Shared Psychotic Disorder in the Digital Age: A Case Series of Virtual "Folie à Trois"

Индуцированное бредовое расстройство в эпоху цифровых технологий: серия случаев виртуального «folie à trois»

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Case report

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ABSTRACT

BACKGROUND: This case series presents a unique manifestation of shared psychotic disorder "folie à trois" transmitted entirely through digital interactions. It is among the first documented clinical accounts demonstrating that immersive online alliances — without physical proximity — can serve as fertile ground for psychotic contagion. The report contributes to evolving psychiatric frameworks by highlighting the role of "virtual cohabitation" in shaping shared delusional systems.

CASE SERIES PRESENTATION: Three young adult males from different cities in West Bengal developed a shared persecutory delusional system over three years of daily interaction within an online gaming guild. The inducer (Case A) presented with severe paranoia, digital surveillance delusions, and insomnia. Recipients (Cases B and C) displayed alignment with these beliefs, marked social withdrawal, and psychological dependency on the inducer. All patients were diagnosed with shared psychotic disorder. Interventions included second-generation antipsychotics (risperidone, olanzapine, aripiprazole), structured cognitive-behavioral therapy, digital hygiene protocols, and psychoeducation. Separation of digital communication among the triad facilitated therapeutic gains. All three demonstrated symptomatic improvement over 2–3 months, with partial restoration of social functioning.

CONCLUSION: This case underscores that psychological proximity fostered through immersive digital platforms may suffice for the transmission of delusional beliefs. Clinicians must routinely explore virtual relationships and digital group identities as potential vectors of psycho-pathology. Early detection, digital boundary setting, and integrative therapy approaches are essential in managing such emerging presentations.

АННОТАЦИЯ

ВВЕДЕНИЕ: В работе представлены клинические случаи индуцированного бредового расстройства «folie à trois», уникальность которых заключается в том, что пациенты контактировали друг с другом только в цифровом пространстве. Это одно из первых документальных подтверждений гипотезы, что тесное онлайн-общение без физических контактов может стать благоприятной средой для развития указанного расстройства. Данная работа расширяет концепции психических расстройств, подчеркивая значение виртуального сосуществования в формировании общих бредовых идей.

ОПИСАНИЕ СЕРИИ КЛИНИЧЕСКИХ СЛУЧАЕВ: У трех молодых мужчин, проживающих в разных городах индийского штата Западная Бенгалия, развился общий бред преследования после трех лет ежедневного общения во время онлайн-игр. У индуктора (случай А) наблюдался тяжелый паранойяльный синдром,

бред цифрового преследования и бессонница. Реципиенты (случаи B и C) начали разделять эти убеждения, у них отмечалась выраженная социальная изоляция и психологическая зависимость от индуктора. У всех пациентов диагностировано индуцированное бредовое расстройство. Терапия включала антипсихотические препараты второго поколения (рисперидон, оланзапин, арипипразол), структурированную когнитивно-поведенческую терапию, а также программу цифровой гигиены и психообразование. Прекращение онлайн-коммуникаций между пациентами способствовало достижению целей лечения. Через 2–3 месяца у всех троих пациентов было достигнуто симптоматическое улучшение с частичным восстановлением утраченных социальных связей.

ЗАКЛЮЧЕНИЕ: Представленные клинические случаи подчеркивают, что психологической близости, возникающей при тесном общении на цифровых платформах, может быть достаточно для передачи бредовых идей. Врачам следует систематически оценивать виртуальные отношения и групповую цифровую идентичность в качестве возможных путей распространения психопатологических нарушений. Раннее выявление, формирование цифровых границ и интегративные подходы к лечению имеют решающее значение в ведении этих новых проявлений.

