

also observed that "in proportion as food becomes abundant, so each person is obliged to be thin" and fad becomes an instrument for expressing distress within family systems. Cassidy (1982) even suggests protein-energy malnutrition or kwashiorkor as the culture-bound eating disorder typical for West Africa and the Third World. Cultural factors may even selectively encourage the presentation of the more life-threatening anorexia nervosa (e.g. Gregory & Buchan, 1984) rather than bulimia nervosa which has not been reported so far among Africans.

Case report: A 24-year-old single professional woman from Southern Nigeria first presented socially to the second author (SMN), to whom she complained of prolonged impulsive overeating which had recently worsened. She claimed to have often eaten bread loaves enough for 6 persons. At times she also binged on biscuits. Binges had recently been followed by severe abdominal pain and spontaneous vomiting. Relief so provided was often overtaken by feelings of disgust, sadness, and guilt. Other weight-related habits included jogging and fasting. She had at times gained up to 3 kg, but at time of presentation had lost about 1 kg.

Background information revealed that patient was a twin of middle-class background. The mother was described as emotionally cold. Family experience was characterised by the stresses of upward social mobility as well as changes of location. For example, the family had moved five times before her eighth birthday, after which they all travelled to a Western country. Having lived and schooled in that country for 5 years she returned with her family to go to secondary school and on to university and professional studies. From early life, therefore, there seemed little opportunity to form lasting attachment to people, places, or values. One characteristic pattern was a preference for older, non-Nigerian or mixed race Nigerian females, the other was a definite difficulty in heterosexual relationships.

The circumstances surrounding the consultation were very instructive. The initiation of contact with SMN fitted her characteristic pattern. In fact, that contact seemed to have been used because SMN had social contacts with another lady to whom the patient had an unusually strong emotional attachment but who had left the country. The patient was actually going through complicated separation/grief reactions, since she was about to emigrate to another continent where she would be near this other woman. The consultations (four in all) enabled the patient to meaningfully appraise her feelings in the light of her impending emigration, unusually strong attachment to another female, and the relationship of her emotional turmoil to the worsening of overeating.

The authors suggest that where, as seems to be the case in Gregory & Buchan (1984), bulimia nervosa or anorexia nervosa is found in the African setting, the patients would have become deculturated in addition

to the usually reported difficulties in attachment, personal and sexual identity clearly elicited in this case.

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References

- CASSIDY, C. M. (1982) Protein-energy malnutrition as a culture bound syndrome. *Culture, Medicine and Psychiatry*, **6**, 325-345.
GREGORY, L. D. & BUCHAN, T. (1984) Anorexia nervosa in a Black Zimbabwean. *British Journal of Psychiatry*, **145**, 326-330.
PRINCE, R. & TCHENGH-LAROCHE, F. (1987) Culture-bound syndromes and international disease classifications. *Culture, Medicine and Psychiatry*, **11**, 3-19.
SELVINI PALAZZOLI, M. (1985) Anorexia nervosa; a syndrome of the affluent society. *Transcultural Psychiatry Research Review*, **22**, 199-204.
SWARTZ, L. (1985) Anorexia nervosa as a culture-bound syndrome. *Transcultural Psychiatry Research Review*, **22**, 205-207.

Catatonia in a 90-Year-Old Patient After Depot Pipothiazine Injection

SIR: Extrapyramidal side-effects are well recognised in patients receiving phenothiazine medication (Gedenberg & Mandel, 1977). These side-effects are less common with drugs containing piperidine rings in their chains (Riley *et al.*, 1976). We report here the case of a patient who developed a catatonic reaction while on neuroleptic therapy.

Case report: A 90-year-old patient with senile dementia was admitted to hospital for holiday relief. No other psychiatric or physical abnormalities were noted. There was no previous psychiatric illness known. She was receiving thioridazine (12.5 mg b.d.) and nitrazepam (12.5 mg) upon admission, and this was continued. After admission she became agitated and was given 25 mg of pipothiazine (piportil depot) intramuscularly. Forty-eight hours later she began refusing food and fluids, and five days later was admitted to an acute medical unit in view of the risk of dehydration.

On examination, she was only mildly dehydrated and there were no neurological abnormalities other than her dementia. Biochemically, her renal and hepatic function were normal. She was continued on her oral medication and oral intake encouraged.

The next day (the eighth day after her injection) she was found to be unrousable unless painfully stimulated. There were no localising neurological signs, but she did exhibit waxy flexibility of her limbs and catatonic posturing. There was no evidence of tardive dyskinesia or other extrapyramidal change. Body temperature remained normal. The

patient remained in this condition for 14 hours, after which muscle tone gradually returned to normal. She started to talk and resumed oral feeding without the need for other medical intervention. She was returned to the psychiatric unit for continued care.

