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.

A. A. BARTHOLOMEW

Suite 1, 8th Floor
118 Queen Street
Melbourne 3000
Australia

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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.

IAN A. DAVIDSON

Royal Liverpool Hospital
P.O. Box 147
Liverpool L69 3BX

DOMINIC F. CONNOLLY

Sefton General Hospital
Liverpool

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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.

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Our research design, randomising after admission and after some early in-patient default, does not allow for a meaningful overall comparison of default rates between the in-patient and day patient groups.

Less than 50% of all referrals to our day hospital end up attending—confirming the basic point made by Drs Davidson and Connolly. We try, however, to arrange a preliminary contact and explain fully the implications of day attendance prior to admission so that our early default rate for patients actually admitted is close to the lower reported figure of 16%.

PETER H. DICK

Royal Dundee Liff Hospital
Dundee DD2 5HF

Seasonal Affective Disorder

DEAR SIR,

The paper by James *et al* (*Journal*, October 1985, **147**, 424–428), on winter depressions provided a welcome bit of light relief. Patients were recruited through a newspaper advertisement and reported that they felt less depressed after exposure to bright light than dim light, during a cross-over trial. The authors report that they did not inform the patients of their prediction that bright light would be superior, yet that must surely have been obvious (unless, of course, the patients themselves were very dim).

At one point in the discussion the authors, commenting on the fact that even their dim lights had some antidepressant effect, acknowledge that "we would have predicted that the publicity about the previous studies would have biased patients against responding to the dim lights". Could they throw some light on why they do not mention this as a possible explanation of their findings?

J. R. KING

The Medical Staff
Barnsley Hall Hospital
Bromsgrove, Worcs.
B61 0EX

Drs Rosenthal and James Reply

DEAR SIR,

Dr King raises an important point, which was not addressed in our article, though we have discussed it in detail elsewhere (Rosenthal *et al*, 1985).

It is conceivable that different antidepressant effects in response to bright and dim light treatments might have occurred as a result of different expectations. Such patient expectations might have been generated by the appearance of the light and might have been amplified by comparing the two light conditions and speculating about our underlying hypothesis. While patients were able to make comparisons during the second phase of the cross-over, they had no basis for comparison during the first phase as they were not shown both types of light before the first treatment. If expectations based on a comparison of the two conditions were responsible for the superior effect of bright light, one would have expected that those who received dim light second, after they had already been exposed to the bright light condition, would have responded more poorly than those who received it first. Conversely, one would have expected that those who received bright light second would have responded better than those who received it first. However, analysis of Hamilton Depression Ratings showed no ordering effect, which would suggest that differential expectations resulting from comparison of the conditions did not play a significant role in the different antidepressant effects.

That still leaves open the possibility that, regardless of the order of presentation, the bright light might have generated more powerful expectations of improvement than the dim light. Such a possibility can never be ruled out with certainty in any study where it is impossible to administer the intervention on a double-blind basis. However, the following observations, based on all our light treatment studies, suggest that a placebo mechanism alone is not a plausible explanation for all the resulting antidepressant effects. 1) There is generally a lag time of approximately two to four days both for response after initiating light treatment and for relapse following withdrawal of light. One would expect a placebo to show a more rapid and variable time course for response and relapse. 2) Light treatment has been effective repeatedly and for prolonged periods of time within individuals, whereas placebos generally decrease in efficacy over time and with repeated use. In some cases light treatment initiated in the fall has prevented the development of winter depression. 3) As stated in the paper which Dr King cites, we have found the pattern of response to both bright and dim light to be consistent over the years. In addition, the difference between the efficacy of bright and dim light treatments has not grown progressively larger from year to year, as one might have predicted had the response of patients been due to expectations generated by widespread publicity.

In order to address the question of patients' expectations more directly, future studies of light therapy should incorporate some means of evaluating expectations systematically before each treatment condition.

Although Dr King's comments were provided in a light-hearted vein, we found them illuminating and

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