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When Delusions Become Shared: A Study of Folie À Deux in the Context of Paranoid Schizophrenia and Cultural Values

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Abstract
Paranoid schizophrenia is a chronic psychotic disorder characterized by delusions and hallucinations. In certain conditions, delusions can be transmitted to closely related individuals, known as folie à deux or shared psychotic disorder. This phenomenon becomes more complex when influenced by cultural and social structures. This research aims to analyze the phenomenon of induced delusion in paranoid schizophrenia and examine the role of cultural values in shaping and maintaining shared delusions. This study employed a qualitative descriptive case study approach through clinical interviews, psychiatric examinations, and evaluation of interpersonal dynamics and cultural context. The findings indicate that the primary patient experienced paranoid schizophrenia with persecutory delusions, while the secondary patient developed induced delusions due to strong emotional attachment and intense interaction. Cultural factors, including family loyalty, collectivism, and patriarchal structure, reinforced the internalization of shared beliefs. Interventions such as pharmacotherapy, psychotherapy, and patient separation were effective in reducing symptoms. Shared psychotic disorder is influenced not only by individual factors but also by social interaction and cultural context. A biopsychosocial and culturally sensitive approach is essential for accurate diagnosis and effective management.

INTRODUCTION

Chronic psychotic disorders such as schizophrenia show dysfunction in the individual's perception of reality and cognitive integrity (Javitt, 2023; Mervis et al., 2022). In certain manifestations, the sufferer exhibits erroneous beliefs that cannot be corrected by logic or conflicting evidence. When these beliefs are systematic and centered on external threats that are believed to be personal, there will be a suspicious and defensive mindset, which is characteristic of the paranoid type (Sadock et al., 2015).

An interesting phenomenon occurs when this distorted belief system is not limited to one individual, but begins to affect the closest people with whom he or she has a close emotional relationship, so that other individuals can accept and believe things that were originally only believed by one party and become a common belief. This process does not only occur because of suggestions, but is also reinforced by intensive interaction and minimal correction from the outside environment as well as the limited critical power of the individual who accepts the belief, which will open up space for the formation of an unrealistic process of internalizing beliefs by the second party. This phenomenon is known as *shared psychotic disorder* or *induced delusional disorder* (Arnone et al., 2006; Silveira & Seeman, 1995).

Shared *psychotic disorder*, also known as *folie à deux*, is a fairly rare psychotic disorder. This condition is characterized by the transmission of delusions from one individual who

experiences primary psychosis (*inducer*) to one or more other individuals (recipients) who have a very close emotional closeness or social relationship with *the inducer*. Although classified as a rare condition, induced delusions have complex clinical implications because they are often difficult to recognize directly, especially when the shared delusions are not immediately confirmed as unrealistic by the surrounding environment (Dewhurst & Todd, 1956; Kohut, 1971).

Global epidemiological data estimate the prevalence of induction infertility events <0.01% of the general population, and about 1–2.6% of inpatients in psychiatric hospitals who have the appropriate criteria. A study published in the *Open Access Macedonian Journal of Medical Sciences* in 2019 noted an increase in the reporting of induced influenza cases in Southeast Asia, including Indonesia, although systematic reporting and national data are still very limited. Some previous case reports have shown that this condition is more common in the context of nuclear family relationships, such as between parents and children or married couples, with the dominant role of older or more dominant individuals psychologically and socially, in addition to the role of strong collective norms, as well as the influence of cultural values and spirituality in daily life are also known to contribute to the increase in the incidence of induced misconduct (Arnone et al., 2006; Dewhurst & Todd, 1956; Petrović et al., 2019; Silveira & Seeman, 1995).

In Indonesia, the family system that tends to be collective and strongly structured in many local cultures, for example the Batak culture, can be a supporting factor in the occurrence of induction misogyny. Batak culture, which has strong family values and a social structure that upholds authority in the household, is an interesting example of understanding this psychosocial vulnerability. Inherent values of loyalty, gender roles, and family honor can strengthen emotional attachments that create a framework that is vulnerable to the spread of misperceptions from one family member to another, especially in partner dynamics. Situations like this show that in examining a mental disorder, it is important to consider contextual factors such as relationship dynamics, social structure and cultural value systems. The bio-psycho-social approach aims not only to understand the etiology, but also to determine appropriate intervention strategies and are sensitive to local values (Engel, 1977; Kleinman, 1988; Siahaan, 2002; Simanjuntak, 2018).

