

Correspondence

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Antipsychotic drug-induced dysphoria

Sir: The renewed interest in dysphoria induced by antipsychotic drugs (Lynch *et al*, 1996) calls to mind the famous aphorism of Santayana that those who ignore history are doomed to repeat it. Some years ago, a spate of communications concerned with neuroleptic-induced dysphoria appeared in *Biological Psychiatry*. I was impelled to reply with a letter of my own (Hollister, 1992), in which I recalled that some of the early reviews of adverse effects of antipsychotics (chiefly concerned with chlorpromazine and reserpine, and specifically three of my own reviews) had emphasised possible adverse behavioural effects of these drugs: restlessness, insomnia, bizarre dreams, social withdrawal, excitement, mental depression, feelings of unreality, depersonalisation, delusions, and hallucinations (Hollister, 1961). In an early study, testing chlorpromazine in non-psychotic tuberculous patients, we discovered a clear-cut withdrawal reaction from the drug that was not evident in those patients treated with placebo during a double-blind trial. It was also known early on that non-psychotic individuals were less tolerant of dysphoria than those with psychoses. Thus, dysphoria and other adverse mental effects of these drugs were known early on and were thought to represent common knowledge. Why these phenomena should have to be re-discovered years later is a question worthy of consideration.

The most likely cause of this lack of historical perspective has been the advent of indexing services which make literature searches increasingly easy. For most of today's authors, history begins with the earliest citations in these various indices, seldom going back more than 15 years. All previous history no longer exists and so observations considered now to be new turn out to be old hat.

The paradox is that this issue of neuroleptic-induced dysphoria may have

become moot. Whatever advantages the new 'atypical' antipsychotics may have, it seems clear that they are less likely than the older drugs to produce such a variety of adverse behavioural effects. Another point is that the current trend towards use of smaller doses of conventional antipsychotics may reduce the probability of dysphoric symptoms, which seldom affected all patients even with larger doses.

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Suicide in China

Sir: Yip (1996) has presented a timely and interesting study on suicide in Chinese societies, but readers may benefit from the following qualifications. Yip states that "there is little on suicide in China in the literature". Suicide is a highly sensitive subject for the Chinese government, but in the past five years they have begun to release information (Li & Baker, 1991; World Bank, 1992) indicating that suicide is a very significant problem in China, accounting for 33% of all injury deaths.

Yip comments that the female suicide rate in Hong Kong "could well be the highest in the world". The Chinese data do not support this statement. In contrast to almost every other country of which the present authors are aware, the suicide rate in Chinese females is significantly higher than that in males (24.3 *v.* 27.7 per 100 000). Also there is a sharp difference between the urban and rural suicide rates (10.00 *v.* 27.7

per 100 000). Thus, Yip's examination of suicide rates in Beijing reveals little about suicide rates in China (predominantly a rural country).

In China, suicide peaks in the age range 20–24 years, and among this cohort the rate among women is five times greater in rural than in urban areas (78.3 *v.* 15.9 per 100 000). This pattern is also observed among males (40.7 *v.* 9.9 per 100 000). Such high levels of suicide may reflect the social, cultural and economic changes that China is facing and which have a greater impact in rural areas. Among women the predominant factors include: suicide as a traditional coping and revenge strategy for women in Chinese society; the one-child policy; and lack of women's control over their own lives (Pearson, 1995). Yip also comments on the high rate of suicide among men aged over 70 years in Hong Kong, and concludes that they are affected by the current political uncertainty. In our view, this is a group little affected by political factors but who are vulnerable because of economic change and lack of family support.

Depression is not widely diagnosed in China and individual pathology alone cannot satisfactorily explain such high suicide rates. This suggests the need for community-based preventive strategies not primarily related to individual treatment.

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Pearson, V. (1995) Goods on which one loses: women and mental health in China. *Social Science and Medicine*, **41**, 1159–1173.

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Mass hysteria

Sir: Ali-Gombe *et al* (1996) have reported on an atypical episode of mass hysteria among Nigerian schoolgirls that was precipitated by no apparent stressor. If accurate, the case is unprecedented. The following caveats are based on a study of all known reports of contagious conversion symptoms in schools, involving 116 cases which span 188 years and 22 countries (Bartholomew & Sirois, 1996). Based on the African pattern of 'mass motor hysteria', and the retrospective nature of their

investigation, I strongly suspect that an underlying stressor was present. The recurrence of symptoms upon the school re-opening, suggests that the precipitating stressor was related to the school. African outbreaks typically involve missionary schools (Ebrahim, 1968) or some conflict between students and administrators (Dhadphale & Shaikh, 1983) which may not be readily apparent to outside investigators. They are typified by children dominated by autocratic elders and having little means of redress, with conflict arising from exposure to foreign ideas which challenge traditional beliefs, fostering escape through conversion (Ebrahim, 1968).

