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A Rare Presentation of Foliea Trois with Suicidal Pact.

Dr vamsi sreenivas MD (PSY) DR NARAYANASWAMY MD (PSY)
Corresponding Author: Dr vamsi sreenivas

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I. Introduction:

Shared Psychotic Disorder or Induced Delusional Disorder is a mental illness shared by two or more persons usually involving a common delusional system.(1)(2)If it involves two persons it is referred to as Folieadeux and if three persons are involved it is referred to as Folie a trois[4].

It was first described by Jules Baillarger in 1860 who termed this condition as 'folieacommunique'. (3)Lasegue andFalret coined the term 'folieadeux' in their classic paper titled 'la folieadeux' in 1877.(3)(4)Grainick in 1942 in his review, defined it as "the transfer of delusional ideas and/or abnormal behaviour from one person to another or one person to several others, related or unrelated, who have been in close association with the primary affected person".(3)(5)

It is relatively rare and the literature consists of case reports and the incidence and prevalence figures are lacking. (1)(4)Grainick also described 4 subtypes as follows - impose, simultanee, communiqué and induite[4]. The most frequent among these is Folie impose· (6)It basically involves transfer of delusion from one person who suffers from a genuine psychotic disorder (inducer) most commonly schizophrenia or delusional disorder to other person (recipient) who may have predisposing abnormal personality traits, who is highly suggestible, younger, passive, dependent, submissive, less intelligent and with lower self-esteem who live in close proximity with the inducer and both are socially isolated from external world. (3)Most of the cases involve family members, and women are more often involved than men. Genetic factors are thought to be involved in the etiology.(7)

Here we describe a case of Folieatrois with suicidal pact involving a mother and her two daughters who shared common delusional theme eventually ending in unfortunate events.

II. Case Report:

A 27-year-old unmarried female Miss A was from Tamil speaking, urban upper middle class family background. She presented to the emergency department with alleged suicidal attempt with high intentionality and high lethality. On clarification, it was the part of suicidal pact involving her mother and younger sister. They considered various methods of suicide and finally choose to consume high doses of benzodiazepines. Patient's mother and younger sister died following the suicidal pact. Patient was rescued and psychiatric opinion was sought.

On further clarification, they have seven years history of suspicion that their relatives are doing harm to them and were planning to kill them. They believed that they are trying to kill them by applying some poisonous material on the gate, which would result in giddiness and other somatic problems once touched. They have been acting out on their believes like avoiding all the contacts, not taking outside food, not attending phone calls, travelling in car with windows completely closed, frequently changing their supermarket which they would visit only once a month fearing they were being spied upon, not allowing anybody to visit their house and not touching the main gate of their residence. This was preceded by a conflict with their relative regarding the property.

They had also lodged multiple police complaints against their relative, which apparently lacked evidence to prove. Secondary to this they had significant psychosocial occupational dysfunction. Mother was initially affected by this followed by which both the daughters started sharing their mother's delusions. They did not take any psychiatric consultations and their condition worsened

gradually. They have been planning this suicidal pact for months during which they collected the medicines from multiple pharmacies. They attempted suicide together during which mother and younger sister died and the patient survived. She was locked up in the house for two days following which she called her brother who brought her to the emergency department.

After recovery from the benzodiazepine poisoning, on Mental Status Examination, she had persecutory delusions and referential delusions against her relatives. She was noted to be over familiar and also had regressive behavior but no other pervasive mood symptoms were present. We initially suspected hypoxic encephalopathy and MRI was done which did not reveal any pathology. Neuropsychological assessment was done and was normal. This behavior was attributed to disinhibition caused by Benzodiazepine overdose.

She was started on antipsychotic medication during IP stay. At the time of discharge, she did not have any suicidal ideas/ depressive symptoms. During follow up, she developed significant depressive symptoms and antidepressants were added. She was started on supportive psychotherapy. She lost follow up after 2 visits. Later brother reported patient died by hanging herself when he had left for work.

III. Discussion:

In this case, the three individuals were staying together and had minimal contact with others. The mother was dominant and overprotective over her two daughters who discontinued their studies in course of their illness. Mother was clearly the one who initiated their shared delusions, which she progressively imposed on her two daughters who by nature are very passive, dependent and submissive.

A key aspect in the etiology and psychopathology of folie a trois is the nature of relationship between the inducer and the induced.(3)(7) Not only were the daughters intimately associated with the mother, both in physical proximity and emotional intensity but also the mother had also placed extreme restrictions on their contact with the external world. This had cut off all their connections with reality and catalyzed the development of paranoid delusions.

There are only hypotheses for the etiology of these conditions mainly from behavioral and psychodynamic schools but none of these were systematically tested.(3)(8)

The incidence of co-morbidities in shared delusional disorder is not clear. In the above case, there is history of completed suicide in her mother and younger sister when they were actively psychotic. After treatment the patient improved in terms of her delusions but she developed severe depressive syndrome and significant survivor guilt and she had completed suicide probably secondary to her depressive symptoms. Hence it is important that these patients be hospitalized for a long-term to prevent unfavorable outcomes.

IV. Conclusion:

The above case report is an example of pathological relationship demonstrating the complexity of shared delusional disorder and the severity of psychosocial impairments and behavioral consequences of this illness. Sharing these delusions in the family results in the development of delusional "pseudocommunity".(8)
The first line of management is separation of the secondary case from the primary (dominant) one.(1) If symptoms do not subside, antipsychotics can be used. As literature shows, the disorder is rare but proper recognition of this disorder can result in successful treatment outcomes by separation of the patients, and psychopharmacological treatment. But not all the patients who are emotionally attached and living in close proximity develop these shared delusions, thereby further studies are required to find out the possible etiological factors underlying this contagious form of delusion.

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