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Letter to the Editor

A case of Fregoli syndrome in schizophrenia

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ABSTRACT

Syndromes of delusional misidentification and reduplication are among the many neuropsychiatric conditions that affect both brain and behaviour and pose great challenges to mental health professionals. Fregoli syndrome belongs to the group of delusional misidentification syndromes with the belief that a familiar person is disguised as a strange person by taking different physical appearance but remains the same person psychologically. Though this he syndrome has been associated with organic cerebral dysfunction particularly of the right hemisphere, most cases occur in the setting of schizophrenia. Here we report a schizophrenic patient who developed Frégoli syndrome.

1. Introduction

Syndromes of delusional misidentification and delusional reduplication are among the many neuropsychiatric conditions that affect both brain and behaviour and pose challenges to mental health professionals. Fregoli syndrome belongs to the group of delusional misidentification syndromes and was first described in 1927 by Courbonand Fail (Courbon and Fail, 1927). The hallmark of Frégoli syndrome is the belief that a familiar person is disguised as a strange person, ie, the familiar person has taken on a different physical appearance but remains the same person psychologically (Ellis and Young, 1990). The syndrome has been associated with organic cerebral dysfunction, in particular of the right hemisphere (Walther et al., 2010); however, most cases occur in the setting of schizophrenia. We report the case of a patient with schizophrenia who developed Frégoli syndrome.

2. Case report

Mrs A, 43 year-old married school teacher with family history of depression in first–degree relative and with nine years continuous illness of deteriorating course was referred to our department in 2017. At the time of onset of illness in 2008, the year she got posted as teacher, she developed the belief that her colleague Mr. B had a special affection towards her. She strongly claimed that all other colleagues started gossiping about this relationship. Mr. B was married with two kids. She also believed that Mr. B is not married and the lady and children with him are his sister and sister's children. She spent an excessive amount of time on ruminating about the thoughts, and moments spent with Mr. B, that created family problems and due to this reason her husband got her transferred to another school. In the second school, she developed the belief that another colleague Mr. C, is actually Mr. B in disguise. Whenever she was contacted by Mr. C, she believed that it is Mr. B who now is disguising himself.

Interestingly, Mr. B also was transferred to the same school. Even in the physical presence of Mr. B, client believed that Mr. B and Mr. Care the same person with two different physiques but same psychological features. She also believed that Mr. B can take any physique. She said that she is in love with those figures and was irritable to those opposing her misperception both in school and family. Later she was transferred to another school, where she reported the presence of different persons with the identity of Mr. B. According to patient, Mr. B presented to her even as female disguises. She was interested in pursuing this relationship including sexual, with those different personalities, believing that they all are the same person. Her problems got worsened that even the temple priest, parents of students appeared to her as Mr. B. She strongly argued that all are the different versions of Mr.B, and are in love with her and she also loves them all. In addition to these misidentifications, she also had referential delusions and thought broadcasting. The patient was treated at several places earlier, but had poor compliance to treatment and refused further hospital visits.

Since the patient was not willing to take medicines she was hospitalised and started on risperidone 2 mg per day which was gradually increased to 8 mg per day over a period of 2 weeks. After 2 weeks treatment delusion was persisting and was not willing to continue medicines after reaching home. Hence she was given a course of 12 bilateral modified ECTs. Fourth week onwards patient started showing improvement and was discharged on fifth week with risperidone 4 mg bid and triheiphendyl 2 mg bid. Now the patient is coming for follow up regularly, continuing medicines at lower dose (risperidone 3 mg + triheiphenedyl2 mg /day) and is asymptomatic.

3. Discussion

Frégoli syndrome has been associated with some degree of objective face-processing impairment. It is caused by a breakdown of the identification process, leading to the inability to attribute uniqueness to a specific person. Over activity in cerebral cortex especially right hemisphere seems to account for hyper familiarity seen in Fregoli syndrome (Devinsky, 2009). As this case report reveals, the client had no obvious organic etiology and in addition to delusions of misidentifications, had additional significant psychopathologies that qualified her for diagnoses of schizophrenia. In the setting of schizophrenia, Fregoli syndrome may respond to antipsychotics including ECT (Christodoulou, 1977).

Fregoli syndrome creates specific disabilities in personal,

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professional and social life. As in the present case, hyper identification may not be limited to one single person only, it creates multiple ripples in social contexts. To what extent this shift in social behaviour will be paralleled by a shift of context in which this disorder occurs remains an open yet tempting question that may be answered by further reports and case studies.

Conflict of interest

None.

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