Folie à Trois in a Multilevel Security Forensic Treatment Center: Forensic and Ethics-Related Implications

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Shared (Induced) Delusional Disorder commonly occurs in close relationships and involves a varying number of participants who may be nonconsanguineous. The disorder has been associated with forensic and fatal consequences. Its occurrence in three nonrelated, incarcerated individuals is described in this article. This case of *folie à trois* has forensic implications and raises several questions of ethics that relate to autonomy, confidentiality, safety, and risk estimation. The presentation, management, and outcome of the patients suggest that a high index of suspicion is needed to detect cases in similar settings. The report concludes that the rarity of the disorder in a forensic mental health population may be the result of underdetection, given that conditions are conducive to the development of the disorder. Telltale signs of its manifestation are hypothesized as being responsible for some events in incarcerated populations. Physical separation and antipsychotic medications remain the mainstay of treatment.

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Case Report

Three patients began to share and support each other in several delusions. The three, who were unrelated, were patients of the Regional Psychiatric Center in Saskatoon, Saskatchewan, Canada, a multilevel security forensic treatment center. The center admits patients from the federal penitentiaries who have been sentenced to more than two years and provides assessment, treatment, and rehabilitation. The three patients incorrectly believed, despite contrary evidence, that their convictions would be overturned. They further asserted, despite incontrovertible and obvious proof, that their subsequent release from jail would occur early and not in accordance with the normal processes of the National Parole Board. They, therefore, wrote "affidavits" (legal letters) to guarantee this method of release. When they did not get the expected replies to their affidavits, they believed that their letters were being tampered with as a plan to keep them from achieving early release. They believed that their letters were opened and the contents tampered with, because the institutional logo was stamped on the envelope (stamping all letters coming through the treatment center's mailing system is a usual practice). They found further evidence of this tampering when cellophane tape was used to seal all their letters labeled "private and confidential" (another usual practice for official mail). They also observed the mail deliverer's stare when distributing letters to their individual rooms to be confirmatory of this tampering. They believed that letters written on plain white paper (not embossed) and using a black-and-white logo (not colored) were evidence of nonauthentic replies to their affidavits. They jointly believed these "fake" letters originated from the administrative staff of the treatment center. They also knew that the stares of the security officers on the unit were a normal part of the officers' executing their dynamic security duties. However, when such stares were directed at them, the patients thought that they were being singled out for securing "early release" and because of their race, being nonwhite.

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They believed the officers were talking about them and doing illegal things intended to prevent them from using their affidavits to secure early release. The three also became convinced of the validity of the overinflated identity and ability of the inducer of these beliefs. They repeatedly stated that the inducer was a wise self-ordained criminal lawyer possessing powers to heal, cure, and set prisoners free.

These false beliefs were firmly held despite contrary evidence, and they influenced various actions. The patients wrote and sent letters to many lawyers and magistrates. They complained to their family members, the Executive Director of the Center, and the National Correctional Investigator about the perceived interference. To avoid interception of their letters, they sent some of them through other patients who were being discharged from the center. They instructed the patients to mail the affidavits outside the treatment center to circumvent the system and prevent the perceived mail tampering. They threatened to sue the treatment center and the Correctional Services of Canada. They copied and recopied the inducer's affidavit and sent copies to several councils and organizations, including the Canadian Human Right Council and the Supreme Court of Canada. In believing in the "healing" powers of the inducer, the second induced patient (see individual case later in the article) stopped taking his psychotropic medication and relapsed.

