Case Report

A CASE REPORT OF FOLIE À DEUX WITH DELUSION OF PREGNANCY

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ABSTRACT

Pseudocyesis is common, whereas delusion of pregnancy is a rare psychopathology. The shared delusion of pregnancy is even rarer. We present a case from a tribal community where a wife shares her husband's delusion. It highlights the role of biopsychosocial determinants in forming psychopathology. It also reflects the need for strengthening community psychiatry approach.

Keywords: shared delusion, delusion of pregnancy, Folie à deux

INTRODUCTION

The shared psychotic disorder was first described in 1860 as Folie Communique by the French psychiatrist Jules Baillarger.[1] It is coded as category F24 in ICD-10.[2] Two individuals share a psychological symptom, particularly delusion in Folie à Deux.[1] Moreover, the partners have an intimate association, high commonality in the content of delusion, and they share, support and accept each other's delusions (Dewhurst Todd criteria).[3] It has an incidence of 1.7 to 2.6%.[4] There are four subtypes[5]: Folie imposeè, Folie simultaneè, Folie communiqueè, Folie induitè.

CASE REPORT

Mrs X, aged 42, came to the outpatient wing of the Department of Psychiatry of the District Hospital, Wayanad (a district with the largest tribal population in Kerala), for consultation in February 2020. She was literate and was working as a sweeper in a temple until she got married in 2016. She did not have any children.

She had presented to the antenatal clinic with a history of two years of amenorrhea. However, her ultrasonogram did not reveal any evidence of gestation, and the gynaecologist had repeatedly ruled out pregnancy during each of her visits in the previous four months. She was being treated for pelvic inflammatory disease. Also, gynaecologists were of the opinion that her early menopause was familial. Since Mrs X believed that her expected delivery date was approaching, she brought her mother to speak to the gynaecologist and was referred for the psychiatry consultation. Her mother was ambivalent: keen to believe that her daughter is pregnant and at the same time having trust in what the gynaecologist opined.

She had no family history of significant medical or psychiatric illness. Her father passed away when she was five. Her elder brother is the decision-maker in the family. Financial constraints rendered her childhood difficult and posed challenges in her marriage as well. She got married to Mr A, who did not insist on dowry or a ceremonial wedding. Subsequently, she stayed with her husband and has not visited her home, though it was at walking distance. Premorbidly, she was social, responsible, hardworking and competitive.

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During the interview, she did not sit because she feared that the baby's weight would make it difficult for her to stand up later. She was cheerful, well-dressed and maintained good eye contact. She believed that she was pregnant since 14th November 2019. Her belief originated when her husband Mr A told that he got 'messages from God' about her pregnancy. Next day she experienced vaginal discharge, and since it was Children's Day (India celebrates Children's Day on November 14), she concluded that she carried a child. Also, she could feel movements, 'as if a child was moving inside'. According to her, Mr A had divine power. Her affect and cognition were normal.

For the next appointment, she came with her husband (Mr A), 58 years who appeared shabby but having vermilion on his forehead. He was a manual labourer. At eight years of age, he had lost his mother and got separated from his father and sister in a forest fire. He worked in Goa for nine years and returned to Kerala in 1979, got married the same year and has two daughters. Since 1984, he has been hearing voices of different Gods who addressed him as an elder brother. The voices told him that his wife's sister and husband are conspiring against him and his wife is an infidel. After his divorce in 2006, he filed complaints against ex-wife and her family based on 'messages from God'. He married Mrs X in 2016 based on 'messages from God' that he heard. He had never used any addictive substance like alcohol or cannabis. He does not have any friends and seldom goes out of his home. He earns his livelihood from his 1-acre land. He has not consulted a psychiatrist before. There was no one available to give information about his family of origin and premorbid personality.

Mr A talked in monotonous low volume and used the term "Sulthan" as a neologism which, according to him, meant a female destined to carry a gifted child in the womb. He had a delusion of persecution against his ex-wife and her family, a delusion of divine power unrelated to the first delusion, and a third unrelated delusion that his wife is pregnant and carrying a child with a special mission. He also said that a snake controlled his thoughts. He also had third-person auditory hallucinations where Gods discussed about him and second-person auditory hallucination where a snake dictated to him how his relationship with his wife should be. His affect was cheerful and incongruous to his thoughts. His physical examination and laboratory investigations were within normal limits.

We sought support from the wife's brother, who took her to the parental home. Treatment adherence was ensured with the tribal promoter's involvement. Risperidone was started at a dose of 2 mg for Mr A, which was later increased because of inadequate response even after a month. Supportive psychotherapy was given for the wife. After three months, wife attained remission and the husband symptomatically improved and is on follow up from the District Mental Health Programme.

DISCUSSION

The working diagnosis was schizophrenia, paranoid subtype (F20.0)[2] for the husband and Shared Psychotic Disorder (F24)[2] for the wife. For Mrs X, the false belief that she was pregnant was acute and morbid in origin, unshakeable, and highly preoccupied with it. She was acting out by modifying her daily routines and regularly visiting the antenatal clinic. Hence, the possibility of an overvalued idea was ruled out.[6] Another differential diagnosis considered initially was Brief Psychotic Reaction which was later ruled out as the symptoms persisted for more than six months from onset. (F23-ICD 10)[2]

The delusion of pregnancy is a rare psychopathology.[7] It differs from Pseudocyesis (F45.8) in ICD 10.[2] Even though William Harvey reported "phantom pregnancy" in 1651 where a Folie à deux in two sisters was described, further reports on the shared delusion of pregnancy is rare.[8] The common themes in Folie à deux are persecutory followed by grandiose.[9] In this case, the patient presents with a delusion of pregnancy, and the apparent instigator is her husband. The diagnosis can be Folie imposeè which is the most common subtype.[5] Delusions result from aberrations in how brain circuits specify hierarchical predictions, and how they compute and respond to prediction errors.[10] Though many people with delusions live with their relatives, they seldom share delusions. Hence, identification of the factors leading to sharing of delusion is important.

