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# SHARED PSYCHOTIC DISORDER: A CASE OF "FOLIE A DEUX"

## *PAYLAŞILMIŞ PSİKOTİK BOZUKLUK: "FOLIE A DEUX" OLGUSU*

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**ABSTRACT**

The case we present here is one of "folie a deux" that developed in a 35-year-old, unmarried woman who has been in a long-term dependent and passive relation with a man manifesting a psychotic syndrome. She was examined as a result of a consultation request after having been admitted to the Obstetrics and Gynecology Department at the university hospital with a pre-diagnosis of pelvic inflammatory disease. The symptoms reported were severe fatigue, joint pain, neck pain and edema in nose and throat resulting from an infection that had spread and progressed in our patient two years earlier. We diagnosed her with "folie a deux" and, so as to be able to conduct psychiatric treatment, recommended that she be separated from her partner and admitted to the psychiatric clinic. The couple, however, refused to be separated from one another. The following morning, the day nurse realized that the patient and her partner had left the hospital without paying their bill, which required that an official report be kept.

***Key words:*** Folie a deux, shared psychotic disorder

**ÖZET**

Burada, psikotik tablosu olan bir erkekle uzun süredir pasif ve bağımlı bir ilişki içinde olan 35 yaşındaki bekar bir kadında gelişen "folie a deux" olgusunu sunuyoruz. Hasta, pelvik inflamatuar hastalık ön tanısıyla üniversite hastanesinde kadın hastalıkları ve doğum kliniğine yatırıldıktan sonra istenen konsultasyon sonucunda değerlendirildi. Hastamız, iki yıl önce başlayıp yayılan bir enfeksiyon sonucunda ciddi yorgunluk, eklem ağrısı, boyun ağrısı ve burnuyla boğazında ödem semptomlarının olduğunu belirtiyordu. Hastaya "folie a deux" tanısı koyduk ve psikiyatrik tedavisi için partnerinden ayrı olarak psikiyatri kliniğine yatışını önerdik. Bununla birlikte, çift, birbirlerinden ayrı kalmayı kabul etmedi. Ertesi sabah, gündüz hemşiresi hastanın ve partnerinin tutanak tutulmasını gerektirir şekilde hastane ücretini ödemeden hastaneden ayrılmış olduklarını farketti.

***Anahtar kelimeler:*** Folie a deux, paylaşılmış psikotik bozukluk

## INTRODUCTION

The condition of sharing a psychotic disorder is generally referred to as "folie a deux," which is defined as "a delusion developing in an individual in the context of a close relationship with another person(s), who has an already established delusion" (DSM-IV) (1). Most commonly, it involves two people, a dominant principal person who has developed a psychotic syndrome and a submissive person, who, after a long-term relationship with the dominant person, unquestioningly accepts and develops the same delusion (5).

The first reported case of this disorder in psychiatric annals was that published by Harvey in 1651. It was a case of "phantom pregnancy" viewed as an induced psychosis in two sisters (3). This disorder was named after the reports of Laseque and Falret in 1877 (5,7).

In 1942, Gralnick (4) divided this disorder into four subgroups: Folie Imposee, Folie Simultanee, Folie Communiquee, and Folie Induit. In the case of Folie Imposee, which is the most widespread and classical form of the disorder, the dominant person develops a delusional system and progressively passes it onto a younger, more passive person. Gralnick added that these two individuals have a very close relationship and that upon separation, delusions in the passive individual rapidly diminish. Folie Simultanee was described as the concurrent emergence of identical psychosis in two individuals who have a close relationship and a susceptibility to the illness. In Folie Communiquee, psychosis develops in the affected individual after a long period of resistance and psychotic symptoms continue after separation from the source individual. Finally, in Folie Induite, a psychotic individual develops new

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psychotic delusions after coming in contact with another psychotic individual.

We present a case of "folie a deux" developing in a woman who has been in a long-term dependent passive relation with a man manifesting a psychotic syndrome. The woman, the person with the shared psychotic disorder, did not have a pre-existing psychotic disorder but rather a dependent personality disorder.

**CASE**

The patient was a 35-year-old unmarried female patient who was the eldest of two siblings. She lost her father six years ago and currently lives in Istanbul with her mother. She states that she has been unable to work for two years due to illness. She was hospitalized in the Obstetrics and Gynecology Department of our hospital with the pre-diagnosis of pelvic inflammatory disease. The doctor who admitted her noticing the extraordinary and atypical intent of her complaints, requested an immediate psychiatric consultation. When we visited her in the service, she said that her problems had started two years earlier. However, her partner, who was beside her at the time, immediately started to talk and described the illness as "our illness." Our patient nodded her head to agree with what he said, sometimes contributing additional information. She explained that the illness had first become evident in her partner about 7-8 years earlier. The symptoms were severe fatigue, joint pain, neck pain and edema in nose and throat due to an infection that had spread and progressed two years earlier. The couple mentioned that their relationship had been going on for 15 years. During the course of the interview, it was found that the male partner was 17 years older than our patient and that while she was simply a high school graduate, he had graduated from university. No outside, separate individual social or cultural life apart from the relationship between the couple was described. Under the circumstances, our patient was not able to speak much so the interview with her had to be continued after her partner had been sent out of the room. Our patient explained that she had not taken her partner's symptoms seriously for about five-six years and had thought that they were due to excessive worry. She said that while she had initially argued with him, when the same symptoms started to emerge in her, she slowly, "over a few months," began to be convinced of their genuineness. Just then, her partner came into the room with some examination files, which included the results of various tests, including HIV and syphilis. Interrupting us, he added, using medical terminology, " this arthritis began in the long bones." Continuing the interview in private, our patient stated that sexual relations generally ended up with her being anorgasmic and that only through oral sex was it possible for her to achieve an orgasm. This was why she had contracted her partner's illness and mutual reinfection continued between them through oral contact. They had been monitored by a number of different obstetricians, urologists and infectious disease specialists who saw them as outpatients. None of the tests produced significant findings of illness. Our patient said that they had been told by the doctors that the disease had become chronic and that they could not take care of them. We learned at the time that uncontrolled parenteral vancomycin and imipenem treatments had been conducted for six months in accordance with the wishes of her partner. He had insisted that there was a possible infection due to staphylococcus and entrerococcus in the abdomen and that it had drained from the uterus through a hole that had been opened there. He added that he stopped working because he felt that he was unable to work due to fatigue. Together they drew up and printed a list of symptoms. The first item on this list was "1 cm expansion of the neck". They said that this had occurred suddenly and that afterwards the abdominal area had expanded in the same way. The patient claimed that she had lesions, abnormal deformation in her face, which were seen as plaques and flakes. She frequently used medical terms and said that she had edema in her throat near her vocal cords that does not go away. She kept referring to edema in her facial bones and orbitals, shallowness and edema in her temples, hot flushes occurring whenever she moved, abnormal dryness in the skin, failure of her intestines to absorb food, and to the fact that her hair falls out in large quantities after bathing three times. She added that we should not rush to treat or examine her and that they were as comfortable as they would be in a hotel room, staying together in a private room. It should be noted here again that no objective medical symptoms had been uncovered.