This case report provides an important overview of the complexity of induction disorders in the context of Indonesian culture, focusing on cross-cultural and contextual understanding in dealing with complex psychotic disorders as well as the challenges and strategies that can be applied in daily clinical management. This study aims to analyze the phenomenon of shared psychotic disorder (*folie à deux*) in paranoid schizophrenia, identify the interpersonal dynamics underlying delusion transmission from primary to secondary patients, examine the role of Batak cultural values (family loyalty, patriarchy, and collective norms) in shaping shared delusions, and evaluate the effectiveness of biopsychosocial interventions including pharmacotherapy, psychotherapy, and patient separation. This research is expected to provide theoretical benefits by enriching the literature on cultural psychiatry and the biopsychosocial approach in non-Western contexts, as well as practical benefits by offering culturally sensitive clinical insights for mental health professionals and contributing to the development of effective intervention strategies such as patient separation, family psychoeducation, and culturally grounded psychotherapy.

RESEARCH METHOD

Case report

A married couple, Mr. Y and Mrs. K, aged 40 and 36 years old, Muslim, living in Madiun were escorted to the Emergency Installation (IGD) of RSPAL dr. Ramelan Surabaya by the Navy on May 20, 2025. Mr. Y, the last education of high school, Javanese, currently working as a TNI, was escorted to the emergency room because he had been working unfocused and working together with his wife for the past 6 months. Patients appear to be easily tired, confused and unable to follow work directions. At the beginning of work in 2018, the patient worked as an admin in the Pontianak Navy. The patient found it difficult with the field of work he was doing at that time because it was not in accordance with his last educational background, namely in the field of mechanical engineering. Patients often feel overwhelmed by the workload they receive. As a result of the excessive workload, patients also often complain of physical conditions such as headaches, dizziness, pain all over the body and other complaints to the wife. In addition to the workload that is not in accordance with their abilities, patients also feel that they receive unpleasant treatment from the environment around the official residence. The patient felt "terror" by finding a lot of garbage in the form of leaves and flowers that seemed to be deliberately placed in front of the house for some time. The patient tried to confirm the "terror" to his friends but did not get a satisfactory answer. The patient increasingly felt uncomfortable with the working and living conditions at that time until he had the intention to leave home and leave his wife and children. In 2023, the patient was then transferred by the official to Surabaya and worked as a driver. When working as a driver, patients also often feel overwhelmed by the workload they receive. Patients are often suddenly confused and get lost on the road. This makes patients also often complain about the condition of inability to perform the work tasks undertaken, to the physical complaints felt to the wife.

According to the patient's wife, Mrs. K, who is educated at the end of S1, the Batak tribe, and daily as a housewife, said that her purpose in accompanying the patient to work for the last 3 months was because she saw the inability of her husband to work in the office, so Mrs. K intended to make her husband's work easier while keeping her husband in good health. Mrs. K admitted that since the service in Pontianak her husband often complained about work and they received repeated terror in the official house where he lived. Mrs. K was also worried about her husband's condition because he had intended to leave home, wife and children with *a wig*, because he was overwhelmed by the workload at that time. The things that Mr. Y complained about often made Mrs. K more worried, scared and often panicked. In addition, Mrs. K herself also often felt terrorized while in Pontianak, such as being followed and noticed by strangers, as well as seeing writings on trucks mocking patients or Mrs. K. Since December 2024, Mr. Y and Mrs. K have moved from place to place because they felt unsafe in their place of residence at that time. Mr. Y and Mrs. K often feel terrorized in their new home, in the form of knocks from the ceiling or wall, this makes them even more frightened and convinced that someone is trying to disturb and destroy their household. It is not uncommon for Mrs. K to hear voices from within her heart that speak to Mrs. K. These voices also often give answers when Mrs. K feels confused about something. Mr. Y and Mrs. K have not prayed for a long time, because they feel that they are not in a good enough condition to meet God. The voices in Mrs. K's heart also convinced this, because according to the voice from the heart said that as long as they

remained together with each other, it was already part of the worship itself and was enough to replace the obligation to pray, so there was no longer any need to pray.

