

Shared Psychotic Disorder («Folie a Deux») between Mother and 15 Years Old Son

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ABSTRACT

We presented a rare case in clinical practice: fifteen (15) years old male adolescent with shared psychotic disorder with his thirty seven (37) years old mother. In this case of »folie à deux« child was the passive psychotic partner and his mother who was the dominant psychotic partner. Both patients shared the same paranoid and imperative delusions. With complete psychiatric anamnesis, clinical interview, psychological testing, EEG (examination-electroencephalography) examination and control examinations we came to the diagnosis and efficacious pharmacological intervention for son.

Key words: shared psychotic disorder, paranoid symptoms, delusion, olanzapine

Introduction

Shared psychotic disorder, or folie à deux, is a rare delusional disorder shared by two or more people in close emotional ties. An extensive review of the literature reveals cases of folie à deux, folie à trois, folie à quatre, folie à family members or even a case involving a dog. Although *Harvey* described the first case of phantom pregnancy associated with induced psychosis in two sisters in term folie à deux dates to a classic report by Lasegue and Falret in 1887. Since the time of Lasegue and Falret, shared psychotic disorder has been identified more frequent in women, the traditional submissive role of females in the family. Both female and male secondaries are equally affected by female primaries^{1,2}.

The aim of this publication was to display shared psychotic disorder between mother and son.

Mother and son were treated clinically at the same time in psychiatric institutions. Boy was taken and treated in the Psychiatric clinic, University department for child and adolescent psychiatry and mother in the Department for acute psychiatry for adult persons in another town.

Concerning rare appearance of similarly disturbances, we made efforts to display approach in dealing and treating adolescent, efficacy of the therapeutic intervention and justifiability of usage antipsychotics newer gen-

eration, but also point to possible obstacles in achieving complete clinical effect. Moreover, it is very important to emphasize the role of psychiatric heritage on etiology of psychiatric disturbances. Boy's mother has been earlier treated because of psychotic disturbance, she did not take recommended therapy and she had not enough criticism to her own disease, very quickly she is came in relapse of psychotic manner, and there was a risk of newly influence on inducing similarly symptoms in her son. In fact it is well-known that in shared psychotic disorder, patients with earlier diagnosed psychotic disturbance have an influence on close persons and can provoke similar psychotic clinical picture and delusions in second person who until that did not display similarly symptoms.

Boy's father was also earlier treated because of symptoms within posttraumatic stress disorder with psychotic elements, his contacts with son and wife were very rare, he was not motivated to take care about adolescent, and adolescent's brother has left home because of complex family situation and now he is living out of Croatia.

Beside pharmacologic intervention with atypical antipsychotic olanzapine we reduced successfully psychotic symptoms in adolescent.

Case Report

Personal anamnestic findings: the boy was eighth grade elementary school student, lived only with mother. His father abandoned them two months before hospitalization. Due to frequent conflicts with mother, his older brother in age of twenty seven (27) has also left family and now is living nomadic lifestyle with a group of Indians.

The boy was firstly admitted on Department of Psychiatry in other Hospital in V. as a result of expressing difficulties in psychological functioning accompanied with police officer and social worker. The boy was not attending school for ten days before admission. Disturbances in overall functioning were perceived. He was extremely strained, expressing restless behaviour, followed with numerous paranoid delusions towards his surroundings, mostly focused on father and brother.

He was cited that his father permanently observed him and mother. He thought that father has monitored and spied them, and also he and his mother have thought that his brother was tried to poison him and mother. His brother have also monitored him like father but with more modern apparatus, Indians with whom older brother have left to play helped him, etc. He did not want to go in school in last ten days, because he wanted somebody to notice that he is absent and to react on his warning that his father and brother want to poison him. The same is with his mother. They wanted to poison her, and they have permanently monitored her. Because of this she was hospitalized like him. The boy's mother was also hospitalized on the Department for biological psychiatry with intensive care at the same day as her son. She was thirty seven (37) years old, unemployed, with elementary school.

She was disturbing people on the street, throwing herself in the canal and obstructing in the public place.

Regarding psychiatric condition of the mother we were not able to find out facts concerning his early psychomotor development and course of pregnancy.

Somatic and neurologic state of adolescent in admission: congruous to his age without signs of trauma, focal neurological deficits and lateralization.

Psychiatric state of adolescent in admission: he was conscious, able to establish contact, disorientated behaviour. Psychomotor agitation was presented. Thought content was characterized by delusions, obsessive rumination, and hypervigilance, manifesting dissociated mind course, with ideas of reference, religious and paranoid delusions (mostly toward brother and father). He was describing hearing delusions of imperative character. Reasoning, judgment and insight was lacking. Attention and concentration were preserved, he did not present suicidal or homicidal ideas.

The hospitalization in Department was required in order to ensure that he would be remain separated from mother through his treatment and stayed in safe and controlled environment.

