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A CASE REPORT OF SHARED PSYCHOTIC DISORDER OR *'FOLIE A FAMILLE'* AMONGST FOUR FAMILY MEMBERS

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Abstract: *Shared psychotic disorder is a common condition and there are many subtypes of this condition. Of these subtypes, only a small percentage involves families. In previous versions of the 'Diagnostic and Statistical Manual of Mental Disorders (DSM), this was popularly known as 'Folie a Deux' (Srivatsava and Borkar, 2010). In the latest DSM-5 version, this diagnosis has been removed and grouped under the umbrella of 'Delusional Disorders' owing to the fact that the belief in question might normally be widely shared amongst people of the same culture (DSM 5, 2013). In ICD-10 diagnostic codes however, 'Shared Psychotic Disorder' still remains relevant. Folie a Famille (sub-classification of 'folie a deux') is characterized by two or more members within a family sharing the same delusion. We report a case of 4 family members who shared the same spiritually themed delusions. Shared Psychotic Disorder is commonly managed by separating the index case from other family member(s) and treatment with antipsychotic medication.*

Keywords: *Mental Illness, Delusional Disorder, Shared Delusion*

Introduction

Lasegue-Falret Syndrome, also more commonly known as Folie a Deux (synonymous with Folie Communiqué) was first coined in 1877 by French Psychiatrists Charles Lasegue and Jean-Pierre Falret (ICD 10, 1992) (Lasegue and Falret, 1877). However, Jules Gabriel Francois Baillarger (French neurologist and psychiatrist) had described shared psychotic disorder as Folie a Communiqué earlier in 1860. Since it's conceptualization, shared psychotic disorder has become

an umbrella for its various sub-types (folie a deux, folie a trois, folie a famille, folie a quatre, folie a cinq) (Enoch and Trethowan, 1991) (Cetin, 2001). In 1942, Gralnick had written a review that remains a popular reference to this date, defining shared psychotic disorder as 'the transfer of delusional ideas, and/or abnormal behavior from one person to another, or one person to several others, related or unrelated, who have been in close association with the primary affected person[7]. In his review, Gralnick has also broken shared psychotic disorder into 4 main subtypes as shown in table 1 (Nishihara and Nakamura, 1993). Women are believed to be more commonly affected and the delusions are the product of a dominant personality who then affects more suggestible and weaker personalities (Gralnick, 1942) (Kashiwase and Kato, 1997). This said dominant personality has an associated co-morbidity of a primary psychiatric disorder (in addition to the shared psychotic disorder) which may comprise of schizophrenia, delusional disorders, mood disorders, often with persecutory or grandiose fixations. The weaker and more suggestible personalities usually don't have any other psychiatric diagnosis and are seen to improve at a faster rate than the primary after separation (Patel and Holroyd, 2017).

Subtypes	**Description**
Subtype A – Folie Imposée	Most common form of folie a deux, in which the inducer is typically dominant, intelligent, forceful and autonomous> The recipient is typically dependent, less intelligent, submissive, and more passive. Closely associated individuals. Upon separation, delusions often disappear.
Subtype B – Folie Simultanée	Simultaneous appearance of identical psychosis in closely related individuals with often a genetic link between the two. Higher prevalence in the elderly. Symptoms of delusion do not reduce with separation.
Subtype C- Folie Communiquée	Transfer of delusion after a prolonged duration of resistance by the recipient. Recipient usually develops his/her own delusion, independent of the primary, which typically persists despite separation
Subtype D - Folie Induite	In an individual already having a delusion, the development of a new delusion occurs under the influence of another deluded subject.

Table 1: Classification of 4 subtypes of Folie a deux

Case Presentation

Sister C is a 21-year-old Malay lady who presented to the emergency department with disorganized behavior and poor sleep for 2 weeks. She had no known psychiatric illness before. She is a university student. She started exhibiting changes in her behavior during her exam period In January 2018. She cried excessively because she felt guilty about her sins in the past. She was also religiously pre-occupied and had visual hallucinations of red figures tormenting her. On the 12th of January, she went to visit her sister (sister A) in another state. During this period, sister C was arduously chanting and praying until she fainted. Sister A had to call the ambulance to bring her to the state hospital. She was administered intravenous fluids and discharged straight after. Afterwards sister C began to disturb other residents at her sister's hostel with her loud chanting and abnormal behavior. She told everyone that she wants to fulfill her religious duties and she has been chosen by god to help people. She prayed continuously late into the night. When sister A tried to bring her into the toilet as the patient appeared unwell, the patient reacted aggressively by pushing her sister away and shouting in a gruff voice as though she was possessed. Fearing for their safety, patient's sister brought the patient back to their hometown.

The following day, it was noted that sister A had auditory and visual hallucinations and thus brought to a local health clinic and was later referred to a hospital for further management. The referral letter from the health clinic stated that sister A was experiencing auditory and visual hallucinations with a religious theme and she felt that God had given her a special task (similar to that of the patient, sister C). She was administered IM Haloperidol prior to her journey as she

was putting up a struggle. In the emergency department, after being separated from Sister C she improved markedly. Sister A was then given a 2-week appointment at the psychiatric outpatient clinic.

