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Case Report *Volume 7 Issue 2*

Shared Psychotic Disorder: A Case Report of "Folie a Deux"

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Abstract

Shared psychotic disorder also known as the induced psychotic disorder is characterised by sharing of a set of delusions by two or more people who are closely knitted together and isolated from the external world. The shared psychotic disorder is rarely recognised, diagnosed, and treated. The case of a couple described here is a shared psychotic disorder incidentally encountered in the hospital.

Keywords: Shared Psychosis; Social Isolation; Primary and Secondary Patient

Introduction

Shared psychotic disorder, also known as "folie a deux" or induced psychosis, is a rare delusional disorder [1,2] shared by two or more people with close emotional ties. The very first case of this type was described in 1819 and the contagiousness of this condition was first highlighted in 1940 by Gralnick A [3] and it was first described as Folie Communique by a French Psychiatrist in 1866 and then the term "folie a deux" was coined by Lasegue C, et al. [4]. Various other terms used to describe this illness include 'double insanity', 'communicated insanity' and 'psychosis of association [4,5]. In the early 1940s, Gralnick A [3] defined it as a psychiatric entity characterized by the transfer of delusions from one person to one or several others who have a close association with the primarily affected person and further described four types of the disorder [3]. Shared psychotic disorder is characterized by the transfer of beliefs from Primary, Inducer or dominant partner to secondary, induced or recipient partner. The primary appears to be superior in intelligence or age or imagination and the secondary patient can be over dependent, submissive, vulnerable or have self-doubting behaviour [6].

Many other terms were used to characterise the persons involved such as Boyd called the primary "parasite" and the secondary "the infected one" [3]. The common thing is that the two people in the psychotic twain typically live together in relative social isolation and have an unusually close relationship [7]. Although the exact prevalence in the population is difficult to assess, the incidence rate of 1.7% to 2.8% have been reported in psychiatric patients admitted in the hospital [8]. In DSM-5 it is included in the section on other specified schizophrenia spectrum and other psychotic disorders [9]. ICD-10 lists it as induced delusional disorder [10].

Case Report

Mr. p, 42 years old married male, presented to the outpatient department, with complaints of suspiciousness, muttering to self, irrelevant talks, poor self-care, decreased sleep with total

duration of illness of 5 years. Mr p got married 10 years ago and after almost 1year of his marriage patient's wife began having same delusions as well as auditory hallucinations. She was suspicious towards her husband's family members. She would often talk about evil spirits and how those spirits were surrounding their house and were ejecting some kind of rays towards their house to hurt them. Sometimes she would use abusive words while looking towards the roof and said that she was fighting with the spirits. Mr. p would remain preoccupied with his wife's illness and he would often argue with his family members whenever they tried to discuss his wife's irrational beliefs and allegations and soon after that he started believing that his family members could harm them and family members were plotting against both of them just like his wife. He started fighting with his family members and both of them would remain confined to their room and then thought of living somewhere else, away from their family members. He isolated himself and his wife from their family and was not in contact with any of his friends.

After few months one of his neighbours called his brother and informed that they were fighting with other neighbours and now the husband had started sharing beliefs with his wife. Patient's brother brought them back and they started living with their family. The patient started sleeping very less at night and believed that some spirits were out to harm him and his wife. He burnt all electrical appliances like air conditioners and TV and laptop because he thought those demons can enter his room through these appliances. He covered all windows of his room because he thought someone was trying to look into his room. He was wearing yellow clothes only and also putting some kind of yellow cloth over his head because he believed yellow clothes would not allow spirits to see him and he would be invisible to them. On mental status examination he had delusion of persecution, magical thinking, neologism, loosening of association and 2nd person auditory hallucinations.

Mr p was brought into the hospital by his brother when his paranoid delusions worsened. Management plan was framed and secondary patient was admitted in the ward and the further plan was to shift him to the closed wards in the hospital premises to separate him from his wife. He was started on tab olanzapine titrated up to 20mg/day and tab lorazepam 2mg was started at night and on sos basis. Further assessment of secondary patient (husband) was done in the closed ward. After almost one month his beliefs weakened and PANSS score reduced from 87 to 40. At the time of discharge, there was significant improvement and his delusions and hallucinations had resolved. Assessment of primary patient (wife) using PANSS and was started on OPD basis and there was significant improvement with reduction of PANSS score from 96 to 42.

Discussion

In 1956, Dewhurst K, et al. [11] proposed a criterion for diagnosing folie a Deux. The duo described in this case report fulfils that criterion as there is marked similarity between the content of psychosis and the partners share, support, and accept each other's delusions and they have been intimately associated over a long period of time. The majority of the cases reported are among family members and married couples are the most frequently involved dyad followed by siblings [12]. In this case wife is the primary or inducer who had a prolonged psychotic illness and the husband is the induced one who was overly attached, insecure and exclusive. This expansion of psychosis from primary patient to secondary is multifactorial. The core element is the kind of relationship between the primary and secondary patient. The husband was intimately associated with his wife both physically and emotionally. A significant component in this case is the duration of association between inducer and induced which is 10 years [12].

Another factor is the chronic untreated illness in the primary patient i.e., wife and her husband was overly concerned and involved with her illness and eventually started believing into her beliefs and after succumbing to his wife's beliefs he distanced himself from every other person who questioned them and this made him emotionally and physically distant from others and then they were completely cut off from relatives and friends [13]. The social isolation of husband with his wife for months have influenced the development of shared psychosis and both of them tried to remain attached while disengaging themselves from outside world [14]. Separation of both patients from each other for few months was considered the traditional treatment [15] but separation from primary remained insufficient and antipsychotics should be started [16,17].

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