Two Minds, One Delusion: A Case of Folie à deux

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Background

Folie à deux, shared psychotic disorder, is a historical psychiatric disorder affecting two or more individuals and are often members of the same family. Multiple medical treatments including separating affected individuals, medications, multiple forms of therapy are needed to effectively treat them. Commonly, social isolation, limited environmental influence, little reality testing contribute to this condition [4]. The term folie à deux includes several syndromes in which mental symptoms, particularly paranoid delusions, are transmitted from one person to one or more others with whom the apparent instigator is in some way intimately associated so that he or she and they come to share the same delusional ideas [8]. It is usually chronic with shared persecutory delusions being the most common form of psychosis with preserved functionality compared to other disorders [1]. Although there are four types, the most common is Folie impose'e. This consists of one dominant individual and one passive, submissive dependent who learns behaviors from the latter [8]. This is derived from the psychodynamic theory of a dominant-submissive relationship [1]. Although this presentation is rare, there is concern it is under-diagnosed due to avoidance of medical care which parallels with lack of insight and isolation [2]. The most important etiological factors are familial and interpersonal dynamics while others include socioeconomic challenges, geographical isolation, and language difficulties [7]. Ultimately, the dominant patient can be managed with treatment similar to delusional, psychotic disorders while the secondary patient is often isolated with or without medication management.

Case Presentation

We describe the case of a 36 year old female with past psychiatric history of brief psychotic disorder, PTSD and an 11 year old female with no significant past psychiatric history who originally presented to the emergency room for pain, constitutional symptoms but ultimately were admitted to separate mental health units due to paranoia, delusions, bizarre behavior. Medical workup was ultimately negative for any medical causes of altered mentation. The mother presents with fixed beliefs that she is being spied on, that her phone is hacked, and that cameras are monitoring her in her home, bathroom, and car, impairing her day-to-day living. She also reports persistent auditory hallucinations of a male voice. Mother was ultimately initiated on oral risperidone for paranoid delusions and hallucinations. She was eventually transitioned to Risperidone ER (Uzedy) 200 mg every 2 months because of noncompliance in the outpatient setting. The daughter exhibited parallel symptoms, endorsing identical persecutory beliefs and reporting similar auditory hallucinations. The daughter presented as guarded, shy, passive, internally preoccupied, scanned the room, endorsed auditory hallucinations, and had thoughts that people were breaking into her home trying to harm her. With mother's consent, she was started on aripiprazole and demonstrated improvement in symptoms prior to discharge. Some delusions, paranoia remained as she continued to have thoughts of people stalking her but no longer appeared internally preoccupied. The child's symptoms appear to mirror and reinforce the mother's psychopathology, highlighting a possible shared psychotic disorder with significant risk to the child's psychological safety and development overall.

Folie Impose'e: delusions transferred from individual with psychosis to an individual without psychosis and can improve with separation.

Folie simultane'e: identical psychoses in two predisposed persons with a long and intimate association, genetic link. Noted in elderly, no dominant partner, separation does not alleviate symptoms.

Folie communique'e: transfer of psychotic delusions after a long period of resistance by the secondary partner who develops own psychosis independently; persists after separation.

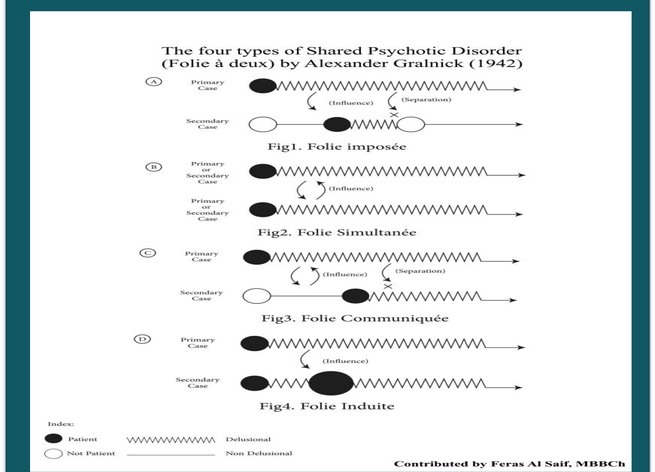
Folie induite: new delusions added to previously shared delusions under the influence of the dominant individual; separation is not an effective therapy [4].

Treatment Modalities

- Hospitalization/separation as the primary partner's influence diminishes.
- Separation alone may be insufficient or, in some cases, may worsen symptoms.
- Both partners may benefit from medication: antipsychotics or antidepressants alone, consider adjunct mood stabilizer.
- Initiation of medication often reflects greater severity and risk of residual symptoms.

Psychotherapy: May be offered individually or as conjoint therapy for both partners.

Electroconvulsive therapy (ECT): Considered in select or refractory cases.



Conclusions

- *Folie à deux* (now conceptualized under Other Specified Schizophrenia Spectrum and Other Psychotic Disorders in the DSM-V, remains a rare but clinically powerful illustration of of psychopathology which can emerge and persist within the context of a close relationship.
- Although uncommon, it challenges us diagnostically. It requires careful assessment of relational dynamics, social isolation, dependency, and the possibility of coercion.
- From a treatment standpoint, early recognition is critical. Separation of the involved individuals is often the pivotal intervention, particularly for the secondary case, who may show significant improvement once removed from the reinforcing environment. Antipsychotic treatment is typically indicated for the primary individual and may be considered for the secondary individual depending on symptom persistence. Psychotherapy and social reintegration are essential for sustained recovery.
- Ultimately, folie à deux reminds us that psychosis does not always occur in isolation. It can be relational, systemic, and reinforced within interpersonal bonds. As clinicians, maintaining awareness of this phenomenon allows us to intervene effectively, reduce risk, and improve outcomes for both individuals involved.

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