FOLIE À DEUX

A CASE OF FOLIE IMPOSÉE À QUATRE AND À TROIS

By

D. H. ROPSCHITZ, M.D., D.P.M.

Senior Assistant Psychiatrist
The Pastures Hospital, Mickleover, Derby

Definition of Folie à Deux

"Folie à deux is the transmission of delusional ideas from a psychotic to closely-associated individuals, who have experienced his domineering influence for a prolonged space of time. This condition may be transferred to three and more individuals" (Lasègue and Falret (14)).

Introduction

Cases of folie à deux are not as rare as one would expect, judging by their infrequent description in psychiatric literature. This view is also held by Ascher (3) who states: "Although only about 100 cases of folie à deux are on record, it is my belief that the disorder is commoner than would appear."

There are few clinical entities for which so many names have been proposed as for the one commonly known as folie à deux. This fact in my opinion, is mostly due to a lack of conceptual agreement as regards: essential preliminary factors, mode of onset, transmission, the nature of symptoms and their duration in the passive partner. The question of consanguinity has been also raised and debated. To stress the divergence of opinion I only need to quote an incomplete list of names supposed to be synonymous such as: infectious, contagious, reciprocal, induced, imposed, simultaneous, communicated insanity. Tuke (17) called it double insanity and Gralnick (8) named it Psychosis of Association.

As regards the term "folie à deux" "à trois" "à quatre", etc., Kallmann and Mickey (13) remark that it is of little use apart from the opportunity it provides the psychiatrist of "counting in French"; for in fact it conveys little to the reader apart from the number.

History

Isolated clinical cases were reported early in the nineteenth century, as for example in 1819 by Berlyn (5) and in 1838 by Ideler (12). But it was Baillarger (4) who in 1857 and again in 1860 gave a more detailed description of the condition. He wrote: "It happens sometimes that two or more members of the same family are brought to the psychiatrist on the same day, each suffering from Monomania, and each exhibiting identical delusional trends." He continues, that after having examined one of them, it is possible to forecast delusions of the other. Baillarger emphasized that this condition did not develop simultaneously in both individuals, but that there was an interval of several months between the outbreak of psychosis in the one and the psychotic response in the other. The condition he called Contagious Delirium.

Sporadic cases were reported after that, such as the one described by Hofbauer (11) in 1864, but it was not until 1873 that Lasègue and Falret (14) made their classical communication to the Medico-Psychological Society of

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

Paris. They were the first to coin the term of folie à deux or folie communiquée.

At this stage, although the conception of folie à deux was broadened and better defined, there still remained many points which required clarification. Was the transferred psychosis to be permanently induced? Had the delusional ideas to be identical in both partners? Was a psychotic predisposition permissible in the passive partner?

Cases reported differed in nature and circumstances. Thus arose the need for further subdivision. It was Marandon de Montyel (15) who recognized the need for classifying "folie à deux" in three clinical categories.

Classification of Marandon de Montyel

1. *Folie Imposée*

In this group, one of the individuals is the active partner. He is the more intelligent and the first one to develop delusions, which he gradually imposes on the passive partner. The "lesser" partner although deluded, need not be hallucinated. In fact he is not really psychotic in the strict sense of the term, but only "un malade par reflet" who will return to normal after separation from the active element. Predisposition plays only a minor role. Suggestion and intimacy are important.

2. *Folie Simultanée*

Here the factor of transmission is either non-existent or only negligible. The delusions happen to develop simultaneously in the two subjects because of various concomitant factors, the most important ones being: morbid predisposition, prolonged intimate association and—what is most important—the same precipitating trauma acting simultaneously on both. This condition is not likely to subside with separation of the two individuals. Delusions and hallucinations may be present.

3. *Folie Communiquée*

In this category, the passive partner resists for a variable length of time, but eventually succumbs to the overpowering influence of the psychotic, developing finally a delusional and hallucinatory state. But although the delusional state is shared in the beginning, the passive partner soon follows his own trend, developing a psychosis *sui generis*, which does not subside after separation. Predisposition and hereditary constitution are said to play a major role.

