A rare case of shared mania: An unusual entity

Kamal Nath, Hasina Anjuman Choudhury, Robin Victor

Department of Psychiatry, Silchar Medical College and Hospital, Silchar, Assam, India

Correspondence to: Robin Victor, E-mail: robinvictor111@gmail.com

Received: May 29, 2017; **Accepted:** August 21, 2017

ABSTRACT

Shared maniac syndrome or mania is a very rare entity, and literatures available on this topic are also very sparse. This entity is quite different from the other more common disorder known as "shared psychosis" or "folie à deux" or "induced delusional disorder." We report about a rare case of a 30-year-old female, exclusively sharing manic symptoms (without any delusion or hallucination) with her father. Due to lack of diagnostic and therapeutic literature on this topic, we also discuss the challenges we encountered in the management of this disorder.

KEY WORDS: Shared Mania; Shared Maniac Syndrome; Case report; Induced Maniac Disorder

INTRODUCTION

So long, we are acquainted with the term "shared psychotic disorder" or "induced psychotic disorder" which was first described by Lasègue and Falret (Lasegue C, Falret J 18:321)[1] in 1877 which is popularly known as "folie à deux.[2]" Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revised (DSM-IVTR)[3] defines it as "delusion developing in an individual in the context of a close relationship with another person or persons, who have an already established delusion and it is similar in content to that of the person who already has an established delusion." While in DSM, 5th edition (DSM-5),[4] the nomenclature of this disorder has been changed to "delusional symptoms" in partner of an individual with delusional disorder. Other special forms of this disorder reported are "folie simultanee" in which two persons become psychotic simultaneously and share the same delusion. Occasionally, more than two individuals are involved (e.g., folie a trois, quatre, and folie a famille), but such cases are especially very rare. The relationships described most common are sister-sister dyads (fateman), while husband-wife, mother-child, and other combinations are also been described.[5] In "folie communiqué," (a subtype of the shared psychotic disorder), the delusions can pass on to an individual with a genetic predisposition to psychosis and can last in this individual even after he/she has been separated from the others.

Access this article online	
Website: http://www.ijmsph.com	**Quick** Response code
DOI: 10.5455/ijmsph.2017.0515121082017	

There are very few literatures which mention shared mood disorder among patients suffering from mood disorder,[6] and sharing of exclusive mood symptoms without delusion or hallucination among close family members are further more uncommon.

Here, we describe an unusual case of affective disorder without psychosis which triggered mood disorder and some transient psychotic phenomenon in other family members also.

CASE REPORT

Mrs. X, a 30-year-old married female hailing from a rural area, belonging to lower socioeconomic strata with no past medical or surgical illness was brought to psychiatry ward through an emergency. She presented with the complaints of over talkativeness, singing (religious and movie songs) and crying to self-spells, restlessness, destroying household things, and decreased need for sleep for the past two and half months. She had been married since past 12 years and was

staying with her husband and two sons in a nuclear family. Two and a half months back while she was at her residence, she gradually developed the above-mentioned symptoms which aggravated with time. As her husband was unable to manage her, the patient was sent back to her parent's home after 1 month of appearance of symptoms for better care and management. She was staying with her 60-year-old father, a 50-year-old mother, and 33-year-old elder sister (unmarried), and two younger brothers 17 years and 13 years old, respectively. The family members attributed all these symptoms to "possession of goddesses," and she has been receiving faith healing remedies so far. After a week of stay with her family, the mother, who was the primary care giver of the patient, suddenly developed spells of abnormal behavior with unusual sensation in whole body. She indulged herself in a quarrel with other ladies in the village without any reason or provocation and became excited and violent with disturbed sleep. She had this spell continuously for 2 days after which her symptoms disappeared without any medication. Thereafter, the father became the primary care giver to the patient, as her mother was still recovering. As days passed, the patient Mrs. X became more excited and violent and her symptoms further aggravated. On 15th day of her stay with her parent, the father gradually developed similar symptoms such as over talkativeness, restlessness, singing (religious and movie songs) and crying spells, tall claims, and use of languages not customary to that socioeconomic strata and decreased oral intake and decrease need for sleep. But unlike the mother, the father's symptoms did not subside. Following that, her 13-year-old brother, developed symptoms like apprehension, hearing voices not being heard by others and disturbed sleep which lasted for 2 days and then subsided on its own. However, the patient (Mrs. X) and her father's symptoms did not show any improvement, and they were hospitalized in our center. Detailed evaluation and Mental State Examinations of the daughter reflected increased psychomotor activity, elated mood with appropriate but labile affect with increased pressure of speech, overfamiliarity, flight of ideas, and grandiose ideas but no delusion or hallucination, although abstract thinking and judgment and reasoning were impaired and had no insight. The father had similar symptoms of increased psychomotor activity, pressure of speech, elated mood and appropriate affect with rhyming and punning, grandiose ideas, no other delusion or hallucination, impaired abstract thinking and judgment and reasoning and had no insight toward the illness. Most of the symptoms in both the cases were overlapping, and both were diagnosed to have first episode mania without psychosis (F30.1) according to the International Classification of Disease and Related Health Problems (ICD-10)[7] criteria (clinical descriptions for diagnostic guidelines) and were put on mood stabilizers. Initially, Tab. Sodium valproate was tried at 300 mg twice daily doses for 3-4 weeks, but since there was little response, Tab. Lithium at 300 mg thrice daily was added, and valproate was gradually tapered off. Both the patient and her father responded satisfactorily with Lithium which was then continued. Since the mother and brother were not available for evaluation, no definite diagnosis could be made, but the history suggested that both of them might have developed a "transient psychotic phenomenon."

