CASE REPORT

FOLIE A DEUX COMPLICATE MANAGEMENT OF A CHILDHOOD ONSET SCHIZOPHRENIA

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Abstract

Objective: **This case report highlights folie a duex of a caregiver that complicate the management of a case of childhood onset schizophrenia.** ***Methods:*** **We report a case of a young Malay girl with symptoms of schizophrenia and her caregiver who share her delusion.** ***Result:*** **Folie a duex in the caregiver caused difficulty in the initiation and maintenance of treatment of a child with schizophrenia.** ***Conclusion:*** **Treating children with schizophrenia is not easy and could be complicated by the folie a duex in caregiver. Although Child Act 2001 can be applied in order to deliver appropriate treatment to this group of patients, one must be cautious about the implication in therapeutic alliance.** ***ASEAN Journal of Psychiatry, Vol. 13 (2): July – December 2012: XX XX.***

Keywords: Folie A Duex, Childhood Onset Schizophrenia, Child Act 2001

Introduction

Childhood onset schizophrenia is always a challenging case for psychiatry team. Apart from the concern about the short and long term side effects of medication on a young individual, the treating team needs extra skills to deal and convince caregivers about the medication . This issue is further complicated when the main caregiver has no insight about the disorder, or even shares the delusion of the index patient as illustrated in this case report. Hence, the issue of involuntary treatment and custody of the child inevitably becomes the concern of many clinicians (1).

Case Report

An unfortunate 12 year-old girl, Miss AHL, was brought by her aunt to the psychiatric clinic of Hospital Universiti Sains Malaysia with the complaint of school refusal for about one and a half year. Her aunt is her main caregiver since AHL's mother had chronic psychotic illness and her father went missing after divorce.

On exploration, the main reason for the school refusal was due to her psychotic symptoms. Since 2 years ago, Miss AHL believed that she is a boy and not a girl. She calls herself Adam (a boy's name). She described herself as a boy who is handicapped, limp and lisp. One of the reasons that she refused schooling was because she was not allowed to wear boy's uniform. She felt very disgusted as she has to wear skirt to school. She developed such belief since she saw a white shadow, which she believed is the prophet's helper. The white shadow told her that she was actually a boy but the devils had hidden her penis. She was very sure that she will not

have menses as she was told by the white shadow. Her delusion strengthened after her visit to a family medicine clinic during an episode of abdominal discomfort. After informing the medical officer that she is a boy rather than a girl, the medical officer was curious and performed an ultrasound scan to look for the uterus. Furthermore, the medical officer also suggested the family member to do karyotyping for her to determine the sex chromosome. The uncertainty of medical officer regarding her gender status further reinforced her delusional belief. She also believed that there were millions of invisible spirits which occupied each and every part of her body. She claimed that the spirits entered her body since she was 6 years old. All the spirits have names but she mentioned only a few prominent one, which were Khidri, Khuwairi, Manja, Jelita and Comel. The first two spirits were boys and another three spirits were girls. They helped her to walk, run and talk fluently. She was very happy with the presence of the spirits. When she became Adam, she was lisping but when she assumed the role of Khidri, she spoke fluently. Sometimes, the spirits took turns to talk, so her voice and the way she talked changes depending on which spirit was talking. In addition, the ghosts frequently threatened to harm her should she go to school. This is the second reason why she failed to attend school. She was diagnosed as schizophrenia in view of the bizarre delusions.

Her aunt, who was the main caregiver, began sharing the similar beliefs not long after AHL revealed it to her. Not surprisingly, the aunt did not accept any medical explanation about the problems. The aunt insisted that patient was actually a boy and given special ability to see and talk to spirits. She had requested a letter from doctor to certify that AHL is actually a boy, in order to change the patient's name to a boy's name when applying for the identity card in future. She even approached the school headmaster and requested for AHL to wear boy's uniform at school.

The aunt initially refused treatment for the child. However, she changed her mind after she was given the explanation on the legal implications in accordance with the Child Act 2001. This case was referred to the social worker for social workup. The child psychiatry community team also took an active role in visiting the family. Until day of writing, AHL's aunt seems to agree with the treatment plan and attend the psychiatric clinic appointment as scheduled. Should there be no improvement after optimizing medication with adequate duration, in-patient treatment might be necessary.

Discussion

This case illustrated a condition whereby a child with a florid psychotic symptom, and a systematized delusion had influenced her caregiver. The similar delusion was strongly held by her caregiver (folie a deux), who is in a close relationship with the patient. The aunt has fulfilled the DSM-IV-TR criteria for Shared Psychotic Disorder(2). This fact has unveiled the difficulty in term of management. As the aunt is the only legal guardian available for AHL, her collaboration is of paramount importance in the treatment of AHL. Unfortunately, though seemingly agreed on the treatment, the aunt might not actually serve the medication at home in view of her shared delusion. Moreover, physical separation, which has been showed to be an effective treatment for shared psychotic disorder (3,4), is virtually infeasible given the similar delusions held by the aunt. To make the matter worse, the validity of the consent for treatment for the minor, given by the sole caregiver in this case, is also not without controversy. The presence of full mental capacity of the aunt in giving a valid informed consent is particularly difficult here. Guidelines for good practice on consent illustrated that if a parent is not competent in giving consent, local welfare authority should be consulted (5) . In adherence to Malaysian law, we might consider using the Child Act 2001, Part V (Sec 17): *Children In Need Of Care and Protection*, to get her into proper treatment if the caregiver refuse treatment and show evidence of risk of emotionally injured (6). However, this measure should be considered as the last resort since to maintain bilateral therapeutic alliance is a key factor in long term successful management. Multidisciplinary approach is extremely vital in dealing with this situation.

Another interesting point in terms of management that should be highlighted is the role of inducer and induced. Generally speaking, in a classical case of folie a deux, there is only one person who has genuine psychotic disorder (with florid bizarre delusions as showed in AHL), who is supposed to induce similar symptomatology in another person who shall remain a very close relationship with the primary inducer (1). Though it is more common that the primary inducer is dominant while the induced is usually independent and submissive(7), the opposite is true in this case. However, it is sometimes difficult to differentiate the primary inducer and secondary induced (3), nonetheless effort should be made to distinguish this as it implicates in the management plan.

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