

- CUMMINGS, J. L. (1985) Organic delusions: phenomenology, anatomical correlations and review. *British Journal of Psychiatry*, **146**, 184–197.
- KUMAR, V. (1987) Capgras syndrome in a patient with dementia. *British Journal of Psychiatry*, **150**, 251.
- LEWIS, S. W. (1987) Brain imaging in a case of Capgras syndrome. *British Journal of Psychiatry*, **150**, 117–121.
- LIPKIN, B. (1988) Capgras syndrome heralding the development of dementia. *British Journal of Psychiatry*, **153**, 117–118.

### Multifactorial intoxication?

SIR: I read with interest the article by Peh *et al* (*Journal*, June 1990, **156**, 891–893). However I fear that the discussion of possible mechanisms is perfunctory and potentially misleading.

Hyponatraemia is a relatively common finding in clinical practice, and numerous possible causes have been recognised (Foote, 1990). Spurious analytical errors may occur either from 'drip artefacts' or from conditions of hypertriglyceridaemia or hyperproteinaemia. Convincing evidence against these potential errors is lacking in the case described.

The limited clinical data given indicate the presence of a cardiomyopathy in a relatively young woman, apparent from early 1984, and the injudicious use of small quantities of intravenous fluid is dangerous, with disastrous consequences in this case. Biochemically, a picture of hypervolaemic hyponatraemia would be expected.

The syndrome of inappropriate antidiuretic hormone (SIADH) is rightly discussed, albeit briefly, by the authors. However no mention is made of tobutamide's recognised ability as a sulphonylurea to induce this endocrinological abnormality. Moreover, head injury, convulsions and 'psychosis' are all described as individual causes of the same syndrome of excess antidiuretic hormone secretion in the face of low serum osmolality.

I would propose that the reasons for this unfortunate woman's hyponatraemia are at least multifactorial rather than isolated water intoxication as suggested.

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### Reference

- FOOTE, J. W. (1990) Hyponatraemia: diagnosis and management. *Hospital Update*, **16**, 248–258.

### Memories in depression: pleasant or unpleasant?

SIR: It is generally accepted that depression is associated with unpleasant memories which are congruent with the affective state (e.g. Dunbar & Lishman,

1984; Teasdale & Dent, 1987). However, we have repeatedly been finding contradictory results regarding memory while studying other phenomena in pre-electroconvulsive therapy (ECT), drug-free, depressed (DSM-III-R diagnosed) patients admitted to hospital. For example, we unexpectedly found that over a period of 72 hours, depressives forgot significantly ( $F=6.283$ , d.f. 1,20:  $P<0.021$ ) more negative than positive affect words, as compared with normals and schizophrenics (e.g. Calev, 1988).

In another study (Bachar *et al*, 1987), pre-ECT depressed patients tended to produce, during a reminiscing interview (encouraging subjects to speak about events which happened five years or more previously), more positive memories (mean = 51%; s.d. = 37) than did normal controls (mean = 44; s.d. = 15), although this difference was not significant. In a reminiscing group (Bachar, submitted), depressed patients produced a mean of 83% (s.d. = 18) positive affect memories. In a study of dream recall (Bachar, in preparation), we found that depressives tended to recall more positive than negative dream contents. Twenty-one out of 37 dreams were classified as positive (using Hole & Castle's (1966) classification system), and only 16 dreams were classified as negative. While dream recall norms are lacking, this finding once again shows that depressives tend to recall more positive than negative contents.

The common denominator of all our findings, in contrast to most former findings, is *delayed testing* for the 'to-be-remembered' materials. It is thus possible that positive emotional contents may be suppressed and temporarily unretrievable during depression because of state-dependent negative thought-processes. These negative materials may be well consolidated in memory, as shown by our paradigms (delayed recall, remote memory reminiscing, and dream recall). Depressives may retrieve these memories later and use them as a means for recovery.

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### References

- BACHAR, E., DASBERG, H. & LERER, B. (1987) Remembering in depressed aging patients: effect of ECT and tricyclic antidepressants – implication for psychotherapy. Paper presented at the International Conference on New Directions in Affective Disorder, Jerusalem, Israel.

