

Shared Obsessive-Compulsive Disorder: A Case Report

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ABSTRACT

Shared obsessive-compulsive disorder: a case report

Shared obsessions and compulsions are a very rare disorder known to be represented by very few case reports in the literature. We report a case of two sisters displaying similar obsessions and compulsions. Knowledge about clinical features, treatments and prognosis in shared obsessive-compulsive disorder is limited to a few cases. New cases need to be reported in order to provide new information and experience about the shared disorder.

Keywords: Obsessive-compulsive disorder, shared disorders, shared psychotic disorder

ÖZET

Paylaşılmış obsesif kompulsif bozukluk: Bir olgu sunumu

Paylaşılmış obsesyon ve kompulsyonlar çok nadir bir bozukluktur ve literatürde çok az olgu sunumu ile temsil edildiği bilinmektedir. Bu olguda benzer obsesyon ve kompulsyonları olan iki kız kardeş sunulmaktadır. Bu paylaşımlı obsesif kompulsif bozuklukların klinik görünümü, tedavileri, prognozu hakkındaki bilgiler az sayıdaki vaka sunumları ile sınırlıdır. Bu paylaşılmış bozukluk hakkında yeni bilgiler ve deneyimlerin sağlanması için tespit edilecek yeni olguların bildirilmesi gereklidir.

Anahtar kelimeler: Obsesif kompulsif bozukluk, paylaşılmış bozukluklar, paylaşılmış psikotik bozukluk

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Date of receipt / Geliş tarihi:
June 5, 2014 / 5 Haziran 2014

Date of acceptance / Kabul tarihi:
November 6, 2014 / 6 Kasım 2014

INTRODUCTION

Shared psychotic disorder (Folie à deux) is described as the occurrence of a similar delusion as a consequence of close interaction with an individual who already suffers from the pre-existing underlying delusion (1). The first known case was presented 135 years ago, and new information on this disorder still emerges with case presentations and case series (2-5). Incidence and prevalence of the phenomenon are not known. According to a literature review performed in Turkey pooling cases of shared psychosis, a total of 21 cases have been reported since 1962 (3).

Shared obsessive-compulsive disorder (OCD) was first diagnosed in the case of a married couple (6). In the literature, there have been two cases in married couples, one case in identical twin brothers, a case in an extended family, and a case in two sisters (6-10).

Two sisters with similar obsessions, compulsions and avoidances are discussed in this case presentation. There are differences in demographics, obsession

content and treatment compared to the previously reported case involving two sisters and, as a case of shared OCD, it is the second report for this constellation in the international literature and the first in Turkey.

CASES

Case 1; Mrs. A, the older sister of Mrs. B, is a 40-year-old housewife with a primary school degree, of low socioeconomic level, with a 4-year disease history.

Case 2; Mrs. B, is a 33-year-old housewife with a primary school degree, of low socioeconomic level, with a disease history of about 3 years. Her symptoms started a year after the onset of Mrs. A's OCD and aggravated after her husband abandoned home.

Clinical Characteristics of the Cases: Both patients showed excessive nervousness due to contamination obsessions and cleaning compulsions as well as anxiety and avoidances. Both patients required their family members to take a bath when they came in

from outside, thinking they had been contaminated by exposure. Some of their behaviors included not admitting other people than their family members to their homes and not visiting their neighbors. Both patients believed that any yellow-grey colored objects were oily and contaminated; they avoided touching objects with these colors or objects reminding of such properties, washed their hands or bathed repeatedly when they touched or were contaminated by such objects and avoided places where there were objects of that kind. Neither of the patients had illusions, hallucinations, organic pathology, alcohol or substance abuse, childhood trauma or any other Axis I disorders.

Familial histories: Coming from a family of low socioeconomic status with 7 members, Mrs. A and Mrs. B have a mother who appears to have a hoarding compulsion. There were no other psychiatric disorders in the family. Mrs. A is the second child and Mrs. B is the fourth child of the family. Mrs. A, the elder sister, has dominant and Mrs. B has dependent and passive personality traits. Having a close sibling relationship, Mrs. A and Mrs. B had lived together until they got married, and since their weddings, they have been living in nearby districts. They visit each other at least 3-4 times a week.

Course of symptoms: Mrs. A has contamination obsessions and cleaning compulsions which started 4 years ago, and Mrs. B, due to her close relationship with Mrs. A as well as the latter's accusations of being contaminated and having to wash her hands, started to develop contamination obsessions and cleaning compulsions. On one occasion, Mrs. A, thinking that oil had spilled on her bed, threw away the objects in her bedroom and later developed the obsession that any object yellow-grey in color is oily and dirty. She also started to exhibit the behavior of not touching yellow-grey objects and avoiding places where there were such objects. After Mrs. B's husband abandoned the house eleven months ago, Mrs. A's relationship with Mrs. B got even closer, following which Mrs. A's contamination obsession and cleaning compulsions for yellow-grey colored objects and avoidances aggravated in Mrs. B as well.

Course of treatment: When Mrs. B presented to the emergency service of our clinic for severe anxiety and crying fits, she was wearing a coat despite summer heat to prevent anyone from touching her. She was admitted to the inpatient ward. During the period of her hospitalization, she was visited by Mrs. A on several occasions, and it was observed during these times that the patient's cooperation with her treatment deteriorated and her anxiety worsened. Following these observations, Mrs. A's visits were restricted and treatment efficacy improved. Cognitive behavioral therapy was administered with Clomipramine 225mg/day and Risperidone 1mg/day. At treatment start, her Yale Brown Obsession Compulsion Scale (Y-BOCS) (11) score was 37, decreasing to 18 by the time of her discharge after two months. During outpatient monitoring of Mrs. B, her treatment compliance deteriorated and the severity of her symptoms started to increase when she once again intensified her communication with Mrs. A. One month following discharge, her Y-BOCS score was 26. She was admitted for inpatient care again, and having received the same treatment as before (cognitive behavioral therapy with clomipramine 225mg/day, risperidone 1mg/day and restricted interaction with Mrs. A), she was discharged after two months with a Y-BOCS score of 14.

