A case of folie à trois

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Summary

Folie à deux is defined as "A mental disorder afflicting at least two closely related persons, where both share identical delusions and sometimes psychotic behaviour besides strongly supporting each other on a mutual basis" [1]. A case of folie à trois with certain variations from a typical case was encountered.

Clinical history

A, a single 39-year-old Japanese male, was forcefully taken to a psychiatric ward because of psychomotor excitement. He had a delusion that agents persecuted him and his family, and his family was also convinced of it.

A had been residing in a flat with his mother and his elder alcoholic brother (B). Owing to mental suffering induced by B's alcoholism, both A and his mother had been treated for depression. The mother relied on A economically and psychologically. B stopped drinking alcohol 3 years ago and had been going to a daycare centre regularly. Apart from that, he remained idle at home. His mother could not go out alone because of physical impairment of her legs.

Four years ago, his mother insisted that a family upstairs intentionally made noises that followed her movements in the house. For example, they flushed the toilet as soon as she went into her own toilet (located immediately under the upstairs toilet). Both A and B sympathised with her plight. Other than having occasional quarrels with the family upstairs about their making noises, there were no other troubles.

As A had been yearning for independence for some time, he rented a flat and started living alone 3 years ago. About the same time A left home, B and his mother thought that they were being wiretapped, and as a result they often searched for listening devices in their dwelling.

A moved to a new house he bought a few months ago. Since then, he had a delusion of reference that neighbours were always talking about him. The idea that both the neighbours and the previous family upstairs were agents belonging to the same organisation flashed across his mind because he seemed to notice that cameras were set around his house. He then invited B and his mother to join him. Although they again lived together as a family, they still suffered from persecutions of the previous family upstairs.

As soon as living with A, his mother encountered no persecutions, although B insisted that the new house was still being wiretapped. B then started tearing down the interior of the house to search for listening devices. Meanwhile A started to wander up the mountains and injured himself on several occasions. According to A, he was often driven by messages from the radio to protect his family. He did that by brandishing a knife.

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Clinical evolution

When A was taken to the hospital, he resisted the medical staff physically so hard that he needed restriction for the first week. As he fulfilled the criteria of DSM-IVTR for paranoid-type schizophrenia, he was treated daily with 6 mg of risperidone (Risperdal®) for 3 weeks before his discharge from the hospital. After having returned home, he heard no more rumours about him. Five weeks after A had been discharged from the hospital, B mentioned that he had been doubtful about persecutions from the family upstairs for the first time.

Discussion

In this case, the experiences, behaviour and responses were different from a typical folie à deux, where the first person who develops the delusion is schizophrenic. However, the mother in this case was not showing any signs of schizophrenia. This may account for the absence of either serious social or clinical problems for a long period of time in the delusion induced. Therefore, the delusion in the early stage had merely played a role in moulding the family solidarity. It is also possible that the situation had not been completely closed, since both A and B went out to work and attended the daycare centre, respectively. However, this balance was disturbed by A's search for independence (i.e. moving out and leaving the family to live alone), thus inducing his mother and B to start searching for listening devices.

In ordinary cases of folie à deux, delusions of the second or the third person usually subside by separating these subjects from the first person. In this case, however, the delusion suffered by A had developed with his independence. In addition to that, the delusion experienced by the mother had diminished as soon as she started living together with A again, and she accompanied A on his visit to the hospital. This is an unlikely situation because in most cases of folie à deux, delusions in solidarity are neutralised by compulsive intervention. Delusions in A were induced by the mother's symptoms, which are often situation dependent; and they happened to be neurotic in the present case. Furthermore, the development of the psychotic process in A was too intense to accommodate the delusion unity the family used to have.

Finally, the mentioning of doubts about persecutions from the family upstairs by B for the first time is indeed interesting. As this remark was not heard from him directly, the situation in which he made the remark remains unclear. However, taken literally, B suffered delusions and responded aggressively even though he was doubting it inwardly. His behaviour cannot be interpreted as a factitious disorder, but may rather be understood as a form of pseudo-community, a state where one person denies another person's delusions inwardly but outwardly agrees and thus is keeping up these delusions in the other person.

Conclusion

A case of folie à trois with certain variations from typical cases of folie à deux was encountered. Delusions in the early stage merely played a role in moulding the family solidarity. Delusions suffered by A developed because of family dynamics and failure to achieve independence. Despite suffering from delusions with homogeneity, the respective subjects responded with different outcomes that were dependent on the state of individual psychopathology.

References

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