FOLIE À TROIS: A CLINICAL STUDY

By

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THE following case of Folie à Trois, in which a married couple and the husband's brother shared a system of paranoid delusions, is being reported firstly because of the rarity of the condition, and secondly because it presents several unique features which it is hoped will shed further light on the nature of induced psychosis.

INCIDENCE OF FOLIE À TROIS AND OF CONJUGAL PSYCHOSIS

Gralnick (1942), in his review of Folie à Deux, quotes 96 cases previously reported in the English literature, and adds 7 of his own. Of these, 103 cases of what he called Psychosis of Association, 11 were instances of Folie à Trois. Since 1942, only 4 further cases of Folie à Trois have been described in the English literature (Kepner, 1943; Kesselman, 1944; Partridge, 1950; Bauer, 1953). In Gralnick's series husband and wife were affected in 26 cases, 2 of them being instances of Folie à Trois. The woman was the dominant partner in 15 of the 26 cases. Since 1942, 7 further cases affecting husband and wife have been reported (Kesselman, 1944; Kramer, 1947; Schmidt, 1949; Prins, 1950; Partridge, 1950; Zabarenko *et al.*, 1950; Freyhan, 1952), of which two were instances of Folie à Trois. In 6 of these 7 cases the wife was the dominant partner.

Thus, in the English literature, only 15 cases of Folie à Trois have been reported. The number of cases of induced psychosis, in which the affected persons had been husband and wife is 33. In 21 of these the wife was the dominant partner.

CASE REPORT

Mrs. A.D., aged 62, was admitted to the Maudsley Hospital on 2 January, 1956. She believed that her flat was being sprayed with acids and oils by her neighbours, against whom she was constantly making accusations.

The history goes back to 1944, when the patient, then aged 49, and her husband, Mr. A.D., then aged 51, moved into a basement flat which they had long coveted because of its attached garden, and began to grow vegetables. When these appeared, Mrs. A.D. saw white spots on them, and thought that her next-door neighbour was poisoning her plants because he was envious of the garden. She told her husband that she had seen this neighbour spraying her vegetables with caustic soda and carbolic acid. The husband believed her, and on examining the cabbage leaves more closely, he found tiny holes in them, which he took to support her allegations. He began to shout complaints at the neighbour, and later approached a solicitor on whose advice he brought an action against the neighbour, which he won. The neighbour, however, appealed, and won the appeal. This caused much upset to the patient and her husband. They continued to feel persecuted, stopped growing vegetables, and have referred to the proceedings ever since as "the garden case".

In 1945, the husband's crippled brother, Mr. B.D., then aged 53, who had spent much of his life in institutions, came to live with the couple. He was told about the "garden case" by Mr. A.D. and soon he also claimed that he saw the neighbour spray something into the garden, and accepted his brother's explanation that it was acid.

It was then that Mrs. A.D. became convinced that acids, oils, and caustic soda were being poured into their flat. She said she saw liquids coming through holes at the edges of the ceilings, and that sometimes they splashed on the floor by her feet. She pointed out marks on her own and her husband's clothing, and complained of a burning sensation on her arms which, she said, was due to the neighbours directing a spraying machine at her from their upstairs flat. She thought the neighbours were scheming to get her family out of the house. She complained about this to her husband, who then said that he also saw the stains, which

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he later described as "all different coloured stuff on the sheets". On one occasion he felt a puff of air on his face, and was convinced that this was the spray. The stuff that was sprayed on them he described as "a kind of an oil" which seemed "as though it had come from a car spray from the corner of the room".

The brother-in-law said that he could not but help agreeing with the others about this persecution. He occasionally felt his skin burning, noticed pimples on his arms, and commented on an odd smell in the flat. He, however, took no part in the activities of the others to take precautions and to seek redress. All three felt that Mrs. A.D. was the main target of the attack. She began to protect herself by wearing a house coat and two pairs of stockings indoors, covering her head with a scarf, and keeping her glasses on at night. Mr. A.D. wore a cap indoors. Mrs. A.D. soon proceeded to move all the best furniture into the bedroom, and to cover it and the beds with dust sheets. She also hung sheets across the kitchen ceiling, and wrapped paper around all the indoor pipes. She and her husband frequently complained to the neighbours, and several of them moved away on this account.

