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Erotomania in relation to childbirth

SIR: Murray *et al* (*Journal*, June 1990, **156**, 896) do not discuss the possible role of alcohol in the illness of their patient. Organic factors are well known in the aetiology of this disorder, as described in a number of the references they list. Their patient is described as "never a heavy drinker, she drank two cans of beer most nights in the six months before referral". A statement like this by a 40-year-old mother of two children should have made one press harder about the history of alcohol consumption. For instance, what does "never a heavy drinker" mean? Did she drink spirits? What beer did she drink – some beers are approximately equivalent to six units per can? Is there any independent confirmation of the alcohol history? Is there any question of other drug abuse? In this connection one is bound to note that there were financial problems and that her husband was anxious and irritable and one wonders whether he might have been drinking as well.

Symptoms caused by alcohol would be expected to subside within a matter of weeks in most cases. If alcohol had been considered then she would have been kept in hospital for some weeks for diagnostic purposes before beginning drug treatment, and only if symptoms persisted would other diagnostic possibilities have been considered. One would therefore like to know how long after admission was the trifluoroperazine started, and how soon the resolution of symptoms began.

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Effect of beliefs on grief

SIR: Kavanagh (*Journal*, September 1990, **157**, 373–383), in his otherwise stimulating review of adult grief reactions, almost totally ignores the effect of an individual's belief or not in an 'after life'. Such beliefs can have a significant impact on the attitude of the recently bereaved person to the loss. Dr Kavanagh clearly identifies the possible conflicts between belief and actual experience: "A continuing problem for many people is the challenge that the death can pose to central attitudes by which we maintain goal-directed behaviour . . . beliefs about the meaningfulness and fairness of existence . . . belief in a divine being . . . may also come under threat". However, Dr Kavanagh fails to incorporate an understanding of the benefits such beliefs may give to the sufferer. In the cognitive-behavioural interpretation that he suggests, "normative issues are discussed and irrational guilt is minimised".

Whose baseline is taken in deciding 'normative' and 'irrational'? A firmly held Christian belief in an afterlife of Heaven and Hell would be interpreted by many mental health workers as 'abnormal' and 'irrational'. Yet, to challenge and attempt to deny the sufferer's belief system would, I suggest, be to exacerbate their already significant and normal distress.

Any intervention for grief must make allowance for the philosophical or religious attitudes of the bereaved towards the meaning of life and death. This will help to achieve Dr Kavanagh's laudable aim "to maximise survivors' achievements and minimise the pain they suffer to gain them."

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SLE and multi-infarct dementia

SIR: Green (*Journal*, November 1989, **155**, 707–711) published the account of a 54-year-old woman with abnormal involuntary movements, who, over the years, had been given diagnoses of hysterical conversion syndrome and bipolar affective disorder. It transpired that a single diagnosis of systemic lupus erythematosus (SLE) could account for all these features, based on the evidence of selective microinfarcts in the frontal and temporal lobes and serum autoantibodies to DNA.

We describe a second case of SLE presenting with protean psychiatric symptoms, again with discrete microinfarcts, this time in the frontal and temporal regions on nuclear magnetic resonance (NMR) imaging.

Case report: A 70-year-old Caucasian woman was transferred to Mossley Hill Hospital with a subcortical dementia-like picture. She had a deadpan expression, was uncommunicative and glided silently about the ward, occasionally with tears streaming down her face. Sometimes she would vary her behaviour by answering questions monosyllabically, or lying down on the floor or attacking other patients.

Following the drowning of a grandchild, she presented to psychiatric care in the USA in 1984 with a 'major depressive disorder with psychotic features'. She responded to tricyclics and neuroleptics. This was followed by a relapse of her depression with a 'paranoid psychosis' in 1985 after the death of another grandchild. She was treated with electroconvulsive therapy (ECT). Having returned to England, she suffered a further depressive illness in 1988 which featured nihilistic delusions, evidence of short-term memory loss, and behaviour such as throwing herself on the floor or lying across chairs. She responded slowly to tricyclics and antidepressants. Her face was mask-like and her responses were slow. Her recovery was limited and a presumptive diagnosis of multi-infarct dementia was made based on the cognitive deficits of disorientation, short-term and long-term memory loss and dyscalculia together with the NMR report of 1985 quoted above.

A serum autoantibody screen performed in 1990, however, revealed markedly abnormal homogenous autoantibodies suggestive of SLE. This, together with the NMR report of microinfarcts in 1985, suggests that a single diagnosis of SLE would account for this woman's six-year psychiatric career. It is of note that she had no family history of SLE, nor psychiatric disorder, and that her past medical history showed no manifestation of SLE in any other bodily system. Her pre-morbid personality was that of a religious, outgoing and friendly woman, used to public speaking and passionate about her garden.

There are echoes between this case and the earlier one described by Dr Green – both are manifestations of solely cerebral SLE diagnosed after a career of affective illness. In the early stages, carers and case notes of both cases refer to 'histrionic', 'hysterical', 'negativistic' or 'paradoxical' behaviour. The later stage of both cases appears to be characterised by movement disorders, one being a focal athetosis and the other a strange gliding gait and Parkinsonian facies.

If SLE can be seen twice in the psychiatric catchment area of Liverpool, it may follow that there is a much larger number of cases elsewhere, remaining as yet undiagnosed. If the diagnosis can be made and a series established then perhaps we will be that nearer a treatment for this most disabling condition.

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A HUNDRED YEARS AGO

The non-restraint question

We were under the impression that the discussion between Dr Yellowlees and Dr Alex Robertson had exhausted itself in our last number. Each physician had fully and freely expressed his views on a subject in regard to which they honestly hold different opinions. To continue the discussion would, we think, be little more than a repetition of the same statements, if not the same words, without adding any real force to the arguments employed by these able combatants. Dr Robertson, however, wished to make it unmistakably clear that he regards "locked gloves" as one form of mechanical restraint. As he places in the same category "side arm dresses" and the "protection bed", and as Dr Yellowlees recommends their use in exceptional cases, Dr Robertson maintains that he was not in error referring to "the considerable use of mechanical restraint" advocated by him. Another statement Dr Robertson wishes to make, which is, that although he has been connected with an asylum which during the last five years has not had a larger number of patients than 125, it was, during many years previously, licensed for 248 patients, a large proportion of whom were dangerous, both in respect of suicide and homicide.

Reference

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