Based on the heteromannans of Mrs. K's family, the family also acknowledges the changes that occurred with Mrs. K and Mr. Y's families. The most significant changes are more visible in Mrs. K, where Mrs. K becomes more afraid of things and often feels terrorized in her home. This fear caused Mrs. K to always be close to her husband so that she felt safe, including when her husband was working, so that most of the housework was no longer done by Mrs. K. In addition, Mrs. K also believes that their child experiences a disorder that causes children to get sick easily so that currently the child is not in school and also moves from place to place. The family also said that Mrs. K had hallucinations such as seeing something that had not been seen for the past 2 years. The family also suspected Mrs. K and Mr. Y of adhering to certain religious teachings because they had different thoughts from their previous religious backgrounds, so that in recent years they have not carried out religious obligations such as prayer.

Based on the anamnesis, physical examination and psychiatric examination of Mrs. K, the diagnosis of paranoid schizophrenia can be established. The treatment plan on Mrs. K was given a combination of typical antipsychotics, and typical *long-acting antipsychotic injections* before the patient went home. On the first day of hospitalization, the patient was given 2x5mg trifluoperazine therapy. On the second day, the patient received additional therapy, namely Haloperidol HCl 1 amp IM injection for three consecutive days and was admitted to an isolation room. On the 4th day, the patient became more cooperative so that he was transferred from the isolation room to the female inpatient room to separate the patient from the husband.

Patients' complaints gradually improve during the treatment period. Patients no longer feel overly afraid, are calmer, cooperative and can think clearly. The voices from within the heart were no longer heard. Patients begin to dare to leave the room and interact with other patients in the inpatient ward. The thought of always being close to the occasional husband is still present, but the patient is more able to divert. Patients are more able to provide opportunities for their husbands to work and not go to the office.

Meanwhile, in Mr. Y, based on the anamnesis, physical examination and psychiatric examination, the diagnosis of induction sickness (*folie à famille) can be established*. Mr. Y's therapy plan is a combination of atypical antipsychotics, anti-depressants of the SSRI group (*Selective serotonin reuptake inhibitors) and* long-acting *antipsychotic injections*. On the first day of hospitalization, patients were given sertraline 1x50mg and aripiprazole 2x5mg therapy. On the third day, additional therapy was given Olanzapine IM injection for 3 consecutive days. On the 4th day of treatment, the patient is transferred to a separate room with his wife until the hospitalization period is over. Supportive psychotherapy and psychoeducation are also carried out for patients, families and TNI officials.

After getting therapy and separation with the wife, the patient becomes more cooperative, the state is calm, fear and suspicion are reduced, the night sleeps are no complaints. Patients begin to be able to participate in activities in the treatment room such as gymnastics without always having to be with their wife, occasionally there is still a desire to be close to their wife but is more able to be transferred. Patients also feel better prepared to return to work.

RESULTS AND DISCUSSION

Mental health disorders are characterized by disturbances in thinking, emotions, perceptions, behaviors, or social relationships, which cause significant dysfunction in an individual's life. The causative factors of mental disorders are complex and multidimensional, including biological factors such as genetics, neurochemistry, psychological factors such as personality, trauma, and social factors such as social support, economic status, as well as spiritual and cultural factors. In the case of Mr. Y and Mrs. K, the patient experienced severe difficulties in assessing reality, behavioral changes and thinking disorders so that they were included in psychotic disorders (Sadock et al., 2015).

