Case Report

Shared psychotic disorder

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ABSTRACT

We describe a rare case of psychotic disorder, with unique family dynamics and management difficulties.

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Shared psychotic disorder is also known as folie à deux and induced psychotic disorder. The essential feature of this disorder is a delusion that develops in an individual who is involved in a close relationship with another person (the primary case) who already has a psychotic disorder with prominent delusions.[1] The secondary case is frequently less intelligent, more gullible, more passive, or more lacking in self-esteem than the primary case.[2] Schizophrenia is probably the most common diagnosis of the primary case, although other diagnoses may include delusional disorder or mood disorder with psychotic features.[1] It is most likely rare, but incidence and prevalence figures are lacking and the literature consists almost entirely of case reports[2] (fewer than 300 cases have been published).[3] A recent summary of the Japanese literature indicated that in 97 cases of folie à deux, the phenomenology and epidemiology were similar to those in western reports,[2] and to the best of our knowledge, no similar cases have been published from this region.

Case Report. The patient was a 17-year-old single girl, a 7th grade student who was brought to the Emergency Department by her mother with a drug overdose after ingesting 20 paracetamol tablets. Her mother discovered her, in the early hours of the morning, talking to a stranger on the telephone, which is not acceptable according to religious and social standards of the society. She was admitted to the medical floor under observation, and referred to the psychiatrist for evaluation regarding the suicidal attempt.

On interview, she admitted that she had ingested the tablets without a previous plan, rather, just to avoid her family's reaction to her unacceptable telephone calls. She denied having low mood, lack of interest, death wishes or any other depressive symptoms. However, she had a strong belief that she had been under the effect of witchcraft for many years. She believed this to be carried out by her paternal aunt who employed housemaids to perform the witchcraft; especially as she is infertile and feels jealous toward the patient's family. She also believed that people follow her wherever she goes. Despite this, she continued to have good self care, share the household activities with her mother and go to school regularly with average performance. She had no paranoid attitudes towards her family members, hearing of voices, disturbed behavior or history of substance abuse.

On interviewing the mother, she reported that her daughter is active, helpful, goes to school regularly, takes care of her personal hygiene, has good relationships with her family with no history of self-talking behavior, hearing voices or disturbed behavior. The mother is also convinced that the paternal aunt is performing witchcraft with the help of housemaids. In addition to that, the mother believes that her mother, sister and neighbors are all against the family. Therefore, she decided to avoid

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any contact with them for the last 12 years; even when her father died 2 years ago, she did not attend the funeral and did not join her family or visit them.

This patient's family lives in a flat in a 7-storey building and the mother has a strong belief that a stranger is following the whole family, and that he used to park his car daily in front of the building. She therefore asked her husband to cover all the windows with metal plates. She brought a faith healer, but came to realize that he was following the aunt's orders to perform witchcraft.

The father confirmed that the main problem is the mother's behavior and attitude towards almost everybody over the last 12 years. She is suspicious of her mother, sister, sister-in-law and she believes that these people, in addition to neighbors, are performing witchcraft against her and her daughter. The father also added that he had recruited 7 housemaids and his wife had fired each of them for the same reason. Although he does not agree totally with his wife's beliefs, in order to avoid clashes with her, he mostly goes along with what she says; he is convinced that she has a mental illness and requires treatment, which she refuses. A psychiatrist has seen her twice, however she did not continue treatment and refused to take medications. The father also reported that his daughter is usually at home and his wife does not allow her to go out anywhere, except with her, and does not interact with other people. He believes that his daughter beliefs are not her own but her mothers, especially as she is the eldest among her siblings who do not have these beliefs. The father has adapted to his wife's beliefs, and despite his suffering, he has no other choice, especially as she is taking care of herself and her children and performing her household activities well.

After admission for 2 days to the medical floor, the patient was discharged in good medical condition with no more suicidal plans or intentions. She was given an outpatient appointment in the psychiatry clinic.

Discussion. This patient is delusional in the context of a close relationship with her mother who already has established delusions. The delusions are similar in content to those of the mother. These delusions cannot be explained by another mental illness and these findings fulfill the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, diagnostic criteria for shared psychotic disorder. Based on her well fixed, unshakable non-bizarre systematized beliefs, having normal level of functioning and no history of hallucinations, the mother seems to have a delusional disorder. The dominant primary case and submissive secondary case pattern is well represented here as the mother has the authority and maintains a close proximity to the daughter and at the same time does not show severe psychotic symptoms that may affect her daughter's acceptance of these beliefs. In addition, the extent of social isolation the mother imposes on her children does not allow her daughter to have normal social contact and interactions with others, which has also contributed to her vulnerability to this disorder. Moreover, the father is so passive and is used to obeying his wife's orders; although he believes that she is mentally ill. He feels helpless because she totally refuses to seek any psychiatric help or to take medications for herself or her daughter.

The mechanism by which shared psychotic disorder develops is not clear. The mechanism involving classic learning theory was initially suggested,[4] which could be relevant to this case where the daughter learns from her mother and begins to think and behave in a psychotic manner. On a simplistic level, it has been suggested that shared psychotic disorder evolves because both partners derive some psychological benefit from it; particularly when the couple are isolated from a seemingly hostile world.[5] For the mother, it could be that the final attempt to keep in touch with reality is to maintain her relationship with her daughter. However, for the daughter it is difficult to explain why she accepts those beliefs. There must be some abnormalities in genetic make up, personality, social milieu or all of these that predispose her to acquire the mother's delusion.[6]

Treatment usually involves separation of the 2 people. Despite the popular belief that separation will always prove effective, results have been disappointing and found not to be therapeutically effective.[7,8] For the secondary case, separation leads to full recovery in only 40%.[5] Furthermore, in this case separation may be difficult to achieve unless by admission which the mother refuses. In addition, she refuses to take antipsychotic medication, even through long acting injections. For the daughter, antipsychotic medications are indicated as strongly as for the mother.[5] Family and social support are also indicated to modify the family dynamics and to make sure that the family unit is exposed to input from outside sources to decrease isolation.[2]

Each case should be regarded as unique in terms of the management and treatment needs.[5] In this case, the mother is the primary case and plays the dominant role, not only in her relationship with her daughter, but even with the whole family. She refuses any medical intervention for herself or for the daughter. The mother should be considered the main target in any form of intervention and admission may have to be under a mental health act,[5] which is unfortunately not applied in Saudi Arabia. So this crucial step may not be undertaken, especially within these unique family dynamics.

The daughter continued to have the same beliefs on several follow-up appointments; then she did not

show up in the clinic despite personal contact with the father who was not happy with his daughter's condition but unable to do much.

This is a unique case in terms of diagnosis, psychodynamics and interactions within the family settings, which have their impact on management.

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