In 1949 Mrs. A.D. was bound over to keep the peace after attacking a neighbour with a bottle.

In 1950 the patient and her husband began to write letters of complaint to the landlord. They frequently called on the sanitary inspector and showed him their bedding, and bottles full of a liquid which, they said, contained some of the acids and oils. They also complained to the R.S.P.C.A. that a particular neighbour upstairs was poisoning their cat. This neighbour found it necessary to put black paint on the glass of her front door because the patient and her husband often stood on the landing outside, shining a torch through.

In 1951, Mr. and Mrs. A.D. consulted their doctor, since they felt their health was being undermined, and they subsequently attended the psychiatric department of a London teaching hospital. Admission to a mental hospital was not then considered necessary, and, in the hope that a change of environment might lead to improvement, application for rehousing was encouraged and supported. Meanwhile, Mrs. A.D. arranged for all three to have their meals at the civic restaurant, and to spend as much time as possible out of doors.

However, their distress increased. They accused the neighbours daily, and Mrs. A.D. in particular, was heard to shout and swear at them until late into the night. They began to chalk on the walls of their house that they were being poisoned, and in 1952, they put up a large board in their front window with writing on it saying "we are being poisoned with acid and oil, torture day and night". This caused crowds to gather in the front garden, particularly on football match days. Finally, when the patient threatened to burn the house down, the neighbours wrote a joint letter to the landlord, who took action, and all three people were admitted to an Observation Ward.

Here Mrs. A.D. was certified and sent to a mental hospital. The two men were discharged home in the hope that separation from the dominant member might lead to a remission. However, five weeks later they ordered the release of the patient under section 72, and she had to be discharged. They continued to disturb the neighbourhood, and three months later all three were certified and admitted to a mental hospital.

On admission they were all agitated and deluded, and complained that they were being tortured by their neighbours. At first they were in a block where they saw a good deal of each other. Later Mrs. A.D. was separated from the men. These became voluntary patients three months after admission, and a few days later gave in their notice of discharge and returned home. One month later Mrs. A.D. assumed voluntary status, and she also then discharged herself from hospital. All three patients were assessed as being in a state of reasonable remission when they left the hospital, having lost their active delusions, but not having regained insight.

Despite the fact that they subsequently maintained that they had been mentally perfectly normal at the time, and that they had been wrongfully sent away as the result of "poison pen letters" written by the neighbours, they were contented in hospital. Mrs. A.D. said they were well treated there, and that the country air did her good. The two men enjoyed working in the garden, and the brother-in-law subsequently made presents for the wards for Christmas. Their only complaint was that they were kept in hospital for too long, thereby losing wages unnecessarily.

After their return they had no complaints to make about the neighbours. This "improvement" they attributed to the intervention of a social worker who had called on the neighbours while they had been in hospital. Shortly afterwards they were rehoused and since then they have lived in a pleasant modern flat on the outskirts of London. Here they were visited by a social worker late in 1953, and were found to be cosily settled. The husband had returned to his former job, the brother-in-law kept himself busy polishing the furniture, and making artificial flowers and wooden ornaments, while Mrs. A.D. did the shopping and was at that time looking for a new job, which she found shortly afterwards. For recreation they went for walks, and looked out of the window.

All remained well until July, 1955, when the family by whom Mrs. A.D. was employed as a daily help went on holiday, leaving her in charge of the house. Both she and the brother-in-law worried a great deal over the fact that nothing was locked up inside the house, and that silver and valuables were displayed for anyone to see. The brother-in-law warned her of burglars at the time, and she felt her responsibilities to weigh heavily upon her.

In August she complained to her doctor of a burning feeling inside the chest, which she at first attributed to overwork. Subsequently her mouth felt dry, the burning sensation spread

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all over her body, and gradually all her past delusions returned, the only difference in her statements being that in addition she now complained at length about a drill which she felt on her skin, and which made her shake.

