predictive of mood fluctuations (particularly dysthymic swings) over time (Williams, 1981).

Our reference list (44 items) does contain recent reviews of conversion disorder and will be adequate for most readers of a publication of this nature. We stated on the first page of our text our reasons for considering globus to be different from disorders such as pseudoseizures.

It remains our opinion that globus might make a good model for conversion disorder. The results of our preliminary study have encouraged us to continue our study of psychological factors in globus. A report, in preparation, of a substantial number of patients, including an ENT control group, uses questionnaires designed to index psychoneurotic disorder and attempts to replicate our previous results on the personality traits of globus patients.

We agree with the workers from NHND that journal clubs can be educationally rewarding. Sometimes, however, the joint perusal of a document can lead to errors in understanding.

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Reference

Williams, D. G. (1981) Personality and mood: state – trait relationships. *Personality and Individual Differences*, **2**, 303–309.

Hospital suicides

Sir: During our psychiatric training, it has been our combined experience that when a patient commits suicide, the responsible team responds with a mixture of sorrow, guilt, embarrassment, and concern about possible litigation; there is little open discussion.

In our training, much attention is given to learning about known risk factors for suicide. However, despite an extensive literature, assessing suicide risk remains an imprecise art and virtually all psychiatrists recognise that despite their best efforts, some patients will successfully take their own lives.

It seems to us strange that emphasis is placed on learning about the theoretical aspects of assessment of suicidal risk, but that when a suicide does occur, the absence of ensuing discussion severely hampers the learning of practical lessons.

We believe that a completed suicide in a psychiatric patient is an extremely valuable opportunity from which lessons may be learnt for the benefit of future patients. It is our belief that formal discussion of such cases would have several benefits: firstly, and most importantly, it would help the responsible team and other staff to learn from the case: secondly, it would reduce unhelpful speculation; thirdly, if conducted sensitively, it would reduce, rather than increase, the anxieties of involved professionals; and fourthly, it could facilitate later discussion with bereaved relatives.

In medicine and surgery it is standard practice to hold post-mortem review of 'difficult' cases, with formal discussions of findings in the light of clinical presentation and interventions. We are not aware of this practice in psychiatry, but would be keen to learn of its existence and of the opinions of those who have experienced it.

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Sir: Goh *et al* (*Journal*, February 1989, **154**, 247–249) draw attention to the special features of suicide by psychiatric day and in-patients, and highlighted the importance of factors that related not only to the patient's illness but also to the immediate ward environment. Using the Edinburgh Suicide Case Register, I recently identified and reviewed the case notes of psychiatric in-patients who committed suicide in the Royal Edinburgh Hospital between 1977 and 1985. There were 29 such cases, and this population shared many of the characteristics of that described by Goh *et al*. However, in the Edinburgh survey there was an increased proportion of females, and the diagnoses of neurosis, personality disorder, and adjustment reaction were more common than in the Birmingham study. Also, over half had a past history of deliberate self-harm.

The notion of the high-risk patient can be described with reference to the characteristics of those who complete suicide, but it is more difficult to predict from patient characteristics which ones actually go on to commit suicide. Pokorny (1983) identified patient characteristics on admission in an attempt to predict which ones would later kill themselves, without success. Thus, it is particularly relevant to consider what local environmental factors influence suicide, as such factors may lend themselves more liable to change. Local ward layout is of obvious importance – such as the types of windows, window locks, and bathroom arrangements. In the Edinburgh study, means of suicide ranged from hanging by a bathrobe cord in the ward toilet area to jumping off the Forth Road Bridge.

Some studies of in-patient suicide have commented on staff factors which may influence the risk of patient suicide – from a case-note review it is particularly apparent that in some cases there are claims for negligence against the hospital or medical/nursing staff. Although the impact on staff is not usually so extreme or direct, the way in which staff respond and deal with the aftermath of a suicide at ward level is a relatively unexplored area. A prospective descriptive study of how different teams and wards deal with suicide would be of value. Going on from this is the question of how one suicide influences the other patients and whether it makes further suicides more likely.

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POKORNY, A. D. (1983) Prediction of suicide in psychiatric patients. *Archives of General Psychiatry*, **40**, 249–257.

Homo-erotomania

SIR: Two cases of homo-erotomania were recently reported by Dunlop (*Journal*, December 1988, **153**, 830–833), although several have already appeared. Fretet (1937) discussed an alcoholic male and Peterson & Davis (1985) a schizophrenic man with this variant. Lovett Doust & Christie (1978) make it clear that two of the eight cases in their series had homoerotic delusions: patient 2, with a cortisone-precipitated (affective) psychosis and increased alpha activity over the right hemisphere, believed an older married woman was in love with her; patient 6, whose imagined "calls" from a former male lover were triggered by alcohol ingestion, also had a son who believed he was being sexually pursued by another man. A schizoaffective woman had a possible prior homo-erotomanic episode (Signer & Isbister, 1987), and there are reports of two bipolar women, one (with left temporal lobal epilepsy) (Signer & Cummings, 1987) who had exclusive homo-erotomania, and another who had one prominent homo-erotic episode mixed in among several hetero-erotomanic ones (Bastie, 1975). Fretet (1937) mentioned a female homo-erotomania in passing.

A vast majority of cases show the features of an 'exalted' or excited state that serves as the marker for severe mood disorder, usually mania or psychotic depression. Almost all patients with erotomania become involved with the legal system because of their relentless pursuit of the object of their delusion, a classic feature of the 'psychoses passionnelles'; meeting or confrontation does not ameliorate the condition because of the cognitive distortions of psychosis.

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References

BASTIE, Y. (1973) Paranoia passionnelle. *Annales Medico-Psychologiques*, **131**, 639–649.

FRETET, J. (1937) Erotomanie homosexuelle masculine. *Annales Medico-Psychologiques*, **95**, 328–331.

LOVETT DOUST, J. W. & CHRISTIE, H (1978) The pathology of love: some clinical variants of de Clérambault's syndrome. *Social Science & Medicine*, **12**, 99–106.

PETERSON, G. A. & DAVIS, D. L. (1985) A case of homosexual erotomania. *Journal of Clinical Psychiatry*, **46**, 448–449.

SIGNER, S. F. & CUMMINGS, J. L. (1987) De Clérambault's syndrome in organic affective disorder: two cases. *British Journal of Psychiatry*, **151**, 404–407.

SIGNER, S. F. & ISBISTER, S. R. (1987) Capgras syndrome, de Clérambault's syndrome, and folie a deux. *British Journal of Psychiatry*, **151**, 402–407.

Violence in sleep: a further diagnostic consideration

SIR: Scott (*Journal*, November 1988, **153**, 692) has failed to mention a recently described sleep disorder which should be included in the differential diagnosis of sleepwalking and night terrors. This is a rapid eye movement sleep behaviour disorder (REM behaviour disorder) as described by Schenck *et al* (1986). This parasomnia is characterised by loss of the normal atonia accompanying the REM sleep stage, with the emergence of violent behaviours such as punching, kicking, and leaping from bed. Dreams are often portrayed as having been extremely vivid. The authors describe one patient who attempted to strangle his wife while dreaming of fending off a mauling bear.

Schenck *et al* (1988) characterised a group of 33 such patients with a mean age at presentation of 65.7 years, mean age of onset 55.5 years, 94% male, 24% with psychopathology, and 30% with neurological disorders (various CNS vascular and degenerative disorders). The polysomnogram was diagnostic in 100% of the cases, with loss of REM atonia and emergence of significant behaviour during REM sleep. Significant improvement was seen in 90.6% of these cases with the use of clonazepam (0.25–2.0 mg at bedtime).