DISCUSSION

This is a rare and unique case of psychiatric illness in terms of interactions within the family settings and the diagnosis. Rarely such cases have been reported until now, and interesting point in this case report is the completely shared maniac syndrome without any delusion.

On taking detailed family history, we came to know that the father of the patient had strong genetic predisposition to develop psychiatric illness as his father and three siblings had some chronic psychiatric illness for which they received medical treatment but had a poor compliance. There was no known positive family history in maternal side.

The husband of Mrs. X also revealed that he had noticed a subtle change in his wife's behavior for past 2-3 years. She used to have episodes of high expectations and tall claims with excessive spending of money, change in business multiple times, least involvement in domestic activities, roaming here and there for no apparent reason and had a disturbed sleep. However, the symptoms have exaggerated for past 2-3 months only. Although in this case, the behavioral abnormality developed in close family members, it did not fulfill all the criteria of shared psychotic disorder which led to the diagnostic dilemma. However as described in literature, a severe psychiatric morbidity can occur in secondary case, who have an extensive family history of psychiatric illness, as in our case the father of the patient. In some cases, exposure to the primary subject could act as a psychological trigger for a "transient psychotic phenomenon" in a subject who would have developed a psychotic episode in any case, and may not necessarily have a genetic loading. This may explain the brief psychosis in mother and the brother of the patient.

In folie a deux, delusions are usually persecutory[8] or grandiose,[9] although in our cases no delusion could be established either in primary or the secondary case. Usually, persons are closely associated for a long time and typically live together in relative social isolation.[5] However, in this case, the family members were together only for a short period of 1 month in which the symptoms developed.[10] Rarely more than two individuals are involved (e.g., folie a trois, quatre, cinq, and also folie a famille), but such cases are very rare.[11] In our case, the patients are related, and they may share the same genetically driven psychiatric illness.[12] Shared psychotic disorder among patients suffering from bipolar disorder is very rare. Risk factors are reported to include close relationship (i.e., family), social isolation, passive personality, cognitive deficit, linguistic disabilities, and stressful life events.[13]

Since the introduction of validated diagnostic criteria, very little has changed in the description of the phenomena, standardized criteria adopt two main terms "induced delusional disorder" (ICD-10)[7] and "shared psychotic disorder" (DSM-IV).[3] The principal limitation of such definitions is that they describe phenomenon initially formulated in milieu of societal values and psychodynamic views of a different era. To complicate matters even further, there have been attempts to organize the disorder into subtypes according to the psychopathology encountered.[2] Terms such as "folie imposee," "folie simultanee," "folie communiqué," and "folie indiute" designate subtypes of the phenomena of "folie à deux.[11]" The lack of clarity, its rarity, as well as the limited knowledge of its natural history and prognosis has contributed only a little to increase our knowledge of the neuropsychological mechanisms underlying the phenomena, beyond pure phenomenological descriptions.[1]

