Induced delusional disorder: A case series

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Phenomenon of induced delusional disorder has a relatively long, controversial history of conceptualization. It is a rare entity and goes undiagnosed mostly as only the primary partner is brought to clinical attention. We present a case series of induced delusional disorder with different presentations. For effective management, understanding the dynamics of relationship shared by the partners and addressing the biopsychosocial factors are crucial. Failure to adhere to treatment poses additional challenge in these cases.

Keywords: Olfactory hallucinations, shared delusions, somatic hallucinations

Induced delusional disorder (folie à deux, shared psychotic disorder) is characterized by the sharing of delusional ideas and/or abnormal behavior from one person to one or more others who are in close association with the patient who is primarily affected. It was initially described by Lasègue and Falret in France in 1877. Partners of induced delusional disorder were distinguished as “inducer–induced” or “principal–associate” or “primary–secondary.” It was previously assumed that the primary partner had a domineering personality and initiated the delusions. Secondary partner, a generally submissive individual, acquired the delusion from the primary as seen in our cases. Later, when it was learned that the dominance and submission do not always manifest, the concept of folie a deux as an “imposed” entity was deemphasized. Instead, the formation of a mutual delusional system was seen as an adaptive function that allows the partners to identify with each other, channel aggressive drives, and preserve intimacy.¹⁻⁴ We present three such cases, two referred from dermatology and one directly reporting to the psychiatric outpatient department.

CASE REPORT

Case 1
They used to be a family of six, comprising parents and four children. Three daughters got married and moved out. Son...
A 37-year-old homemaker was residing in the same neighborhood. Seeing the mother in distress, she requested her mother to stay with her. She provided her mother with new clothes and good-quality personal hygiene products and sought treatment for the malodor from different physicians/dermatologists. None of it helped. By the end of 2 weeks, the household objects her mother used started to stink. By the end of 1 month, she noted the malodor from her body. She believed to have contracted the disease of body malodor from her mother and was quite distressed. She was concerned that it may spread to her children so requested her mother to go back to her own residence.

Daughter 2

A 34-year-old homemaker was living in the same neighborhood with her family. She would pay her mother daily visits. After a while, she noted malodor from her body and believed that she has contracted the disease due to contact.

Both the daughters reported that their body would smell of pus and blood, exactly like how their father would smell initially and then mother. They had consulted many physicians/dermatologists and engaged in excessive cleaning practices to get rid of the odor. When asked if their spouses could smell/have spoken about the malodor anytime, both said no. They added that very recently, few of their children have admitted that their mother and grandmother smell badly and have stressed on treatment. There was no relevant past or family history of any medical/psychiatric illness. Their premorbid personalities were well adjusted. General physical examination was unremarkable. On mental status examination (MSE), mother and daughters were well groomed and well kempt. Mother requested the psychiatrist to examine her sari and purse for foul odor; when she was told there was no smell, she and her daughters reported to be surprised with the fact that doctors are not able to detect the malodor. Affect was distressed. She had somatic delusions, delusion of reference, and olfactory hallucination. Insight and judgment were impaired. With a diagnosis of induced delusional disorder, they were advised to come with their respective spouses for treatment planning and management. When the scheduled follow-up was missed, they were contacted over telephone and advised to visit, and they reported to have decided to seek treatment from another dermatologist and would visit when need is felt.

Case 2

Husband

A 30-year-old man, hailing from Nepal, uneducated, working in a restaurant in Pune, married for the past 10 years and has a son, came with complaints of an insect crawling under his skin for the past 3 years which was distressing him. A few years after his marriage, he had unprotected intercourse with a commercial sex worker and got infected with syphilis for which he took treatment. All this while, he was separated from his wife as she was in the village while he was living in Pune. Three years back, his wife and family shifted to Pune and he disclosed about his illness to her. They never had unprotected intercourse after that, but the wife would constantly ask if he is okay and would repeatedly ask him to visit a doctor. Meanwhile, he developed a belief that there is an insect crawling under his skin which travels throughout his body and bites at places, with an explanation that this insect got into his body from the exposure which was years ago. He visited
multiple dermatologists, with no remarkable physical or investigatory finding. He was then referred to the psychiatry department as the belief was held with conviction.

**Wife**
A 25-year-old homemaker, who shifted to Pune to live with her husband, started developing similar complaints of an insect crawling under her skin over her entire body which occasionally used to bite her and released some pus/water under her skin. She also started complaining of normal vaginal discharge as the fluid released by the insect. Her symptoms followed that of her husband, and despite multiple tests and reassurances that she is healthy by the dermatologists, she believed that the insect has multiplied in her husband’s body and transferred into hers via intercourse. Over the past few weeks, she kept thinking that this insect will make all the utensils contaminated and that her 10-year-old son would also get infected and she sent him back to the village out of this fear. Their premorbid personalities were well adjusted. Physical examination was unremarkable. On MSE, both were kempt and well groomed. The wife kept pointing at the site where the insect was biting and showing how its releasing water inside her skin. Affect was distressed. They had somatic delusions and somatic hallucination. Insight and judgment were impaired. With a diagnosis of induced delusional disorder, the woman was admitted and the husband was told to follow-up frequently. Both were started on second-generation antipsychotics, and the woman showed complete improvement within 2 weeks once she was separated. After a few weeks, she decided to go back to the village for a few months while her husband was treated here. She was psychoeducated about the need for compliance, while the husband came for regular follow-ups for 2 months and was improving on the same.

