Folie à deux in a Seychellois mother and adult son

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INTRODUCTION

Folie à deux, a French term which literally means psychosis of two, was first coined by Lasegue and Falret in 1877 to describe a rare clinical syndrome in which delusions are shared by two or more people who have a close and intimate relationship and are often isolated from the outside world. The phenomenon was later defined by Gralnick (1942) in his classic review of 103 cases as:

'a psychiatric entity characterised by the transference of delusional ideas and/or abnormal behaviour from one person to one or more others who have been in close association with the primary affected patient.'

Within a decade of Lasegue and Falret's definition of folie à deux, four different subgroups were described. These four subgroups have remained the accepted classification and appear throughout the literature. They have been summarized by Gralnick (1942) as:

1. Folie imposée (imposed psychosis). The delusions of the psychotic person are transferred to a mentally sound person. The disease in the recipient tends to disappear as soon as the two are separated
2. Folie simultanée (simultaneous psychosis). Delusions occur simultaneously but independently in two or more morbidly predisposed individuals
3. Folie communiquée (communicated psychosis). The recipient develops psychotic symptoms after a variable period of resistance. After adopting the content of the delusion, the recipient then goes on to develop delusions that are independent of the first subject and are maintained even after separation of the two
4. Folie induite (induced psychosis). This subtype refers to an already psychotic, often hospitalized individual who is influenced and develops the delusions of a fellow patient, adding these to his/her previous delusions.

In all four types of folie à deux, one person (the dominant partner) initiates the delusion and the other (the submissive partner) accepts it (Lasegue and Falret, 1877). The primary inducer is often found to be to be more dominant as well as intelligent, forceful, older and in a position of greater seniority and authority (Enoch and Trethowan, 1979; Howard, 1994). The secondary or induced partner is often noted to be of a submissive, dependant personality and may be less intelligent, seclusive and depressed (Howard, 1994). In addition mental handicap (learning disability) or impairment is common among recipients (Soni and Rockley, 1974; Meakin and Renvoize, 1987).

The genetic and environmental aetiology of the phenomenon is controversial (e.g. Dewhurst and Todd, 1956; Kallmann and Mickey, 1946; Scharfetter, 1972). It has been suggested that folie à deux evolves because both partners derive some psychological benefit from it (Howard, 1994). This is particularly so when the couple are isolated from a seemingly hostile world. In many reports of individuals with shared psychotic disorder, the individuals concerned are isolated or seclusive from the remainder of society (Layman and Cohen, 1957).

Floru (1974) has suggested that the relationship between the family members is important in the development of folie à deux. These can be either prolonged togetherness (with emotional and financial dependence) or in people in socially isolated communities, with special reference to small families living alone (with 'monovalent' feelings). Floru emphasized the important part played by isolation, lack of adjustment and both social and economic inferiority. In a large proportion of cases the isolation is self-imposed and results from the hostile and rejecting attitude that accompanies the delusions (Sacks, 1988). However, the isolation may derive from non-illness factors such as poverty, physical disability, language difficulties and geographic isolation (Dewhurst and Todd, 1956; Sacks, 1988; Soni and Rockley, 1974).

In the case report presented here alleged racism between ethnic minorities living in London may have been a factor in the development of a folie à deux. This involved a 23-year-old man living with his Seychellois mother who had persecutory delusions about their neighbours (a couple, one of whom was West Indian).

DISCUSSION

Mrs A and her son suffered from a psychotic illness which fulfils the criteria of folie à deux (subtype folie imposée as delineated by Lasegue and Falret, 1877). Dewhurst and Todd (1956) set out three criteria for the diagnosis of folie à deux: positive evidence that partners have been intimately associated; a high degree of similarity in the general motif and delusional content; and unequivocal evidence that the partners accept, support and share each others delusional ideas. The case illustrated satisfies all these criteria.

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Most cases of folie à deux show a pattern of dominance and submission. Nine-tenths of cases of folie à deux are reported to occur in families (Signer and Ibister, 1987), with the mother–child combination being the third most common (Howard, 1994). The primary agent (in this case Mrs A) must be in close proximity, be a figure of authority or identification, and be in the early or less severe stages of psychotic decompensation in order to be in touch with reality enough to influence the other (Hart and McClure, 1989). In addition the secondary partner must derive some gain from adopting the symptoms (Hart and McClure, 1989).

Gralnick (1942) reported on Brill's theory that the underlying process was one of identification by the submissive party, which may be unconscious. Folie à deux is therefore an example of a pathological relationship in which the dominant party strives to maintain a link with reality while the other fulfils dependency needs (Hart and McClure, 1989).

