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Correspondence

Erotomania in an Arab

DEAR SIR,

We were interested to read the reports concerning 'De Clérambault's syndrome' or 'pure erotomania' (*Journal*, January 1985, **146**, 90–95 and *Journal*, June 1985, **146**, 661–663). We here report the first Arabian case.

A 25-year-old Arabian female, single, jobless, with borderline intelligence, had received psychiatric treatment for paranoid schizophrenia during the past nine years. Her illness started when she was 16 years old with delusions of persecution and hallucinations. She had frequent relapses, several admissions, and was treated with major tranquillisers and electroconvulsive therapy. Recovery was never satisfactory. She left school at the intermediate level, never worked, and never got married. She is a shy, over-sensitive, religious, introverted person, who had never had sexual experience or a love affair. She is the only child of conservative, religious parents. Her father died when she was one year old and she was brought up by her grandmother. Her mother remarried and has four children. Now the patient lives with her mother and stepfather and his family.

More than three years ago while attending an engagement party of a distant relative, she suddenly developed a strong belief that this relative loved her and wanted to marry her. He was a university graduate, whom she had never seen before. Since then she has been preoccupied by this false belief, and insists that he sends her messages. She heard his voice everywhere, and at the same time she had other auditory hallucinations and passivity feelings. She had sexual fantasies involving her lover. She is still convinced that he loves her despite his denial and her family showing her a videotape of his marriage, and repeated confrontations. Her condition remained unchanged with deterioration in her personality.

We agree with many others that most cases of erotomania are secondary and that the associated diagnosis here was paranoid schizophrenia.

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Neuroleptics in Culture-Bound Syndromes

DEAR SIR,

Farmer and Falkowski's illuminating description (*Journal*, April 1985, **146**, 446–448) of two West African women in whom psychotic excitement seemed to be partly triggered and maintained by their belief in bewitchment raises important questions about psychotic processes. In the cases described, fluctuating disturbances of thought, mood and behaviour persisted for several months, and were resistant to large doses of major tranquillisers and ECT. Final resolution of psychosis only occurred when the patients were permitted to take appropriate action to lift the spells. Their belief in being bewitched antedated any overt psychiatric disturbance, and in any case was shared by normal people from their own culture.

In similar vein, I recall the recent case of a young Nigerian who, after a period of unhappiness and homesickness at his new English school, developed an acute excited psychosis with protean grandiose and religious delusions, expansive, volatile mood, and persistent overactivity and destructiveness. His disturbance was unchecked by oral and parenteral haloperidol, at one stage given in doses of up to 240 mg per day. Large doses of neuroleptics maintained over several weeks produced mild drowsiness and obtundation of thought, without significant alleviation of psychotic excitement. His eventual and sudden recovery seemed to coincide with our decision to acknowledge his and his parents' belief that he was under a spell cast by another relative, and to arrange for his repatriation so that appropriate exorcism could be carried out by a local healer.

Acute florid psychoses arising in immigrants in the context of cultural alienation and threatening life events are often regarded as variants of hysteria. In such cases psychosis may represent a defence against conflict or threat, its manifestations being elaborated more or less unconsciously to correspond with the patient's idea of insanity or bewitchment. Although hysterical psychoses are usually defined as brief reactive episodes, a relatively protracted course may be common in disorders which otherwise meet criteria for hysterical psychoses, and therefore presumably have a good eventual outcome (Gift *et al*, 1985). Why should hysterical psychoses