Case Report

A Case Report: Folie A Family

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Summary

Shared psychotic disorder is rarely seen in common clinical practice in psychiatry. Only a small percentage of cases involve families. Folie a families is characterized as a shared psychotic disorder within a family in more than two members. The involved patients have a close relationship. We describe here a case of folie a famille involving a nuclear family consisting of the husband, the wife, and their three children. The primary patient was suffering from paranoid schizophrenia with prominent delusions of persecution that were imposed upon and later shared by his family. Temporary separation decreased the intensity of shared delusions in the other family members.

Bang J Psychiatry 2008; 22 (2) : 90-93

Introduction

Shared psychotic disorder (SPD) was first described by Jules Baillarger in 1860,who term this condition as "Folie a communiqué". It has been variously called as psychosis of association, shared paranoid disorder, communicated insanity, contagious insanity folie a deux, folie a trios, folie a quatre, folie a cinq, folie a famille etc.[1,2] Its characteristic feature is transmission of delusion from "inducer" (primary patient), who is the "originally" ill patient and suffer from psychiatric disorder, to another person who may share the inducer's delusions in entirely or in part.[3,4,5] Depending on whether the delusions are shared among two, three, four, five and even twelve people, it is called folie a deux , folie a trios, folie a quatre, folie acinq and folie a douze.[6] Rarely all the family members shared the same delusions, and this is called folie a famille.[7] Folie a famille is said to be present when more two members of the same family are involved. It is classified as SPD in Diagnostic and Statistical Manual of Mental Disorders(DSM) 4th edition[8] and induced delusional disorder in International Classification Of Diseases(ICD) 10th edition.[9]

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Date of submission of the article: 10.12.2012
Date of acceptance of the article: 15.01.2013

SPD is said to be rare[10,11] and SPD involving the entire family is even more rare.1 Its true population prevalence is difficult to assess.[12] All kinds of delusional contents can be seen in this disorder.[7] Risk factors includes female gender, mental retardation, suggestibility, passivity histrionic personality, trait and suspiciousness, in the secondary person. Moreover, dependency, ambivalent relationships and repetitive crises have been seen in the family.[13,14,15]

We describe here a case of folie a famille involving a nuclear family consisting of the husband(59 years), wife((47 years) and their three children (29,24 and 14 years old) respectively.

Case Report

A young man of 30 years old with his paternal uncle attended psychiatry out patient department in Bangabandhu Sheikh Muzib Medical University (BSMMU) seeking help for the purpose of treating his mothers mental illness. He claimed that his mother was forcefully treating his younger sister as a case of mental illness. He was requested to bring his mother. History taken from mother, revaled that, her second issue the only daughter N.S, 24 years old was suffering from schizophrenia over last 09 years and treated with antipsychotics with difficulty due to suspicion of being poisoned. She was hospitalized several times due to medication refusal during severe episodes of illness. For the last 6 months her symptoms exacerbated but the mother failed to supervise medication taking due to non cooperation of her elder son with whom she came to out patient department. The girl was ultimately admitted in psychiatry department. During the interview it was identified that she had a persecutory delusion about being poisoned by her mother. She thought that her mother wanted to poison other family members also. She refused to take food and drink at home and only takes dry food, sometime prepares food by self. She believed that her mother maintained relationship secretly with classmates of her college, so they try to conspire against and did not help her as per her need. She stopped to go to college. Her family members were invited to gather more information. Her elder brother had dependent personality and same delusional beliefs of poisoning .His belief started one and half year back. He took most of the large meal outside of the home, sometime prepared food by self. N.S' father was a retired custom officer and then served as a law advisor of Supreme Court. He had poor tolerance to his wife's dominating character and obsessive behavior. Marital schism is present in this family. He was mistrustful toward his wife since beginning of marital life and he had the same delusion of persecution. He is fully convinced that his wife made his younger son ill by mixing something with foodstuffs. He had intimate relationship with other family members. Patient's mother is suffering from obsession of dirt and contamination and has cleaning rituals . She was irritable and always tried to lead others in her own way. We could not interview another younger brother of the patient who was 14 years old. According to mother's statement, her younger son does not take food at home and remains outside of the home most of the time for last more than one month. He became chachectic and was admitted in a private clinic with serious nutritional problem. N.S was on

antipsychotic medication, tablet Risperidon 2 mg twice per day, which was increased to 8 mg pre day in two divided doses. The brother's visit to the patient and contact with the patient over mobile phone was totally inhibited during the course of admission in the hospital which lasted around two months. Father only allowed to visit twice a week. Brothers were refused to join in family therapy of treatment but their delusional beliefs weekend over two months period. Parents were counselled and advised to avoid overt expression of emotion. Physical and psychological treatments were given to mother for obsessive compulsive disorder. Following discharged from the hospital two follow up visits were possible, upto that period elder brother still remained separated. Patient's symptom improvement was satisfactory. After that patient was lost in follow up.

