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RELATIONSHIP PATTERNS IN "FOLIE À DEUX"

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Summary. - *"Folie à deux" is characterized by the communication of delusional ideas from one subject to other ones who have been living closely with him for a long time, usually his relatives. Before illness shows, there is a leader-follower relationship between partners, who are lacking of external sources of pleasure and are socially or culturally isolated. The dominating partner usually is a paranoic subject who strongly needs his ideas to be accepted by other people, while the dominated partner is a dependent subject who shares the other one's ideas in order to get pleasure from him and who is not able to criticize these ideas because of the lack for external influences. The two partners project hostility into the external world because, if the dominated partner does not share the other one's ideas, hostility will be projected into him and he will become very anxious. Interpersonal mechanisms in "folie à deux" are similar to those which take place in brainwashing, hypnosis and psychotherapy.*

KEY WORDS: paranoia, dependent relationship, brainwashing, psychotherapy.

Riassunto (Tipologia relazionale della "follia a due"). - *La "follia a due" è caratterizzata dalla trasmissione di idee deliranti da un soggetto ad altri che vivono a stretto contatto con lui da lungo tempo, di solito appartenenti alla sua famiglia. Preesistono una relazione di tipo leader-seguace e la mancanza di fonti esterne di gratificazione, in una condizione di isolamento sociale o culturale. Il dominante di solito è un soggetto paranoicale con un forte bisogno che le sue idee vengano accettate dagli altri, mentre il dominato è un soggetto dipendente che accetta di condividere le idee dell'altro per ottenere gratificazioni, in assenza di influenze esterne che lo inducano alla critica. I due partners proiettano l'ostilità sul mondo esterno in quanto, qualora il dominato non condividesse le idee del dominante, questi diventerebbe ostile nei suoi confronti, generando in lui un'ansia intensa. Esistono analogie fra le dinamiche interpersonali della follia a due e quelle del lavaggio del cervello, dell'ipnosi e della psicoterapia.*

Parole chiave: paranoia, relazione dipendente, lavaggio del cervello, psicoterapia.

"Folie à deux" or the *psychosis of association* is a psychiatric entity characterized by the transmission of delusional ideas from an individual to other ones who live closely in touch with him [1]. In most cases, the disease is transmitted within a family environment [2].

As to the inducing factors and the relationship between partners, we have to say that *people who have been living together intimately for a long time* [3], making the same experiences and having the same needs, are likely to become affected by this disease. The dependent subject is generally younger than the dominating one and women are more likely to be the dependent subject, because of their often subdued social status [3].

The pre-existent conditions consist in a *leader-follower like relationship* and intimacy between partners, combined with a disposition to live in seclusion. The latter condition arises from fundamental mistrust for neighbours, that tends to degenerate into paranoid ideas. Isolation will foster the domination of the stronger individual over the weaker one, who gets cut off from external influence, which is indispensable to counter-balance the partner's influence [1].

Another important element of domination is the *superiority* of one of the people involved, in intelligence, culture and initiative [1, 4].

Imitation, submission and *persuasion* are other characteristics of this type of relationship [5, 6].

"Folie à deux" generally takes place when the inducing subject is in the *initial stage of illness*, before withdrawal from reality and when he has authority over the dominated subject [7].

In the pre-psychotic stage, the *dominating partner intensely depends on the dominated one* and he is lacking in external sources of pleasure, while within the relationship he yields pleasure to the other person [6]; this type of psychotic families *lack of sources of pleasure* which could replace the lack of steady emotional ties with their parental families; emotional isolation is the only incentive for the parental couple to stay together [8]. This kind of couple is often made of one consort who is dependent and masochist, while the other one seems strong and protective [8].

Isolation is another prominent factor: whether it is social, cultural or linguistic, it has the same consequences that sensorial deprivation has and it leads to misunderstand and to interpret as persecutory even the most innocent conversation [1, 9]. Therefore, isolation is determining for the influence of one person on another one [2, 10, 11].

