Shared Psychotic Disorder and Criminal Responsibility: A Review and Case Report of *Folie à Trois*

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We present a case of shared psychotic disorder involving three sisters who were successful in establishing an insanity defense on numerous felony charges in the South Carolina criminal court system. Two of the authors of this article were court-appointed examiners in this case. We then present a history of shared psychotic disorder, an overview of the use of this diagnosis in the defense of insanity, and a discussion of the disposition of individuals with "temporary insanity." Finally, we compare shared psychotic disorder, culturally based belief systems, and religious cults, with a focus on their common and contrasting characteristics.

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In South Carolina, a case of shared psychotic disorder—in this case a *folie à trois* involving three biological sisters—resulted in successful insanity defenses for all three defendants. We present the case and then discuss the history of shared psychotic disorder and the use of this diagnosis as an insanity defense. In addition, the disposition of individuals with "temporary insanity," in contrast to traditional insanity acquittees, will be discussed. Finally, we will compare shared psychotic disorder with culturally based religious ideation and cults.

Criminal Responsibility Standards

The insanity defense has been around for centuries. In ancient Rome, legal codes distinguished between those who were insane (and thus not accountable for their wrongful conduct) and those who were sane (and thus held responsible for their actions).[1] A basic assumption of Anglo-American law is that each person has the ability to distinguish and the freedom to choose between lawful and unlawful conduct.[2] Most jurisdictions in the United States employ one of several tests to determine legal insanity: the Insanity Defense Reform Act of 1984 (for federal courts and all branches of the military), the American Law Institute's Model Penal Code (19 states), the M'Naghten standard (25 states), or the "product" test (one state).[3–6] In South Carolina, a defendant cannot be held criminally responsible if "as a result of mental disease or defect, the defendant lacks the capacity to distinguish moral or legal right from moral or legal wrong or to recognize the particular act charged as morally or legally wrong."[7]

A controversial topic that stems from the insanity defense is the notion of temporary insanity. Most major mental illnesses are chronic and characterized by periods of exacerbation and sustained or partial remission. Temporary legal insanity argues that a defendant was briefly insane at the time the crime was committed and therefore met the particular jurisdiction's insanity standard, but is now sane with little or no likelihood of future recurrence. This defense was first used by Representative Daniel Sickles of New York in 1850 after he killed his wife's lover, Phillip Barton Key. Sickles' lawyers claimed that "an uncontrollable frenzy" created a "brainstorm" resulting in

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Table 1 DSM IV-TR Diagnostic Criteria for Shared Psychotic Disorder

A. 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, medication) or a general medical condition.

temporary insanity, although there was no expert medical testimony to support Sickles' insanity plea.[8]

The induced or secondary (non-index) cases of shared psychotic disorder could be considered an example of "temporary insanity." The following case of *folie à trois* resulted in a successful insanity defense for the defendants in the two secondary cases who recovered from this "temporary insanity" without antipsychotic medication.

Case Presentation

The information contained in this case presentation was accessed through public documents (newspaper articles, trial transcripts, police reports, and court reports that were admitted into evidence).

This case of shared psychotic disorder (see Table 1) involved three biological sisters without documented mental health histories before the incidents. The sisters did not have developmental delay, mental retardation, or other significant problems during childhood and schooling. They were not victims of physical, sexual, or emotional abuse. They did not have a history of alcohol or illicit substance use, and there was no evidence of alcohol or illicit substance use at the time of the incidents. The family psychiatric history was significant for schizophrenia in two first-degree relatives (mother and a brother). The mother was frequently noncompliant with treatment and had been hospitalized often. The sisters and their older brothers cared for their mother.

Sister 1

Sister 1 was the index case. She was the youngest of the three sisters and was 21 years old at the time of the incidents. During her last year in high school, she had difficulty sleeping. The transient lack of sleep did not affect her academic work, and she matriculated to college. She did not have further difficulty until her sophomore year in college when she again developed insomnia. This time, however, it was accompanied by social isolation. She subsequently left college and lived with her sisters. She displayed a flattened affect. She was not married and did not have children. At the time of the incidents, she was gainfully employed, working in a local food processing plant.

