A CASE OF FOLIE A DEUX IN TWIN SISTERS AND ITS TREATMENT IN A DAY HOSPITAL SETTING

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TWIN SISTERS with a rare psychotic disorder known as folie a deux came to our community day hospital. Although the staff was familiar with the treatment of other psychoses, we had not seen this particular shared disorder and the dependency problems which accompanied it before. A special approach had to be devised. We used a thorough consideration of the presenting symptoms and complaints as well as the determined etiology in developing a treatment plan. We decided that a holistic use of our psychological, sociological and biological services was best suited for the treatment of these women and their resulting rapid and successful recovery attested to this. The reader is presented with a brief explanation of folie a deux, some intake information, treatment plan formulation and the actual course of treatment including examples of significant changes which took place in the therapy. This case study is presented not only to permit the reader a view into the clinical features and history of folie a deux but also to suggest a possible model for the rapid and effective management of cases in which this rare disorder is present.

Folie a deux, a rare psychotic condition first described by Lasegue and Falret in 1887, is characterized by a transference and sharing of common behavior and delusional ideations, usually paranoid, between two or more individuals (Freedman and Kaplan, pp. 1151–1153). It is not so rare as to be unobserved, however, and a psychotherapist in private practice may treat several examples of this disorder during his career. Folies of course are seen more commonly in mental hospitals.

Often found between sisters, folies develop usually in families and involve close relatives who tend to live in more or less exclusive contact with one another for long periods of time, although this condition may also surface in any individuals whose similar pathogenicity and close proximity permit the "infectious" association (Haberlaudt, pp. 325–343). In order for a diagnosis of folie a deux to be made, several important conditions must be met:

First, the two members must have had intimate association with one another and, as a result, have a common delusional system. Also, these

members would have to support each other's delusional claims without question, each accepting what the other states as fact. There tends to be one member who is more intelligent or at least more dominant whose core psychosis is the one around which the folie centers but this is not always the case (Freyhan, pp. 191–195).

The epidemiology of folie a deux indicates that it is found more often among the poor, underprivileged and less educated, but there appears to be no limitations to this disease's occurrence culturally or ethically and it is found in all strata of cultures (Soni and Rockley, pp. 230–235). Folies of three major types are described by De Montyl (1959) and are called:

a. Folie simultanee in which common psychotic symptoms erupt at the same time in intimate individuals but appear not to have been induced in one by the other.

b. Folie imposee in which one member, the more dominant seems to induce the symptoms in the more passive member.

c. Folie communique in which hereditary predisposition may play a significant role and in which both members adopt symptoms, specifically paranoid ideations from one another (pp. 18–23).

This paper examines one case of folie a deux (a folie imposee) and its treatment in a day hospital community. The usual course of treatment for folie imposee is the separation of the two members following which the passive partner is a little easier to treat. The dominant member is treated as a case of functional psychosis with medication and other appropriate therapies in an inpatient setting and usually requires a considerable amount of time before management of the psychosis is effective. In our experience, an effective, speedy and integrative outpatient treatment of both members of a folie imposee type of folie a deux was effected utilizing the total program of our day hospital.

Case Report

Joan and Jane (fictitious names) are twin sisters who were referred to the day hospital from our outpatient mental health clinic where they had been sent following a brief hospitalization at the local state hospital. The attractive 21 year old black women arrived at the program with the following complaints: Joan said she was afraid of other people and was terrified of her family in particular. She was moderately anxious, was conceptually disorganized, showed confused thinking, expressed feelings of guilt and evidenced vegetative signs of depression. Walking rigidly, she had other signs of motor retardation. She sat comfortably but occasionally would stand up and walk around nervously. Quite suspicious of the other patients, Joan acted withdrawn and tended to cling physically to Jane,

often holding her hand. Her affect was blunted and she stared straight ahead most of the time, making only infrequent eye contact. Her dress and hair style were similar to Jane's. Except for a small mole above Joan's upper lip and that Jane was slightly heavier, the two girls appeared identical.