Sensorial deprivation that follows isolation causes an intense longing for external stimuli, increases suggestibility, reduces thought organization, causes depression and, in severe cases, hallucinations, delusions and confusion [12].

Thus, the subject falls a prey to his own imagination, lacking in an opposite kind of stimuli from external world to protect him and uncapable of a correct appraisal of reality because of the lack of contact with other people [13].

As we said above, families affected with "folie à deux" are scarcely or not in contact with the external world and thus nothing can oppose their peculiar interpretation of reality.

Before describing the distinctive features of the dominating subject, we have to say that he usually is a paranoiac subject, strongly wanting his ideas to be accepted by others [7].

In this type of subject, especially in early stages of withdrawal, isolation brings about a feeling of threat, due to the loss of contact by dominating the weaker partner [7, 14, 15]. The latter behaviour is reinforced, in the inducing subject, by the lack of gratifying experiences, and by a situation in which he is providing for the other person [6].

In order to describe the dominated partner, we first have to say that the lack of normal social relations makes him *lose the external influences* necessary to counter-balance the influence of the stronger partner; so the former is likely to accept the latter's ideas without finding fault with them.

The importance of *shock* and *tension* suffered by the dominated partner while being present at the arising of the partner's illness must be emphasized [1, 5]: in fact, we can suppose that afterwards the weaker partner will imitate the other one, according to a process of *identification with the inducing partner* [16].

The *sense of guiltiness* and the *excessive dependence* on the delusional partner are other factors that get relatives to give up their own interpretation of reality and agree with the ill member [14, 15, 17].

Children accept their parent's illness by suggestion and dependence and also in order to preserve self esteem. Passive, fearful and impressionable children are more likely to accept delusions [5, 18].

At last, it has been seen that the induced partner accepts delusions if the gets an *advantage* from that, which may consist in close control of the dominating partner, threats of abandonment, unreasonable claims or many other behaviours [6].

We can now make an hypothesis on the relatioship patterns that, in the situation described above, can lead to "folie à deux".

The situation is characterized by the dominated partner drawing advantage from the dominating partner's need of him, in a condition of isolation. While becoming aware of this, the dominating partner feels more and more angry but, fearing he will lose the other person, he defends himself from his own hostility by projecting it onto an external "object", thus giving rise to a paranoiac psychosis. In order to do that, he needs the other one to support his delusional ideas: if this does not happen, he turns the projection onto the dominated partner, to whom he becomes directly and openly hostile. In the latter, hostility causes intense anxiety, which is partially due to his fear lest he should lose an important source of pleasure and partially to his feeling of guilt for taking advantage of his partner: thus, when tension becomes unbearable, he ends by sharing delusions [6].

Deflecting the dominating partner's hostility from himself, the dominate partner can thus, on the one hand, express the anger he feels for the dominated partner in a projected form and, on the other, he can relieve his feelings of guiltiness because now is "someone else" who is doing his partner harm [6].

In this way, the subjects of "folie à deux" get to make a delusion by a feedback process, due to the weaker partner unceasingly repeating the stronger partner's ideas [1].

Relationship patterns of "folie à deux" can be explained by comparing them with analogous patterns recognizable in other situations, such as brainwashing, hypnosis and psychotherapy [9].

The close resemblance between "folie à deux" and *brainwashing* can be understood by examining three stages which are common to both situations:

First stage. - Disorganization and regression. It consists in the fall of resistence and it takes place in a condition of isolation and sensorial deprivation.

Second stage. - Identification with the aggressor. This kind of defense doesn't only relieve anxiety, but it actually protects the weaker subject from the aggressor, who is now approving his behaviour.

Third stage. - Instruction, given by imposing on the other person a continuous monothematic ideation [9].

