

in actually carrying out the intervention programme. Undoubtedly in this case the intervention programme had a rather artificial air about it. This may lead practitioners to be rather wary of its findings. The paper is however subtitled 'a process evaluation', and does achieve its purpose of demonstrating that an intervention of this sort can be incorporated into practice with the probability of beneficial results.

Social Work Services Group,
Edinburgh

Psychology and Psychiatry

Jeffrey Garland

G. E. Berrios and P. Brook. Visual Hallucinations and Sensory Delusions in the Elderly. *British Journal of Psychiatry*, **144** (1984), 662–664.

A patient on the psychogeriatric ward where I have my office continually circles the whole area looking for the way out. There is nothing unusual in that, as it is generally a pastime for several of the 16 patients at a given time. What is remarkable about this man's behaviour is that he frequently stops in front of a full-length mirror in the day room and interrogates his own reflection, seeking advice with the pathetic entreaty: 'Look here, mate! You look like a sensible bloke. Can *you* tell me the way out of this place?'

His repeated requests go unanswered until with mounting anger he storms off to resume his circling. Recently, he has taken to returning to the mirror shortly after his fruitless interrogation, with a patient he has befriended in tow.

'Here, my duck', he instructs the bemused woman, '*You* ask him. Maybe he'll tell you. Be a gentleman, now! Talk to the lady!'

This kind of behaviour puzzles even ward staff who accept a wide range of deviant acts by patients in this setting. It is a pleasure therefore to welcome this admirably clear description of 150 successive referrals to a Cambridge psychogeriatrician who were assessed for visual hallucinations.

No less than 44 (29 per cent) reported visual perceptual disturbances, and there was a significant correlation between presence of hallucinations and eye pathology, and delusions.

In only 4 cases were 'visual hallucinations' the direct reason for referral as mentioned in the G.P.'s letter, and as the authors remind us

this is a little-explored area, with no data available on the prevalence and phenomenology of visual hallucinations in the elderly.

As they conclude: 'The presence of visual hallucinations adds to the other psychiatric symptoms affecting the elderly and may contribute to their dysphoria, poor orientation and resulting psychosocial incompetence. . . . The management of orientation failures in the elderly should include an active search for overt or covert hallucinatory states. Whether by increasing patterned sensory input or by psychopharmacology, attempts should be made to reduce their intensity and frequency.' (p. 664).

The only point clearly omitted by these authors, however, is a consideration of the extent to which sensory input constellations met with in geriatric or psychogeriatric care environments actually *promote* sensory delusions.

I was vividly reminded of this on a recent visit to the seventh floor of Oxford's new general hospital, to see a geriatric patient who was fractiously tossing and turning in his bed by a huge picture window with a panorama of the surrounding countryside looking so close that one could reach out and touch it.

'Here', the patient pleaded, 'Can you help me? I've got to catch this hedgehog, somewhere, it's in the bed, I think.'

'Hedgehog?' I asked. 'Where did it come from?'

I knew the answer before it came. 'From those fields out there, of course', he responded impatiently.

'Putting me down in the middle of a field, like this!' he continued. 'I thought this place was a hospital. What do they think they're doing?'

I recommend Berrios and Brook's contribution which should help us all to 'think what we're doing' in this respect when dealing with the disorientated elderly.

Oxford District Health Authority