assessment in respect of abnormal behaviour following severe head injury.

His personality type was of the overactive, ambitious, and aggressive type, with an above-average IQ – the epitome of the Type A personality. He ran two businesses simultaneously, and his hobby was competitive cycling. There was no past history or family history of psychiatric illness.

In December 1986 he fell from his push-bike and was found unconscious in the road. He showed signs of a right sub-dural haematoma, and was transferred to a neurosurgical department where CT scan confirmed this. An emergency craniotomy and evacuation of extra-dural and sub-dural clot was performed. At operation, laceration of the right temporal lobe was noted. His post-operative course was stormy – he was unconscious for several days, and then required sedation for restlessness and aggression. He was treated with phenytoin and phenobarbitone. He subsequently made a reasonable recovery physically, with only a persistent right-sided facial nerve palsy and hemianopia.

However, on his return home (three weeks after the injury) he developed markedly abnormal behaviour, with over-activity, outbursts of unprovoked aggression, disinhibition, extreme emotional lability, grandiosity, and irritability. The extent of these symptoms severely threatened his marriage and his business. At this time he refused tranquillisers or psychiatric treatment.

Some weeks later he accepted psychiatric assessment. On admission he presented as an intelligent man, mildly elated in mood, garrulous, and obsessed with his physical fitness. He had the fixed idea that his problems were entirely due to an abnormal glycogen metabolism which he could cure himself by strict dieting. He was physically overactive, but co-operative.

His EEG showed "abnormal asymmetrical activity and a persistent excess of slow activity over the right anterior to mid temporal region". CT brain scan was abnormal, showing "contusion and ischaemia at the right temporal and parietal regions and severe right temporal atrophy". Psychometric testing showed strong evidence of impairment of functioning at the anterior portion of the right temporal lobe (Rey Osterrieth) and also of the frontal lobe (verbal fluency and behaviour on the Wisconsin). It is likely that his frontal lobe pathology is *contre coup* injury, and the right temporal and parietal signs correlate well with this head injury.

He is now back at work, his mood has improved and stabilised, and he has developed some insight, although he continues to believe that his psychological problems have been due entirely to problems of glycogen metabolism. His wife says he is still "overdoing it", but he is no longer frankly hypomanic.

S. P. McKeown
C. J. Jani

Altrincham Priory Hospital
Rappax Road,
Hale, Cheshire WA15 0NX

Acute Psychotic Episode Caused by the Abuse of Phensedyl

Sir: Following the recent publications concerning ephedrine abuse and ephedrine psychosis (Whitehouse & Duncan, *Journal*, February 1987, **150**, 258–261; Jelley, *Journal*, September 1987, **151**, 418–419), we report a case of phensedyl abuse precipitating an acute psychotic episode.

Case Report: A 49-year-old asthmatic married woman was admitted to our psychiatric unit as an emergency in an agitated and excitable state. She was talking non-stop with some incoherence, was visually hallucinating, said that she was seeing "white spots", and was suspected of hearing voices. She thought that thoughts were being put into her mind and "made her do things", and was disoriented in time, getting the day, month, and year wrong, but was oriented to person and place. She had to be sedated because of her excitability, especially at night, and the psychotic symptoms and disorientation disappeared 48 hours later, at which point the medication was discontinued. Interview 24 hours later confirmed the visual hallucinations and thought insertion, but not the auditory hallucinations. In addition, she described experiencing something like thought broadcasting and passivity feelings. The patient was able to remember most of the period of her delirium with very minor gaps in detail. She stayed in hospital for the next five days and remained symptom-free with no medication.

Her history of phensedyl abuse dated back about 10 years. She remained vague about the amount she consumed, but on checking with her husband it appeared that she had been drinking 3–4 bottles per week. However, the week before her admission she had consumed a larger amount than usual. She also had a history of alcohol abuse, but no other psychiatric history.

Riadh T. Abed
Pamela J. Clark

Rotherham District General Hospital
Moorgate Road
Rotherham S60 2UD

Compensation Psychosis

Sir: In describing a case of compensation psychosis, White *et al* (*Journal*, May 1987, **150**, 692–694) highlight a topic of growing importance. We report another case of psychosis in the context of compensation, also complicated by bereavement.

