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

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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

pseudocyesis and is the first case to demonstrate an interval of normality between resolution of pseudocyesis and onset of psychotic symptoms. This case highlights the necessity for adequate follow-up of patients with pseudocyesis: severe psychiatric illness may supervene even after a period of normality.

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Ethics of 'brain transplants'

Sir: O'Shea (*Journal*, August 1990, **157**, 302) raises the issue of brain transplants and their relation to the ancient debate concerning mind and body. A number of points seem worth making.

The hypothetical operation of transplanting A's brain into B's body (and *vice versa*) was discussed by Shoemaker (1963) and further elaborated by Williams (1970) in connection with the problem of personal identity. The issue initially appears to be whether one believes that the self (however constituted) will similarly be transferred with the brain or will remain with the body. Williams shows that both views can be cogently argued for, and discusses the links between the issue of personal identity and that of the relation of mind and brain.

It might be thought that such speculation was best left to the realms of science fiction, but there are two reasons for regarding discussion of such hypothetical cases as important. Firstly, as O'Shea implies, less dramatic forms of brain surgery already occur. One example is that of commissurotomy for intractable epilepsy. The philosophical difficulties raised by this operation are addressed by Nagel (1976). He discusses how many minds these patients can be said to have and shows that the results of the operation tend to break down our natural assumption that we (the unoperated) have one mind.

A second reason for considering these operations lies in the special way that they point up the links between issues in the philosophy of mind and ethical difficulties that are of particular relevance to psychiatry. Consider the question: How much change does someone have to undergo before thay do not exist any more (for example, removal of the brain and replacement by another)? This now looks very like the question that we ask and answer in cases of brain death. From this point it is a small step to considering cases of direct relevance to psychiatry such as the dementing relative ("she's not herself any more") or the psychotic patient during a florid episode ("he's changed beyond all recognition").

O'Shea's informal poll of a number of psychiatrists produces much the same result as my own. Most psychiatrists appear to hold either to a form of materialistic behaviourism or to some kind of dualistic position, and few are aware that the debate has moved on considerably. Neither position is philosophically coherent (good critiques of both can be found in Smith & Jones (1986)). Importantly, it cannot be a matter of indifference that we hold incoherent positions, since they do have practical consequences and lead to incoherent actions. An example worth considering in this respect would be the rationale of offering a combination of psychotherapy and medication for depressive illness. Whenever this question is discussed it is clear that (often unexamined) assumptions about the philosophy of mind are in operation.

We have begun to recognise that these issues are important. A philosophy group has now been formed within the College, and at my own hospital we now hold regular philosophy meetings.

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CORRIGENDUM

Journal, August 1990, **157**, 316. The author of *Not Always on the Level* is E. J. Moran Campbell.