psychiatry. At follow-up, 16 months after the intake began, there were 67 cases closed; these were evaluated by two clinicians, mutually blind to each other's assessments. The assessments were made from recordings of the parents' overall description of their children's present state. Inter-observer disagreement occurred in 5 out of the 46 cases assessed by both.

The interesting result was that response to intervention was greatest with behaviour disorder (76%) and least with neurotic disorder (57%). This is opposite to the generally held view, supported by numerous studies (West & Farrington, 1977; Mulligan *et al*, 1963; Richman *et al*, 1982), that behaviour disorder is difficult to treat and has a poorer prognosis than childhood neurosis (Rutter, 1972; Kovaks *et al*, 1984).

Perhaps the introduction of a family therapy approach (which always involves the father in our clinic) changes the prognosis compared with more traditional therapeutic approaches. A three-year follow-up of all 207 cases will be completed shortly

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Indecent Exposure – A Report of a Female

SIR: Indecent exposure is a rare problem in women (O'Connor, 1987), and the few reported cases are generally associated with factors such as hypomanic episodes or alcohol use. We report an ex-nun with a history of inappropriate sexualisation as a young child, referred because of genital exposure.

Case Report: A 36-year-old sales assistant was referred because of feeling depressed and a six-year history of genital exposure, usually to authority figures: for example, the mother superior while living in a convent, and the priest running a therapy centre. She had also exposed in order to get attention when feeling miserable and lonely. The exposure was planned; she would enjoy a response of shock and anger and lie on the floor kicking her legs, talking in a babyish fashion, and hoping to be smacked. She would also make repeated telephone calls, and haunt the front door of her victims (usually women).

The patient's mother had no time for talking, playing, or cuddling with her four children (her husband was a violent man and a heavy drinker), and would masturbate her children to comfort them if they were upset; their only bodily contact was smacking. Her younger brother was impotent as an adult, and our patient had never had a sexual relationship, but enjoyed looking at other women's bodies.

We aimed to help the patient to make friends and to relate normally in a therapeutic community of patients with mainly long-term neuroses, while continuing at work. She managed to keep this job, but made no friends and continued to expose to senior nursing and medical staff.

This report illustrates the lasting damage of inappropriate sexualisation in a young child (Mzarek & Kempe, 1981). She had no experience of affectionate non-sexual handling, and attached erotic sensations to non-sexual infantile behaviour and so regressed in this way. This was sexual abuse from stressed parents who did not derive sexual gratification themselves but were in need of help with their family. Early intervention in such families is very important (Werner, 1985).

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Mania Following Head Injury

SIR: We read the report by Clarke & Davison, (*Journal*, June 1987, **150**, 841–844) and would like to report another example.

Case Report: A 38-year-old self-employed married businessman was admitted in May 1987 for investigation and

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.

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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.

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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