A STUDY OF FOLIE À DEUX.

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DURING the last century the fact that two people share a psychosis has been recogni ed as constituting a problem of psychiatry. Although quite a number of cases have been published, we were surprised at the relatively small number. The subject lends itself admirably to systematization, and the classification which has been accepted by most writers is the one evolved by French authors. According to this we have to distinguish between the following groups :

(1) *Folie communiqueé.*—In this the second patient to whom the psychosis is communicated is predisposed. By this Marandon de Montyel (6) means hereditary or other predisposing physical and psychological factors. Under the incessant influence of his partner the second patient ends by developing a similar delusional system.

(2) *Folie simultanée.*—Two persons equally predisposed, start the same delusion simultaneously under the influence of the same factors acting on them both. They have a bad influence on each other.

(3) *Folie imposée.*—In this group one person only is really insane and impresses his delusions upon another who is intellectually and morally his inferior.

Lasègue and Falret (5) stated some conditions which they regarded as essential for the development of *folie à deux*. Amongst them are the following two points which have been accepted by the majority of workers: (1) One of the two partners is the active element, he is the more active personality, he is more intelligent, he creates the delusion and gradually impresses it upon the other; (2) the two patients must have lived together for a long time in complete intimacy and removed from outside influence.

Marandon de Montyel (7), in a very interesting study published forty-five years ago, has shown that there are cases which do not conform to these rules, and he assumed that although these conditions are often fulfilled and are certainly helpful in the production of this syndrome they are not essential. We hope that our paper is going to show that this view, which seems to have been overlooked or forgotten, is supported by clinical evidence.

In this brief résumé of the literature, mention should be made of the psychoanalytic contribution (1, 4). For this school of thought the mechanism of identification plays a most important role. The delusional idea of one person, it is contended, will only be taken over by a second person when there already exists in the latter a repressed phantasy life of similar content. Such a phantasy will concern the Œdipus situation and the inducer will be identified, in the mind of the induced, with the parents, whose place in the original phantasy he takes over.

We now turn to the description of our cases :

A timekeeper, aged 63, complains that for the past year he has been obsessed by the idea that there are insects crawling all over him. He has never seen them, but is convinced that they are there because his wife says he is filthy. For the past year his wife has spent her time scrubbing the walls of his room. She continually tells the patient he is dirty and contaminating the house with vermin. In order to protect herself she baths several times a day. Gradually sensations of formication appeared, and he is now convinced these are due to insects. He is unable to explain how he became infected in this way, and wonders if he could have caught them from his canaries. His wife insists that his clothes are contaminated and on this account he changes them three times a week. He has to wash and boil them himself because his wife refuses to touch them. He states that he is normally cheerful and active, but that lately he has become depressed, emotional, feels his memory is impaired, and has lost confidence in himself. He is totally devoid of insight and is not open to reason. The fact that he himself has never seen any vermin is of little weight compared with his wife's reiterated statements. The relevant points in his history are that as a boy he had fits, and that he had his last fit when aged 22, following the death of his first wife. His own account of this is that he " fell on the ground and struggled ". He married again when aged 34, his second wife being three years younger than himself. He admits that she had been mentally ill for the past ten years. Prior to this illness the marriage was a happy one. There is one son, aged 28, who is considered to be not very bright. He has been unemployed for the past five years on account of his " nerves ".

Three years ago the patient lost a very good position as a head timekeeper through the fault of one of his subordinates. He was given an inferior job, which he still holds, but his earnings have been halved. His pride has suffered much through this setback.

By appointment with the patient, the wife was visited by the social worker. She appeared at the door clad in a petticoat. It was clear that she was very suspicious, and she would not allow the social worker to enter the house. In consequence, the interview was conducted at the front door, held a few inches ajar.

