

Folie á Deux Between Two Unrelated Individuals

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Abstract

Folie à deux is a rare condition characterized by transmission of delusions from a primary patient to another individual, usually a blood relative or spouse, while living in relative isolation. We report a case of *folie à deux*, which resembled *folie communiquée*, in a 37-year-old man that acquired it from an older woman (primary patient). Although not related by blood, the patient was emotionally very close to the woman and they shared common features, including grandiose delusions about the supernatural powers of the primary patient and persecutory delusions concerning office colleagues, as the woman had, and then neighbors, fellow villagers, and even family members. Behavioral changes were observed in the secondary patient as he started wearing strange clothing and peculiar ornaments, and neglected his personal hygiene. He also started following the same rituals and routines as the primary patient, and changed his religious practices, which he had followed devoutly since adolescence. He began seeking her opinion concerning almost all decisions he had to make, including personal and professional matters. Yet, unlike the usual clinical picture, they did not live in social isolation; rather, they lived in an apartment in a well-known residential area of the city and he regularly worked at his office until the late stage of illness. Premorbidly, there were no features suggestive of dependency or low intelligence in the secondary case. After separation from the primary case, improvement was observed about 7 weeks after beginning risperidone treatment (6 mg/day).

Key Words: *Folie à deux*; *Folie communiquée*; Delusion; Shared psychotic disorder

INTRODUCTION

Folie à deux is an interesting and rare condition, first described by Lasague and Falret (1964), in which mental symptoms, usually but not invariably delusions, are transmitted from one psychiatrically ill person (primary patient) to another individual (secondary patient) who considers the delusions real. Criteria for the diagnosis of *folie à deux* was proposed by Dewhurst and Todd (1956) as follows: 1) The persons should be closely associated; 2) The content of delusions of the 2 individuals should be identical or very similar; 3) The persons should accept, share, and support each other's delusions. In current nosological systems they are diagnosed as induced delusional disorder (WHO 1992) or shared psychotic disorder (APA 2000).

Gralnick (1942) suggested 4 subtypes of *folie à deux*: 1) *Folie imposée*, the classical form in which an individual preoccupied with a false belief transmits it to another impressionable person; 2) *Folie simultanée*, in which there is the simultaneous appearance of identical psychosis in 2 predisposed people than have been closely associated with each other for a long time; 3) *Folie communiquée*, in which a transfer of delusion occurs after a long period of resistance by the secondary individual who then develops independent delusions of his own; 4) *Folie induite*, in which the patient suffers from a primary psychotic illness and new delusions are added under the influence of another deluded patient. The first 2 types are thought to be the primary types and the last 2 types are considered variations of *folie imposée* (Munro, 1998).

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It was reported that adults under stress often succumb to serious regression if there has been any disturbance in the separation-individuation process during childhood. This regression results in psychotic identification with the inductor (Mentjox et al., 1993).

We report a case of folie à deux, which resembled the folie communiquée subtype described by Gralnick (1942), in a man that acquired it from an unrelated older woman. Detailed psychological and other relevant investigations were conducted. There was improvement in his psychotic symptoms after separation from the woman and antipsychotic treatment.

CASE REPORT

Mr. A, a 37-year-old single male, was working as an accounts officer in a central government institute when he met an older woman (in her seventies) living on the street. She was a known figure in the area and was educated, but lost her job under dubious circumstances more than 25 earlier. Following unsuccessful attempts to sustain herself she was forced to live on the street and had very poor personal hygiene. Mr. A, out of sympathy, had her stay with him and his family (his mother, younger brother, sister, and a cousin) in his apartment. He ignored his family's persistent requests to return her to the street. The woman stayed with Mr. A. for more than two-and-half years; then he was brought in for psychiatric consultation.

Description of the Primary Patient

The woman had a disheveled appearance. Her hair was matted and she wore a shabby dress, several rings and beaded garlands, and arm and waistbands. She would wear the same dress for 7 consecutive days and bathe in extremely hot water once every 3 weeks, even during the summer. She would wander out at night, collecting discarded flowers from drains, pieces of plastic, and broken pieces of tiles, which she would bring home and wash carefully. She would use the collected items in worship, in gross violation of religious norms. She regularly followed some rituals. Whenever she went out she would carry a bottle of water and sprinkle water on almost every object she passed. She would mutter and smile to herself and claim that she talked with gods and fought with evil spirits. At times she'd scream as if she'd been attacked. She'd worship before images of Hindu gods, and a number of pictures of symbols and monuments not known to be used for worship. After worshipping she would wash the walls of the entire room with soap

and water all night and then sleep during the day. Mr. A. considered the behavior of the older woman abnormal and consulted a psychiatrist who diagnosed her with schizophrenia. Although medications were prescribed for the woman, Mr. A. could not ensure medication compliance when she resisted.

