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Case Study Review On Shared Delusional Disorder : Follie À Famille

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Shared psychotic disorder (SPD) was initially identified by Jules Baillarger in 1860, who referred to it as "folie a communiqué." Over time, it has been known by several names, including psychosis of association, shared paranoid disorder, communicated insanity, contagious insanity, folie à deux, folie à trois, folie à quatre, folie à cinq, and folie à famille (Srivastava and Borkar, 2010). Folie à famille is said to be present when more than two members of the same family are involved (Srivastava and Borkar, 2010). SPD is said to be rare and SPD involving the entire family is even more rare (Srivastava and Borkar, 2010).

In the study by Shrivastava and Borkar (2010), V.F, a 40-year-old man with untreated paranoid schizophrenia and antisocial personality disorder, was brought to the hospital by police after a complaint by his sister and neighbours. He believed his neighbours were out to kill him and his family, leading him to isolate his wife and children at home for four years. Over the last year, his wife and children also developed similar delusions, though they had no prior psychiatric history. V.F was treated with Risperidone and electroconvulsive therapy, improving during his two-month hospital stay. His family, refusing treatment, saw their delusions weaken but insisted on living with him after his discharge. V.F did not adhere to his treatment plan and was lost to follow-up after four outpatient visits.

Folie à famille, where a family's shared delusions form a "pseudo-community," arises from their attempt to stay united against a perceived threat. Key factors include social isolation and dependent personality traits. Typically, the disorder involves a dominant psychotic inducer and a dependent person. Though rare, recognizing this condition is crucial for effective treatment, which involves separating the patients and using

medication. However, maintaining treatment compliance can be difficult, as shown in our case (Srivastava and Borkar, 2010).

Symptoms and Causes : As per Cuncic (2021) Symptoms of shared psychotic disorder include shared delusions between the primary person and the secondary person or persons, lack of insight into the delusions, and potential secondary mental health issues like anxiety and depression. Physical health can also be affected due to increased stress, and both individuals may struggle with daily living and social interactions.

According to Cuncic (2021) causes include social isolation, high stress levels, a dominant primary person, a close relationship between the primary and secondary person, dependent personality traits in the secondary person, and untreated mental illness in the primary person. Risk factors also include neurotic or passive personality styles and existing mental illnesses.

Diagnosis: Diagnosis of shared psychotic disorder by (Cuncic, 2021) (SPD) involves a multifaceted approach. Clinicians start with a comprehensive clinical interview and a medical examination to rule out other causes of psychosis, such as substance abuse or organic brain disorders. A detailed mental state examination is conducted to assess the presence and nature of delusions. Gathering third-party history from family members or close associates is crucial to understand the dynamics of the relationship between the primary and secondary individuals. SPD is classified under "other specific schizophrenia spectrum and other psychotic disorder" in DSM-5 and as "induced delusional disorder" in ICD-11. Accurate diagnosis can be challenging due to the lack of insight from both the primary and secondary individuals involved. In many cases, the secondary person's delusions dissipate once separated from the primary person, which serves as a key diagnostic indicator. It's essential for clinicians to differentiate SPD from other psychiatric disorders to ensure appropriate treatment.

Coping: Coping with shared psychotic disorder (Cuncic, 2021) requires a combination of professional intervention and supportive measures. The primary step is to separate the secondary individual from the primary person to break the cycle of shared delusions. Psychotherapy, including cognitive-behavioural therapy (CBT), is often used to help both individuals recognize and challenge their delusional beliefs. Family therapy can also be beneficial to address the dynamics that contribute to the disorder and to support family members in understanding the condition. Medication, such as antipsychotics, may be prescribed to

the primary individual and sometimes the secondary person, depending on their symptoms. Building a trusting relationship with a therapist is crucial for effective treatment. Long-term follow-up is necessary to monitor progress and prevent relapse. Education about the disorder for both the affected individuals and their families can aid in managing the condition and promoting adherence to treatment plans.

Prevalence: Jose and Mary (1995) case reports from 1942 to 1993 that met DSM-IV criteria for shared psychotic disorder (SPD), focusing on patient demographics, relationship dynamics, duration of exposure to the primary's psychosis, family psychiatric history, comorbidities, social isolation, presence of hallucinations, delusional types, and primary diagnoses. The results revealed equal frequency of SPD among males and females and similar prevalence in both younger and older patients. Most cases (90.2%) involved married couples, siblings, and parent-child dyads. Common comorbidities included dementia, depression, and mental retardation, with hallucinations frequently present. The majority of dyads (67.3%) experienced social isolation. These findings suggest that SPD likely occurs in individuals predisposed to mental illness who live in socially isolated conditions with a psychotic illness.

Review of literature:

Roberto Catanesi, M.D. and Giovanna Punzi, et all: Folie a deux is a rare clinical syndrome characterized by the transference of delusional ideas from one person to one or more other people in close association with the primary affected patient. Mummification indicates the preservation of the corpse of a person for a variable period of time. A brief review of the literature in this field is presented, and an exceptional case is described, characterized by the association of both these rare phenomena. The case is an example of folie a fammille which developed out of a condition of extreme religiousness and seclusion of an entire family. The shared psychosis led to the horrible death of some of the family members, while the last surviving member of the family lived for more than a year and a half with their mummified remains. The Judge commissioned a forensic psychiatry assessment to verify the survivor’s ability to bear witness. The development of the psychiatric syndrome and its consequences are extensively discussed.

