ISSN: 2149-2018

Applied Medical Research, 2024
VOL 11, NO. 6, PAGE 1 – 3
DOI: doi.org/10.47363/AMR/2024(11)250

REVIEW ARTICLE

Open Access

The Madness for Two Invites Herself in Forensic Psychiatry, about a Case

Bouguermouh Y

Department of Psychiatry, Faculty of Medicine, EHS Frantz Fanon, Blida, Algeria

ABSTRACT

Madness for two is a rare, out dated psychiatric curiosity that is still relevant to a psychiatrist's practice. Most theoretical data are based on case studies, attempting to understand and explain this disorder, which poses nosographic and management problems and raises questions about the "contagion" of the symptom in psychiatry. The aim of our work is to illustrate this rare disorder and to respond to the various problems it poses. It presents a clinical case of madness for two in a couple. A review of the literature in relation to our case has enabled us to highlight the clinical characteristics of this entity, the conditions favoring the "contagion" of the symptom in psychiatry, the nosographic difficulty as well as the therapeutic modalities of this concept.

ARTICLE HISTORY

Received April 22, 2024
Accepted April 27, 2024
Published June 22, 2024

KEYWORDS

Madness for Two, Induced Delusional Disorder, Shared Psychosis, Shared Delusional, Contagion of Psychosis

Introduction

Despite the reality of folie à deux in the psychiatrist's practice, its rarity and the paucity of data in the literature make this entity a work of fantasy. It gives rise to a host of myths and questions, and widens the gap between it and psychiatry.

We have drawn a parallel between a review of the literature and our clinical case, with the aim of illustrating and establishing the veracity of the theoretical data and trying to provide answers to certain questions about this doubly "mad" concept.

A Couple in Forensic Psychiatry, an Example of a Rare Pathology

On May 24, 2019, the forensic psychiatry department receives a married couple in judicial confinement for the charge: neglect and abuse of their children. They are hospitalized separately in 2 different units. Neither of them has a medical or surgical history.

The various interviews and clinical and Para-clinical examinations carried out with them revealed the following:

Mr. B.I, 40 years old, married for over 18 years, father of 2 children (3 and 8), from an ethnic group he describes as very conservative and patriarchal, where women are absent from the public arena. He began his university studies in mechanical engineering, which he eventually dropped out of interest at the age of 22. The following year, he took up self-employed masonry and decided to marry a woman from the same village as himself, in keeping with local tradition. He married H.S, then aged 17.

H.S comes from a modest family, with an average 3rd grade education. She says that her upbringing emphasized the importance of the husband's place in the couple, and the honor and duty of serving and obeying him. She describes her husband as a "God-man", someone she idealizes on a daily basis.

The couple began life in the husband's parents' large house, while the husband started building a house in the village, eventually moving 8 years later. A year after moving into their own home, the couple had their 1st child, and a 2nd four years later. They describe their relationship as harmonious and symbiotic, based on love, solidarity and mutual respect.

In 2010, a few months after their move, the husband says he noticed a change in his parents' behavior towards him. He says they had become cold, distant and no longer showed him respect. He thinks they never appreciated the fact that he had left the big house. The patient argues that it was through their facial expressions, mimics and actions that he understood their unhealthy intentions towards him and his family. Persecuted and convinced that he was hated by his family; he decided to break off all contact with them, going so far as to absent himself from his brother's wedding and his grandmother's funeral.

In the months that followed, the couple's only guests were the wife's family. The wife's family tries to intervene to resolve the conflict. This led the patient to feel watched and persecuted by his in-laws, and he shared his discomfort with his wife. But after a year and a half, she says she began to face reality, and came to understand that her family was persecuting them. She says she understood this by paying attention to the very subtle but very obvious actions of the various family members who visited them. These included: sideways glances, hand gestures, grimaces... etc. Convinced in turn that her family was hiding malicious intent, she and her husband decided to break off relations with them.

Contact Bouguermouh Y, Department of Psychiatry, Faculty of Medicine, EHS Frantz Fanon, Blida, Algeria.

Caught up in this psychosis of persecution, and afraid that the two families would call on neighbors in the neighborhood to get at them, the couple decided to isolate themselves completely in their house, breaking off all contact with the locals, starting in 2016. Since then, the couple have drawn on their reserves to survive, going out only on Sundays and Wednesdays to do the shopping or take their children for a walk, and forbidding them any contact with the outside world. What's more, they go so far as to decide not to send their eldest son, who is a year over the compulsory school age, to school.

Distraught by this very worrying situation, the couple's parents saw only one way out: to lodge a complaint with the courts.

The various examinations and interviews we carried out with them during their stay at the hospital, each time brought us face to face with a couple with a good presentation, a clear and understandable discourse. They were convinced of the rightness of their beliefs, and of the idea of being persecuted by those around them. They sought to win our support by using a plausible discourse of interpretation and demonstration. All these factors, together with the absence of any medical condition or substance intake that might explain these disorders, led us to diagnose the husband with a delusional disorder in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [1]. On the other hand, these elements led us to wonder about the wife's possible diagnosis, given the context of the onset of her disorders: A delusional content identical to that of the husband, and a chronological shift in the onset of her disorders. Our first question was: coincidence or real influence?.

We tried to answer some of these questions by reviewing the literature.

Literature Review

The first descriptions were provided by Lasègue and Falret in 1877, who examined this entity and the "contagion" of the symptom in psychiatry [2]. However, they soon came up against a paradox: how can one speak of contagion and explain the absence of an upsurge in mental illness among their carers?.

