMES

North Devon District Hospital
Barnstaple
Devon

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ECT for Depression in Dementia

SIR: I was interested to read Liang *et al's* description of two women with depressive illness and dementia, whose depressive symptomatology responded to ECT (*Journal*, February 1988, **152**, 281–284). In a series of 122 patients treated with ECT at the University Hospital of South Manchester, 4% (5 patients) had depressive illnesses complicated by dementia (Benbow, 1987). Two patients did not respond to ECT, one had two courses during the study period and was well on completion of each, one improved, and the last recovered completely. Four of the five patients were discharged to live in their own homes in the community after treatment and the fifth (who had failed to respond) died following transfer to a medical ward.

There is a single case report in the literature of a man in his 50s with depression and Huntington's chorea who responded to ECT, which concludes that ECT is often useful in treating depression in the presence of dementia (Perry, 1983), as have other authors (Salzmann, 1982; Benbow, 1985). Unfortunately, the literature on cognitive changes in the demented treated with ECT is very limited. Most studies of ECT and memory exclude patients with organic brain disease. A recent paper describes the successful use of ECT for 12 of 14 people with post-stroke depressions (Murray *et al*, 1986).

There is no reason to withhold ECT from elderly people who have severe depressive illnesses, solely because they have an established dementing illness.

S. M. BENBOW

Manchester Royal Infirmary
Oxford Road
Manchester M13 9BX

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Dangerous Delusions: Violence and the Misidentification Syndromes

SIR: De Pauw & Szulecka (*Journal*, January 1988, **152**, 91–96) describe several patients who manifested delusional misidentification and as a result either attacked their 'false' persecutors or threatened to do so, or were themselves assaulted as a direct result of acting on their beliefs. I agree with their observations, which appear to support my own. In a one-year period, of 8400 patient presentations to a