Modern Trends

The modern trend is to eliminate subdivisions as far as possible and to beware of diagnostic labels. Nevertheless and especially in the case of folie à deux with its numerous synonyms, it would be impossible to discuss the matter, without some basic agreement of conception. Marandon's classification may be open to criticism, it provides however a workable guide in differentiating diverse clinical pictures. Modern writers have again discarded this classification, thus adding to the confusion of the term. To stress the point of conceptual disagreement I will quote from modern writers. Henderson and Gillespie (10) remark: "Suggestibility plays a part among other factors in the genesis of 'folie à deux' or 'communicated insanity', which is the term applied when two persons closely associated with one another suffer a psychosis simultaneously

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

and when one member of the pair appears to have influenced the other . . . It is usually a paranoid or manic depressive state." Here the term "communicated" is synonymously used for folie à deux and it is also remarked that they "suffer a psychosis simultaneously". No further details are given, i.e. whether this condition is permanent or likely to subside after separation; thus this description, although rather sketchy, could be used for all three of Marandon de Montyel's varieties.

Bleuler (6) states: "It happens, that paranoid or paranoiac, and rarely hypomanic patients not only can make those with whom they live close together believe in their delusions, but they so infect them, that the latter under conditions themselves continue to build on the delusions." This description would be more in keeping with Marandon's *communiquée* variety.

On the same topic, Aubrey Lewis (1) writes: "Unless there has been predisposition at hand, the condition is a reactive affair, which may have no deep roots and clear up quickly as do prison psychoses if the circumstances are changed." This again is a different description, corresponding more or less to the *imposée* variety.

We can see that in these three descriptions folie à deux assumes a different meaning. It is therefore suggested to discontinue the use of the term "folie à deux" and to re-introduce Marandon de Montyel's classification. This means that emphasis would be laid on the nature of the transmitted psychosis, the number completing only the circumstances of a particular case. In this way we would speak for example of folie simultanée à deux, folie simultanée à trois, folie communiquée à quatre, or whatever the case may be.

Another point of importance which requires clarification is the question of whether the use of the term "folie à deux" (or any other term) is justifiable in the presence of close blood relationship. Thus Kallman and Mickey remark: "The term has been used to describe the occurrence of various psychotic syndromes in entire sibships or other family units and also for twins who developed schizophrenia or a manic depressive illness." According to Kallman 85 per cent. of Monozygotic twins develop schizophrenia, if one of the pair is affected. It is therefore understandable that the use of "folie à deux" in twins, be they Mono- or Dizygotic, be they reared apart or not, does not seem justifiable to many writers, owing to the preponderant constitutional factor. The concept of folie à deux would lose its significance if used indiscriminately in blood relatives. To prove this point, Kallman quotes a case in which psychosis coexists in two parents and seven children and asks: "Would it be justifiable to call this a 'folie à neuf'?" He mentions another case of multiple psychosis involving both parents and five children. Here also the term "folie à sept" would appear out of place. Kallman continues: "The additional restrictive qualification to be advocated is that similar delusional syndromes should not be called 'induced' or folie à deux if they appear in units of blood relatives, and if the primary significance of the factor of blood relationship cannot be safely excluded."

From this point of view it is interesting to note that a great number of cases of folie à deux described in medical literature occurred between consanguineous individuals. To quote only a few, Adler and Magruder (2) speak of folie à deux in identical twins, Greenberg (9) mentions a case occurring between mother and son, Page (16) describes a case of "psychosis of association" involving a mother and 3 sons, and again Wellisch (18) a case between mother and son. Similarly Craike and Slater (7) discuss a case of folie à deux in uniovular twins reared apart.

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

Contributory and Concomitant Factors

Most writers agree that prolonged social isolation, strong emotional ties, domination and forceful suggestive powers in one, coupled with a high degree of suggestibility and submissiveness in the other, play an important role in the diverse varieties of folie à deux. Viewed from this angle "passionate love" with its turmoil of emotions and irrationality may be considered sometimes as a "modified" folie à deux; and not seldom in fact may lead to the tragic end of "felo de se à deux".

Marandon de Montyel holds the view that predisposition and "morbid impression" in the passive partner, are of primary importance. He doubts whether all other factors taken together could ever be effective, in the absence of the last two mentioned ones. It is generally said that mental defective weds mental defective. This in my opinion may also apply in the case of pre-psychotic personalities. Thus it may be that those who form close relationships with a pre-psychotic individual, either in the form of friendship or marriage, are themselves potential carriers of a latent psychosis. This point of "mate selection" is also emphasized by Kallman, in cases of folie à deux occurring between husband and wife.