Other cases of folie à deux involving a mother and child which have been recorded in the literature usually involve young children who are developmentally too immature cognitively and emotionally to resist their mothers influence by independent reality testing (Lasegue and Falret, 1877; Gralnick, 1942; Waltzer, 1963; Evans and Merskey, 1972; Hart and McClure, 1989). In addition folie à deux in the children of paranoid parents often develops when the child has no substantial relationships with other

CASE REPORT

Mrs A, a 47-year-old divorced Seychellois and non-practising Hindu who had been a resident in the UK for 30 years, was first seen in outpatients at the request of her general practitioner. She complained of a year-long history of frontal headaches which she believed were caused by the 'dangerous chemicals' fed into her flat by her neighbours.

Her problems with her neighbours began a year before admission, when Mrs A believed they put a dead animal outside her front door and bicycle grease on her front doorstep, just after she had cleaned it. The couple had been neighbours to Mrs A throughout her 10-year residence at her current flat. However, she felt at this time that she had seen the couple once before on another housing estate in London. Her previous relationship with the neighbours had been cordial. The 'persecution' became more serious 9 months later, when Mrs A noticed a strange smell in her flat and the appearance of brown stains on the letter box, front door and window frames. Mrs A believed that these were caused by her neighbours putting chemicals into her flat in an attempt to force her out and allow their own relatives to move in. She described the smell as 'orangey' with an unpleasant overtone described as similar to 'sewerage'. The smell was strongest in the evening when her neighbours returned from work. On one occasion, Mrs A claimed she caught her neighbour crouched outside her door and apparently 'feeding' the chemicals into her flat. This confirmed her suspicions although she did not confront him.

Initially, Mrs A tried to ignore the chemical smells. However, she felt that they caused her to have headaches and itchy eyes. Eventually she put an electric fan by her front door in an attempt to blow them away and complained to her local council. Although the council refused to take her initial complaint seriously, she believed that her neighbours knew of her complaints and decided to change their tactics.

Mrs A claimed that about a month later the chemicals stopped coming through her doors and windows but instead started to come from the ventilation shaft which connected her flat to the bakery below. In addition, Mrs A complained that she could feel vibrations coming up through the floor and furniture and following her about the flat. They were worse at night and only occurred when she was alone. She believed that the vibrations were generated by a large fan beneath her floorboards and that her persecutors were able to follow her movements by recognizing her footsteps. Mrs A was certain that the vibrations could not have been caused by the machines in the bakery as she had not noticed them before, and had noticed several cracks in her floors and walls since they began. She believed the woman who worked in the bakery to be in league with the next door neighbours. She also said that her neighbours were persecuting her because she was 'not white, quiet and unmarried' and that her problems regarding her flat were the result of 'racism'. She admitted to hearing her neighbours talking about her while standing outside her flat and, although she was unable to clearly make out the content of the conversations, the voices referred to her in the third person.

In the weeks leading up to hospital admission, Mrs A had been afraid to sleep in her flat out of fear of what the vibrations might do to her. She had spent most of the days and nights in the local hospital accident and emergency waiting area where she felt safe enough to sleep.

Mental state examination at the time of admission revealed a small, thin, tired woman who looked her age and was well kept. Her affect was warm but desperate and anxious. She had almost continuous eye content throughout the interview. Her mood was depressed and she admitted to insomnia, poor concentration, poor appetite and low energy. However, she denied anhedonia but admitted to suicidal ideation but no intent. Her speech had a normal rate and pattern. Her thought content was preoccupied with her troubles with her neighbours and her delusions were fixed. She admitted to third person auditory hallucinations, olfactory hallucinations and somatic hallucinations. She had no thought interference, or passivity phenomenon nor any homicidal feelings against her neighbours. She showed no evidence of disorientation or cognitive impairment. She had no insight into her delusional beliefs.

Her son B was 20 years old. He had left school at the age of 16 with no qualifications and had been unemployed ever since. B has eczema but otherwise had no medical or psychiatric history. He had always lived with his mother and described his relationship with her as good. At first he thought his mother may be unwell and did not believe her story. However, when interviewed at the second meeting during an outpatient appointment he admitted to believing about 80–90% of his mother's story. In fact it was he who apparently originally found the dead animal and had been the first to notice the yellow stains on the letterbox and window frames. He had also seen the grease on the front doorstep and had noticed a strange smell in the flat which he also described it as 'orangey' and unpleasant although it had no adverse effects on him. The floor vibrations did not bother him but he admitted to having felt them occasionally when he stepped close to his mother. Initially he thought that the chemicals and dead animal had been a joke. However, when he realized how upset his mother was his ideas changed and he had called a plumber twice, the gas board and a health inspector.

