



Shared Psychotic Disorder in a Child and His Family

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Abstract

Introduction: Shared psychotic disorder (folie à deux) is an uncommon psychiatric condition characterized by the transmission of delusional beliefs from a dominant individual to another closely associated person, who is often dependent.

Case Presentation: This case report describes an 11-year-old boy who developed psychotic symptoms identical to those of his mother and siblings, who shared persecutory delusions that the father was a spy intending to harm them. The child presented with anxiety, social withdrawal, impaired self-care, and cognitive decline. Following hospitalization and separation from the inducing family members, the patient showed marked improvement with pharmacological treatment (escitalopram and risperidone) and supportive treatment.

Conclusions: This case highlights the importance of recognizing shared psychotic disorder in young patients, the therapeutic necessity of separating affected individuals, and the value of a comprehensive, multidisciplinary approach to support successful recovery and family reintegration.

Keywords: Psychosis, Shared Psychosis, Children

1. Introduction

Folie à deux, also known as shared psychotic disorder or induced delusional disorder, is an uncommon and complex psychiatric condition characterized by the transmission of delusional beliefs from a dominant individual (the primary patient) to one or more closely connected, vulnerable individuals (the secondary patients). First described by Lasègue and Falret in 1877, this condition typically arises in relationships marked by strong emotional bonds and social isolation, most often among family members such as spouses or siblings. The primary individual, who is generally older and more assertive, has a diagnosed psychotic disorder—most commonly delusional disorder or schizophrenia—whereas the secondary individual, usually younger and more dependent, adopts similar delusions despite not having an independent psychotic disorder. Although folie à deux primarily affects adults and is more frequently reported in

females, it remains rare and diagnostically challenging, with few documented cases, particularly among elderly populations (1). Diagnostic criteria have evolved, and DSM-5 now classifies this condition under other specified schizophrenia spectrum and other psychotic disorders (2). This article presents a case involving a boy with folie à deux and examines the clinical characteristics, diagnostic challenges, and treatment considerations associated with this unusual psychiatric condition.

2. Case Presentation

An 11-year-old boy from a middle-class family was admitted to the Child and Adolescent Psychiatry Ward of Razi Hospital in Tehran, affiliated with the University of Social Welfare and Rehabilitation Sciences, because of severe fear, anxiety, and developmental regression. On examination, the boy appeared confused and dazed and had poor eye contact. He appeared anxious and spoke in a very quiet, hesitant tone. He stated that he was afraid

because his father was a bad person and intended to harm him.

Family assessment revealed that his mother and siblings had a psychotic disorder and were experiencing the same delusions. The child had been excluded from school for 2 years because his mother had kept him at home due to fears arising from her delusions.

According to the history, his mother and siblings (a 21-year-old sister and a 16-year-old brother) had been suspicious of the father for 2 years. One year earlier, they had been admitted to a psychiatric hospital with similar symptoms, but after discharge, they stopped taking their medication, and the symptoms recurred. During these 2 years, while the mother and children were suspicious of the father, they forced him to leave the house, and he slept in his car at night. Because of the unusual behavior of the mother and children, the neighbors reported the situation to the social emergency service, which ultimately led to the hospitalization of the mother and her 3 children.

Physical examinations and initial tests revealed no abnormalities. At the time the patient was hospitalized, his mother, sister, and brother were also hospitalized at the same hospital. Unfortunately, because of the lack of a reliable informant, no information was available regarding the child's attachment status or related problems. However, the child's behavior in the ward suggested an insecure attachment to his mother.

Initially, because the patient's brother was 16 years old, both brothers were hospitalized in the same child and adolescent psychiatry ward. During hospitalization, it became apparent that the older brother was highly protective of the younger brother. He did not allow the child psychiatrist to visit his younger brother and even prevented the child from communicating with the nursing staff and other patients in the ward. Therefore, the younger brother was transferred to another ward to separate him from the older brother, who was reinforcing his suspicious beliefs. At the same time, because of the child's severe anxiety, he was prescribed escitalopram 10 mg and risperidone 1 mg daily, in addition to supportive treatment. Following separation, supportive therapy, and the prescribed medications, rapid improvement was observed. Eye contact improved, the child communicated well with other children, showed appropriate affect, and demonstrated substantial progress in verbal skills, reading, and writing. Although he was suspicious of his father at the beginning of hospitalization and was unwilling to meet him, he gradually accepted visits and developed a positive relationship with his father during these visits.

