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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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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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).