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Correspondence

On Serious Violence During Sleep-Walking

DEAR SIR,

I write to supplement the article by Professor Ian Oswald and Dr John Evans (*Journal*, December 1985, **147**, 688–691). The authors refer to a case in which a lady who stabbed her husband fifteen times was freed at Preston Crown Court. They note that psychiatric evidence was offered but are unable to give details. I saw the lady in February 1978 on two occasions and was helped in assessing her by Dr John H. Evans, (Consultant Neurologist). I have also been able to make follow-up enquiries about her for this letter.

She was 32 at the time, had been happily married for ten years and had two young children. She had worked as a civil servant until five years before the episode.

There was no significant previous medical or psychiatric history. She and her husband had both been in the civil service when they met, but she had retired five years before to have her children. Her husband was a heavy sleeper and for four years before the offence she had been in the habit of shaking him at night to wake him. This had started when she had wanted him to get up to look after their daughter. She had hit him quite hard in her sleep on several previous occasions.

She had not been sleeping well for five days before the attack because she had a cough. She had been waking at about 5 a.m. On the morning of the attack, she went downstairs wearing slacks and a sweater and she peeled some potatoes. She then cut them up with a knife in order to make chips. She came upstairs with the knife and went to sleep on the bed next to her husband. At about 8 o'clock, she woke to find her husband saying, "Look what the hell you've done". She had stabbed him in a quite random way in three different areas—the right anterior chest, the left lower back and the lateral aspect of the left thigh. She called the ambulance herself and her husband was taken to hospital and she was charged with assault.

There seemed to be no conscious reason for her to have stabbed her husband. When interviewed with intravenous Methedrine and Sodium Amytal, still no psychogenesis for the attack emerged. She was admitted to hospital and fasted for two days. After this fast, her electroencephalogram was recorded and a blood sugar was taken. Both of these investigations were normal.

When she appeared in Court the couple came together and the judge accepted that what happened had been something of which she had no conscious awareness. He directed that the charges should lie on the file.

Eight years later, the couple have moved. They are still together happily and there has been no recurrence of this behaviour. These further details show that the case fits in very well with those recorded by Professor Oswald and Dr Evans and that in fact serious violence can occur in sleep of which the conscious mind is not later aware.

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DEAR SIR,

The article by Oswald and Evans (*Journal*, December 1985, **147**, 688–691) is of considerable interest and puts me in mind of a case in Victoria concerning a mother charged with the murder of her 19 year old daughter when the defence of sleep-walking (automatism) was successfully raised (R *vs* Cogdon (1950), Supreme Court, Melbourne, unreported, but see Morris (1951)).

The facts were that the mother and daughter, Pat, were agreed by all to have had a very good relationship. That the night before the death the mother dreamt that their house was full of spiders and that these spiders were crawling all over Pat. In her sleep the mother left her bed, entered Pat's room and awoke to find herself violently brushing at Pat's face. Pat awoke and her mother stated she was just tucking her in. At the trial the mother stated that she still believed that spiders were being bred by the occupants of a nearby house. The mother also stated that she dreamt of ghosts and had said to one "Well you have come to take Pattie". A final worry of the mother was with concern for the Korean War. On the night of the killing the mother dreamt that "the war was all round the house", that soldiers were in Pat's room, and that one soldier was on the

bed attacking Pattie. Her first "waking" memory was of running from Pat's room out of the house to her sister living next door when she said "I think I've hurt Pattie". She had indeed; she had struck the daughter with two axe blows to the head.

The defence case has been outlined by Morris (1951) and the relevant part reads as follows: Mrs Cogdon's story was supported by the evidence of her physician, a psychiatrist, and a psychologist. The burden of the evidence of all three, which was not contested by the prosecution, was that Mrs Cogdon was suffering from a form of hysteria with an overlay of depression, and that she was of a personality in which such dissociated states as fugues, amnesias, and somnambulistic acts were to be expected. They agreed that she was not psychotic, and that if she had been awake at the time of the killing no defence could have been spelt out under the *McNaughton Rules*. They hazarded no statement as to her motives, the idea of defence of the daughter being transparently insufficient. However, the psychologist and the psychiatrist concurred in hinting that the emotional motivation lay in an acute conflict situation in her relations with her own parents; that during marital life she suffered very great sexual frustration; and that she overcompensated for her own frustration by over-protection of her daughter. Her exaggerated solicitude for her daughter was a conscious expression of her subconscious emotional hostility to her, and the dream of ghosts, spiders and Koreans were projections of that aggression.

How manifold can be the possible motives for a "motiveless" killing.

It is suggested that this case, which is not cited by Oswald and Evans, is of importance to the literature on this subject whether or not the details of the evidence given can be accepted or not.

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Day and Full Time Psychiatric Treatment

DEAR SIR,

The use of day hospital care is an increasingly important part of comprehensive psychiatric treatment. We welcome new research in this area and we were particularly interested in the case for the economic benefits of day care, which was advanced in the recent articles by Dick *et al* (*Journal*, September 1985, **147**, 246–253).

We feel, however, that research into day hospital care, especially the economic aspects, must take into account the utilisation of that resource. One important aspect of the under-utilisation of psychiatric day care is non-attendance or early default by patients who have been offered a place. The figures in the literature suggest that this may involve between 16% and 53% of referrals (Tyrer & Remington, 1979; Guy *et al*, 1969; Herz *et al*, 1975). It is our clinical impression that this remains a significant problem.

We wonder if Dick *et al*, demonstrated a default rate and whether this showed any difference between the in-patient and day patient groups.

We would also be interested to know whether the intensive recruitment procedure used for the day hospital rate had any influence on drop-out in that group compared to day hospital attenders from other sources.

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Dr Dick Replies

DEAR SIR,

With regard to early default seven of the patients initially allocated to day care were excluded prior to entry into the study—four because they then refused or became too ill, and three because after discharge they telephoned the day hospital to say they were coping effectively. After entry into the study two day patients and one in-patient left treatment against advice. Our relatively low overall early default rate for day treatment (<20%) can be explained by the selection procedures outlined in our paper.