Jane was also anxious and even more withdrawn than Joan. She evidenced corresponding elevations in conceptual disorganization, guilt feelings, body rigidity, staring and depression. Jane had active suicidal feelings and reported disturbances of sleep and appetite.

Both complained of feeling stupid, uneducated and worthless. Neither of them had finished high school and Jane as well as Joan felt ashamed of this fact.

Joan acted as spokesperson for the two girls and always referred to herself as "we". There was no effort to be personal or individual and the two hung together throughout the first few sessions.

Both Joan and Jane had just returned from their only mental hospitalization at a local state institution following a psychotic episode with similar symptoms and common delusions. Joan said these symptoms might have been chemically induced by breathing chlorodane used to exterminate roaches in their home. However, in intake, it became clear that the present problem had existed since age 10 when Joan and Jane began to move from house to house in an effort to escape from their father. The father, an alcoholic, had physically abused the children, had raped an older sister of the twins, Marie, and had attempted unsuccessfully at one point to rape Joan and Jane. The family made ten moves in as many years and the twins had difficulty keeping up relationships with friends in new locations and were forced to seek each other out as constant companions.

Family Constellation

The family consisted of: the mother, a talkative, argumentative woman who seemed genuinely concerned about her children though overly protective of them. She was outgoing, of apparently average to above average intelligence and had no history of emotional illness. The mother and the grandmother were responsible for teaching the female children that men were "dirty" and "evil" and couldn't be trusted. Joan attributed much of her reluctance to date men to this persistant message and not to any difficulties which the family had with the father.

The father was described as a "loving, considerate and intelligent man" when not drinking but was vicious, abusive and explosive when intoxicated. During his frequent drunkenness, he would beat up his wife and other children. These beatings were never severe but were frightening to

the entire family. The father used aliases. Frank was his real name, but he also referred to himself as Joseph and Robert. He apparently had quite different personality dimensions accompanying each name and the mother felt that he had a "split personality".

The mother and father divorced one year after his leaving the home. The father was murdered one year ago by an acquaintance at his own birthday party. The family rejoiced at his death at first. Later the twins jointly felt guilty about their initial reaction.

The older sister, Marie, now age 23, was an A student in school but at home exhibited a volatile temper. She had been raped by the father when she was 12. Both twins reported feeling afraid of Marie especially when she was angry with them.

The younger sister, Katy (now age 8) was a "problem child" who did poorly in school and was a discipline problem at home and in school. Joan described Katy as "tempermental and moody."

The youngest child in the family was a brother, Albert (age 7) who was apparently intelligent, a good student and was the mother's favorite. Jane said that Albert was spoiled and Joan concurred that he "always has to have his own way". Joan and Jane liked Albert, Katy on the other hand, was frequently jealous of the attention he received from mother.

Most of the time the family avoided contact with the twins and their lives were for the most part exclusive from the others.

All of the members of the family lived together and were supported on welfare throughout our working with them.

Treatment

Two sessions following the intake interview, a schedule of treatment for each of the women was discussed in staff meeting. In view of the diagnosis of folie a deux and especially folie imposee we decided it was important to:

1. Maintain the medication which they received while at the state hospital in order to reduce accompanying anxiety and reduce psychotic symptoms. Prolixin, 25 mg., B.I.D. and Cogentin, 2 mg., T.I.D. were initially given to both patients. Medications were changed later to reenforce the sense of separateness for the two sisters.

2. Separate the twins as much as possible while at the day hospital through the use of behavioral techniques to keep them from influencing each other's thinking. Specifically:

   a. Hand holding would be discouraged; frequent embracing or holding onto each other would also be interrupted.

b. Sitting next to one another in warm up and wrap up groups would not be allowed.

