Case Report

A Case Report of Folie a Deux: Mother and Daughter

Nikita Dhaka, R. K. Solanki, G. D. Koolwal, Sanjay Gehlot, Surender Kumar
Department of Psychiatry, Dr. S.N. Medical College, Jodhpur, Rajasthan, India

Abstract

Shared paranoid disorders, a relatively rare psychiatric disorder in which paranoid delusions are transferred from one individual to one or more other susceptible person(s) in close association. Folie a deux is characterized by a complex dependent relationship between the involved individuals, yet a challenging diagnosis. In the paradigm of changing nosology, where the term shared/induced psychotic disorder is going obsolete, it is important to recognize such cases due to the potential for recovery in the submissive partner. Here, we present a case report and discussion of folie a deux involving inducer mother and induced daughter. In the clinical case presented, folie á deux was easily diagnosed, but its treatment proved to be a bigger challenge.

Key words: Induced psychosis, primary and secondary case, separation

Introduction

The term "folie a deux," coined by Lasegue and Falret in 1877, also known as shared psychotic disorder, induced delusion disorder, psychosis of association, or double insanity, describes a syndrome in which paranoid delusions are transferred from one individual to one or more other susceptible person(s).[1] Cases of induced psychosis have been reported dating back to 1563.

There are four types of folie a deux: (1) Folie impose'e; (2) folic simultane'e; (3) folie communique'e; and (4) folie induite.[2] Folie impose'e is the most common form of folie a deux, in which the primary case is typically dominant and forceful. The secondary case is usually dependent and highly suggestible. Folie simultane'e describes the simultaneous appearance of identical psychoses in two predisposed persons who have had a long, intimate association. Folie communique'e involves the transfer of psychotic delusions after a long period of resistance. In folie induite, new delusions are added to old ones under the influence of another deluded patient.

Dewhurst and Todd set forth three diagnostic criteria for folie a deux: (1) There must be a marked similarity between the delusional content of the partners' psychosis, (2) the partners must accept, support, and share each other's delusional ideas, and (3) there must be positive evidence that the partners have been intimately associated over a long period of time.[3]

Access this article online

Quick Response Code:

Website: www.jmhhb.org

DOI: 10.4103/0971-8990.182099

According to 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 an individual in the context of a close relationship with another person(s), who has an already-established delusion, similar in content, not better accounted for by another psychiatric/medical/substance-induced disorder."[4]Induced delusional disorder is the term used in the International Classification of Diseases-10 (ICD-10) for the same.[5] DSM-5 and ICD-11 (draft) no longer separate delusional disorder from shared delusional disorder.[6,7] If criteria are met for delusional disorder, then same diagnosis is made. If the diagnosis cannot be made, but shared beliefs are present, then the diagnosis "other specified schizophrenia spectrum and other psychotic disorder" is used.

Case Report

The mother "A," a 45-year-old divorced female, came to our attention when she was admitted in psychiatry hospital. "A" was brought to hospital by her sisters, brothers, and nephews.

Address for correspondence: Dr. Nikita Dhaka, Department of Psychiatry, Dr. S.N. Medical College, Jodhpur, Rajasthan, India.
E-Mail: nikitadhaka08@yahoo.com

How to cite this article: Dhaka N, Solanki RK, Koolwal GD, Gehlot S, Kumar S. A case report of folie a deux: Mother and daughter. J Mental Health Hum Behav 2016;21:66-8.

Her daughter "B" also came with her mother, both were blaming their relatives for forceful psychiatric consultation and not leaving each other's side, even for a minute.

As per the given information and documents shown by relatives, "A" had her first episode of psychotic illness at the age of 20. At the onset, "A" held delusions of persecution against her sisters and believed the reason was her beauty, the sisters were jealous of (as stated by informant, her sisters). Meanwhile, "A" took treatment on and off from a psychiatrist and was diagnosed with paranoid schizophrenia for past 12 years. Electro-convulsive therapy was also given, although complete documentation was not available. "A," married at the age of 25, had divorce at 28 (reason as per informants were frequent quarrels). Since then, "A" is living with her daughter "B" at her mother's home. "A," since her separation from her husband, believes that there is a man "X" (who actually helped as an inter-mediator in solving the divorce terms between the couple, but never saw her again) in her ex-husband's city who want to marry her and ready to accept her with her daughter "B." She believes that it is her family members, who don't let "X" meet her and that the family members want to declare her mentally ill, so that "X" will not marry her. Six months back, "A" discontinued her treatment and for past 3 months, confided her daughter "B" and herself to home, and threatened her own mother to leave the home. "A" had no contact with any of other family members, since then. She did not even allow her daughter to attend her school, as she thought that the family members may harm her daughter too.

The daughter "B" who is 17-year-old, also held the same belief for past 3 months. According to her, the man named "X" came to her school 3 months back and gave his name as her father's name in school documents (which was actually given by her mother). She also believes that this man came over to her school multiple times in past 1 year, but she could never meet him because of the relatives, who along with her teachers conspired against them and never let them meet. One week back, the duo went to the city, they believed "X" lives in and started searching for him for days. The family members searched for them and found them wandering here and there in shaggy unwashed clothes, no slippers, and not taken proper meal in past 2 days. That is when the family members brought them to psychiatrist for treatment.

