hypothesised that the tactile extinction phenomenon in schizophrenia might also depend on transcallosal pathway deficits.

O. GAMBINI
L. BELLINI
S. SCARONE

Psychiatric Branch
Department of Biomedical and Technological Sciences
University of Milan Medical School
San Raffaele Hospital
via Prinetti 29, 20127 Milano, Italy

References

GAMBINI, O., CAZZULLO, C. L. & SCARONE, S. (1986) Interpretation of abnormal response to the QET in schizophrenia. *Journal of Neurology, Neurosurgery and Psychiatry*, **49**, 997–1001.

SCHWARTZ, A. S., MARCHOK, P. L. & FLYNN, R. E. (1977) A sensitive test for tactile extinction: results in patients with parietal and frontal lobe disease. *Journal of Neurology, Neurosurgery and Psychiatry*, **40**, 228–233

——, ——, KRENIC, C. J., *et al* (1979) The asymmetric lateralization of tactile extinction in patients with unilateral cerebral dysfunction. *Brain*, **102**, 669–684.

Violent Incidents in Special Hospitals

SIR: We read with interest the paper by Larkin *et al* (*Journal*, August 1988, **153**, 226–231). Results from our own investigation of violent incidents over a 12-month period at another Special Hospital (Park Lane) agree in some respects, but differ substantially in others.

In common with Dr Larkin *et al*, we did not confirm previous findings of increased frequency of violence at mealtimes (Dietz & Rada, 1982; Hodgkinson *et al*, 1985; Pearson *et al*, 1986). We also agree in that incidents generally took place in ward areas. Our study did not find a significantly greater number of incidents on Monday and Friday as did theirs. In our study, 59% of incidents occurred spontaneously, in contrast to their figure of 85%. Our finding that staff and patients are equally likely to be targets of assault differs from their results, which indicate that nursing staff were three times more likely to be the victim of assault than the other patients. Park Lane has no female patients, and we are not able to comment on their finding that female patients were responsible for a disproportionate number of assaults.

Reasons for our differing findings may be found in the differing patient populations between the two hospitals – Rampton caters for all four of the categories of disorder in the Mental Health Act, whereas Park Lane only has mentally ill or psychopathic patients, of a level of intelligence within the normal range. Additionally, our study within Park Lane related almost exclusively to those patients with chronic mental illness.

Finally, our most striking finding was that of a marked seasonal variation in incidents, with significantly increased frequency of assault in the winter months. We postulate an important seasonal variation whereby increased population density in indoor areas, during cold and dark winter months, leads to increased levels of extrapunitive violence. Larkin *et al* report on incidents between May and September, the period when we recorded fewest incidents, and do not comment on a seasonal trend. In view of this, it may be that their calculation of an incident rate for the whole year may be seriously underestimated.

J. B. COLDWELL
L. J. NAISMITH

Park Lane Hospital
Park Lane
Maghull
Liverpool L31 1HW

References

DIETZ, P. E. & RADA, R. T. (1982) Battery incidents and batterers in a maximum security hospital. *Archives of General Psychiatry*, **39**, 31–34.

HODGKINSON, P. E., MCIVOR, L. & PHILLIPS, M. (1985) Patient assaults on staff in a psychiatric hospital: a two year retrospective study. *Medicine, Science and the Law*, **25**, 228–294.

LARKIN, E. P., MURTAGH, S. & JONES, S. J. (1988) A preliminary study of violent incidents in a special hospital (Rampton). *British Journal of Psychiatry*, **153**, 226–231.

PEARSON, M., WILMOT, E. & PADI, M. (1986) A study of violent behaviour among in-patients in a psychiatric hospital. *British Journal of Psychiatry*, **149**, 232–235.

Capgras' Syndrome

SIR: Dr Anderson's intriguing case report (*Journal*, November 1988, **153**, 694–699) adds more weight, if such were needed, to the notion that delusional misidentification syndromes can be said always to signal the presence of cerebral pathology. By my calculation, 21 of the 23 cases of Capgras' syndrome now reported with neuroimaging data have shown focal or diffuse abnormalities: an impressive score even allowing for publication bias. One small caveat, which Dr Anderson acknowledges, is that the case he describes is not classically a Capgras delusion. Previous authors have included the 'delusion of inanimate doubles' within that sublime group of neurological disorders called the reduplicative paramnesias (Weinstein, 1969). However, such fine distinctions are mainly in the eye of the beholder, be he psychiatrist or neurologist. The underlying mechanism offered by Dr Anderson, that of a lesion