British Journal of Psychiatry (1984), **145**, 669–672

Correspondence

Correspondents should note that space is limited and shorter letters have a greater chance of publication. The Editors reserve the right to cut letters and also to eliminate multitudinous references. Please try to be concise, strictly relevant and interesting to the reader, and check the accuracy of all **references in Journal style.**

DREAMS AFTER AMPUTATION

DEAR SIR,

I read with interest the letter by L. Burd (*Journal*, October 1984, **145**, 448) with the above title. It referred to change of body image in dreams following amputations and the time over which this developed. It was stimulated by the article by Frank *et al* (*Journal*, May 1984, **144**, 493–497) on psychological response to amputation.

When I first grew a beard my self image in dreams remained obstinately clean shaven for over 18 months. I wonder if the various observations made are in support of Mathers' (1974) hypothesis that 'critical experiences which initiate a change in a man's sense of identity are not usually emotionally digested until about 18 months have elapsed'.

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Reference

MATHERS, J. (1974) The gestation period of identity change. *British Journal of Psychiatry*, **125**, 472–474.

DEAR SIR,

I was interested to read Dr Burd's remarks on the content of amputees' dreams, and I should like to offer a few observations of my own.

As part of a recent survey of 75 amputees, I took the opportunity to ask them about their dreams in the month prior to interview. Of the 50 subjects who could remember the content, the majority (44%) still figured in their dreams intact and unmutilated, 14% consistantly dreamt of themselves as amputees, and the remaining 22% had variable dreams in which the amputated limb would be present on some occasions and not on others. There was no association between any particular dream type and the length of time since amputation; seasoned amputees were as likely to dream of themselves with two limbs as were the more recent cases. As this was a cross-sectional survey, I cannot comment on how individuals' dreams changed over time.

There was no evidence that the presence or absence per se of the amputated limb in dreams was any index of adjustment. What did appear to be important, however, was the extent to which amputation or its implications were an issue within the dreams. For example, a larger proportion of the poorly-adjusted amputees remembered their dreams, and those who dreamt of having only one limb often reported such dreams as "nightmares". Conversely, if they dreamt that they were intact, then they were usually engaged in strenuous activities such as running and jumping, and they themselves would comment upon the wish-fulfilling aspects of these dreams when recounting them to me. In contrast, the well-adjusted amputees were more likely to have no memories of their dreams, or if they did, their amputation usually appeared incidental to the content.

The analysis of dreams is a tricky business; it seems unlikely that we shall find reliable indicators of 'adjustment' or 'acceptance' in such general features as the body image of the dreamt self. As Freud himself remarked: "In the case of the decoding method (of dream interpretation) everything depends upon the trustworthiness of the 'key'—the dream book, and of this there is no guarantee."

Doubtless, the examination of an amputee's dreams can help in understanding the personal meaning and significance of his loss, and may well be useful in the context of properly conducted psychotherapy. However, we should not expect a superficial 'decoding' of such dreams to tell us anything that is not already perfectly apparent in other areas of the patient's life.

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DEXAMETHASONE SUPPRESSION TEST (DST) IN DEMENTIA

DEAR SIR,

The paper by McKeith (*Journal*, Ocober 1984, **145**, 389–393) while reporting an incidence of 58% non-suppression in patients with senile dementia (SD), confirms the non-specific nature of the abnormal DST. However, interest is now centred around the clinical features which might be associated with the abnormal DST, as was discussed by Berger *et al* in the same issue of the *Journal*. Particular interest has been expressed

in the progression of the dementing process in relation to the abnormal DST (Mahendra, 1984) with the speculation that relatively high cholinergic activity in slowly progressing cases of Alzheimer's disease (AD) cound account for the abnormal DST. Mendlewicz *et al* in their paper (*Journal*, 1984, **145,** 383–388) also suggest that a relationship exists between abnormal DST results and shortening of REM latency in major depression, invoking a possible cholinergic mechanism as one explanation.