Keeping with this view, we propose a broader nosological entity than the one described by Lasègue and Falret, because the phenomenon of "folie à deux" is insufficient to elaborate all symptoms in this day. The data show that the primary case need not have to have schizophrenia only, to induce shared psychotic symptoms in the secondary, but that a variety of other mental illnesses could also be responsible. Similarly, the shared symptoms need not have to be delusions or hallucinations only but may be mood symptoms also. This may include a wider range of psychiatric conditions in the primary, the possibility of psychiatric morbidity and susceptibility in the secondary. The secondary cases, traditionally described to have a submissive role in the dyad but otherwise mentally sound, could, actually, be extremely vulnerable to develop or have a significant mental illness themselves and may or may not have any genetic predisposition even. The treatment that is often advocated, i.e., separation, has also been shown to be inadequate or insufficient in a large number of cases, and so also in our case.[1]

CONCLUSION

Shared maniac syndrome or mania is a very rare entity, and literatures available on this topic are also very sparse. This entity is quite different from the other more common disorder. Due to lack of diagnostic and therapeutic literature on this topic, we encountered significant challenges in the management of this disorder.

REFERENCES

1. Arnone D, Patel A, Tan GM. The nosological significance of Folie à Deux: A review of the literature. Ann Gen Psychiatry. 2006;5:11.
2. Wehmeier PM, Barth N, Remschmidt H. Induced delusional disorder. A review of the concept and an unusual case of folie à famille. Psychopathology. 2003;36(1):37-45. Available from: http://www.ncbi.nlm.nih.gov/pubmed/12679591. [Last cited on 2016 Dec 24].
3. American Psychiatric Association. DSM-IV. Diagnostic and Statistical Manual of Mental Disorders. 4th ed., Vol. 210. Washington, DC: American Psychiatric Association; 2000. p. 373-4.
4. American Psychiatric Association. DSM 5. Am J Psychiatry. 2013;991. Available from: http://www.ajp.psychiatryonline.org/article.aspx?articleID=158714%5Cnhttp://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:DSM-5#0. [Last cited on 2017 Sep 06].
5. Ranjbar-Kouchaksaraei F, Norazar GR, Mohaghghegi A. Shared psychotic disorder between a girl with her mother and younger sister (folie a trois). Arch Iran Med. 2006;9:417-8.
6. Patel AS, Arnone D, Ryan W. Folie a deux in bipolar affective disorder: A case report. Bipolar Disord. 2004;6(2):162-5.
7. World Health Organization. The ICD-10 Classification of Mental and behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva: World Health Organization; 1992. p. 1-267. Available from: http://www.apps.who.int/iris/handle/10665/37958%5Cnhttp://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:The+ICD-10+Classification+of+Mental+and+Behavioural+Disorders#1. [Last cited on 2017 Sep 06].
8. Oshodi A, Bangaru R, Benbow J, Gralnick A, Waltzer H, Mentjox R, et al. A paranoid migrant family-folie à famille. Ir J Psychol Med. 2005;22(1):26-9. Available from: http://www.journals.cambridge.org/abstract_S0790966700008776. [Last cited on 2016 Dec 24].
9. Kashiwase H, Kato M. Folie à deux in Japan--analysis of 97 cases in the Japanese literature. Acta Psychiatr Scand. 1997;96(4):231-4.
10. Ghasemzadeh MR, Vasfi MG, Nohesara S, Shabani A. Shared psychotic manic syndrome in monozygotic twins: A case report. Iran J Psychiatry Behav. 2012;6(1):75-7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24644474. [Last cited on 2016 Dec 24].
11. Sadock B, Sadock VA. Kaplan and Sadock' s Comprehensive Textbook of Psychiatry. Psychiatry Interpers Biol Process. 2000;2:4884. Available from: http://www.amazon.co.uk/Sadocks-Comprehensive-Textbook-Psychiatry-Saddocks/dp/0781768993. [Last cited on 2017 Sep 06].
12. Reif A, Pfuhlmann B. Folie a deux versus genetically driven delusional disorder: Case reports and nosological considerations. Compr Psychiatry. 2004;45(2):155-60.
13. Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry. 11th ed. Philadelphia, PA: Wolters Kluwer; 2015. p. 356-9. Available from: http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc11&NEWS=N&AN=2014-37072-000. [Last cited on 2017 Sep 06].

How to cite this article: Nath K, Choudhury HA, Victor R. A rare case of shared mania: An unusual entity. Int J Med Sci Public Health 2017;6(10):1555-1557.

Source of Support: Nil, **Conflict of Interest:** None declared.