Available online at www.sciencedirect.com

ScienceDirect

Comprehensive Psychiatry 54 (2013) 1032–1033

COMPREHENSIVE PSYCHIATRY

www.elsevier.com/locate/comppsych

Systemic lupus, folie a trois and homicide

André C. Caribé[a,*], Renato Daltro-Oliveira[a], Ricardo Henrique Araújo[a], Ana Paula Cardoso[c], Paulo Barreto Guimarães[c], Ângela Miranda-Scippa[a,b,d], Lucas C. Quarantini[a,b,d]

[a]*Mood and Anxiety Disorders Program (CETHA), University Hospital, Universidade Federal da Bahia, Salvador, Brazil*
[b]*Programa de Pós-graduação em Medicina e Saúde (PPgMS), Universidade Federal da Bahia, Salvador, Brazil*
[c]*Hospital de Custódia e Tratamento, Salvador, Bahia, Brazil*
[d]*Department of Neurosciences and Mental Health, Universidade Federal da Bahia, Salvador, Brazil*

Abstract

Folie a trois is a syndrome characterized by the transfer of delusional ideas from one person to two other persons. This condition rarely ends in the murder of any involved and we are unaware of where the primary case had the diagnosis of acute psychosis in systemic lupus erythematosus (SLE). We present a case report of folie a trois resulting in murder, secondary to acute psychosis in SLE.

1. Introduction

Shared psychosis, *folie a deux*, is a rare condition described for the first time in 1877 by Lasègue and Falret. The syndrome is characterized by a transfer of delusions and abnormal behaviors from one person to others. The delusions are shared by two or more, closely related, socially isolated, people, usually family members [1]. The primary case often has diagnosed schizophrenia, delusional disorder or mood disorder with psychotic features [2]. The secondary case is characteristically younger, has a passive personality or shows mental retardation [3].

2. Case report

Patient AR, a 50-year-old married mother of six, described as centralizing and domineering personality in family relationships, without history of previous psychiatric disease, was arrested in her town, along with her youngest son, DS, and sent to a psychiatric hospital, after murdering her oldest son, AB.

Thirty days before the crime, she presented a two-day episode of agitation and incomprehensible speech. The episode was self-limited and the patient could not explain what had happened. Eleven days before the crime, her younger daughter returned to the city presenting maniac and psychotic symptoms after childbirth. The family believed it was some kind of "spiritual obsession" and solicited local healers. Another local religious group, knowing the situation, imposed uninterrupted sessions of exorcism in her daughter. The entire situation resulted in stress and sleep privation for the family.

Seven days before the crime, AR showed changes in behavior inconsistent with social and religious customs of the family. She presented soliloquy, agitation, visual and auditory hallucinations, religious sayings and references to the devil. Four days before the crime, three days after AR symptoms, DS, her younger son, mentally retarded and emotionally dependent on her, developed the same symptoms. AR said the household objects were moving and fragmenting in her hand, saw people resembling goats, local reference for devils, confirmed by DS. Two days before, AB returned home, for 3 h, holding DS and AR, praying aloud. AB started to behave like his brother and mother, and one day before the crime, they tried to kill their father, AR's husband, after her accusation that he had goat legs and ears, therefore replaced by the devil. Wounded, he managed to escape. During the night, while they slept, AR began hearing voices, seeing shadows, and identified a half-human, half-animal being. They started fighting in the dark. AR only

* Corresponding author. Hospital Universitário Professor Edgard Santos, terceiro andar, Serviço de Psiquiatria, 40110-909 Salvador, BA, Brazil. Tel.: +55 71 9192 7186; fax: +55 71 3023 4111.
E-mail address: andrecaribe@terra.com.br (A.C. Caribé).

0010-440X/$ – see front matter © 2013 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.comppsych.2013.04.011

remembers the day dawning, a creature on the ground, dead. DS saw the same creature, and left home to seek help. Shortly after, the father returned home to see his oldest son killed, strangled with wire. He found his wife bloodied and angry, and she told him a goat-faced demon had invaded the house, which she had to kill to defend the family. She did not recognize her son.

