



Lasègue-Falret Syndrome – Folie Simultanée

Authors

Sushma Viswanathan¹, Swetha Raghavan², Akshay Singh³, Sathianathan R⁴

^{1,2}Senior Resident, ³Junior Resident, ⁴Professor

Department of Psychiatry, Sri Ramachandra University, Porur, Chennai-600 116

Tamil Nadu, India

Corresponding Author

Swetha Raghavan

Email: drraghaswe@yahoo.co.in

Abstract

Psychosis of Association, also known as folie à deux, as described by Gralnick refers to “the transference of delusional ideas and/or abnormal behavior from one person to one or more others who have been in close association with the primarily affected patient”^[1]. This report describes a 35 year old man who presented with paranoid symptoms and was diagnosed as Schizophrenia. However, on detailed evaluation it was found that his wife too harboured similar delusions. A definitive diagnosis of Shared Delusional Disorder was finalised. Here we report this challenging psychiatric condition of ‘Folie simultanée’ in a non-consanguineous married couple for the rarity of its occurrence.

Keywords-*Psychosis of association, folie à deux, paranoid, delusions, folie simultanée.*

Introduction

The French term ‘folie à deux’ literally meaning ‘insanity of two’ was first coined by Lasègue-Falret in 1877.^[2] It was described by them as shared delusional disorder, in which a delusion is transferred from a psychotic person to one or more non-psychotic recipient(s). Usually, the couple lead a life in relative social isolation and the primary patient (inducer) has a close emotional association with the secondary (recipient) and. Hence, the recipient starts sharing the same belief. They also proposed that the primary inducer was an active and intelligent individual who could induce delusional beliefs in an otherwise submissive, less intelligent secondary partner. They also made a note that the delusional beliefs often bore reference to common everyday life events, experiences etc.^[2]

Regis (1880), coined the term ‘Folie simultanée’ in his theses, where he described that sharing of delusions was possible between individuals who had genetic disposition to psychosis. He further explained that two subjects who have lived in close and continuous association could develop delusions simultaneously consequent to a same accidental event.^[3]

Gralnick, in 1942 elaborated upon the same by describing ‘Folie simultanée’ (simultaneous psychosis) characterised by simultaneous appearance of paranoid or depressive delusions in two individuals hereditarily predisposed to psychosis.^[1]

There are very few cases of ‘Folie simultanée’ that have been reported in literature and hence this case is discussed here to illuminate upon the presentation and phenomenology of this rare subtype.

Case Presentation

A 35 year old graduate, living with his wife and two children was working as security personnel in a guest house. He reported with his brother-in-law with complaints of suspiciousness, fearfulness and sleep disturbance for 3 months. It all began after an argument with a co-worker, who threatened to harm the patient and his family. Later that night, the patient discussed the incident with his wife. Fearing revenge, the couple spent sleepless nights over the next few weeks. They frequently checked upon each other's safety through phone calls. Gradually, they cut down their social contacts and restricted the activities of their children. Thereafter, the patient confined himself to a room in the house. He did not attend to his obligations as before. He preferred being inside the house for most part of the day. However, he maintained adequate grooming and hygiene. Apart from this, there was no history of hearing voices, substance use, head injury, seizures, road traffic accident or any previous episodes of mental illness. Neither was there a contributory history of mental illness in the family nor any evidence of deviant personality traits. At the time of initial assessment, mental status examination revealed a moderately built male who appeared his stated age. He avoided gaze contact. He endorsed delusion of persecution, delusion of reference, but denied hallucinations in any modality. His cognitive functions were unimpaired with no insight into the illness. With a provisional ICD-10 diagnosis of F29 Unspecified Nonorganic Psychosis, patient was started on T. Olanzapine 10mg and asked to review with his spouse in two weeks.^[4]

The patient failed the next visit. He was brought after 3 months by his brother-in-law with complaints of decreased self care, decreased interaction, sleep disturbances and fearfulness. Though the symptoms persisted, patient had not complied with medications for the past three months. During the current evaluation, the patient appeared dishevelled and presented with thought insertion, thought broadcasting, delusion of persecution, and delusion of reference with grade 1 insight. The diagnosis was revised as F20.0 Paranoid

Schizophrenia. Patient was admitted for detailed evaluation and dose titration.

The wife was interviewed during the patient's admission. Her mental state examination revealed delusions of reference and persecution, the content of which was identical to the patient's delusions. She also reported that this suspiciousness had begun simultaneously. Her psychological evaluation was suggestive of Delusional Disorder and she was started on low dose Olanzapine 5mg at night.

