### References

BARGLOW, P. & BROWN, E. (1972) *Pseudocyesis. Modern Perspectives in Psycho-obstetrics*. New York: Brunner/Mazel.

BROWN, E. & BARGLOW, P. (1971) Pseudocyesis. A paradigm for psychophysiological interactions. *Archives of General Psychiatry*, **24**, 221–229.

DEMONTYEL, E. M. (1881) Contribution a l'etude de la folie a deux. *Annals Medico Psychologiques Journal de L'Allienation Mentale et de la Medecine Legal des Aliens, 6 serie*. Paris: G. Masson.

DEVANE, G. W., VERA, M. I., BUHI, W. C., *et al* (1985) Opioid peptides in pseudocyesis. *Obstetrics and Gynecology*, **65**, 183–188.

FRIED, P. H., RAKAFF, A. E., SCHOPBACH, R. R., *et al* (1951) Pseudocyesis. A psychosomatic study in gynecology. *Journal of the American Medical Association*, **145**, 1329–1335.

HARDWICK, P. & FITZPATRICK, C. (1981) Fear, folie and phantom pregnancy. Pseudocyesis in a fifteen year old girl. *British Journal of Psychiatry*, **139**, 558–560.

HUNTER, R. & MACALPINE, I. (1963) *Three Hundred Years of Psychiatry*, p. 130. London: Oxford University Press.

KROGER, W. S. (1962) *Obstetrics, Gynecology and Endocrinology*. Springfield, Illinois: Charles C. Thomas.

MOULTON, R. (1942) The psychosomatic implications of pseudocyesis. *Psychosomatic Medicine*, **4**, 376–389.

MURRAY, J. L. & ABRAHAM, G. E. (1978) Pseudo-cyesis - a review. *Obstetrics and Gynecology*, **51**, 627–631.

SHOPBACH, R. R., FRIED, P. H. & RAKOFF, A. E. (1952) Pseudocyesis. A psychosomatic disorder. *Psychosomatic Medicine*, **24**, 129–134.

STARKMAN, M. N., MARSHALL, J. C., LA FERLA, J., *et al* (1985) Pseudocyesis: psychological and neuroendocrine interrelationships. *Psychosomatic Medicine*, **47**, 46–47.

STEINBERG, A. (1946) Psychoendocrine relationships in pseudocyesis. *Psychosomatic Medicine*, **8**, 176–179.

ZARATE, A., CAVALES, J. S., JACOBS, L. S., *et al* (1974) Gonadotrophin and prolactin secretion in human pseudocyesis. *Annales d'endocrinologie*, **35**, 445–450.



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# Folie à Deux: A Socio-psychiatric Study

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A classic case of folie à deux from India is described in a couple unrelated to each other. The need for socio-cultural understanding of the clinical phenomenon and its implications is stressed.

By far the most comprehensive description of folie à deux is that given by Lasegue & Falret (1877), in their very first paper. Later literature reports cases verifying the original description (Enoch & Trethowan, 1980), as well as isolated case reports of association or combination of certain psychiatric conditions with folie à deux: Down's syndrome (Meakin & Renovoize, 1987), and Capgras syndrome and de Clerambault's syndrome (Signer & Ibister, 1987). Gralnick (1942) analysed the frequency of family relationships between the two partners in a series of 103 cases reported between 1877 and 1942. He also classified the syndrome into four subtypes. Soni & Rockley (1974) described socio-clinical aspects of the syndrome after retrospective analysis of long case histories. Here we report a case with emphasis on the socio-clinical substrate, and its prognostic as well as therapeutic implications.

## Case report

Mr A, a 28-year-old Roman Catholic bachelor of Indian origin, had been working as a clerk in the Middle East for seven years. It was reported that he had changed his lifestyle three years after the death of his mother. He had believed that he was a 'born again' Christian and was enlightened by the Holy Spirit. Accordingly, he had been associating himself with a staunch religious group abroad. He had started praying excessively.

He returned to India five days before admission to our hospital and presented to us with frank psychotic behaviour. On examination, he had delirious perplexity and delusions of persecution and grandeur. He misidentified patients in wards as Jews in disguise. He was extremely irritable and guarded. He did not have any cognitive deficits. There was no history of substance abuse. He showed significant improvement with haloperidol in the 12–15 days after admission.