Keywords: *shared psychotic disorder; folie à trois; digital cohabitation; online gaming; persecutory delusions; virtual psychopathology*

Ключевые слова: *индуцированное бредовое расстройство; folie à trois; цифровое сосуществование; онлайн-игры; бред преследования; виртуальная психопатология*

INTRODUCTION

Shared psychotic disorder (SPD), traditionally referred to as “folie à deux” (“madness shared by two”) [1], is a rare psychiatric syndrome in which delusional beliefs are transmitted from a primary individual (the “inducer”) to one or more close associates (the “recipients”) through prolonged interpersonal closeness and emotional bonding [2]. While the classic phenotype was first described in 19th century asylum settings [3], the syndrome has since evolved conceptually to include variants such as “folie à trois” (“madness shared by three”) and “folie à famille” (“madness shared by family”), characterized by shared delusions among three or more individuals within closely knit environments [4].

With the exponential rise of digital communication platforms, virtual cohabitation has emerged as a modern analogue of traditional physical proximity [5]. “Digital households/communities” characterized by emotionally intense and immersive interactions within online gaming guilds, fan communities, or ideologically bonded social media groups [6] may offer fertile ground for the development of shared psychoses. The digital age has expanded the psychosocial landscape, allowing individuals to form tightly interconnected identities and alliances without physical co-location. To the best of current evidence, no prior published case has documented shared psychosis transmitted solely through digital interactions, without any physical proximity. A thorough search of the scientific databases during the literature review did not yield any relevant sources that have mentioned shared psychosis through digital/virtual media.

Emerging evidence suggests that social media can contribute to the amplification of conspiracy theories, health-related anxieties, and belief reinforcement, often without critical external appraisal [7]. While these phenomena have been well-documented in the realm of mass psychogenic illness and sociogenic spread of ideas, their role in the crystallization of frank psychotic delusions in digital dyads or triads remains underexplored [8].

To the best of our knowledge, no prior case has been published that describes “folie à plusieurs” (“madness shared by several individuals”) manifesting entirely within virtual relationships. Here, we report a rare and clinically instructive series of three individuals — each residing in different cities within West Bengal — who developed a shared persecutory delusional system within the context of an online gaming guild and daily social media interactions. This report highlights the evolving nature of delusional contagion in the digital era and emphasizes the need for clinicians to remain alert to the psychiatric risks embedded in technologically mediated relationships.

CASE SERIES PRESENTATION

Patients' information

Identification and referral pathway

The index case (Case A) was the first to seek psychiatric attention at our outpatient department. During the clinical evaluation, his family disclosed that he had been part of a tightly bonded online gaming group with two other individuals — Cases B and C — whom he referred to as his "only real family". Suspecting that their son's paranoid beliefs might be digitally reinforced by his companions, the parents contacted the families of the other two individuals through phone numbers and gaming platform logs. Both families reported similar patterns of behavioral change in their sons, prompting referrals to our facility over the next 10 days.

All three individuals were male (ages 24–30), Bengali-speaking, from middle-class families in different cities of West Bengal (Kolkata and Barrackpore). They had known each other for 3 years through a shared online multiplayer gaming guild and interacted daily via encrypted chat and voice platforms. None had met in person for over two years due to the COVID-19 pandemic and financial constraints, yet they maintained close emotional ties, describing themselves as "soul allies".

Table 1 presents the characteristics of three patients with shared psychotic disorder and a brief description of the clinical events.

Shared delusional system

All three individuals subscribed to a cohesive delusional narrative involving targeted cyber-surveillance, AI-based psychological profiling (refers to the patients' delusional belief that their online activities and interactions were being systematically analyzed by external entities to predict their behaviors, intentions, or vulnerabilities), and persecution for "digital activism". They believed they were being hunted for exposing "truths" about government-backed surveillance embedded in online gaming networks.

