

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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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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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