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# Psychopathological identification of roles in induced delusional

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## Abstract

The article presents a case report of a family whose members became ill with induced delusional disorder (folie a famille). The bio psychosocial basis of induced psychosis and psychopathological aspects of patient identification are discussed. The authors hypothesized that paranoid psychosis in the described case developed depending on the interaction between the inducer with the primary endogenous paranoid psychopathological symptomatology and the two induced emotionally bound individuals. One of the induced individuals simultaneously suffered from personality disorder and the other from primary organic brain dysfunction. This is a case of induced psychosis, a type of folio a impose that developed within the family. The inducer was a daughter; her mother and grandmother were secondarily induced by the disease, while the grandmother's role was the role of a catalyst.

**Keywords**: Induced delusional disorder, Psychopathological analysis, patients role.

## Introduction

The French term Folie à deux is referred to in the English literature as shared psychotic disorder, induced psychotic illness, induced delusional disorder or induced psychosis (7), in German literature isalso referredthe term symbiotic psychosis (23). The disease was first mentioned by Baillarger in 1860 and he called it folie à comuniquée. Nevertheless, the authorship of the term induced psychosis is usually attributed to Laségue and Falret, who in 1877 published diagnostic criteria for the disease (16). Kraepelin (1915) named the disease an induced insanity (Irresein) (15).

The diagnosis of induced delusional disorder can only be made in those cases where there is certainty that the induced partner not only takes over and supports the delusional system created by the inducer, but also elaborates it byhim (3). The disorder most often affects two people - an inducer (often a dominant person) with primary endogenous psychosis and an induced person (often a submissive person), which is referred to as a patient with induced delusional disorder. It is usually induced in the position of an emotionally dependent or submissive partner. Consistent with the foregoing, Pine describes the folie à deux as an expression of an inability to become independent (20). Dewald directly pointed out that folie à deux is more common in a pathologically dependent relationship with another person (2). He also described other factors that increase the likelihood of developing induced psychosis, such as social isolation, a family history of schizophrenia, physical disability, or mental retardation in a submissive partner. Although the psychosocial basis of the disease was originally considered, this fact indicates a significant influence of the possible genetic predisposition. In most cases, the disease affects members of one family, so it is also referred to as family psychosis (folie à famille) (7,23).

Whenitfirstappeared in the Diagnostic and StatisticalManual of MentalDisorders (DSM-III) itwasdiagnosed as "shared paranoid disorder."Then, in the DSM-IV, it was diagnosed as "shared psychotic disorder". The diagnostic criteria of DSM-IV for the SPD are as follows: a/ delusion develops in the context of a close relationship with another person(s), who has an already established delusion. b/ the delusions are similar in content to that of the person who already has the established delusion. c/ the disturbance is not better account for by another psychotic features and is not due to the direct psychological effects of a substance or a general medical condition (4).

Finally, in the most recent DSM-5, it is no longer identified as a separate diagnosis; rather, it is diagnosed under Section 298.9: Other specific schizophrenia spectrum and other psychotic disorder. The specific description is given below: "Delusional symptoms in partner of individual with delusional disorder: In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder" (5).

Currently, in ICD-10 (26), folie à deux is a synonym for induced delusional disorder (F24), but this shows diagnosis only of the submissive partner. While new revision ICD-11simplifyes the classification system into single diagnostic cathegory Delusional Disorder containing induced delusional disorder, persistent delusional disorder and other acute predominantly delusional disorder (1, 27). In DSM 5 is included to diagnostic category Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (298.8) (5).

Five types of induced psychosis are described in the literature (Table 1). The most common type is folie à imposée, where the delusional system developing in the dominant partner causes the progressive development of the delusional system in the submissive partner (11). The inducer forces some delusions under the influence of emotion, due to close coexistence, to be induced. Shortly after separation, the psychotic symptoms of the induced person disappear. Mysliveček points out that in some cases, the disorder is on the border of delusion and misconception of the primitive man (18). In the case of folie à simultanée, persons who have a close relationship develop a similar delusional system as a result of identical causes and circumstances, initially independently of each other (26). Mutual influencing does not appear until after the outbreak of psychosis. Unlike folie à imposée, mutual separation does not improve the symptoms of any of the affected people. The rarest type of induced psychosis is folie à comuniquée, in which the submissive person is not only affected by the delusional system that develops in the dominant person, but also elaborates it further (24). Kalmus points out that in folie à comuniquée the patient develops psychosis of the same type as the inducer (11). Separation between the two affected patients does not improve the symptomatology of either of them. In folie à induité, two primarily independent delusional systems are affected, with one person expanding his delusional system through the delusional content of another (17). Košč et al. (1957) described synchronously induced psychotic illness of four siblings, which developed as a response to the death of a dominant mother within the collective helplessness of those affected (14). In a discussion with the hitherto known descriptions of induced psychoses, they called it folie à synchrone.