During hospitalization on the Department older brother visited him. He described mother like person who was always bizarre, a lot of time she spent with younger brother, and because of permanent conflicts in family and very difficult social situation he has left home after he finished secondary school. Boy's father was also treated by psychiatrist because posttraumatic stress disorder with symptoms of psychotic manner (paranoid ideas). Older brother have cited that his mother had lived in difficult social conditions, she was physically abused by her father who was an alcoholic, etc.

During adaptational weekend at home boy still have had fixed paranoid ideas, impaired affect, ideas of reference. After he was returned from weekend he has come with mother in who we noticed the same symptoms, and mother has described that she has not confidence in doctors and she will stop taking recommended medication.

During hospitalization the boy underwent psychological assessment and EEG testing.

Psychological testing: patient was extremely tense, anxious and frightened with test situation. Contemplative flow is confused up to dissociation, and in content were prevailed explanations of disturbed family dynamics. In content paranoid ideas and ideas of relation were dominated (spying, following from father, threats, poisoning attempt from brother – »he wanted to kill him because of landed property«, persecuting from police...). His sentences are periodically fragmented, without logical and meaningful links. Judging and logically concluding was aggravated and he was without insight in his own condition and to that he was completely uncritical. Based upon psychological test it can be concluded that it was psychotic reaction induced by his mother. Boy expressed paranoid symptomatology and difficulties in everyday social functioning with cognitive-mnemonic deficits (attention, intelligence, memory, visuomotoric coordination). EEG test was normal according to his age.

The adolescent was included in continuous psychotherapeutic and psychopharmacologic treatment. Concerning pronounced psychotic symptoms, we recognized the need in starting treatment procedure with atypical antipsychotic of second generation (younger age) – olanzapine.

The starting therapeutic dose was five (5) mg per day in one dose every evening. One week later we increased the dose of olanzapine to fifteen (15) mg and then twenty (20) mg per day divided in two doses in the morning and in the evening. We have spoken with his mother one time after she finished her hospital treatment in V. She was extremely suspicious toward her husband and doctors, with some paranoid interpretation and anxious behaviour. We observed that she had a great influence on her son, accusing her older son and husband for reason why she and her son received psychiatric care.

After two months of treatment, we were consulting Social service and boy finished our treatment. Firstly, he started to live with his father and was under the oversight of Social Service. His psychological state was in stable remission.

Discussion

A shared psychotic disorder, »*folie á deux*«, is a rare syndrome that has attracted much clinical attention. Lasegue and Deux first described the phenomena of the transference of delusional ideas from a primary affected individual to one or more secondaries in close association. They coined the term »*folie á deux*«, a relatively rare syndrome that has long since attracted much clinical attention¹.

Although »*folie á deux*« is probably the most widely used term for this type of disorders, many other terms are used synonymously such as »double insanity« and »psychosis of association«, leading to considerable confusion.

Standardised criteria adopt two main terms »induced delusional disorder« according ICD-10 classification and »shared psychotic disorder« according DSM-IV criteria.

ICD-10 diagnostic criteria for *folie a deux* are: two people share the same delusional system or delusion and support one another in this belief; they have an unusually close relationship and temporal or contextual evidence exist that indicates the delusion was induced in the passive member by contact with the active partner. DSM-IV diagnostic criteria for shared psychotic disorder or *folie a deux* are: a delusion develops in an individual in the context of a close relationship with another person or persons, who have an already established delusion; the delusion is similar in content to that of the person who already has an established delusion; the disturbances is not better accounted for by another psychotic disorder (eg. schizophrenia) or a mood disorder with psychotic features and is not due to the direct psychological effects of a substance or a general medical condition^{3,4}.

In the Gralnik classification of 1942 the term *folie á deux* is classically divided into four basic subtypes: *folie imposeé*-primary psychotic illness in one adopted by another; *folie communiqueé*-primary psychotic illness in both at different times with delusions shared or passed on; *folie simultanée* primary psychotic illness in both with identical delusions and *folie induite*. This last one refers to the addition of new delusions in a previous psychotic patient, under the influence of another patient^{5,6}.

The mean characteristic of this psychiatric disorder is a rare delusional disorder shared by two or occasionally more people with close emotional links. Only one person suffers from a genuine psychotic disorder, the delusions are induced in the other(s) and usually disappear when the people are separated. The psychotic illness of the dominant person is most commonly schizophrenic, but this is not necessarily or invariably so. The individual in whom the delusions are induced is usually dependent or subservient to the person with the genuine psychosis. Little data are available to determinate the prevalence of shared psychotic disorder. A clinical interview is required to diagnose shared psychotic disorder. The treatment approach most recommended is to separate the secondary partner from the source of the delusion. If symptoms

have not dissipated within one to two week, antipsychotic medication have to be used^{7,8}.