She spoke vaguely and irrelevantly, and it soon became clear she was hallucinated and deluded. She believes that the neighbours use her body for immoral purposes, and she thinks that her husband is involved. He probably receives money for the outrage. She states that this form of persecution has been going on for ten years. She also thinks that her son is subject to similar abuse. Asked why she refuses to wash her husband's clothes she answered that when standing at the sink she was aware of " interference ".

After the patient had been seen at our out-patient department he was admitted to another hospital. In addition to the symptoms mentioned above he now expressed ideas of reference. We have to thank Dr. Masefield for this information. The patient's wife was in a mental hospital about eight years ago, when a diagnosis of delusional insanity was made.

The interest of this case lies in the fact that the symptoms induced resemble those of an obsessional neurosis. The man's compulsion to wash, to change his clothes because of insects, sounds like the well-known neurotic symptoms. However, he lacks any insight, whereas the neurotic retains the knowledge that his symptoms are abnormal: our patient is convinced of the reality of his infection. In addition, some other delusions have lately made their appearance. A further analysis of these cases was rendered impossible by the patient's failure to attend the clinic.

We now come to the second pair of patients, whom we know better.

Mrs. V. W— was aged 42 when admitted in November of last year. As far as the family history could be traced the only incidence of mental disorder elicited was that of a paternal aunt who suffered from fits and died in a mental hospital.

The patient herself was late in walking, and was considered backward. She went to a private school, was a poor scholar, and never learnt to write properly. Little is known about her work, but there is a suspicion that for a time she lived as a prostitute. She met her husband in the street where he was singing hymns. The patient went up to him and gave him a penny and a doughnut, saying: "Sing it again, it touches me".

The husband is a picturesque figure, known in the town as "Bible Jack". He is much up against authority as he feels he has always suffered persecution. This started in his schooldays when his master hid a pin in his cane. He has frequently been arrested and sentenced for begging, and for obtaining money under false pretences. He thinks that his free-lance evangelism and preaching has made the Baptists turn against him. He has not worked for years. However, his beliefs allow begging. From a previous marriage he has seven children. By his marriage to the patient there have been six children. All the children have been taken from the parents and are in various homes and institutions. There is a doubtful history of syphilis.

Returning to the patient, it has been said that she was often sulky and bad-tempered. She never made many friends. When questioned on this fact she explained that she had always been shy and sensitive, self-conscious in company and afraid of blushing. She often thought that other people were laughing at her and making remarks about her.

She is supposed to have imagined, some years ago, that a cowboy film-actor, "Broncho Bill", used to come and see her at her home. She later acknowledged that it had been imagination.

About four years ago the patient and her husband went to see a film starring Robert Taylor, and ever since she has been preoccupied with him. She has bought all available magazines about him and has collected innumerable photographs. She has been so neglectful of her home duties that her husband had to bribe her into scrubbing the floor by buying her *The Picturegoer* or other journals. About a year before the patient's admission her husband used to play up to her, saying that she would probably meet Robert Taylor when she went out. She soon announced that she frequently met him in Lambeth Gardens. When her husband thought this was becoming too much of a good thing he told her to "cut it out". She was so positive that her husband sometimes thought there was some truth in the story, and when, four months before her coming to Runwell Hospital, she declared that the baby born was the outcome of her visit to Denham Film Studios, there was something of a row.

About one year before admission the patient and her husband met the family B—, who took them into their flat, where they lived for six weeks. From that time on the patient and Mrs. B— became inseparable friends. Since the summer the latter has declared that she has saved Robert Taylor's life by her psychic

powers, and has cured Greta Garbo of tuberculosis. Mrs. B— has been feeding the patient's baby as well as her own. The patient was said to believe that Robert Taylor had died and that the money left for the baby had been lost on the Stock Exchange.

On admission, no physical abnormality was found, except a congenital strabismus. The patient was 4 ft. 11½ in. in height, and weighed 7 st. 3½ lb.