Case Report: Our patient was a 36-year-old plumber. Two years previously his wife had died unexpectedly while in hospital, leaving him with three young children. He soon began legal proceedings against the Health Authority concerned, and appeared unable to mourn his wife's death. Fifteen months later his solicitor sought a psychiatric

https://doi.org/10.1192/S0007125000137250 Published online by Cambridge University Press

opinion because of anxiety about his mental health. He presented with a two-month history of depressive symptoms with prominent biological features.

His mother killed herself when he was aged 7, and his elder brother had also committed suicide three years previously. A second brother and his cousin were both victims of homicide. The patient had suffered a major depressive illness three years before, following his brothers death, and this had responded to out-patient treatment with antidepressants. His premorbid personality was extroverted.

On examination he was severely depressed, perplexed, and held the delusional belief that he, and not the hospital, was responsible for his wife's death. He also believed that psychiatrists knew this and were in league with his wife's family to punish him. He was admitted and treated with amitriptyline and chlorpromazine. Suicidal ideas and impulses emerged, and he required intensive nursing for a month. Over the next six months his illness followed a protracted and fluctuating course. Although no longer severely depressed, he still believes that he will not be well until the Health Authority is successfully sued, thus absolving him of all blame.

We think he has had a morbid grief reaction complicated by a psychotic depression in which compensation could be a maintaining factor. We are not aware of any reports of such cases in the UK literature, but this may become an increasingly common phenomenon in the wake of tragedies such as Bradford and Zeebrugge. Our patient, like many survivors of those tragedies, has suffered multiple losses and is also involved in a compensation claim.

Rosenblatt (1983) suggests that lawyers involved with this client group should be aware of their special needs, and that "the recurrent review of the loss brought about by involvement in a suit may disrupt the normal detaching process, thus leading to a morbid grief reaction". Litigation may also be an increasingly fashionable style of response to such losses. While it is tempting to speculate further, there remains little systematic evidence on which to base important clinical decisions about management. This is an area which merits further study.

LYN PILOWSKY
ALAN LEE

The Maudsley Hospital
Denmark Hill
London SE5

References

ROSENBLATT, P. (1983) Grief and involvement in wrongful death litigation. *Law and Human Behaviour*, 7, 353–359.

Consent to Investigation

SIR: The philosophy of the Mental Health Act 1983 was to "strengthen the rights and safeguard the liberties of the mentally disordered" (Bluglass, 1984). This ethos emerged in the innovative consent-to-treatment area of the Act. However, the relevant sections are specific in nature, and thus situations could arise which are not dealt with by the Act. The following case report illustrates such a problem in organising investigations.

Case report: A 47-year-old housewife was admitted under Section 2 of the Mental Health Act 1983, suffering from her first psychiatric illness of an episode of typical agitated depression. After a four-week trial of amitriptyline and chlorpromazine there was no improvement, and ECT was prescribed. The patient refused consent to this treatment, and so Section 3 was applied. The Mental Health Commissioner agreed to a course of ECT, as the patient was unable to eat or drink. Two months later there was a little improvement, but a request for a second course of ECT was declined by the Commissioner on the grounds that even though the patient remained ill the situation was no longer life-threatening.

Throughout the hospital stay the patient refused investigations. Consequently, even though she was not responding to medication or ECT, an organic cause for her illness could not be excluded because of her non-cooperation. Enquiries were made to discover whether investigations could be performed without consent. The Mental Health Commission stated that the issue was not covered by the Act and a medical defence organisation advised us not to proceed, as so doing would probably constitute a battery.

Half-way through the duration of the patient's treatment under Section 3 the Commissioner returned to decide if the patient could be given medication against her consent. A treatment plan was provided suggesting a trial of lithium, in view of the failure to respond to antidepressants alone. However, if approved, the legality of forcing investigations to monitor serum lithium was not known. Further correspondence with a medical defence organisation revealed that they too were unsure. Fortunately, the Commissioner resolved the problem by agreeing to the treatment plan and to the investigation of the patient. Necessary blood tests were therefore taken, and an EEG was performed. The latter was reported as normal, and the patient responded well to the trial of lithium.

The requirement to consult Mental Health Commissioners in order to plan the treatment of detained patients is appropriate to safeguard their liberty. However, investigations are an important component of the management, but as they are not dealt with specifically by the Act they are covered by common law, which permits procedures only to be performed against or without consent if they are life-saving. Investigations are rarely life-saving, and so necessitate consent.

The importance of investigations are highlighted by the above patient, whose unresponsiveness to treatment may have been due to an organic cause. If

https://doi.org/10.1192/S0007125000137250 Published online by Cambridge University Press