- CALEV, A. (1988) Effect of emotion on the rate of forgetting in normals, schizophrenics and depressives. Paper presented at the First International Conference on Individual Differences, Tel Aviv, Israel.
- DUNBAR, G. C. & LISHMAN, W. A. (1984) Depression, recognition memory and hedonic tone: a signal detection analysis. *British Journal of Psychiatry*, **144**, 376–382.
- HOLE, C. & CASTLE, R. (1966) *Content Analysis of Dreams*. New York: Appleton-Century-Crofts.
- TEASDALE, J. D. & DENT, J. (1987) Cognitive vulnerability to depression: an investigation of two hypotheses. *British Journal of Psychiatry*, **26**, 113–126.

### Expressed emotion and lithium prophylaxis

SIR: In a previous study (Priebe; *Journal*, March 1989, **154**, 396–399), expressed emotion (EE) in key relatives of 21 patients with bipolar affective or schizoaffective psychoses was assessed by the Camberwell Family Interview (CFI). All patients had been on prophylactic lithium for at least three years. Patients living with high-EE relatives showed a significantly poorer response during the three years before interview and particularly during the nine-month follow-up.

Twenty-eight months after the initial CFI, the key relatives of 15 patients were re-interviewed. All 15 patients had continued on prophylactic lithium throughout the 28 months. Two critical remarks designated high EE. There were 10 relatives identified with high EE in the first interview and eight in the second, since two relatives changed from high- to low-EE status. The course of patients' illness was assessed by means of a morbidity index (Coppin *et al*, 1973) reflecting severity and length of recurrences (a recurrence was defined by hospital admission or a temporary additional antidepressive or neuroleptic medication).

Regardless of whether EE status was defined according to first or second CFI, morbidity indices concerning the 28-month period were more than six times higher in patients living with high-EE relatives (regarding the first CFI:  $t = 2.91$ ,  $P < 0.05$ ; regarding the second CFI:  $t = 3.83$ ,  $P < 0.01$ ). Four out of five patients with consistently low-EE relatives, and one patient with a relative who had changed from high- to low-EE status were virtually without any recurrences during the 28-month period. This applied to none of the patients living with consistently high-EE relatives.

A clear answer as to whether high-EE status of relatives leads to an unfavourable course of illness or vice versa was not found. Both course of illness and relatives' EE status might be influenced by interactional patterns in the patients' families, and by changes in those patterns. As far as this small and highly selective sample is concerned, it may be con-

cluded that patients living with consistently low-EE relatives rarely need therapeutic interventions of whatever kind in addition to prophylactic lithium.

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### Reference

- COPPEN, H., PEET, M., BAILEY, J. *et al* (1973) Double-blind and open prospective studies of lithium prophylaxis in affective disorders. *Psychiatry, Neurology and Neurosurgery*, **76**, 501–510.

### Pseudocyesis followed by depressive psychosis

SIR: Pseudocyesis is a false belief in pregnancy associated with its symptoms and signs (Cohen, 1982). It may be associated with psychiatric disorder, most commonly depression, which usually does not reach case level (Brown & Barglow, 1971). Occasionally, it is associated with psychosis (Taylor & Kreeger, 1987; Mortimer & Banberry, 1988; Milner & Hayes, 1990). We would like to report the first case of depressive psychosis following pseudocyesis after an interlude of normality.

*Case report:* A 38-year-old married domestic worker of stable pre-morbid personality had children of ages 20, 14 and 10 years. She had had one miscarriage at age 35 years and one elective abortion when 37 years old. Six months after this abortion she was referred to the psychiatric services because she believed herself to be pregnant, despite two negative pregnancy tests. She had missed two periods, had back-ache, breast swelling and tenderness and morning nausea. Examination revealed a distended abdomen but non-pregnant cervix and uterus. After three weeks of supportive psychotherapy all symptoms resolved. She remained completely well for three weeks but then became depressed, with early morning wakening, reduced energy, poor appetite and weight loss. She was severely agitated, believing herself to be in danger. She was deluded that her face was being distorted and that her body was rotting. She made three suicide attempts. Her symptoms failed to respond to antidepressants and phenothiazines but resolved rapidly with a short course of electroconvulsive therapy. She returned to her pre-morbid functioning and has remained well for two years off all medication.

Our patient's illness satisfied DSM-III-R criteria for a major depressive episode with psychotic features and ICD-9 guidelines for manic-depressive psychosis, depressed type. To our knowledge, this is the first report of a depressive psychosis following