3. Provide each woman with separate and individual support to aid her in the loss of the other member of the folie a deux and that to achieve this we would:

a. Place each girl in separate therapy groups, art therapy and community living groups. Joan was placed in group A, Jane in B.

b. Assign separate therapists to them. Our occupational therapist worked with Jane and I worked with Joan for 1:1. Our art therapist worked with either one when an assigned therapist was absent.

c. Encourage group support of each girl as an individual and not as a twin.

d. Require that they dress differently and wear different hair-do's so we could easily tell them apart.

e. Encourage different and less psychotic patients to form separate friendships with them. These other patients would nurture development of relationships outside of the folie. A well integrated woman by the name of Wilma was attracted to Joan and an older woman, Gloria, chose to spend time with Jane. (It turned out that Gloria was not a helpful companion because she reminded Jane of her mother. Therefore, another patient, Florence, was approached. She succeeded in developing a close and supportive friendship with Jane.)

4. Identify the more dominant and intelligent member and be aware of her influence on the more submissive. It became clear that Joan was the primary member of the folie. Jane only took over an influential role when Joan showed signs of improvement.

5. Confront delusional material in individual as well as in group and family sessions.

6. Avoid intellectually oriented therapy in view of the rigid and "armored" nature of the patients and use instead: Gestalt therapy to get to emotional material, bioenergetics for establishing renewed contact with the body (Lowen, pp. 43–47) and with surroundings and group psychotherapy and psychodrama for group support and social interaction. Psychodrama was especially productive in aiding Joan in owning delusional projections and undoing retroflected anger (Moreno, 1972, pp. 179–184).

7. Go to the home and organize separate schedules for each sister while outside of the program.

8. Involve the family in the treatment process through family therapy and through the group and their support of the behavioral measures used in the home.

Results and Verbatim of a Psychodrama Session

The maintenance of medication helped to initially reduce anxiety in both women and to moderate psychotic symptoms. However, they both exhibited a few psychotic and depressive signs that continued through most of the early stages of therapy. In group and in psychodrama, both repeatedly confronted key familial figures. Previously retroflected feelings such as anger were released toward the restrictive and domineering grandmother, the mother and various aunts and uncles. Guilt for the father's death was diminished and both sisters returned to premorbid state after only two months.

The schedule of treatment was as follows: 1:1 sessions were provided on an unstructured "need" basis, psychodrama was held for two hours each week, and other groups totalled six hours of therapy group, two hours of family group and 18 hours of other activity therapies per week. Each of them attended most of the groups provided and there was never any resistance evidenced by truancy. When we had family therapy, the mother usually attended and was an active participant throughout treatment. Other family members refused to be involved and were only contacted outside of the program by our social worker. They never interfered (to our knowledge) with the home schedule of treatment.

Several of the group therapy and psychodrama sessions toward the middle of therapy are of particular interest in that some of the key delusional defenses were altered by Joan and both sisters were able to break down a lot of body rigidity. Jane also took one last attempt at suicide in what appeared to be an effort to thwart Joan's therapy, draw attention to herself and preserve the folie. Jane was then facilitated to experience her "death" in fantasy and thereby learn how unwilling she was to die.

In the following psychodrama session, Joan volunteered to participate after a warmup session about fear. She explained that she was "terrified" of her grandmother and that she would like to confront this frightening woman in the role play. Joan had not been chosen for psychodrama before but on this occasion the group selected her. After much gentle preparation and some explanation of what she would be doing and of the purpose of video taping, I asked Joan to select one patient who reminded her of her grandmother. She chose Sandy, a short, dark-haired, very paranoid and intellectually defended woman to play the part. Joan briefed Sandy on how the grandmother acted, gave her some of the grandmother's favorite phrases and instructed Sandy on the attitudinal stance to take during the enactment. A gentle motherly woman played Joan's double (Auxiliary ego) and was instructed to express what she felt was happening inside of Joan, especially at times when Joan was silent (Moreno, 1953, p. 83). Joan

was told that she could say "yes" or "no" to accurate or inaccurate auxiliary ego statements respectively.

