

Folie à cinq

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Abstract

***Objective:** To describe a rare case of folie à cinq, as a psychotic disorder in an Iranian family. **Method:** We present a family with folie à cinq, who were visited in "Razi" psychiatric hospital in Tebran. The family consisted of a mother and her four daughters. **Results:** The youngest daughter was the 'primary' case with schizophrenia, whilst the mother and her other three daughters were all 'secondary' cases with Shared Psychotic Disorder. **Conclusions:** These cases highlight the need for more investigation into atypical presentations of psychosis. As a result of attempts to separate the family members from each other during treatment, all of the patients broke away from the delusional system and developed in a healthy manner (German J Psychiatry 2007; 10: 46-49).*

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Introduction

Shared Psychotic Disorder (SPD) was first described by Jules Baillarger in 1860 who termed this condition "folie à communiquée". Later, Falret described it as "folie à deux" in 1877. Other described forms of SPD are: folie à trois, folie à quatre, folie à cinq and folie à famille (Cuhadaroglu et al., 2001), being very rare. The essential theme of delusional system in SPD is often persecutory or grandiose. Delusions are not necessarily bizarre and find acceptance in subcultural contexts, for example, as religious or political beliefs (Howard et al., 1995). The delusions are first manifested in the dominant personality, who in turn influences the weaker personalities and suggestible and less intelligent people. The delusional system may be part of schizophrenia, or it may be a primary delusional disorder or mood disorder. The spread of delusional ideas to family members has attracted attention in the literature since the 17th century (Gelder et al., 1996). Folie à famille, where all the members of a family share the delusion, is an especially rare disorder that has been reported on the basis of a careful review of all published cases of Shared Psychotic Disorder. Progression of delusional symptoms to a folie à famille is

thought to reflect a dramatic attempt by a family to maintain cohesiveness in the presence of a perceived hostile environment (Gelder et al., 1996). Reports of folie à cinq are very rare and this may be the first reported case involving an Iranian family. We present here a family with "folie à cinq", who were admitted to the Razi Psychiatric Hospital in Tebran, Iran.

Index Case (Case 1)

A 26-year-old unmarried woman, with high school education. She was the last child in her family. Since 2000, when her father died, she started to believe that her older brother would harm her. In 2002, at the death of her younger brother, which was a disturbing event for her, because he was the closest attachment figure in her life, she could not form any close relationships in her new environment. She was completely isolated from her surroundings, and gradually her false beliefs expanded to the government. Gradually she was convinced that her older brother and the Iranian government were oppressing her close family and infiltrating

an opposition party in order to persecute them. One month later, delusion of control started appearing. She was convinced that the government controlled her behavior via electrical wires and hidden cameras. To start with, she started seeing frequently a holy ghost who told her hopefully that she, her mother and her sisters would at last be freed from the oppressive activities of the government. She used to feel happy whenever she heard these words. She also described auditory and visual hallucinations, like she had the experience of hearing God's and imams' voices and seeing them. These symptoms were not an expression of extreme religiosity.

In addition to her delusion of persecution by the government, delusion of control and her auditory and visual hallucinations, she also had grandiose delusions of having the power of causing national calamities and death of prominent political figures by the sheer force of her prayers via prophets and imams, specially of Imam Sajjad, the fourth religious leader in Islam.

She did not report any medical illnesses, medications or substance abuse history, and no medical condition was found to explain her beliefs.

Induced Cases

The other cases consisted of the mother and the three sisters of the index case.

Case 2. Her youngest sister, who was 28 years old, unmarried, and had a high school education, was the next person in her family to suffer from a similar condition. The experience of hearing God's and imams' voices and seeing them was more pronounced than in the other persons of the family, with the exception of the index case. She had a closer relationship with the index case than the other sisters.

Case 3. The second daughter of the family, 31 years old, unmarried, had a high school education. She showed all of the symptoms of the first case, however to a milder degree.

Case 4. The oldest sister was 40 years old, unmarried, and was illiterate. Again, she had a similar condition to the index case, but her perceptual experiences were much less than in the first case.

Case 5. The final family member showing psychotic symptoms was the mother, an illiterate widow who was 68 years of age. She had the least degree of symptoms among all family members.

All of the family members were intimately associated throughout their lives. The symptoms in all of the other cases gradually started one year after their son/brother died, on whom they all were very dependent. After that, they shared a symbiotic relationship and an unhealthy bonding with the first case and amongst each other. The family showed growing social isolation from the social network of neighbors and relatives.

The delusional content and other symptoms of psychosis were similar in all involved family members, and the shared

belief system was also accepted and supported by all persons. However, the severity of these psychotic symptoms differed. The hallucinatory experiences in all of the induced cases occurred less frequently, were of shorter duration, and were less intense than the first or truly psychotic patient.

There was no family history of psychotic disorders and psychiatric treatments.

All patients were examined using psychological tests such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Wechsler Adult Intelligence Scale (WAIS). These assessments did not reveal any specific psychopathology or mental retardation except some dependent personality traits in all of the induced cases and a borderline IQ in case 4 (IQ=75).

