

Shared Obsessive-Compulsive Disorder: an Italian case-report

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Lasègue and Falret first described the phenomena of the transference of delusional ideas from a 'primary' or 'inducer' affected individual to one or more 'secondaries' or 'induced', in close association [1]. Shared psychotic disorder, "folie à deux", has been subsequently defined as an infrequent entity mainly described in the context of delusions [2]. In the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* [3], shared psychotic disorder was removed as a separate disease entity and was included in the section of other specified schizophrenic spectrum and other psychotic disorders. According to the *DSM-5*, in the context of a relationship, the delusional material from the dominant - primary/inducer - partner provides content for delusional belief in the individual - secondary/induced - who may not otherwise entirely meet criteria for delusional disorder [3].

Obsessions and compulsions have been described in the context of shared psychopathology [2]. However, in 2006 Grover and Gupta described shared Obsessive Compulsive Disorder (OCD) in two sisters with similar symptoms and, in 2010, Mergui and colleagues proposed to expand the concept of shared psychosis as shared OCD describing the case of induced OCD in a married couple [2,4]. More recently, in 2012, Singh and colleagues described the case of shared OCD from a mother in law to her daughter in law [5].

In order to provide further evidence in the field, in this report we describe the case of shared OCD in a married couple.

A 38-year-old man (IM) with an anxiety family history, presented to our tertiary OCD outpatient clinic. He was married to a 33-year-old woman (EL), born in Latino America. EL had no previous psychiatric symptoms and indeterminate family history, since there was no information about her biological parents. The couple had a 5-year-old daughter, with no current psychiatric symptoms.

During the first assessment, IM showed contamination obsessions, fear of infective diseases, radiophobia and related compulsions (repetitive washing and cleaning, avoidance of hospitals and other potential contamination sources). His clinical history overview revealed the onset of the first

symptoms at 12 years of age, mainly fear of being contaminated with an infectious disease. Nevertheless, patient's first psychiatric contact occurred at the age of 25, when obsessive and compulsive symptoms impaired substantially his social and working life; he was diagnosed with OCD and Sertraline was prescribed, titrated up to 100 mg/day. Meanwhile, cognitive behavioral therapy was started. In the absence of any improvement of OCD symptoms, Sertraline was switched to Fluvoxamine, titrated up to 150 mg/day and then to Paroxetine, titrated up to 20 mg/day. However, such treatments did not significantly change the clinical picture.

When the patient came to our attention, the OCD diagnosis was confirmed and a score of 22 was obtained at the Yale-Brown Obsessive Compulsive Scale (Y-BOCS) [6], revealing a moderate severity of illness [7]. Patients was then prescribed Escitalopram, titrated up to 20 mg/day. Due to a partial response, after 6 weeks, Risperidone 1.5 mg/day was added, as suggested by currently available OCD guidelines [8,9].

After 8 additional weeks of treatment, patient showed an improvement of the symptomatology and the Y-BOCS identified a mild OCD, with a score of 10 [7].

It has to be noticed that, during the previous years of marriage, EL had witnessed the many obsessions of her husband, modifying consistently her behavior and habits (e.g., cleaning the house carefully many times per day) in order to avoid possible arguments and a symptom worsening.

While her husband's symptoms were improving, EL started experiencing a mild OC symptomatology, characterized by the same OC subtype of her husband (mainly obsessions with cleaning compulsions). In a few weeks, however, washing and cleaning compulsions got worse and led to an important disability for EL, since she spent almost 3 hours/day cleaning the whole house, including the walls, from potential pathogens. Even though she felt ashamed while in front of other people, she had very little control over her actions, hence she started spending most of her time home alone with her daughter. When IM noticed her symptomatology, after an initial resistance of his wife, he convinced her to seek psychiatric help. She was then diagnosed with moderate OCD, as her husband, and scored 23 at the Y-BOCS [7]. Escitalopram was prescribed, initially titrated up to

10 mg/day, with no side effects. At first, she showed an improvement on the anxiety related to obsessions and compulsions; however, symptoms persisted for at least one hour a day with poor control over them, therefore escitalopram dosage was raised up to 20 mg/day, with a decrease of Y-BOCS score to 15 (mild OCD) [7]. However, EL seemed less compliant with the treatment, compared to her husband, often missing or changing the appointments with her psychiatrist, and it was difficult to determine the exact effectiveness of the pharmacological treatment. After 6 months of treatment, EL did not show any further improvement and asked for a reduction of her therapy.

Authors reported this case since it shows many common features with “folie à deux” and with the mentioned cases of shared OCD [2,4,5]. Even though EL represented the induced/secondary individual; there is no data on her family history and about her childhood before the adoption, it cannot be excluded a condition of childhood neglect before the adoption, leading to a higher predisposition to psychiatric diseases [10]. The exposition to IM (inducer/primary) symptoms, ingrained since his adolescence, could have represented the milieu in which EL symptoms developed.

Alternatively, EL could have manifested a spontaneous OCD onset, with a late age at onset (33 years), as already described in females samples [11], triggered by environmental stressors (e.g. adoption and her husband disease) [12].

In a cognitive-behavioral perspective, continuous repeated instructions by IM, connecting a ritual to some benefits and to avoidance of possible dangers, might have developed in EL a learned behavior over a period of time, thus leading to a change in her cognitive structure [13], e.g. associating certain objects and circumstances with fear and performing certain rituals to release the consequent anxiety.

Obsessions differ from delusions in terms of insight, egodystonic features and intrusiveness; however, both obsessions and delusions could be considered as extremes of the same spectrum – an option recognized by the DSM- 5 within the category of ‘OCD with poor insight’- and shared obsessions could represent the continuum of obsessions and delusions [2,3,14]. However, in the

current psychiatric diagnostic nomenclature, DSM 5 and ICD-10, there is no category for a non-psychotic shared psychiatric disorder.

More controlled studies are required in order to better understand the psychopathology and mechanisms of psychotic and non-psychotic shared disorders in psychiatry, with specific investigation on OCD, with different reports, including the present one, suggesting this may not be an uncommon condition.

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