The beginning of the session came slowly and with great care taken not to propel Joan into an emotionally overtaxing situation. Other patients, including Jane looked on. After several minutes Joan, hands clutched rigidly in her lap, eyes staring straight ahead and jaw clenched, expressed her fear.

Joan: You want to cut us up in pieces. You want to hurt us (she begins to tremble).

"Grandma": No I don't deary, I love you. I raised you from a little girl.

Joan: You raised us for a while, but you don't love us.

Therapist: Joan. Could you try using *me* instead of *us* to see how that feels . . . to speak for yourself?

Joan: (nods) O.K. . . . I know you don't love me; you want to kill us!

Therapist: Kill *me?*

Joan: (nods) You want to kill me! (She leans forward and wrings her hands. I think "She may want to wring grandma's neck").

Double: I'm so scared right now.

Joan: Yes. (She begins to shake)

Therapist: Can you tell your grandmother how scared you are of her? (I want Joan to stay with the process of her feelings and experience them fully.)

Joan: I'm so scared of you. . . . You showed us pictures of cut up people and you want to cut us up. . . . but I won't let you.

Therapist: Your grandmother wants to cut you up?

Joan: Yes. We just want you to leave us alone. (Here Joan looks glassy. I become aware that when she uses "we", she looks especially dazed.)

Therapist: *I* just want you. . . .

Joan: (Looking suddenly more contactful) I want you to leave *me* alone.

Double: I know you don't really want to hurt me. You're probably a very nice lady. (My guess is that the double is getting scared here of all this talk of "cutting up".)

Joan: No! (She corrects) She does! She wants to rape us. . . . I mean *me* (I nod) and kill me.

"Grandma": Now Joan, you know I love you. I just want to protect you, that's all. It's those men out there that want to hurt you.

Joan: No they don't! . . . It's you!

Therapist: (I want Joan to experience being grandma; to own that part of her that is the internalized version of the grandmother.) Joan, would you mind changing seats with "grandma"? (She does.) What I'd like you to try is for you to *be* grandma now and let Sandy play you, O.K.?

Joan: I think so. Do you mean I'm going to be my granny and I gotta tell Sandy about Joan?

Therapist: That's partly right. What I mean is how about Sandy playing you . . . being "Joan" in that chair.

Joan: (Looking out of contact again) O.K. (Turns toward Sandy and stares, but with her body sitting more erect in the chair.)

Therapist: You look foggy and spacey to me right now. What are you thinking? (She looks at me with a puzzled expression.)

Joan: I'm thinking that I don't want to cut nobody up.

Therapist: So how about saying that to "Joan" over there (Sandy.)

Joan: I don't want to cut you up. But you must not go out with those dirty black men. Black is dirty. They just want to hurt you. (Joan looks even larger in the chair now.)

Therapist: Wait a minute "grandma" (Joan) I'm confused. . . . How come you don't like black men?

Joan: Because I'm white (a gasp goes up in the group. This is the first anybody has heard of this.) . . . and the only good thing about Joan is that she has my blood in her veins. (Turns to Sandy) You are worthless otherwise. You can't read. You can't write worth a damn (her voice becomes stronger, angry, and scathing. Her body becomes more supple). You're no damn good, just like the rest of your worthless family. . . . just like your father! . . . You'll never amount to nuthin'.

Sandy playing Joan: Now grandma. . . . That's not so. . . . (She gets stuck here and doesn't know what to say. I look at Joan. She looks strong and comfortable.)

Therapist: Joan, how does it feel to be grandma?

Joan: (Looking more bright eyed) Scary . . . and kind of . . . I don't know . . . O.K.

Therapist: O.K.?

Joan: Uh . . . Yeah. Like she's real powerful. (I nod and let her sit with the feeling of power for a minute. She remains silent.)

