

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

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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.

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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

somewhere between visual and limbic cortices causing visual images to become dissociated from the affective memories previously associated with them, may well be applicable to both sorts of disorder. This mechanism has certainly been suggested previously in attempts to explain Capgras' syndrome (Lewis, 1987) and reduplicative paramnesia (Staton *et al.*, 1982).

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SIR: I was fascinated to read Dr Anderson's paper on the delusion of inanimate doubles (*Journal*, November 1988, **153**, 694–699) and its implications for Capgras symptoms. Dr Anderson suggests that the delusion of doubles for objects rather than people is a logical extension of the Capgras phenomenon, in the same way that the term prosopopagnosia has seemingly been extended to include rooms, buildings, and objects. There are two corollaries to this suggestion.

If the Capgras syndrome is more common than is suggested by the number of published case reports, then by extending it to cover the delusional misidentification of objects, it must be even more commonplace. I tentatively suggest that the majority of these cases must occur within the context of 'functional' illness. I have seen two cases which would fulfil Dr Anderson's criteria, both within the setting of paranoid schizophrenia.

Case reports: (i). A spinster of 74 first became ill at the age of 59, with a psychosis characterised by second-person auditory hallucinations and persecutory delusions. She is now maintained on injections of modectate. Living alone in a seaside bungalow with her elderly dog, she occasionally lapses into illness. She becomes acutely suspicious of neighbours and friends living in her road. She then rings the local police station to tell them that while she has been asleep these neighbours have been going through her belongings. She asserts that although her prized art book collection and paintings are still in the bungalow, and appear identical, they have been meticulously faked and replaced.

(ii) A widow of 55, again living alone, and with a diagnosis of paranoid schizophrenia, has become estranged from her family. In relapse she alleges that they persecute her, although the truth is somewhat the reverse of this. The widow sends them angry letters and plagues the police with unfounded accusations against them. When she is admitted to hospital she frets about her empty flat. After some leave at home she complained on return that her brother had been in her flat while she had been in hospital. She knew this because he had replaced a wardrobe and a chest of drawers with identical items, but that these lacked various marks of wear and tear that the originals had borne. She was convinced that her brother had gained access with her own keys, having stolen them from her while she was in hospital, after leaving a replica set in their place.

Neither of these patients admit to these ideas when well, and neither have any identified organic neurological disease. The delusion of inanimate doubles may thus be an intrinsic part of an elaborate delusional system in some cases of paranoid schizophrenia. The pure Capgras syndrome seems mainly to occur in 'functional' illness, in the absence of lesions detectable by computerised tomography imaging (Green, 1988; Green & Birchall, 1988).

Although macroscopic brain lesions do appear to account for a few cases of the delusion of doubles, the aetiology of the Capgras phenomenon seems to be rather wider than this, and it seems that we must not rely solely upon either a psychodynamic or organic explanation.

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Parasuicide in Young Asian Women

SIR: We were interested in the paper by Manium (*Journal*, August 1988, **153**, 222–225), which, like the paper by Merrill & Owens (1986), drew attention to the high parasuicide rate of young Asian women.

We analysed the attendances of patients aged 10–24 presenting with self-poisoning to the two casualty departments of The London Hospital during the years 1980–1984. This hospital serves an area with a large Bangladeshi population.

We used figures derived from the 1981 census and from ILEA statistics to estimate the proportion of