FOLIE A DEUX IN A 13 YEAR OLD GIRL AND HER ELDER SISTER

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ABSTRACT

Folie a deux, is a rare delusional disorder shared by two or more people in close emotional ties, so that delusion of the primary patient is adopted by other person. We are presenting a rare case in our clinical practice of a thirteen year old female from ethnic minority with shared psychotic disorder, with her twenty three year old elder sister. In this case of Folie a deux the 13 year old girl was the passive psychotic partner and her 23 year old elder sister was the dominant psychotic partner.

Key words: Delusional disorder, Shared psychotic disorder.

INTRODUCTION

Folie a deux is a French term which literally means "Psychosis of two"[1]. It was first coined by Lasegue and Falret in 1877[2]. Folie a duex has been identified more frequently in women, possibly because of the traditional submissive role of females in the family. Both female and male secondaries are equally affected by female primaries[3].

CASE HISTORY

Our patient is a 13 year old young girl of Bangladeshi origin born and brought up in the UK. She was referred to Child and Adolescent Mental Health Services (CAMHS) as an urgent referral by GP, because of low mood, visual and auditory hallucinations along with paranoid delusions. During the CAMHS assessment, she gave 1 month history of seeing flashes of bright light or people with twisted faces staring at her. She was able to hear strange male and female voices laughing at her. She believed that someone grabbed her from behind and she was unable to breath. At times she felt that she was being poked inside her body. She had fear of being alone to the extent that she needed to be accompanied even when going to the toilet. This had a significant impact on her social interactions. She was unable to go to school.

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She was living in a 3 bedroom house with 9 family members. She described being brought up in a strict conservative environment. Father was 47 and worked as a Chef. Mother was 39 and a housewife. 2 elder brothers worked in a local restaurant and younger brother was in year 4. One sister lived in a residential home because of learning difficulties. Eldest sister had married against her parent's wish but had returned home because of marital difficulties.

Collateral history from various sources including parents, GP and school identified that she started experiencing hallucinations and delusions since return of her sister. Her older sister was having paranoid delusions of someone trying to harm her as well as hallucinations. Her symptoms closely resembled her older sister's symptoms. Initially father took both sisters to a faith healer but was reluctant to take them to the GP. Subsequently school raised concerns and she was referred to CAMHS. We offered to liaise with the faith healer but no success. After persistent efforts, father agreed to take her older daughter to the GP. GP urgently referred her to the PIER team (psychosis intervention and early recovery team) and we also liaised with them.

Other multiple issues such as overcrowding, school refusal were considered to be perpetuating factors in her illness. We involved the "Team around the child". We invited representative from School, housing officer, integrated service manager and PIER team for a meeting to address these issues individually.

With combined input from us and PIER team, her sister was started on anti-psychotic medication. It was noted that her sister responded well to the anti-psychotics. In order to help her sister's marital difficulties, PIER team involved a marriage counseling agency. We followed her on regular basis. Community psychiatric nurse supported her in the community and she did

supportive psychotherapy. As her older sister's symptoms improved; she also started feeling better. She did not need any medications. Improvement was noticed within 6 weeks after initial visit. Periodic physical separation happened as sister was taken to her house by PIER team. Considering her age views of her parents and the improvement she showed; antipsychotics were not started. A meeting was held at school and she was gradually re-integrated back to the school. Her attendance at school improved. Her sister left home to live with her husband. We continued to support her in the community and consequently she was discharged.

DISCUSSION

The main characteristics of Folie a deux are 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 others and usually disappear when the people are separated[4].

Some authors suggest non psychotic pathology[5-8]. The true population prevalence of Folie a deux is difficult to assess as under-diagnosis and underreporting are likely to be considerable [9,10]. The mechanism by which induction of delusions in the secondary person takes place is poorly understood.

Our patient met the criteria for Shared psychotic disorder based on DSM-IV . Her delusions were similar in content to that of her elder sister and delusions were induced in her after being in contact with her elder sister. Evidence regarding treatment of Folie a deux is sparse. The inducing subject has to be treated with specific medical interventions, including antipsychotics. Separation is sometimes enough to eliminate the delusional ideas from the induced subject. Collateral information from all the available sources in this case of Folie a' deux is of paramount importance[11,12].

Our case has shed some light on the evolution of delusional ideas and the external influences maintaining them. This may help clinicians and researchers in the future to focus on more fundamental questions of psychopathology and proper recognition of this disorder can result in dramatically successful treatment outcomes.

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