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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References

Jefferson, J. W. & Griest, J. H. (1977) *Primer of Lithium Therapy*. Baltimore: Williams and Wilkins. p. 122.

Tyrer, P., Alexander, M. S., Regan, A. & Lee, I. (1980) An extrapyramidal syndrome after lithium therapy. *British Journal of Psychiatry*, **136**,191–4.

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