None of the family members worked. It seemed as if the negative symptomatology of the first case had been transmitted to the others. Some money came by inheritance, but it was not used for paying electricity and water bills because the family members believed that their "persecutors" inflicted a governmental power on them by disconnecting the electrical power and water supply of their house, which resulted in a lot of problems in their life. Thus, they did not pay any bills, in order to fight against the government and to force it to step down.

At a home visit, the entrance of their home and the stairs were very dirty and untidy, with an unpleasant smell. Rubbish had been hoarded to the extent that most of their entrance space was taken up with full cardboard boxes and heaps of electricity and water bills. On the other side, the inside of the home was simple, clean and neat and the rooms were arranged in good order in spite of the lack of electrical power and water supply. There were barrels of water in the corner of the entrance hall that they had brought from the park near their house, and candles were used to light the rooms.

The family's neighbors protested to the courts about their odd behavior and then, as required by law, psychiatric evaluations were performed. All psychiatrists agreed that the family required psychiatric evaluation and treatment. At the request of the court, cases 4 and 5 were not hospitalized, so they were properly evaluated in the outpatients clinic. The first case and cases 2 and 3 were admitted to separate wards of the Razi Psychiatric Unit for further assessment and treatment. The initial psychiatric tasks include arriving at a proper diagnosis, identifying the primary patient, and attempting medical intervention with psychotropic medications and psychotherapeutic methods.

In the cases described here, several differential diagnoses were considered and ruled out, including delusional disorder, schizoaffective disorder, and mood disorder with psychotic features.

The first case showed social isolation, some delusions, hallucination and odd behavior for more than five years. She did not have any notable manic or depressive episodes or symptom-free periods. Her functioning in areas of work and interpersonal relationship was markedly lower than before the onset of her mental illness.

The onset of the symptoms in all of the other cases was one year after the symptoms of the primary case started. The symptoms were similar to the first case but were milder.

The first case demonstrated most criteria for schizophrenia according to DSM-IV^{TR}, while the other cases showed most features of Shared Psychotic Disorder.

During the first week of hospitalization, the patients were noncompliant, but after establishing a therapeutic relationship, the patients were separated and drug treatment was started. All hospitalized patients received psychotropic drugs as well as cognitive and supportive therapy.

In the first case, risperidone was started with 1 mg/day and then increased to 4 mg/day over one month. Outcome was relatively good, so that positive psychotic symptoms were nearly in remission, while social isolation still was present. She was released from the hospital after 3 months.

The two passive hospitalized cases did not require antipsychotic treatment, but they received low doses of benzodiazepines (clonazepam, 0.5 mg/day) for anxiety resulting from their separation from their sister. Their thoughts gradually cleared during 1–2 weeks after separation. They left the hospital after 3–4 weeks.

The symptoms of cases 4 and 5, who were not hospitalized, resolved after 2–3 weeks without any drug treatment. They only received cognitive and supportive therapy.

After separating the family members from each other, the induced cases lost their delusional system and developed in a healthy manner.

Discussion

We examined a case of folie à famille involving a mother and her four daughters. In one case, schizophrenia was diagnosed, while the other members of the family received a diagnosis of Shared Psychotic Disorder.

During that period when the primary case was gradually becoming more psychotic, others accepted the role of being her helper. At the same time, she started to impose her ideas on her family. Being away from their familiar environment and lacking close relations with other people, her family became even more attached to her and this subconsciously resulted in a symbiotic relationship with them and led to acceptance of her delusional system (Enoch et al., 2001). Finally, her family gradually adopted her delusions. At this point, a “folie à famille” in the form of a “folie imposée” developed. It is obvious that other cases who were healthy persons shared the paranoid system, so after separation from the primary case, these delusions disappeared.

Progression of delusional symptoms to a folie à famille is thought to reflect a dramatic attempt of a family to maintain cohesiveness in the presence of a perceived hostile environment (Thaddeus et al., 1997). Sharing these delusions in the family contributed to the development of a delusional “pseudocommunity”. It is the most impressive example of a pathological relationship (Enoch et al., 2001).

Predisposing factors of this disorder were dependent personality traits in all of the index cases and a borderline IQ in the older sister.

Treatment is usually refused by the patients on the basis of delusional beliefs (Teresita et al., 2001). Treatment of SPD can be both complicated and difficult because frequently only one member of the shared delusional system presents for therapy (Silveira et al., 1995). It is generally accepted, that separation from the primary patient is an essential part of treatment (Mela et al., 2005).

The problem of compliance with treatment becomes even more complicated when the patients refuse treatment on the basis of their religious beliefs (Jones et al., 1997). For many individuals, religious beliefs are a central component of personal identity and exert particular influence on their adaptation to major life events such as birth, death, and illness (Elizabeth et al., 2004). Religious beliefs can be defined as a commitment to an ultimate meaning in life. The integrity of religious belief is vulnerable because, unlike delusion, it can be modified (Mela et al., 2005). In our cases the beliefs in religious leaders in Islam, specially in Imam Sajjad, changed to grandeur delusions which could be modified by neuroleptic agents.

As the literature suggests, folie à famille is rare, but proper recognition of this disorder can result in successful treatment outcomes by separation of patients and psychopharmacological treatment.

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