Folie à Deux

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Folie à deux, also called dual psychosis, involves the transfer of delusional ideas from a psychotic individual to a nonpsychotic individual within the framework of a close relationship, with the eventual incorporation of the delusional system into the psyche of the previously nonpsychotic individual.

This rare syndrome was first reported by Laseque and Falret (1) in 1877. It was described as more common in females than in males and occasionally involved more than two people. A transfer of psychotic symptoms can only occur in an exceptional combination of conditions (2):

a) One person is the dominant individual. He or she is usually more intelligent than the other and gradually imposes his or her delusions on the more passive and originally nonpsychotic partner.
b) The two persons have lived a closely knit existence in the same environment for a long period of time, relatively isolated from the outside world.
c) The shared delusion is usually kept within the realm of possibility and may be based on past events or certain common expectations.

Brill (3), in 1920, proposed that the essential psychological process in Folie à deux is unconscious identification. Hartmann and Stengel (4) later stated that there is extreme dependence of the two partners on one another and identification is accomplished in order to avoid separation. In 1942, Grolnick (5) reported that among 109 pairs reported in the literature, 40 consisted of two sisters, 26 of husband and wife, 24 of mother and child, 11 of two brothers, 6 of brother and sister, and 2 of father and child. Although rare, Folie à deux has been included in DSM-III (6) as "shared paranoid disorder" because of its distinct clinical phenomena and the treatment implications that subsequently arise.

CASE REPORT

Mrs. A., 87 years old, and her daughter, Miss B., 58 years old, were both admitted to a hospital because they had kept the dead body of the husband of Mrs. A. in their home for three years, believing he was alive, that evil spirits had entered him, and that he was in a trance state. Miss B. was a high school graduate who had never worked outside of the home. Her mother had bilateral cataracts

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rendering her legally blind; she had not, in fact, left the family home for six years prior to the hospital admission. Miss B. left the home only to walk to the grocery store or to the bank, where she cashed her welfare checks. The family had been isolated from the rest of their relatives for the past 20 years.

According to the medical examiner's report, the husband had died three years before his wife's admission to the hospital. It was found that both mother and daughter kept the dead body in the house, propped up in bed and wrapped in a blanket. All three family members slept in the same bedroom; the mother shared the bed with her dead husband. They kept the kerosene heater burning throughout the year which caused mummification of the corpse by the hot, dry environment. On the day of admission, one of the neighbors went to deliver kerosene to the family and detected a strange odor in the vicinity of the house. She notified the police, who later discovered the mummified body.

At the time of admission, the daughter was overtly psychotic, stating that she heard angels talking to her, and that she communicated with the angels in return. She harbored the delusion that her father was still alive, but sick, and that she was a physician treating him. The mother presented with bilateral cataracts, yet showed no evidence of psychosis, other than the circumscribed delusion, shared with her daughter, that her husband was still alive. It was determined that the IQ of the mother was 98 and that of her daughter was 58.

After admission to the hospital, mother and daughter were treated on separate wards. Within a week of their separation, the mother showed improvement without any medication, and started believing that her husband had probably been dead for a long time. The daughter was started on antipsychotic medication and continues to require this for relief of psychotic symptomatology.

DISCUSSION

Psychotic symptoms are ordinarily not transferred from psychotic to healthy persons unless exceptional circumstances prevail. It is believed that in this case, separation from the outside world facilitated the transfer of delusional beliefs between family members.

Cases reported thus far in the literature have described the transfer of psychotic symptomatology from a more intelligent, psychotic individual, to a less intelligent, nonpsychotic person. Of particular interest in this case, the delusion was transferred from the less intelligent but dominant daughter to a mother who was almost entirely dependent on her.

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