Based on Mrs. K's auto anamnesis and heteromannans, psychiatric status assessments were obtained by women according to age, full body stature, long straight hair, and sufficient self-care. Consciousness changes, less cooperative, eye contact and verbal well. Spontaneous talk, clear articulation, enough volume, enough quantity. Mood *irritable*, superficial affect, *appropriate*. In the thought process, autistic – unrealistic thought forms, loose association thought flows, and persecutory thought content. There are visual and auditory hallucinations, decreased willpower, behavioral and psychomotor within normal limits. Concentration and memory are good. Orientation of time, place and good people. Degree 1. This entire group of symptoms corresponds to the diagnostic criteria of Paranoid Schizophrenia (F20.0). The triggering factor for this patient's condition is psychosocial stress due to the events experienced by the patient and her husband while living in Pontianak. Physical examination results and vital signs within normal limits. Complete blood support tests, random blood sugar, kidney function and serum electrolytes showed normal results.

Mrs. K's multiaxial diagnosis can be described as follows, Axis I in this case is paranoid schizophrenia (F20.0) with a comparative diagnosis of sedentary disorder (F22.0) and depressive type schizophrenia (F25.1). In Axis II, the patient has paranoid personality disorder and *avoidant*. In Axis III, no other medical conditions were found. Axis IV has problems from *primary support group*, psychosocial and environmental. The V-axis of GAF patients during MRS was 30-21, namely severe disabilities in communication and value power, unable to function in almost all fields, while in the last 1-year GAF patients were 50-41, namely moderate difficulties in social functioning, work, or daily life.

Approaches to management of paranoid schizophrenia are multidisciplinary, including pharmacotherapy, psychotherapy, and psychological interventions aimed at controlling symptoms, improving function, and preventing relapse. Pharmacotherapy is the main pillar in the management of paranoid schizophrenia. Antipsychotics are the main drugs of choice, either typical (conventional) or atypical groups. At the beginning of the hospitalization, patients receive atypical antipsychotic therapy, namely trifluoperazine 2x5mg. On the second day, patients received additional therapy of *long-acting antipsychotic* injections, namely Haloperidol HCl 1 amp IM injections for three consecutive days. On the 6th day of treatment, the patient received additional therapy *of the mood stabilizer* group, namely Depakote ER 2x250mg.

Based on athanasies and heteromannans, the assessment of psychiatric status was obtained by men according to age, thin stature, long curly hair, and sufficient self-care. Consciousness changes, lack of cooperation, eye contact is easily distracted and verbal contact is limited. Spontaneous talk, clear articulation, sufficient volume, limited quantity. Hypo

thymic mood, superficial affect, *appropriate.* In the thought process, the form of non-realistic thought, the flow of thought *flight of ideas* and the content of the thought is concerning. There are no visual or auditory hallucinations, decreased willpower, behavioral and psychomotor within normal limits. Less concentration, good memory. Orientation of time, place and good people. Degree 1. Mr. Y's symptoms are in accordance with the criteria of Induced Personality Disorder (F24.0). The triggering factors for the patient's condition are psychosocial and environmental stress as well as problem factors at work at this time. Physical examination results and vital signs within normal limits. Complete blood support tests, random blood sugar, kidney function and serum electrolytes showed normal results. The results of *the Minnesota Multiphasic Personality Inventory* (MMPI) assessment show somatic clinical symptoms associated with psychological problems, clinical symptoms of excessive suspicious thoughts, clinical symptoms of excessive negative emotions, clinical symptoms of strange and unnatural psychological experiences.

Mr. Y's multiaxial diagnosis, namely, Axis I of this case is Inductive Mood Disorder (F24.0) with a comparative diagnosis of paranoid schizophrenia (F20.0) and depressive type schizophrenia (F25.1). Axis II patients with dependent personality disorder and *schizoid*. Axis III patients had no other medical disorder conditions. Axis IV contains psychosocial and environmental problems as well as problems at work. Axis V, the patient's GAF during MRS was 30-21, namely severe disability in communication and value ability, unable to function in almost all areas, while GAF in the last 1 year was 60-51, which is moderate difficulty in social functioning, work, or daily life.

Pharmacological treatment of induced sleep disorder (*folie à deux*) generally follows the therapeutic principles of psychotic disorders, with adjustments to the individual conditions of the patient, especially in the person who receives the induction (secondary patient). The first line in the pharmacological management of this disorder is antipsychotics. The choice of antipsychotic type depends on the symptom profile, response to previous treatment if there is a history of treatment, and potential side effects. On the first day of hospitalization, patients were given sertraline 1x50mg and aripiprazole 2x5mg therapy. On the third day, additional therapy was given Olanzapine IM injection for 3 consecutive days. On the 6th day of treatment, the patient is transferred to a separate room with the wife until the hospitalization period is over. Supportive psychotherapy and psychoeducation are also carried out on patients and families.

