with severe EPSE (pseudo-parkinsonism) combined with confusion, dysarthria, double orientation for place, poorly formed delusions which were different and unrelated to the original ones, and ataxia. All medication was stopped, benztropine was prescribed, fluids pushed, and again recovery was rapid and uneventful.

In these two cases there seems to have been a pattern: at a high serum lithium level the illness suddenly "broke" much as Jefferson and Griest (1977) have described when lithium is used to treat acute mania, the original psychotic symptoms disappeared and the patients developed severe EPSE and toxic confusional symptoms. The EPSE could have been due to a direct dopamine blocking effect of lithium (Tyrer *et al*, 1980) which would have been enhanced by chlorpromazine. It is possible that the toxic confusional symptoms were caused by the high serum lithium levels reached. These cases show the value of frequent serum lithium levels when one is trying to sort out a mixed clinical picture where EPSE and toxic confusional symptoms co-exist.

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FAILURE TO MOURN AND MELANCHOLIA

Dear Sir,

I should like to compliment Dr Pedder on his article dealing with pathological mourning (*Journal*, October 1982, **141**, 329–37).

One point that I would wish to make is that the dichotomy between the behavioural psychotherapist and the dynamic psychotherapist, in regard to the treatment of pathological mourning, can only be an unfortunate and damaging hindrance to patients requiring treatment. In my article—"Nineteen Cases of Morbid Grief"—the description of the therapy, I believe, clearly indicates the therapist conscientiously combining behavioural principles of systematic desensitization and implosion with psychodynamic principles in which the therapist remains warm and empathic. I further state that the therapist must prepare the patient for the eventual loss of the patient-therapist relationship and that failure to do so could block the successful conclusion of therapy.

I also feel that it has been insufficiently stated that the effects of morbid grief can mimic an entire range of psychiatric disorders, from neurotic disorders such as agoraphobia through to the precipitation of relapses in schizophrenic illnesses.

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MANIA ASSOCIATED WITH WEANING: A HYPOTHESIS

Dear Sir,

Dr Abou-Saleh's letter (*Journal*, May, 1982, **140**, 547,) postulating that a sharp decrease in blood prolactin level that followed weaning was involved in the pathogenesis of post-partum mania requires qualification. I have personally treated 286 patients with puerperal psychosis and the vast majority were affective or schizo-affective but relatively few suffered from mania. Those with acute mania were generally referred while still in the maternity hospital or had been recently discharged. Abrupt weaning was not a factor in these cases.

I had a patient with an acute and severe post-partum mania who, several years later, had a carbon copy psychotic episode following appendectomy and it is doubtful whether prolactin levels were involved in the second episode. This does not mean that in very susceptible people a sharp fall in prolactin level could not be the insult which triggers the psychosis. What is required is a more detailed study of puerperal mania and the variety of insults that can precipitate it.

Dr Abou-Saleh's suggestion of hormonal treatment in these cases is an interesting one but over the years haloperidol has taken over from chlorpromazine as a tranquillizer of choice in puerperal mania and it is the latter which is more potent in raising prolactin levels.

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EPIDEMIC PSYCHOSES, OR EPIDEMIC KORO?

Dear Sir,

I read with interest Dr Harrington's account of three outbreaks of widespread psychological reactions in Thailand (*Journal*, 1982, **141**, 98–99) and wish to make the following comments.

The symptoms of the first outbreak of Rok-Joo or the genital shrinking disease seems to be remarkably similar to koro, a culture bound psychogenic syndrome in which a subjective experience of penile shrinkage occurs in association with acute anxiety. Whether the victims of the Thailand epidemic had the fear of their genitalia shrinking into their abdomens with a fatal

outcome, a feature characteristic of koro, is not clear. In any case, such a koro pattern of depersonalization experience (better described as a body image disturbance) as the common basic phemomenon may be universal in its distribution, with different interpretations in different cultures (Edwards, 1970; Yap, 1967). In a recent study of 40 patients with neurotic disorders related to semen loss, we found that 20 (50 per cent) had such an experience attributed to fear of loss of vitality (Machado *et al*, 1981). In Thailand, noxious food seems to get blamed. Interestingly, an epidemic of koro reactions has been reported from Singapore following ingestion of the flesh of recently vaccinated pigs (Mun, 1965).

Clearly, subjective experiences of bodily change are a concomitant of anxiety among suggestible individuals with self-scrutiny and overconcern about their genitalia. Their irrational beliefs, being shared by the others in their culture, are not delusions and the label psychoses is unlikely to be appropriate.

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STRESS AND STRAIN

DEAR SIR,

The concepts of 'stress' and 'strain' are used so widely in the psychiatric literature that it may be worth while looking at their technical meanings. In statics, 'stress' is defined as a deforming force and 'strain' is the amount of deformation so produced. Elasticity is the property of returning to the original state after deformation, and Young's modulus of elasticity is approximately equal to stress divided by strain. There follow from this the secondary concepts of perfect and imperfect elasticity, and also of perfect plasticity.

These constructs could perhaps be transferred almost literally to the field of mental health. The human organism is subjected to various stresses from time to time which tend to distort the personality; such stresses may be traumatic circumstances, adverse biochemical changes, etc. If the personality recovers completely and returns to its former state, we may describe it as being 'perfectly elastic', the equivalent of full recovery. In the 'imperfectly elastic' condition some degree of chronic distortion is left; or one might say incomplete resolution of symptoms. In much worse state is the 'perfectly plastic' type of personality, one which retains completely the whole of the deforming change so that all the initial symptoms become chronic.

It would be speculative to try to apply these ideas to clinical states, although parallels are readily apparent; but given adequate scaling for life events and for symptom formation, a modulus of personality elasticity may not be too far distant.

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WHAT IS IT LIKE FOR THE PATIENTS?

DEAR SIR,

Having now been a reader of the *Journal* since 1955, it is perhaps not out of place to express surprise at how little attention we appear to pay to the experience of patients undergoing psychiatric treatment of all kinds. The spate of articles academically accurate, statistically sound, and some coldly objective, is indeed a tribute to the involvement of professional workers. Yet in listening to patients, in reading the press and reading between the lines, we get hints of a different world. I find that I now regret not taking more seriously the accounts patients gave me of various abuses, bullying and irregularities which affected them. But accounts in the press and on TV are now such that many of us working in the field are increasingly disturbed by it.

Perhaps a series of contributions commissioned by the Editor of the *Journal* of accounts by patients of what actually happens to them while in our care, would be enlightening, and might help to bridge the gap which seems to exist between ourselves as the givers of psychiatric care, and ordinary people who are the recipients.

Maybe our reluctance to explore properly this aspect of our work amounts to a resistence to look, which does us little credit.

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PUBLICITY AND BULIMIA NERVOSA

DEAR SIR,

We would like to comment on an apparent increase