Pre-Morbid Personality and Adjustment of the Secondary Patient

Premorbidly he was a social and benevolent person. His life centered mainly on his family and relatives, and he did not have too many friends outside of this circle. He voluntarily assumed financial responsibility for many of his relatives, in terms of education, marriage, and other issues, providing emotional support to them when required. He was, therefore, much loved by his family and friends. In his leisure time he was fond of reading books on spirituality and religious matters. He was careful in handling his belongings (e.g. books) and valued them quite highly, but he was always happy to share them if someone asked. He was equally committed to maintaining a proper dwelling wherever he lived and was hospitable to his guests and relatives. He deeply valued the ideas provided by religious leaders and saints, and sought their advice on various personal issues, including when and whom he should marry. Later, when he was in a romantic relationship with a woman his age, he was caring and friendly with her, and both were interested in getting married. Yet, he brought his fiancé to a saint for approval of their plan to marry. He got the saint's approval, but the marriage did not occur because his father opposed it. At home and at his office, however, he was quite capable of making his own decisions. At his office he had a reputation for being reliable, sincere, and responsible, and had good and stable relationships with his colleagues and superiors. He never had habit of taking any substance of abuse.

Past and Family History

One of his paternal cousins had a single depressive episode; however, the patient's past history was unremarkable. The family boundaries were open and clearly defined, with appropriate permeability. His paternal grandfather was the nominal head of the family, though his father and paternal uncle were the functional heads. Decision making in the family was democratic. There was an adequate role structure and functioning, and communication was direct, clear, and verbal. A healthy cohesiveness was there among all family members along with adequate reinforcement and adaptive pattern.

Course of Illness in the Secondary Patient

Within 2-3 months of contact with the woman (primary patient) behavioral changes were observed in the patient. He began accompanying the older woman at night when she wandered out, carrying the water bottle for her. He started collecting garbage with her and washed it at home. He stopped worshipping in his usual way, instead worshipping with the women before her collection of pictures. He would wash the walls with her after worshipping. He started to bathe only once every 3 weeks in extremely hot water, just like the woman. He grew his hair long, which became shabby and matted due to lack of grooming. He wore rings, necklaces, and arm and waistbands like the old woman did, and dressed like she did, changing his clothes only once a week. He would call her 'mother' and tell people that she was a goddess with supernatural powers. He claimed that she had saved him from evil forces on several occasions. He alleged that the people from his native village, more than a thousand miles away, were performing black magic to harm him. He would shout abuses directed at the voices that he heard. This persecutory belief about the villagers later involved many other people. When his family members came to visit he would not allow them to interact with his neighbors, saying they were 'wicked people'. He would eavesdrop on his neighbor's when he heard them talking. Even when his family members talked among themselves he'd ask them what they were talking about. He refused to eat food served by his mother and would eat it only after the old woman approved it. He said that just like the colleagues of the old woman had done when she was working, his office colleagues were plotting against him and trying to make him lose his job. This suspiciousness of his office staff persisted and, in fact, increased when he was transferred to a city in a different part of the country.

Gradually, his reliance on the woman increased for practically every issue, personal and professional. He sought her advice before making any decision or commitment. He took her to his office and asked for her approval before signing any papers, making his work slow and erratic. In the office he didn't object when the woman performed her ritual of sprinkling water on everything around her, which damaged many costly electronic devices. He cancelled his engagement on her advice and did not accept any further proposals for marriage from others because the woman never allowed him to. He distanced himself from his family and their relationship deteriorated, as they never liked the woman and the role she was playing in his life. He began to live with

the older woman alone and took her with him when he was transferred to a new city for work. He didn't allow his family members into his home after they had traveled all the way from his native village.

When brought for consultation on a hot day he was wearing a long overcoat and his long hair was matted; his beard and nails were also long. He was diagnosed with shared psychotic disorder, according to DSM-IV-TR (APA 2000), and was admitted to hospital. Baseline investigations, including complete blood count, and liver and renal function tests were normal; qEEG revealed no definite evidence of abnormality.

Psychometric Evaluation

Detailed psychometric evaluation, including the Rorschach ink-blot test, Thematic Apperception Test, Sack's Sentence Completion Test, Minnesota Multiphasic Personality Inventory, Part 2 (MMPI 2), and International Personality Disorder Examination (IPDE) showed that he was quite defensive and that he tried to make a favorable impression. His reality testing was impaired, with conceptual distortion. He showed excessive internalization of feeling, had unmet need states, and was emotionally deprived. The tests also revealed conflict with his parents and showed that he was under chronic overload of emotional stress, which possibly had resulted in disorganization. He was impulsive and self-deprecating; however, no formal thought disorder or personality disorder was diagnosed.

Dynamic Formulation

Being the second of 6 children Mr. A. did not receive as much respect and autonomy as his eldest brother did, nor as much affection as his younger siblings did. As such, his sense of self did not fully form. To compensate he became an overly responsible person who looked after almost everybody. In the process he got the attention that he must have craved as a child. Later, when he was not allowed to marry his fiancé he experienced it as parental rejection. The old woman entered his life as a source of validation of his ego and fulfilled all of his needs that were not met by his parents.