Predisposition is obviously necessary in the *simultanée* and to a lesser degree in the *communiquée* variety; but it may also play a part in folie *imposée*. In those cases where it is totally lacking, the imposed insanity is not a true psychosis, but more in the nature of a hysterical phenomenon, due to strong suggestibility, submissiveness and close affective relationship.

✓ Case Report

This case occurred about two years ago in a nursing home in the north of England. The central figure is a doctor suffering from a manic-depressive psychosis. He had some psychiatric training, having worked in a mental hospital for a year or so. The second protagonist, the main figure in the constellation of "lesser partners" is a middle-aged woman. She had always conveyed the impression of being rather odd and aloof, but could not be described as outside the flexible limits of normality. She also happened to hold a responsible position in the nursing home in question, being one of the directrices. The third person involved was a patient, a youth of seventeen, an emotionally immature personality with pronounced schizoid features. Finally there were two passive partners, involved to a lesser degree, two psychoneurotic patients (male), with predominant hysteric and phobic traits. Thus we have one central figure and four lesser partners with varying degrees of involvement in this case.

The doctor in question, whom we will call A., suffered from a manic-depressive illness for some years. He was 28 years old, and on one occasion he had been a voluntary patient in a mental hospital. I met him for the first time at the nursing home one year prior to the occurrence of the present case. He was not a patient, but stayed there as a guest of the previously mentioned directrice, with whom he had established a very close relationship. On that occasion he was in a depressive phase, and Mrs. B., the directrice, asked whether I would mind looking after him unobtrusively. I succeeded in persuading him to undergo a course of electro-convulsive therapy. He improved considerably and I seized the opportunity to follow up physical treatment with intensive psychotherapy of some duration. Dr. A. was of good intelligence and insight, and seemed to benefit from psychotherapy. Eventually he got sufficiently well to take up his post again at a mental hospital, where he managed all right for about 10 months.

The following year, at the time in question, he came to visit the nursing home again. By an unlucky twist of circumstances, the chief visiting psychiatrist was abroad on holidays, while I was taken ill unexpectedly. There ensued a gap of two days in which no visiting psychiatrist was available at the nursing home, to deal with the patients. This course of events became the starting point of interesting, though highly unpleasant developments. Dr. A. was this time in a hypomanic phase. He saw an opportunity for intensive activity, and act indeed he did. He was in the "live wire" state, full of exuberant energy and verbosity. Nothing was too difficult, no case seemed too complicated for him. He took full charge of the nursing home and began to treat patients.

The first victim to fall under Dr. A.'s hypomanic spell was Mrs. B., the directrice, who was emotionally involved with the doctor. She followed him around in a subservient and ecstatic mood, watching with veneration the "miraculous cures", as they were called by the hypomanic magician. She lived almost in a trance, incapable of realizing the true situation.

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

Dr. A.'s euphoria and overactivity took hold of her, so that she soon became but a reflexion of his personality. Both of them were constantly on the move, talked incessantly and interfered with the routine of the nursing staff. Dr. A. believed that he possessed extraordinary therapeutic powers; in fact his hypomania had a true schizophrenic flavour. The matron of the nursing home made a desperate attempt to bring Mrs. B. down to earth. She reminded her of Dr. A.'s past history, of the course of electroplexy he had undergone only ten months before. But she was sharply rebuked and told to mind her own business.

Two male patients with hysteric and phobic traits were the chief recipients of psychological treatment. One of them, Mr. C., an ex-pilot, suffered, apart from other complaints, from an intensive fear of ever flying again. Dr. A. belaboured him and, in the space of 24 hours, he bluntly declared him as cured. Similarly the other patient, Mr. D., who had marital difficulties on account of sexual disturbances, was informed that his troubles were over. Both patients accepted his suggestion and regarded themselves as cured. The ex-pilot declared that he could fly again. Where long and laborious psychotherapy had failed, the hypomanic impact, with its authoritative and infectious optimism had succeeded.

Mrs. B. felt triumphant—and frankly, who can blame her—for this was a "miraculous cure" indeed; though unfortunately short lived. Dr. A., Mrs. B. and these two patients formed an inseparable and enthusiastic quartette. The criticism, amusement and crude jokes of the rest of the nursing home community did not disturb them. Dr. A. insisted that it was of the utmost importance to show this astonishing cure to Dr. L., the chief psychiatrist. To wait until Dr. L.'s return was out of the question, as the matter was too important. True, the chief psychiatrist was holidaying abroad, but what did this matter! They would fly, all of them. Right away!