Schizophrenia is a chronic and severe psychotic disorder that affects a person's thinking, perception, emotions, and behavior. The paranoid subtype of schizophrenia is characterized by predominance of delusions and hallucinations, without severe impairment of affect, speech, or motor behavior. Paranoid schizophrenia is one of the main forms of schizophrenic disorder characterized by the appearance of systematic delusions that last for a long time, often in the form of persecution or *delusion of persecution,* as well as auditory hallucinations that support the belief system. Chasing is a form of delusion in which an individual strongly believes that he or she is being watched, followed, or about to be harmed by a certain party, even though there is no objective evidence to support this belief. For example, patients often feel convinced that they are being followed by large institutions such as intelligence, neighbors, and even their own family and will interpret various neutral events as confirmation of their beliefs (American Psychiatric Association, 2013; World Health Organization, 2022).

In the case of paranoid schizophrenia, the persecutory narrative is often very complex and rooted in the patient's mindset and perception. This belief can develop in such a way that it forms a complete and consistent belief system, and becomes central to the interpretation of the patient's daily experience so that the patient is often influenced by fear, suspicion, extreme self-defense, interpersonal tension, and sometimes aggressiveness due to the perception of constant threats. In the DSM-5 classification, schizophrenia is characterized by a minimum of two of the five main symptoms over a ≥1 month, namely delusions, hallucinations, slurred speech, very irregular or catatonic motor behavior, and negative symptoms (Arnone et al., 2006).

Neurobiologically, paranoid schizophrenia with a persecutory attitude is associated with hyperactivity of the mesolimbic dopaminergic pathway, especially in the ventral area of tegmental and *nucleus accumbent*. The dopamine hypothesis states that an excess of dopamine in this pathway increases misinterpretation of the neutral stimulus, which can lead to the formation of delusions. The dopamine imbalance in the prefrontal cortex also decreases the patient's ability to assess reality and inhibits control over delusional thoughts (Grace, 2016; Howes & Kapur, 2009).

In some cases, the infirmity of the main patient (*inducer*) can be transmitted to the person with whom he or she has a close emotional relationship (*induce*), especially if the person is psychologically weak, isolated, or highly dependent (dependent), it can also be aggravated if the *inducee* have a submissive, passive, or mild psychiatric disorder personality and if long duration of contact and limited access to external reality. This phenomenon is known as *folie à deux* (shared psyche), or more broadly called *shared psychotic disorder*. The individuals involved often live in one household, have symbiotic relationships, and rarely socialize with the outside environment. This condition suggests that psychotic structures are not only intrapsychic, but can also be formed in intense intersubjective contexts. The DSM-5 categorizes *shared psychotic disorders* as *Other Specified Schizophrenia Spectrum and Other Psychotic Disorders* (Silveira & Seeman, 1995).

According to Gralnick (1942) and Dewhurst & Todd (1956), *shared psychotic disorders* can be classified as follows:

1. *Folie imposée*: Personality is transmitted from psychotic (primary) individuals to normal (secondary) individuals. Separation from *the inducer* causes the vapor to disappear.
2. *Folie simultanée*: Two individuals with a psychotic predisposition experience the same discourse simultaneously, without the dominance of ideas from either side.
3. *Folie communiquée*: The fascism develops in the *inducee* after prolonged contact, and the fascism persists even after the relationship ends or is separated.
4. *Folie induite:* A secondary individual who has had a precursor to the soul and has experienced an increase in the content of the soul due to exposure to the soul from others (Gralnick, 1942; Tsuang & Faraone, 1990).

