

# Shared Psychotic Disorder: A Case Report

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## ÖZET

Paylaşılmış psikotik bozukluk: Bir olgu sunumu

Paylaşılmış psikotik bozukluk (folie à deux) nadir görülen, sanırların ön planda olduğu ve kültürler arası farklılık gösteren bir bozukluktur. Literatürde bildirilen olgularda, etkilenmiş olan bireylerde daha çok perseküsyon, referans ve mistik sanırlar başta olmak birçok farklı tip sanrı bulunmaktadır. Diğer yandan paylaşılmış psikotik bozukluğu olanlarda erotomanik sanırların olduğunu bildiren yayınlar oldukça az sayıdadır. Bu yazıda, şizofreni tanılı annenin sanırlarından etkilenen iki çocuktan biri olan ve erotomanik sanırların eşlik ettiği bir paylaşılmış psikotik bozukluk olgusu sunulacaktır.

**Anahtar kelimeler:** Paylaşılmış psikotik bozukluk, folie communique, erotomanik sanrı

## ABSTRACT

Shared psychotic disorder: a case report

Shared psychotic disorder (folie à deux) is a rare disorder characterized by delusions and demonstrates intercultural differences. Cases reported in the literature have considerable persecution, reference and mystical delusions. However, erotomanic delusion has been rarely reported. In the present paper, we present a case, the daughter of a schizophrenic mother who has shared psychotic disorder accompanied by erotomanic delusion.

**Key words:** Shared psychotic disorder, folie communique, erotomanic delusion

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## INTRODUCTION

Shared psychotic disorder (folie à deux) is a rare disorder featuring delusions that vary in content and appearance according to culture (1). The DSM-IV-TR (2) defines it as “a delusion develops in an individual in the context of a close relationship with another person or persons, who have an already established delusion and it is similar in content to that of the person who already has an established delusion” Risk factors are reported to include close relationship (i.e., family), social isolation, passive personality, cognitive deficit, linguistic disabilities, and stressful life events (3).

In folie communiq  , a subtype of the shared psychotic disorder, the delusions can pass on to an individual with a genetic predisposition to psychosis and can last in this individual even after he/she has been separated from the others (4). The case presented here is of the daughter of a schizophrenic mother who has shared in particular her erotomanic delusions and who fits the clinical description of folie communiq  , a subtype of

the shared psychotic disorder.

## CASE

R.A. was 28-year-old single female patient, the sixth of seven siblings. She was a housewife with an elementary school education. She was brought to our clinic by her relatives, with complaints of skepticism, irritability, distress, introversion, and nervousness that had started four years ago. The patient had recently had serious problems with her interpersonal relationships in social environments and substantial functional disabilities and was thus admitted to our clinic. According to information from the patient’s relatives in the first interview, our patient claimed that she was married with two children and that a minibuss driver, 6 years older than her, was in love with her and had some secret connections with many people and organizations in the city.

The parents of the patient had first-degree consanguinity and two of the other children in the

family were diagnosed with depressive disorder, one with bipolar disorder. The patient's father had died of myocardial infarction fourteen years ago. Her mother was also skeptical and irritable woman with very restricted interpersonal communication, who had continuously been assuming since her childhood that men loved her and even might abuse her sexually and who had been diagnosed, treated, and followed up for a long time for the diagnosis of chronic schizophrenia. Since the mother had delusional ideas that her children would also be loved and sexually abused by strangers, she had broken off all interpersonal relationships and pressured her children to do the same. She had tried to compensate for the lack of authority, which might have resulted from the father's death, with a harsh attitude and behaviors. Despite the treatment which she had been administered for years, the mother's skepticism, absurd speech, and behaviors persisted and she began to require care as her cognitive functions further deteriorated. The first complaints of the brother, who had been followed up for a year in our clinic with the diagnosis of bipolar disorder, started three months after he had entered military service. He claimed that he had had an affair with a nurse in the infirmary, but that some people had tried to hinder it and even had interfered with them to have the nurse marry another man. A psychiatric examination of the brother revealed symptoms of distractibility, loosening of associations, logorrhea, akathisia, irritability, disorganized behavior and speech, grandiosity, and insomnia. After approximately two months of inpatient treatment for bipolar disorder (manic episode), he was sent back home as unfit for military service. Since then, the brother had had similar complaints in periodic attacks; however, his thoughts about the nurse never changed, neither during these attacks nor his partial recovery periods. Initially, he often looked for a way to see the nurse, but as he was not successful in doing so, he started to feel anger and hate towards many people whom he thought interfered with their love.