| Subtype of SPD | Author | Characteristics |
|---|---|---|
| Folie à imposée | Kölpin, 1901 (13) | • Dominant partner developed a delusional system and then progressively has imposed delusional systems onto the submissive person<br>• Separation of these two persons led to improvement in either person. |
| Folie à simultanée | Wöllenberg, 1888 (26) | • Similar delusional systems have been developed independently in two persons who have been closely associated.<br>• Separation of these two persons hasn't led to improvement in either person. |
| Folie à comuniquée | Schonfeldt, 1894 (24)<br>Kalmus, 1901 (11) | • Dominant person has been involved in the induction of a similar delusional system in the submissive person. Moreover, the submissive person has developed his/her own additional delusional system, which hasn't remit after the separation of the two parties. |
| Folie à induitée | Lehmann, 1883 (17) | • One delusional person has his/her delusions extended by taking on the delusions of the second person |
| Folie à synchrone | Košč et al., 1957 (14) | • Shared psychotic disorder develops reactively and synchrony, predominantingly within one family. |

**Table 1:** Subtypes of shared psychotic disorder

It is difficult to estimate the incidence and prevalence of these disorders. Some studies report 1.7 to 2.6% of psychiatric admissions (21). There is a common unfortunate factor, that psychiatrists may treat the primary patient, while not being aware of the existing delusions in others (9,21). Although induced psychosis is relatively rare, it often becomes the subject of professional discussion (10, 18, 19, 22).

In the present case report, the authors discuss the bio-psycho-social basis of induced psychosis in the context of the use of modern diagnostic criteria (4, 27,28). This is a case report of a family whose three people contracted psychosis (folie à famille) (Figure 1).

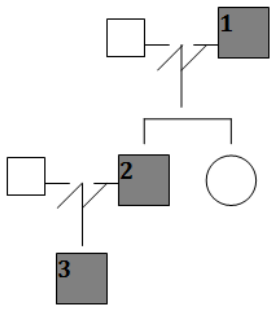
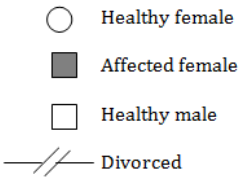



**Figure 1**: Genealogical tree of family




1 Mrs. K., grandmother
2 Mrs O., mother
3 Ms M., daughter

The aim of the presented case report is to point out the importance of psychopathological analysis of symptomatology in identifying the role of individual patients in induced psychosis.

## Case study

Mrs. O. (mother) is a 41-year-old divorced woman who lives in the same household as the divorced Mrs. K. (grandmother) and Miss M. (daughter). Due to her health concerns, general practitioner referred her to a psychiatrist. She claimed that she was in urgent need of detoxification because she and her daughter and mother were poisoned by rat poison. Ms. O. works as a nurse in an internal medicine clinic. The doctor she works for has long been satisfied with her work. In recent weeks, she had found her extremely nervous and tired, so she advised her to see a general practitioner.

In the outpatient documentation of the patient at the psychiatric department, there were records of several examinations over the course of 8 years. The diagnosis from the previous period was concluded as a personality disorder. Psychopathological symptoms varied over an eight-year period, although anxiety symptoms were prevalent in most examinations. There was also a period of increased reference sensitivity.

Mrs. O. refused hospitalization and psychiatric treatment. She asked for detoxification because she was erroneously convinced that rat poison had damaged her liver. She could not explain the situation in the family in detail. She believed that her father and sister, who lived separately, were part of a conspiracy against them. She did not make any eye contact during the psychiatric examination and was easily agitated. She was admitted to the psychiatric department without signing informed consent. Shortly after admission, she fully complied with the ward regimen and passively underwent therapy.

During the first day of Ms. O.'s hospitalization, her mother, Ms. K, arrived at the psychiatric department. During an interview with the psychiatrist, she confirmed that the family was poisoned by a rat poison, which she explained as part of a conspiracy against the family.