The patient was able to give a good account of herself. She told the same story as her husband about having met Robert Taylor and becoming friendly with him. Some time before her admission Robert Taylor had returned to America. According to her, she was talking to her newspaper agent one day about Robert Taylor, when he asked whether she knew of his recent illness. He then showed her a book containing a report on the actor's illness. She went on to say that the agent offered to telephone Robert Taylor for her, and even promised to pay for the long-distance call. Subsequently he did this for her a number of times, and eventually she started to use the telephone herself. Her friend, Mrs. B—, also sent messages to the actor through the patient. Robert Taylor's imagined death is believed to have been due to the interference of gangsters. She knows that in his will Robert Taylor left Mrs. B— property to the value of £50,000. The gangsters however, prevented Mrs. B— from having it and even threatened the two women with death if they made any attempt to gain possession. On this account they do not wish to have anything more to do with the whole affair.

Mrs. B—, aged 31, was admitted on the same day as Mrs. W—. The family history reveals that there is one case of mental illness on the paternal side, a brother of Mrs. B—'s father having died of general paralysis in a mental hospital. On the maternal side there is a severe psychotic heredity. The mother had three psychotic episodes and died in a mental hospital. A diagnosis of mania was made twice and delusional insanity once. A maternal uncle was found with his throat cut, and three maternal aunts are described as being " strange ". The maternal grandmother died in a mental hospital. Of the siblings, two are mental defectives and the other brother is described as " wild ".

Little is known about the patient's early development; she was brought up in various homes where it was reported that she was " highly strung, querulous and difficult to control ". She changed her employment frequently. She has worked as a domestic as well as in factories. It should be noted here that she has always been very preoccupied with her bodily health. On this account she has been in and out of many hospitals, her complaints being vague and varied. She now believes that there is something wrong with her heart and that she may be suffering from tuberculosis.

In view of the low intelligence of all informants, it is difficult to get a satisfactory description of her personality. She is stated to have been of a lively and excitable disposition, to have been sociable and to have had many friends, to have liked amusements, to have been extravagant with money and to have been an indifferent housewife.

Her husband is a pathetic, undersized, mental defective. When interviewed it soon became clear that he believed in his wife's psychic powers and in her persecution by the G-men. He spontaneously mentioned her estate. Here it may be noted that Mrs. W—'s husband has also believed in at least a part of the delusional system.

As stated above Mrs. B— and Mrs. W— had become inseparable companions. Though much younger Mrs. B— was definitely the leader. In fact, Mrs. W— had never had a proper friend before. During the summer of 1938, Mrs. B— professed to be clairvoyant and when she was away on a holiday she found that she was able to tell peoples' fortunes. Later she came to believe that she had saved the life of Robert Taylor. In return for this the actor had left her a large estate. This estate, she imagined, had been intercepted by the Government and the Duke of Windsor. During her pregnancy she walked about in a purple velvet cloak. She refused to obtain a cot or prepare any baby clothes, explaining that Robert Taylor would provide all that was necessary. The baby was born four months

before prior to her admission to hospital; approximately at the same time Mrs. W— had her confinement. After the baby's birth, Mrs. B— remained interested in clairvoyance and also took to reading books on hypnotism. She became neglectful of her person. As her husband put it: "She was not as clean and nice as she should have been". A few days before admission she became excited and definitely deluded, declaring that the G-men were after her.

On admission she was free from organic disease except for a well-compensated mitral stenosis. She was just under 4ft. 6 in. in height, weighed 7 st., and was of pyknic build. Her behaviour was fairly satisfactory though she was somewhat overactive, talked volubly and on occasions had to be given sedatives. She was mildly elated and although frequently asking for her discharge, seemed, on the whole, contented. At times a little rambling, she gave a fairly connected account of her delusional ideas. She corroborated her friend's tale. She told how she had been left a property in Hollywood, worth £50,000, for having treated Robert Taylor. She had known by clairvoyance how to treat him, and her friend had telephoned the necessary instructions. She admitted that she herself had never spoken to Robert Taylor. She just knew that he was suffering from "black consumption". The doctors, however, did not carry out her treatment; for instance, when she prescribed a warm syringe, Robert Taylor was given a cold one. On this account he eventually died of "arsenical poisoning". She went on to explain how she was being persecuted by gangsters and German spies. The latter could be recognized by their "goose-step-like walk, long pointed noses and bent shoulders". She also reported how she had treated other film stars and had predicted events in her family circle. She said that in the September crisis she had saved both Southend and London. Returning to the matter of her estate, she stated that the gangsters who were after it were now threatening and persecuting her and every one connected with the affair.

