Folie à Deux:
A Case of Husband and Children

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Shared delusional disorder (according to the *DSM-IV*) is a rare condition wherein a similar delusion system is shared by 2 or more patients in a close and often long-term relationship.[1] It is also referred to as "delusional symptoms in partner of individuals with delusional disorder" (*DSM-5*),[2] induced psychotic disorder (*ICD-10*),[3] folie à trois, folie à familie, shared paranoid disorder, double insanity, Lasègue-Falret syndrome, psychosis by association, and, most commonly, folie à deux.

Shared delusional disorder has 4 subtypes[4]:

- Folie imposée: healthy secondary imbibes the delusions of a psychotic primary.
- Folie simultanée: 2 patients, each with a psychotic illness, concurrently develop shared beliefs.
- Folie communiquée: similar to folie imposée, but preceded by a period of resistance from the secondary.
- Folie induite: psychotic illness afflicts both individuals, but unlike folie simultanée, 1 patient takes on the partner's delusion.

When considering the etiologic factors of the disorder, the most important seems to be the familial and interpersonal dynamics. The inducer (primary) usually plays a dominant role with an impressionable secondary, who might have limited intellect or a personality disorder.[5] Other factors include socioeconomic challenges, geographical isolation, and language difficulties. In 1995, Silveira and Seeman[6] found equal age and sex prevalence; couples, siblings, and parent/child pairs represented 90% of cases; two-thirds were socially isolated; and depression, dementia, and mental retardation were the common comorbidities. The theories surrounding this disorder include psychodynamic theory (isolated secondary fears losing a significant loved one or repressed oedipal fantasies realized in the backdrop of psychosis), learning theory (learning through observation), and social isolation theory.[7]

Persecutory delusion is most common, followed by religious, grandiose, and somatic delusion, and a primary's delusion content decides the shared belief. Folie à deux can cause a grave threat of altruistic mass suicide by presenting as cult apocalyptic theories and quasi-religious beliefs.[6] The primary patient is managed by assessment and treatment similar to that for simple delusional disorder. The secondary patient can be treated by isolating him or her from the primary. The secondary in folie à communiquée associates discarding delusions to rejecting the implicated relationship and thus also requires psychological management. In folie simultanée and folie induite, both patients require pharmacologic treatment.[8]

Due to the rarity of this disorder presenting in a clinical setting, the exact presentation, clinical course, and prognosis are not fully understood. The case presented here of a delusional secondary patient attempts to add to the scarce epidemiologic literature.

Case Report

A 20-year-old man presented to the emergency department (ED) in a tertiary care center in Northern India with acute psychosis manifesting as agitation, irritability, and restlessness with his father and paternal aunt. He was immediately managed with intravenous (IV) lorazepam 2 mg and IV haloperidol 5 mg, after which he became drowsy.

The initial history was given by his father and later confirmed by the patient after he regained composure. There was a 1 to 1.5–year history of "presence of different entities" and weird noises made by the patient, noticed by his family members with a continuous fluctuating course. The patient complained of a burning sensation, uncontrollable trembling, abnormal movements, and hearing internal voices in these episodes, during which he felt a loss of identity. The family felt that he was overtaken by another personality, spirit, or external force, and they noticed he was talking in different voices, varying in pitch, tone, and volume. They observed a snake crawling and hissing, "Lady Mustafa," a Mujra dancer, and a personality with frequent crying spells. The patient shared 2 additional entities, "Paris" and "Christopher," and explained how he met his personalities in his mind, calling them his "friends." He believed his mother and maternal uncle were the cause of his "possession." The disorder affected his daily life with decreased appetite and sleep, loss of interest (eg, getting up from bed or daily religious recitals), and missing college (he was a first-year undergraduate engineering student). He became irritable and decreased his interaction with family. He desired space, freedom, and financial independence. The paternal family had taken him to see a religious healer,

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who the patient believed had "taken out" many of his other entities.

Prior to admission to the hospital, the patient left home without informing anyone, roamed the streets the entire night, and was "roaring like a lion" when he was brought home. The next day the patient deliberately harmed himself by banging his head on the wall and by hitting himself on the head with a broken coconut shell. This odd behavior and internal conflict of opposing forces continued until he presented to the ED with acute psychosis.