Investigations

Complete hemogram, liver parameters, renal function test, thyroid function test and lipid profile were normal. Imaging studies of the brain which included CT brain and EEG were essentially normal.

Psychometry

The following scales were administered:

- The Brief Psychiatric Rating Scale (BPRS) scale revealed a score of 50.
- In Positive and Negative Syndrome Scale (PANSS), patient obtained T scores of 55 (average) in positive symptoms, 39 (below average) in negative symptoms and 49 (below average) in general psychopathology.
- Rorschach protocol showed average productivity, average mentation, presence of many dehumanised responses, few popular responses, presence of many S responses, presence of poor form level, colour naming and low number of FC responses. These findings were suggestive of Paranoid Schizophrenia.

Differential Diagnosis

After the initial evaluation, a provisional diagnosis of F29 Unspecified Nonorganic Psychosis was made. However, on follow up, the patient's delusions persisted and other first rank symptoms of schizophrenia had appeared. Hence, the diagnosis was revised to F20.0 Paranoid Schizophrenia.

Upon more detailed evaluation, it was identified that the wife shared similar delusions and the symptoms

had begun simultaneously in both of them. Hence the diagnosis was clinched as F24 Shared Delusional Disorder ('Folie simultanée' subtype).

Treatment

Patient was restarted on T. Olanzapine 10mg and T. Clonazepam 1mg after admission, both at night. Over a period of 10 days, patient's sleep and self care improved. He was discharged with the same medications. It was also suggested that the patient and his wife stay apart for a short duration. Patient was asked to follow up after two weeks. The need for regular compliance with medication was explained to the couple.

Outcome and Follow Up

During the subsequent follow up after two weeks, the couples' anxiety had decreased after the primary patient had stayed apart from his family. His wife had been residing at her mother's house along with their children and was on medication as advised. At the time of third visit (about a month later), index patient had resumed his job, though he continued to harbour fears of being persecuted by the co-worker (who no longer worked with him). His family had been staying away from him during this duration and wife had shown significant improvement in terms of her delusional beliefs and hence they were advised to re-unite. At present the family lives together, the wife's medication has been tapered and stopped, whilst the husband continues to be on Olanzapine 10mg at night.

Discussion

Folie simultanée' has been described in earlier studies to be seen commonly in people who share a genetic linkage. However in the above couple, the husband was the primary patient (inducer) and his wife (recipient), due to her intimate emotional association, shared the delusion of her partner.

Lazarus emphasized that two preconditions must co-exist for folie à deux to develop: First, an intimate emotional association between the inducer and affected person, and second, a genetic predisposition to psychosis, such as blood relations

with primary patient.^[5] He also went on to explain that the diagnosis need not be restricted to non-consanguineous patients; it should also be made when family members are involved.^[5]

Dewhurst and Todd (1956) had put forth three concise criteria which were widely accepted for the diagnosis of folie à deux as follows:^[6]

1. There must be marked similarity of the delusional content.
2. The partners should share, support and accept each other's delusional beliefs
3. There must be adequate evidence of close association between the partners.

Folie simultanée represents a therapeutic challenge as both patients develop symptoms at the same time. Most cases till date have been reported in patients with shared genetic components. The closeness of association is an important factor for the development of psychotic symptoms. Both patients must be thoroughly evaluated to assess the severity of the symptoms. Treatment plan must be structured according to the individual needs, which include pharmacotherapy, psychotherapy and separation if needed. This case emphasizes the importance of sub-classification of induced delusional psychosis for further etiological and clinical research.

Conclusion

- Psychosis of association can present in genetically related as well as emotionally connected individuals.
- A thorough history taking is essential to weigh a differential diagnosis.
- The treatment plan must be tailored according to the need of the patients and should include individual plans for each affected person.

Source of Support: Nil

Conflict of Interest: None

References

1. Gralnick A. Folie à deux-the psychosis of association. *The Psychiatric Quarterly*. 1942; 16(2):230-63

2. Lasègue C, Falret J: La folie à deux. Ann Med Psychol. 1877; 18: 321-355.
3. Regis E: La folie à deux. Paris, Thèse. 1880
4. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva; 1992
5. Lazarus A. Folie à deux': psychosis by association or genetic determinism? Comprehensive Psychiatry. 1985; 26(2):129–35.
6. Dewhurst WG, Todd J: The Psychosis of association- folie à deux. J Nerv Ment Dis 1956; 124:451-459