Tohru Ohnuma and Heii Arai (2015), Genetic or Psychogenic? A Case Study of Shared psychotic disorder, characterized by shared delusion among two or more subjects (termed “Folie a deux,” “trois,” etc.),

is often associated with strong religious beliefs or social isolation, factors creating strong psychological sympathy. Recently, we treated a rare familial case of "Folie a quatre" in central Tokyo without such influences.The proband was a schizophrenia patient and younger brother within monozygotic twins. Positive symptoms were "transmitted" to remaining family members, his elder brother, mother, and father father, in a relatively short period of three months. Although the pathophysiology of these positive symptoms(delusions and hallucinations) remains unclear, the transmission pattern suggests the primacy of social and environmental factors(and/or their interaction), while genetics appeared less influential in this "Folie a famille."

Morag Patterson,, Jane Lonie, and , John M Starr (2009), Is every shared psychosis a folie a deux: folie a` deux. Gralnick describes 'an already psychotic, often hospitalised individual who is influenced and develops the delusions of a fellow patient, adding these to his/her previous delusions.' (Gralnick, 1942). The associate, patient B shared a 2-bedded room with the principal Patient A in the first 9 days of the associate's re-admission. The associate shared the remaining 3 weeks with the principal in different rooms but still in close daily proximity within the 6- bedded POLL unit. Within 10 days of their contact the associate became preoccupied with swallowing difficulties. In the review of 61 cases by Silveria (1995) they confirm that the length of exposure can range from hours to years. Both patients shared the small dining/ common area for meals and activities. The shared delusions may have resulted from the 'social milieu' in that both patients shared a common 'intimate' eating and activities area.

Nasima Selim (2009): An extraordinary truth? The Adam ''suicide'' notes from Bangladesh. 2007, nine members of the Adam family committed suicide in a small town of Bangladesh. They had left suicide notes inside the house. The Adams believed in an anti-Islamic faith, the Adam ''religion,'' founded by the father, Abdul Adam, who had died seven years ago. Only one of the members of the Adam family is still alive, a daughter who was not part of the mass suicide. Most newspapers in the country reported the incident, but few journalists explored the story in depth. Based on a close reading of the suicide notes and a brief analysis of the major newspaper reports, the author argues that while the Adam ''religion'' was rooted in the Be-shara (against orthodoxy) tradition within Islam, the Adams were also suffering from a shared delusion. The Adams probably practised kufri kalam (underground satanic practice), and they were part of the sub-culture of protest existing in contemporary Bangladesh.

Conclusion

Shared psychotic disorder (SPD), also known as folie à famille when involving entire families, is a rare and complex condition with a rich historical nomenclature. This disorder is characterised by the development of shared delusions among closely related individuals, often family members, who form a "pseudo-community" united against perceived external threats. The condition typically involves a dominant psychotic inducer and dependent individuals, with social isolation playing a crucial role in its development.

SPD manifests in various ways, as evidenced by case studies ranging from extreme religiousness and mummification to shared delusions in hospital settings. The Adam family suicide incident in Bangladesh further illustrates how cultural and religious beliefs can influence the content and expression of shared delusions, highlighting the disorder's diverse presentations.

Recognizing and diagnosing SPD presents significant challenges, requiring comprehensive clinical interviews, medical examinations, and third-party information gathering. The interplay between social, environmental, and genetic factors in the development of SPD is complex, with some cases suggesting that social and environmental influences may outweigh genetic predisposition.

Effective treatment of SPD is crucial and typically involves separating the affected individuals, administering medication when necessary, and employing psychotherapeutic approaches such as cognitive-behavioral therapy and family therapy. However, maintaining treatment compliance often proves challenging, as illustrated in several case studies.

The varied manifestations of SPD, from religious extremism to shared delusions in close- proximity settings like hospitals, underscore the need for mental health professionals to be vigilant and knowledgeable about this condition. Long-term management and follow-up are essential for preventing relapse and ensuring continued recovery.

Given the rarity and complexity of SPD, further research is needed to better understand its mechanisms and develop more effective treatment and prevention strategies. Raising awareness about this condition among mental health professionals and the general public is crucial for ensuring timely intervention and support for affected individuals and families.

In essence, shared psychotic disorder represents a unique challenge in the field of mental health, requiring a nuanced understanding of its dynamics, careful diagnosis, and a comprehensive treatment approach that addresses both individual and familial factors.

This review of case studies on shared psychotic disorder opens up several avenues for future research. There is significant potential to delve deeper into the cultural, religious, and genetic aspects of this condition. While the current study primarily focused on examining existing case reports, it highlights the need for more comprehensive investigations.

One particularly relevant area for future exploration is the phenomenon of mass suicide and its potential connection to shared psychotic disorders. This topic could provide valuable insights into the extreme manifestations of shared delusions and their consequences on a larger scale.

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