

was at the time of a significant loss. In six cases, this was connected with a death: the death of a spouse or a parent on whom the patient had been extremely dependent, or an anniversary of such a death, or on reaching the age at which that parent had died. In the remaining six cases the attack was connected with a different type of loss; for example, the redundancy of a lonely middle-aged man whose work had been his way of life.

A striking finding was that 11 of the 20 patients had, in infancy or childhood, suffered a severe loss. Four had lost one or both parents, all of whom had been killed in various types of sudden or violent accidents; three had lost one or more younger siblings; one, as a small child, had been brought up in an active war zone; and three had experienced prolonged or total separation from their parents in infancy or childhood. Ten patients had experienced both an early loss and a significant loss at the onset of blepharitis. The memory of the early loss and the memory of its expression (the painful crying and the sobbing) were often reactivated by the distress of the later loss. In most of the patients, we found varying degrees of difficulty in their grieving of painful losses.

We suggest that the failure of many cases of blepharitis to respond to medical treatment alone can probably be partly explained by the presence of a symptom of unresolved grieving.

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#### Corrections:

Apologies are due to Dr Richard Baker whose name was omitted from the letter submitted by himself and his colleagues, M Lakhani, T Stokes, and K Khunti, and published in the November issue of the *Journal*, p 749. There was also a mistake in the email address for Dr Marek Koperski who wrote one of the editorials also published in the November Journal. His email address should have read: kopersk@itsa.ucsf.edu

## VIOLENCE IN GENERAL PRACTICE - FACING THE OCCUPATIONAL HAZARD



Nearly one in five GPs are attacked in their surgeries, and other practice staff such as receptionists face a daily dose of aggressive or verbally abusive behaviour. Yet despite the raised level of awareness, few practices have devised any formal training which could help avert the situation.

A new video, called Occupational Hazard aims to address this situation, by encouraging all members of staff to participate in a discussion on potential 'flashpoints' in surgery life.

The video shows three dramatised scenarios of patients who have become violent or abusive with surgery staff. As the circumstances of each patient unfold, the narrative shows how responses to patients can either antagonise or resolve the situation. There are 'stopping points' during the video, where viewers are invited to discuss what they have just seen.

"Violence in the health service is a fact of life," says GP Dr Peter Shaw, who advised Wyeth in the production of the video. "However, it can be minimised and handled by an informed response from the practice team. Hopefully, practises will not face a violent patient who gets out of control, but this video encourages them to think ahead of what could happen and be equipped to deal with an incident should it arise."

For further details of the video, phone 01628 604377, extension 4528.