Table 1. Summary of the cases

Item	Case A (Inducer)	Case B (Recipient 1)	Case C (Recipient 2)
Demographics	30-year-old male, unemployed computer science graduate from Kolkata	27-year-old male from Barrackpore, freelance video editor	24-year-old male from Kolkata, aspiring illustrator
Presentation	Increasing fear of surveillance, insomnia, refused to leave house, believed syndicate tracked his internet and targeted his gaming group	Destroyed home router, mute and withdrawn, feared "data taps" in electronics, emotional dependency on Case A	Felt "bugged" via electric lines, refused to speak at home, believed group conversations were used against them
Mental status examination	Well-kempt, guarded, intense persecutory delusions, partial insight (Grade 2/5), attention intact	Disheveled, ideas of reference, persecutory delusions aligning with Case A, minimal insight (Grade 1/5)	Speech soft, thought content dominated by delusions of surveillance, minimal insight (Grade 1/5)
Clinical findings	PANSS (Baseline): Positive=22, Negative=18, General=40; BPRS=62; Follow-up: PANSS=50, BPRS=38	PANSS (Baseline): Positive=24, Negative=20, General=42; BPRS=66; Follow-up: PANSS=44, BPRS=36	PANSS (Baseline): Positive=20, Negative=16, General=36; BPRS=58; Follow-up: PANSS=40, BPRS=34
Diagnostic assessment	Normal blood tests; no substance use	Computer tomography of brain, labs tests normal	Low Vitamin B12 and Vitamin D
Therapeutic interventions	Risperidone 3 mg/day, weekly CBT, family psychoeducation	Olanzapine 10 mg/day, supportive counselling, structured routine, digital abstinence	Aripiprazole 10 mg/day, family psychoeducation, boundary-setting regarding digital access
Follow-up and outcomes	Significant reduction in delusions, resumed freelance digital work, maintained improvement at 3 months	Full remission of acute symptoms, improved family communication, residual guardedness	Reduced suspiciousness, improved social functioning, ongoing psychotherapy

Note: BPRS — Brief Psychiatric Rating Scale (baseline) [9], CBT — cognitive behavioral therapy, PANNS — Positive and Negative Syndrome Scale (baseline) [10], Partial insight — patient was aware at times that his fears might be exaggerated, but still maintained firm belief in the persecution narrative; insight assessed clinically via structured clinical interview focusing on self-awareness of symptoms and beliefs [11]. Minimal insight — patient showed virtually no awareness of the abnormal nature of his beliefs despite clear contradictory evidence; assessed via structured clinical interview on self-awareness of beliefs and behaviors [11].

The beliefs were reinforced through daily voice chats and gaming roleplays, with Case A perceived as the most "informed" and directive member.

The possible inference that inducer caused dependence in recipients 2 and 3 was drawn from clinical interviews, wherein Cases B and C consistently described Case A as the authoritative source of information, emotional reassurance, and direction. Both Cases B and C reported distress and impaired functioning when unable to communicate with Case A, indicating psychological dependence.

Therapeutic intervention

All three were treated with second-generation antipsychotics and digital hygiene protocols.

1. Psychoeducation was provided to each family on the mechanisms of shared psychosis and digital enmeshment.
2. Direct communication among the three patients was restricted during the acute treatment phase to reduce the shared delusional network.
3. Cognitive behavior therapy for Case A: involved structured psychotherapeutic techniques such as cognitive restructuring, reality-testing exercises, guided questioning, thought-challenging tasks, and Socratic dialogues, aimed at modifying distorted beliefs and promoting more realistic appraisals [12, 13].

Follow-up and outcomes

At follow-up (2–3 months), all three showed functional improvement with reductions in PANSS and BPRS scores. However, Case A (inducer) demonstrated comparatively slower improvement in insight and higher residual suspicion than Cases B and C, indicating a differential course of psychosis recovery consistent with primary versus induced psychosis dynamics [1, 3].

Residual cognitive rigidity and suspicion persisted in Cases A and C, but insight had partially improved in all three.

Diagnostic assessment

The working diagnosis for all three patients was Shared psychotic disorder or "folie à trois", with persecutory delusional disorder as the primary differential diagnosis considered and ruled out due to clear evidence of delusional transmission from Case A to Cases B and C. This was based on the Diagnostic and Statistical Manual of mental disorders, fifth edition (DSM-5) [14].

Prognosis

Overall prognosis for all three patients was optimistic. While significant symptom improvement was achieved in the short term, prognosis was dependent on continued therapeutic adherence, ongoing management of digital exposure, and supportive family involvement. Residual symptoms such as cognitive rigidity and intermittent suspiciousness warranted continued psychotherapeutic intervention.

Timeline

A rough timeline showing the chronology of evaluation, treatment and response of the cases is presented in Table 2.