In order to supplement the objective history, the psychiatrist telephoned Ms. O.'s daughter, Miss M., who confirmed that a conspiracy was being held against them, probably by her grandfather. In addition, she stated that she was in telephone contact with D. C., a world-famous illusionist who is her close friend. Ms. M. further claimed that she worked as a railway accident investigator, while she herself was a participant in about twenty of them. She refused to visit psychiatric department due to her 4th month's high-risk twin pregnancy.

We learned from Miss M.'s medical records that she was first hospitalized in the children's ward of a psychiatric department8 years ago at the age of 11, when she was diagnosed with schizophrenic psychosis. After hospitalization, the family refused to continue outpatient treatment.

Ms. O.'s father went to a psychiatric department during her daughter's hospitalization and requested treatment for all three actors. He stated that in recent months Ms O., Ms M. and Ms K. had refused to communicate with him, claiming that he had poisoned them with rat poison and wanted to harm them further. He asked if even mental illnesses could be of an infectious nature, because the symptoms in all three actors seemed very similar to him.

The results of the physical examination, laboratory tests and EEG were within the reference values for Ms O. The psycho-diagnostic testing revealed signs of psychosis, but not signs of a schizophrenic psychopathological structure.

Since the beginning of treatment and separation from the family, a significant weakening of the affective charge of the delusions has been observed in Ms. O. Although the delusional system did not disappear, the patient did not further elaborate the delusional system. Antipsychotic treatment was prescribed and six electroconvulsive treatments were applied. The hospitalization lasted 53 days, and at discharge patient failed to have critical insight to the delusional contents. She was discharged from the hospital the same day when her daughter, Miss M, was admitted to the psychiatric department.

Miss M., Mrs. O.'s daughter, a 19-year-old single high school student, was admitted to the psychiatric department with florid psychotic symptoms. The clinical picture was dominated by persecution, extra potency and megalomaniac delusions, and auditory and intrapsychic hallucinations and emotional flatness.

The delusion of a twin pregnancy was also present. The patient used a pillow to create a pregnant belly. After being discovered that it was a pillow by nurse, she claimed that it only protected the baby from injury. Miss M. was autistic, she was not urgent in asserting delusional erratic topics, she tried to dissimulate. After separation from the family, the patient did not reach a convincing relief of psychotic symptoms and continued to develop a delusional system.

The results of the physical and laboratory examinations were within the reference values. Repeated CT examination of the brain at one-year intervals confirmed congenital four-chamber hydrocephalus without dynamics.

The patient was treated with an antipsychotic. Like her mother, she underwent six electroconvulsive treatments that improved florid psychotic symptomatology.

Ms. K., Ms. O.'s mother, is a 79-year-old divorced pensioner. We know the data from her medical documentation only indirectly, as she was treated in another medical facility. During the hospitalization of her daughter and granddaughter, Mrs. K. often visited their attending physicians. She accused them of corruption, demanded an explanation of limited contact with her daughter and granddaughter. She sent a written complaint to the director of the hospital, alleging that her daughter's doctor was part of a conspiracy against her family. Mrs. K. was highly hostile and urgent. The content of her delusional system was similar to Mrs. O. and Miss M, however, it led to aggressive enforcement. On the recommendation of her daughter's attending physician, Ms. K. was finally admitted to another psychiatric department. She perceived her forced hospitalization as a part of the conspiracy. After separating from her family, Ms. K. further developed her own delusional system.

From her medical record we learned that she exhibits the signs of mild organic brain damage. The hypothesis was that she was an induced person. Mrs. K. was treated with nantipsychotics and nootropics.

## Discussion

Diagnosis of induced delusional disorder is difficult due to missing heteroanamnesis. Rarely does a psychiatrist have the opportunity to equally examine and observe all actors and their relations. It is not always possible to identify a disease inducer at the outset. We also encountered the mentioned problems in the described case.

In the first step, the induction mechanism must be confirmed. According to Kraepelin (15), who referred to Schonfeldt, the influence of an inductor must be the specific reason for mechanisms of induction. It must therefore not be a simultaneous disorder, asemphasizes, in addition to Kraepelin, also Myslivecek (18). Similarly, it must be a more difficult situation than a mistaken explanation.