Individual Cases

The Inducer

The inducer was a dangerous offender in his 40s serving an indeterminate sentence for serious felonies. Previous incarcerations were for violent offenses, including kidnapping. He was born to an alcoholic mother. His documented history contained reports suggesting that he had had fetal alcohol syndrome. He reported physical abuse while in residential schools. The patient contracted pulmonary tuberculosis at an early age and was treated with combination therapy. He recalled having episodes of sexually transmitted diseases that were inadequately treated. A full medical assessment and laboratory investigations revealed a diagnosis of high serum cholesterol (hypercholesterolemia). The investigations with normal results included chest x-ray; Mantoux test; complete blood count and differential; erythrocyte sedimentation rate; syphilis screening with a Veneral Disease Research laboratory test; and kidney, thyroid and liver function tests. He suffered with Delusional Disorder and Personality Disorder Not Otherwise Specified with Schizotypal and Antisocial Personality features. He also had alcohol dependence currently in remission in a controlled environment.

He manifested mild to moderate cognitive disabilities. Looking older than his age, he had odd facial features. He usually carried papers of a supposed legal content. He was circumstantial, overly elaborate, and metaphorical in speech. Furthermore, he manifested grandiose and persecutory delusions and appeared domineering in interviews. He believed that the sentencing judge gave him the role of healing, curing, and setting prisoners free. About a month and a half after admission to the treatment center, he reported that he was counseling and healing some of the other patients. A few months later, he induced two other patients to share his delusions, and he interfered with their treatment and progress.

He became very hostile and was considered a risk to himself and others if not treated. Consequently, the patient was certified and treated with risperidone (up to 4 mg/day). The level of hostility decreased, but the patient continued to hold firmly to the delusional themes. He further stopped replying to his letters, stating that the letters did not possess the quality of the "real McCoy," referring to the absence of embossed paper and color logo of the replying agencies. He alleged that the treatment center staff wrote the fake letters. He was physically separated from the two induced patients for two weeks. He then voluntarily signed an agreement to keep away from them, even though they lived in the same unit. Enforcing this separation was difficult ethically and practically. The inducer seemed to have the ability to attract the induced patients to return to him by offering them hope of being released early. He requested and was granted a transfer back to his parent institution where he believed his letters would not be intercepted. He complied with the risperidone but retained his erroneous beliefs.

First Induced Patient

The first induced patient had Schizophrenia. He was in his 20s and was serving a sentence for assault. He was raised by his grandparents and in several group and foster homes. He reported being sexually

abused as a child and had manifested Conduct Disorder as an adolescent. The patient had engaged in extensive alcohol and hallucinogen misuse in his adolescent years. He experienced auditory hallucinations, delusions of control, delusions of reference, depressive thoughts, thought interference, and formal thought disorder. Following the introduction of clozapine treatment, the psychotic symptoms and consequently his level of functioning improved. Owing to the lengthy sentence, the patient was desperate to be released. He tried to complete his correctional programs and also applied for parole but was denied. In 2002, he stopped attending the psychoeducational programs and gave up his medication, stating that his friend, the inducer, had the power to heal and cure him. Subsequently, his appetite decreased, with evidence of weight loss and deteriorating level of functioning. He further exhibited polydipsia, insomnia and bizarre behavior. He manifested a lack of cooperation, poor concentration, inappropriate affect, auditory hallucinations, and formal thought disorder. At that time, he acquired and manifested the delusions of the inducer. He believed that the "three of us who are being released right away" were being laughed at and discriminated against and were having unfairness and injustices meted out "to us." He declined any professional legal advice to deal with these injustices, because he believed the inducer was a learned gentleman who could help him. He spent most of his time writing and copying the inducer's affidavit. Separation from the inducer, milieu treatment for the polydipsia, and recommencement of clozapine formed the patient's treatment plan. Within two weeks, his mental state showed areas of improvement, with the exception of the induced delusions. When attempts were made to keep the three patients separated longer, he threatened to sue the institution. He continued to believe that the letters were being opened, despite contrary evidence. This behavior continued until the inducer was granted a transfer from the treatment center. The induced patient stopped copying the affidavits but kept them, stating "you never know; they may be handy someday." He seemed to continue to hold the beliefs of the inducer, but not as strongly.