Sister 2

Sister 2 was 23 years old at the time of the incidents. She graduated from college with a degree in early childhood education and worked as a fourth grade teacher for two years. She was employed until the incident dates. She was not married and did not have children. At the time of the incidents, she had ended a relationship with her boyfriend.

Sister 3

Sister 3 was 22 years old at the time of the incidents. She graduated from high school and attended four years of college, but quit a few months before graduation because she had become depressed. She did not receive treatment. She had married at 19 years of age and had three children at the time of the incidents: a three-year-old daughter and twin one-year-old boys. She was not employed outside of the home.

Facts of the Case

The lives of the three sisters became increasingly enmeshed approximately 18 months before the incidents that precipitated their arrests and prosecutions. At that time Sister 3 became fearful of harm coming to her children at the hands of her mother due to the mother's mental illness. Within six months, Sisters 1 and 2 moved in to assist with childcare, but later moved to the home next door at the request of the husband of Sister 3. In the next several months, the three sisters became inseparable. They were increasingly preoccupied with religion and spent hours praying together. They began holding their own prayer service and Bible study group. They became isolated from everyone, including other family members.

For three days before their arrest, the sisters prayed continuously without sleeping. Sister 1 became convinced that God had special plans for her and her sisters and would provide for them. She also concluded that the Bible had been tampered with and was now incorrect due to the alternate spellings of

Immanuel and Emmanuel. She had become convinced that God was trying to tell her something, and she convinced her sisters of the same. On the day of the incident, the sisters disrobed in their home to "free themselves from the confines of clothing." Upon reading a Bible verse, Sister 1 believed that God wanted her to have the house that she and her sisters were accused of burglarizing. Sister 1 later told the court-appointed forensic psychiatrist that she had seen this house several months before the alleged offense and had always wanted to live in a "house like that." She had become convinced over several days that God was going to provide for all her needs in that house. She believed that her situation was similar to that of Moses when God told Moses to claim the Promised Land. The three sisters drove to the victims' house wearing only pajamas. They also brought the children of Sister 3 with them. They prayed while driving and believed "anything was possible at the time. . .God had intended for us to stay at that house for a while. . .He was guiding us."

They arrived at the home and knocked on the door. One sister asked if her "room was ready." As the occupant closed the front door, the sisters tried to force their way into the home but were unsuccessful. They then broke windows in an attempt to gain entry. As an officer arrived, he ordered the women to stop, but the women did not obey the officer's orders. Sister 1 entered the house through the broken window. The other two sisters attacked the officer as he attempted to prevent the entry of Sister 1 while screaming, "Kill him," to one another.[9] Sister 1 ultimately assaulted one of the occupants before being restrained by an off-duty officer who arrived on the scene. According to police reports, the three sisters continued to "be very violent with their legs and teeth" if there was an officer in their proximity. When the officers asked the sisters about the children, the women became increasingly aggressive and did not provide information except to make references to "God," "Satan," and "the effects of judgment day." The children were taken into custody by the state social services agency. Each sister was arrested and charged with burglary, assault and battery with intent to kill, assault and battery of a high and aggravated nature, and resisting arrest.

Unfortunately, the three sisters were placed in the same cell in a small local jail. Two days after the incident, deputies noted that the sisters chanted, sang, sat in a circle, and invoked the name of God while nude in the cell. According to Sister 1, they had removed their clothes because God had created them in his image and that image did not include clothing. They did not eat or attend to personal hygiene. All three sisters reported paranoid delusions about the jail officers. As the officers opened the cell door to communicate with the sisters, the women attacked the officers. According to police reports, the sisters "bit, clawed, and kicked" the officers. The officers sprayed the sisters with mace, but this had little effect on the women, and they continued on their rampage, assaulting the officers. Fifteen sheriff's deputies and correctional officers required two hours to subdue the three sisters and place them in handcuffs and legcuffs. For this incident, each sister incurred an additional charge of assault and battery of a high and aggravated nature.