Another relationship pattern characterizing "folie à deux" is *suggestion*: like in hypnosis, the dominating partner repeats monothematic ideas and the dominated subjects reinforce him by paying attention to him unceasingly and by accepting his ideas passively [1, 9, 19-21].

As for psychotherapy, the analogies with "folie à deux" can be also described by three stages:

First stage. - Fall of resistance and defence.

Second stage. - Identification with the therapist and positive transfert.

Third stage. - Doing insight and making changes in pathological behaviour [9].

Nevertheless, the fundamental differences between brainwashing and "folie à deux", on one hand, and psychotherapy and hypnosis, on the other must not be neglected: actually, in the former situations, one of the subjects tries to overcome the other one and they are both ill subjects. On the contrary, obviously, psychotherapy and hypnosis are *asked by the patient* and the therapist's strategies are aiming to help the patient achieve awareness and make free choices.

In conclusion, we can say that people who are sharing delusional ideas are very dependent on one another and they want to avoid separation, which is intolerable for them [14, 15].

Apparently it is the dependent partner who fears separation, but, as a matter of fact, each person involved in "folie à deux" is longing to find a lost oedipical object again and to have an archaic relationship pattern.

Subjects sharing delusional ideas are also unable to have suitable contacts with the external world: in fact, the dominating partner tries to do that using the dependent partner, who in his turn uses him for a correct interpretation of reality. Thus relationship patterns in "folie à deux" have a circular course within the delusional system, because of fear and suspicion, reinforced continuously by the impossibility to verify delusional beliefs. Thus complementary roles of the partners and their collusion in constructing a paranoiac delusional system seem aimed to perpetuate isolation.

Subjects involved in "folie à deux" are *afraid of intrusion* from outside, because it would bring about the "risk" of change, which is intolerable for a fragile system based on delusions.

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INTEGRATED HISTORY IN A PSYCHIATRIC WARD

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Summary. - *The present study begins from the hypothesis that the psychiatric admission can be considered to be, in many cases, a symptomatical act in which the patient, his family, the relational context that sends him and the institution as a whole take part. Such hypothesis has become necessary at the moment of the request for hospitalization, together with news from the patient and from his context about: the sender, the motivations, the type of request, the type of the insufficiency-urgency it is responding, the phenomen of the "presenting disturbance", a greater definition of the problem by everyone... This work will have the object to look for a correlation between the course of the illness and the life cycle, to attempt to give a hystoricity of the crisis and the request of the hospitalization, too often presented, lived, received and cured as historically closed.*

KEY WORDS: crisis, context, symptom, history, admission, chronicity.

Riassunto (Storia integrata in una corsia psichiatrica). - *Il lavoro partendo dall'ipotesi che il ricovero psichiatrico possa essere considerato, in molti casi, come un atto sintomatico a cui partecipano il paziente, la sua famiglia, il contesto relazionale di invio e l'istituzione tutta, ha evidenziato l'importanza e la necessità al momento della richiesta di ricovero di raccogliere dal paziente e dal suo contesto informazioni precise sull'inviante, sulle motivazioni, sul tipo di richiesta, sul tipo d'insufficienza a cui l'equipe crede di rispondere, sul fenomeno di facciata che visualizza la richiesta di ricovero, sulla definizione del problema da parte di tutti, sulle loro aspettative... Tale lavoro avrà come linea guida il ricercare una possibile correlazione tra decorso della malattia e ciclo vitale, per tentare una storicizzazione della crisi, della richiesta di ricovero, troppo spesso presentata, vissuta, ascoltata e trattata come storicamente chiusa.*

PAROLE CHIAVE: crisi, contesto, sintomo, storia, ammissione, cronicità.

Working hypothesis

Applying a systemic relational approach, our working hypothesis is to verify the idea that psychiatric hospitalization can be considered to be a symptomatic act in which not only the patient takes part but also his family, the relational context that sends him and the institution as a whole.