Unlike other psychotic disorders, induced behavior is not formed due to biological susceptibility or internal neurocognitive processes alone, but through external processes in the form of suggestions, psychological dominance, and relational dependence. The process of formation of induction attitudes shows a unique aspect of interpersonal interaction as a field of psychotic disorders. This shows that mental disorders are not just an individual problem, but

can develop in a closed micro-social system. In addition, shared discourse tends to have similar themes, especially around the perception of threats, persecution, or injustice. In many cases, it is reported that the content of delusions involving chase or greatness becomes the center of a deviant shared reality (Siahaan, 2013; Simanjuntak, 2018).

Cultural values and spirituality also contribute to the incidence of inductive disorders. In the context of Batak culture, which is known to have a patriarchal and hierarchical kinship system, the social structure normatively places men, especially husbands, in a superior position as family leaders and guardians of clan honor. However, *gender* roles in everyday practice often exhibit more flexible dynamics. Not a few Batak women show dominance in family communication, domestic decisions, and perception of reality, especially when they have a firm, vocal character, higher education level, dominant personality or extensive social experience. In such a condition, a husband who is personally experiencing psychosocial distress due to work conflicts, feelings of failure, or social isolation can become emotionally and cognitively vulnerable to his partner's suggestions (Pasaribu, 2020; Siahaan, 2013; Simanjuntak, 2018).

When a wife shows intense delusional beliefs such as feeling watched, terrorized, or being the target of certain threats, and conveys it intensely to her husband in a closed interaction space, then a husband who is vulnerable and has a strong emotional attachment to his wife can be encouraged to join in believing the narrative. This is exacerbated if the couple has a history of highly symbiotic relationships, rarely interacts with the outside social environment, and avoids reality corrections from third parties. In Batak culture, emotional attachment within the family is often reinforced by the value of loyalty and a sense of "bearing together" the family's suffering. If a husband doubts his wife's beliefs, it is a form of betrayal of the unity of the household, so that the tendency to internalize his wife's beliefs is carried out as truth, in order to maintain harmony, commitment and a sense of "one struggle" and not the result of cognitive deficits. This is in line with *the values of marsiadapari* (mutual support) which are highly upheld in Batak culture. In addition, the concept of "*malu*" (*malu do sude*) in Batak culture also has important implications. A husband who cannot maintain domestic stability or is considered to have failed to protect the family from external threats, including terror that his wife believes, can make the husband feel a loss of self-esteem. In these conditions, it is easier for him to accept his wife's beliefs as a form of responsibility, as well as a justification for the failure of social function that he feels (Siahaan, 2002).

From the aspect of spirituality, the Batak people also still have a legacy of belief in supernatural signs and hidden meanings behind daily events. Thus, delusional beliefs with symbolic or spiritual nuances such as supernatural terror, messages from writing on trucks, or consciences can be easily facilitated by the cultural framework that accepts these suprarational narratives. Thus, if the discourse experienced by the wife is framed in a spiritual or supernatural narrative, the husband as a secondary party can adopt it more easily without strong rational resistance (Koentjaraningrat, 2002; Situmorang, 2011).

The diagnosis of induced delinquency requires a comprehensive psychiatric interview and a thorough assessment of the dynamics of social relations. The diagnostic criteria for induction disorder based on the DSM-5 include (American Psychiatric Association, 2013) :

1. A person develops a discourse that has the same content or is very similar to that of other individuals who already have an established disposition.

2. Individual interpersonal relationships are close and exclusive, such as family relationships, married couples or other very close social relationships.
3. Waham in the recipient individual does not appear independently, but is the result of intense exposure to individuals who are more dominant with the previous waham.
4. The disorder did not meet the full criteria for schizophrenia or other primary psychotic disorders on the part of the recipient.
5. This condition causes clinically significant impairment in social, occupational, or other important areas.
6. The disorder is not better explained by other medical conditions or the effects of substances/drugs.

The diagnosis process of patients with a combination of paranoid schizophrenia disorder with chasing disorder and the formation of a shared delusion requires separate interviews, examination of the mental status of each individual, and analysis of interpersonal relationships that occur. In addition, anamnesis from a third party, distinguishing between primary and adopted beliefs, the time of symptom onset, and whether beliefs arise independently or secondary to interaction, are also important.