So far there is nothing unusual in the patients' acceptance of their cure. It is simply a case of hysterics accepting a strong suggestion. But one would have expected them to return to their homes, to their families, instead of taking to the air. Both patients however seemed enthusiastic about the plan. In their eyes, too, this was a matter of urgency. As it happened, neither the doctor nor the two patients possessed sufficient means to finance the air-trip to Italy, but this was no obstacle for Dr. A.; Mrs. B. would pay for the lot! And so she did.

During my two days of illness, I had been kept informed by the matron of the developments at the nursing home. When I finally arrived on the third day, I found the party ready for the flight and had no opportunity to stop them. And so this constellation of four took to the air and descended upon the unsuspecting chief psychiatrist in Italy. Dr. L. was well acquainted with Dr. A.'s past history. He pleaded with him as well as with Mrs. B., urging them to return to England, but both of them were impervious to reason. Finally the chief psychiatrist succeeded in getting in touch with the British Consul and in having Dr. A. repatriated to the U.K.

Meanwhile I had a hard time to get the nursing home back to normal working conditions, as it was completely thrown out of gear by Dr. A.'s short but fervent activity. I was almost on the point of regaining control of the situation, when the second hurricane broke loose. Mrs. B. was the first one to return from that memorable trip. She was euphoric, garrulous, overactive and conveyed the impression of a person extremely pleased with a work well done. Notwithstanding the cold reception—Dr. L. wrote "they turned my holiday into a nightmare" —she showed no sign of disappointment, or realization of the futility of her enterprise. The two patients, having meantime cooled off and come to their senses, did not return to the nursing home. It was quite an ordeal for them to get back to England. Dr. A. however, after successful disengagement from the repatriation officials, appeared on the scene again and renewed his stay at the nursing home. By this time he was in a fully blown maniacal state, unmistakable even to the most unobserving layman. He was overactive to the extreme and his delusions of noble birth and omnipotence became more pronounced and persistent. I had to speak to Mrs. B. She was after all the directrice. I explained to her that it would be impossible for me to take any responsibility in the nursing home unless Dr. A. was impeded to interfere with the patients. My request fell on deaf ears.

On my next visit to the nursing home, I learned that Dr. A. had surrounded himself with new apostles, some mocking, some doubtful; and yet there was a new victim to fall under his spell. This was the formerly mentioned seventeen-year-old youth; an effeminate, immature and pronouncedly schizoid personality. He came to the nursing home on account of shyness, difficulty of concentration, incapacity to settle down to his studies, as well as some minor manifestations of juvenile delinquency. Dr. A. and the youth, whom we will call "E.", became inseparable. The one commanded, the other obeyed blindly. It was almost unbelievable how Dr. A., who at this stage was frankly psychotic, could have possibly exerted such strong influence on E., who, although of schizoid make up, was after all rational and in touch with reality. The matron informed me that both had absconded the night before, had visited the village pub, causing great consternation and bewilderment among the public. Various complaints from all quarters began to reach the nursing home.

My position was very unpleasant. It seemed hard to take steps against a colleague; and besides I was technically subordinate to the directrice of the nursing home. Having treated Dr. A. the year before, I pleaded with him to undergo treatment again, or alternatively, to seek admission as a voluntary patient in a mental hospital. He refused either. I made it clear to Mrs. B., that unless Dr. A. transferred his residence elsewhere, I would be left with no

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

alternative but to have him certified. It did not impress her. She asked me not to worry, said that everything was all right, and that the chief psychiatrist approved of it all. It was clear that she was frankly deluded.

At this stage there was a solid triangle formed by Mrs. B., Dr. A. and the young man E.; and, living as they did in close association, they derived great moral courage and strength from this symbiosis. Both of them idolized the doctor and believed in him as a kind of Messiah. It was by now a case of folie imposée à trois.

As Dr. A. was free to move, complaints from the neighbourhood reached the nursing home in increasing numbers. I had no choice apart from certification and told Mrs. B. about it. The same night I received a telephone call from Dr. A. He asked for an appointment on the following day. The feeling of impending danger brought a temporary remission in his mental condition. I agreed to see him and arranged also for a colleague psychiatrist to be present at the interview.

