

## Exploring Shared Delusions among Three Sisters in Folie à Trois: A Case Report

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### Abstract

### Case Report

In this case report we present the case of three sisters experiencing shared psychotic disorder (SPD), or folie à trois, characterized by the transmission of delusional beliefs within close familial relationships. The primary patient presented aggressive behaviors and paranoid delusions, leading to hospitalization, while the other two siblings displayed similar beliefs but with less severe symptoms. Treatment involved physical separation and pharmacological intervention, resulting in significant improvement, particularly in the induced siblings. The case underscores the importance of a comprehensive approach to managing SPD, combining pharmacotherapy and psychosocial interventions. Further research is needed to improve understanding and optimize treatment strategies for shared delusions. Documenting and sharing such cases can contribute to improved outcomes for patients and their families.

**Keywords:** Folie À Trois, Shared Psychotic Disorder, Shared Psychosis.

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## INTRODUCTION

Shared psychotic disorder (SPD), also known as folie à deux when shared between two individuals, is a rare psychiatric condition characterized by the transmission of a delusional belief among individuals in close relationships or groups. For instance, within a family context, it may manifest as folie à famille [1]. Despite being rare, SPD presents an interesting phenomenon in which shared delusions impact interpersonal relations and clinical presentation. The literature on SPD remains limited, primarily consisting of case reports, thus contributing to its status as an understudied and poorly understood condition.

In this paper, we present a case report of folie à trois observed within a familial setting. Through our report, we aim to contribute to the existing literature on shared psychotic disorders, offering insights into clinical practice and suggesting recommendations for future research on this rare phenomenon.

## CASE REPORT

Ms. M is a young woman of 28 years old with no prior psychiatric or medical history, single, lives alone, and is a factory worker, her colleagues started noticing some changes in her behaviors that started occurring abruptly in a few days: she became irritable

and then started harassing them, they noted that she was often talking to herself, her family was then contacted and then they brought her home, she then claimed that she was followed by a gang who were trying to use her blood as it is sacred, she started doubting her family and accusing them of conspiracy with the said gang.

A few days later, the patient's sister Ms. L, 26 years of age, started making the same claims as she repeated her sister's version of the claims adding that she also was being targeted by the said gang and that they are of noble birth.

Similar beliefs regarding this conspiracy were shared by the younger sister, Ms. I a young woman of 21 years old who was studying in another city and living with her roommates, but came later to help manage her sisters' cases. She started stating the same claims a day after her contact with her sisters.

Managing all three sisters proved to be challenging, furthermore, Ms. M, exhibited escalating aggression towards her parents as the initial signs of shared psychosis began to surface. They were then brought to the psychiatric emergency department.

During her evaluation, Ms. M exhibited behaviors consistent with responding to internal stimuli,

such as appearing to interact with unseen entities, although she did not explicitly acknowledge experiencing hallucinations. She described paranoid beliefs, firmly asserting that she was being followed and monitored as part of a larger conspiracy. The patient displayed disorganized speech and behavior, appearing agitated and confused during the assessment. The patient's mood was anxious, and her affect was labile. The thought process was tangential, with disorganized and paranoid content. No apparent cognitive deficits were noted.

During the evaluation of the other two sisters, they also displayed signs of delusions and conspiracy beliefs but with no sign of disorganization, they expressed fears of being targeted by the same gangs but maintained coherence in their speech and behavior during the assessment. They appeared composed and denied experiencing any hallucinations.

At the hospital, Ms. M the first sister was displaying threatening behavior towards her parents and the staff, requiring the use of antipsychotics and restraints to complete a full evaluation. The decision was made to hospitalize the patient for the management of her psychosis. The other two siblings were treated with antipsychotics: risperidone and were asked to continue with a follow-up as outpatients. Their evaluation in the next appointment showed major improvement in the delusions as they started criticizing them, and by the fourth appointment, we noted a complete resolution of symptoms.

As for Ms. M who was hospitalized, was also treated with risperidone in addition to a sedative neuroleptic: levomepromazin, we observed a rapid improvement in her affect and behavior. During the hospitalization, she continued to experience delusions regarding the gangs. One such delusion was that some of the hospital staff were hired by him to monitor her and to ensure that her blood was not contaminated.

Fortunately, with further progress, we observed a slower improvement in her delusions as she started criticizing them but she will report them to authorities if they ever started following her again. The patient was discharged a month after her admission and was recommended to continue the follow-up as an outpatient.

A few months after her discharge, the patient was staying at home. Her relationships with her parents and sister were good and they stopped reporting any delusions during later consultation

## DISCUSSION

Shared psychotic disorder, or shared madness, is a psychiatric entity considered rare. The first definitions were provided by Lasègue and Falret in 1877: two subjects, living in close association, in a closed and isolated environment, share delusional ideas on the same

theme [2]. Its epidemiology is poorly understood, and most data are based on simple case reports. Little systematic information on the prevalence of shared psychotic disorder is available. Three surveys that reviewed all case presentations of this pathology indicate that 242 cases were published from 1877 to 2005 [3]. Limited data suggest that shared psychotic disorder is slightly more common in women than in men.

The Key points in the diagnosis of induced psychosis include the following:

- a) The induced cases have similar delusions to those of a close associate who has already had delusional psychosis before the onset of the induced cases;
- b) The induced cases and the individual with delusional psychosis live in a relatively closed environment (typically a family) with little socialization with outsiders;
- c) There is empathy between the original (index) case and the induced cases;
- d) The original case is an authority figure and the induced cases have dependent and obedient personality traits; delusion is the major clinical presentation [4].

"Individuals who eventually share delusional beliefs are often connected through familial or marital ties and have typically cohabited for an extended period, sometimes experiencing relative social isolation. The primary individual, often referred to as the 'source,' is typically older, possesses higher intelligence and education levels, and exhibits stronger personality traits, with delusions predominantly centering around themes of persecution [5]. However, contrary to the expectation of shared delusions occurring solely in close-knit relationships, other studies have reported cases where patients share delusions despite being hospitalized without prior acquaintance [6]. Additionally, there are documented instances of shared delusions emerging in the context of collective grieving over a shared family member [7]. In our case, the individuals involved shared similar demographic characteristics, including gender and ethnicity. Ms. M, our primary patient, was the eldest among them and had recently relocated for employment purposes, having previously lived with her family. She was known for her assertive personality and played a significant role in providing for her family members."

The primary therapeutic approach recommended by the alienists who first described this clinical scenario involves separating the patients. In this process, the non-psychotic patient typically relinquishes the delusional belief relatively quickly and returns to their previous symbolic grounding, while the primary patient maintains their conviction steadfastly [8]. In the case we present, the three sisters were physically separated, with the primary patient admitted to the hospital while the other two received outpatient care in separate settings. Interestingly, the sisters identified as

induced showed initial signs of stabilization. However, it's worth noting that it's not always clear whether separation alone is sufficient for the recovery of the induced individual. Therefore, as suggested by other authors, we also supplemented this approach with psychopharmacological treatment.

## CONCLUSION

This case highlights the importance of a multidimensional approach to the management of shared psychotic disorders, with both pharmacological and psychosocial interventions tailored to the unique needs of each patient.

Further research is needed to diagnose, manage, and optimize treatment for shared delusions in contexts. By documenting and sharing cases such as this, clinicians and researchers can contribute to a deeper understanding of shared psychotic disorders, leading to more effective management and improved outcomes for patients and their families.

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