monozygotic twins reared apart is) and care should be exercised when trying to generalise about it.

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Dexamethasone Suppression Test

SIR: I refer to the review article by Braddock on the dexamethasone suppression test (DST) (*Journal*, April 1986, **148**, 363–374), with particular respect to nonspecific factors which might affect non-suppression. I feel the omission of the effects of caffeine merits updating.

Uhde *et al* (1985) studied 22 normal volunteers and depressed patients (diagnostic criteria not specified). The DST consisted of dexamethasone 1 mg at 11 pm and a 4 pm cortisol sample. Analysis was by radioimmunoassay. All subjects were given a single blind placebo controlled challenge of 480 mg caffeine (equivalent to about 4 cups of filtered coffee) between 2 and 2.30 pm. Caffeine was found to increase the mean post-dexamethasone cortisol value from 2.3 to 5.3 μg/dl ($P<0.001$). For both volunteers and patients, when using the 5.0 μg/dl standard cut-off point, non-suppression occurred in 14% on placebo and 36% on caffeine. This dose of caffeine is not unusual when compared to the average daily consumption (Gilbert *et al*, 1976), and indeed in psychiatric patient populations more caffeine may be used (Galliano, 1982). In addition, depressed patients in particular may actually increase consumption of caffeine as a result of their illness (Greden *et al*, 1978; Neil *et al*, 1978). Caffeine therefore should be added as an additional non-specific factor which might affect non-suppression.

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Is Hysteria (Conversion Reaction) Still Alive?

SIR: The article by Shalev and Munitz entitled Conversion Without Hysteria: A Case Report and Review of Literature brings out the controversy which exists around the diagnosis of hysteria (*Journal*, February 1986, **481**, 198–203).

My experience in a psychiatric hospital in India in a semi-urban area is that there is a well defined group of patients who can be given a diagnosis of hysteria. We have described the clinical features of such a group of 276 patients (Subramaniam *et al*, 1980). Similar patients are very common in most of the psychiatry clinics in India. The following are the common clinical features: presence of physical symptoms, more often monosymptomatic, in motor or sensory system without any organic basis; premorbid hysterical personality traits; age of onset of symptoms before 20 years; more among females; dramatisation of symptoms with belle indifference; presence of some unconscious conflict not necessarily sexual in nature and complete recovery with psychoanalytically oriented psychotherapy. Any physical symptom in the absence of an organic basis should not be considered hysterical. If this is established, it is likely that hysteria or conversion reaction will continue in spite of the obituaries pronounced on it by Slater and others.

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On Serious Violence During Sleep-walking

SIR: Drs Oswald and Evans (*Journal*, December 1985, **147**, 688–691) presented some interesting material on somnambulism, including a case of a criminal act committed in sleep. We report another case.

Case report: A young man stayed overnight at his mother's. In the middle of the night he was awakened by an unpleasant dream in which his mother criticised and attacked his girlfriend. He sat up and dressed, with the dream going on in his head, but aware of where he was. Suddenly he got the thought—as if a voice in his head told him—that he should threaten his mother not to be so derogatory and aggressive to his girl-friend. So he went to get a hammer in the basement and went to his mother's bed. Just as he was about to wake her she moved in her sleep. To his surprise he hit her again and again with the hammer without a conscious thought, until after a while he

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realized what he was doing. Seeing the blood he left and went around the streets. A little later he returned to his mother's house, hoping to see an ambulance in the street. Next he went to her door, hoping to hear some sign of life from inside. Neither of his hopes were fulfilled, so he went to his own home, where hours later, he was arrested for the murder of his mother.

Throughout his earlier life the young man had suffered from frequent nightmares and as a smaller child he had been known to sleep-walk. The relationship between mother and son had never been very good and it had worsened because of the mother's disapproval of the son's girl-friend. In the days before his mother's murder the young man's dreams about his mother had been extremely vivid. Whenever he woke up he had to concentrate for a time in order to tell dream from reality. The young man stressed convincingly—and he was supported by the evidence of others—that it was very far from his nature to react with violence.

In the requested psychiatric report it was concluded that the young man was in good health physically, examination by specialists in neurology and EEG revealed no abnormalities. Psychiatric examination showed that he was immature and insecure, but there were no decisive signs of psychopathology. A similar conclusion was drawn from a full scale psychological test, where, in addition, evidence of difficulties in controlling aggressive impulses were seen.

It was claimed that at the time of the crime he had been in a somnambulistic state, a state of reduced consciousness and consequently he had been in psychosis-like condition. According to the Danish Penal Code, section 16—"Acts committed by persons being irresponsible owing to psychosis or similar conditions or pronounced mental deficiency are not punishable"—it was suggested that the crime should be dealt with by treatment and supervision. The case was presented to the Danish Medico-Legal Council, and the Council too concluded in favour of a psychosis or a similar condition. The court followed the medical experts. Discharge took place soon after, and in the first year the young man regularly consulted his psychiatrist, who described him as still immature and periodically anxiety-ridden. In the periods of anxiety he was not able to sleep without sedative medication. He was again admitted to hospital for a time, mostly because of lodging-problems. In the following years he saw his probation officer regularly, and seemed to undergo a positive development, both emotionally and socially. Seven years after the criminal act he was tested by the same psychologist who examined him during the period of mental observation. The psychologist reported the young man to be quite well functioning and compared with his earlier condition he was now quite well controlled, almost inhibited emotionally. Thus the test indicated character neurosis and thereby confirmed the clinical impression of personal stabilization.

Our case might be found somewhat more controversial than those presented by Oswald and Evans—some motive could be postulated and the degree of consciousness-reduction is not quite clear. Still, as the border between sleeping and waking is perhaps not very well defined, we have great sympathy for our older colleagues who remembered the possibility of somnambulism.

In his precise and thorough survey of the subject Schmidt (1943) differentiates somnambulism from epilepsy, discusses psychiatric and forensic aspects and presents material on 15 cases of homicide. Furthermore a nosological subdivision is made; along with the sub-type called the dreamy type ("Die traumhafte Form"), there is a discussion of crimes committed—as in our case—while under the influence of a dream. In his conclusion Schmidt advocates that somnambulism should legally be treated like psychosis. The question whether the defendant is responsible or not must be answered with a no ("verneint"). In these cases the medical opinion is therefore fundamental. We close this letter, like Schmidt did his paper, by observing that even the most careful examination can leave the investigator in doubt.

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SIR: The article by Oswald and Evans (*Journal*, December, 1985, **147**, 688–691) states that sleep walking can be accompanied by violent injury to the self or others. We would like to report another case.

Case report: A 25 year old divorced man was admitted to our service, having been charged with the attempted murder of his *de facto* wife. The circumstances surrounding the attack were unusual. After an uneventful day he helped his wife to prepare the evening meal, played a game of dice and then watched a movie on TV. On finding this uninteresting they had another game of dice and retired to bed at midnight. His wife's young son was ill and at that time was sleeping, in a single bed, in their room. The boy woke up several times during the night, vomiting, and our patient and his wife at various times got up to attend to him. This occurred till at least 2.00 am. His next recollection was of waking up as it was becoming light and seeing his wife sitting at the corner of their bed with something around her neck. He said that it looked like a piece of string or rope. He pulled it from her neck as a result of which she fell on the floor. He immediately ran down the hallway to the kitchen and telephoned for an ambulance

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