

Correspondence

Letters for publication in the Correspondence columns should be addressed to:

The Editor-in-Chief, *British Journal of Psychiatry*, Chandos House, 2 Queen Anne Street, London, W1M 9LE.

CHARTER ADDRESS AND DURKHEIM'S VIEWS ON SUICIDE

DEAR SIR,

Readers of the *Journal* will be glad of the opportunity to study Sir Martin Roth's Charter Address (April, pp. 359-66). One section—the medical model—will no doubt be of particular interest. In this section, Professor Roth refers to Durkheim's *Suicide* (1897, translated 1952), but rather than draw attention to the valuable discussion of the social factors involved and the question of causality he does, I believe, rather overemphasize the inadequacy of Durkheim's examination of suicide in relation to mental illness (psychopathic states).

Durkheim was concerned to find the factors which accounted for the variations in the suicide rate. He not unreasonably felt he would thus be led to the causes of the phenomenon. He was satisfied that these were social, and his discussion of 'insanity' is based on his belief that it is essentially intrapersonal and extrasocial. He reached the conclusion that 'insanity' and 'neurasthenia' could not account for the variations observed, but he did not try to deny that they played their part at an individual level. It is clear that there are several unsatisfactory things in his discussion of suicide and psychopathic states. He was wrong, for instance, to regard neurasthenia as being merely a less severe form of insanity. This is surprising in one way, in that he had already categorized the different types of suicide occurring in the insane, but understandable in that he was unable to examine the relationship between neurasthenia and suicide directly for lack of available data. He admitted that there must be many more neurasthenics than insane, but he put forward the view that the neurasthenic would merely be more susceptible to the (social) suicidogenic currents than the normal person.

As is to be expected, much of Durkheim's discussion in the latter part of the book centres around the question of causality. In modern terms, the issue revolves in part around the relationship between suicide and depression, but both, not to mention crime, alcoholism and drug dependence, can be usefully seen in terms of Durkheim's thesis (Carstairs, 1962).

We who are used to letting our notions reverberate in computers, and who have tasted the delights of

factor analysis, may well find Durkheim's own multivariate analysis of the data available to him rather tedious, and there are certainly many minor points over which he has been proved wrong. His basic thesis, however, still stands, and the results of recent research are by no means incompatible with it.

It was Hume (1777) who first disentangled suicide from 'superstition and false religion' and exposed the bogus nature of the reasoning used to defend the sanctions against it. It was Durkheim who, with his account of Egoistic and Anomic suicides in particular, effectively answered Hume's extreme position 'that suicide may often be consistent with interest and with our duty to ourselves', and provided psychiatrists with a most valuable framework within which to tackle the problem.

R. F. ROCKSTRO.

*Royal Cornhill Hospital,
Cornhill Road,
Aberdeen, AB9 2ZH.*

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THE ROYAL COLLEGE OF PSYCHIATRISTS' MEMORANDUM ON THE ABORTION ACT IN PRACTICE

DEAR SIR,

I was interested to read the College's 'Memorandum on the Abortion Act in Practice' (*Journal*, April 1972), but surprised that there was no mention of psychiatric follow-up.

Whilst the majority of recent papers report favourable results (e.g. Peck and Marcus, 1966; Patt *et al.*, 1969; Whittington, 1970; Senay, 1970), there are undoubtedly some women who react unfavourably to termination of pregnancy.

Nidwander and Patterson (1967) found that only 5 per cent of 161 women who had been aborted suffered regrets, and these were married women aborted for medical reasons. Pare and Raven (1970) noted that psychiatric sequelae were much more common in those patients reluctant to have the

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.*

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DE CLÉRAMBULT'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 passionnelle* 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. Acting 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