This figure outlines the chronological sequence of clinical events over a 12-week period in three individuals diagnosed with shared psychotic disorder. At baseline (week 0), the primary case (Case A, inducer) presented for psychiatric consultation. Within one week, Cases B and C (recipients) were referred for evaluation following similar behavioral issues. Full diagnostic assessments were completed by weeks 2–3. Therapeutic interventions including antipsychotic medication, digital abstinence

Table 2. Timeline of clinical progression, diagnostic evaluation, and therapeutic intervention in the shared psychotic disorder ("folie à trois") case series

Week	Key event
0 (Baseline)	Initial consultation with Case A (inducer)
1	Case B and C referred for treatment
2–3	Diagnostic assessments completed for all three cases
4	Treatment started for all three cases
6–8	Initial improvement in Cases B and C
10–12	Remission in Cases B and C / partial remission in Case A / functioning improved in all three cases

protocols, and family psychoeducation were initiated at week 4 for all three cases. Initial symptomatic improvement was observed in Cases B and C by weeks 6–8, with Case A showing slower but notable progress. By weeks 10–12, Cases B and C achieved remission, while Case A showed partial remission with functional improvement. This shows the synchronized trajectory of illness emergence, the effectiveness of early intervention, and the role of temporally coordinated treatment in targeting delusional symptoms via digital platforms.

DISCUSSION

Historically, SPD was considered a product of intense interpersonal bonding and sustained physical proximity, often documented among family members, close friends, or institutional cohabitants [3]. However, the digital revolution has redefined the landscape of interpersonal relationships, prompting the need to revisit established psychiatric models through the lens of virtual interactions.

In the present case series, we documented three individual who developed a tightly interlinked persecutory delusional system through prolonged virtual cohabitation — namely, their involvement in a shared online gaming group and encrypted messaging platforms. This delusional system, which centered on themes of surveillance, persecution, and ideological martyrdom, evolved entirely within the confines of digital interactions.

To our knowledge, this is one of the first documented case series from South Asia exploring shared psychotic disorder emerging from an online context among individuals who had not met physically in recent years. Similar cases documenting SPD in entirely virtual contexts have been reported globally but remain exceedingly rare for a recent systematic review and comparison [15].

Several key factors aligned with classical SPD: emotional dependency, cognitive rigidity, social isolation, and thematic coherence [2]. Case A, who functioned as the inducer, showed stronger delusional conviction, resistance to contrary evidence, and a higher PANSS score at baseline, consistent with previous literature describing the "primary case" as the more dominant and psychotically ill individual [4]. Recent studies by Incorvaia [2] and Schneider et al. [15] similarly underscore the dominance and greater psychopathology of the inducer in shared psychotic disorders. Case B and Case C showed features of suggestibility, passive belief acceptance, and psychological vulnerability — traits common among recipients in SPD [2].

The mechanism of delusional transmission in our cases challenges the traditional necessity of physical proximity. Digital platforms allowed not only for consistent contact but for the *immersion* of recipients within the inducer's narrative universe. Online gaming, in particular, fosters sustained shared attention, reward anticipation, and identity fusion — conditions conducive to group delusion formation [5, 6, 16]. The role of algorithm-driven content reinforcement on social media and chat platforms further potentiates belief confirmation and delusional crystallization [7, 8]. As Kirmayer and Gómez-Carrillo argue, technology may not just facilitate social contagion, but actively shape psychopathology itself by altering modes of attention and narrative construction [17].

Cultural context also played a vital role. The shared language, worldview, and sociopolitical beliefs of the triad enabled rapid cross-validation of delusional ideas. Bhui and Bhugra emphasize that when delusions are culturally resonant — especially in contexts of governmental mistrust or marginalization — they are more likely to be accepted without scrutiny [18]. In our group of patients, real-world examples of surveillance (e.g., Pegasus spyware debates, internet bans during political unrest) may have served as fertile ground for paranoid elaborations.

Despite of the unusual etiology, treatment followed conventional lines: antipsychotics, digital detox, boundary setting, and psychoeducation. Importantly, separating the recipients from the inducer (temporarily limiting digital contact) facilitated the dismantling of the shared delusional system, even without use of antipsychotics — a finding echoed in the literature [1, 3]. All three patients showed improvement in PANSS and BPRS scores within 2–3 months, with no rehospitalizations reported.

