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.

GEOFFREY C. FISHER
DOUGLAS MURDOCH

Department of Psychiatry
University of Calgary
Alberta, Canada

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.

ANNE M. NIGHTINGALE

Psychotherapy Unit
Royal Edinburgh Hospital
Morningside Park
Edinburgh EH10 5HF

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