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Mr A belongs to a middle-class minority family. His father was an alcoholic and his two elder sisters had suffered from a brief reactive psychosis at the time of their mother's death. The whole family is religious, believing in occult phenomena and faith healing.

Nine months before admission, Mr A met Miss B at a religious meeting while in the Middle East. Miss B was going through great emotional turmoil at the time, and a mutual friend persuaded her to seek the help of a clergyman. She was suffering from anxious preoccupations and pangs of guilt about her sexual involvement with a Moslem colleague. Mr A took over her treatment from the visiting clergyman and started seeing her regularly. He assured her that he would help to deliver the evil spirits which had possessed her as a result of black magic done by the Moslem colleague. At first Miss B found great relief, only to suffer later from 'possession attacks' and fainting episodes, which increased in frequency and finally resulted in her resignation from her job and return to India in July 1987.

Five days before the index admission, Mr A visited Miss B in India and found her still symptomatic. He volunteered to treat her and she readily accepted. Both engaged themselves in deliverance. They were continuously praying to God and were speaking 'in tongues'. They deprived themselves of food and sleep, and isolated themselves from the outside world. On the fifth day they left the house in a grossly excited state, were frantically roaming around and travelling for the next 36 hours, everywhere encountering the evil spirits and the Jews, until the police were informed of their deranged behaviour.

On admission Miss B was fearful, restless, physically exhausted, manneristic, making sexualised gestures, and constantly referring to the Jews and her sister and brother-in-law, who she said were persecuting her. She had delusional misidentifications and believed that patients in the wards were plotting to kidnap both her and Mr A (who was on a separate ward). She showed consistent improvement on haloperidol. At the end of one week she was able to modify her behaviour, and she no longer suffered delusions.

Miss B was a 35-year-old Roman Catholic spinster who had worked as a stenographer in the Middle East for the past nine years. Her own family had migrated from East Africa to India in 1970. She lost her father when she was an infant. As a child she had low self-esteem and compared herself with her other sisters. She was submissive, insecure, and suggestible. Miss B remembered herself as always craving attention and affection. Her family also believed in occult phenomena.

At the end of their hospital stay of 12 days, both patients showed considerable improvement. Miss B had lost her delusions of persecution, although she was still desirous of meeting the clergyman for guidance.

Mr A continues to believe in his enlightened status. However, he curtailed practising deliverance, and he spends a more appropriate amount of time praying. He continues psychiatric follow-up. He relapsed one week after discharge, when he felt that a shopkeeper was performing black magic on him, and he sent for the police. He was put on higher dosages of haloperidol. He no longer claims to be in love with Miss B, and believes that her evil spirits have weakened him, so he now shuns any contact with her.

## Discussion

Mr A and Miss B suffered from a psychotic illness which fulfils all the criteria of folie à deux as delineated by Lasegue & Falret (1877). Dewhurst & Todd (1956) set out three criteria for the diagnosis of folie à deux: positive evidence that partners have been intimately associated; a high degree of similarity in the general motif and delusional content; and unequivocal evidence that the partners accept, support, and share each other's delusional ideas. The case illustrated satisfies all these criteria. We now discuss a few uncommon features and their implications.

Nine-tenths of cases of folie à deux are reported to occur in families (either blood relations or spouses) (Signer & Ibister, 1987). Our patients were neither; their close association and the subsequent shared psychosis were determined by their unique personality organisations and socio-religio-cultural milieu. Mr A, the dominant character, was already suffering from paranoid schizophrenia, as is commonly reported in folie à deux (Soni & Rockley, 1974). Miss B showed a personality profile suggestive of histrionic dependent traits. She had always been suggestible and insecure, with low self-esteem. By virtue of her personality she acquired delusions more easily, but also shed them more easily (Dewhurst & Todd, 1956; Soni & Rockley, 1974). Mr A instilled into the mind of Miss B the notion that her sexual indulgence was the result of black magic performed by her Moslem colleague. This explanation seemed plausible to her and provided her with solace. She continued to be in close association with him in order to be delivered of evil spirits. The original sexual conflicts remained unconscious, and she remained symptomatic, for example by manifesting 'possession attacks'.