This time, however, her delusions were not shared by the two men, who saw and felt nothing and told her it was all her imagination. They explained her symptoms on the basis of worry, which they thought had caused the memories of "the garden case" and their subsequent persecution to play on her mind once more. Nevertheless, the husband did say that at that time the upstairs neighbours were particularly noisy, that they used a drill for carpentry, and that they often laughed very loudly in order to annoy him, his wife, and his brother, because they kept themselves to themselves too much.

Mrs. A.D. felt that a change had come over her husband, and that she could no longer discuss anything with him because he had "become so stubborn". Once more, despite protests from the men, she began to wrap herself up, and to spend most of her day out of the house. On several occasions she was seen pointing to the window, or shaking her fist and shouting at the wall. The brother-in-law then said to the husband "she'll have to go away again". In October, 1955, she consented to hospital admission as a voluntary patient, but discharged herself four weeks later. Subsequently the neighbours took action once more, and she was re-admitted to an Observation Ward, from where she was transferred to the Maudsley Hospital in January, 1956.

Family History

In neither family has there been any mental disease, and there is no genetic relationship between the patient and her husband.

Personal Histories

Mrs. A.D. comes from a working-class family. Her father was a sign-writer and carriage maker. She is the sixth of seven siblings of whom her favourite was an older sister who died in October, 1955, having been ill with cancer of the breast for the previous 5 years. The patient's childhood was a happy one. Her father was good but very strict, and of her mother she said "she was very lovely". She reached top standard in an elementary school, helped her mother at home for 3 years, and then went into domestic service, holding a series of jobs, since according to her "a change is as good as a rest sometimes". During the first World War she worked in a munition factory, and she talked with satisfaction of her dealings with poisons there, and of how she had to wear protective clothing and drink extra milk to keep herself fit. After her marriage she did daily domestic work, particularly enjoying jobs where there were children.

She was extremely reticent about her sexual life. She had had few boy friends. She had had an illegitimate baby who died, and in this connection she had had a pelvic operation the details of which she would not disclose. At the age of 39 she married Mr. A.D., whom she had known for 6 months. They had been very happy together until the summer of 1955. The patient had a protective motherly attitude towards him, and referred to him as an invalid on account of the chronic chest trouble which he had had since the first World War. He in turn always allowed her to buy whatever she wanted. She was very pleased when her brother-in-law came to live with them, and of him she said "he's what you'd call a nice young man if he weren't a cripple".

The patient's social life had for years been limited to her own immediate family. She seldom spoke to anyone except the children in the streets, among whom she used to distribute sweets. Her main interests were her home and her "sick husband".

She had always had a happy nature. Her husband described her as outspoken, active and hardworking, and her brother-in-law agreed with this. Her husband's sister, who disliked the patient, described her as domineering, and mentioned her interest in spiritualism.

The two brothers also come from a working-class family. Their father was a porter at Covent Garden market. There are four siblings, B.D. being the oldest, and A.D. the second. There are a younger sister with whom relations have been poor since A.D.'s second marriage, and a younger brother who is in the army.

Mr. A.D., the patient's husband, spent the latter part of his childhood with his grandparents in the country. This was because when his grandmother saw him at the age of five, she said she would cure his squint which he had had since early childhood. She kept him away from the sun, and made him wear a green shield over his eyes. He also considers his childhood to have been very happy, and on his return home at the age of fourteen he became a brass finisher and polisher, working with acids. Apart from three years in the army during the first World War, he continued with this job until around the onset of the present illness. At this time he became a metal sprayer, working with oxygen, acetylene, and air, all of which he considered to be very healthy.

He had been married before, his first wife dying of puerperal fever. He has a daughter aged 40, and a son who is a little younger. After their mother's death, both children were sent to institutions, for which they and their aunt have not forgiven their father. The son lived with him for a time after his second marriage. He was in a Borstal institution at one stage, but was said to have married subsequently, and to be doing well.

Mr. A.D. was described by everyone as a very quiet, steady man, interested only in his home and garden.

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Mr. B.D., the patient's brother-in-law, developed osseous tuberculosis at the age of 7, and spent most of his childhood in various hospitals, where his schooling was irregular. He had one leg amputated, and became seriously deformed as a result of his disease and multiple operations. At the age of 16 he returned home to live with his mother until she died when he was in his thirties. Thereafter he lived in various institutions, where he became fond of gardening and of making things with his hands.

