Folie à deux: case report

Dr Amit Sindhi, ST6 old age psychiatry, Northwest deanery
Dr Catia Freitas, CT3 old age psychiatry, Northwest deanery

Corresponding author: Amit Sindhi (dramitsindhi@yahoo.com)

Introduction
Mr A is a 77 year old married gentleman. He initially presented with symptoms of hypomania with psychosis. However, some of the psychotic symptoms were originally displayed by his wife.

Circumstances of initial presentation
Mr A was assessed in September 2013 in a surgical ward following an urgent repair of an incarcerated right inguinal hernia.

Whilst in the surgical ward he was described as being overfamiliar with staff and patients. He displayed chaotic behaviour and at times was disinhibited. He was writing bizarre notes with unknown symbols which he placed neatly around his bed. There were also reports that Mr A was seen tampering with some of the electrical equipment around his bed. He packed and unpacked his suitcase but never attempted to leave the ward. Mr A believed he was not in a real hospital and that other patients were actors.

On initial assessment of mental state, Mr A was labile in mood, laughing hysterically and then bursting into tears. He sleep and appetite were poor. His speech was pressured and difficult to follow at times. He also had flight of ideas. Mr A talked extensively about his ‘scientific diaries’. He had some suspicious ideas which were difficult to explore and was paranoid about his son’s intentions for further review by a psychiatrist. The differential diagnoses considered were psychosis, hypomania and acute stress reaction. Delirium was unlikely as Mr A had no difficulties on orientation, attention or concentration and there was no evidence of infection.

Mr A’s behaviour remained chaotic and his racing thoughts continued. He refused his prescribed medications and expressed, “I have felt alive for the first time in my life.” He agreed to an old age psychiatric ward admission for further assessment.

Past Psychiatric History
Mr A was not known to mental health services prior to this admission. He did however report that in 1997 he felt high after a brief admission in a general hospital. He states his symptoms resolved in less than a week without any medical treatment.

Sometime in 2003, Mr A attempted suicide by electrocution at home which resulted in minor burns to his hands. He did not seek any medical help.

Family history
Mr A’s son had mentioned that his mother has had some obsessional traits and displayed some odd behaviour for many years but refused any help from her GP or mental health services. There are no other reports of mental illness in the family.
Medical history
Mr A has no chronic medical conditions.

Premorbid personality
Mr A described himself as a quiet and shy person with no particular hobbies or interests other than physics.

Social History
Prior to admission to the surgical ward Mr A was residing in a hotel room for two weeks. Prior to that he was living with his wife.

Mr A met his wife in 1956 and they married in 1961. They have one son. Mr A describes the relationship with his wife as isolative, unpleasant and restrictive. Mr A reported that difficulties in their married life started after his retirement in 2000. Mr and Mrs A seem to have no close friends or relatives. They have little contact with their neighbours.

Mr A has never used illicit drugs or alcohol. He has no financial difficulties.

Mr A reported that his home is in a poor condition. Photographs shown by his son revealed that the furniture was worn and seemed unsafe, with the house in need of renovation.

Collateral history from son
Mr A’s son described him as quiet, intelligent and reserved. According to him, Mr and Mrs A lived an eccentric and reclusive life with very little contact with the outside world.

His son also reported that both he and the rest of the family were alienated and not allowed in the house for many years. After making numerous attempts over years, he was seldom allowed in and when he was, he had to knock on specific windows and doors a numbers of times so that his mother would open the door. He stated that similar happened with the telephone and he had to ring a certain numbers of times before the telephone was answered by Mrs A. He also reported a number of paranoid beliefs which both Mr and Mrs A had about electricity wires outside their family home.

Mr and Mrs A never attended family weddings. They have never visited him. They slept separately with his mother on the floor using a thin old mattress with springs coming through and Mr A slept on two chairs attached to each other by strings.

His parents always had a cold relationship and he has never seen any affection between them.

A few weeks prior to his admission he reported a change in Mr A’s personality; Mr A was preoccupied with lamp posts outside his home and was talking about electric wires. Soon after, he moved into a hotel. Mr A was also giving his possession away, for example, his mobile phone and a significant amount of money was withdrawn from his account.
Collateral history from GP
Mr A’s GP reported that he had very little contact with Mr A and his family. The reviews were mainly related to routine checks such as blood pressure. Mrs A always refused to engage and has always declined domiciliary GP visits.

In 2009, Mrs A telephoned the GP to complain that Mr A had smeared faeces around the house. During the solitary domiciliary visit the GP did not find any evidence of this and instead noted that Mrs A was wearing a bin bag as a skirt. The GP reported that she was odd in her presentation and displayed some psychotic and obsessional features. The GP reported that she declined to have any assessments with mental health services. The GP did not think that Mrs A was detainable.

The son wrote frequently to the GP requesting mental and social care for his parents but they always declined help.

Progress on the mental health ward
The initial diagnosis was bipolar affective disorder, current episode manic with psychotic symptoms. Mr A was commenced on Olanzapine velotabs 2.5mg at night. Initially Mr A was reluctant for treatment but with reassurance accepted it. The dose was increased to 5mg at night after a week. During the initial weeks, Mr A’s behaviour remained chaotic. Mr A was messing with electric wires, television wires and the refrigerator.