The induced delusional disorder is not the same as the primary endogenous psychotic disorder, but from a psychopathological point of view it is also severe condition. Although it does not have a known biological basis, the patient without critical insight accepts the delusional themes of the inducer, which he/she does not verify as a mistake. Thus, the pathological evidence is clear. According to Guensberger (8), the psychopathological concept of pathological evidence is understand as a condition in which the patient has firms certainty about the reality of false beliefs without examining arguments and uses them mainly to convince others about his/her truth. The current concept of psychosis has biological basis as a core starting point. However, in history of development of the psychopathological concept of psychosis, psychotic disorder was understood also as the result of reactive state or reactive development, which explains reason why psychologically induced mental disorder can be named as psychosis (10). Psychotic symptoms such as delusional mood, memory delusions, and illusions leading to behavioral disturbances are present. The induced person is, to varying degrees, able to independently develop own delusional system.

All three actors were obviously psychotic. During Ms O.'s investigation, it was noticeable that the information she provided was evidently taken over. The patient did not further develop the delusional system by herself. The pathological evidence of delusion was significant. There were illusions, but not hallucinations in perception. For example Mrs. O. saw her daughter on the phone with D. C. She did not hear his voice, but "heard" English words from the receiver. She herself does not speak English and her daughter told her what they were talking about. Ms O. considered her beliefs to be true and sought no other arguments. The hearing of English words had the character of an auditory illusion, but it could also be an illusion of memory, or it was a simple lie by which Mrs. O. wanted to convince psychiatrists of the truthfulness of her statements. In the case of conscious lies occurring in paranoid states, they can be considered as a psychopathological symptoms (5).Mrs. O. refused hospitalization, but, on the contrary, her passivity in undergoing treatment and lack of the expected temperamental arguments, gave the impression of schizophrenic disintegration, but can also be explained as an effect of treatment. The diagnosis of induced psychosis was also evidenced by the rapid improvement in the patient's condition. However, delusional topics lost their affective charge; they were not completely corrected by the patient. She did not provide any arguments to explain her changed attitudes. It must be taken into account also her prepsychotic personality characteristics which were evaluated on the basis of long-term observation as asthenic, introverted and suspiciously schizoid. In relation to the other actors, the patient played a clearly submissive role. The influence of the genetic predisposition cannot be neglected in the etiopathogenesis of induced family psychosis.

The second subject, Miss M., Mrs. O.'s daughter, was the first one to produce delusional contents. At the age of 11, she was treated in the children's ward of a psychiatric clinic for schizophrenic psychosis. Already in this period, the family was not critical to her mental disorder. Her current psychopathological changes, especially in emotions and thinking, seemed to by primary and have the character of an endogenous schizophrenic psychopathological structure. The autistic nature of delusional productions was clear. Autistic character can be observed also in the delusion of pregnancy. Moreover, schizophrenic splitted criticism was noticed, because Miss M. used a pillow to make her pregnancy visible. We attribute Miss M. the role of the inductor despite the fact that it cannot be considered dominant in the

group of actors. The type of induced psychosis between Mrs. O. (mother) and Miss M. (daughter) is evaluated as folie a imposée.

The third actor, Mrs. K., mother of Mrs. O. and grandmother of Miss M., was observed unsystematically during sporadic visits of her daughter and granddaughter during their hospitalizations. She independently developed her own delusional system (e.g., the delusional belief that the hospitalization of her daughter and granddaughter was part of a conspiracy against their family). Her energetic, querulous and hostile behavior can also be explained by the fact that she was without any treatment and suffered with mild cognitive impairment which makes her more sensitive to be influenced by an inducer. We understand her dominance as important in the development of mechanism of induction in her family. Her role could be described as a "catalyst" of induction, which precipitated the mechanism of induction. All three women lived in close symbiosis. They ruled out contact with their grandfather and with any other people either.

## Conclusion

Induced delusional disorder is relatively rare diagnosis with unclear nature. In occurrence within family all the components of bio-psycho-social basis are important. In the presented case, the difficulties in identifying the mechanisms of induction are confirmed. From the view of psychopathological identification of the roles of individual actors, it can be stated that Ms. M. and Ms. O. were in a submissive position with respect to Ms. K. It cannot be overlooked that Ms. M. was inductor, treated primarily for endogenous schizophrenic psychosis in her childhood. Therefore, we understand Ms. K.'s dominant role not as the role of an inductor, but as a "catalyst" of induction, which contributed to the acceleration and strengthening of the induction mechanism. We identify type of induced psychosis as folie a imposee between Miss M. and Ms. O., but not Ms. K. We attribute to Ms. K. the role of a precipitator of induction.

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