As a child he was said to have had temper tantrums; later he was regarded as a stable, quiet man, who until Mrs. A.D.'s relapse, lived harmoniously together with the other two, assuming a slightly protective role towards his sister-in-law. A minor domestic detail was that he used to clean her shoes, while she cleaned those of her husband.

Condition on Admission

Mrs. A.D. was a pale, large but frail woman, with a marked right internal strabismus, present since a childhood attack of whooping cough. Of this squint the husband, whose grandmother had not succeeded in curing his own strabismus, was entirely unaware. She had a generalized coarse tremor, which was particularly marked when she spoke about her delusions. This again was a family symptom, the brother-in-law being inclined to tremble when upset.

The main abnormalities in her mental state were her behaviour, her mood, and her delusions. She spent most of the day walking about, hands clasped behind her, and kept very much to herself. She helped a little in the ward, knitted at times, and often wrote on scraps of paper which she threw away before anyone could see them. Every day she collected pieces of paper to use as padding under her clothes to protect herself against the spraying. She scraped the top layers of butter off her bread, insisted on having the first cup from the teapot, and never allowed food to remain uncovered for any length of time. She frequently threw food she considered to have been contaminated on to the floor, and at one stage she spat a great deal. She refused to have a bath, since she considered the water to contain acids, and also refused medication of any kind. On her husband's visits she tended to be angry with him, criticized the presents he brought her, and often ignored him altogether.

She made good contact with other people, and was pleasant as a rule. Her talk was normal in form, and concerned itself mainly with her delusions and her husband. Her mood was one of cheerful friendliness, which became incongruous when it persisted during detailed descriptions of her sufferings. At times she was suspicious and verbally aggressive. She believed that even in hospital the neighbours were spraying and drilling her, that similar things were happening to her family at home, and that the other patients would be burnt if they came too near her. When asked why her neighbours should do all this, she said she supposed it must be a habit by now, and that they wanted to take their revenge on her. She talked with particular emphasis of how the neighbours had drilled her husband's brain, and seemed to explain what to her was his recently changed attitude on this basis. As for herself, she thought that acids were poisoning her blood and her water, and that to remedy it she needed fresh air and plenty of fruit and milk.

She was correctly orientated, and her memory was not impaired. Her attention was easily aroused but not sustained and she refused to co-operate over formal tests, saying that the neighbours should be tested and not she. She did not consider herself to be mentally ill, but expressed a desire to return to her former mental hospital, which was situated out of London, and where she thought the air would be better.

Mr. A.D., the husband, was a quiet, small, thin, unhealthy looking man, with a mild squint and a cough. He was friendly and uncertain in manner, and talked of his wife with great respect. His intelligence appeared to be low. He was still quite convinced that his past beliefs had been true, but, although not entirely happy about the present neighbours, insisted that no one was now persecuting his family. He disliked discussing his wife's complaints and preferred to talk about her strange behaviour. He was very anxious that she should stay in hospital until she was well, and he felt rather bitter about the fact that they had still not "seen the end of the garden case".

Mr. B.D., the brother-in-law, looked healthy and young for his age, despite his severe deformities. He also was quiet, but although his intelligence was probably as low as that of his brother, he had a more forceful personality, and made more definite if even more guarded statements. He described how he had tried to argue the patient out of her strange ideas and had failed. He also had no retrospective insight into his illness. He avoided discussing it, but if pressed, admitted that their former neighbours had sprayed their garden and their flat and that he also had felt the acids at times. He said the present neighbours were inquisitive people, who were always peeping through their curtains, but otherwise he was quite satisfied with them.

Progress

Attempts were made to try the effect of Largactil on the patient's mental state, but she was unco-operative. After six weeks she gave in her notice of discharge, was once more admitted to an Observation Ward, and was from there sent to a mental hospital as a certified patient.