Separation of Mr A and Miss B, pharmacotherapy, and psychotherapeutic handling of the patients and their families resulted in Miss B's rapid recovery. On discharge Miss B was no longer deluded but believed in occult phenomena only to the extent shared with and accepted by her family. Mr A continues to be schizophrenic and is under psychiatric treatment.

The roles of individual families in the development of psychopathology are noteworthy. Mr A's two sisters had suffered from a brief reactive psychotic episode at the death of their mother. The whole family at that time believed that the mother had succumbed to black magic performed by their maternal uncle. The sisters became divorced from reality and exhibited frank psychotic behaviour which remitted spontaneously within a week. At that time the family did not consider medical treatment necessary, and so it is not surprising that they did not bring Mr A for treatment

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three years ago, when he became symptomatic for the first time. Closer investigation revealed that more than half the family possesses the 'gift of tongues'.

Miss B's family shared similar beliefs in the occult, and thus she did not realise the intrapsychic nature of her problem. One may speculate that the exacerbation of a shared paranoid psychosis, which started ten months previously, served the purpose of bringing the two partners to medical attention. It may not be too far fetched to suggest that the onset of their shared psychosis itself announced the need for their geographical movement away from the alien culture towards the culture to which they belonged. As long as their delusions fell within the realm of possibility, which in turn was determined by their own culture, the problem was not appreciated as an illness; however, when they crossed the cultural limits of plausibility (e.g. feeling that the neighbours were Jews in disguise), the families became alarmed.

In a country like India, where there is a rich, strong, religio-cultural milieu, such psychoses with religious themes are commonplace and the majority may not be referred to psychiatrists. A liaison between the psychiatrist and the faith healer would go a long way towards helping such patients.

### References


DEWHURST, K. & TODD, J. (1956) The psychosis of association folie à deux. *Journal of Nervous and Mental Disease*, **124**, 451–459.

ENOCH, M. D. & TRETHOWAN, W. H. (1980) *Uncommon Psychiatric Syndromes*. Bristol: John Wright.

GRALNICK, A. (1942) Folie à deux – the psychosis of association. A review of 103 cases and the entire English literature: with case presentations. *Psychiatric Quarterly*, 16491–16520.

LASEGUE, C. & FALRET, J. (1877) La folie à deux (of folie communiquee). *Annales Medico-Psychologiques*, **18**, 321–355. (Trans. 1964 by R. Michaud, *Supplement to American Journal of Psychiatry*, **121**, 1–23.)

MEAKIN, C. J. & RENOVOIZE, E. B. (1987) Folie à deux in Down's syndrome. *British Journal of Psychiatry*, **151**, 258–260.

SIGNER. S. F. & IBISTER, S. R. (1987) Capgras syndrome, de Clerembault's syndrome and folie à deux. *British Journal of Psychiatry*, **151**, 402–404.

SONI, S. D. & ROCKLEY, G. J. (1974) Socio-clinical substrates of folie à deux. *British Journal of Psychiatry*, **125**, 230–235.



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# Phentermine and Psychosis

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A case of paranoid psychosis induced by phentermine in a young woman with no previous history of psychiatric illness is presented.

In a young and weight-conscious population, dieting among Singaporeans is fashionable, and the main methods used to reduce weight are diet and exercise. Medications to aid dieting are also available, including traditional herbs (Chinese and Indonesian medicines) and Western drugs, such as phentermine, fenfluramine, and chlobenzorex.

Psychotic reactions to appetite suppressants other than amphetamines are not well documented. The majority of these anorectic drugs are also central nervous system (CNS) stimulants, and in descending order of approximate potency, they are dexamphetamine, phentermine, chlorphentermine, mazindol, diethylpropion, and fenfluramine (Nir, 1980). Phentermine has a similar spectrum of pharmacological effects to amphetamines, but it has weaker CNS stimulation effects (Yelnosky *et al*, 1969). Structurally, phentermine has a close

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