Dr. A. arrived in the company of Mrs. B. After introducing both to my colleague, I invited Dr. A. to give his version of the last events. He began by stating that there was nothing the matter with him whatever. Then he proceeded with a frontal attack on psychiatric treatment and it must be conceded that part of his criticism was sensible enough. He next went on to accuse me of plotting against him and of not understanding his inborn therapeutic powers. Soon enough he made it transpire that there was royal blood in his veins, and that he could not be judged by common standards. Gradually he began to lose the thread of his conversation as his flight of ideas did not permit him to dwell for long on the same topic. He expressed frank delusions of grandeur and stated that he was working for the Foreign Office. He spoke without interruption for over an hour and would undoubtedly have continued for longer, were he allowed to do so.

For fairness' sake I asked the other psychiatrist to give his opinion to Dr. A. He did so and explained to Dr. A. that he was in urgent need of mental treatment. He also volunteered his help as regards admission to a mental hospital. But again Dr. A. refused flatly, and went out to an adjoining room. I then invited Mrs. B. who had witnessed the interview throughout to express her opinion. The conversation went approximately as follows: "Do you agree that Dr. A. is mentally ill?"—"No, I don't. You can check, he is associated with the Foreign Office."—"Supposing he worked for the Foreign Office, would that prevent him from becoming mentally ill?"—"But you can check, he works for the Foreign Office". She had no realization of the seriousness of Dr. A.'s mental condition, and for that matter no appreciation of her own condition either.

That same day circumstances forced me to make arrangements for certification. The Duly Authorized Officer, as well as a Justice of the Peace, arrived at the nursing home. Dr. A. arrived on the scene unperturbed and was invited by them to have his say. He sat down assuming an over-erect position, holding his walking stick in a sceptre-like fashion and spoke again of his noble birth, his astonishing healing powers, and his persecution by the ignorant, as for example myself.

His uninterrupted speech had lasted for a considerable time when he was finally invited to wait in another room. At this point an unexpected incident occurred. There was a knock at the door and Mr. E., the young man, made his entrance. He seemed very agitated and stated that Dr. A. was being wrongly accused and that there was nothing whatever the matter with him. He affirmed that I was conspiring against Dr. A. because I was jealous of his extraordinary successes. Although the position was explained to the boy by the Justice of the Peace, he was incapable of appreciation.

For technical reasons—I suspect the D.A.O. wanted to check with the Foreign Office—it was decided to postpone Dr. A.'s removal to a mental hospital until the following day. The same night I was awakened by the telephone and informed by the matron that both Dr. A. and the boy had eloped from the nursing home. The police were informed and eventually they were found and detained overnight. Next day Dr. A. was admitted to a mental hospital as a certified patient, while the young man was brought back to the nursing home.

After Dr. A.'s exit from the scene, the youth regained his previous personality in the space of four days. He remained the same schizoid and emotionally immature individual as before, but he was no longer deluded about Dr. A.'s persecution, nor did he regard him any more as a miraculous healer. He came to me on the fifth day and apologized for the inconvenience he had caused.

Mrs. B.'s return to "normality" was a more drawn-out process. Soon after Dr. A.'s certification, she pretended to have known all the time that he was mentally ill. In contrast to her former hypomanic behaviour, she gradually grew distant, aloof and somewhat suspicious. I gained the impression that she was holding back and that she was afraid of being sent to a mental hospital herself. After a month or so, she reverted to her former self.

Discussion

In all four satellites, the separation from the active partner was followed by a return to previous personality. This fact by itself makes this case eligible for the term "folie imposée" in the sense of Marandon de Montyel's definition. In the case of the two psycho-neurotic male patients, suggestion and heightened

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

suggestibility played an important role. Theirs was not a true psychotic reaction, except perhaps for the short duration of the air-trip from England to Italy. I think their response was more of a hysterical nature. Mrs. B.'s reaction was frankly psychotic, the pattern of her transient psychosis and delusions being almost identical with that of her active partner. She was the most emotionally involved of the "lesser partners". Predisposition probably played also a part in it, for it is difficult to know, without a closer examination, what was hiding behind her façade of "oddity". It may be of some interest to mention—especially as regards "mate selection"—that her daughter had chosen to marry a schizophrenic patient some years previously.

The adolescent, who had a marked predisposition, reacted psychotically in that he was unable for a time to keep in touch with reality, and also because he shared some delusions with the active partner. It would be incorrect however to state that the pattern of his temporary psychosis was identical with the original one. In this respect I share the opinion of Woltring (19) when he states: "The opinion that we can speak of folie *communiquée* or *imposée* only if the secondarily induced psychosis is identical in form and content with the primary psychosis, seems to me to be too one-sided."