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Discussion

It is proposed, in the light of the above case, to examine some of the conclusions of other authors about the nature of the process of induction. It is not proposed to consider further the possible constitutional predisposition to paranoid schizophrenia or other psychoses which may or may not exist in these cases. In our case there is no evidence for this, in the absence of a family history of mental disorder and of a genetic relationship between the patient and her husband.

It has been said by almost all writers since Lasègue and Falret published their views in 1877, that the acceptance of delusional beliefs by one person from another occurs only after lifelong and intimate association. That this need not be so is illustrated by our case, in which the brother-in-law had joined the household of the patient and her husband only very shortly before he came to accept their delusions.

Helene Deutsch in 1938 reported the case of a schizophrenic girl who accepted the delusions of a chronic paranoiac very shortly after her first contact with him in the village of her birth, which she had revisited on a holiday. The suggested explanation for this instance of induction was that the girl was able to identify with the man because the content of his delusions corresponded to her own unconscious fantasies, and that in accepting them she was furthering her own wish fulfilment.

The important factor in the process of induction appears to be that of identification of the induced partner with the inducer. This may take place on the basis of the content of the delusions alone, as in Helene Deutsch's case, but more commonly it occurs as the result of a particular type of relationship between two or more people, which as a rule has developed on the basis of long and intimate association with each other, in relative isolation from the outside world. Greenberg (1954) in his review of the literature mentions the mental mechanisms which were at various times thought to be involved in folie à deux. He agrees with the importance of identification, but, in addition, leans on MacAlpine and Hunter's psychopathological theory of paranoid schizophrenia. He suggests that the induced, perhaps as a result of contact with the inducer, develops a hypochondriacal state which he then explains in terms of the delusions of his dominant partner.

The fact that the sharing of delusional beliefs by members of the same family is very rare, whereas the development of common customs, habits and opinions in members of the same household is usual, must be due in part to the nature of the delusional beliefs. These, as was pointed out by Coleman and Last in 1939, are as a rule based on a very personal fantasy, and develop as a solution to a very personal problem. They are therefore of little value to other members of society or even of the same family. In fact they act as a wall around the patient, which at first he attempts to break through to save himself from his painful isolation.

It appears, therefore, that in addition to the special type of relationship between the people involved, which favours induction, and which will be dealt with in more detail below, it is necessary that the content of the delusions of the inducer is such that they are understandable for the induced, can assume a place in his fantasy life, and do not increase his isolation to any considerable degree.

It is well recognized that induced psychosis occurs in small family or other social groups which are isolated from the rest of the community, either because of eccentricity, or on account of poverty or other misfortunes. Examples of such social isolation apart from that of poverty, which is mentioned in most

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of the published cases, are the two blind women living in an institution, reported by Brussel in 1938, the two brothers with physical defects reported by Gillespie in 1922, the two women, both with mentally defective husbands, living in abject poverty, reported by Coleman and Last, and the schizoid girl reported by Helene Deutsch.

It seems that for such people, who already feel themselves to be isolated from society, the additional isolation through the assumption of delusional beliefs is far less threatening than it would be for people normally integrated in the community. Furthermore, it seems that in these isolated groups the estrangement from each other through delusions not shared is of far greater moment than it would be for people with links outside their own small group.

In this connection it is no doubt significant that the most common delusions to be induced are those of persecution. The object of the supposed persecution is usually the small isolated group as a whole, rather than the inducer alone. Next in frequency come delusions of grandeur and wish fulfilment, again affecting the group as a whole. Marandon de Montyel, in 1881, expressed the view that the content of delusions acceptable to others was determined by the social climate and the prevailing ideas of the times. He said that just as religious mania flourished in the middle ages, an era of faith and superstition, so delusions of persecution were the form of insanity typical of the nineteenth century, an epoch of strife and distrust. The content of the delusional system in our case conforms to that most commonly found in induced psychosis; the patient believed her family to be persecuted by the neighbours. The particular form which this persecution took, i.e. the spraying, was obviously related to her own and her husband's experiences. She had worked in a munition factory during the First World War, and had had dealings with poisons there, while he had recently become a metal sprayer.

Even before the onset of the illness, all three people had been isolated socially, the patient and her husband probably through a number of factors both of temperament and personal experience, the brother-in-law on account of his physical deformity and institutional life.