After a couple of weeks in hospital, she developed slight persecutory ideas against the staff. Then, after a few more weeks, a striking change in her attitude was noted. She now disavowed belief in the whole story. She insisted that she had been told lies, blaming her friend and her friend's husband for having talked her into all this. She became most anxious to create a good impression, denying all her previous psychotic ideas with eagerness. She was discharged March 19, 1939.

Finally, we propose to put forward a few tentative theories of our own regarding the psychological mechanisms that may be responsible for *folie à deux*. It has already been made clear that the essential feature of the condition is induction, i.e., the active propagation of an idea or ideas not generally accepted by the social ***milieu***, and the passive acceptance of the idea or ideas by one or more persons. Here it may be noted that cases of communicated insanity involving up to ten persons have been reported (8, 5). Induction therefore presumes first, a psychotic individual anxious to convince others of the truth of his delusional system; and secondly, a person or persons prepared, and therefore presumably predisposed to accept, the false belief.

Turning for a moment to normal psychology we find that the propagation of an irrational idea and its acceptance by large numbers of the community is by no means an uncommon event among normal people. This point need hardly be laboured. Everyone is acquainted with such mushroom-like growths as new religious cults, pseudo-philosophical or political groups, the vogue of some patent remedy or dietetic fad, the belief that some locality is cancer-ridden or a house haunted. H. Deutsch (1) has stressed this point, holding that, "we

also find the process (communicated insanity) as a mass phenomenon where entire groups of psychically healthy people are carried away by psychically diseased members of the group: world reformers and paranoiacs, for example. Indeed, great national and religious movements of history and social revolutions have had, in addition to their reality motives, psychological determinants which come very close to the pathological process *folie à deux*."

The ready acceptance of an irrational idea, being then, a common phenomenon among the so-called normal, the surprising fact about *folie à deux* is not so much that it occurs as that it does not occur more often. Actually it is a comparatively rare occurrence. It is a matter of general experience that mental patients in hospital do not take over each others delusions. We, for instance, having had jointly twenty-five years psychiatric experience have observed personally only these two examples. The moderate number of cases reported in the literature is a further indication of its infrequent occurrence.

In order to explain how it comes about that people take over ideas ready-made from other members of a community, psychologists make great play with the phenomenon of suggestion. Authorities are agreed that suggestibility is one of the primary binding forces of the herd and the most essential factor in the formation of the herd instinct. In practice, of course, by no means every suggestion is taken over by the group; other factors are called into play. In the first place the individual who attempts to sway the community and to foist on to them his new idea must be of the leader type. That is, he must have the prestige and attributes of authority, provoking in his fellows the emotions of admiration, awe and even blind faith in the rightness of his point of view. Secondly, the idea to be suggested must represent some real or imagined advantage not only for the leader but also for the whole group. It may be noted that the proportion in which these two benefit depends upon a qualitative factor; the magnetic personality of the former as compared with the degree of suggestibility or gullibility of the latter. Lastly, for the new idea to gain acceptance it should not be too much at variance with current custom. The more difficult it is found to fit the new idea into the system of traditions and beliefs of the herd, the less likely it is to obtain general approval; there will be the powerful counter magic of former authority. In so far as the behaviour of the particular group is based upon rational thinking and scientific method, the new idea will be more difficult to put across if it does not fit in with these principles. While stressing the similarities between suggestibility, as it occurs in normal people, and *folie à deux*, it must be remembered that in the latter the induced person, after a period, nearly always elaborates the delusional system. He is seldom content to take over the false belief unaltered.

