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Correspondence

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SOCIO-CLINICAL SUBSTRATES OF FOLIE À DEUX

DEAR SIR,

I read with interest the paper by Drs. Soni and Rockley in the September 1974 *Journal* (**125**, 230–5).

In three of their case reports (and possibly in case 7 also) there was no active treatment of the associate other than separation. These three cases (4, 5 and 6) and case 7, which presumably needed no active treatment, could all be considered 'folie imposée'. Similarly, the two persons considered 'folie imposée' in a recent Australian report (Goldney, 1972) also needed no active treatment. This is in marked contrast to Layman and Cohen's (1957) observation that 'dropping of the delusion appears to be an extremely rare occurrence'. Layman and Cohen do not comment on the particular subgroups of folie à deux, and unfortunately most case reports omit this also. It would seem that recovery without active treatment after separation may not be as uncommon as Layman and Cohen suggest, but that it only occurs in the subgroup of 'folie imposée'. This is implied by Drs. Soni and Rockley.

It would appear, then, that the prognosis for the subgroup folie imposée is much more favourable. It is also possible that though the literature does not seem to support the popularly held belief that separation causes a remission in the associate's symptoms this may be an artefact of the less dramatic examples of folie imposée being less often reported because of their prompt remission.

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FACT AND FICTION IN THE CARE OF THE MENTALLY HANDICAPPED

DEAR SIR,

I find myself confused by Dr. Shapiro's proposition on the role of the doctor in the care of the mentally handicapped (*Journal*, September 1974, **125**, 286). Is he talking about the 'psychiatry of mental handicap' (and its 'total psychiatric management'), or the 'role of the co-ordinator', or 'mental handicap specialization'? All these are quoted, apparently interchangeably, but they mean significantly different things. Sir George Godber's main proposal (*Journal*, December 1973, **123**, 617) was that 'we ought to look again at the role of the *doctor* in the care of the mentally handicapped'. Although Dr. Shapiro's article presents some interesting historical examples in the development of the services, it does not, in my view, convincingly meet this challenge. It is not enough to argue that 'the management of total life patterns of patients' is medicine; this evades the issue as to the criteria under which a mentally retarded person should assume the role of 'patient'. Whilst it is true that, perhaps because of default of other services, some doctors and nurses (not necessarily from psychiatry) have become involved in the problems of the mentally handicapped in the past, it does not follow that their training or discipline are necessarily the most appropriate for them to undertake the major contribution to the present-day task. We still lack precise definition of the *medical* skills, attitudes and specialized knowledge that are specifically related to the mentally handicapped; if we confined ourselves to a consideration of the psychiatric needs of these persons we might more effectively ward off the 'coup de grâce to medical involvement' which Dr. Shapiro apparently fears.

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