Second Induced Patient

The second induced patient was a sexual offender in his 20s. He was raised by alcoholic parents and reported sexual abuse as a child. He was considered to be a slow learner and had to attend remedial school. He was dependent on solvents, alcohol, and other drugs, with intravenous usage. In 2001, he was admitted to the treatment center. He attended all his psychoeducational therapy group sessions and made significant improvements in his attitude and behavior. A few months after admission, he manifested delirium with disorientation, visual hallucinations, preoccupations, and inappropriate behavior. These followed the ingestion of drugs that were confirmed to be benzodiazepine and amphetamines. The patient had been making progress until 2002, when he presented with the same delusions as the inducer. To manage his delusions, medication was offered, but he declined. He was not deemed certifiably insane. Therefore, the treatment team sought to provide contrary evidence in various settings to combat the delusions. The patient's actions did not change. He continued to believe that his letters were being opened to stop him from being released. He also submitted grievances to the Executive Director. He was then transferred to another unit to undergo a different treatment program. After three weeks of separation, he stopped pursuing his case and his belief in the erroneous notions began to lose strength.

Discussion

Several cases of Shared Psychotic Disorder[1] or Induced Delusional Disorder[2] (*folie à deux*) have been reported in the literature. Some of these have forensic implications, but no case has been reported with origins in a forensic hospital involving unrelated patients. *Folie à deux* has been described as an intriguing condition of great relevance to the understanding of human psychopathology. It is the most impressive example of a pathological relationship.[3] Forensic complications of fatality, admissions into a secure hospital, and suicide pacts related to the condition have been reported.[4–7] About eight percent of a series of cases of Induced Delusional Disorder occur among nonconsanguineous patients or friends.[8]

Certain conditions are needed for Shared Delusional Disorder to occur during incarceration or in a forensic hospital. Floru[9] reported, for example, that the environment of intimate relationships over the years and isolation are fertile grounds for the development of Induced Delusional Disorder. For incarcerated populations and especially those with long sentences, living together for long periods fosters intimacy. The population from which the three pa-

tients came includes those with long sentences. Solitary confinement also produces isolation, which is a breeding ground for delusional ideas and paranoid disorders.[3] The interaction between patients with various diagnostic characteristics of dominance and submissiveness could fuel the development of these disorders. These conditions are conducive to paranoia because of the various disordered personality types in the residents of forensic treatment centers. Hypothetically, induction could happen when a patient with suspicious and self-important cluster B personality characteristics befriends a timid, dependent, and suggestible patient with cluster C personality symptoms. The absence of several cases in these settings (prison and forensic hospitals) may be the result of underreporting or the lack of recognition of rare psychiatric syndromes in the penal system.[2]

This case is intriguing in the sense that the delusions were not bizarre, were shared strongly, and influenced the patients' functioning. These features are characteristic of Shared Delusional Disorder in the three patients. Their delusions were held despite incontrovertible proof to the contrary. Although the three were nonwhite, they were only significantly different from the remainder of the patients in their belief in the delusions. The center caters to the mental health needs of over 200 patients, 70% to 80% of whom are nonwhite. The two induced patients had never expressed these beliefs prior to the inducer's admission to the center. The inducer was the last of the three to be admitted to the center. He was also the oldest, commanding the respect and seniority needed to produce a domineering tendency. He was also looked on as a respected older person by the two induced patients. The first induced patient was vulnerable to desiring early release because of his long sentence. His previous schizophrenic delusions were extended in the form of *folie induite*[3] (induced psychosis). The third patient, the second one induced, manifested a strong desire to feel important and had recently thought of himself as having a high "social status." The loss of status may have led him to identify with the promises of the delusions. His represents a case described as *folie imposée* (imposed psychosis).[10] Separation from the inducer led to a loss of delusional beliefs in his case. Furthermore, he was reported to be a slow learner and was thought to have mental retardation. His psychological assessment placed him at the lower end of the normal intelligence range. It is therefore still possible that diminished intelligence, known as a significant etiological factor in developing Shared Delusional Disorder,[11] may have played a part in his case.