In the mental state examination of the patient, she looked her stated age with average level of self care. She was dressed in accordance with her sociocultural conditions. She was willing to talk but she had a passive attitude in the presence of her partner. She was conscious and cooperative. When she was with her partner, her speed and rate of speech decreased as well as her tone of voice. When she was alone, her speech got slightly louder and faster. Her psychomotor activity level was within normal range. Her mood was slightly depressive. She looked anxious. Her speed and amount of associations decreased and she ruminated about her somatic complaints. Her thought content included somatic delusions and she appeared convinced her that she has a physical illness. Her level of attention decreased and she had difficulty to concentrate. She had low appetite and disturbed sleeping pattern. Her insight was very poor as was her judgement.

Her partner also had similar somatic delusions. He had delusions such as their necks enlarge suddenly, he has permanent edema on his throat, nutrients are not absorbed in his intestines, he has panicula on back of his neck. Because of these delusions he had hypocondriacal obsessions. He had a defensive and paranoid attitude towards the interview. He had a high rate of speech and pressured voice. He had interfering behaviors and he presented irritable affect. He appeared to have difficulty in aggression inhibition.

Our initial suggestion was for the patient to be separated from the dominant partner and admitted to hospital. But after repeated interviews, they had mentioned that they were anxious and angry because we considered their illnesses as being psychiatric in nature. As a result, our patient developed a negative and insecure attitude. She stated that she would not accept hospitalization in the psychiatry service unless her partner accompanied her. After both we and the obstetricians in-

sisted that her hospitalization was necessary, she said that they wanted to think it over for a night.

The following morning, the day nurse found that the patient and her partner had run away without paying the required fees, which necessitated that an official report be kept.

## DISCUSSION

Our case is compatible with the description laid out by Gralnick for folie imposee, the classic and most often seen form of "folie a deux." As a result of a long-term relationship with the dominant psychotic partner, although she initially denied the existence of such a hypochondrical hallucinative state, she eventually developed the same belief and defense system. Ricon described this disorder as psychosis in two people with a symbiotic bonding relationship (10). An important study where 97 cases were scanned over a period of 90 years was carried out in Japan. The literature revealed that the affected were mostly women and young people, with 75 percent of the cases being couples and the rest being shared by families. The most frequent cases were the mother-child dyad and married couples (6). A mother-child case was also reported in Turkey. Similar to our case, a "folie a imposee" with dependent personality characteristics in the secondary person was reported in this case, too (9). The fact that our case consisted of a woman who had maintained a long-term close symbiotic relationship with her partner makes it compatible with these findings.

The source individual is generally older, more intelligent, better educated and has stronger personality traits and delusions that are mostly persecutory or hypochondrical in nature (5). In our case, the psychotic individual manifests similar characteristics, is 17 years older than his partner, is better educated and has hypochondrical delusions.

The co-morbidity of dementia, mental retardation and depression was reportedly high and the most frequent predisposing factor was social isolation (11). This was evident in our patient, who, throughout the years she had spent with her partner, had become increasingly introverted, socially withdrawn, leading to a final break with job and friends.

In a recently updated literature review by Sharon, it was suggested that "separation from the primary source" is the first step, but it is generally not sufficient by itself and should be supported with a neuroleptic treatment (3). We, too, attempted separation as the first step by admitting our patient to the psychiatric clinic.

Frequent plans to commit suicide or murder, which are generally accepted as threats, are common (2). One case report describes the murder intervention to the general practitioner by a female patient suffering from delusional parasitoids as "folie a deux" due to her affinity for paranoia (2). The common point in most of the reports is that partners project intense hostility towards the outer world (8). Similarly, in our case, couple who had hostile and paranoid attitudes ran away from the hospital early in the morning without completing required procedures and paying the hospital fee.

In conclusion, we believe that cases like this one are important since they are difficult to diagnose and do not usually involve seeking the services of psychiatric clinics. They generally make use of primary health services and various hospital clinics, involving the carrying out of mostly unnecessary and invasive evaluations that are costly and generate a loss of manpower. Moreover, because of the cases in the literature involving dangerous and sometimes criminal behavior directed at the health team, we believe that it is particularly important for family doctors to be aware of the existence and description of such conditions.

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