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Olgu Sunumu / Case Report

Shared Psychotic Disorder: A Case Report

Paylaşılmış Psikotik Bozukluk: Bir Olgu Sunumu

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ABSTRACT

Shared psychotic disorder; although has seen since 19th century is a rare and little-known syndrome. As with schizophrenia, etiology is not finalized yet. In this case report, with the accompaintment of persecutory delutions, the psychotic disorder of a boy who was affected by his schizophrenia diagnosed fathers delusions, will be submitted. In our case, the separation of the son from his father had been suggested and settled in a safe rehabilitation center where drug treatment started.However,the knowledge about the process after reatment of the patient could not be complied due to lack of control visit.

Key Words: Shared psychotic disorder, folie a deux,

ÖZET

Paylaşılmış psikotik bozukluk 19. Yüzyıldan bu yana tanımlanmasına rağmen nadir görülen ve az bilinen sendromdur. Şizofrenide olduğu gibi, etyolojisi halen kesinleşmemiştir. Bu yazıda, şizofreni tanısı düşünülen bir babanın sanrılarından etkilenen bir erkek çocuğunun kötülük görme sanrılarının eşlik ettiği psikotik bozukluk olgusu sunulacaktır. Olgumuzun babadan ayrılması ve güvenlikli bir rehabilitasyon merkezine yatılması önerilmiş ve ilaç tedavisi başlanmıştır. Ancak olgu kontrole getirilmediği için tedavi sonrası süreç hakkında bilgi sahibi olunamamıştır.

Anahtar Kelimeler: Paylaşılmış Psikoz, Folie e deux

INTRODUCTION

Shared psychotic disorder, also known as folie a deux ("the folly of two"), is a rare condition in which a healthy person (secondary case) shares the delusions of a person with a psychotic disorder (primary case)[1]. Shared psychotic disorder was defined by Lasègue in 1877 first time in the literature, with his friends[2]. There are four types of foli e a deux: 1) Folie impose'e; 2) Folic simultane'e; 3) Folie com m unique'e; and 4) Folie induite. Lasegu e and Falret described folic impose'e the most common form of folie a deux, in which the primary case is typically dominant, intelligent, strong, and autonomous[3]. The one who has the delusions first (the index case) is often chronically sick and is generally the influential member of a close relationship with the more tended one (the secondary case), who afterwards build up delusions.

The primary case is usually diagnosed schizophrenia and displays scenes of paranoid delusions. Some other diagnoses may include delusional disorder or mood disorder with psychotic properties. The subject of the shared delusional beliefs may be dependent on the diagnosis of the primary case and can include unusual delusions, mood-congruent delusions, or non-bizarre delusions[4]. Most of the people with shared psychotic disorder lack insight and do not

find out for treatment. The course is usually chronic without intervention because this type of disorder is most commonly seen in long-term relationships that are less likely to change. On the other hand if the other individuals break up the relationship with the the primary case the delusional beliefs of the other individuals may decrease or disappear[5].

Information regarding the etiology of shared psychotic disorder, heredity, biological factors, and psychodynamic factors, environmental factors are concentrated axes. Hereditary factors have been seen in families and twin cases[6]. The reasons of Shared psychotic disorder have not been found yet; however, the most important reason seems to be known as social isolation[7]. What we present in this case report is a child case, who is one of the two children of a father who is diagnosed with schizophrenia, and is affected from his father's delusions. This case is an example of shared psychotic disorder. In this article; infected madness, which was defined by Gralnick (1942) has been discussed as delusions which are being transferred from father to son. Detailed investigations have been carried out. The separation of two cases and an antipsychotic drug treatment have been proposed.

CASE REPORT

The case sent us by the court is to evaluate a child's mental health and determine accuracy of the statements. The father and child were examined separately.

Father

50-year-old male, abandoned by his wife. He lives with his mother and his two children in a village house. Recently, he experiences significant problems in social life, and personal relations. The father claims that he has been subject to rape everyday in last two years by gendarmes (soldiers). He states in his claims that his brother, who died about 20 years ago ,was in connection with illegal organizations. Because of that the soldiers break into their home every night and use spray to anal-rape him. He specifies that he claimed crime reports many times to the office. Patient is found normal in physical examinations, however irritability, agitation, aggression, persecutory delusions were seen in psychological exam.