Hartman and Stengel, in their two papers of 1931 and 1932, also stressed the mechanism of identification as essential for the acceptance of delusions by one person from another, but they saw the basis for this not in the content of the delusions, nor in the social setting of the people involved, but in the particular relationship existing between them. These authors reported three cases of induced psychosis, which resembled our own in many ways. In all three the illness involved husband and wife, and in two children were also affected. In all the wife was the inducer. She was further characterized by being the dominant partner in the marriage, and by being extremely eager to instil her own beliefs into her husband. The authors described these women as belonging to a type of paranoia which has been called "Kampf Schizophrenie". These patients will go to great lengths in attempting to convince others of their own beliefs, in order to keep some hold on the external world. Failure in this may lead to an aggressive outburst, as in one of Hartman and Stengel's cases, in which the woman attempted to murder her husband and daughter when these no longer shared her beliefs. In other cases such failure may result in total withdrawal into the delusional world.

Our patient resembled these women closely. For her also it was very important that her husband and her brother-in-law should share her delusions. After her relapse, when she failed to persuade the two men of her beliefs, she became very distressed, turned from them in anger, and threatened to leave

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her husband. She developed delusional ideas to explain his "stubbornness", saying that the neighbours' drilling had affected his brain.

In Hartman and Stengel's cases all three husbands were weak, timid men, who were inadequate both sexually and in the economic sphere. The authors suggested therefore that these men had a deep sense of guilt towards their wives, and that this explained their readiness to identify with them and to accept their delusions.

In our case also, despite the lack of evidence about the sexual relationship, it was obvious that the husband was weaker than his wife, of whom he always spoke with great respect and admiration. She was intellectually superior and physically stronger than he, referred to him as an invalid, and talked in a severely maternal manner of her concern for his physical welfare. She was always active and gainfully employed, and was responsible for most of the decisions made in the household.

In considering the position of the brother-in-law, the following factors appear relevant. He is a year older than his brother who, at the age of 5, was sent away from home to live with their grandparents. This removal of what can be assumed to have been his rival, is likely to have resulted in much guilt. Moreover, very shortly afterwards, at the age of 7, he developed tuberculosis and was himself sent away to hospital, where he was subjected to multiple mutilating operations, and led a restricted life away from home for the remainder of his childhood. Such events are likely to have fostered not only resentment against the world at large, leading to his reputed irritability and temper tantrums, but also an increased feeling of resentment against his younger brother, resulting in a still deeper feeling of guilt towards him. When in 1948 after years of institutionalization, he was offered a home by this brother, the isolation due to his physical deformity, his unmarried and insecure social state as compared with his brother's relatively successful position, as well as his old sense of guilt, can all be understood to have contributed towards his readiness to identify with his brother, and to accept the delusions then held by him and his wife.

So far the development of the illness in our case has been used to illustrate three main factors, which, apart from constitutional predisposition, would seem to be of importance for the induction of psychosis: (*a*) the social isolation of the small group affected, (*b*) the content of the delusions developed by the dominant partner which are such as to be acceptable to the other members of the small isolated group, and (*c*) the identification of the induced with the inducer on the basis of guilt feelings enhanced by social isolation.

Our case is remarkable in three respects:

1. Induction of the delusions proceeded in a hierarchical manner.
2. A change of environment produced a remission not only in the submissive partners, which is a relatively common event, particularly after their separation from the dominant partner, but in the dominant partner herself.
3. When the delusions recurred in the dominant partner, she was no longer able to impose them on the other two members of her household. This failure of induction, in the absence of significant changes in the social setting of the group, and in the content of the delusions, must be attributed to a changed relationship between the three people within the group.

In most of the reported cases of induced psychosis involving more than two people, the dominant partner was responsible for the induction of all the others. In our case, the patient imposed her delusions on her husband, and he in

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turn imposed them on his brother. This sequence of events is understandable in terms of the social setting of the three people, the relationship between the patient and her husband, and the initial relationship between the husband and his brother, all of which factors have been analysed above.