Brother B began looking pre-occupied and was chanting holy verses to himself exactly a day after Sister A presented. He reported poor sleep as he was taking care of Sister C. The family then brought both siblings to the hospital emergency department. On initial review, both siblings were behaving abnormally. They were dancing and chanting holy verses in the emergency department. They were physically and chemically restrained as they were behaving hostile and uncooperative. Sister A also stated that their mother had also begun talking to herself at home and praying fervently. Their mother had developed early signs of the abnormal behavior she had noted in her siblings. However, the family was not keen for the mother to be admitted yet as they wanted to go to a spiritual healer first. A plain CT brain was done for both siblings but revealed no abnormalities. They were then admitted to the psychiatric ward for further management.

During admission to the psychiatric ward, brother B showed rapid improvement with antipsychotic treatment and separation from his sister. The mother and Sister A who were both at home also improved markedly after being separated from the index family member. Both siblings responded well to atypical antipsychotics and were discharged home with a diagnosis of a Brief Psychotic Episode. They were subsequently followed up in the outpatient clinics.

Discussion

According to Lazarus certain conditions have to be present for the development of folie a deux, these include an intimate emotional association between the primary and secondary and a genetic predisposition to psychosis such as blood relations with the primary case (Lazarus, 1985). This case illustrates a case of folie a famille involving three siblings and their mother. This case presentation highlights some important characteristics of a shared psychotic disorder. Between the family members, they seem to have an unusually close relationship and an abnormal emotional bonding. The primary case was imposing her ideas and delusions on her family members causing a considerable disruption in their lives. Subsequently, the family members passively submitted to and shared the imposed delusional belief of the patient. They did not have any other psychiatric diagnosis before. With temporary separation, delusional beliefs and psychotic symptoms of family decreased in intensity.

There are certainly important considerations in this case in comparison to other case reports. The presentation of the primary and the secondary patients somehow is different compared to reported cases. As stated through reported cases, the primary is usually the dominant individual, who usually suffers from a psychotic illness, imposes his/her delusion on the secondary who are more submissive individuals. The primary usually professes certain characteristics that place him/her in the position of dominance. As suggested by other case reports as well, the inducer is usually at an advanced age, superior in intelligence with a forceful aggressive character while the induced is younger in age, paranoid, dependent and less intelligent than the primary (Mentjox and Kooiman, 1993) (Manschreck, 2000).

However, in this case, the primary is the youngest of the affected family members, does not have any psychiatric illness before, does not have superior intelligence and was not dominant amongst all. The dominant person, in this case, is Sister A, the eldest of the affected siblings who is the most successful amongst them which currently in her Master program in a university.

Other than that, the development of shared delusions and psychotic symptoms in family members were within such a short period which took about 1 to 2 weeks to be imposed on all individuals involved. The individuals affected were staying together but never reported to had minimal

contact with relatives or friends. Persecutory delusion is reported most commonly in different case reports of folie a famille, however in this report nature of delusion was mainly religious pre-occupation.

The above report demonstrated the complexity of folie a famille and the severity of behavioral consequences caused by induced or shared delusions. As the literature shows, the disorder is rare, but a proper recognition of this disorder can result in successful treatment outcomes. Separation is often the treatment option most advocated, but it may be inadequate or insufficient. Patel *et al*. have reported that separation of the dyad or more does not always result in the disappearance of psychopathology. Thus, psychopharmacological treatment such as antipsychotics are always recommended in managing this kind of cases.

In the DSM-IV-TR classification, Folie a deux appears as Shared Psychotic Disorder. The criteria included; delusion develops in an individual in the context of a close relationship with another person(s), who has an already established delusion (Criterion A), and delusions are similar in content (Criterion B), the disturbance is not accounted for by another psychotic disorder or physiological effects of a substance or any general medical condition (Criterion C). However, the literature considered the criteria for shared psychotic disorder are insufficient or inadequate (Arnone and Patel, 2006). DSM-5 does not consider Shared Psychotic Disorder (Folie a Deux) as a separate entity. The DSM-5 classification only refers "Delusional Disorder" or "Other Specified Schizophrenia Spectrum and Other Psychotic Disorder", abandoning the concept of Shared Psychotic Disorder / Folie a deux.

Conclusion

To conclude, *Folie a Famille* can occur in many situations outside the confines of current diagnostic classification systems, and is perhaps not as rare as is believed. *Folie a famille* is not only a colorful and intriguing condition, it also serves to emphasize how uniquely psychotic symptoms are actually contagious. Although the diagnosis of Folie a deux / folie a familie is not included in the DSM-5, we consider that this classical concept should not be forgotten. The treatment plan must be tailored according to the need of the patients and should include individual plans for each affected person.

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