Therapist: Would you mind changing chairs?

Joan: Sure. (Switches again)

Therapist: Do you like the power that granny has?

Joan: Yeah. Not the way she uses it though. She's really mean. She tells me I'm no good . . . Like I feel most of the time.

Therapist: (I think of two things to say. One of them will direct her awareness toward how the grandmother's message of "no good" has become Joan's message. I chose to say the other.) She really "cuts you up" with her words!

Joan: (Leans forward immediately, buries her head in her hands and weeps wrackingly.)

Double: I hurt so much!

Joan: (Nods and cries.)

Therapist: (Moves forward and kneels near her chair.) Joan, if you could let your hurt talk for you, what would it say?

Joan: I'm not sure whether she actually threatened to kill us or not. I don't know. Maybe I made it up. I don't think she did. Maybe I'm crazy. (Looks scared) I'm no good. She's right. I'm no good. (Cries very heavily now.)

Therapist: You *feel* like you're no good!

Joan: Yes. (Sobs heavily, her fists clenched tightly against her head, her body very much alive. After a minute Joan yells down at the floor.) Goddamn it! . . . Goddamn it! I don't want to be no good for the rest of my life. I don't want it no more! . . . Grandma. . . . (She looks up at Sandy in the "grandma" chair) . . . Don't tell me I'm no good.

"Grandma": (Looks at me for a clue)

Therapist: Play it the way Joan did.

"Grandma": You are black, deary . . . And black is dirty! You'll never amount to nothin'.

Joan: (Screams) Stop it! (More heavy crying.) I tried to please you. I did everything you told me to do. You're wrong about me. (She screams out the next lines angrily) You're a bitch. You goddamn bitch. (She begins to foam as she spits out her words.) I hate you. I hate you for what you've done to us. You kept us afraid of everyone all the time. You told us not to trust nobody (Said mockingly) . . . We had nobody but each other. We stayed at home. Had to watch T.V. Never went nowhere. (To me.) We stayed in the house for two years once without coming out.

Therapist: (Nods understandingly.)

Joan: (Back to "Grandma") You are horrible! (Screams) I hate you. (Here her whole body becomes animated. She shakes her fists at "Grandma" and her legs are pushed back under the chair as if to spring.)

Therapist: Are you aware of your hands?

Joan: Yeah. (To "Grandma".) I'd like to punch you out. (There is a short silence during which Joan relaxes back into her chair, and just breathes easily and rapidly. After a while she smiles, winks at me and wipes her face.)

Therapist: Feels good, huh?

Joan: Yeah. . . . (Smiles and blows her nose) . . . Woof, I feel a lot better. (Her face is radiant and her eyes bright.)

The session ran another 45 minutes with Joan enumerating instances where grandma had "cut her up" verbally and instilled a mistrust of men. She occasionally got quite angry and at one point beat on a cushion to demonstrate how intensely she felt. At the end of the session Joan was relaxed, loose and smiling. When asked if she was fearful of her grandmother at that point, she replied, "Nope. She can't screw me up no more." (This use of "screw me" came up frequently in subsequent work that Joan did and later was discovered to be the basis for the projected delusion that the grandmother wanted to rape her.)

While this session did not permanently change Joan's delusions it was the first step in a more effective process.

Jane who was rigidly watching the psychodrama excused herself near the end to go to the ladies' room. She returned to announce that "I just took my pills." She cried and told Joan that she didn't want to hurt her any more and just wanted to die. Of course, Joan became hysterical, blamed herself for Jane's suicidal gesture and they both started for each other, arms outstretched, and professed mutual alliance and unity forever. I got between them and sat them each down at opposite ends of a cafeteria table. I expressed my anger at Jane for this "cheap display of attention getting" and interpreted that she "messed up Joan's work nicely." The group was equally disappointed in Joan's wanting to cling to Jane again and several members took sides to support and/or confront each of the sisters separately. I told Jane that if she wanted attention, she'd have to get it in more appropriate ways and I called the ambulance to take her to our emergency room for gastric lavage. I also told her she could expect a hospitalization for this.