It is suggested that more detailed family and social investigations should be undertaken to unearth psychopathology in the social environment of the patient. In cases involving relatives, this may be another dimension to the genetic influence of mental illness⁹. *Psychodynamic* theories include the fear of losing important relationship in an otherwise isolated individual with little scope for reality testing or the passive acceptor has represented oedipal fantasies that are released by the psychotic partner causing identification of dominant partner with a partner. *Learning* theory suggests that psychotic thinking is learned through »observational learning«¹⁰.

Epidemiologic data indicate equal frequency in men and women, equal prevalence in younger and older patients, equal distribution between married couples, siblings and parent-child dyads. This disorder can be in comorbidity with dementia, depression and mental retardation². One study was examined demographic data of shared psychotic disorder case reports published from 19th to the 21st century and found that some of the earlier hypotheses such as females being more susceptible, older and more intelligent individuals being more likely to be inducers and sister-sister pairs being the most common relationship, were not supported. In Western countries the original delusions in the dominant person and the induced delusions in the submissive person are usually chronic and either persecutory or grandiose in nature. In Japan, acute psychotic reaction have noted to be delusions of a religious nature¹¹.

Data about treating this disorder are sparse, but the most authors consider that the separation of the two subjects has to be the basis of any intervention. The inducing subject has to be treated with specific medical interventions, including prescription of antipsychotics. Sometimes, the separation is enough to eliminate the delusional ideas from the induced subject, who according to the ICD-10 and DSM-IV meet the criteria of shared delusional disorder. Therefore specific studies are needed to understand the specific implications of this disease¹².

The new standard of treatment for shared psychotic disorder includes the use of atypical antipsychotics agents, mostly aripiprazole or quetiapine but also olanzapin, risperidon, or some newer-generation anticonvulsants¹³. Separation may lead to complete remission in up to forty (40) % cases¹⁰.

Our patient (adolescent) was fulfilled criterias for shared psychotic disorder based on DSM-IV or ICD-10 classifications. He developed delusions in the context of close relationship with his mother who had already established paranoid and religious delusions. His delusions were similar in content to that of his mother and delusions were induced in the passive member (adolescent) by contact with the active person (mother).

In presented case, adolescent finished elementary education with the support of school and clinical pedagogue and he has enrolled in the first class of secondary school.

It was recommended surveillance by Center for social well-fare work.

We have insisted for an accompaniment of mother on every clinical control of adolescent, because of possible relapse of psychotic symptoms in mother, in order to react timely on adolescent's condition. We were worried considering that mother did not take recommended medications again, and she has not had insight in the nature of her own disease.

After finishing hospitalization, he has come on control examination twice a month, accompanied by mother who was also dismissed from hospital. Mother was placed in a shelter.

Considering treatment with *olanzapin*, it was recommended blood analyses with lipid profile and liver tests. All values were in reference range.

With help of department pedagogue, school was informed and adolescent have had a chance to taking exams.

At first control we observed that the boy was in stable remission, he was attending school regularly and his grades were improved. He continued taking recommended medication. Mother left shelter and joined to her family.

Father stay lived in one part of house, mother and son in another part. Boy's communication with father was only during occasionally fishing. He mostly communicated and spent a time with mother. Mother did not take medications, we noticed discrete religious delusions in both mother and son. They still had paranoid interpretations toward father, stronger mainly in mother. In the next controls we gradually reduced dose of olanzapin, firstly on fifteen (15) mg, two months later on ten (10) mg, and three months after last control maintaining dose is five (5) mg in the evening.

Conclusion

With complete psychiatric anamnesis, clinical interview, psychological testing, EEG examination and control examinations we came to diagnosis and efficacious pharmacological intervention for son. Besides the treatment of disease alone, it is necessary to render boy and his mother in everyday activities and provide them functioning within the family, school and all community. Except of family heritage which is for sure present in adolescent, social and existential circumstances can interfered with further course of disease.

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ZAJEDNIČKI PSIHOTIČNI POREMEĆAJ (FOLIE À DEUX) IZMEĐU MAJKE I PETNAESTOGODIŠNJEG SINA

SAŽETAK

Prezentirali smo rijedak slučaj u kliničkoj praksi: petnaestogodišnji muški adolescent sa zajedničkim psihotičnim poremećajem sa svojom trideset sedam godina starom majkom. U ovom slučaju zajedničkog psihotičnog poremećaja dijete je bilo pasivni psihotični partner, a njegova majka je bila dominantni psihotični partner. Oboje pacijenata su dijelili jednake paranoidne i imperativne deluzije. S kompletnom psihijatrijskom anamnezom, kliničkim intervjuom, psihološkim testiranjem, elektroencefalografskom pretragom (EEG) i redovitim kontrolnim pregledima došli smo do dijagnoze i učinkovite farmakološke intervencije za sina.