There are many questions requiring clarification through interviews with a representative sample of those affected, and not just 12 pupils. It is clear from our sample that 'mass motor hysteria' subsides only after school administrators reduce or eliminate the anxiety-generating precipitant which typically involves strict academic or religious discipline. Hence, it is imperative for investigators to provide some ethnographic description of the participants. It is not enough to state that symptoms were attributed by parents to illness or evil spirits, as this is not a case of mass hysteria by proxy (*vide* Philen *et al*, 1989). Of key import is the folk belief of those affected, as conversion symptoms are a symbolic representation of an unresolvable conflict.

Two episodes bearing a remarkable similarity to that in Ali-Gombe *et al*'s report (laughing in conjunction with abnormal movements) have been recorded. One affected six schoolgirls aged 11–14 in France over 18 days (Armaingaud, 1879), while the second was a three-day epidemic in Zambia among 125 students aged 16–17 (Dhadphale & Shaikh, 1982). Both were triggered by rigid educational policies and involved identifiable index cases.

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Dhadphale, M., & Shaikh, S. P. (1983) Epidemic hysteria in a Zambian school: "the mysterious madness of Mwinilunga". *British Journal of Psychiatry*, **142**, 85–88.

Ebrahim, G. J. (1968) Mass hysteria in school children, notes on three outbreaks in East Africa. *Clinical Pediatrics*, **7**, 437–438.

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Recovered memories

Sir: If Merskey (1996) is saying simply that great care must be exercised in evaluating memories of early childhood events recovered in therapy, then we are clearly in agreement (Brewin, 1996). However, it is not possible on the basis of personal opinions, position statements, court judgements, insurance company policies or allegations about the political bias of other investigators, to address the scientific issue of whether memories of events may be forgotten for long periods of time and then remembered with essential accuracy. Now that researchers are turning their attention to finding evidence for genuine recovered memories, new and more convincing data are being reported. For example, four additional case studies with high-quality corroboration have been presented by Schooler *et al* (1997, in press). Another recent study conducted by Andrews *et al* (details available from author) involved in-depth interviews with 108 chartered British psychologists concerning patients they had seen with recovered memories of trauma. Between them, the psychologists described 690 cases, and provided detail in 236 cases. Of the 236 patients, 97 (41%) had obtained some corroborative evidence for their memories; 33 had obtained corroborative evidence from more than one source. In 11 cases, the psychologist had seen this evidence at first-hand. Similar rates of corroboration have also been reported by Feldman-Summers & Pope (1994).

As in a recent survey of British False Memory Society members (Andrews, 1997; Gudjonsson, 1997), Andrews *et al* (details available from author) found that only a small minority of memories concerned events that had supposedly begun and ended before the age of three years. About one-third of memories involved non-sexual traumas such as physical abuse, traumatic medical procedures, or witnessing the death or injury of a close other. About one-third of memories were recovered prior to any therapy. These observations are only some among many that are inconsistent with Merskey's view that genuine recovered

memories of trauma are either impossible or vanishingly rare. The evidence at present is supportive both of the possibility of genuine recovered memories and of the possibility that inappropriate therapeutic procedures can lead to the production of false memories. Far more research is needed before either of these positions may be rejected with confidence.

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Brewin, C. R. (1996) Scientific status of recovered memories. *British Journal of Psychiatry*, **169**, 131–134.

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Cognitive impairment associated with lamotrigine

Sir: Lamotrigine is well established as adjunctive anticonvulsant medication in people with epilepsy. It is of particular value in individuals who have seizures secondary to brain damage (Buchanan, 1995). We report the case of a 69-year-old female patient with a 10-year history of epilepsy and alcohol-induced dementia, whose epilepsy had been well controlled for 2 years with valproate 1000 mg b.d. and lamotrigine 100 mg b.d. She had had no seizures for three months. She had been abstinent from alcohol for 10 years. She was admitted for assessment because of a gradual deterioration in her cognitive state and functional level over a six-month period. She was alert, without psychotic features. She was very disoriented and unable to cooperate with most of the Mini-Mental State Examination (MMSE; Folstein *et al*, 1975), speaking in her native tongue despite usually having a good command of English.

Apart from an unsteady gait, physical examination was unremarkable as were routine laboratory investigations. Serum valproate was 95 mg/l (normal range