**Case 3**

**Mother**
A 52-year-old widow, belonging to middle socioeconomic class, initially used to work in a company, stopped working in 2018, living with her son was brought by her relatives. Over the past 2 years, she had gradually developed a belief that whatever amount of money they are getting will not suffice. She stopped cooking food at home, not to save money, but believing that they just did not have enough, and all this while, they were getting money from pension in her husband’s account. In the past year, the food consumption decreased to one meal a day from a tiffin service which both she and her son would share. They never left the house and did not allow anyone to visit as well. A few days before admission, she had a fall and could not get up from the floor. Her son tried to pick her up but was unable to do so because of physical weakness. They both kept sitting in the house in a pool of her excreta for about a week. At that time the neighbors observed a foul smell from their house. The neighbors contacted her sister who came with her family and broke the door of the house only to find it in a filthy state, and brought them to the hospital.

**Son**
This 23-year-old, B Com, gold medalist in accounts, was told by his mother initially not to take up a job that does not pay well. Gradually, he stopped applying for the same, especially as jobs became scarce due to COVID-19 lockdown. Over the past 8 months, he had lost over 30 kg of weight from not being fed, for which he gives an explanation of not having enough money. He was unaware of the amount of his father's pension but held the belief of not having enough money with conviction. His reason for not eating was that they were barely surviving and whatever little food they did manage to get was first given to the mother. He said that his mother deserved the food because of her ill health and advanced age. He was found sitting along with the mother in her excreta, not having consumed even a single meal in the past 6 days, extremely weak, unable to recognize his relatives in dirty clothes, uncut hair, unshaved beard from months, and long dirty nails. They were brought to the hospital where after electrolyte correction, he gradually started recognizing everyone and talking.

Their premorbid personalities were very dominant mother, while son was anxious dependent. General physical examination revealed poor nutrition in both with severe deficiency of thiamine in son. On MSE, both were poorly groomed and ill kempt. Affect was distressed. They had delusions of poverty, and delusion of persecution was seen in mother. Insight and judgment were impaired. With a diagnosis of induced delusional disorder, they were admitted in male and female wards and kept apart. Both were started on second-generation antipsychotics and supplementation. The son reported considerable improvement in the initial symptoms within the first few weeks and accepted having money and started searching for jobs online, while the mother showed gradual improvement.

**DISCUSSION**
In Case 1, mother developed the psychotic illness first. Return of her husband after 10 long years of separation reminded her of the past traumatic experience of losing son and husband leaving her behind and choosing the spiritual path when she was still recovering from the sudden demise of her son. Further, it was difficult for her to see her husband in the bad state of health having multiple wounds and to have cared for him. The stress may have heralded the onset of illness. Mother and the
daughters had gone through tough times and had stood for each other. They shared a very loving relationship. The second and youngest daughters (living in the same neighborhood) could not smell any foul odor initially while visiting mother but eventually could sense the malodor and also believed to have been suffering the same disease as their mother. The eldest daughter (living in a different state) who came down to see mother initially could not pick the malodor but while returning home after 3 weeks of stay admitted to have smelled foul odor from her mother and the household objects. However, she did not believe that she was suffering from the same disease. Short duration of stay and separation may have prevented the disorder.

In Case 2, husband developed psychotic symptoms first after revealing to his wife about his unprotected intercourse with a commercial sex worker and eventually getting infected with syphilis. Following this, they had a few altercations and the wife was extremely worried about both getting infected. About a month of her husband developing the symptoms, she developed exactly similar complaints of an insect crawling inside her body and biting at places. During management, it was observed that she did better when initially separated from husband and both were started on antipsychotics.

In Case 3, the mother developed delusion of poverty first, followed by similar features in the son. On admission, the son improved first regarding the delusions and gradually the mother. Their premorbid personalities along with loss of job for mother and son following her injury could have been a precipitating factor with the financial burden after the demise of her husband who was the bread winner for the family being a predisposing factor for the family.

**CONCLUSION**

Phenomenon of induced delusional disorder has a relatively long, controversial history of conceptualization, and redefinitions are continued till date. Little is known about its epidemiology and treatment because of its rare presentation. It often goes undiagnosed because only the primary partner gets registered for treatment in a classical presentation. Awareness regarding the dynamics of relationship shared between the partners is crucial in the management. The failure to adhere to treatment is an additional challenge in the management. A holistic approach wherein the biopsychosocial factors are addressed will favor better outcome.[1,3]

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