Following involuntary hospitalizations, Sister 1 was diagnosed with schizophrenia, chronic undifferentiated type. Fluphenazine was prescribed, to which she showed a favorable response. The court-appointed evaluating psychiatrist opined that her delusion that God wanted her to have the victim's house coupled with the perceived consequence of being turned into a pillar of salt if she walked away prevented her from recognizing the moral wrongfulness of her actions. There were no opposing experts. The court concurred with the expert's opinion and she was adjudicated not guilty of all charges by reason of insanity (NGRI) during a bench trial. The court found that she was NGRI because she did not recognize the acts to be morally wrong. She was subsequently committed to the Department of Mental Health. After inpatient treatment, she was discharged to a community residential care facility with court-ordered outpatient follow-up at the local mental health facility. The judge prohibited her from contacting the house occupants or her two sisters.

The other two sisters were involuntarily hospitalized and separated from each other and Sister 1. Their delusions resolved without antipsychotic medication. At a bench trial, they were similarly adjudicated not guilty by reason of insanity (NGRI) due to lack of knowledge of moral wrongfulness. After an inpatient commitment to the Department of Mental Health, they were each discharged to outpatient care under the provision that they not reside together or near the victims. All three sisters are prohibited from visiting each other without supervision. At the time of this report, all three sisters were discharged from

inpatient commitment and were living in separate counties as ordered by the court.

Shared Psychotic Disorder: History, Description, and Clinical Course

Shared psychotic disorder was first described in 1877 as *folie à deux*.[10] It is a rare disorder shared by two or more people with close emotional ties. Cases involving three or more people are very uncommon.

In 1942, Gralnick[11] published a classification of four shared psychotic disorder subtypes:

> Subtype A is termed *folie imposée*. The dominant person with delusions imposes his or her delusions on a younger, more submissive person. Both persons are intimately associated, and the delusions of the recipient disappear after separation.
>
> Subtype B is termed *folie simultanée*. The simultaneous appearance of an identical psychosis occurs in two intimately associated and morbidly predisposed individuals.
>
> Subtype C is termed *folie communiquée*. The recipient develops psychosis after a long period of resistance and maintains the symptoms even after separation.
>
> Subtype D is termed *folie induite*. New delusions are adopted by an individual with psychosis who is under the influence of another individual with psychosis.

Information regarding the incidence and prevalence of shared psychotic disorder is lacking, as the literature consists entirely of case reports.[12–18] The disorder is characterized by the transfer of delusions from one person to another. About 95 percent of cases arise between members of the same family, and over 70 percent are between a husband and a wife, mother and child, or two sisters.[19] The incidence in married or common-law couples is equal to that in siblings. Among siblings, the disorder is more common in sisters than in brothers.[19] Almost all cases involve members of a single family.[20]

The individual who first has the delusion (the index case) is often chronically ill and is typically the influential member of a close relationship with the more suggestible person (the secondary case), who subsequently develops the delusion. The primary case often has diagnosed schizophrenia and displays episodes of paranoid delusions. Other diagnoses may include delusional disorder or mood disorder with psychotic features. The content of the shared delusional beliefs may be dependent on the diagnosis of the primary case and can include bizarre delusions, mood-congruent delusions, or non-bizarre delusions.

It has been reported that the secondary case is characteristically younger, less intelligent, more gullible, and more passive, with lower self-esteem than the index case, although these findings have not been consistently replicated.[19] Affected individuals frequently live together and usually have an enmeshed relationship that isolates them from others, a situation that contributes to the lack of detection by others.[19] The degree of impairment is usually less severe in the secondary case(s) than in the index case.

Most individuals with shared psychotic disorder lack insight and do not seek treatment. Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. However, if the relationship with the primary case is interrupted, the delusional beliefs of the other individuals may diminish or disappear. Recent data gathered from an analysis of case reports show that separation of the secondary case from the primary case may not be sufficient for resolution of the delusion (Ref. 21, pp 517–20). More commonly, the recovery of the secondary case follows separation from the index case and the administration of antipsychotic medications.

