CASE REPORT

"Folie Á Deux": A Delusion Shared by Two

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Abstract

Folie a deux, or shared psychotic disorders, is an unusual psychiatric disorder in which delusional beliefs are transferred from one individual to one or more other susceptible persons in close connection. To date, it remains a rare, yet challenging psychiatric diagnosis. Here, we present a case report and discussion of folie a deux, involving two sisters.

Keywords: Induced, Inducer, Separation, Shared psychotic disorder, Two sisters.

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Introduction

"Folie A Deux", also known as shared psychotic disorder, is a rare psychiatric disorder, first described in 1887 by Lasègue and Falret[1] and later divided in 1942 by Gralnick into four subgroups. The disease now includes the following divisions: Folie Imposee, Folie Simultanee, Folie Communiquee, and Folie Induit.[2]

The condition can be characterized as a transfer of delusional beliefs from one person, the primary patient, to another, the secondary patient.[3] The primary patient is known as the "dominant", "inducer", or "principal partner", and the secondary patient is known as the "submissive partner", "induced", or "associate", who is affected by the primary patient.[4] The condition exists mostly in families, often between spouses, as well as between two siblings.

The usual age of onset of illness in both primary and secondary patients is in the adult age-group,[5,6] but may affect any age of the population.[7] The review of the literature revealed only 17 cases of "Folie a deux" in the geriatric population aged 65 and older.[8] The disorder is more prevalent in females than in males in both primary and secondary patients.[4,5,9]

Primary patients are usually seen to be more intelligent, older, and dominant, while secondary patients are generally younger, less intelligent, sensitive, and dependent.[3,10] A review of the literature revealed that the most frequently diagnosed psychiatric illnesses in the primary were delusional disorders and schizophrenia.[5] Characteristically, the secondary patient, rather than a shared psychotic disorder, has no other psychiatric diagnosis.

As per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), the diagnosis of shared psychotic disorder is made if "a delusion develops in a person in the context of a close relationship with another person(s), who has an already established delusion, identical in content, not better explained by another psychiatric/medical/substance induced disorder".[11] The International Classification of Diseases-10 (ICD-10) listed it as induced delusional disorder.[12] However, in the latest edition, DSM-5, it was moved under other specified schizophrenia spectrum and other psychotic disorders.[13]

Case Description

Patient "A", a 30-year-old unmarried female, who was educated up to BA 2nd year, residing at Tonk, Rajasthan, was admitted to the Female Medicine Ward of Mahatma Gandhi Hospital for decreased food intake, and extreme weakness. On Initial assessment, her blood pressure was 90/50 mm Hg, pulse rate was 110 beats per minute, and was afebrile. CBC, LFT, RFT, RBS, S.TSH, ECG, and X-ray chest P-A view were done, which revealed Hb = 8.9 g/dL as the only significant finding for which she was given oral IFA supplementation. She was referred to the psychiatry department after a complete medical evaluation and stabilization regarding her presenting complaints.

She was referred to the psychiatry department in view of refusal to eat and highly agitated behavior. Patient "A" was brought to the hospital by her father "Mr AK". Her younger sister, "B" who also accompanied her, was blaming their father for forceful psychiatric consultation of patient A and was not leaving her side even for a minute.

On inquiring about their father, he said that patient "A" had started developing her psychiatric illness at the age of 24. At the onset, the patient's father observed a shift in the context of fear that her father is plotting against her and wants to harm her. It was initially mild in severity, as she would be convinced for a few days whenever her father tried to explain that he was her well-wisher and not anyone who would harm her.

Gradually, the suspiciousness progressed into a false, fixed, and unshakable belief of persecution against her father. Secondary to this suspiciousness she started experiencing trouble in sleep and altered food habits including skipping meals whenever food was given to her by the father. The patient, "A" was taken to a psychiatrist and was diagnosed with paranoid schizophrenia as informed by her father. The patient had poor compliance with the treatment.

About 4 years after the onset of patient A's illness, her mother died due to cardiac arrest as per the informant and since then

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her symptoms worsened. During this period, patient, "B", i.e., the younger sister, a 23-year-old unmarried girl started taking care of patient, "A". Patient, "B" who was academically poor, introvert, and submissive started spending most of her time with patient "A" confined to their house and was very obedient toward her elder sister. She was told not to socialize with anyone outside the house.

