CASE REPORT

The elderly couple was admitted to our clinic by ambulance with the same referral of their general practitioner. In the referral, the GP

husband became symptom-free, her psychotic symptoms also began to descrease, by the time of discharge they could not be explored.

DISCUSSION

Induced or shared psychotic disorder is a rare psychiatric condition which was frst described by Primrose (1651), Hofbauer (1846) and Baillarger (1860) (Enoch & Ball, 2001). The name “folie a deux” originates from Lasegue and Falret (1877). Typically it develops in two persons of strong emotional attachment (siblings, marital partner, parent-child) who live separated from the outside world. Rarely, it can include three or more persons (folie a trois) or even an entire family (folie a familie) (Enoch & Ball, 2001; Lasegue & Falret, 1877). ICD-10 codes it as induced delusive disorder, while in DSM-IV it was listed as shared psychotic disorder. In DSM-5 induced psychotic disorder is no longer a separate diagnostic entity, it is noted as a subtype of delusional disorder.

For the diagnosis of induced psychotic disorder it is necessary to identify an inductor suffering from a psychotic disorder who acts as a dominant agent in their interpersonal relation and one or more recipient in submissive position. They usually live in a symbiotic relationship, isolated from their surroundings (Tényi, 2009). The inductor is usually diagnosed with delusive disorder or schizophrenia, or seldom with an organic psychotic disorder, for example organic hallucinosis and alcohol-induced psychotic disorder (Tényi et al., 1999), metilfenidate-abuse (Greenberg, 1956) or even Huntington’s (Roth et al., 2009). Although the recipients usually show submissive, dependent traits - sometimes reaching the severity of personality disorder, subclinical paranoid behavior is also possible. The estimated prevalence of mental retardation is roughly 20-30% among recipients, and around 25% of them suffer from some sort of physical handicap - mostly sensory – that further increase their vulnerability towards the inductor (Tényi, 2009). Thematically persecutory and grandiose delusions are most common, but transference of hallucinations is also possible (Tényi et al., 1999; Dantendorfer et al., 1997).

In our case, we would like to point out the role of the inductor suffering from and organic psychiatric disorder, and also highlight the fact that a case reporting an inductor with Parkinson’s disease is yet to be published.

Parkinson’s disease – also known as primary or idiopathic parkinsonism – is a neurodegenerative disorder of the central nervous system, which mainly affect the nigro-striatal dopaminergic system. The best known symptoms are the motoric ones (brady-hypokinesis, rigor, tremor, postural instability), but psychiatric conditions (cognitive impairment, psychosis, depression, anxiety) have the same, or even greater impact on quality of life (Sandeep et al., 2015). Next to Alzheimer’s disease, Parkinson’s is one of the most common neurodegenerative disorders, with a prevalence of 0.3% of the whole population. Over the age of 60, it affects approximately 1% of the

REFERENCES

Dantendorfer, K., Maierhofer, D., & Musalek, M. (1997). Induced hallucinatory psychosis (folie à deux hallucinatoire): pathogenesis and nosological position. *Psychopathology*, *30*(6), 309-315.

Enoch, D., & Ball, H. (2001). *Uncommon Psychiatric Syndromes*, 4ed. London: Hodder Arnold Publication.

Gilles, F., Florence, M., Renaud, H., & Marc, Z. (2000). Hallucinations in Parkinson's disease: Prevalence, phenomenology sy ą ris