Catatonic-like reactions have been described with phenothiazines and particularly with chlorpromazine, trifluoperazine and prochlorperazine (Dorevitch & Gabbay, 1983). Only two such reactions have been reported with pipothiazine, and these patients were on oral therapy (Brouselle *et al*, 1971). The time course of the catatonia suggests that the pipothiazine was the precipitating factor, although the thioridazine may have altered her susceptibility. It is of interest, however, that despite the slow release properties of the preparation the onset was quick, the duration was very brief, and the condition settled without drug therapy. We suggest that catatonia should be considered when altered consciousness is found in patients taking any phenothiazine medication. As with all neuroleptics, we suggest caution with pipothiazine in this age group.

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References

- BROUSSELLE, P., GRAMBERT, J. & HADDAM, (1971). Clinical evaluation of a new incisive neuroleptic pipothiazine 19366 RP. *Annales Medico Psychologiques*, **129**, 463-472.
- DOREVITCH, A. & GABBAY, F. (1983) Neuroleptic-associated catatonic reaction. *Clinical Pharmacology*, **2**, 581-582.
- GEDENBERG, A. J. & MANDEL, M. R. (1977) Catatonic reactions to high potency neuroleptic drugs. *Archives of General Psychiatry*, **34**, 947-950.
- RILEY, T., BRANNON, W. C. & DAVIS, W. (1976) Phenothiazine reaction simulating acute catatonia. *Postgraduate Medicine*, **60**, 171-173.

Mania Following Bereavement in a Mentally Handicapped Man

SIR: There has been a recent increase of interest in the subject of association between life events and mania (Roseman & Taylor, 1986; Ambelas, 1987). However, literature on life events and psychiatric illness in the mentally handicapped is scarce. McLoughlin & Bhate (1987) described a case of depressive illness in a mentally handicapped woman following bereavement. Ours is a case of mania in a subnormal patient following the death of his father.

Case report: B. C. is a 36-year-old mentally handicapped man. His mental impairment is secondary to hypoxic brain damage. When well he is usually found sitting and watching events on the ward. He can be playful on occasion, but such episodes last barely a minute. Whereas he can speak, he generally opts not to; when he does, it is a two or three-word phrase. His demeanour is pleasant and friendly. A study of his case notes revealed a 20-year record of periodic disturbances, mostly described as "aggressive" and "hyperactive". These disturbances would last between 6 and 10 weeks, would be treated with small doses of neuroleptics or minor tranquillisers, and ultimately would subside. A fuller account from the nursing staff of the changes in him during these episodes describes him to be persistently and rapidly striding about the ward and physically attacking members of staff and patients. Other changes included a prolonged and exaggerated grin, an intense scowl, marked overactivity, and frequent but brief shrieks of laughter. This picture presents a marked change from his usual self. The latest episode was preceded six weeks earlier by the death of his father. The father was very close to his son. He visited his father during his terminal illness and efforts were made to make him aware of the eventual outcome of the illness. The news of his father's death produced a noticeable and appropriate change in his countenance. He later expressed his loss by saying "Poor old (father's name)", "Dad gone", etc. Thereafter, every Sunday afternoon he visited home. Three days after one of these visits he became sufficiently uncontrollable to require seclusion, an event occurring only twice previously in 20 years. On the ward he flew at others indiscriminately in rage, and constantly rushed around unless restrained. He remained in seclusion for 20 hours. His sleep was disturbed. He responded to droperidol (5 mg b.d.) and diazepam (5 mg q.d.s.). This episode lasted nine days, and he eventually came off the additional medication.

Diagnosis of manic illness presents special problems in the mentally handicapped, as highlighted by our case. In the severely mentally handicapped it is difficult to comment on thought content and form. Speech is rudimentary, and there is no systematic method of determining manic thought disorder. In diagnosing mania it is essential to have knowledge of the pre-existing personality, marked alteration of mood and behaviour, and a past history of episodes of sustained mood changes. In our case this episode cannot be explained by either his handicap or any physical illness. Comparison of his premorbid personality with his behaviour during the episodic disturbances leaves little doubt that he suffers from recurrent manic illness. Published literature shows bereavement to be the most commonly reported life event preceding manic illness (Ambelas, 1979, 1987). According to Ambelas, most breakdowns follow within four weeks of a major life event. In our case it was six weeks. It is likely that the same life event generates different degrees of stress in different individuals, which in turn determines the time interval between an event and the breakdown. Our patient