The younger sister, i.e., patient "B" started following every command that patient A gave her. She also stopped going to college and spent all day with her sister. Not only that, but she also started believing, just like her elder sister, that their father would harm them and was the sole reason for their mother's death. The younger sister who previously was very polite, loving, and caring but now started threatening their father to leave the house whenever he visited the house since his father resided in another town due to his job. Initially, he was not able to recognize that the younger sister also needed medical attention.

One day the college authority had informed the father about the absence of "B" in the college for long time. The family members found them at home in shabby clothes and were in starvation. That is when the father brought them to the hospital for decreased food intake and extreme weakness. On psychiatry reference, it was revealed that the duo started fasting on most of the days, with the belief that it is the only way through which their mother might get "a place in heaven" and have barely eaten for 1 month.

NCCT head of the patient "A" shows no significant brain parenchymal abnormality. Initially, patient "A" was given Tab. Risperidone 1 mg twice a day with Tab. Trihexyphenidyl 2 mg once a day, and Tab. Clonazepam 0.5 mg at bedtime. Since the younger sister of the primary patient was accompanying the patient, it was advised to the attendant, i.e., the father, to separate the two sisters for a few weeks to improve the condition of both the patient.

As per our advice younger sister, "B" was sent to her uncle's home and was referred to a psychiatrist in their city. No psychotropic medication was given to the younger sister. She was asked for a follow-up after 7 days.

On the 3rd day of admission, doses of T. Risperidone have increased to 2 mg twice a day and T. Trihexyphenidyl 2 mg twice a day. After 5 days of inpatient care, the attendant reported around 30 to 40% of improvement in the suspiciousness of patient "A". She started taking food, appetite, and her sleep disturbance also showed considerable improvement. She was discharged on request on day 5th of inpatient care and was prescribed the same treatment for another 7 days with the advice of weekly follow-ups.

Patient "B" reported with her uncle after 7 days of separation with around 40–50% improvement in her suspiciousness. Insight-oriented psychotherapy was given to her. By the 3rd week, patient "B" developed complete insight and realized that her belief toward her father was false. She also re-joined her academics and carried out her normal daily life routine. Patient "A" also showed 70–80% improvement in the form of suspiciousness, agitation, appetite, and sleep disturbance. It was advised to keep them separately for another 1 month.

Discussion

There is limited research on the incidence and prevalence of folie a deux, precisely because patients may not seek treatment as they do not recognize their symptoms as untrue.[9] Wehmeier et al. in their review reports 1.7–2.6% of psychiatric hospital admissions of folie a deux. It is, however, difficult to determine the true population prevalence, as underreporting and underdiagnosis are likely to be significant.[14]

In this case, it is clear that the sister "A" was the inducer as she had a prolonged psychotic illness, and the sister "B" was the induced one, who was over-dependent, insecure, and seclusive. As seen in this case, much of the thought content in patients with folie a deux consists of persecutory delusions.

According to Lazarus, certain factors are necessary for the development of "folie a deux", such as an intimate emotional bond between primary and secondary and genetic susceptibility to psychosis, such as a blood relation with the primary patient.[15] The social isolation of the sister "A" with "B" for months may have influenced the development of her shared paranoid psychosis. On maintaining distance between two, the symptoms of sister "A" decreased in intensity and symptoms disappeared in sister "B" without any psychotropic drugs. In this case, shared environmental factors appear more influential than genetics.

A patient of folie a deux may have a complaint that may be entirely unrelated to his/her psychiatric disorder. The diagnosis can be possible only after a thorough history and examination as was also mentioned in this case scenario.

The duo presented here meets the criteria for diagnosis, given by Dewhurst and Todd, ICD-10 and DSM-IV-TR, for folie a deux. This pair fits in the category of folie impose's, as described by Lasegue and Falret. According to the DSM-V, the pair matches the criteria of delusional disorder. Our case report is in concordance with the explanation of the "folie imposee" given by Gralnick in 1942.[2]

Conclusion

Recognition and proper referral are of utmost importance, as with any rare disease. With prompt action and systematic follow-up, Folie a deux has a remarkable prognosis. Thus, recognizing the psychodynamics of the disorder and preparing for long-term management is crucial for psychiatrists. In this case, the significance of separation, in recovery is clearly illustrated.

There is a possibility of hereditary transfer of psychotic disorders among two sisters. Ultimately, it is recommended that further gene transmission studies should be considered.

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