References

SPITZER, R. L. & ENDICOTT, J. (1978) *Schedule for Affective Disorders and Schizophrenia (SADS) (3rd edn)*. New York: Biometric Research, New State Psychiatric Institute.

——, —— & ROBINS, E. (1978) *Research Diagnostic Criteria (RDC) for a Selected Group of Functional Disorders*. New York: Biometric Research, New State Psychiatric Institute.

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.

SAMUEL I. COHEN

The London Hospital Medical College
Turner Street
London E1 2AD

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."

DAVE HAMBRIDGE

Ashtree House
The Moors
Branston Booths
Lincoln LN4 1JE

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.