Genetics and environmental factors are complementary when Folie à deux develops.[11] Case reports suggest childhood trauma as risk factors for the secondary (induced) patient.[12] Social isolation limiting environmental input and opportunities for reality testing is also common.[13,14] There is a similar prevalence

of schizophrenia in families of both individuals in Folie à Deux.[15] The described secondary case does not have a family history of psychotic disorder, but childhood trauma and stress are present in both the inducer and induced. The induced is socially isolated and has not even visited her family after her marriage, unlike their society's usual practices. In Folie imposeè, the primary case is dominant, intelligent, forceful and autonomous. One of the postulated mechanism in Folie à deux is the immediate association between the inducer and induced (both physical proximity and emotional intensity), thus learning the behaviour from the more dominant and driving inducer.[16] In the described case, though the wife has a premorbid personality of being autonomous and competitive, the cultural beliefs where husband plays a dominant role in marital relationships, and the words from God has supremacy, could have made her adopt a submissive role after marriage. Identification, recipient-ambivalence, love-hate relationship and role of imitation and sympathy are postulated as psychodynamic mechanisms in Folie à deux.[16] Beliefs exist in their community that marriage is not fruitful if a child is not born. This could have made her anxious when she had amenorrhoea for 2years. The relationship between conditioning and formation of delusion and the underlying neurobiology is already documented.[10] The psychodynamics in the patient and the cultural beliefs existing in the tribal community might have conditioned to share this particular theme of delusion while being immune to other psychopathologies of her husband.

The prognosis of the shared psychotic disorder depends on multiple factors, including the primary mental disorder, secondary biopsychosocial predisposing factors, and exposure to the delusion. However, adherence to the management plan is beneficial. In the described case, the husband's lack of support system duration of untreated illness, personality factors in wife, the proximity of themes of delusion to the existing religious beliefs and cultural norms in their tribal community were detrimental. However, support from the wife's relatives and the efficient functioning of Community psychiatry via Family Health Centre and District Mental Health Programme helped ensure treatment adherence for the husband.

REFERENCES

1. Lasègue C, Falret J: La folie à deux. Ann Med Psychol. 1877; 18: 321-55.
2. ICD-10 Classifications of Mental and behavioural disorders: Clinical Descriptions and Diagnostic Guidelines: Tenth revision-2nd edition. Geneva. World Health Organisation. 2004.
3. Dewhurst K, Todd J. The psychosis of a association; folie à deux. J Nerv Ment Dis. 1956 Nov;124(5):451-9.
4. Wehmeier P, Barth N, Remschmidt H. Induced delusional disorder, a review of the concept and an unusual case of folie a familie.Psychopathology.2003 Jan-Feb;36 (1):37-45
5. Gralnick. Folie a Deux, the psychosis of association: A review of 103 cases and the entire English literature.Psychiatric Quart.1942;6:230
6. Mullen R, Linscott RJ. A comparison of delusions and overvalued ideas. J Nerv Ment Dis. 2010 Jan;198(1):35-8.
7. Yadav T, Balhara YP, Kataria DK. Pseudocyesis Versus Delusion of Pregnancy: Differential Diagnoses to be Kept in Mind. Indian J Psychol Med. 2012 Jan;34(1):82-4.
8. Hunter R, Macalpine I. Three Hundred Years of Psychiatry. London, UK: Oxford University Press; 1963.
9. Al Saif F, Al Khalili Y. Shared Psychotic Disorder. [Updated 2020 Aug 10]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK541211/
10. Corlett PR, Taylor JR, Wang XJ, Fletcher PC, Krystal JH. Toward a neurobiology of delusions. Prog Neurobiol. 2010 Nov;92(3):345-69.
11. Lazarus A. Folie à deux: psychosis by association or genetic determinism? Compr Psychiatry. 1985 Mar-Apr;26(2):129-35.
12. Vargas Alves Nunes A, Odebrecht Vargas Nunes S, Strano T, et al. Folie a` Deux and its interaction with early life stress: a case report. J Med Case Rep. 2016;10(1):339.
13. Nishihara, Ryan M. and Nakamura, Craig T. "A Case Report of Folie A Deux: Husband-and-Wife," Jefferson Journal of Psychiatry.1993;11(1):43-50 Available at - https://jdc.jefferson.edu/jeffjpsychiatry/vol11/iss1/9
14. Silveira JM, Seeman MV. Shared psychotic disorder: a critical review of the literature. Can J Psychiatry.1995;40(7):389-95.
15. Scharfetter.Studies of heredity in symbiotic psychosis.Int J Ment Health.1972;1:116-123
16. Suresh Kumar PN, Subramanyam N, Thomas B, Abraham A, Kumar K. Folie à deux. Indian J Psychiatry. 2005 Jul;47(3):164-6.