Later during the patient's stay, his mother brought to our attention the frequent conflicts and interpersonal disputes she and her husband were having due to financial issues and how the husband had a bizarre belief that she was using "black magic" to harm him. He had presented these accusations multiple times in front of the patient and the patient's sister and had warned them to stay away from their mother. She had not noticed any of the patient's current symptoms, as she had not seen him in a year. About a year ago, the father had fled the city with his children and the patient's paternal aunt and grandmother without informing the mother due to the same fear. They did not let the mother contact the kids, and she filed a police complaint for missing children and the paternal family deliberately preventing contact. The mother stated that the patient and the patient's father, sister, paternal grandmother, and both paternal aunts firmly believed that she and her brother were responsible for the patient's current psychiatric condition. The patient's sister later confirmed this theory by sharing her firm belief that her mother was the root cause of the patient's condition through black magic and spirit possession and stated that she and the patient had filed a police complaint against the mother for mental harassment and torture. The patient also believed this and hence feared his mother.

Hospital course: After initial management in the ED, the patient was transferred to the psychiatry ward in a drowsy condition. On examination, the patient had self-induced abrasions and cuts on his forehead and restraint marks on his wrist. In a later interview, he was still drowsy but euthymic and denied any abnormal perception at the time. He started to suddenly behave and talk like a different accented girl mid-interview and later returned to his normal self. Throughout the hospital course, the patient exhibited different "identities" in a random pattern with no noticeable triggers. After detailed evaluation and ruling out other organic causes of psychosis, a provisional diagnosis of acute and transient psychosis, dissociative disorder–trance and possession in Axis I, and severe social, familial, and personal dysfunction in Axis II was made. After the differing accounts from the family, the additional diagnosis of shared delusional disorder was considered. The patient was initially managed with lorazepam 2 mg/8 hours IV and haloperidol 2.5 mg twice/day IV, and he was later shifted to corresponding oral medications. Nonpharmacologic therapy in the form of psychoeducation was also administered. His condition gradually improved, and after a few doses of antipsychotic medications, his delusions were shaken and converted into ideas. In the last 2 days of admission, he developed extrapyramidal symptoms. Due to the legal complications, the patient's relatives wanted him discharged. Thus, he was discharged on request despite requiring further care.

Discussion

The patient presented to the ED with acute and transient psychosis (*ICD-10* code F23.0),[3] which was adequately managed. Stress of parental conflicts triggered episodic alteration in consciousness with loss of personal identity and feeling of being possessed. With no evidence of any other physical disorder or organic disease, the diagnosis of dissociative (conversion) disorder (subcategory: trance and possession disorders, *ICD-10* code F44.3)[3] or dissociative disorder not otherwise specified (dissociative trance disorder *DSM-IV* code 300.15)[1] was made. The patient referring to entities as his "friends" might relate to the theory of imaginary companionship.[9] The dissociation could have been due to adverse childhood experience[10] and household dysfunction.[11]

According to Enoch et al,[12] folie à deux intriguingly exemplifies pathological relationship. The present case fulfills the criteria of folie à deux (*ICD-10* code F24, *DSM-IV* code 297.3) with a close association between the patient and his father, commonality of delusion content (persecutory delusion[6] against mother and uncle), and absence of an organic cause.[1,3] The father's dominant role, with long absences of the mother due to her demanding job, fit as a primary in folie imposée category. The 20-year-old impressionable,[5] socially isolated[7] patient who craved personal freedom, financial independence, and space in his life was an appropriate secondary. Absence of constant supervision by the primary during the hospital stay and pharmacologic and psychoeducational therapy helped shake our patient's delusions. Despite needing further care, the patient was discharged at his relatives' request and could not be followed up due to the sensitive nature and medico-legal involvement associated with his case.

There are only a few case reports[13–15] in the available literature combining shared delusional disorder with dissociation, another rare and less understood psychiatric pathology. Despite similarities to the present case, the dissociation described in previously published reports does not manifest as identities or possession. The most similar was a psychological analysis of a book on the life of Shirley Mason,[16] which has been highly criticized for the validity of her diagnosis.

This case adds a diagnostically difficult account of folie à deux, masked by a background of dissociation trance and possession disorder, to the scarce existing literature. This case may aid in understanding the interactions between the 2 disorders.

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