This case report extends the debate regarding the gene-environment interaction in the development of delusional disorders. Separation, a simple environmental manipulation with therapeutic effects, weakens the genetic argument.[12] This notion is not conclusive, as there are cases of resistance after separation.[11] However, the diagnosis of schizophrenia in the first induced patient and drug-induced delirium with low-normal intelligence in the second induced patient strengthens the idea of genetic and organic pathogeneses of the disorder.[13,14] Dalby and Duncan[15] reported that organic brain syndromes and substances like methylphenidate and cannabis have been factors strongly associated with Induced Delusional Disorder. This connection is especially applicable in the case of the second induced patient. The use of psychotropic medication, cognitive verbal challenge, empirical provision of alternative explanations to erroneous beliefs, and the environmental manipulation of the patients resulted in moderate improvements, thus confirming the pathoplastic nature of the origins of the disorder.

The management of this case of shared (Induced) Delusional Disorder produced questions of ethics and forensic ramifications that are the focus of the following sections.

Ethics-Associated Considerations

The three patients lived in the same hospital unit. It was thus important to maintain the principles of autonomy and confidentiality in the areas of assessment, treatment, and reporting of this case.[16] The Canadian Medical Protective Agency was contacted with regard to matters of confidentiality and separation of the patients as a form of treatment. The patients were all individually assessed as possessing the capacity to give consent. They then gave verbal and written consent to a reasonable limit of disclosure that would reveal only the relevant and necessary information on the stated beliefs. Thus, one patient's beliefs and not other aspects of his case were discussed with the patients who shared his delusions. If one or more of the patients had refused to consent to the reasonable limits of disclosure, management would have conducted a further assessment of involuntary disclosure of information. This eventuality would have been more difficult if different psychia-

trists had managed the patients. Ethics-related consideration of the possible exploitation and need to protect the two induced patients, the deterioration of the mental health of the first induced patient, and the level of risk of the inducer would guide decisions. This may include involuntary disclosure of information between health professionals on a need-to-know basis. However, in this case study, it so happened that the same psychiatrist (the author), on three different treatment teams, was involved in the treatment of these patients. Whether this setup (a single treating psychiatrist for the three patients) has more advantages over having different psychiatrists responsible for each of the patients is open to discussion.

With respect to physical separation as a crucial method of treatment,[12] the Canadian Medical and Protective Agency advised caution. It was the opinion of the agency that the decision to separate the patients should not only be clinical but also operational. Therefore, discussions with the Program Director and operational staff determined a feasible method of separation. In this case, the patients resisted the separation and threatened to sue the institution. They also threatened to request their discharge to their parent institutions. (Patient admissions to this treatment center, from parent penal institutions, are voluntary. Patients can request discharge from the program except when considered certifiably insane.) The team believed that the inducer constituted a risk to the induced, gains from treatment were being lost, and mental deterioration had to be halted. These factors outweighed the desire of the three to be together, as they spent their time almost isolated from the more than 100 other patients in the unit. The inducer signed an agreement to stay away from the induced or face physical separation to a different wing of the unit. Despite this, the induced patients continued to congregate around the inducer until the second induced patient was transferred to another unit. It can be concluded that separation in certain cases of Shared Delusional Disorder may pose numerous challenges in a forensic hospital, or a similar setting, which is smaller than a penitentiary. Separation, though helpful especially in classic *folie imposée*,[3] may also be difficult in a community where only hospitals provide the physical separation. It may be contraindicated or less successful in the elderly.[17–19]

