

'FOLIE A DEUX'
(A Case Report from Kenya)

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SUMMARY

The author presents the first case report of folie a deux from Saharan Africa. The clinical presentation of this disorder in Africa does not significantly differ from those reported elsewhere. But cultural factors like superstitions and witchcraft play an important role in the management of these patients. In the author's view, cooperation with the traditional healer with simultaneous administration of modern drugs may be the ideal way to treat such patients.

Folie á deux is also known as communicated insanity, the psychosis of association or double insanity. It is defined as an identical or similar mental disorder affecting two individuals, usually the members of the same family (Stedman, 1976).

Jahann Weyer was the first psychiatrist to mention 'folie á deux' in the 16th century but the first case of this illness was reported by Kenelm Digby in the 17th century (Freedman *et al.*, 1975). Lasegue and Falret (1877) described seven cases of 'la folie á deux' (ou folie communiquée). Subsequently, Gralnick (1942) reviewed 103 case reports of this disorder.

In the author's knowledge, this report is the first one from sub-Saharan Africa.

Patient A (the Principal)

'A' was a 31 year old, married African woman with an upper socio-economic class background. She was married for 3 years and had a 2 year old son. The patient worked as a secretary to an executive for more than 10 years. One of her aunts suffered from paranoid schizophrenia and was being treated with depot phenothiazine. The predominant features of A's personality were suspiciousness, social isolation and introversion. She had frequent quarrels with her husband over his fidelity. A month before the referral there were intense quarrels in the family and the patient openly

accused the husband of being interested in her property, somehow trying to get rid of her and marry another woman.

The patient was admitted after she had barricaded herself in her house with her maid (patient B). Both were found praying loudly calling for God's help in saving their lives. They were convinced that the food in the house was poisoned and an attempt was being made to kill both of them.

When seen on the ward, patient A was well dressed and was in a clear state of consciousness but refused to eat or drink. She was deluded that the husband was to kill her, assume her property and marry another woman. Her affect was inappropriate and she lacked insight.

A diagnosis of paranoid psychosis was made and the patient was commenced on parenteral Haloperidol. The patient was seen by the author once a month. Six months later, the patient still had paranoid delusions and had legally separated from her husband, but was taking Thioridazine as prescribed. She was advised to return to work which she did promptly.

Patient 'B' (the Associate) :

The Associate was a 29 year old African unmarried mother of a 9 year old son. She had primary school education and was a distant cousin of the Principal. She shared the accommodation with the

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former and was a religious person. She worked as a housekeeper and maid looking after the Principal's son. She had no past history of any mental or physical illness.

On the day the Principal was taken into a private hospital for treatment. 'B' was also admitted to the Government mental hospital for being restless, praying loudly, refusing to eat or drink and barricading herself in the house with the Principal.

She shared the Principal's delusions and supported them. She prayed God loudly, asking Him to save her and her employer's life. She refused to eat or drink as she was convinced that poison was mixed in the food and water by the Principal's husband to kill both of them. With E.C.T. she improved rapidly and was discharged after three weeks on Chlorpromazine 100mg nocte. As her symptoms had remitted after three months, the medication was stopped. Six months later she was well and asymptomatic.

DISCUSSION

This report shows the well-documented features of folie à deux and also highlights the influence of cultural factors such as superstitions, bewitchment and related beliefs which should be understood, and taken

into consideration while treating such patients. It may be advisable to co-operate with the traditional healer in the treatment to achieve better results but at the same time persuading the patients and the relatives to continue with modern drugs. Perhaps this practice can alone bring the advantages of both kinds of therapies, although this may not always be easy and depends heavily on the cooperation offered by the relatives of the patients, the psychiatrist's knowledge of and respect for the local traditional beliefs, and his skill in successful management of such patients.

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