Jane was hospitalized for two days. Joan received support both inside and outside the program from patients and staff. When Jane returned to the program, Joan told her she loved her but did not approve of the suicidal gesture. This was the strongest sign of separation we had seen to date and it proved to be an important turning point. It was interesting that when the dominant member of the folie had made significant progress, the submissive member did not easily improve as might be suggested in the literature (Potash and Brunnell, 1973, 1974). Instead Jane attempted to regenerate the folie, to return Joan to her dominant and psychotic position. I imagine that the eventual dramatic improvement in both members occurred as a result of our not removing Jane entirely from contact with Joan but by allowing Jane to witness some of Joan's significant movements in therapy. This was made possible in the tremendously supportive atmosphere of the milieu setting.

In subsequent therapy sessions both Joan and Jane learned how to "act

black'' and accept their blackness. Joan could joke with staff and patients and referred to us occasionally as ''whitey''.

The milieu group was essential during and between the continuing psychotherapy. It provided peer support and reality testing. It was a place where Joan could check out her imagined unacceptibility and paranoid fear of others. It provided a source of potential friends and some sense of commonality with people with similar though not the same fears.

By the third month both agreed to dress and fix their hair differently. Accompanying this we began to notice changes in facial expressions and details which the sisters had mimicked in each other formerly.

Jane gave up her suicidal thinking by the end of the third month but only after a great deal of catharsis and owning of alienated aspects of her own personality. (Jane had denied that she was angry with anyone prior to this time, for example.) In one Gestalt therapy session Jane was encouraged to imagine herself to have committed suicide and to play dead. As she lay on the floor and was questioned about how it felt to be dead and she was repulsed by the feelings. Insight came when she realized that she was ''already dead'' in a lot of ways and sobbed out her wishes to change things and improve her life (the first sign of investment in *life*.) She soon reclaimed the part of her that was enraged by the stagnation her life had become and afterward showed great progress.

Realistic friendships with other patients developed by 3½ months for Joan, and both volunteered to be apart even during times of the program schedule when we had not restricted them. Paranoid delusions occasionally returned but steadily decreased in intensity and frequency and were extinguished in Jane after 3½ months and in Joan after 4 months.

As time went on Jane expressed a great deal of satisfaction regarding her new found individuality. She even occasionally showed envy or contempt for Joan and was able to say this to her.

In occupational and art therapies, separate talents began to emerge with Joan showing remarkable sketching and painting skills and with Jane demonstrating better abstracting capabilities.

Followups at home by our social worker and consultation with the mother in family group insured that environmental separation and other behavioral restrictions were continued while outside of the program. (As mentioned earlier, the mother attended most sessions of family group. She was also quite cooperative with home behavioral measures and carried out suggested behavior modification techniques without any difficulty or resistance.) In the family groups, Joan and Jane each confronted mother about her attitudes regarding men, sexuality, and achievement. Mother admitted that she often reenforced the things that grandmother said (and had taught her as a child) but that she no longer believed many of