Questions of ethics also arise in determining the voluntariness of the patients to undergo treatment. The two patients, the inducer and the first induced, who needed psychotropic drugs, were respectively managed involuntarily and voluntarily. The patients did not sue the hospital, and no request to appeal the certification of the inducer was put forth. The inducer's hostility and the first induced patient's schizophrenic symptoms improved after they received antipsychotic medication. However, the shared delusions only abated when there was physical separation in the case of the first induced patient. The second induced patient seemed to have initially had a weaker strength of belief, and it subsequently abated with physical separation. The use of psychotherapy has been helpful in several reported cases. In this case, however, it was not possible, since one of the patients declined and the other two were discharged. McGauley[20] has described similar difficulties in offering psychotherapy in secure settings. Thus, the two patients left prematurely. The resultant interinstitutional transfer of the patients without completing their required treatments has resource and ethics implications. Informal psychotherapy in the form of support and provision of contrary evidence were useful in the case of the first induced patient. The use of a culture broker was a culturally sensitive addition to the treatment armamentarium, especially in the case of the second induced patient. This positively influenced his responsiveness to further treatment.[21]

Forensic Factors

To provide contrary evidence to the patients' beliefs, the treatment team agreed to treat the three patients' letters differently from those of the other patients, by making compromises in the policy of the center regarding treatment of the mail. Only confidential letters are normally left unopened. This security check is to prevent the entry into the center of contraband such as drugs. The mail deliverer allowed their letters not to be checked, stamped or taped for three weeks. The patients knew their letters were not being opened for three weeks. During the three weeks, support, provision of evidence, and consultations were intensified. This plan of action unfortunately did not reduce the strength of the delusions about their mail. The concession may be seen as a compromise to security, but necessary steps were taken to protect all involved in the opening of letters, and the period was limited to therapeutic efforts.

The patients' complaints against the institution could have produced several outcomes—for in-

stance, a full investigation by the Correctional Investigator, and even the Canadian Human Rights Council. Furthermore, dissatisfaction with their stay in an institution they viewed as interfering with their release and their legal rights could have led to various outcomes. The patients could have responded in violent ways. They could have discharged themselves much earlier, or the program facilitators could have discharged them for nonattendance at psychoeducational programs. This initially occurred in the case of the first induced patient. The possible negative outcomes all had financial implications. Investigations of complaints and grievances are costly and laborious and could affect the critical success factors of the institution.[22,23] If the beliefs had been taken at face value, the suspicion directed at the institution could have been damaging, and the news media could have had a field day reporting a perceived injustice. Losing patients before completion of treatment (attrition) is associated with an increased risk of recidivism. Such loss has also been known to have direct, indirect, and intangible costs to the forensic service and society at large[24] and would have been another unnecessary cost if the condition had been missed.

A high index of suspicion is needed to evaluate similar cases or those that resemble Shared Delusional Disorder in forensic settings. The environment offers itself to the nurturing and development of the disorder. Thus, recognition of certain behavior among incarcerated individuals may point to possible missed cases of Shared Delusional Disorder. For instance, shared ideas or induced delusions could provide explanations for suicide pacts, multiple suicides, the occurrence of riots, prison homicide, extreme gang-related activities, violence, and hostage taking. Rosen[6] reported that dependency and social isolation could explain the suicide pacts found in cases of *folie à deux*. Although, the number is low, it is possible that some have been carried out as a result of shared delusions between the participants. Joint or multiple litigious behavior also should be evaluated for possible Shared Delusional Disorder in forensic settings, as litigious behavior has been associated with *folie à deux*.[25] Submissive individuals in prisons who are ripe for the picking[26] are vulnerable and desperate. The high prevalence of learning difficulties and organic brain syndromes in this setting are strongly associated with the disorder. These are common occurrences in the population of prisoners and forensic mental health patients, and such patients need adequate assessment, treatment, and protection.

Thus, there is the need for medication, psychotherapy, and social separation to be incorporated in the treatment of those who manifest Induced Delusional Disorder in an incarcerated population. A high index of suspicion is necessary to identify cases, especially in an unusual group that engage in joint infelicities. Management of the patients by one psychiatrist could reduce the complex ethics-related problems. Multidisciplinary input is needed to manage the associated forensic factors.

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