Having agreed, then, that suggestibility is a potent factor among normal people, a binding force within society, and that it is largely responsible for the acceptance of new ideas by the community, we next ask why this should

occur so rarely among psychotic persons. In the first place it can be shown that though the psychotic may be of the leader type, the second and third postulates are not fulfilled. The delusional idea, which the psychotic is anxious to propagate, represents little pragmatic advantage to other members of society. The important point is that the phantasy of the psychotic is a purely personal solution to a personal problem. It is of no help in solving the difficulties of other people.

A second causal factor mitigating against the taking over of the psychotic's delusion is what may be called the isolation of the mentally ill. Though a few cases of induction of manic-depressive states have been recorded (6, 7), it is, in by far the majority of cases, delusions which are induced ; the inducer being a paraphrenic or paranoiac. Schizophrenics rarely, if ever, induce a psychosis. This is not so surprising when their exceptionally poor contact with their surroundings is borne in mind. The schizoid personality is too autistic and introverted to trouble about making converts. This also appears to be so for the large majority of paraphrenics in mental hospitals. At least as far as their delusions are concerned, they are shut in and withdrawn from reality. They keep their morbid ideas to themselves and may even deny them if they think that they are unlikely to meet with a sympathetic reception. Again, it is generally recognized that these psychotics are very resistent to suggestion and are unlikely to accept new ideas, more especially if these do not fit in with their preconceived convictions.

We have, then, in our chronic wards numbers of deluded individuals, who, at least on the surface, appear to jog along fairly well together and appear to have a fair amount of social intercourse. Each, however, has his private world ; a delusional system which represents a personal solution to his especial conflict with reality. Around this phantasy is built a rigid wall of non-suggestibility, impervious to outside influence.

Taking these factors into consideration it is hardly surprising if *folie à deux* seldom, if ever, occurs within the mental hospital. The question is no longer, why is the condition so rare, but under what circumstances and why should it occur at all ? Two observations may help towards a solution of this problem.

In the first place the view that the paraphrenic, as far as his delusions are concerned, has withdrawn from his environment is only relatively true. We know, for instance, that many paraphrenics, though they pay little attention to their immediate surroundings, may continue for years trying to convince those they believe concerned with their delusions to their way of thinking. We also know that the early paraphrenic is only too anxious to converse upon his morbid ideas and to convert his relatives, immediate associates and his physician to believe as he does. As far as we know Hartmann and Stengel (2, 3), were the first to become interested in the psychology of the active partner of a *folie à deux*. This problem has been neglected by most authors. Hartmann

and Stengel stress the point that the importance of induction to the inducer lies in its being an attempt to keep in touch with the exterior world just at a time when he feels himself threatened with isolation by loss of contact. It is failure to convert others which results in total or partial withdrawal and the building of a barrier between his innermost convictions and the rest of mankind. It may be hazarded that in so far as the paraphrenic is successful in foisting his fantastic ideas upon other people he is not insane. He is a prophet, a mystic, a quack scientist, leader of some new pseudo-philosophic school or what not. Again, he may sublimate his queer ideas in some literary or other artistic form acceptable to society. In a word, he has adapted to his *milieu*.

So far the following point has been made. It has been shown that actually the paraphrenic is as anxious to induce others to accept his irrational idea as, for instance, the most ardent reformer. It is only failure in this respect which sooner or later results in complete or partial withdrawal. A second observation may explain why, under special circumstances, he may occasionally be successful in inducing his delusions. A psychopathological manifestation having points in common with *folie à deux* is hysteria. The two essential features of this psychoneurosis are the capacity for dissociation and for accepting suggestion. Actually dissociation and suggestion are probably attributes of a common factor seen from different viewpoints. A third feature, now equally well recognized, is that the hysterical symptom is a solution to a personal problem or conflict. It represents, for the hysteric, an imagined pragmatic advantage. Less explicitly appreciated, though following as a direct corollary from the phenomenon of suggestibility, is the fact that the symptoms are induced.