Mrs. A's treatment history involved a one-month hospitalization and treatment incompliance following discharge. Currently, Mrs. A is reluctant and in compliant with treatment, and her current Y-BOCS score is 20.

DISCUSSION

OCD is a multifactorial disorder that involves biological, genetic, behavioral, and psychosocial risk factors (12). Family studies have shown that 35% of the first degree relatives of OCD patients are also afflicted with the disorder but, to date, definite genes for the disorder have not been identified (12,13). In our case, as the patients' mother had hoarding compulsions, these obsessions and compulsions may be linked to a genetic component. Even though the symptoms of OCD may be biologically driven, psychodynamic meanings may be attached to them. Interpersonal

difficulties increase the patient's anxiety and symptomatology. After Mrs. B's husband abandoned her, Mrs. A's relationship with Mrs. B got even closer due to Mrs. A dominant and Mrs. B dependent and passive personality traits. Mrs. B may become invested in maintaining the symptomatology because of secondary gains. The behavioral model emphasizes obsession and compulsion as learned phenomena, as patients develop these repetitive acts over a period of time in response to coping with anxiety (9). As the patients in our case had lived together until they got married and afterwards maintained a close sibling relationship, the two sisters may display a similar response to anxiety. While there may be some relationship between childhood trauma and OCD, our cases had no history of childhood trauma. All of these factors may have contributed to aggravating the two sisters' symptoms. However, both cases included similar processes of contamination obsessions, cleaning compulsions, and avoidances, which point towards a shared clinical feature.

This case involves some features commonly observed in shared psychotic disorder, i.e., female gender, age at onset, low education and socioeconomic statuses, occurring between members of the same family, especially sisters, one of them being dominant and the other dependent and passive, with a positive contribution to therapy by limiting their interaction (3-5).

On the other hand, the main differences were that the shared and similar symptoms were obsessions and compulsions rather than delusions, and that the diagnoses of both of the cases, when examined individually, were non-psychotic OCD. Additionally, although it has been reported that an individual may recover simply by separating the patient from the secondary individual in some shared psychotic disorders (14), nevertheless pharmacotherapy and cognitive behavioral therapy (CBT) were also given in addition to separating the secondary individual in the case presented here.

Shared psychotic disorder is a rare condition. Shared obsessions and compulsions are much rarer and are known to be represented by five different case reports

in the literature (6-10). Previous presentations of OCD cases involved married couples (husband and wife), monozygotic twins (male), extended families (father-in-law, mother-in-law and four sisters-in-law) and two sisters with an age range of 25-58 years, with one of the individuals involved having dominant and the other dependent and passive personalities. In some cases, the primary and secondary individuals were of the same age, while in others the primary individual was older and in others, younger (6-10). Of the two sisters presented here, the primary patient was older, unlike in the other case report of two sisters (10).

Obsessions and compulsions of several different types including contamination, religious, aggressiveness, uncertainty, symmetry, death-related, knowing and remembering obsessions and cleaning, controlling, ritual charities, reiterations, and the urge to explain were identified for these patients (6-10). In this case presentation, the obsession that yellow-grey colored objects were oily and dirty was predominant, while in the other presentation, death-related obsessions were dominant in the two sisters. Avoidances involved yellow-grey colors in our case, while in the other report, patients avoided events reminiscent of death such as funeral services and condolences (10).

In the treatment of one case, the secondary patient's (wife) condition improved without therapy when the dominant individual (husband) was treated, and no physical separation had to be imposed for these patients (7). In another case, the primary individual received pharmacotherapy and CBT while the secondary individual was given only pharmacotherapy and interaction was not limited despite it being recommended; clinical improvement was achieved during treatment in both individuals (8). In a further case, moderate clinical improvement was reported with pharmacotherapy and behavioral therapy in all individuals (9). In the case involving two sisters, the individuals were separated physically, and during this period, the primary patient with dominant personality trait was hospitalized and given pharmacotherapy and CBT while the secondary individual received only pharmacotherapy; both responded to treatment.

During the follow-up period, however, restriction was not possible, treatment compliance became irregular, and the symptoms returned (10). In our case presentation, both patients were given hospitalized pharmacotherapy and CBT during different periods. The primary patient, with dominant personality trait, was in compliant and reluctant to seek treatment after being discharged from hospitalized treatment, and she still has moderate OCD. For the secondary patient, with passive and dependent personality traits, increased level of anxiety and reduced treatment compliance were observed after visits by the primary patient while the secondary patient was in the inpatient unit. Following first discharge, she intensified her interaction with the primary patient, after which her symptoms increased. In her second hospitalized treatment, isolation from the primary patient was ensured and

pharmacotherapy and CBT were continued. She was discharged with clinical improvement.

Both of these patients also have OCD individually. While similar obsessions and compulsions shared by more than one patient are currently not included as a category in the DSM IV-TR criteria (1), it is still uncertain whether these patients are to be considered under a new diagnostic group, under OCD, a new variant of OCD, shared non-psychotic disorder, or process from obsession to delusion.

In these shared OCDs, knowledge about clinical features, treatment and prognosis is limited to a small number of case presentations. Clinicians should be careful in patients with OCD that may be sharing their symptoms with others. It is evident that new information and experience on this disorder will be available as new cases will be identified.

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