The different explanations for the abnormal DST in arteriosclerotic dementia (ASD) and acute confusional state (ACS) seem also to be needlessly multiplied. It is surely not permissible to explain the abnormal DST as being due to "serious physical illness" in ACS and then seek other explanations for ASD and SD. By any standard of measurement, ASD and most forms of SD are serious physical illnesses and, at least in respect of the possibility of reversal being remote, considerably more serious than confusional states. The parsimonious explanation would be that serious illness in the presence of intact cholinergic activity, as in ASD and ACS, is likely to produce a high incidence of abnormal DST. A useful hypothesis would be to try to relate this state, which is presumably more likely to exist in slowly progressing than rapidly progressing forms of AD, to the abnormal DST.

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Reference

MAHENDRA, B. (1984) Dementia and the abnormal dexamethasone suppression test. *British Journal of Psychiatry*, **143,** 98–99.

JUMPING FROM A GREAT HEIGHT

DEAR SIR,

We report the case of an eighteen-year-old boy who jumped 250 ft. (76 m.) from the Clifton Suspension Bridge in Bristol and survived.

He fell vertically, entering the water (which was 18 ft. (5.5 m.) deep at that point) feet first with toes pointed, at an estimated velocity of 75 m.p.h. (120 k.p.h.). On surfacing, he swam to the bank where he was pulled from the water by a passing policeman. The fall was reported in the local and national newspapers.

At hospital he gave an accurate account of events, having remained conscious throughout. His physical injuries were: dislocation of the left shoulder joint with a fracture of the greater trochanter of the humerus and crush fractures of T_9, T_{10} and L_1 vertebrae. With the dislocation reduced, his physical state improved rapidly with bed rest.

Psychiatric assessment in casualty revealed a depressed mood with suicidal intent over the previous week. A preoccupation with his isolated existence, together with the delusional fear that he had killed a friend by introducing him to heroin, progressed after a few days to further morbid delusions and also hostile auditory hallucinations. He had a four-year history of multiple drug abuse, was unemployed and lived a solitary life, seeing very little of his parents, both of whom had started new families since their divorce when the patient was aged eight. He improved over the course of four weeks with pharmacological and psychotherapeutic measures.

Perhaps the most interesting aspect of his story was his description of the fall itself. He said that while falling he developed the calm conviction that he would not die and experienced only pleasure and a sense of peace. He felt that time passed slowly and that he was a detached observer. He felt no pain on impact.

His survival of a fall of 250 ft. is remarkable. The only other known survivor was 24 year-old Sarah Henley who jumped from the Clifton Suspension Bridge in 1885, landing in the mud and sustaining multiple injuries (Bristol Times and Mirror, 1885). This is claimed to be the world's high diving record (McWhirter, N., 1984).

Injuries and survival factors have been considered in detail by Lukas *et al* (1981), who reported a series of 720 jumps from the Golden Gate Bridge across the San Francisco Bay (240 ft. 73 m.). Most died on impact and autopsy showed contusion or laceration of major organs in the chest or abdomen. There were fourteen survivors; the least injured being a 17 year-old, who had compression fractures of T_6, T_8, and L_1 vertebrae. Position and orientation of the body on impact appears to be critical, the vertical feet first position combining minimal surface area with the opportunity for gradual deceleration.

The patient's mental state may well have been altered by unknown drugs and psychosis, but his description is remarkably similar to those reported by Lukas *et al*, and in accounts of potentially fatal falls in alpine climbers (Noyes, R., 1972). They describe peace and pleasure, a slowed perception of time and no pain or distress.

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BRISTOL TIMES AND MIRROR (1885) Attempted suicide from suspension bridge—miraculous escape.

LUKAS, G. M., HUTTON, J. E., LIM R. C. & MATHEWSON, C. (1981) Injuries sustained from high velocity impact with water: An experience from the Golden Gate Bridge. *The Journal of Trauma*, **21,** 612–618.