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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Mania Following Bereavement in a Mentally Handicapped Man

SIR: There has been a recent increase of interest in the subject of association between live 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 uncontainable 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

has spent a major part of his life in hospital, so the psychological closeness of relationship may not be the same as the biological closeness may suggest. Furthermore, underdeveloped cognitive abilities may cause delayed realisation of loss. The mentally handicapped do react adversely to stressful changes, e.g. change of wards or staff. This report of psychiatric illness following a major life event highlights the significance of bereavement and grief work with the mentally handicapped.

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Psychiatric Munchausen's Syndrome: A College Register?

SIR: We wish to report an unusual psychiatric variant of Munchausen's syndrome and to propose the formation of a College Munchausen's register.

Case report: A 23-year-old woman arrived by taxi at the A & E department of a provincial teaching hospital. She was mute, but wrote that she was being pursued by aliens, whom she could see and hear, and who were telling her to kill herself.

It was decided to admit her informally to a psychiatric ward. During the admission procedure she claimed to be of no fixed abode, writing the abbreviation NFA in a defiant fashion. She gave no addresses of family and friends, but provided a list of contacts with people and establishments, for example a battered wives refuge, all of which proved to be fictitious. Immediately after admission she bought chocolates for the ward staff. She also bought soft toys and children's books from the hospital shop and sat playing with them. She then demanded in writing that the police be called because she had been raped prior to admission.

After six days of silence, and following a visit from the police, she began to talk, denying that rape had occurred. She said that she had been in many hospitals, travelling throughout the country using a railcard. She explained that she lived with a much older man who had befriended her on one of her train journeys. He was contacted and finally arrived to collect her. He confirmed her story, saying that she had been living with him for a year and that she frequently disappeared from his home leaving him to wait for a telephone call from yet another hospital. He listed 25 hospitals at which she had presented. She had been admitted to both medical and psychiatric wards and had at times been detained under section 2 of the Mental Health Act.

The patient then claimed to have been sexually abused in childhood by her father and to have been abandoned by her parents. Her real wish was "to have parents like everyone else". She also claimed to have trained as a psychiatric nurse but to have failed her examinations. Before her history and mental state could be explored further, the patient and her cohabitee packed her belongings and left to catch the train to their home.

We report this case for two reasons. Firstly, we are unaware of any other descriptions of elective mutism as a central feature of the psychiatric variant of Munchausen's syndrome. We think that this case will be of general interest to those of our colleagues who have not seen our patient in person. Secondly, we wish to propose that, since psychiatric Munchausen's syndrome may be increasing in frequency (Jones & Sternberg, 1985), there is a strong indication for establishing a central register of such cases. The Royal College of Psychiatrists is uniquely placed to administer this and could record patient descriptions, aliases, and previous patterns of presentation. In the case described above we suspected a factitious disorder from early in the patient's admission. If a register had been functioning at the College, then instead of many telephone calls, a single one may have sufficed.

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Migraine, Insomnia and Reactive Depression Due to Brain Serotonin Deficiency?

SIR: Within a little over a one-year period, ten female patients (age range 20–40 years) were seen in our outpatient department, complaining of severe migraine, troublesome insomnia, and depressed mood. In six of these subjects, the first symptom to occur was severe migraine, with a frequency of two-three times per week; this was followed several weeks later by troublesome insomnia, and later on by a feeling of