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adults. However, in this case the son was a fully grown adult who had contact with other adults outside the home and yet he still developed a folie à deux. The only other case in the literature which reports folie à deux in a mother and fully grown son is that of a 29-year-old man with Down's syndrome living with his deluded 77-year-old mother (Meakin and Renvoize, 1987).

Few people in close association with deluded individuals acquire their delusions as attested by the rarity of folie à deux (fewer then 300 cases have been published; Lazarus, 1986). There must, therefore, be some abnormalities of the associate either in his/her genetic make up, personality, social milieu, or all of these which predispose the recipient to acquire the principal's delusions (Soni and Rockley, 1974).

At present the mystery as to why the recipient abandons reality and takes on the delusions of the dominant partner has yet to be answered. Each case of folie à deux is unique and has something to offer in terms of an answer. The importance of culture differences between two ethnic minority groups could have been an important factor in shaping the content of the delusions seen in the case presented.

Finally, this case illustrates the legal problems which can arise in practice when treating a case of folie à deux. During her first admission Mrs A was very disturbed and tried to leave the hospital. However, her son shared her beliefs at the time and was resistant to

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CASE REPORT cont'd

B was interviewed on several occasions over approximately an 18-month period by mental health professionals, and there was no evidence of psychiatric illness, apart from corroborating his mother's history and delusional beliefs at her initial presentation. It is also of note, however, that it was her son who in fact recommended she consult a doctor about her problems. He felt (as said) that she was unwell and did not believe her story initially and he later shared with professionals that if she was found to be ill, so be it and she could be treated; on the other hand, if she was found to be well, then all the business about her neighbours would be 'proven to be true'. When she was treated and improved, his beliefs dissolved and disappeared without medication.

Mrs A was born in the Seychelle islands and her early development and schooling there were unremarkable. She emigrated to the UK in her teens and had a good employment record. She soon became involved with a Seychellois man with whom she had her first child. Differences in their religions forced them to separate and their baby was adopted. She married in her twenties to another Seychellois man and had three further pregnancies, the first ending in miscarriage, the second in a neonatal death and finally her son B, who therefore became a precious child. The marriage ended in divorce after 4 years when difficulties arose between Mrs A and her parents-in-law but she was awarded custody of the child.

Mrs A described herself as a happy person who preferred to keep herself to herself but with good relationships with family and friends. She had no medical history of note, and denied any psychiatric history, although she did admit to a suicide attempt after giving up her first child for adoption many years before. She was taking hormone replacement therapy. Both she and her son denied any history of illicit drug abuse and neither drank alcohol.

Mrs A was the eldest of six siblings. Her father had been a successful business man until he became an alcoholic and died of liver disease at the age of 60. Her parents separated when Mrs A was 10 years old. All except one of her siblings emigrated to the UK and all except a sister had a good relationship with Mrs A. Apart from her father's history of alcoholism there was no family psychiatric history of note. One of her brothers, C, also had problems with his neighbours in a London council flat. He believed that his neighbours were drug dealers and this bothered him to the extent that he endeavoured to find alternative accommodation.

A diagnosis of an encapsulated paranoid delusionary state with a secondary depressive disorder was made in Mrs A and of a folie à deux in her son. She was admitted to hospital on an informal basis. Physical examination was normal. Routine haematological tests, vitamin B_{12}, folate, urea and electrolyte, serum copper and caeruloplasmin, erythrocyte sedimentation rate and C-reactive protein, liver and thyroid function tests were all within normal limits. Urine cultures and syphilis serology were negative. A computed tomography scan, single photon emission computed tomography scan, electroencephalogram (EEG) and sleep-deprived EEG were also normal. A drug screen showed cannabis in her urine but was otherwise negative.

While in hospital Mrs A did not experience any somatic or olfactory hallucinations although her sleep remained poor, requiring zopiclone (Zimovane, RhonePoulenc Rorer, Kent) at night. She became agitated during one ward round and expressed her desire to leave. She was placed on a section 5/2 of the Mental Health Act 1983 with a recommendation for a section 3. However, her son refused to give permission for a section 3 and she remained an informal patient but fortunately agreed to stay and start medication.

A home visit revealed that Mrs A had turned her home into a fortress. Masking tape surrounded the front door and several windows to stop the gases, most of the movable furniture had been moved away from the walls and the curtains were drawn. Mrs A explained that she had tried to sleep on the kitchen work surface on top of several phone directories in an attempt to get away from the vibrations.

She was treated with sulpiride (Sulpitil, Pharmacia & Upjohn, Milton Keynes) 200 mg in the morning and 400 mg at night. The rest of her 2-month hospital stay was uneventful and she was allowed intermittent home leave which went well with no reports of vibrations or chemical fumes. She was discharged on sulpiride 200 mg in the morning and 400 mg at night with occupational therapy, home visits and outpatient follow-up.