Discussion

In shared psychotic disorder, delusion develops in the context of close relationships. The delusion, developed in this way, is similar to that of the person with established delusion.[16] Persons are closely associated for a long time and typically live together in relative social isolation. Occasionally, more than two individuals are involved (e.g., *foliea trois, quatre, cinq, also folie a famille),* but such cases are very rare.[17] The majority of dyads (67.3%) are socially isolated.[5] In our case, N.S was the origin of the delusion. She had great influence on her family, especially her father and both brothers. They had close relationships with each other as well. In folie a deux, delusions are usually persecutory.[18] Folie a deux is rare and information is obtained mainly from case reports.18 About 90% of the relationships described are within the nuclear family; sister-sister dyads are the most common forms.[18] When patients are related, they may share the same genetically-driven psychiatric illness.[19] Our patients had persecutory delusion with mother. The suggestible persons (the secondary case) were more than two persons; they were *folie a quatre,*as involved members of a same family it can be called *folie a famille*. Usually, the "primary" case, i.e., the person who first develops psychotic symptoms, can be distinguished from one or more "secondary" cases, in whom the symptoms are induced.[20] Since the 19th century, many studies have reported folie a deux in subjects with endogenous psychosis. According to German traditional psychiatry, "we-type" paranoid solipsism may correspond to "psychogenic" delusional formation mechanism, and "I-type" schizophrenic solipsism to endogenous mechanism.[21] The inductor often appears to be suffering from schizophrenia.[22] N.S. with her brother and father had "we-type"paranoid, might have psychogenic delusion.

References

1. Enoch MD, Trethowan WH(eds). Uncommon psychiatric syndromes. 3rd ed. Oxford: Butterworth-HeinemannLtd; 1991.pp 184-215.

2. Cuhadaroglu-Cetin F. Folie a famille and separation-individuation. Eur Child Adolescent psychiatry. 2001;10:194-9.

3. Dewhurst K, Todd j. The psychosis of association—folie a deux. J Nerv Ment Dis. 1956;124(5):451-459.

4. Gralnick A. Folie a deux-the psychosis of association. A review of 103 cases and the entire English literature: with case presentation. Psychiatric Q. 1963;16(2): 230-263.

5. Silveira JM, Seeman MV. Shared psychotic disorder: a critical review of the literature. Can J Psychiatry. 1995;40: 389–395.

6. WaltzerH.Apsychotic family—folie adouze. J Nerv Ment DIS.1963;137:67-75.

7. Arnon D. Patel A,Ming-yee Tan G. The nosological significance of folie a Deux: a review of the literature. Ann Gen Psychiatry. 2006;5:11

8. American Psychiatric Association. Diagnostic & statistical manual of mental disorder.4th edition. Washington DC; 1994.

9. World Health Organization. The ICD-10 Classification of Mental and Behavioural disorder. Geneva; 1992.

10. Howard R. Induced psychosis. Br J Hosp Med.1994;51:304-7.

11. Trabert W. 100 years of delusional parasitosis: Meta analysis of 1,223 case report. Psychopath. 1995;28:238-246.

12. Peter M,Wehmeire NB, Remschmidt H. Induced delusional disorder: A review of the concept and an unusual case of folie a familie. Psychopathology. 2003;36:37-45.

13. Ghaziuddin M. Folie a deux and mental retardation: review and case report. Can J Psychiatry.1991;36(1):48-49.

14. Mazzoli M. Folie a deux and mental retardation. Can J Psychiatry. 1992;37(4):278-279.

15. Lasarus A. Folie a deux:psychosis by association or genetic determinism? Compr Psychiatry. 1985;26(2):129-135.

16. Munson CE. The Mental health diagnostic desk reference: Visual Guides more for L EARNING TO Use the Dignostic Statictical Manual (DSM-IV TR). 2nd ed. New York: Haworth Press; 2001: 154.

17. Theo C. Delusional and shared psychotic disorder. In: Sadock BJ, Sadock VA, Kaplan HI, eds. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 7th ed. Philadelphia: Lippincott Williams and Wilkins; 2000:1257-1258.

18. Bhandari S. Unusual psychiatric syndromes. In: Wright P, Stern j, Phelan M, eds. Core psychiatry. 1st ed. London; New York:WB Saunders; 2000:329.

19. Reif A, Pfuhlmann B. Folie a deux versus genetically driven delusional disorder: case reports and nosological considerations. Compr Psychiatry. 2004; 45: 155 – 160.

20. Wehmeier PM, Barth N, Rem-Schmidt H. Induced delusional disorder. A review of the concept and an unusual case of folie famille. Psychopath. 2003; 36:37-45.

21. Shimizu M. Folie a deux in Scizophrenia—"psychogenesis" revisited.Seishin Shinkeigaku Zasshi. 2004;106:546-563.

22. Mentjox R, van Houten CA, Kooimam CG. Induced psychotic disorder: clinical aspects, theoretical concederations, and some guidelines for treatment. Compr Psychiatry. 1993;34:120-126.