For example, in Janet's famous case the religious and hysterical girl spends her time reading the life of Saint Theresa, and in due course levitation and the stigmata are induced. In another case the hysteric nurses a near relative suffering from some form of paralysis. At the appropriate moment the hysterical individual herself presents a similar paralysis. A spoilt child finds that by means of screaming tantrums she is able to get her own way. In later life and under the same sort of circumstances she may have an hysterical fit. The fit has been induced by the childhood experience, viz., that by this form of behaviour a personal advantage is to be obtained.

All schools of psychotherapy agree that hysterical patients are among their most hopeful cases, and the paraphrenics, on the whole, the most resistent to treatment. Whatever the particular creed of the psychotherapist, it is, explicitly or implicitly, his ultimate aim to persuade his patient to believe that he will gain more for himself from society if he renounces his symptoms and accepts the life-pattern as put forward by that particular school of thought. Putting aside the objective validity or not of one or another method of treatment, it is patent that the enthusiastic adherent is more likely to induce a

fervent disciple in the suggestible hysteric than he is in the resistent paraphrenic. For, as we have already seen, the paraphrenic himself is also a potential leader and as anxious as the therapist to make converts.

It is our opinion that for the rare condition of *folie à deux* to occur a number of contingencies must be available at one and the same time.

First there is the inducer ; a paraphrenic holding a delusional scheme which he is anxious to induce. It is essential that he should still be at the resilient stage ; that is, he must not have come in for so much hostile criticism as to have resulted in total withdrawal into himself. Again, his delusional system must not be of so personal a nature and inelastic as to present no pragmatic solution for the personal problems of another individual.

Secondly, there must be in close proximity, usually for a number of years, a highly suggestible individual of the hysterical type, capable of taking over the delusion. It is also essential that the ideas which the inducer wishes to propagate should be acceptable to the life-line and wish-fulfilments of the person to be induced. These ideas must represent a pragmatic advantage for him as well.

Thirdly, as has been generally agreed among writers on *folie à deux*, the inducer, in some way or another, must represent authority.

Lastly, we have noted, as an empirical fact, that extreme poverty is the ground upon which *folie à deux* flourishes. This is true of our own two cases and also for the vast majority of the cases in the literature. This is hardly surprising. Economic distress is a most potent reason for causing dissatisfaction with reality. Any belief that brings a real or imagined alleviation will all the more readily be accepted. Where two or more persons are suffering extreme poverty they already have a strong bond in common—they are brothers in distress. It is a matter of common knowledge that new creeds and religions have often found their most ardent supporters among the poverty-stricken and oppressed. Christianity was first accepted by the slaves of the Roman Empire. Communism and fascism only came into being as a result of the economic chaos in the countries which embraced them. The man whose aims are fulfilled in reality is content to accept the creeds and traditions of his fathers.

Finally, it remains to be seen how far our two examples of *folie à deux* fulfil these requirements.

In the inducer of our first series we have a typical paraphrenic with a fixed delusionary scheme. The fact that she had remained outside a mental hospital for the past ten years suggests that she had not lost contact with her environment. The history also indicates that she was the dominating influence in the household.

Regarding the induced individual, the very fact that he had accepted a part of his wife's delusional system is evidence of increased suggestibility. But, over and above this, we have in this case concrete evidence of the

hysterical character: the history of an hysterical fit occurring shortly after the death of his first wife.