Recent studies [2, 14] have supported earlier findings by Ungvari & Leung [19], confirming that separation from the inducer remains a central therapeutic strategy. Recent evidence suggests that recipients can show significant symptom improvement merely through isolation from the inducer, especially if their psychosis is transient and less severe [4, 15]. However, antipsychotic medication remains standard clinical practice, particularly for severe cases, persistent symptoms, and relapse prevention — as isolation alone may be insufficient for sustained remission [20].

These findings underscore the pressing necessity for psychiatrists to integrate digital history-taking as a core part of assessments in paranoid and delusional disorders. Familiarity with the patient's online networks, digital

alliances, and virtual group identities may be just as critical as family and occupational histories [21, 22]. Methods for early detection of psychosis risk in online communities could include monitoring for rapid shifts toward paranoia, increased immersion in conspiratorial narratives, abrupt digital withdrawal from diverse interactions, and intensified emotional dependency on virtual communities [23].

Virtual interaction, while lacking physical co-location, can replicate key psychosocial ingredients necessary for delusional transmission through mechanisms such as emotional intensity, persistent exposure, and identity fusion [24]. Platforms like online gaming guilds and encrypted chat groups enable sustained shared attention, ideological reinforcement, and affective enmeshment, thereby functionally mirroring the "prolonged interpersonal closeness" classically seen in "folie à deux" and its variants [25].

In our patients, the concept of "digital cohabitation" was operationalized through nearly daily contact over years, shared rituals (gaming, strategy discussions), emotionally validating conversations, and role-based alliances — creating a persistent interpersonal environment analogous to shared physical living. As highlighted by Starcevic and Aboujaoude [25], such immersive digital environments can serve as psychological retreats, increasing vulnerability to delusional ideation.

However, online interaction alone is rarely sufficient. As highlighted in our report, additional psychosocial and intrapersonal factors likely mediate susceptibility. These include:

- real-world social isolation, as seen in all three individuals during the post-pandemic period and financial constraints;
- psychological dependency, especially of the recipients on the inducer (Cases B and C);
- cognitive rigidity and suggestibility, which contributed to belief absorption;
- pre-disposing vulnerabilities, including prior subclinical anxiety traits and lack of offline emotional supports.

These findings are consistent with broader frameworks proposed in cultural and social psychiatry, which posit that structural vulnerability, context, and affective resonance are as crucial as content transmission in psychosis formation [8, 9].

Strengths of this case series include detailed clinical descriptions, robust use of standardized psychometric tools (PANSS, BPRS), clear demonstration of digital transmission mechanisms, and the novelty of reporting SPD exclusively within digital interactions. Limitations include small sample size, absence of long-term follow-up, inability to objectively measure online interaction intensity or exposure, and lack of detailed exploration into predisposing personality and familial factors. Further, the association between the psychotic symptoms of Case A and those of Cases B and C has been inferred by the author based on clinical evidence and the timeline of psychopathology, and does have a subjective bias. Larger-scale studies are warranted to generalize these findings.

CONCLUSION

This case series highlights a novel manifestation of shared psychotic disorder in the context of digital cohabitation, underscoring that psychological proximity, rather than physical closeness, may suffice for the transmission of delusional beliefs in the modern age. Immersive virtual platforms, emotionally intense online alliances, and algorithmic echo chambers can serve as powerful amplifiers of psychotic contagion. While our cases responded well to standard antipsychotic and psychotherapeutic interventions, this phenomenon calls for an expanded clinical framework that incorporates digital relational dynamics into routine psychiatric evaluation. Future research is warranted to better understand how online communities influence the structure and content of emerging psychopathologies.

Informed consent: Written informed consent was obtained from all three patients after they had clinically improved for publication of this case series report and any accompanying anonymized clinical data or imagery (Case A — 31.03.2025, Case B — 04.04.2025, Case C — 04.04.2025). Efforts were made to protect patient identity, and no identifiable information is included in this article.

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