Child

10-year-old boy; 4th grade student claims to be academically successful in his class. He claims that he himself, his father and his sister have been raped regularly for a year. He claims that the gendarmes begin to rape his father first, then they rape them, but he does not eye-witness or see or remember anything. He states that when he wakes up, his butt is in pain and there are scars on his face. He states that the rape is repeating 4-5 times a week; and it is denied by the state officials. In order to rule out any possible pyshical reasons, some tests were applied to the child. Lab tests were normal. Various psychometric tests were applied to the child after a psychiatric observation. The other psychotic disorders which must be approached in the differantial diagnosis were ruled out by the anamnesis and the clinical measures. After that he was diagnosed wiht shared psychotic disorder by DSM-IV-TR. For the delusions, risperidone 1 mg/day treatment was started. The statements of the child could not be trusted by the court; the father was considered a psychotic disorder, and advised to be hospitalized in a psychiatric clinic. After admitsion, assesment and approvals by the experts in the psychiatry clinic, the children were advised to be seperated from the father, the child be hospitalized in care center, the family be examined for the good of the child by social workers. Although the regular controls were requested; the child-case-was not brought to the clinic and therefore there is no information about the fate of the family.

DISCUSSION

Information about the incidence and prevalence of shared psychotic disorder is very little, as the literature consists mostly case reports[8,9]. The disorder is defined by the transfer of delusions from one person to another. About 95% of cases comes up between members of the same family, and over 70% are between a husband and a wife, mother and child, or two sisters[10]. The rate in married or common-law couples is equal to that in siblings. In siblings, the disorder is more seen in sisters than in brothers10. Almost all cases involve members of a single family[11]. In our case, it is consistent with the literature that influence is from father to son, the emergence is in rural areas, the diagnosis of the first case is schizophrenia.

We think of as shared psychotic disorder, father and sun, the case of the family consisting, since as close in terms of emotional and physical bonds between people affected by the presence of each other, as well as due to the fact that the father had schizophrenia, children have a genetic predisposition for psychosis supports a diagnosis of this disease. The patient identification process began to share his father's delusions gradually adopted abnormal behaviour[12]. The people who has a failure of the process of separation-individuation in childhood, stress is common occurrence under the regression13. The patient, after the loss of his mother started to live closer emotionally with his father, the fact that while father was isolated from the environment because of his disease the relationship between the son and his father became more intimate. This emotional and financial deprivations are thought as the primary psychological stress factors. Such a decline can lead psychotic identification with the illness mobilising[13]. In our case, apart from family, relatives and neighbors, including the family itself have been holding consultation with an isolated life. Since the father is unemployed and having persecutory delusions; it increased the isolation of the family because of the belief on not to rely on or trust anyone. The family had been in very close relationship because of the security issues. Recurrent economic crises of the family is in question. The primary case-the father was the least educated person in the family and he represented the authority. Although in some cases, traumatic impacts can be seen after the separation in shared psychotic patients, accepted method of treatment is the separation of the secondary patient from the primary patient. However, in such cases, the seperation is not the only solution of the delusions of the patient, an antipsychotic treatment may be required. Nevertheless, the common conclusion is, with the support of psychotherapy, the seperation of the affected case from the primary case would be appropriate. When this approach is not sufficient, the addition of drug therapy is recommended. Together with the separation and confrontation with reality, the treatment of our patients with risperidone (1 mg per day) was started[14]. Although the event sounds unconvincing; by the combinated evaluation of the point view to the military by some of the individuals who are living in Eastern and Southeastern Anatolia; claim that rape was taken into consideration by the court and started the process of a lawsuit. Differentiating cultural beliefs from delusions is a difficult task because of the existence of an embarrassment of cultural belief systems. Cultures are very complex and symbolic systems, and an understanding of culture is significant when understanding an individual. Explanations of what makes and builds up a personilty, the internal and external forces that animate or affect a person, and beliefs about how these forces interact with an individual are all a part of the person’s culture[15].

Raped by soldiers in the region in a different community or by the child's claim to be free from the convincing features of its own, but this psychotic transition is thought to occur because of the common features of that region. In this case, there are some facts that lead us to a conclusion, that is: the lack of an introverted personality

characteristics of the child to be good premorbidinde, peer relations, academic achievement, good overall compliance, continued of the event for two years, the child's physical examination by forensic experts to be normal, lack of any indication of entering into the house, neighbours who did not see any abnormal situation in this house is suggesting that the event is not true. Another important issue is that the patient has not brought to control visit after judicial report. In our country, courts should be trained to be more sensitive about getting health policy. Shared psychotic disorder, is one of the most extreme examples of the pathological relationships in psychotic disorders. Due to cultural differences, due to its prevalance is very rare and can be different in each community due to the appearance of delusions content and elucidation of unknowns interpersonal provide important clues about the reporting of these cases. Shared psychotic disorder, is seen often where the autonomy of family members is limited and the borders of the members are not clear. Reporting of cases in our country is important because of the conditions like the culture linking the eastern and western rural areas in terms of cultural geography and the traditional family structure. I believe that future studies and cases, which will show cases with similar differences, will make a contribution to the diagnosis and treatment of this rare disease.

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