INDUCED DELUSIONAL DISORDER IN AN ADOLESCENT:
A CASE REPORT

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ABSTRACT

Induced delusional disorder or folie a deux in a 19 year old girl from India whose 16 years old younger sister had paranoid schizophrenia is described. Transient sharing of delusional beliefs by those living with the patients may be an extension of unsubstantiated beliefs held by the community.

Key words: Induced delusional disorder, folie a deux, adolescent

Lasegue and Falret (1877) were the first to describe folie a deux or induced delusional disorder. Later, Gralnick (1942) classified the syndrome into four sub types, namely, folie impose (imposed psychosis), folie simultanee (simultaneous psychosis), folie communique (communicated psychosis) and folie induite (induced psychosis). ICD-10 (WHO, 1994) put forth the syndrome of induced delusional disorder and laid down criteria for its diagnosis. Recent reviews available provide guidelines for diagnosis and treatment of this rare disorder (Mentjox et al., 1993). A case of folie a deux was reported earlier from India, which occurred in non family members (Pande & Gulbani, 1990). Here we report a case of induced delusional disorder in which both the partners are adolescents.

CASE REPORT

Ms A, a 16 year old girl studying in 12th standard, from a middle class nuclear family living in a suburban town with her parents and two elder sisters in the same household since birth. A year back while studying in the 11th standard, she developed a fancy for a boy who returned her feelings by sending a greeting card during the beginning of the school year. Ten months before consultation she reported to her parents that the boys in her class were teasing about the above incident. Later she began to feel that whatever was discussed at her home was known to her classmates. She told her parents that her classmates had planted an electronic device in her home to learn what was discussed in the family. Two months later she refused to attend school or the tutorial institute. She felt that the songs being played from the nearby shop were about her and requested her parents to intervene and stop them. She developed intermittent sleep disturbances and became withdrawn. She continued to hear voices abusing her and had occasional outbursts. She gradually became totally disinterested in her personal care and reacted violently when prompted. She spent most of the time lying down. Her posture, in her mother’s words, was that of a “baby in the womb”, and her father described it as “curled like a millipede”.

Ms A was born out of nonconsanguineous union and is the youngest of three siblings. There is no family history of any significant psychiatric disorder. Her birth was a full term, normal delivery. There were no eventful incidents in childhood. She attained menarche at the age of 14, her sexual history is unevent-
ful and did not suffer from any major physical illness. Premorbidly she was reported to be a quiet, not very active or sociable person. She was interested in gardening and household activities. Her relationship with her siblings was good. A diagnosis of paranoid schizophrenia was made (ICD-10, F 20.0).

Ms B, 19 years old sister of Ms A, a final year student of the three year degree course, has been living with Ms A, since childhood. Ms A used to confide in Ms B initially for about 2 months. The latter tried to convince Ms A that her experiences were imaginary. Ms B also suggested several methods for Ms A to cope with the disturbances. After two months she also started having similar experiences as that of her younger sister. At the time of consultation, she reported that she has been experiencing changes in the behaviour of people around her, that they had been teasing her for the past 8 months. Elaborating on her observation, she reported that others were making fun of her and commenting on her, on her way to college and in the college. At home, she complained that the music being played loudly from nearby audio-cassette shop referred to her and requested her parents to warn the shop owners against playing the derogatory songs. She became hostile to her parents since she felt that they were not capable of protecting her and her younger sister Ms A from the harm being done to them by the neighbours and college mates. While attending college, she felt that her classmates were talking about the events at home and she found it very disturbing. Though she could tolerate the behaviour of her classmates, she could not bear the events at tuition centre. Since both Ms A and Ms B complained about students at the tuition centre, the parents contacted the authorities and accused them of not maintaining discipline at the institute. An enquiry was made into the matter and the allegations were found to be false. However, they promised the parents that further incidents would not occur in future on the premises of the institute. Inspite of this Ms A and Ms B refused to attend the college and tuition centre. Three months latter Ms A and Ms B consulted a psychiatrist but both refused medication. Ms A agreed to attend college but not the tuition centre.

Ms B's birth was a full term normal delivery and her milestones of development were normal. There were no eventful incidents during childhood. She attained menarche at the age of 13, her sexual history was uneventful and did not have any major illness. She was obedient and active, although not very sociable.

A diagnosis of induced delusional disorder was made.

Ms A was started on trifluoperazine hydrochloride 10 mg per day. She showed significant improvement with regard to her delusions. However she continued to have negative symptoms and was socially withdrawn. Ms B was given chlordiazepoxide 10 mg at bed time. She became free of her symptoms by 2 weeks. She could appear for her final year degree examination. Eight months follow up over telephone revealed Ms A continuing the same status though she discontinued medication. Ms B also discontinued medication and joined teacher training. Parents responded that they consulted an astrologer, who told that both of them are having "sani dasa" (bad time) and would improve in due course of time.

**DISCUSSION**

The case of Ms B fulfils the diagnostic criteria of induced delusional disorder (F-24, ICD-10). Ms B was closely associated with Ms A since childhood, who was diagnosed to have paranoid schizophrenia. Ms B didn't have any delusional idea or belief prior to Ms A's communication of her delusional perception to her. Ms B did not have any psychiatric disorder before she developed the delusional perception of her sister. She even dissuaded Ms A initially for her faulty perception and generalisation.

Cases of patients with folie a deux
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reported earlier mainly relate to adults. Lazarus (1986) reviewing fifteen twin case reports found one of the partners to be 20 years of age. In the present case both the cases are adolescent sisters and the dominant partner is younger to the recipient. Both Ms A and Ms B were not socially isolated from other people. Dippel et al. (1991) also did not find any adverse social or environmental circumstances in the case reported by them.

Though psychotherapeutic help was offered, the parents did not respond. Either the lack of awareness regarding the effectiveness of psychotherapy or the cost involved may have dissuaded them from seeking help. It has also been observed that in Indian situation the interest to continue psychological help fades after the initial consultation (Manickam & Kuruvilla, 1986). It was suggested to the parents that the separation of Ms B from Ms A might help. But their family migrated since they felt that the house in which they were inhabiting might have been the genesis of the disorder of both their wards. This is one of the unsubstantiated beliefs reinforced by astrological findings which is held by many people in Kerala (Sumaranjitha, 1992).

In India, unsubstantiated beliefs have a strong influence on people in general (Pande & Gulabani, 1990) and this is likely to alter the belief system to a pathological level sometimes for transient periods. Therefore the parents taking an active role to protect their daughters by complaining to the tutorial authorities cannot be taken as a manifestation of induced delusional disorder. However, it is rather difficult to assess when these unsubstantiated beliefs cross over to pathological delusions. There may be many more cases of induced disorders in our country which go unreported by the clinicians.

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