operation, e.g. those with organic disease or mentally ill husbands. Senay (1970) comments that psychiatric complications were predictable in the sense that they emerged from an identifiable high risk group.

In a small ongoing prospective study (unpublished) of 52 women whose pregnancies were terminated, I found at 6-month follow-up 11·5 per cent with psychiatric sequelae, all of whom had obvious pre-operative ambivalence.

The memorandum mentions that the patient's 'true wishes may be hard to ascertain, and yet this is clearly an important prognostic factor. With the number of patients being seen by a psychiatrist dwindling sharply since the Abortion Act became law, the current system makes little provision for careful pre- or post-operative assessment. Hordern (1971) comments that after operation, where necessary, psychiatric care and support should be provided. Clark *et al.* (1968) state that psychiatric damage can be avoided by selection and psychiatric support during the woman's stay and after.

I wish to suggest that, where a pre- or post-operative psychiatric assessment is not routinely obtained, a psychiatric social worker, or other staff-member with at least equivalent training, should be available to see all patients referred for termination, and when crisis intervention is considered an unsuitable alternative should make provision for care and support for those considered at risk, for as long as may seem necessary.

BRYAN LASK.

The Maudsley Hospital,
Denmark Hill,
London, S.E.5.

REFERENCES

PECK and MARCUS (1966). 'Psychiatric sequelae of therapeutic interruption of pregnancy.' *J. of Nervous and Mental Diseases*, **143**, 417–25.

PATT *et al.* (1969). 'Follow-up of therapeutic abortion.' *Archives of General Psychiatry*, **20**, 408–14.

WHITTINGTON (1970). 'Evaluation of therapeutic abortion.' *American Journal of Psychiatry*, **170**, 1223.

SENAY (1970). 'Therapeutic abortion.' *Archives of General Psychiatry*, **23**, 408–15.

NIDWANDER and PATTERSON (1967). 'Psychological reaction to therapeutic abortion.' *Obstetrics and Gynecology, New York*, **29**, 702.

PARE and RAVEN (1970). *Lancet*, *i*, 635.

HORDERN (1971). *Legal Abortion: The English Experience.* Oxford: Pergamon.

CLARK *et al.* (1968). 'Sequels of unwanted pregnancy'. *Lancet*, *ii*, 501–3.

DE CLÉRAMBAULT'S SYNDROME ASSOCIATED WITH FOLIE À DEUX

DEAR SIR,

The firmly held delusional belief, held despite all evidence to the contrary, that someone, usually of superior social status is in love with the patient—the so-called *psychose passionelle* of De Clérambault (1)—is a relatively uncommon syndrome to-day and seems likely to become more so with the passage of years. Its occurrence in a middle-aged spinster associated with *folie à deux* between the patient and her mother seems worthy of recording.

In April 1971 an elderly woman was visited by a Mr. P., an officer from the local Social Security office, for the purpose of assisting her over some matters connected with her supplementary pension benefit. As she herself felt unable to deal with the paper work involved, she asked that he would call again when her 54-year-old spinster daughter would be at home, and this he did a few days later. Shortly after this second visit the daughter (hereinafter 'the patient'), became increasingly convinced that this man was the 'soldier boy' whom she had met some 30 years before and who had on one occasion taken her to a local dance. This was her first and only 'date' with a member of the opposite sex, and the patient had neither seen nor heard from the boy since that time. A few days after his second visit Mr. P. had passed the patient in his car and had acknowledged her with a wave of his hand. During the weeks following, the patient experienced increasingly vivid 'telepathic' communications with him in which, she claimed, he had made it abundantly clear that he would wish to marry her as soon as he was in a position to do so. On one occasion she had a sudden delusional belief that he had been severely injured in a car crash and she had pestered the life out of the staff at a local hospital for news of him. At the time she was first referred she was unshakable in her belief that he was currently in an 'iron lung' in the operating theatre of the local hospital, that both of his legs were severely injured and that his right lung had been removed. She ascribed the absence of any written communication from him to his severe injuries, but meanwhile seemed quite content with her 'telepathic' experiences and the comfort which his loving messages afforded her.

At first her mother had been incredulous of her daughter's revelations but later on began to believe that they must have some basis in fact and finally had become firmly convinced of their reality. When confronted with the fact that Mr. P. was a happily married man in excellent physical health, neither could accept that this could possibly be so. Both insisted that, as he had 'pledged himself' to the patient, any so-called marriage must have taken place without his full knowledge and consent and must, therefore, be 'bigamous' and that the failure of the hospital to provide information about him merely confirmed their own worst fears regarding the severity of his injuries. Actng on her delusions the patient had caused a disturbance in her local church by informing a young male member of the congregation that she 'knew' he was praying for his father 'my loved one'. It was following this and several other such incidents that she had finally been admitted to hospital.