Theoretical premise

From this hypothesis we derive the necessity to analyse every type of phenomenon that shows up during the hospitalization of each patient. We will, in other words, study the power of the relation and the relation of power in the casual and motivational order through the integrated history, the observation of the course of the illness and the behavior of the staff [1].

This will involve analysing the relationship between the two causal and motivational orders concerning hospitalization, distinguishing them in order to correlate them from a point of view of a relational approach to understanding, to point out the difference information makes.

We thus hypothetically create a dynamic relation between different orders of analysis, so that we may conclude at the end of the research that in the case of hospitalization one order prevails over the other, creating a kind of discriminating characteristic in relation to the series of cases examined, categorized according to the various pathologies.

Research methodologies: the integrated history

In this type of research it is necessary to reconstruct a strict chronology, date by date. This should not take the form of a dynamic story but should consider all the life

events in relation to the life cycle. It should not concern the usual entrances and exits from the system but all two-order data, all those events that have provoked an oscillation of the system either towards the order of process or towards the order of praxis. In a subsequent phase of the research we will also attempt to give an overall evaluation of how these oscillations can be absorbed within the praxis of hospitalization. Finally, it could be said that the problem is one of finding a logical thread and for this it is necessary to include all the data of two orders without prejudice.

For this purpose it is important to consider the patient, his family and context as our best aids for the collection of the information we need [2].

It is therefore important to create a new climate from an interactive point of view, alive and that can open the way into meaning, sense.

It is no doubt useful for this purpose to have an interview plan, an outline of the data to be researched. But it is important above all to have that emotional availability in the clinical encounters that alone makes it possible to collect that kind of meaningful verbal and non-verbal input that signals the necessity of an interior branching out, of further investigation. In fact, the history is constructed piecemeal with regard to the phenomena that are later put into order according to an explicit motivational chain.

They present at first a constant back and forth between present and past, present and future, and it is only in this way that we can create that minimum of historical understanding that unhooks the event of hospitalization from a situation that is mechanical and atemporal and gives it back its proper sense, its proper time. To this end it is important to be able to oscillate with the patient and the family to be able to pick up that new word, that different rhythm that we can sometimes feel at a certain moment of the meeting. An example is given by those verbal and non-verbal bits of information, indirect, overlapping or decentralized that the patient and his family often give us with their answers to our questions. Actually, we usually feel that the information the patient and his family give us is the direct result of our questions, while instead, much useful information derives from their collateral responses or even from the questions the patient and family ask *us*.

Because of these considerations we have thought it useful to pause to examine first the analysis of the request for hospitalization and in particular on the context from which the patient is sent, on who took determinant action, on who (manifest "sender") may have been delegated to refer from the main "senders" (hidden "sender"), on how, pragmatically, this referral took place, who supported it by giving indications, who opposed it, and what relationship does the health worker who may have had the patient in treatment have with this referral to hospitalization.

The "sender", being the most involved in the situation of hospitalization is also the one who expects to be confirmed in his view of the problem and is therefore the one to whom we must give proper consideration if we wish to redefine this particular request. If it turns out that the "sender" is our colleague who is treating that patient, then we can see how we have come across one of those few observed cases where the proxy of technical power is even stronger and more complex and can often underlie a desire of the therapist to "free himself" from the burden of a difficult situation.

It would be useful to compare this fact with that of other psychiatric situations, in particular diagnostic and treatment services, where perhaps the time limit of hospitalization shapes, not only in the patient-family but also in the referring colleague, a certain type of expectation that may be less one of proxy or delegation.

We then paused to consider in particular the motivations for the request for hospitalization. In this case, by "motivation" we intend something that moves, that motivated the request for hospitalization and that brings with it a particular type and level of expectation that is characteristic of hospitalization [3].

The distinctive phenomenological characteristics of this motivation are: subjectivity - intentionality - value - understandability - possibility - conditionality - purpose - objectives.

