Case report

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Bound by belief and entangled minds: Shared psychosis in two isolated mother-daughter dyads from a Sri Lankan psychiatric setting: A Case Series of Folie à Deux in an Acute Female Inpatient Unit

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Abstract

Background

Shared psychotic disorder (folie à deux), first described by Lasègue and Falret in 1877, refers to the transmission of delusional beliefs from a dominant individual to a closely associated secondary, usually in the context of social isolation (1). Although it is no longer a distinct entity in DSM-5 or ICD-11 (2,3), it remains clinically significant, particularly among dyads with emotional dependence, disability, or sensory deprivation.

Case presentation

We describe two mother-daughter dyads admitted to a female inpatient psychiatric unit in Sri Lanka. Both pairs had lived in extreme isolation and developed elaborate delusional systems reinforced by mutual dependence. The first dyad included a mother with congenital deaf-mutism and her daughter with cerebral palsy, epilepsy, and intellectual disability. The second comprised a mother with schizoaffective disorder and her daughter, recently separated from her spouse. In both instances, the daughters improved markedly following separation, confirming their roles as secondaries, while the mothers required more intensive interventions, including electroconvulsive therapy.

Conclusion

These cases illustrate folie communiquée within isolated family settings and highlight the importance of early recognition, separation, and culturally sensitive multidisciplinary management. They also underscore current nosological debates: although both cases fulfilled Dewhurst and Todd's classical criteria for folie à deux (4), they would now be classified within broader schizophrenia spectrum disorders in DSM-5 and ICD-11 (2,3).

Keywords: shared psychotic disorder, folie à deux, Sri Lanka, social isolation, mother-daughter dyads, schizoaffective disorder

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Introduction

Shared psychotic disorder (SPD), historically known as *folie a deux* (FAD), is a rare condition in which delusional beliefs are transmitted from a primary (inducer) to a secondary (induced), typically within a close relationship under social isolation (1,5). While the term was coined by Lasègue and Falret in 1877, earlier descriptions exist (1).

Several subtypes have been identified: *folie imposée* (dominant primary imposes delusions on a dependent secondary), *folie simultanée* (simultaneous psychosis in predisposed individuals), *folie communiquée* (delusions adopted after resistance), and *folie induite* (new delusions added to existing ones) (5).

Dewhurst and Todd (4) later proposed diagnostic criteria emphasizing shared delusions, prolonged close contact, and mutual reinforcement. These align with the ICD-10 classification (F24 – Induced delusional disorder), which describes delusion transfer within isolated dyads, often resolving upon separation (6).

Although SPD appeared as a distinct entity in DSM-IV-TR and ICD-10 (7,6), it has been subsumed under broader psychotic categories in DSM-5 and ICD-11 (2,3). Nonetheless, it remains clinically relevant, especially among individuals facing dependency, disability, or sensory impairment.

Key risk factors include isolation, emotional dependence, cognitive deficits, sensory loss, and psychosocial stressors like bereavement or relationship breakdown (7-9). While dyads are most common, larger groups (*folie a famille*) have been reported (9). In parent-child dyads, the child is typically the secondary in up to 74% of cases (8).

We present two mother-daughter dyads admitted to a female psychiatric unit in Sri Lanka, illustrating the clinical and cultural complexity of SPD.

Case 1: Disability, isolation, and sensory deprivation

A mother in her sixties and her daughter in her thirties lived in rural isolation. The mother was congenitally deaf and mute; the daughter had a learning disability, cerebral palsy-related weakness, and epilepsy. They sustained themselves through carpet weaving and had minimal external contact.

Their isolation worsened six years earlier when the mother's other daughter-previously their main social link-married and moved away. They had already relocated five times following disputes with neighbors. At one point, a violent confrontation with the mother's sister over property ownership led to their arrest and two weeks of remand. Both mother and daughter had attacked the aunt-throwing chili water in her face and repeatedly striking her with a manna knife, a heavy traditional cleaver. Since then, they had frequent police encounters, with multiple complaints lodged both by and against them.

The daughter was eventually brought for psychiatric care by her sister, with support from villagers, after escalating aggression and bizarre conduct. She had shouted obscenities at neighbors, hurled stones, broken windows, and reported persecutory delusions that others mocked her disabilities. She also experienced third-person auditory hallucinations of neighbors commenting on her undergarments, harbored a romantic delusion involving a police officer, and believed neighbors were monitoring her through Facebook.

Their home was significantly altered: windows covered with aluminum sheets, chili water bottles placed for "protection," and garbage stacked near walls (Figure 1). The mother shared identical delusions and was also psychotic.

Figure 1. Secured environment: Covered windows and perimeter with bottles of chili-infused water as defensive weapons.

The daughter showed intellectual impairment and pseudoseizures. Initially lacking insight, she improved rapidly after separation and responded well to low-dose risperidone-consistent with a secondary role. The mother, communicating only through a private sign language with her daughter, remained highly suspicious and resistant, requiring ECT in addition to antipsychotics. Diagnosed with schizophrenia, she represented the primary. The case illustrated folie communiquée. Both were discharged with legal support and community psychiatric follow-up.