Mother and son were conducted to local hospital, maintaining the symptoms and hospitalized for one month, treated with haloperidol, chlorpromazine, mechanical restraints and injectable haloperidol when necessary. They were admitted to the psychiatric hospital two months later without any medication. AR was oriented, collaborative, thought organized, no changes in sensory perception, depressed mood, aware of the facts, but using spiritual justification for her actions. She argued that she would never kill her son and believed she was possessed. DS was also aware, but with childish behavior, difficulty with abstracting, interpreting the facts in a religious context. An acute psychotic disorder was diagnosed for AR, mental retardation for DS, and a shared psychotic disorder for both. Both were considered legally exempt from punishment.

In the hospital, DS was separated from his mother and treated with clonazepam. He evolved without symptoms and was followed as an outpatient. In the following months, AR evolved with short, intermittent episodes of agitation, slurred speech with mystical content that improved with use of antipsychotics. After, she presented asthenia, decreased muscle strength in legs, knee and right wrist arthritis, constipation, abdominal pain, malar rash and fever. The laboratory presented antinuclear antibody (ANA) positive 1:160 (mixed pattern: nuclear fine speckled and homogeneous), PCR = 6.35, Hemoglobin = 8.0, Platelets = 100,000. The patient developed seizures and died with diagnosis (SLE).

3. Discussion

According to our knowledge, this is the first case of *folie a trois* where the primary patient is diagnosed with SLE with psychotic features. This case stands out because of the rare and unexpected disorders developed by the patients. Psychotic disorders, including the Schizophrenia spectrum that accounts for approximately two-thirds of all psychotic disorders, usually onset between 15 and 35 years [4]. Regarding the shared psychotic disorder, various features of the case fit the descriptions found in the literature, having international classifications DSM-IV and ICD-10, albeit with no clear evidence of social isolation in this case. Despite the presence of this feature in the first descriptions of *folie a deux*, this is not included in DSM-IV and ICD-10 as a criterion. However, Silveira and Seeman found revising published case reports between 1942 and 1993, where social isolation is a frequent feature in these cases [5].

In this family, we observed a strong influence of local religious culture. Even after the mother's death, due to a confirmed disease, all family members continued to contextualize the phenomena through a mystical and religious understanding. The existence of a plethora of cultural belief systems sometimes makes distinguishing cultural beliefs from delusions a difficult task. Cultures are complex and symbolic systems, and awareness of that specific culture is important in gaining an understanding of an individual [6].

SLE is an autoimmune disease that onsets more frequently in adolescents and young adults [7]. Although psychosis is one of the most severe psychiatric manifestations in SLE, it is a rare disease manifestation with low prevalence, ranging from 0% to 11% [7]. Furthermore, psychosis as the first symptom of SLE is even rarer: in a sample of 458 patients, Pego-Reigosa et al. found only six where psychotic symptoms occurred as initial presentation of SLE [8].

Although a systematic search for ANA in all psychotic patients is of little use, as presented by Hopkinson et al. [9], in this case it could have been suitable. With atypical age of onset for psychotic disorder, the acute nature of the symptoms and the presence of vivid visual hallucinations, one must raise the question of and investigate the possibility of organic diseases.

References

[1] Mouchet-Mages S, Gourevitch R, Loo H. Folie a deux: update of an old concept regarding two cases. Encéphale 2008;34:31-7.
[2] Joshi KG, Frierson RL, Gunter TD. Shared psychotic disorder and criminal responsibility: a review and case report of folie à trois. J Am Acad Psychiatry Law 2006;34:511-7.
[3] Arnone D, Patel A, Tan GM. The nosological significance of folie à deux: a review of the literature. Ann Gen Psychiatry 2006;8:5-11.
[4] Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry 2007;20:359-64.
[5] Silveira JM, Seeman MV. Shared psychotic disorder: a critical review of the literature. Can J Psychiatry 1995;40:389-95.
[6] Gaines AD. Culture-specific delusions. Sense and nonsense in cultural context. Psychiatr Clin North Am 1995;18:281-301.
[7] Jghaimi F, Kabbaj A, Essaadouni L. Systemic lupus erythematous revealed by an acute psychotic episode. Rev Neurol (Paris) 2009;165:1107-10.
[8] Pego-Reigosa JM, Isenberg DA. Psychosis due to systemic lupus erythematosus: characteristics and long-term outcome of this rare manifestation of the disease. Rheumatology (Oxford) 2008;47:1498-502.
[9] Hopkinson ND, Bendall P, Powell RJ. Screening of acute psychiatric admissions for previously undiagnosed systemic lupus erythematosus. Br J Psychiatry 1992;161:107-10.