Management

He was started on risperidone tablets (2 mg per day) and flupenthixol depot injection (20 mg every 2 weeks) was added due to poor compliance. After the first month of hospitalization his disorganization abated, but persecutory delusions persisted. Initially, he did not consider

his or the older woman's behaviors as abnormal. Subsequently, risperidone was gradually increased to 6 mg per day. After another 3 weeks in the hospital he agreed that the old woman had a mental illness that required treatment. His initial score on the 18-item Brief Psychiatric Rating Scale was 31 and following 7 weeks of intervention his score was 13.

DISCUSSION

Folie à deux reflects the outcome of a pathological relationship between 2 people living in relative social isolation before sharing symptoms. They are usually blood related or spouses, with the majority of cases being reported between sisters, followed by husbands and wives (Enoch and Ball, 2004). Secondary patients often have mental retardation (Ghaziuddin, 1991) or dependent personality disorder (Petrikis et al., 2003), and have been reported to be transmitted by a third person that acted as a healthy precipitator (Salganik et al., 2006). Although not related by blood, the present case was emotionally very close to the older woman. They shared common delusions and supported each other's ideas and behaviors, thus fulfilling the criteria for folie à deux, as proposed by Dewhurst and Todd (1956). But, unlike the usual clinical picture, they did not live in social isolation and there were no features suggestive of dependency or low intelligence in the secondary case.

At home Mr. A. never had autonomy or power, especially in terms of important decision-making issues. His father's presence had always been overpowering and his mother played a very submissive role in the family. Therefore, instead of affection and succor, which he craved, there were strict rules and enforced discipline. A stable sense of self never formed and it was weakened even further when his wish to get married was denied by his father. These conflicts with his parents and his emotional deprivation, which were confirmed during his psychometric evaluation, might have played a role in his emotionally close relationship with the older woman.

Shared delusions include convictions of persecution (Kendler et al., 1986), delusional parasitosis (Gieler and Knoll, 1990), belief in having a child that does not exist, misidentification of the Capgras type (Hart and McClure, 1989), etc. Apart from delusion, hallucination can also be induced, though rarely, and it does not negate the diagnosis of induced delusional disorder (WHO, 1992). Primary patients are frequently diagnosed with schizophrenia, delusional disorder, severe depressive illness with delusions, or early dementia. Some are diagnosed

with non-psychotic conditions, such as obsessive-compulsive disorder, somatoform disorder, and dissociative disorder (Munro, 1998). In our patient behavioral changes (e.g. collecting garbage, odd rituals, wearing peculiar clothing) were the initial manifestations of the shared psychopathology. He believed in the older woman's special abilities, and thought that she was a goddess and was protecting him from evil forces. Apart from this grandiose delusion, which was common to them both, our patient also believed that the old woman was being persecuted and was convinced of the presence of evil forces acting on his life just as the forces did act on the woman. Later, the delusion of persecution involved his family members as well as office staff. The she shared features were behavioral at the beginning and subsequently included grandiose and persecutory delusions that expanded in context, eventually involving his family members and office staff.

The present case is another example of folie communiquée in which the patient developed delusions similar to the older woman in the initial stage, but later developed independent delusions as well. Illness onset in such patients occurs after a variable period of resistance following initial contact with the primary patient, as was seen in our case. Gradually he began sharing her delusions and adopted her abnormal behaviors through the process of identification (Enoch and Ball, 2004). As previously described, regression is common in stressful situations if the separation-individuation process in childhood was disturbed (Mentjox et al., 1993). Our patient met the primary patient when his marriage plans failed to materialize and when he was transferred to a new city for work. He was also financially supporting many of his cousins and nephews that were living with him and were studying. This emotional and financial impoverishment might have acted as psychological stressors. This type of regression can lead to psychotic identification with the inductor (Mentjox et al., 1993).

Another interesting aspect of this disorder is that most of the dominant or primary cases reported in the literature are females (Gralnick, 1942; Lasegue and Falret, 1964). Among the various explanations of this is the female role of caregiver (Mentjox et al., 1993), as was observed in the presented case in which the patient related to the old woman as a mother figure.

Isolation of the secondary case from the primary case is the accepted mode of treatment for folie à deux (Porter et al., 1993), although the traumatic impact of such separation in the patients has been reported (Sacks, 1988).

Nonetheless, in cases of folie communiquée, unlike folie imposée cases, it is reported that the delusions do not resolve after separation and may require antipsychotic medication. Our patient required risperidone (up to 6 mg per day) along with separation and reality contact. This case

report draws attention to the fact that there can be shared psychotic disorders between 2 unrelated individuals when there is underlying psychosocial and dynamic risk factors present, which require detailed exploration in order delineate the psycho-pathogenesis of such cases.

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