Case 2: Cultural delusions and child neglect

A mother in her sixties and her daughter in her twenties lived in near-total isolation for over five years following the daughter's marital separation. Paranoid beliefs appeared to predate the separation and progressively intensified over time.

Their isolation came to attention when a concerned sibling raised alarms after they refused to send the daughter's child to school, citing fears of sexual abuse by teachers from the very first day.

They reported a range of bizarre delusions, including claims of Palestinian ancestry, being injected with skin-darkening chemicals, having tracking implants, and possessing squirrel-snake hybrid lineage. They also believed the grandson was the reincarnation of an aborted twin.

Their behavior had become increasingly disruptive. They had thrown stones at neighbors, engaged in verbal altercations, and displayed escalating hostility-believing others were mocking or threatening them. Their home environment reflected their delusions: supermarket fruit were believed to be relatives in disguise; rice was used to create protective cosmetic mixtures; and all natural light was blocked from entering the house (Figure 2).

Both were admitted under the Mental Health Act due to psychiatric and child protection concerns. The daughter showed intellectual impairment and partial insight, improved after separation, and responded well to antipsychotics – consistent with a secondary role. The mother, however, remained grandiose and delusional, requiring ECT in addition to antipsychotics. Diagnosed with schizoaffective disorder, she represented the primary. The child was re-enrolled in school with child protection involvement, and multidisciplinary psychiatric follow-up was arranged.

Figure 2. Obstructed windows and the use of unscientific, plant-based cosmetic preparations.

Discussion

These cases reflect the classical features of SPD, fulfilling Dewhurst and Todd's criteria (4): close relationships, prolonged exposure, and shared delusions. Both are best classified as folie communiquée, with delusions transmitted through sustained proximity (5).

Dyadic dynamics

In both cases, the mothers-each in their sixties – were the primaries with entrenched psychotic illness. The daughters, though both secondaries, differed significantly. The daughter in Case 2 was cognitively intact and emotionally dependent, recovering rapidly post-separation – typical of traditional descriptions (8,9). The daughter in Case 1, however, had intellectual disability, epilepsy, and a history of aggression. Her complex profile challenges the idea of secondaries as merely passive, suggesting a dimensional spectrum of vulnerability (8).

Isolation and communication

Social isolation was central to both cases. In Case 1, isolation intensified after a family member's departure; in Case 2, it followed a marital split. Transmission modes differed: a closed sign language system reinforced delusions in Case 1, while verbal communication played a role in Case 2.

Cultural content

Both delusional systems were infused with cultural and symbolic themes: reincarnation, snake-squirrel ancestry, and chili water as a defensive tool. Psychotic content often blends cultural idioms with pathological structure (8). In South Asia, differentiating between culturally sanctioned beliefs and delusions is crucial to avoid misdiagnosis.

Treatment and outcomes

Separation was key to recovery. In both cases, daughters improved rapidly with minimal intervention, while mothers required ECT and long-term treatment. This aligns with literature suggesting secondaries often remit within weeks of separation (8,9). Relapse risk increases with continued contact, highlighting the need for psychosocial support and follow-up (typically 6-12 months) (9,10).

Despite changes in diagnostic systems, these cases demonstrate that SPD remains clinically important – particularly in low-resource settings where diagnostic clarity affects access to care and legal protection.

Conclusion

These cases reaffirm the core features of SPD and underscore its continued relevance. They illustrate how disability, cultural beliefs, and relational isolation shape delusional transmission. The contrasting profiles of the secondaries – one submissive, the other neurologically impaired – highlight the need for culturally sensitive, individualized assessment and flexible intervention strategies.

Ethical considerations

Informed consent was obtained from all patients. Identifying details have been anonymized.

Conflicts of interest

The authors declare no conflicts of interest.

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Author contribution

NEH conceptualized the study and led data collection and manuscript drafting. HDDMJ and LDGKC contributed to data collection, interpretation, and editing. MSD supervised clinical management and reviewed the manuscript. All authors approved the final manuscript.

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References

1. Lasègue C, Falret J. La folie à deux. Ann Med Psychol. 1877; 18: 321-55.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Washington, DC: APA; 2013.
3. World Health Organization. ICD-11: International Classification of Diseases for Mortality and Morbidity Statistics. Geneva: WHO; 2019.
4. Dewhurst K, Todd J. The psychosis of association: folie à deux. J Nerv Ment Dis. 1956; 124: 451-9.
5. Sims A. Symptoms in the Mind: An Introduction to Descriptive Psychopathology. 2nd ed. WB Saunders; 1995.
6. World Health Organization. The ICD-10 Classification of Mental and Behavioural Disorders. Geneva: WHO; 1992.
7. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th ed, text rev. Washington, DC: APA; 2000.
8. Silveira JM, Seeman MV. Shared psychotic disorder: A critical review of the literature. Can J Psychiatry. 1995; 40(7): 389-95.
9. Arnone D, Patel A, Tan GMY. The nosological significance of folie à deux: A review of the literature. Ann Gen Psychiatry. 2006;5:11.
10. Balducci PM, Gobbicchi C, Moretti P, Tortorella A. Delusional sharing: A history focus-on and case report of folie à deux. Riv Psichiatr. 2017; 52(4): 168-71.