Ward staff also reported that Mr A was preoccupied with order and cleanliness. He would clean the refrigerator at night. He also presented with poor attention span and was unable to complete tasks. He wore clothes inside out. His sleep pattern was chaotic and he slept sitting up in bed. He walked around the ward in his underwear. His speech was fragmented and pressured.

At times, Mr A was overfamiliar and tactile with staff and other patients. He would talk about settling down with female members of staff and patients on the ward. Mr A talked extensively about chemical formulae and physics principles. He would often write them down and place the papers in his room in an orderly manner.

Mr A cooperated with the treatment plan and remained compliant with the Olanzapine. Gradually his chaotic behaviour improved and his speech became more coherent.

After a few weeks, the hypomanic symptoms subsided and Mr A became insightful. Mr A was very sociable in the ward and caring towards other patients. He enjoyed going out for walks. There were no concerns with regards to his diet, sleep pattern or personal care.

Mr A described his wife’s behaviour prior to his admission and agreed with the information provided by his son. Mr A acknowledged that prior to admission his behaviour was out of character, especially leaving his wife and the family home.

Mr A decided to seek alternative accommodation and remain separated from his wife. Mr A was discharged in December 2013 to a residential care home.
Investigations and neuropsychological assessment following admission
On admission, the physical examination revealed no abnormalities. Blood tests and ECG were normal.

MRI brain scan showed some cortical atrophy affecting occipital lobes bilaterally with mild degree of established small vessel cerebrovascular disease with the frontal lobes relatively preserved.

Mr A also had a neuropsychological assessment. The tests revealed minor difficulties in organisation of information and mental arithmetic. He did well on tests of assimilating new information. There were no problems with retrieval of information. He performed well on tests of executive function such as the Wisconsin card sorting test, trails A and B and design fluency task. Mr A scored 92 out of 100 in the Addenbrooke’s cognitive examination-version III, loosing points in memory and fluency.

Follow up post-discharge and current mental state
Mr A visits his wife weekly for a couple of hours. His mental state is stable and there are no reports of hypomanic or psychotic symptoms. He has expressed that both he and his wife are not compatible and its best to live independently. He remains compliant with Olanzapine velotabs 5mg once at night.

Several attempts were made by our team to obtain collateral information from Mr A’s wife and also assess her needs. Unfortunately she did not wish to engage with us and telephoned us to express that.

According to Mr A, his son and the GP some of the behaviours and psychotic symptoms displayed by Mr A were similar to those displayed by Mrs A which suggested the diagnosis of folie à deux.

Discussion
Folie à deux is a rare, challenging, fascinating yet a poorly understood psychological disorder. It was first described by Lasègue and Falret in their classic paper titled ‘Lafolie à deux’ in 1877 (1). It is referred to as a shared psychotic disorder in DSM-IV and induced delusional disorder in ICD-10. In this condition, similar delusional beliefs are shared by two or more people who are often intimately related (2) (3). Depending on whether the delusions are shared among two, three or four people, the condition is referred as folie à deux, folie à trios and folie à quatre, respectively; it is called folie à famille when all family members share the same delusions, an extremely rare condition (2). The delusions in the condition could be shared in entirety or in part and in some cases other delusions also develop similar to those that present initially (2).

The ICD-10 diagnostic criteria for induced delusional disorder (F24.0) include:

1. Two people share the same delusion or delusional system and support one another in this belief.
2. They have an unusually close relationship.
3. Temporal or contextual evidence exists that indicates the delusion was induced in the passive member by contact with the active partner.
There is insufficient information regarding the incidence and prevalence rate of folie à deux (4) but it affects both genders equally and all age groups (5).

A literature review of case reports suggests that most of the involved individuals lead quite isolated lives (6). A high number of twin cases are reported and it has also been reported in marital relationships (7). Individuals who develop shared psychosis often have suspicious, antisocial, dependent and histrionic traits (8). Some also have features of prodromal psychosis (8).

Family history and genetic associations have also been suggested as aetiological factors (9) (10). Environmental factors play an aetiological role; it is suggested that couples who live in isolation tend to become mistrustful, feeling antagonistic of each other which eventually leads to emergence of psychotic symptoms (4). A couple of conditions emphasized by Lazarus before folie à deux develops are: first, a close physical association and intimate emotional bond between the affected people, and second, a genetic predisposition to psychosis (11).

Paranoid persecutory and grandiose delusions are the most common psychotic symptoms reported (9). Although the most common diagnosis associated with folie à deux is schizophrenia there is one published case report of the condition in a patient with mood swings (12). Some psychodynamic formulations have suggested features such as ambivalence and a love-hate relationship in this condition (4).

Pharmacological treatment in the management of shared delusions is crucial in preventing relapse or recurrence of illness (12). Most published case reports mention the usefulness of antipsychotics (13). Published case reports have recommended physical separation between those with shared psychosis and this approach is useful in the short term (6) (13). Evidence of benefits of long term separation are seldom mentioned, however, theoretical considerations support favourable outcomes with long term separation (13).

Folie à deux was considered for Mr and Mrs A based on collateral evidence from various sources when it was known that they were living in a closed and an isolated environment for many years. It is of paramount importance that this rare, intriguing disorder is recognized early. With timely intervention and regular follow up it has a good prognosis.

For Mr A we plan to monitor his progress regularly and continue antipsychotic treatment at least for another year. Thereafter this will be reviewed and the dose possibly reduced.

Consent
Written consent was obtained from Mr A for publication of this report.
References


