

Folie à Deux: A Case Report

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Abstract

Folie à deux is a relatively rare mental disorder first described in France in 1877 by Lasègue and Falret. However, folie à deux is still a matter of study and debate today as it remains a challenge for psychiatrists. The aim of our work is to report a clinical case of folie à deux, subtype A of Gralnick, between an inducer daughter and an induced mother who lived quite socially isolated and had a strong and close relationship. In the clinical case presented, folie à deux was easily diagnosed but its treatment proved to be a higher challenge. The main diagnosis of the inducer patient was also quite interesting. Many years after it was first described, folie à deux is still an interesting and challenging disorder to psychiatrists, especially concerning its pathophysiology and treatment.

Key Words: Shared Paranoid Disorder, Case Reports, Diagnosis, Therapeutics¹

Introduction

Folie à deux (FAD) is a relatively rare mental disorder first described in France in 1877 by Lasègue and Falret (1, 2). Nonetheless, there had been previous descriptions of this syndrome in French literature from the late 19th century, although they were differently termed. In 1860, Baillarger described it for the first time as “folie communiquée” and in 1871 Legrand du Saulle reported “idée de persecution communiqué ou délire à deux et à trois personnes” (3). But only since Lasègue and Falret’s description of folie à deux, published in their paper “La folie à deux ou folie communiqué,” has this mental disorder become known worldwide as folie à deux.

Folie à deux was described as the presence of the same psychiatric symptom, usually persecutory delusion, in two individuals in close relation (4). According to the descrip-

tion from Lasègue and Falret, there should be an inducer and an induced individual.

In French psychiatry, after Lasègue and Falret’s description of folie à deux, many authors have studied this disorder, reported clinical cases and described variants to its definition, introducing new subtypes.

In German-speaking psychiatry, FAD was termed “induziertes Irresein” by Lehman (1883), which Scharfetter (1970) translated as “induced psychosis.” Other German-speaking authors also studied this disease, but unlike French psychiatrists’ clinical descriptions of FAD and its subtype, they were more concerned about the mechanisms and pathophysiology of the disease (3).

It was in the United States that Gralnick, in 1942, presented an effective definition of FAD and distinguished four subtypes of the disease: subtype A or folie impose; subtype B or folie simultanée; subtype C or folie communiquée; and, subtype D or folie induite. Gralnick’s subtypes of folie à deux include all the subtypes of folie à deux previously described in French psychiatric literature, but have structured them in a systematic classification.

Nowadays, folie à deux is classified in *DSM-IV TR* (5) as “shared psychotic disorder” and in *ICD-10* (6) as “induced delusional disorder.” In both classification systems, the diagnosis is based in phenomenology and does not assume etiological mechanisms.

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Clinical Case

Patient

The patient is female, 33-years-old, single, an office administrator, lives alone (her mother is her front neighbor). Her primary care doctor oriented the patient to a psychiatry appointment in July 2010 for acute psychosis.

The patient had no past psychiatric, medical or surgical disorders. There was no family history of psychiatric or medical disorders, although her mother has diabetes mellitus type 2.

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In September 2009, one year before the psychiatric appointment, the patient insidiously started feeling radiation in her body, a gas smell in her house, and noted that objects changed places without her intervention. She also started hearing voices from co-workers, and then also heard voices from other people in the street, although she kept working every day, and colleagues noticed nothing different about her. These symptoms were persistent, but in June 2010 the patient started isolating herself with complaints of initial insomnia and fatigue. There were no relevant life events or social functioning changes in the patient’s life in 2009 or the year before, and no previous early signs of delusions were found. In July 2010, her mother noticed for the first time changes in her behavior, specifically isolation. When confronted with her mother’s observation, the patient told her what she had been feeling since September 2009, and showed her the places in the house where radiation was strongly felt. The patient’s mother remembers she then had questioned, “Is my daughter crazy? But no, she isn’t because I also felt the radiation in my body, only did not smell the gas when I visited her home. My daughter is not crazy and I am not becoming crazy by osmosis!”

After that, both of them started living together in the mother’s home because radiation was weaker there and there was no gas smell. The patient and her mother both started medical leaves of absence as they felt unable to work anymore. They also went to the police station to present a claim for “radiation terrorism,” which was not accepted. After that, the patient started some experiments. She went to the “ter-

rorism observatory” and asked for statistical data on “radiation terrorism.” As she was told that there was no data available on that theme, she started searching the web on “radiation terrorism” where she found lots of information and many more people suffering from it. On the web she also found a suggestion to defend herself from radiation: to protect the body with aluminium foil, and so she did it—she rolled herself up (except toes), but with no improvement because she felt radiation entering by the unprotected toes. The patient and her mother had also flown to Switzerland to check if they would feel radiation in the air. They both did, and also felt radiation while in Switzerland. In July 2010, the patient also noticed that while walking in the street, she could hear other people talking, but she did not notice their lips moving. Then she realized she was not hearing other people’s voices but instead it was “them” sending radiation in frequencies that could mimic human voices to frighten and control her mind. In July 2010, the patient finally came to understand what had happened before and the things that she thought strange, “They think they can control people through fear and that people will do what they want them to do but not with me because now I am not afraid anymore.” The patient also said that from that moment on she arranged a secret code with her mother to tell her when she was feeling radiation in her body. Communication would be by small body movements instead of speaking out loud because they could hear them, and so they would think that they could no longer control her.

