CASE REPORT

Assaulting the Psychiatrist : A Rare Case of Fregoli syndrome

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ABSTRACT

Delusional misidentifications include the Capgras delusion, Fregoli delusion, the delusion of subjective doubles and other less common symptoms. A common cause of these non-specific psychopathological symptoms is the patients' denial of their identity or the belief that their identity or the identity of relatives has been altered. These delusional symptoms occur in the context of somatic and mental diseases, most frequently in schizophrenia and dementia. Fregoli syndrome (FS) is commonly associated with aggressive behaviour. We present a case of Fregoli syndrome leading to an assault to the treating psychiatrist.

Key-words : Fregoli Syndrome, delusion, assault, psychiatrist

INTRODUCTION

Frégoli syndrome belongs to the group of delusionalmisidentification syndromes and was first described in 1927. The hallmark of Frégoli syndrome is the belief that a familiar person is disguised as a strange person, that is, the familiar person has taken on a different physical appearance but remains the same person psychologically. The delusional misidentification syndromes (DMSs) include the Capgras delusion, Fregoli syndrome, the syndrome of Intermetamorphosis, and paranoia and hostility towards misidentified objects[1,2]. The syndrome has been associated with organic cerebral dysfunction, in particular of the right hemisphere; however, most cases occur in the setting of schizophrenia.[3] In hospital settings, patients with Fregoli syndrome often misidentify members of the treatment team who work closely with the patients.[4] This misidentification may result in assaultive behavior towards the staff. Unfortunately, however, violence in Fregoli patients has been under studied. Here, we present a case in which a patient with Fregoli syndrome assaulted a psychiatrist.

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CASE HISTORY

Mr. A is a 52 year-old single male with a longstanding history of schizophrenia, paranoid type, who was brought to the emergency room after he became increasingly paranoid and made threatening comments to his neighbours. He is well known to the clinical staff in the hospital and has been hospitalized multiple times, mostly due to persecutory delusions. He was previously treated with multiple antipsychotic medications. Mr. A's medical history

includes history of hypertension and diabetes both controlled on medications, previous medical history is that of head injury 20 yrs back, he also had mild dementia with MMSE score of 21. His non contrast tomography revealed multiple lesions in the right hemisphere located mostly on frontal and parietal regions Mr. A lost his mother during the age of 5 years. He was raised by his father and suffered both physical and mental torture. During the admission interview, Mr. A presented with various delusional beliefs: for example, a attendant at the residence was trying to poison him through food, and staff were responding to commands from external voices telling them to harass him and calling him dog-face. Although he was restarted on Aripiprazole 15 mg/ day, he continued to form new delusions involving his feeling that the staff members at the hospital were against him, and that peers on the unit were putting poisons all over his body. Three weeks into his hospitalization, Mr. A's psychiatric condition continued to be unstable. One morning when the doctor came for routine round and was examining other patients Mr. A suddenly got agitated, forced his way into the examination room, and slapped the doctor on his face.

Later, upon questioning,the patient reported that he believed that his doctor was only masquerading as a doctor and that he was actually the male attendant. He said that the same attendant gave him the wrong medication another night, and that he was taking on the appearance of the doctor to further harm him. The patient was subsequently diagnosed with Fregoli syndrome. This episode of Fregoli syndrome was brief, and there were no previous reports in Mr. A's history of delusions of doubles. Due to the nature of the delusion, patients with Fregoli syndrome may present a subgroup of patients who are of particularly high risk for violence. It is therefore important that Fregoli syndrome is recognized by clinicians in order to decrease the assault risk and to ensure better patient treatment.

DISCUSSION

Fregoli syndrome was first described in 1927[1], years after Capgras and Reboul-Lachaux described the first case of look-alike impostors[5,6]. The syndrome is considered a rare neuropsychiatric condition commonly linked to schizophrenia, schizoaffective disorder, and other organic mental illnesses[7]. The frequency of violence in Fregoli syndrome is unclear. Silva has described 144 cases of patients who exhibited violence towards misidentified people; of these, only 6 had Fregoli syndrome, 86 had Capgras. The most common diagnosis was paranoid schizophrenia (59.8%)[4]. Our patient was also diagnosed with paranoid schizophrenia. Research on DMS points to lesions in both frontal lobes and/or right hemispheres. Fregoli syndrome has been commonly associated with right hemispheric lesions. Underactivity in the perirhinal cortex seems to be responsible for loss of familiarity in Capgras, whereas overactivity seems to account for hyperfamiliarity seen in the Fregoli, Intermetamorphosis, and Subjective Doubles syndromes[4]. Impaired connectivity between the right fusiform and right parahippocampal areas has also been implicated in deficits in visual memory recall, face recognition, and identification processes in these patients[7]. Mr. A exhibited several factors including schizophrenia, hypertension, mild dementia, head trauma, and diabetes—which might have had a detrimental effect on his brain, and may have resulted in Fregoli syndrome. The link between early trauma and later violence is widely known[8]. Traumatic events in Mr. A's early upbringing in the form of losing his parents at an early age and subsequent abuse by his foster father elicited feelings of mistrust in others. This mistrust was evident when Mr. A became angry at his doctor, who in his mind was a attendant masquerading as his doctor. Mr. A also has a combination of various delusions : persecutory, and misidentification. Predicting assaults by psychiatric patients is difficult, and members of clinical staff are often either the

victims or the first responders[10]. Due to the nature of the delusion, patients with Fregoli syndrome may present a subgroup of patients who are of particularly high risk for violence. It is therefore important that Fregoli syndrome is recognized by clinicians in order to decrease the assault risk and to ensure better patient treatment.

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