Unfortunately Mrs A relapsed 2 months after discharge and was re-admitted complaining that once again her neighbours were bothering her. The vibrations had returned and she had been unable to sleep. Her mental state was similar to her previous admission and was without insight. She was adamant that her problems were real events caused by her neighbours and was pursuing resettlement with the council.

During her hospital stay she continued to be treated with sulpiride in addition to paroxetine (Seroxat, SmithKline Beecham, Middlesex) 20 mg once a day. She slept and ate well on the ward and home leave went well. She was discharged a month after admission, accepting the possibility that her problems could have been because she may have been oversensitive.

Mrs A was last seen by us at follow-up 8 months later when, unfortunately, she had once again relapsed. Her son, however, denied any abnormal experiences and no longer felt that his neighbours were persecuting his mother.

ideas of detaining his mother under the Mental Health Act 1983. Both individuals were irrational, but only the mother was psychotic and required admission.

Of course, in an instance such as this, when the 'nearest relative' (in this case Mrs A's son, B) objects to an application being made with regards to a section 3 of the Mental Health Act 1983, one must consider 'displacement' of the 'nearest relative' (Department of Health and Welsh Office, 1993; Jones, 1996; Bethlem and Maudsley NHS Trust, 1997). In the Mental Health Act 1983, an approved social worker has to obtain consent of the nearest relative of the patient before making an application for a section 3, i.e. for admission for treatment; if the nearest relative refuses, the section cannot proceed at that time.

The nearest relative can be displaced or set aside on application to a County Court (section 29) on the grounds that he/she is unable to act as the nearest relative by reason of his/her 'mental disorder or other illness' or because he/she 'unreasonably objects to the making of an application'. Thereafter, the local authorities must provide proper assistance, especially legal assistance. Clearly, if B shares Mrs A's delusions, he would be unable to act as the nearest relative because of his mental disorder, and one could proceed with displacement. **HM**

Some personal details, which do not affect the clinical content of this case report, have been changed for reasons of confidentiality.

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In the Public's View...

Milburn's rude health policy

Alan Milburn is the new Secretary of State for Health. He has started as he means to go on. On day one he upset most of the doctors that I know, and he'll go on doing that until we're all so demoralised that we won't bother even trying to object.

His first interview on BBC Radio 4's Today programme clearly revealed his intentions: he is confrontational and dismissive. Our leaders have been muttering things about Milburn making an impression when Health minister… man who speaks his mind… looking forward to doing business... They obfuscate.

Milburn will ride roughshod over any doctor who doesn't share his view of 'modernisation' of the NHS, which largely consists of more walk-in clinics and blather about people being able to buy insurance any time of day so why shouldn't they get medicine in the same way? If Milburn can't see the difference between insurance and medicine, perhaps he didn't spend long enough at the Treasury before coming back to the Department of Health.

In the same week Milburn was appointed, the *New Statesman* published an essay (25 October, p 32–3) by an inner city GP. He wrote:

> **'Doctors are intelligent people, who have generally worked hard to enter the profession…increasingly they are being treated as if they were criminally inclined and stupid into the bargain, in need of the superior wisdom of the government to keep them in order.'**

I'm not sure how cancer specialists feel at the moment: pleased that there may be more resources for cancer or worried that the pressures will become more intense. They are working their socks off, with mounting numbers of patients to see and increasing numbers of treatments to be given, only to be told the cancer care in the UK is worse than anywhere else in Europe. And, heaven forfend, the Calman–Hine recommendations have not yet been put in place everywhere!

For the Government it is a matter of moving from the un-thought-about to the not-worked-out: waiting lists were an inheritance that Labour did not have the guts to scrap, so the displacement activity chosen is 'target the big killers'. We can target them as much as we like; they will still be the big killers.

The Sun may encourage men to examine their testicles and write emotive editorials about how 'together, we can beat cancer'. But we can't. We can improve things, but the best way we can improve things in health care — for most people, most equitably, in the long term — is by getting away from this emotive, gung-ho, all-things-are-disastrous language.

Call in the 'cancer czar'; don't expect much to happen if the intellectual debate surrounding him is as idiotic as the debate (or complete lack of it) that surrounds the 'drug czar'. In wanting to make the UK cancer figures 'the best in Europe', aren't we ignoring the fact that other nations are unlikely to stand still?

And don't ask rheumatologists and orthopaedic surgeons what they think about all this: the conditions they treat only leave patients in pain for years and years. Big killers are what we need to sort out. **HM**

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