Our examination did not show any obvious deterioration in the functionality of the patient who persisted, though not as intensively as before, in her ideas about being loved. When we looked into our

patient's history, we learned that she had used, from time to time and in an irregular way, medications with the active ingredients sertraline, alprazolam, paroxetine, and quetiapine for diagnoses of depressive disorder, anxiety disorder, and delusional disorder. While the physical examination of the patient yielded normal results, in the mental observance and examination, symptoms of erotomanic delusions, loosening of associations, insomnia, irritability, agitation, aggression, hostility, and paranoid and reference ideas were found. In her mental history, our patient claimed that four years ago, the first day she encountered a driver working on a minibus route in her neighborhood, she realized he was the man she had previously seen in her dream and that he tried to influence her with his eyes. According to our patient, this man had fallen in love with her at first sight, hinted his liking with his facial expressions, and even wanted to propose marriage by touching her hand while he was taking the fare. The patient insisted that since that day, all minibus drivers, all men with perverse ideas in the city and even every man, both young and old, who took the minibus, had been looking at her and were sexually aroused. Meanwhile, the patient also claimed that the aforementioned driver had some secret connections with various people and organizations in the city; that these people had been cooperating with the driver to get to her; and that they had been following her to get all her personal information, and recording her conversations.

The results of the routine laboratory tests, which were performed to exclude any possible organic causes, were considered normal. After the psychiatric examination, the patient was subjected to a short psychiatric rating scale and various psychometric tests. After other psychotic disorders and personality disorders, which must be taken into account in the differential diagnosis, had been excluded by taking the anamnesis and applying clinic scales, shared psychotic disorder was diagnosed according DSM-IV-TR (2). The treatment for her delusions was set as quetiapine 300 mg/day, which was to be increased gradually. But as the patient insisted on being discharged, it was decided during the check-up examination to increase

the quetiapine dose and the patient was discharged. Moreover, it was agreed that the family members must remain separated for some time and face reality to deal with their symptoms. The check-up showed that the patient's complaints had been slightly alleviated, but that the antipsychotic medication dose was insufficient – it had not been possible to increase it due to the patient's request for discharge. Having gotten away from home for a while upon our recommendation, the patient still fostered the same, though less intense, ideas on being loved and followed. The patient's quetiapine dose was increased at intervals of a few days to 800 mg/day and control appointment was made for shortly thereafter.

## DISCUSSION

Shared psychotic disorder is a rare psychotic disorder that evolves through interaction between individuals who have a genetic predisposition to psychosis and have close emotional and physical bonds with delusional individuals (4). In this example of a nuclear family composed of mother, brother, and sister, which we consider a case of shared psychotic disorder (*folie communiquée*), both the existence of close emotional and physical bonds among the interacting individuals and the genetic predisposition of the children to this psychosis because of the mother's schizophrenic condition support the diagnosis. If *folie à deux* affects all family members, it is called *folie à famille*. Since only three of the eight members of the A. family are affected by this disorder, we have moved away from this diagnosis. *Folie à deux* is frequent in women who lead more or less isolated life away from society (5). Mentjox et al. (5) reported that among cases where information about gender was available, 72% of primary cases and 54% of secondary cases were women. In the family case that we present, the fact that the first affected member is the mother and that one of the secondary cases is also a woman supports this view. In this disease, psychotic symptoms can be occasionally observed in other family members who live with the patient. These symptoms are between two close members of the family and can pass from

the patient to one or more healthy individuals (6). In our case, the primary individual, the mother, adopts a very restrictive lifestyle in terms of social relations and tries to raise her children accordingly. Shared psychotic disorder is frequently observed in family types where the autonomy of the members is limited and the personal borders are vague. Similarly, in the case we present, all the family members have very close and dependent relationships with each other. Various studies reported that the pre-psychotic personality of the individuals affected by shared psychosis was more paranoid, antisocial, dependent, and histrionic and that they might have the potential for mental disorder, even though they had not encountered a psychotic individual (7-9). Similarly to other cases in the literature, the patient is considered a secondary case, showing very mother-dependent and histrionic personality traits in social life.

Having been very introverted, skeptical, and irritable, with almost no contact with the outside world before the onset of the disease, the mother had applied psychological and physical pressure on her children for many years, as a result of her paranoid and reference ideas, and had tried to keep them away from interpersonal relationships. And as the people with whom the mother had contact with by necessity were included in the delusion system, the belief that the family must not trust anybody might have intensified their isolation. In this family, whose members were leading a very interdependent life for reasons of 'safety', the primary case (active) was the mother who represented the authority at home since the father was not alive. Given that the harsh, authoritarian, and conservative family structure played a key role in the occurrence of this disease (10), the reason why the mother is the primary case will be further clarified.