Discussion

This case provides an example of shared psychotic disorder as described in the literature: the sharing of delusions among closely associated subjects. The disappearance of the delusions in the secondary cases after separation from the index case is most similar to Gralnick's Subtype A (*folie imposée).* There was also an element of Gralnick's Subtype B (*folie simultanée*) in that this family history was significant for severe mental illness. The younger age of the index case does not conform to Gralnick's subtype descriptions.

Shared Psychotic Disorder Versus Accepted Cultural Beliefs

The existence of a plethora of cultural belief systems sometimes makes distinguishing cultural beliefs from delusions a difficult task. Cultures are complex and symbolic systems, and an understanding of culture is important in gaining an understanding of an individual. Explanations of what constitutes a person, the internal and external forces that animate or affect a person, and beliefs about how these forces interact with an individual are all a part of the person's culture.[22–26] A culturally held belief may be misidentified by a clinician as a delusion due to the strangeness of the belief and the lack of the clinician's exposure to that particular culture or subculture. It is impossible for a clinician to know intimately the vast

number of cultures from which his or her patients may present. While there are no set criteria to distinguish cultural beliefs from delusional beliefs, by definition a delusion is different from a strongly held cultural belief because it is both fixed and false and will be believed regardless of evidence to the contrary. In this case, evidence of the fixed nature of the sisters' religious belief that it was not wrong to enter the house was reflected by the fact that they persisted in their attempts to enter the house despite the unhappiness of the residents and the arrival of the police. Also, an idea or belief is considered delusional if it is externalized, communicated, and subsequently identified as an unshared notion. Unlike cultural beliefs, delusional beliefs are not credible to others in the local cultural context[26] and impair the affected individual's interpersonal, social, or occupational functioning.

As an example, assume a clinician is asked to evaluate a female defendant who is charged with an assault against another woman. When asked why she assaulted the other woman, the defendant replies that the other woman had put her menstrual blood in the defendant's husband's coffee. The defendant explains that the assaulted woman was trying to steal her husband. Upon hearing this statement, the clinician might surmise that the defendant has a bizarre, jealous-type delusion. However, if the defendant is an African-American woman who was raised in a rural setting in the southeastern United States, this belief may not be delusional, but rather a belief that is part of a cultural belief system commonly referred to as "root work." The "root work system," which has its origins in African culture and was later transported to the antebellum South, continues to influence the health of African Americans in rural areas of the southeast and in poor urban areas throughout the United States.[27] This culturally based belief system combines a belief in the magical causation of illness with cures by sorcery, in addition to an empiric tradition stressing the natural causation of illness with cures by herbs and medicines.[27] One of the beliefs in "root work" involves the use of bodily fluids (e.g., menstrual blood, vaginal fluids, semen, and urine) in spell-casting, and the knowledge of how to deploy them is routinely passed from one family member to another.[27] Menstrual blood served to a man in his coffee or tea is a "sovereign recipe for capturing his sexual attention" and there is no ritual or invocation necessary; the idea is to get the female's "scent" into the man's "beloved sphere of consciousness."[28] Upon revelation of the defendant's cultural beliefs (and verification from relatives), the focus shifts away from a jealous-type delusion (and a possible "insanity" defense in some jurisdictions) to an understanding of her cultural belief system (which would not constitute a mental illness that interferes with one's ability to appreciate right from wrong or conform with lawful conduct).

The difficulty in differentiating delusional from cultural beliefs can be extended to cults. Although cults have been around for centuries, they have become more prominent in our society in the past quarter century. The term cult refers to a new system of religious beliefs or rituals.[29] In modern usage, a cult describes an unconventional religious group that may be viewed by the larger society as strange or dangerous. Cults have been at times considered subsets of larger movements referred to as charismatic groups, which include organizations such as self-help groups (e.g., Alcoholics Anonymous) and radical political or social movements.[30] Heaven's Gate, Branch Davidians, and Aum Shinrikyo are examples of modern day cults.[31] Cults are sometimes characterized by the following[32]:

1. Spiritual or religious preoccupation that breaks with accepted religious traditions and that is imposed on its members; these beliefs cannot be proved or disproved.
2. A high level of group cohesion that may prevent members from exercising freedom of choice to leave the group.
3. A profound influence on the members' behavior, possibly inducing psychiatric symptoms.
4. Leaders who are charismatic, are considered special for divine reasons, and are sometimes ruthless in their quest for financial, sexual, or power gains (Ref. 21, p 899).