Unfortunately, it was not possible to investigate this case fully. We know that the husband accepted his wife's delusions, at least in part, but his personal gain thereby is a matter for conjecture. It can, for instance, be presumed that as a result of her bizarre ideas his life was made an intolerable burden. We know that she completely dominated him and that he was forced to decontaminate himself by excessive personal ablutions and by washing and boiling his clothes. It can easily be understood that for such a weak personality the line of least resistance would be to justify these irksome duties by accepting his wife's ideas. The inferiority of his present occupation has probably made him more prone to a psychotic reaction. The poverty and squalor of the home surroundings has been stressed in the case history.

Turning now to our second and more fully studied example of the syndrome we find all these points more satisfactorily shown up. The inducer, Mrs. W—, is suffering from paraphrenia and has well-elaborated delusions. She had, at the time of the induction, maintained good contact with her environment, but she had a number of reasons for wishing to escape from reality. She is an undersized, ugly and stupid woman, married to a man, who at best is something between a crank and a criminal. Economically their situation was extremely difficult. The only pleasant thing that had happened to her was her friendship with Mrs. B—. It is just for these reasons that it became essential for Mrs. W— to make her one friend share her point of view and beliefs. The fact that they were pregnant at the same time was an added bond of intimacy. In the induced woman, Mrs. B—, we again find evidence of the hysterical make-up. She is described as being of an excitable and lively disposition but inclined to react to difficulties with somatic conversion mechanisms. She was interested in hypnotism and clairvoyance. Clearly a hypersuggestible if not hysterical character, liable to embrace any fantastic ideas under suitable conditions.

Though the more dominant and slightly better educated of the two women, she is, in two very important particulars, Mrs. B—'s inferior. She is younger and she was pregnant for the first time. Mrs. B— was the wise woman; she had successfully achieved a number of pregnancies. In consequence she had been able to discourse at great length and with gruesome details upon the agonies of childbirth.

The pragmatic factor is clear. The two women had been thrown together. They were both pregnant. They both knew all the misfortunes and discomforts of extreme poverty. The phantasy of Robert Taylor and his benevolent actions was elaborated. He would free them from all their difficulties. They were not, however, completely out of touch with the world of fact. The wish-fulfilment did not take place. Therefore, secondary persecutory ideas had to be brought in in order to explain the failure of their desires.

Since this paper went to press we have had the opportunity of investigating a further example of the syndrome, the relevant features of which are briefly summarized below:

A woman, aged 52, was admitted to Runwell Hospital suffering from paranoia. She was found to have elaborated a system of delusions based upon ideas of references and misinterpretations. She maintained that a school-master had been making advances to her for about five years, but that there was a conspiracy among the old boys of the school to prevent his marrying her. She asserted that she had been subjected to ridicule by innuendo, and that the old boys intended, covertly, to burlesque her love affair at the local carnival. On account of this persecution the patient had entered into a suicide pact with her son. It was following the suicidal attempt that she was admitted to hospital.

Her son, aged 23, believed his mother's delusions implicitly. He admitted, however, that he argued with her regarding the more recent elaborations, and that it had taken some four hours to convince him that suicide was the only way out. He was, except for some of the more recent details, totally devoid of insight.

Further facts of interest to the present thesis can be enumerated. The patient was found to have been a woman of strong personality, who had always dominated her son. The social history made it clear that she had been the inducer. The onset of the psychosis coincided with the climacteric, and with a period of increasing financial embarrassment progressing to complete dependence on her son. The gain through the delusion was therefore a rich husband and restitution to the son, whose prospects she had ruined. Some of the features of the persecutory scheme also suggested that by this means she shifted the blame for her own stupidity in money matters on to her persecutors.

The son was found to be totally dependent on his mother, to have always accepted her view on all personal affairs—for instance the choice of a wife—and to be strongly bound by a positive Œdipus complex. He was considered to be a highly suggestible type, but no overt hysterical symptoms were discovered. There was some evidence to suggest that there was conflict over the Œdipus situation, and that acceptance of his mother's delusion, marriage to a rich man, meant for him a way to freedom.

We have to thank Dr. Ström-Olsen for kindly allowing us to publish these cases.

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