In our case, the secondary (passive) individuals are the patient and her brother. Both had started to gradually share the delusions of the primary patient (mother) and had adopted her abnormal behaviors in the identification period. As a result, all three family members fostered delusions about being loved by some people and being followed because of these relationships, and even being victims of conspiracies

organized by many people to interfere with their passionate love affairs, and had shaped their lives accordingly. While the delusions had initially been limited to the relatives and neighbors in the immediate surroundings, all individuals and organizations had been included in the system of delusions over time. Our case is similar to those in the literature in that the disorder occurs within the family, in the number of individuals affected, in the existence of a genetic predisposition in these individuals, in the pre-psychotic personality traits, in the schizophrenic condition of the primary case, and in its high frequency among rural areas (11,12).

The most prevalent psychotic symptoms of shared psychotic disorder are delusions. Among them, persecutory and grandios delusions were on first rank (13,14). Doğanavşargil et al. (4) analyzed the cases of patients with shared psychotic disorder reported in Turkey from 1962 to 2009 and stated that in almost half the cases, persecutory delusions were shared,

followed by delusions of reference, mystic delusions, and bizarre delusions, respectively. It is particularly remarkable that, in contrast to cases reported in the literature, in our case, the persecutory and reference delusions were accompanied by erotomanic delusions and grandios delusions. This might have further aggravated the overall picture and contributed to the family's failure to seek treatment due to their lack of insight.

This relatively rare psychotic disorder is becoming increasingly difficult to diagnose because of its prevalence, the fact that the affected individuals are usually from the same family, the lack of insight, and failure to seek treatment. In our case, in addition to paranoid delusions and delusions of reference, erotomanic delusions were observed, in contrast to cases reported in the literature. We believe that future studies, which will present cases with similar differences, will contribute to the diagnosis and treatment of this rare disease.

## REFERENCES

1. Akyüz G, Kuğu N, Doğan O. Paylaşılmış Psikotik Bozukluk: Bir olgu sunumu. 3P Dergisi 2001; 9:404-407.
2. Amerikan Psikiyatri Birliği. DSM-IV-TR Ruhsal Bozuklukların Tanısal ve Sayımsal El Kitabı. Köroğlu E (Çeviri Ed.), Ankara: Hekimler Yayın Birliği, 2007, 470-473.
3. Enoch D, Ball H. Az rastlanır psikiyatrik sendromlar. Büyükkal B (Çeviri Ed.), İstanbul: Okuyan Us Yayınları, 2002, 235.
4. Doğanavşargil Ö, Eryılmaz M, Cinemre B, Metin Ö. Türkiye'de paylaşılmış psikotik bozukluk (Folie à deux). Psikiyatride Güncel Yaklaşımlar 2009; 1:215-228.
5. [Mentjox R, van Houten CA, Kooiman CG. Induced psychotic disorder: clinical aspects, theoretical considerations, and some guidelines for treatment. Compr Psychiatry 1993; 34:120-126.](#)
6. Kocabıyık A, Karşıdağ Ç, Ciğerli G, Kükürt R, Alpay N. Bir olgu nedeniyle folie à deux. Düşünen Adam Psikiyatri ve Nörolojik Bilimler Dergisi 2004; 17:228-233.
7. [Wehmeier PM, Barth N, Remschmidt H. Induced delusional disorder: A review of the concept and an unusual case of folie à famille. Psychopathology 2003; 36:37-45.](#)
8. [Petrikis P, Andreou C, Garyfallos G, Karavatos A. Incubus syndrome and folie à deux: a case report. Eur Psychiatry 2003; 18:322.](#)
9. [Reif A, Pfuhlmann B. Folie à deux versus genetically driven delusional disorder: case reports and nosological considerations. Compr Psychiatry 2004; 45:155-160.](#)
10. [Kashiwase H, Kato M. Folie à deux in Japan: analysis of 97 cases in the Japanese literature. Acta Psychiatr Scand 1997; 96:231-234.](#)
11. Alpay N, Saygılı S, Hanoğlu L, Şuvağ M, Beyazyürek M. Bir olgu nedeniyle folie à famille. Düşünen Adam Psikiyatri ve Nörolojik Bilimler Dergisi 1991; 4:20-21.
12. Zileli L, Çuhadaroğlu F, Orhon A. Folie à famille ve ayrılma-bireyselleşme. Türk Psikiyatri Dergisi 1992; 3:3-8.
13. Silveira JM, Seeman MV. Shared psychotic disorder: a critical review of the literature. Can J Psychiatry 1995; 40:389-395.
14. [Arnone D, Patel A, Tan GM. The nosological significance of folie à deux: a review of the literature. Ann Gen Psychiatry 2006; 5:11.](#)