Hospital course

At the time of admission, "A" and "B" were very agitated, uncooperative, unkempt, and untidy. A battery of tests were done on the duo to rule out general medical conditions as a potential cause of delusions. In pharmacotherapy, "A" was given clozapine, its dose was titrated till 150 mg divided in bd doses. "B" was given haloperidol 5 mg in tds doses. The duo did not show any improvement in first 2 weeks and refused to meet any of their relatives. So, they were shifted to distant beds. In third week, after separation and psychotherapy, their agitation somewhat decreased, but still their delusions were unshaken. After 4 weeks treatment, "A" showed no improvement, but "B" agreed to meet other family members and started believing that her mother may have some psychiatric illness. In 5th week, "B" agreed to give her mother timely medication at home. "A" and "B" both were discharged on their relatives' request, as they wished to continue further treatment from home.

Discussion

While there is no data on the incidence or prevalence of folie a deux, in his 1974 review, Lucian Floru covered at least 245 cases from the psychiatric literature in English, French, and German. Nearly, 90% of all reported cases occur within a family (majority being blood relatives); the most common relationship found between blood relatives is between two sisters and the most common relationship between nonsanguinous relatives is between husband and wife.

The duo presented here fulfills the diagnostic criteria presented by Dewhurst and Todd, ICD-10 and DSM-IV-TR, for folie a deux. This duo fits in the category of folie impose's, as described by Lasegue and Falret. According to the latest nosological classification, DSM-V, the duo fits in the criteria of delusional disorder, so a diagnosis of "delusional disorder" will be made for both mother and daughter.

In nearly all of the reported cases, the dominant partner is diagnosed as either schizophrenic or paraphrenic with the submissive partner having a schizophrenic/paraphrenic disorder, or having a personality disorder, dementia, or mental retardation.[8-10] In this case, it is clear that the mother was the inducer as she had a prolonged psychotic illness and the daughter was the induced one, who was over-dependent, insecure, and seclusive. As the daughter never had any contact with his father and had her mother as only parent, the social isolation of the daughter with her mother for months may have influenced the development of her shared paranoid psychosis. On maintaining distance from mother, the symptoms of daughter decreased in intensity. As with the duo, much of the thought content in patients with folie a deux consists of persecutory delusions; along with the erotomanic delusion of the mother in this case, which her daughter also believed.

The etiology of transmission, whether by chance, genetic factors, environmental factors, and/or some interaction among them, is a matter of speculation.[11,12] The mother spent the greatest amount of time with daughter and exhibited shared delusions faster than the equally related grand-mother, also living with them for years, but spending less time with the mother "A." Thus, shared environmental factors appear more influential than genetics.

The essential therapeutic step in the treatment of folie a deux is separation of the inducer and the induced. Other therapeutic modalities for either the primary or the secondary partners include pharmacotherapy, electroconvulsive therapy, increasing personal autonomy, and/or increasing social interactions.

Conclusion

On first follow-up, the duo came along with relatives and was currently living with them. The mother was not agitated, but was still holding the delusion about Mr. "X" and her family members. The daughter resumed her schooling and was taking good care of herself and her mother.

As with any rare disorder, recognition and correct referral for rare diagnosis such as folie a deux is of paramount importance. Role of separation in recovery is clearly illustrated in this case. Due to this fact, it is important to consider this disorder in the differential diagnosis of psychosis. Enoch stated that when considering the prognosis and treatment, it is important to keep in mind those underlying clinical and social factors which are potent in the production of an environment conducive to the sharing of delusions.[13,14]

The possibility exists for genetic transmission of psychotic illness from mother to the daughter. Hence, it is recommended that further tests for gene transmission should be considered.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

1. Lasègue C, Falret J. La folie à deux. Ann Med Psychol. 1877;18:321-355.
2. Sims A. An introduction to descriptive psychopathology. 2. WB Saunders; Symptoms in the Mind 1995.
3. Dewhurst K, Todd J. The psychosis of a association; folie à deux. J Nerv Ment Dis 1956;124:451-9.
4. American Psychiatric Association. The Diagnostic and Statistical manual of Mental Disorders. 4th ed., text rev. Washington, DC: American Psychiatric Association; 2000.
5. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: World Health Organization; 1992.
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: American Psychiatric Association; 2012-13.
7. Gaebel W, Zielasek J, Cleveland HR. Psychotic disorders in ICD-11. Asian J Psychiatr 2013;6:263-5.
8. Haqqi S, Ali N. Folie a deux: A case report. F1000Res 2012;1:18.
9. Nishihara RM, Nakamura CT. Folie a deux – Husband and wife. Jefferson Journal of Psychiatry 1993;11:43-50.
10. Srivastava A, Borkar HA. Case report – Folie a famille. Indian J Psychiatry 2010;52:69-70.
11. Lazarus A. Folie à deux: Psychosis by association or genetic determinism? Compr Psychiatry 1985;26:129-35.
12. Ohnuma T, Arai H. Genetic or psychogenic? A case study of "Folie à Quatre" including twins. Case Rep Psychiatry 2015;2015:983212.
13. Enoch D, Ball H. Folie a Deux. Uncommon Psychiatric Syndromes. 4th ed. London: Arnold. 2001. p. 179-208.
14. Enoch MD, Trethowan WH. Uncommon Psychiatric Syndromes. 3rd ed. Oxford: Butterworth-Heinemann Ltd.; 1991. p. 184-215.