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Susana Filipa Rodrigues Martins Alves
Folie à deux: how it fits in DSM-5

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Folie à deux: how it fits in DSM-5

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Aos meus pais, irmão e tio-avô pelo incentivo e apoio que sempre me deram.

À Natália, pelo entusiasmo que sempre trouxe às nossas conversas sobre este projeto. À minha cunhada Júlia, por se ter tornado a irmã que nunca tive.

Caminha, vai, dá mais um passo,
todas as grandes coisas
começam pequeninas.
Toda grande jornada
começa com um passo.
Redime o pensamento de fraqueza,
Deus te guiará.
Não olhes para trás,
nem pares no caminho.
Vês lá no fim da estrada
aquele arbusto pequenino?
Não é arbusto, não,
é a árvore mais alta que encontrarás.
Senta-te à sombra dela e te dirá:
"Eu nasci de uma simples sementinha!"

Else Sant'Anna Brum

Title:

Folie à deux: How it fits in DSM-5

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Abstract

Objective: Folie à deux (FD) describes a phenomenon in which mental symptoms, usually delusions, are communicated from a psychiatrically ill person (primary patient) to another individual (secondary patient), who accepts them as true. We propose to evaluate the setting of the disease in the DSM-5 classification and its clinical implications.

Methods: 31 articles, including revisions deemed relevant, were selected from the Medline and Scopus databases, from 2009 to 2013, in Portuguese, English and French. Of these, 12 articles were included. Books of reference in the field of psychiatry were also taken in consideration, as well as the DSM-IV-TR and DSM-5 classifications.

Results: The literature considered the criteria for FD insufficient or inadequate. DSM-5 does not consider Shared Psychotic Disorder (Folie à Deux) as a separate entity. It is for the physician to classify the case of the secondary patient in the “Delusional Disorder” or in the “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder”, attending the specifications and proposing the appropriate treatment.

Conclusion: Although the diagnosis of FD is not included in the DSM-5, we consider that this classical concept should not be forgotten. The treatment should be personalized, taking account of the functional and psychosocial repercussions that the mental disorder may have on the patients’ relationships.

Key-words: Shared Paranoid Disorder, Folie à Deux, DSM-5, Int J Psychiatry Med

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Introduction

Folie à deux (FD) describes a phenomenon in which mental symptoms, usually delusions, are communicated from a psychiatrically ill individual (primary patient) to another individual (secondary patient), who accepts them as true^[1].

The key features are the unquestionable acceptance of delusional beliefs and the temporal sequence of the disorder's development, with one or more individuals having an earlier onset^[2]. The acceptance of these beliefs results from a lack of critical evaluation by both members of the dyad and in the secondary patient it may be aggravated by the social isolation recurrent in these patients^[3].

Lasègue and Flaret, in 1877, pointed out three necessary conditions for the contagion to occur: a) the primary patient creates a delusion and gradually imposes it on the secondary, who, although initially resistant, ends up slowly accepting it, rectifying and coordinating the delusion, which becomes common to both of them; b) for this to happen it is necessary that they live for a long time in a close relationship, sharing their lifestyle, feelings, beliefs and hopes without any outside influence and c) the delusion has to be plausible, remain within the boundaries of possibility and be grounded on facts of the past or beliefs and hopes envisioned for the future^[4,5].

According to the literature, the primary patient has been described as being older, more intelligent and having stronger personality features than the secondary patient^[6], who is portrayed as having a submissive role in the relationship. Personality factors or intellectual limitations justify the secondary's susceptibility^[2]. There are risk factors for the secondary patient to be taken into consideration: female sex, suggestibility, passivity, low intelligence, low self-esteem and poverty^[7,8].

FD's incidence is calculated in 1.7% to 2.6%^[4]. 90% of the cases occur among members of the same family and 50% of the cases happen between the dyads sister-

sister and mother-daughter^[4,7]. The average age is 46-53 years and there are also reports in teenagers that don't belong to the same family^[9].

The most usual themes are the persecutory, as well as religious, of grandiosity and delusional parasitosis^[3].

Almost all cases of FD are reported in association with schizophrenia, delusional disorder and major depressive disorder with delusions^[1]. It may coexist with non-psychotic disorders such as obsessive-compulsive disorder, somatoform disorder and histrionic-dissociative personality disorder^[1].

Several authors argue that the delusion would be beneficial for both individuals, because it allows the cohesion and protection against what is perceived as threatening and hostile in the external environment^[10].

With this paper we intend to fit in the DSM-5^[11] classification patients previously diagnosed as suffering from Folie à deux / Shared Psychotic Disorder, identifying the repercussions that the new classification can bring in clinical practice.

Methods

31 articles, including revisions deemed relevant, were selected from the Medline and Scopus databases, from 2009 to 2013, in Portuguese, English and French. Of these, 12 articles were included. Books of reference in the field of psychiatry were also taken in consideration, as well as the DSM-IV-TR and DSM-5 classifications.

Results

In the DSM-IV-TR^[12] classification, Folie à deux appears as Shared Psychotic Disorder (Table 1), which requires the development of the delusion in the secondary

patient following close contact with the primary patient who had already the delusion established.

-Insert Table 1 here -

It is a known fact that the theories by Lasègue and Falret influenced the way cases of FD were perceived and reported. More recently, the literature has shown evidences wich contradict what was initially advocated:

- FD may not be as rare as once thought, but many cases may can be neglected due to limitation of descriptions and lack of awareness of shared delusions^[3]. Recently, some authors have argued that the current criteria would be inadequate or invalid for the characterization of FD in teenagers^[9].
- Psychiatric comorbidity was noticed in 62% of the secondary patients, suggesting that the majority of these cases were the result of a “temporal trigger for a psychiatric condition in individuals that were susceptible beforehand”, instead of the appearance of delusional beliefs in previously healthy individuals. This hypothesis is heightened by the fact that the separation treatment initially proposed is often inadequate or insufficient [3,13,14].
- There has also been some debate whether the secondary cases are in fact delusional or subjected to the normal “social contagion”, the result of fear and suggestion^[15].
- Delusions are not the only psychotic symptoms. Hallucinations may be experienced as well^[14].