To conclude, I think that Lasègue's and Falret's classical definition of folie à deux should be broadened as follows: (*a*) The transmitted psychosis may be of a temporary or permanent nature, and may or may not subside after separation of the persons involved; (*b*) Delusional ideas and other psychotic traits may, but need not be identical; (*c*) In the *imposée* variety, true psychosis need not be present in the passive partner, but the clinical picture may be more in the nature of a hysterical reaction.

SUMMARY

1. The concept of folie à deux is discussed and the adoption of Marandon de Montyel's classification advocated.

2. It is suggested that owing to the preponderant constitutional factor, it may be advisable to exclude the term folie à deux among close blood relations as advocated by Kallman and Mickey.

3. A case of folie imposée à quartre and à trois is described.

ACKNOWLEDGMENTS

I wish to thank Dr. E. U. H. Pentreath, Medical Superintendent of the Pastures Hospital, for his help and permission to publish this paper.

BIBLIOGRAPHY

1. LEWIS, AUBREY, *Brit. Encyclop. Med. Pract.*, 1952, **10**, 364.
2. ADLER, A., and MAGRUDER, W., "Folie à deux in identical twins treated with Electroshock therapy", *J. Nerv. and Ment. Dis.*, 1946, **181**, 103.
3. ASCHER, E., "Folie à deux (Psychosis of Association)", *Arch. Neurol. and Psychiat.*, 1949, **61**, 177–182.
4. BAILLARGER, L., "Examples de Contagion d'un Delire Monomanique", *Monit. des hôp.*, 1857, No. 45.
   Idem, *Gaz. Hop.*, *Paris*, 1860, p. 149.
5. BERLYN, C., *Z. psych. Aerzte*, *Leipzig*, 1819, **2**, 363.
6. BLEULER, E., *Textbook of Psychiatry*, translated by Brill, New York, 1930.
   COLEMAN, S. M., and LAST, L. S., "A Study of Folie à Deux", *J. Ment. Sci.*, 1939, **85**, 1212.
7. CRAIKE, W. H., and SLATER, E., "Folie à deux in uniovular twins reared apart", *Brain*, 1945, **213**, 68.
8. GRALNICK, A., "Folie à deux: The psychosis of association", *Psychiat. Quarterly*, 1942, **230**, 46.
9. GREENBERG, H. P., "Folie à deux", *Guy's Hosp. Rep.*, *Lond.*, 1954, **103**, 381–92.
   Idem, "Crime and Folie à deux", *J. Ment. Sci.*, 1956, **102**, 772.
10. HENDERSON, D. K., and GILLESPIE, R. D., *A textbook of Psychiatry*. Oxford Medical Publications, p. 117.
11. HOFBAUER, B., "Infectio Psichica", *Oesterr. med. Wochenschrift*, 1864, No. 39.

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press

12. IDELER, K. W., *Grundriss der Seelenheilkunde*, 1838, **2,** 530. Berlin.
13. KALLMANN, F. J., and MICKEY, J. S., "Genetic concepts and folie à deux", *J. Hered.*, 1946, **37,** 298–306.
Idem, "Concept of induced insanity in family units", *J. Nerv. and Ment. Dis.*, 1946, **104,** 303–315.
14. LASÈGUE, C., and FALRET, J., "La folie à deux ou folie communiquée", *Ann. méd.-psychol.*, 1877, **18,** 321.
Idem, Ann. Méd.-psychol., 1873, **10,** 483.
15. MARANDON DE MONTYEL, E., *Ann. méd.-psychol.*, 1881, **5,** 28.
Idem, ibid, 1894, **19,** 266, 467.
16. PAGE, L. G. M., "The Psychosis of Association", *J. Ment. Sci.*, 1942, **88,** 545.
17. TUKE, D. H., *Brain*, 1888, **10,** 408.
18. WELLISCH, E., "A Rorschach study in folie à deux of mother and son", *J. Ment. Sci.*, 1949, **95,** No. 399.
19. WOLRTING, VON L. M., *Schweizer Arch. für Neurol. und Psychiat.*, 1951, **68,** 1. Zurich.

https://doi.org/10.1192/bjp.103.432.589 Published online by Cambridge University Press