We then hypothesized how the motivations behind every type of hospitalization can rotate around three more or less overt requests in a close relationship of interaction with the motivations for previous hospitalizations and with the responses the equipe that is treating the patient make to these motivations. We have further sought to discover what may be the levels of consent in the system requesting help, in the system receiving help and between the two systems.

The three requests we have hypothesized are as follows:

1) protection (dangerousness, seriousness, need for detachment, need for linkage-unlinkage...);

2) diagnosis (diagnostic procedures, diagnostic observation...);

3) treatment (medical, therapeutic monitoring, therapeutic containment, psychotherapeutic intervention, psychopharmacological intervention, EK, therapeutic milieu...).

Moreover, concerning the equipe that is treating the patient it would be useful to determine to what insufficiency-urgency it is responding: insufficiency of the patient, insufficiency of the family, insufficiency of the family doctor, social insufficiency, administrative insufficiency [4, 5].

It would be useful, then, to single out the phenomenon of the "presenting disturbance" for which hospitalization was requested, seeking a greater definition of the problem by everyone: (how did it happen, when did it happen, who was there, which other times did it happen, how does the problem manifest itself, how does it get worse and how is it resolved, and who does what to change it...) [6].

Starting from the "sending" system and the motivations of the request, the definition, idea and hypothesis of the problem that each has, as well as the specific expectations that each has will develop more easily. This will also be very useful in order to analyse the type of plan that it is

possible to impose for that patient in that hospitalization.

In fact what gets referred is not only a problem of a technical nature, for first order problems of the phenomena, but a complex network of meanings of a psychological-teleonomic order which contains within itself the motivations and feelings of an over-involved family group and of a system which sends the patient which is often more interested in an understanding of a part rather than a view of the whole.

The problem is thus more ubiquitous than it may seem and it is neither obvious nor easy for the doctor to manage it.

It will be necessary, then, to find out if there is a relationship between course of the "illness" and life cycle - in the sense of births, deaths, marriages, unlinkages - not in a historical chronicle, a chronological collection of data, but rather through an historical reconstruction which is oriented and has a direction.

Through jumps in time we seek to unhinge a certain way of understanding the family and this will uncover certain family myths on the one hand, and on the other an opening up of the problem area thus creating fertile terrain for re-reading certain situations in a more participatory, connected and systemic way.

This re-reading takes place by means of a new network of significant hypotheses proposed by the observer but also occasionally by certain parts of the system and this will indeed be stimulating and perhaps provocative but I think it will above all be containing.

In fact, I think it is not possible to separate psychic reality from historical reality, perhaps even where it is the process that imposes itself and what is actually an important change in the reading of reality comes off as a strong emotion felt by the patient but perceived also by the observer. The advantage acquired through separate individual work becomes apparent in this case. Only in this way can the internal spheres of emotion that have to be protected from family-parental intrusion be taken into consideration and become part of the material that is elaborated, creating new possibilities and new plans.

Only in this way can we pass from an either-or logic to a both-and logic, from verification to comparison, changing pain into suffering and helping expectations mature into periods of waiting that have more direction and awareness.

I would say, finally, that the integrated history has meant:

1) a new, more complex, more clinical epistemological effort which brings every type of phenomenon into observation;

2) an unavoidable clinical possibility;

3) a unique context of observation for new research hypotheses;

4) an important confirmation of the effort that many have taken to overcome their own theoretical premises and models in order to construct a more clinical context thanks to an obsever who is more mobile and flexible.

In conclusion, the meaning of hospitalization can, perhaps be found only by choosing to "link" the patient at the moment of this hospitalization. And this is the essential problem: how can we link the patient, with what kind of relationship? Certainly, I think, with a relationship that must be placed within the boundaries of a clear contract of hospitalization which will be all the more meaningful the more it is immediate, with the possibility either to accept the type of request, to accept it by changing it, or to refuse it with or without referral.

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