drugs can be continued during breast feeding, the infant would have to be closely monitored in order to identify sedation, or anticholinergic and other side effects. Breast feeding under the supervision of relatives would be necessary, as the mother may not be in a position to care for her infant. In mothers where breast feeding is contraindicated because of homicidal risk, regular reassessment of this status and early reinstitution of feeding when the risk reduces would be beneficial. Thus, assessment of the problems on a case by case basis would be mandatory, and breast feeding should be encouraged in all mothers without the risk of infanticide, as the morbidity and mortality of artificially fed infants is unacceptably high in developing countries.

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Spousal allegations of incest during transient psychotic episodes

SIR: The interesting case report of Remington & Rosenblat (*Journal*, August 1991, **159**, 287–288) draws attention to the necessity of thorough investigations of sexual abuse made while psychotic. The authors speculate as to the genesis of the content of the psychotic material. We would like to add two points based upon our recent experience of treating a 37-year-old woman who became acutely psychotic two months after childbirth. She accused her husband of infidelity and of sexually abusing her 11-year-old daughter by her first marriage. After five days, her psychotic symptoms resolved and she withdrew the allegations.

In the cases described by Drs Remington & Rosenblat, the father was perceived as neglecting his parental responsibilities. The authors speculate as to the role of this perception and the associated anger in the psychotic material. In our patient, perceived neglect was not an issue but, as with the patients described, there was marital conflict. Diminishing sexual activity in the context of marital conflict may lead to fears about sexual desirability, and the mechanisms of denial and projection could lead to false allegations of infidelity and sexual abuse. In our patient, not only had pregnancy and childbirth interfered with sexual activity but also her husband's recent prostatectomy and vasectomy.

The authors rightly emphasise the importance of thoroughly investigating such allegations despite the presence of psychosis. Such investigations, however, must be carried out sensitively, as the effect of false allegations upon the accused and the alleged victim may be traumatic. In our case, once the allegations had been shown to be false and withdrawn, several interviews were necessary to allow the spouse and daughter to express their distress. In the management of false allegations of sexual abuse, consideration must be given to the effect of both the investigation and the allegations themselves.

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SIR: We were interested in the two Canadian cases reported by Remington & Rosenblat (*Journal*, August 1991, **159**, 287–288) in which false allegations of sexual abuse were made by patients with transient psychotic illness. These were apparently the clearest reported examples of such allegations arising directly from acute psychosis, and on recovery the patients withdrew their claims, so no action was taken to deal with the abuse. However, the consequences of such allegations can be far more serious than this. We report a British case in which protracted legal proceedings have resulted.

Case report. Mrs X, a 29-year-old mother, presented with a paranoid psychosis one month after the birth of her fourth child. Her two elder children lived respectively with their grandmother and father. All the children were by the same father. Mrs X had a recent history of two similar psychotic episodes, precipitated by stress, and on both occasions she had made a full recovery. There was no known family history of psychiatric disorder.

At the onset of the current episode she alleged that her common-law husband had sexually abused their 10-year-old daughter. The daughter, who lived with her, confirmed

the allegation. On hospital admission, the patient was hostile and suspicious towards all staff. When asked to give consent for her daughter to be examined by the police surgeon, she refused and, as consent could not be given by anyone else, no physical evidence for or against abuse was obtained.

On recovery, Mrs X stated that the allegations of sexual abuse had been untrue and that she had told her daughter to say that she had been abused. Her daughter again confirmed her mother's story. However, local social workers were now concerned not with whether the child had been sexually abused but with whether she could have suffered emotionally by being party to false accusations. As a result, an initial interim care order was extended and further care proceedings are currently planned.

There are three points to note from this case. Firstly, although Remington & Rosenblat believe it is rare for false accusations of sexual abuse to arise solely from psychosis, it may become more common as sexual abuse joins other preoccupations of our society in the content of delusional psychosis. Secondly, the outcome of such accusations can be far-reaching and serious, in part because of the sensitivity of social workers in this field. If such cases are increasingly common, it is therefore vital that psychiatrists and social workers are able to develop a joint approach to the management of women whose allegations are features of their illness. Thirdly, the case illustrates how a child can be persuaded to confirm a parent's delusions, although whether this is in itself damaging to the child remains a subject for debate.

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Fitness to plead

SIR: The law on fitness to plead is generally held to be highly unsatisfactory (Bluglass & Bowden, 1990). If a jury (and it has to be a jury) finds that a person is unfit to instruct solicitors, challenge jurors and comprehend the nature of his acts or the court proceedings, then the law admits no alternative to an indefinite hospital order with release only by the Home Secretary. Few hospitals will accept patients under such strict circumstances and, to obviate this, many defendants are persuaded to plead guilty to small charges when, in fact, much mental illness fully meets the criteria for unfitness.

It is good to know that British Justice can have a human face – and in a Crown Court which has a famous, if not notorious reputation for a rigorously punitive attitude.

Case report. Mr X, a man in his 30s, was arrested as a result of erratic behaviour culminating in a car chase during which several police vehicles were damaged and officers had to be treated in hospital. He faced eleven charges of actual bodily harm, theft, reckless driving, and property damage, but was (somewhat surprisingly) allowed bail. When a psychiatrist called in by his solicitors saw him, he was immediately admitted to hospital under Section 2 of the Mental Health Act. There had been problems in his life during the year before this episode, but he had always been sane and law-abiding. For several months, however, he had become increasingly unpredictable with unrealistic plans of the most grandiose kind. Although unemployed, he claimed to have made £6 million profit, for which reason Social Security was understandably unwilling to allow his family to claim benefit. His recovery in hospital was swift but he lapsed into an anxiety state with panic and some secondary depression as a presumed result of trying to come to terms with the consequences of what he had done. All memory of the four months of his developing illness seemed to have been obliterated, including a whole archive of manic writings and the circumstances of two broken ankles and the plastering thereof.

Three psychiatrists, including one for the prosecution service, concurred with the diagnosis of hypomania or mania and accepted the amnesia as genuine.

The prosecution decided to offer no evidence, and the judge, after consulting with both counsel in Chambers and reading the reports, decided not to put the issue to a jury. Describing in open court "an extremely serious series of events under ordinary circumstances calling for extreme punishments", he agreed that offering no evidence was the right decision by the Crown. He called attention to the special circumstances of the case and the background of the defendant. Severe warnings were given if Mr X defaulted from treatment and relapsed, and the Crown Psychiatrist's report was to be sent to the Driver & Vehicle Licensing Centre in Swansea. Those advising Mr X were both astonished and happy: the reaction of the police is not known.

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Obsessive slowness revisited

SIR: Ratnasuriya *et al* (*Journal*, August 1991, **159**, 273–274) discuss preponderance of males in cases of obsessive slowness, and of Parkinsonism, the latter being associated with pathology in the basal ganglia