In addition, because the child wanted to see his mother, who was hospitalized in the adult ward of the same hospital, a brief visit was arranged under special

conditions in the presence of a nurse who ensured that the mother did not discuss her harmful delusions about the father with the child. During the hospitalization of the child and his family members, the father, who was very supportive, was invited to participate in several psychoeducational sessions. Finally, the child was discharged in good condition into the care of his father. The child psychiatrist also communicated with the physicians treating the other family members and explained the situation to them, emphasizing the importance of treatment, particularly for the mother, and the need for separation while maintaining safe maternal support for the child. Social-work follow-up was also arranged to monitor the mother's treatment and provide the necessary assistance to help the child continue his education and return to school.

3. Discussion

Shared psychotic disorder, historically known as *folie à deux*, is an uncommon psychiatric condition in which delusional beliefs are transmitted from a primary individual to one or more closely related and dependent persons (3-5). Although it most commonly occurs in dyads, shared psychosis may involve several members of the same family, a condition often described as *folie à famille* (3-5). The present case describes a family-based shared psychotic disorder involving 4 individuals: an 11-year-old boy, his mother, his 21-year-old sister, and his 16-year-old brother. All affected family members shared persecutory beliefs about the father. This report highlights the importance of early identification of induced delusional symptoms in children, particularly when a child is exposed to a persistent delusional environment within the family (6-8).

An important feature of the present case was that the delusional beliefs were directed toward the father. Although the father was reportedly supportive and did not share the family's delusional beliefs, he was excluded from the home and could not adequately provide emotional and practical support to the child. This finding illustrates the potentially serious effects of shared delusions on family functioning, parent-child relationships, and the child's access to a protective caregiver (6, 7). In this case, limited social and legal resources also complicated the implementation of comprehensive family-based interventions.

Consistent with previous reports, the mother and older siblings appeared to be the dominant sources of the delusional beliefs, whereas the child, who was vulnerable, socially isolated, and dependent on family members, adopted these beliefs without evidence of an independent primary psychotic disorder (4, 5, 8). Shared psychotic disorder is more likely to occur among individuals who

live in close proximity, have strong emotional dependence, and experience prolonged social isolation (3-5). Children may be especially susceptible because of developmental dependence, a limited ability to challenge parental beliefs, and reduced access to alternative social and educational experiences (6-8).

Unlike many adult cases, pediatric shared psychosis presents particular treatment challenges. Separation of the child from the inducing family member or members is often necessary to interrupt reinforcement of the delusional system; however, such separation must be undertaken carefully because of the child's emotional dependence and attachment needs (3, 5, 8, 9). In the present case, separation from the older brother, supportive treatment, and pharmacotherapy with escitalopram and risperidone were followed by marked improvements in eye contact, communication, social interaction, affect, reading, and writing. This clinical improvement is consistent with reports emphasizing separation from the delusional environment as an important therapeutic component of shared psychotic disorder (3, 5, 8, 9).

Separation from dominant family members can cause emotional distress in children, including anxiety, sadness, insecurity, and difficulties related to disrupted attachment. Consequently, treatment should balance the need to protect the child from continued exposure to delusional beliefs with the need to preserve safe emotional support and contact with non-delusional caregivers, such as the father in the present case (6-8). In addition, ongoing monitoring is required to identify developmental regression, educational problems, and the potential emergence of independent psychiatric symptoms.

Management of pediatric shared psychotic disorder requires a multidisciplinary approach involving child and adolescent psychiatry, treatment of the primary psychotic patient, social-work services, family intervention, psychoeducation, safeguarding procedures, and support for school reintegration (6-8). The child's outcome may be influenced by age, duration of exposure to the delusional system, severity of social isolation, family hierarchy, quality of attachment relationships, availability of supportive non-delusional relatives, and successful treatment of the primary patient(s) (3-5, 8).

This case contributes to the limited literature on pediatric shared psychosis and family-based folie à famille. It supports early recognition of children at risk, timely separation from reinforcing delusional influences when clinically indicated, active treatment of affected family members, and planned restoration of the child's contact with safe and supportive relatives (3-9). Comprehensive medical, psychological, social, and educational

interventions are essential to improve recovery and reduce the risk of persistent functional impairment.

3.1. Conclusions

This case highlights the complexity and rarity of shared psychotic disorder, particularly when it occurs within a family and affects a child. Timely identification is vital because prolonged interaction with the individual inducing the condition can reinforce delusional beliefs and hinder social and cognitive development. Key components of treatment include separation, medication management, and psychoeducation, and the reintroduction of contact with non-delusional family members should be closely monitored. The present case demonstrates that, with prompt intervention and a supportive environment, children affected by shared psychotic disorder can achieve complete recovery and regain normal functioning. Further research is needed to better understand family dynamics, risk factors, and preventive measures in cases of induced psychosis among children.

Footnotes

AI Use Disclosure: The authors declare that no generative AI tools were used in the creation of this article.

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