Whilst the precise status of De Clérambault's

https://doi.org/10.1192/S0007125000001744 Published online by Cambridge University Press

syndrome as a nosological entity in its own right remains somewhat questionable, its occurrence in classical form is sufficiently distinctive to justify the retention of the eponymous term. This particular case was of interest from several points of view. It departs, to some extent, from the classical syndrome in that, although Mr. P. undoubtedly existed and the patient had seen him on two occasions, she had made no further attempts—apart from the one frenzied enquiry at the local hospital—to get into physical contact with him and had seemed quite content to continue with her 'mystical union' until, 'in the Lord's good time'—to use her own words—he would openly declare his love for her.

The relative contributions made by heredity and by environment to the clinical picture were particularly well demonstrated in this patient's illness. Both her sister and a maternal aunt had suffered psychotic breakdowns of paranoid type in the past—the former after attending a particularly vivid 'hell fire' sermon at her local church, and the latter in her senium. Both had responded dramatically to antipsychotic treatment and it seems reasonable to suppose that the patient herself had a genetic predisposition to psychotic, rather than neurotic, illness. The precise form of her illness and its delusional 'content' were pathetically obvious from her early history. A narrow and somewhat puritanical childhood and a restricted and sexually inhibited adolescence had been followed by many years of social and emotional isolation. Her only outlets had been her frequent attendance (with her mother) at their local Evangelical church; here both had developed a somewhat bigoted and intolerant attitude towards those who did not share their convictions or whose daily lives fell short of the rigid standards the couple had set for themselves. Against such a background it is not difficult to understand the breakdown of a vulnerable defence system and the 'eruption' into consciousness of long repressed desires.

Within a week of the patient's admission to hospital her mother lost all her induced delusions and accepted without question that these had been the product of her daughter's disturbed mental state. Up to the time of writing the patient, despite some six weeks of intensive antipsychotic therapy, remains unconvinced of their falsity although more willing now to concede the possibility that she may have been a little 'over-imaginative' on some points.

With the revolutionary socio-cultural changes that have taken place in the Western world over the last half century coupled with the far greater freedom of expression in sexual matters now enjoyed by young people it seems likely that this particular syndrome will become an even greater rarity that it is at the moment.

ARNOLD PEARCE.

Park Prewett Hospital,
Basingstoke,
Hants.

REFERENCE

1. DE CLÉRAMBAULT, G. G. (1942). *Les Psychoses Passionelles.* Paris: Presses Universitaires.

FATAL HEART BLOCK AND CARDIAC ARREST FOLLOWING ECT

DEAR SIR,

Lest the issues raised by M. O. A. Malik's case report (*Journal*, January 1972, **120**, 69) be clouded, we feel that a few comments regarding J. L. Barton's letter to the Editor (*Journal*, March 1972, **120**, 355) are in order. Barton seems unaware of two lines of evidence. The first is that, to the best of our knowledge, no one has ever been monitoring an ECT with an electrocardiograph when a fatal incident has occurred. Specific cardiac rhythms immediately following treatments that have proved fatal are therefore unknown. The second is that, in the largest published series of monitored ECT (over 1,500 treatments), we have never had anything approaching a life-threatening vagal-induced arrhythmia, and we have exclusively used the subcutaneous route of atropine administration in doses ranging from 0·65 mg. to 2·5 mg. Patient acceptance of subcutaneous atropine, likewise, has never been a problem at this hospital.

Relatively minor changes in treatment technique are not the issues. To rephrase Malik's clearly stated conclusion, proper caution with pretreatment patient evaluation (including an EKG) and proper preparation for rare and unexpected emergencies should always be made.

C. L. RICH.
F. N. PITTS, JR.

Department of Psychiatry,
Washington University School of Medicine,
4940 Audubon Avenue,
St. Louis, Missouri, 63110, U.S.A.

REFERENCES

RICH, C. L., WOODRUFF, R. E., JR., CRAIG, A., and PITTS, F. N., JR. (1969). 'Electrotherapy: the effects of atropine on EKG'. *Dis. nerv. Syst.*, **30**, 622–6.

WITZTUM, J., BAKER, M., WOODRUFF, R. A., JR., and PITTS, F. N., JR. (1970). 'Electrotherapy: the effects of methohexital on EKG'. *Dis. nerv. Syst.*, **31**, 193–5.

WOODRUFF, R. A., JR., PITTS, F. N., JR., and CRAIG, A. (1969). 'Electrotherapy: the effects of barbiturate anesthesia, succinylcholine and pre-oxygenation on EKG'. *Dis. nerv. Syst.*, **30**, 180–5.

https://doi.org/10.1192/S0007125000001744 Published online by Cambridge University Press