Management in primary patients follows the guidelines for schizophrenia therapy, including the use of second-generation antipsychotics as the primary option to reduce hallucinations and hallucinations, supportive and psychosocial psychotherapy by educating the family and cognitive interventions that will help improve insight and improve social functioning. This includes interventions with long-term rehabilitation to support independence and social adaptation, especially if the patient has a chronic disability (Howes & Kapur, 2009).

As for *inducee patients*, the main intervention that can be carried out is separation from *the inducer*. In some cases, psychotic symptoms in *inducees* may subside spontaneously within a short time after isolation from the primary patient. Psychotherapy and psychoeducation help to restore a sense of reality and overcome dysfunctional emotional dependence relationships, if symptoms persist after separation from antipsychotic administration can be considered. Family interventions are also important to prevent *re-exposure* and facilitate a supportive environment for inducee rehabilitation (Dewhurst & Todd, 1956; Leucht et al., 2013).

The prognosis of induction waits shows varied results. *Inducees* who have no previous mental disorders often experience spontaneous remission after separation. However, when *the inducee* has a biological or psychosocial vulnerability, the discourse can persist and develop into a full-blown psychotic disorder. Therefore, longitudinal assessments and post-acute support are essential to perform.

CONCLUSION

The case of paranoid schizophrenia with a chase attitude that develops into an induction disorder (*folie à deux*) in a married couple relationship illustrates the complexity of the interaction between biological predispositions, personality structures, interpersonal relationship dynamics, and strong cultural influences. In this context, individuals with primary deception exhibit typical psychopathological characteristics in the form of delusional belief system dominance, disordered reality functioning, and paranoid personality structures reinforced by defense mechanisms such as projection and denial. The personality structure of each individual in this couple plays an important role. Patients with primary deafness tend to

have paranoid personalities with a high need for control and excessive vigilance against external threats. In addition, induced individuals often show dependent, *suggestible* personality traits, with a tendency to submit to the reality constructed by the dominant figure in order to maintain relationships that are considered essential for their psychological stability. This interaction creates a situation in which the delusional belief system that was initially individual becomes a shared reality that is mutually believed. This mechanism also reflects an imbalance in the dominance-submission relationship that is often symbiotic and dysfunctional. In the framework of Batak culture that emphasizes patriarchy, family loyalty, social hierarchy, and respect for dominant figures in the household, are further strengthened. Cultural norms that prioritize family solidarity and obedience to the spouse can facilitate the internalization of the system of feelings, especially when the induced is in a more subordinate social or emotional position. This culture, while supporting family cohesion, can also suppress the expression of individual autonomy as well as hinder the correction of external reality. Psychodynamically, this couple describes a maladaptive dynamic of identification, in which the boundaries of the ego become blurred due to the fusion of identities in unbalanced relationships. Psychological defense mechanisms such as regression, projective identification, and idealization of the partner strengthen acceptance of the system of perception. When the individual is unable to stand autonomously against the psychological pressures of significant figures in his or her life, especially in marital relationships isolated from a supportive social environment, then irrational beliefs can also be accepted as a shared truth. Thus, this case emphasizes that a holistic approach in diagnosis and management is of great importance, which includes not only pharmacological and psychotherapeutic interventions, but also an understanding of relationship dynamics, local cultural value systems, and the personality structure of each individual in the context of close interpersonal relationships. A cross-disciplinary approach that integrates clinical psychiatry, cultural psychology, and family interventions is essential for the recovery and prevention of recurrence of these disorders later in life.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.

Arnone, D., Patel, A., Tan, G. M., & Thekkumpurath, P. (2006). The nosological significance of folie à deux: A review of the literature. *Annals of General Psychiatry, 5*(1), 11. https://doi.org/10.1186/1744-859X-5-11

Bacal, H., & Newman, K. (1990). *Theories of object relations: Bridges to self psychology*. Columbia University Press.

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.

Dewhurst, K., & Todd, J. (1956). The psychosis of association—A folie à deux. *Journal of Nervous and Mental Disease, 124*(5), 451–459.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129–136. https://doi.org/10.1126/science.847460

Freud, S. (1960). *The ego and the id* (J. Strachey, Ed.). W. W. Norton & Company.