these messages. She also admitted that men could be "good or bad" and that "you have to judge a person by who they are" and not act on prejudice. The daughters both expressed relief at hearing the mother's new attitudes and negotiated dating schedules with her. (Joan developed a close relationship with Ted, a white patient at the program and mother was able to approve the dating. She expressed some initial fears about Joan's dating but subsequently accepted it. This was an especially important area of reparenting for Joan and it gave her a great deal of confidence about herself as a person and acceptance of herself as a woman.) The mother also worked through her own guilt feelings for not "raising the children properly"; she was eventually able to accept how difficult her role of mother was when the father was alive. Joan and Jane grew much closer to mother in the therapy but not in any unhealthy dependent way. Joan left therapy on the 7th month and Jane left a week later. At the time of discharge they both reported no depressive feelings, no hallucinations or delusions, nor did they evidence any sign of the folie a deux with which they came to us. Both were optimistic about the future and had separate plans. At the present time (8 months post discharge) Joan, who already completed a remedial literacy program, is attending a technical school for computer operation and Jane is taking courses to improve her reading capabilities and gain general knowledge of other adult education subjects. Joan and Jane both have other friends. Joan is still dating. Jane has not yet begun to date but she expresses an interest. Jane is also working part time and does not indicate any interest in pursuing her sister's goals. There is no evidence of depression or psychosis in either women at the time of the writing of this case study.

Both women overcame psychosis and depression, became brighter, optimistic, more alert, better focused and without any indication of the original unhealthy dependency after a total of only 7 months of outpatient milieu therapy and both women are presently off of all medication.

It is my guess that the speed with which this case was treated was at least in part if not greatly due to the holistic nature of milieu therapy. Support from other patients, a chance for new friendships, emotion evoking therapy and creative activities and therapies have all been instrumental in undoing the pathology which maintained this folie a deux of over 10 years duration.

REFERENCES

"*Beitrag zum Problem des Induzerten Irreseins*", Psych., Neur., Med., Psych., Leipzig, 1959 (Jan), 11: 18–23.

Blodgett, A. C., "*Folie a Deux: A case report with some comments on treatment difficulties*", Psychiatric Opinion 1974 (April), 11 (2), 37–42.

Craike, W. H.; Slater, E., *"Folie a Deux in Univular Twins Reared Apart"*, Brain, 1945, 68: 213–221.

Evans, Philip; Merskey, Harold, *"Shared Beliefs of Dermal Parasitosis: Folie Partagee"*, British Journal of Medical Psychology, 1972 (March), 45 (1), 19–29.

Freedman, Alfred; Kaplan, Helen, *Comprehensive Textbook of Psychiatry*, Baltimore, Williams and Wilkins Company, 1967, pp. 1151–1153.

Freyhan, Fritz A., *"Folie a deux—A Clinical Contribution"*, Delaware State Medical Journal, 1952, 24: 191–195.

Harberlandt, W. F. *"Contribution to the study of 'Folie a Deux' "*, Psyche, 1950, 5:325–343.

Lowen, Alexander, *The Betrayal of the Body*, Collier Books, New York, 1967, 43–47.

Moreno, J. L., *Psychodrama*, Beacon House, Inc., Beacon, N.Y., 1972, 179–184.

Moreno, J. L., *Who Shall Survive*, Beacon House, Inc., Beacon, N.Y., 1953, 83.

Potash, Herbert; Brunnell, Lillian, *"Folie a Deux: Some Further Considerations: A Report on Three Cases"*, Proceedings of the 81st Annual Convention of the American Psychological Association, Montreal, Canada, 1973, 8: 509–510.

Potash, Herbert; Brunnell, Lillian, *"Multiple-Conjoint Psychotherapy with Folie a Deux"*, Psychotherapy: Theory, Research and Practice, 1974 (Fall), 11 (3): 270–276.

Scharfetter, Christian, *"Studies of Heredity in Symbiotic Psychoses"*, International Journal of Mental Health, 1972 (Spring), 1: 112–123.

Soni, S. D.; Rockley, G. J., *"Socio-Clinical Substrates of Folie a Deux"*, British Journal of Psychiatry, 1974 (Sept), 25: 230–235.

Spensley, James, *"Folie a Deux with Methylphenidate Psychosis"*, Journal of Nervous and Mental Disease, 1972 (October), 155 (4): 288–290.

Weeks, Ruth B.; Kelly, Cretchen L., *"Folie a Deux or Not a Deux"*, Child Psychiatry and Human Development, 1975 (Spring), 5 (3): 131–141.

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