- Until the secondary patient manifests symptoms, the exposure time to the primary patient may range from hours to years. The long duration of the exposure is not a necessary condition^[4].
- Reviews have found no arguments to support the superior intelligence of the primary patient, nor differences in age or sex, although there are more occurrences in women^[14].
- There are scholars who consider that the secondary patient also influences the primary. This circular feature of the disease may difficult the distinction between primary and secondary patients^[8].

The terms used to describe FD, such as the four subtypes of FD grouped by Galnick according to other authors' postulates (*folie imposée, folie simultanée, folie communiquée* and *folie induite*), added to the confusion on the nature of the condition. Furthermore, FD's delusional beliefs defy conventional definitions of delusions, which require that the delusional belief is not shared by others and also its incompatibility with the cultural and social background of the delusional individual^[3,16].

We believe that all this has resulted in the DSM-5^[11] no longer separating Delusional Disorder (Table 2) from Shared Delusional Disorder.

-Insert Table 2 here -

According to the DSM-5, if the delusional disorder's criteria are met in the secondary patient, then that diagnosis is made. In this case, in addition to identifying the type of delusion (Table 2), the physician should specify whether the delusion has bizarre content or not, given that the DSM-5 will now consider equally possible the presence of non-bizarre delusions, which did not happen in the DSM-IV-TR. If the disorder is lasting longer than one year, the physician must consider, at the time of observation,

whether it is the case of: a) first episode (in acute phase, of partial remission or complete remission); b) multiple episodes (in acute phase, of partial or complete remission); c) continuous; d) indeterminate. Considering that patients with Delusional Disorder may have normal behavior and appearance and provided that their delusional ideas are not discussed, the physician may also specify the severity of the disease, finding the necessary guidance in the DSM-5^[11].

If this diagnosis cannot be done, but shared beliefs are present, then the diagnosis “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder” is used^[11].

One example of the presentations that can be specified using the designation “Other psychotic disorder” present in the DSM-5 is “Delusional symptoms in the partner of individual with delusional disorder: in the context of a relationship, the delusional material of the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.”^[11] which we consider also matches the concept of Folie à deux.

Cases of obsessive-compulsive disorder, such as reported by Mergui’s, no longer represent dubious diagnostics because in the DSM-5 they are now treated independently, as well as those that meet the schizophrenia’s criteria.

Also to be mentioned is the possibility of assigning the diagnosis of Brief Psychotic Disorder to these patients, at least temporarily.

While evidence suggests that these cases will be treatable, the major difficulty is to convince the patient of the need of psychiatric help. One way to overcome this resistance is the cooperation between psychiatry and other specialities so that the psychiatrist can proceed with the observation without impressing upon the patient the stigma of being mentally ill^[11].

Since the separation often appears to be ineffective and given that the patient is suffering from a psychotic disease without insight, the treatment in most cases, if not in all, will be with antipsychotics. Regardless of the pharmaceutical's choice, at the beginning it is recommended its lowest effective dose, increasing it gradually only if necessary. The patient must also be reevaluated within narrow intervals^[1].

Antidepressants, mood stabilizers and electroconvulsive therapy are not first-line treatments, nor is the cognitive-behavioral approach, which helps reduce psychotic symptoms, although it has not been proven that it completely eliminates already established delusions^[1].

The response to treatment is not uniform. It may range from two weeks to several months, or it might not even solve the disorder^[1].

As FD is a potentially chronic disease, the treatment should be continued for an indefinite period, always at the lowest effective dose, and the physician should be attentive to mood symptoms that may result from either the psychopharmacology drugs or an awareness of the reality of illness, medicating appropriately if justified^[1].

Discussion

The DSM-5 classification only refers “Delusional Disorder” or “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder”, abandoning the concept of Shared Psychotic Disorder / Folie à deux.

It is the physician's role, through the clinical evaluation, to diagnose the patient as suffering from Delusional Disorder, Brief Psychotic Disorder or “Other Specified Schizophrenia Spectrum and Other Psychotic Disorder”, specifying the type of presentation in the last case. One example given by the DSM-5 is “Delusional

symptoms in partner of individual with delusional disorder,” which we believe corresponds to the concept of Folie à Deux.

Although the designation FD has disappeared from the DSM-5 and apparently will also disappear from the ICD-11, we consider that it should not be disregarded. Since the separation often proved ineffective in cases of FD, we advocate an initial approach using antipsychotics.

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Table 1: Diagnostic criteria for Folie à deux – Shared Psychotic Disorder in DSM-IV-TR (American Psychiatric Association, 2000)^[12]

DSM-IV-TR
Shared psychotic disorder
A. Delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.
B. The delusion is similar in content to that of the person who already has the established delusion.
C. The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Table 2: Diagnostic criteria Delusional Disorder in DSM-5 (American Psychiatric Association, 2013)^[11]

DSM-5
Delusional Disorder
A. The presence of one (or more) delusions with a duration of 1 month or longer.
B. Criterion A for schizophrenia has never been met.
Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.
Types: Erotomanie; Grandiose; Jealous; Persecutory; Somatic; Mixed; Unspecified.

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Anexos

International Journal of Psychiatry in Medicine

Instructions to Authors

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