Freud, S. (1961). *Civilization and its discontents* (J. Strachey, Trans.). W. W. Norton & Company.

Gabbard, G. O. (2014). *Psychodynamic psychiatry in clinical practice* (5th ed.). American Psychiatric Publishing.

Grace, A. A. (2016). Dysregulation of the dopamine system in the pathophysiology of schizophrenia and depression. *Nature Reviews Neuroscience*, *17*(8), 524–532. https://doi.org/10.1038/nrn.2016.57

Gralnick, A. (1942). Folie à deux: The psychosis of association. A review of 103 cases. *Psychiatric Quarterly*, *16*, 230–263.

Howes, O. D., & Kapur, S. (2009). The dopamine hypothesis of schizophrenia: Version III—The final common pathway. *Schizophrenia Bulletin*, *35*(3), 549–562. https://doi.org/10.1093/schbul/sbp006

Javitt, D. C. (2023). Cognitive impairment associated with schizophrenia: from pathophysiology to treatment. *Annual Review of Pharmacology and Toxicology*, *63*(1), 119–141.

Kaplan, H. I., Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (11th ed.). Wolters Kluwer.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. Jason Aronson.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. Free Press.

Koentjaraningrat. (2002). *Kebudayaan, mentalitas dan pembangunan*. Gramedia.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. International Universities Press.

Leucht, S., Cipriani, A., Spineli, L., Mavridis, D., Örey, D., Richter, F., Samara, M., Barbui, C., Engel, R. R., Geddes, J. R., Kissling, W., Stapf, M. P., Lässig, B., Salanti, G., & Davis, J. M. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: A multiple-treatments meta-analysis. *The Lancet*, *382*(9896), 951–962. https://doi.org/10.1016/S0140-6736(13)60733-3

Mahler, M. S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant: Symbiosis and individuation*. Basic Books.

Mervis, J. E., Vohs, J. L., & Lysaker, P. H. (2022). An update on clinical insight, cognitive insight, and introspective accuracy in schizophrenia-spectrum disorders: symptoms, cognition, and treatment. *Expert Review of Neurotherapeutics*, *22*(3), 245–255.

Oyebode, F. (2018). *Sims' symptoms in the mind: Textbook of descriptive psychopathology* (6th ed.). Elsevier.

Pasaribu, R. (2020). Perempuan dalam keluarga Batak: Posisi dan peran dalam budaya patriarkal. *Jurnal Sosiologi Reflektif*, *14*(1), 89–104.

Petrović, G., Milovanović, S. D., Ilić, N., Stojanović, J., Petrović, V., & Milovanović, D. R. (2019). Folie à deux–shared psychotic disorder: Case report and literature review. *Open Access Macedonian Journal of Medical Sciences*, *7*(6), 951–955. https://doi.org/10.3889/oamjms.2019.214

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (11th ed.). Wolters Kluwer.

Siahaan, M. (2002). Struktur sosial dan budaya masyarakat Batak Toba. *Antropologi Indonesia*, *26*(67), 15–25.

Siahaan, P. (2013). *Struktur sosial masyarakat Batak Toba*. Ombak.

Silveira, J. M., & Seeman, M. V. (1995). Shared psychotic disorder: A critical review of the literature. *Canadian Journal of Psychiatry*, *40*(7), 389–395. https://doi.org/10.1177/070674379504000705

Simanjuntak, D. K. (2018). Negotiating gender roles in Batak families: A sociological perspective. *Jurnal Antropologi Indonesia*, *42*(3), 241–255.

Simanjuntak, P. (2018). Nilai budaya patriarkal dalam keluarga Batak Toba: Implikasinya terhadap relasi gender. *Jurnal Masyarakat Budaya*, *20*(2), 223–236.

Situmorang, M. (2011). *Simbol dan mitos dalam budaya Batak*. Yayasan Obor Indonesia.

Tsuang, M. T., & Faraone, S. V. (1990). *The genetics of mood disorders*. Johns Hopkins University Press.

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. W. W. Norton & Company.

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

World Health Organization. (2022). *ICD-11 for mortality and morbidity statistics*. https://icd.who.int/