In the patient’s personal history, after normal delivery and psychomotor development through childhood and adolescence, her parents divorced when she was 15. She witnessed some aggressive attitudes at that time and did not see her father anymore. She interrupted studies for some time at the age of 16 due to headaches, but had always had a good academic record. She had at least one boyfriend six years ago. At age 23 she got a degree in marketing, while also working. No tobacco, drugs or alcohol consumption.

In terms of premorbid personality, she always enjoyed reading and had friends, although they were older. She presented no *DSM-IV* cluster A personality traits in the past.

At her mental state examination, the patient presented apparent age equal to real age, well dressed—although old fashioned—but clean, good general physical condition, no abnormal involuntary movements, proper behavior and level of motor activity. She was apparently calm, with good eye contact, no aggression episodes or distractibility, pressured but organized and logical speech without flight of ideas or other speech alterations; she presented delusional mood without suicidal or homicidal ideation, auditory, olfactory and kinesthetic hallucinations, linear thought, goal directed with persecutory bizarre delusions well structured, delu-

sional perception, delusions of thought interference with thought insertion, thought withdrawal and thought broadcasting. She was orientated to time, place and person, attention, concentration and memory preserved with no insight about the morbid condition.

GAF scale (Axis V) at first assessment was 41.

Patient's Mother

The patient's mother is 62-years-old, divorced with one daughter, a phone operator, and lives alone (her daughter is her front neighbor). She has diabetes mellitus type 2 and no other medical, psychiatric or surgical disorders. No family history of psychiatric disorders.

She suffers from the same symptoms as her daughter since July 2010, starting the day her daughter described to her what she was feeling (as mentioned). Although the radiation she felt in her body was less intense, it was clear to both of them that the main radiation target was the daughter. The patient's mother heard unknown voices twice, outside her head, calling her insane and ordering her to shut up. She also saw the "radiation machine" going up and down her body, and a denture with a sarcastic smile when she was falling asleep.

There is no relevant personal history, as well as no tobacco, alcohol or other drug consumption.

Also interesting in this clinical case is the onset of inducer's symptoms, its evolution and final presentation in the psychiatric appointment resembling the canonical descriptions of the onset of paranoid schizophrenia, which can be diagnosed in the inducer patient according to DSM-IV TR criteria.

In terms of premorbid personality, she described herself as being a happy person, communicative and with lots of friends. She presented no *DSM-IV* cluster A personality traits.

At mental state examination, apparent age was equal to real age, she presented as well dressed and clean with good general physical condition, no abnormal involuntary movements, proper behavior and level of motor activity. She was apparently calm, with good eye contact, no aggression episodes or distractibility, no speech alterations; she presented depressed mood without suicidal or homicidal ideation, auditory, hypnagogic and kinesthetic hallucinations, linear thought, goal directed with persecutory bizarre delusions

structured, and delusional perception. She was orientated to time, place and person, attention, concentration and memory preserved with no insight about the morbid condition.

GAF scale (Axis V) at first assessment was 50.

Discussion

In this clinical report, a case of folie à deux between an inducer daughter and an induced mother is described and was easily diagnosed. If we would classify it according to Gralnick's subtypes of FAD, this is a case of "folie imposée" (the one originally described by Lasègue and Falret) in which the delusions of a psychotic individual (the daughter) are transferred to an apparently psychiatrically normal one (her mother with no previously known psychiatric history), and the recipient offers little resistance in accepting the delusions and does not elaborate them.

On the other hand, treating these patients was a much more difficult challenge. For treatment purposes, inducer and induced patients were followed by two different medical doctors. The inducer went to six psychiatric appointments but always refused any pharmacological treatment, arguing that chemical products worsened radiation intensity. The induced went to three psychiatric appointments and agreed to take ziprasidone 80 mg bid and flurazepam 30 mg, but abandoned them after three weeks without clinical improvement and refused to take other medications. Nevertheless, both maintained psychiatric appointments. Inducer patient started psychological assessment but dropped out after the first session, saying that she did not need psychotherapy but rather a psychological evaluation to prove her mental sanity in order to complain at the police station about "radiation terrorism." She never allowed any rating scale to be used. In November 2010, after four months of medical leave of absence, the induced patient decided to work again and about three weeks later there was clinical improvement with good night's sleep and less intense delusional ideas. She also started to show some insight into her clinical situation. By then, her GAF score improved to 65. On the other hand, the inducer patient maintained the same clinical symptoms, but did start working again the following week. By then the GAF remained 41. In this clinical report we conclude that treatment was hardly advantageous and that separation of both patients, although for work-related reasons, was beneficial at least for the induced one. Our initial treatment plan included: 1) hospitalization, as it would allow mother and daughter to remain separated and in a safe and controlled environment; 2) multiple-conjoint psychotherapy; 3) antipsychotic medication; and, 4) occupational therapy.

There was no attempt made for compulsory admission of these patients because they did not present any danger to themselves or to other people, and they were maintain-

ing good social functioning. However, if the inducer patient could not become functional at work, there might be a strong justification to admit her into a psychiatric department, even if compulsory, but this would be our last treatment option.

Also interesting in this clinical case is the onset of inducer's symptoms, its evolution and final presentation in the psychiatric appointment resembling the canonical descriptions of the onset of paranoid schizophrenia, which can be diagnosed in the inducer patient according to *DSM-IV TR* criteria. On the other hand, the induced patient had a mild depressive episode and became easily psychotic under her psychotic daughter's influence.

Many years after its first description, FAD still remains an interesting and challenging disorder to psychiatrists, especially concerning its pathophysiology and treatment.

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