Clinical Characteristics and Conditions of Symptom "Contagion" in Psychiatry

In their studies, Lasègue and Falret identified very specific principles and conditions for the contagion of madness from one person to another:

- One of the two individuals is the active element, more intelligent than the other, creating the delirium and imposing it on the other, who is the passive element, generally vulnerable, female and docile.
- The passive element initially resists, then reacts in turn to some extent to rectify and coordinate the delusion, which becomes common to both.
- The two individuals must live together for a long time, sharing the same way of life.
- The delusion must be plausible.
- The delusion maintains or reinforces the cohesion of the group [2].

In 1923, de Clérambault made a new contribution, distinguishing in his publications between two-person psychosis and two-person delirium, unlike his predecessors. For de Clérambault, what is transmitted is the ideal themes, the adherence to these themes and the affective background. Delusions are transmitted, but not psychoses [3].

More recently, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders proposes diagnostic criteria close to the historical definitions under the diagnosis "Shared Psychotic Disorder"[4]. It proposes diagnostic criteria for the passive subject only, considering that the active subject should only benefit from his or her own diagnosis.

A\ occurrence of delusions in a subject in the context of a close relationship with a subject already having delusions.

B The content of the delusions is similar to that of the person with delusions.

C\ the disturbance is not best explained by another psychotic disorder or medical condition [4].

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders introduces a new feature, proposing the diagnosis of "delusional symptoms in the spouse of a person with a delusional disorder" in the subgroup "Other disorders on the schizophrenia spectrum" [5].

Therapy and Management

As far as therapy is concerned, there is as yet no specific protocol or recommendation for madness for two. Lasègue and Falret propose the separation of co-delusionists as the mainstay of treatment for passive subjects, and it happens that the subject recovers when he is deprived of the support of the one who has communicated the delusion to him, without having to resort to pharmacological treatment [2].

Indeed, the social isolation of co-delusionists, which is an almost constant factor in cases of madness for two, seems to us to be a key element that can explain the outbreak of delusions in the passive element, by the impossibility of confronting the other's delusional beliefs with the outside world, especially when faced with a plausible delusion, creating a need to resort to imagination and intuition. Add to this the consequences of the symbiotic bond's affective dependence [6].

Some authors consider folie à deux to be a pathology of the bond, and place family therapy at the center of care for the passive subject, the aim being to understand the nature of the bond between co-delusionists and the individual and collective

"utility" of this shared delusion [7].

Discussion

A parallelism between our clinical case and the data in the literature concerning the clinical characteristics and conditions of symptom contagiousness in psychiatry with our case brings us back to a typical picture of folie à deux, as described by Lasègue and Falret.

All the definitions of folie à deux, from Lasègue and Falret through de Clérambault to the DSM-4 and 5, come up against the complexity of this entity, creating real nosographic confusion and a headache for the psychiatrist.

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders is an anomaly. This implicitly asserts that a psychotic subject can infect another, non-diseased subject with his or her psychosis, and thus completely ignores De Clérambault's contributions. The fifth edition rectifies this, but limits the diagnosis of insanity to the spouse of a subject suffering from a delusional disorder.

From a therapeutic point of view, what about the modalities for separating co-delusionists, as recommended by Lasègue and Falret in their therapeutic approach? Should both co-delusionists be hospitalized, as was done in our case, or is hospitalization of the active co-delusionists sufficient to improve the passive subject's symptomatology, and thus avoid hospitalization and its repercussions?.

In our case, despite our patient's separation from her husband, delusional activity persisted, prompting us to introduce a low-dose antipsychotic. This led to clinical improvement, leaving us wondering whether the treatment recommendations of Lasègue and Falret, who propose separation from co-delusionists as the mainstay of treatment for passive subjects, are really true.

Conclusion

In this work, the description of the couple's clinical case illustrates some of the common factors described in the literature: two subjects, living in close association, in a closed environment cut off from the outside world, share delusional ideas. Thus, the contagion of mental illness is impossible under the usual conditions, and requires a set of conditions and a particular relational context.

Management of the passive subject is based on separation of the co-delusionists. Clinical improvement in the passive subject after this separation is of significant semiological value, and supports the diagnosis of madness for two.

Insanity in pairs is a psychiatric concept with a rocambolical allure, describing the condition of the subject, his partner and their relationship, and leading us to ask further questions: Isn't the ambivalence in the demand for care, the rationalization of delirium, and the trivialization and tolerance of certain families towards their delusional relatives, an attenuated form of madness for two?.

References

[1] DSM-5-American Psychiatric Association. Manuel diagnostic et statistique des troubles mentaux, 5ème éd (Version international, Washington DC, 2013). Traduction française par M-A Crocq et J-D Guelfi, Paris : Masson. https://psyclinicfes.files.wordpress.com/2020/03/dsm-5-manuel-diagnostique-et-statistique-des-troubles-mentaux.pdf.

[2] Lasegue C, Falret J. La folie a deux, Arch Gen Med. 1877; 30: 257-297.

[3] de Clérambault GG. Œuvre psychiatrique, Paris PUF. 1942; 3-89.

[4] DSM-IV - American Psychiatric Association. Manuel diagnostique et statistique des troubles mentaux, 4e ed. (Version´ internationale, Washington DC, 1995). Traduction fran¸caise par J.-D. Guelfi et al, Paris Masson. 1996.

[5] DSM-5 American Psychiatric Association. Manuel diagnostic et statistique des troubles mentaux, 5ème éd (Version international, Washington DC, 2013). Traduction française par M-A Crocq et J-D Guelfi, Paris Masson. 2015; 143.

[6] Porot M, Couadau A, Petit G, Lajoinie J. Reflexions sur le délire a deux, Ann Med Psychol. 1968; 126: 435-142.

[7] Drucker M, Shapiro S. Issues of separation related to psychosis in twins, Compr Psychiatry. 1982; 23: 136-142.