On occasion, a cult may resemble a case of "mass" shared psychotic disorder. The cult leader may be similar to an index case with beliefs not based in reality and the cult members may resemble secondary cases who adopt those beliefs. This gives rise to several debatable questions: (1) When are the teachings of a "few" considered part of mainstream beliefs? (2) When should false beliefs be considered part of a delusional disorder (e.g., shared psychotic disorder) rather than a cult system? (3) Is there a minimum number of people who must share the beliefs for those beliefs to be considered cultish rather than de-

lusional? (4) May cult members in some cases be said to share a psychotic disorder?

An argument could be made that the three sisters had formed their own cult. Sister 1 could be thought of as the leader who believed that God had granted them a new home. The other two sisters could be said to resemble the "members" of a cult who adopted Sister 1's belief system. If the two secondary cases had been considered members of a cult rather than the individuals suffering from shared psychotic disorder, they may have been found ineligible for an insanity defense at the time of their actions because they would not have evidenced a diagnosable mental illness.

Permanent Insanity Versus Temporary Insanity: The Same or Different?

Most states do not differentiate between permanent and temporary insanity. In South Carolina, for example, if the legal test of insanity is satisfied, it makes no difference if the insanity is due to a temporary or persistent mental illness. As long as the defendant is adjudicated "insane" at the time of the offense, it does not matter whether the period of insanity lasted several months or merely a few hours. Although the insanity must be fixed and stable for a reasonable duration (i.e., "settled"), it need not be permanent. The usual disposition of NGRI cases in South Carolina is inpatient commitment to a secure psychiatric hospital for a minimum of 120 days following adjudication. Release may be granted by the court once expert testimony establishes that the mental illness is treated to a point that the individual does not pose a danger to himself or others. This case represented "temporary insanity" caused by a functional mental illness (shared psychotic disorder). "Temporary insanity" may also be caused by other treatable and transient conditions such as delirium, brief reactive psychosis, and medical conditions. Should there be a difference in disposition between those with a permanent mental illness (e.g., schizophrenia) and those with a temporary loss of sanity (e.g., shared psychotic disorder) who are adjudicated not guilty by reason of insanity (NGRI)? The psychotic symptoms in the secondary cases resolved rapidly after separation from the index case and without the use of antipsychotic medication.

Court-ordered outpatient treatment may have been a viable alternative to a statutorily mandated 120-day inpatient hospitalization for each of the secondary cases and would have guaranteed outpatient treatment for further monitoring and assistance in dealing with the separation from their mentally ill sister. Given the lack of prior psychiatric history and substance use coupled with the presence of family support, the secondary cases probably could have returned to their respective homes to maintain important links with their non-affected family members (including the children) and community. Vocational rehabilitation could also have been a benefit for the secondary cases in helping them regain the skills necessary to reintegrate into the labor force.

Conclusion

The issues of diagnosis and disposition confronting the legal establishment in cases of shared psychotic disorder and other forms of temporary insanity will remain a controversial topic. Although there is no relevant case law, the court showed a clear understanding of the state of mind of these particular individuals. Despite this understanding, the court perhaps inadvertently deprived the secondary cases of potentially helpful sources of healthful social support during their recovery processes by imposing inpatient commitments in a distant county on each of them.

Although rare, shared psychotic disorder cases will continue to challenge our understanding of psychiatric phenomenology. In forensic pretrial settings, this challenge is multiplied because psychiatric experts must be able to explain this complex disorder to the judge and jury who are most often non-medically trained people.

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