Remission after hospitalization of both partners of a folie à deux and subsequent relapse has been described by Freyhan in 1952. In his case, however, there was never a well-developed delusional system shared, the illness of the two differed in several respects, and when the wife relapsed, the husband developed a catatonic state just as she was to be re-admitted to hospital.

One can only speculate on the cause of the remission in our patient. It may be that her admission to the mental hospital, which received her husband and brother-in-law at the same time, and allowed them to see each other initially, did not as often happens increase her isolation, but on the contrary helped her towards a fuller social life than she had previously found possible. It seems likely that the degree of her social isolation was an important influence on the course of her illness, since she failed to improve when she alone was admitted to hospital, as happened once before her remission and once after her relapse, and since this relapse occurred when her employers went on holiday, leaving her alone in the house. The husband and the brother-in-law also failed to remit after the patient's first admission to hospital, when they were left alone at home, but both improved when all three were admitted to a hospital, where, as they all emphasized, they were kindly treated, and where the two men were able to take an active part in the communal life. Thus, temporary integration of the three people together into a hospital community led to a remission in all of them, whereas the separation of the dominant partner from the other two failed to achieve an improvement. This supports Ascher's suggestion that enforced separation, as advocated by Gralnick, may not be advisable in every case of partners of folie à deux. Gralnick stressed the sociogenesis of induced psychosis and recommended isolation of dominant partners of folie à deux as for infectious cases. Ascher (1949) thought that, in view of the poor prognosis in the case of the two sisters he described, it was not justifiable to separate these two people who could communicate fully with no one but each other. The course of the illness in our case suggests that a diminution of the social isolation of the group as a whole may even on occasion enable its members to give up their delusions.

The explanation for the failure of induction the second time, must be sought in the greater resistance on the part of the husband, since the patient's efforts at induction appeared to have been no less vigorous than before. During their infrequent visits to the patient while she was in the Maudsley Hospital, it was quite obvious that the husband was afraid of again coming under his wife's influence, and that the brother-in-law was trying to prevent this. They attempted sometimes quite brutally to convince the patient of the foolishness of her beliefs, and both tended to avoid discussion of their own past delusions. It appeared that it was no longer necessary for the husband to share his wife's beliefs in order to escape isolation, since he was now neither alone, nor alone in his opposition to her. Perhaps also his feelings of guilt towards his wife on account of his own inadequacy had been lessened by his introduction into the household of his brother, who, though crippled, had adopted a protective and gallant role towards his sister-in-law and was fulfilling some of the husband's function in the home. The brother-in-law's personality was more forceful than that of the husband, and over the years his position in the household had become stronger, so that the husband now turned to him for some of the decisions which

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he had previously sought from his wife. This was encouraged by the brother-in-law, who was seen on occasion to defend the husband against possible threats, including the patient's dangerous beliefs, which, he realized, had previously resulted in all of them being sent away to hospital. It was the brother-in-law who saw to it that the patient was re-admitted to hospital when she relapsed, and who persuaded the husband of the inadvisability of her return home unless she had fully recovered.

Summary

1. A case of Folie à Trois is reported, in which delusions of persecution were shared by a married couple and the husband's brother.

2. The remarkable features of the case are: (*a*) the hierarchical process of induction, whereby delusions were transmitted from the wife to her husband, and from him to his brother; (*b*) the remission of symptoms in all three people, although without return of insight, after their simultaneous admission to hospital; and (*c*) the failure of the woman's attempts at induction when her delusions recurred three years later.

3. The dynamics of the illness are discussed in the light of the social setting, the delusional content, and the changing relationships within the family group. Social isolation is seen to be an important factor in this as in previously reported cases, and its temporary decrease brought about by admission to hospital was followed by a remission. The content of the delusions developed by the dominant partner was meaningful to the others affected, and was such as to encourage their identification with the inducer. The initial relationships between the wife and her husband, and between the husband and his brother, show many features previously observed in cases of induced psychosis. The concept of an increased readiness of the submissive partner to identify with the dominant partner because of guilt feelings is found particularly helpful for the understanding of the initial induction of the husband and the brother-in-law, and of its failure some years later when the pattern of relationships within the family had changed.

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