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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

apparently be totally resistant to physical treatments when other acute reactive psychotic states typically get better quickly if arousal levels are reduced by tranquillising drugs (Lerner *et al*, 1979)? The answer I believe is that hysterical psychoses are pseudopsychoses in the sense that they are generated by ideas and experiences normal in the patient's culture, and they are probably not associated with ego-boundary disturbances. The latter may occur in true psychoses because of abnormal awareness of internally arising stimuli which many authors conceptualise as the result of a defective perceptual filter mechanism (e.g. see Johnson, *Journal*, April 1985, **146**, 429–435). In these cases, major tranquillisers probably help firstly by reducing over-arousal when this contributes significantly to defective information processing, and secondly, and more fundamentally, by directly reducing awareness of internally arising psychotogenic stimuli. Although biological mechanisms which may underlie hysterical conversion and dissociation remain a mystery, the resistance of hysterical 'pseudopsychoses' to neuroleptics suggests that they are quite distinct from those mediating true psychotic states. The apparent presence of ego-boundary disturbances as reflected by Schneiderian first rank symptoms may not reliably exclude hysteria, because elements of these may be incorporated into ideas which determine symptoms in hysterical patients who have had previous contact with psychiatry and psychiatric patients.

From the point of view of management, once a hysterical psychosis is suspected, it may be fruitless to persist with aggressive drug treatment to quell excitement. Instead, an effort should be made to understand the reminiscences from which the patient is suffering, and from which he is trying to escape through the vehicle of culturally determined ideas and disturbed behaviour. This may set the scene for effective catharsis through argument, explanation, or ritual, as appropriate to the patient's culture.

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Cavernosal Alpha Blockade: A Treatment for Erectile Impotence

DEAR SIR,

We read with interest Professor Brindley's article (*Journal*, December 1983, **143**, 332–337) describing his treatment of erectile impotence. We employed this method at the Repatriation General Hospital, Greenslopes, and found it satisfactory.

We have since adopted modifications to the original treatment which have resulted in improved convenience to the patient. The intracavernosal injection of 30 mg of Papaverine and 1 mg of Phentolamine produces a penile tumescence which results in erection when followed by sexual stimulation within 8 hours of injection.

We have found that apparently intractable cases of impotence spanning two to thirteen years respond well. Patients have been instructed in self-injection after being observed fully at outpatients, and are thus able to become autonomous in their control of the treatment. Some have found that erections occur spontaneously without injections after three or four treatments.

Of 13 men treated this year all except two had excellent results and four did not need injections after a course of 6 cavernosal injections. They were able to maintain spontaneous erections.

Three were diabetic and one of these had no response. One man developed priapism which was successfully treated with a Tru-Cut biopsy needle.

Phenoxybenzamine was not used after 1984 because it was felt the response was not physiological. It caused erection without stimulation and did not subside after intercourse. The papaverine/phentolamine injection allows intercourse after stimulation and subsides spontaneously after it.

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Epilepsy, Psychosis, Kraepelin and Bleuler

DEAR SIR,

I was very interested to read the letter by Stevens (*Journal*, September 1985, **146**, 321–322) about 'Epilepsy and Psychosis'. However, I would like to correct the attribution of "formal thought disorder, disturbances of affect and autism" to Kraepelin. He was in fact the one who coined the term "dementia praecox" with all its implications for symptomatology, age of onset and prognosis. This was replaced in 1911 by E. Bleuler's term "schizo-