

## Case Report

# Combined Delusional Syndromes in a Patient with Schizophrenia: Erotomania, Delusional Misidentification Syndrome, Folie à Deux and Nihilistic Delusion

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## Abstract

**Background:** Delusional syndromes may appear in different psychiatric disorders as schizophrenia, dementia or other psycho-organic syndromes. While single delusional phenomena are rather common, combined syndromes of delusional symptoms rarely occur.

**Samplings and methods:** The authors present a case including different delusional misidentification syndromes and other delusional phenomena in one person suffering from schizophrenia.

**Results:** An erotomania was initially diagnosed and led to more delusional syndromes ("Wahnarbeit").

**Conclusions:** The psychopathology is discussed with special reference to socio-cultural aspects and threats to others. The diagnostic difficulties, treatment and outcome of this case are also discussed (German J Psychiatry 2010; 13 (2): 96-99).

**Keywords:** Delusional misidentification syndrome, folie à deux, erotomania, Capgras syndrome, Fregoli syndrome, schizophrenia

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## Introduction

Delusions, commonly defined as a fixed false belief, can be divided into primary (delusional disorder) and secondary symptoms. The latter often appear in patients with schizophrenia or dementia. A broad variety of delusions with multiple symptoms and syndromes exist.

Erotomania is a rare disorder which is characterized by a person holding a delusional belief of being loved by somebody else. It is also called de Clérambault's syndrome, named after the French psychiatrist de Clérambault, who published a comprehensive review paper on the subject in 1921. It has been described either as a singular syndrome without other psychiatric symptoms or occurring in association with

schizophrenia (Ellis and Mellsop, 1985) and affective disorder (Wood and Poe, 1990). A threat to others in patients with erotomania frequently appears and is an often underestimated risk factor (Menzies, 1995) which can result in stalking or bodily harm. Erotomania and different types of delusional misidentifications have been repeatedly reported in literature (e.g. Jaspers, 1973; Pande, 1981; Wright et al., 1993; Brüggemann et al., 2002).

The delusional misidentification syndromes (DSM) are characterized by misidentification delusions of others or of the self. Four main syndromes (Capgras Syndrome, Fregoli Syndrome, the syndrome of intermetamorphosis and the syndrome of subjective doubles) are differentiated. They most commonly appear in paranoid schizophrenia, Alzheimer dementia and head injuries (Edelstyn and Oyeboode, 1999). As these delusions can lead to frustration and aggres-

sive ideas or behaviour (also shown in this case report), this phenomenon is important to be recognized (Aziz et al., 2005). In Capgras syndrome, an individual has the delusion that the psychological identity but not the physiological appearance of another, is significantly transformed (Capgras and Reboul-Lachaux, 1923; Silva et al., 1990). In Fregoli syndrome the affected person believes that others can assume different physical identities while retaining their psychological identity (Courbon and Fail, 1927; Silva et al., 1990). Intermetamorphosis is characterized by the patient's conviction that a person has changed both physically and psychologically. The syndrome of subjective doubles is the delusional belief that a stranger has been altered into the patient's own self.

The induced delusional disorder (DSM-IV: "shared paranoid disorder"), also known as *folie à deux*, is a psychiatric condition characterized by the presence of similar psychotic symptoms in two or more persons. Characteristically one person suffers from a psychosis and the other, primarily a non-psychotic person is affected by the delusional content. *Folie simultanée* describes two people independently suffering from a psychosis who influence the content of each other's delusions that becomes similar as a consequence. The occurrence of induced delusional disorder is a fairly uncommon disturbance and usually members of the same family or persons closely related in another way are involved (Wehmeier et al., 2003).

The nihilistic delusion, also called Cotard's syndrome, is a psychopathological condition that mainly occurs in depressive disorders. It entails nihilistic delusions concerning the body and the nonexistence of the self as outstanding features, accompanied by hypochondriacal delusions as well as immortality (Berrios and Luque, 1995).

There are reports of combinations of some of these syndromes occurring together (Enoch and Trethowan, 1991; Wolff and McKenzie, 1994; Hanin et al., 1994; Margariti and Kontaxakis, 2006).

The case presented below illustrates the co-occurrence of several delusional syndromes. To our knowledge there are no other reports of all these syndromes appearing in one person.

## Case Report

A 22-year-old male German-speaking student of Hungarian origin was involuntarily admitted to the psychiatric hospital after he had misidentified a neighbour's daughter as the one he was convinced of having loved him for a long time.

Ten months earlier the patient had come from Hungary to Germany in order to look for a 17-year old fair-haired and blue-eyed girl, whom he had met some weeks before in his home town at a Young Christians' meeting. He imagined her being in love with him after they talked for a little while. Afterwards he wanted to search for her and marry her.

Knowing her name, her hometown and her school, he travelled to Germany in search of her with no success after several months. He loitered about for days at the alleged

school, tried to get information about the girl and searched the neighbourhood. Some days before hospitalization, he was convinced the neighbour's daughter was the one he was looking for. He harassed this family, observed their house and finally tried to bully his way into the house by threatening her father causing them to call the police. At that time he had the delusion that the girl was dead and her body was lying in the attic.

On admission he was tense, suspicious and reported his intense delusions. He felt that God controlled his thoughts and motor actions. He thought to be sane, that God would help him and that he did not need any medication. Within the first week he walked around singing Hungarian spiritual songs.

At the age of 20 the patient was hospitalized in Hungary due to psychotic behaviour for the first time. There was no family history of psychotic disorders. Clinical examination, including drug screen and syphilis serology were all normal. His condition met ICD-10 criteria for schizophrenia with symptomatic delusional syndromes. It was not possible to perform a brain computed tomography or magnetic resonance imaging to exclude organic causes for these symptoms due to noncompliance, because the patient misjudged the Department of Neuroradiology as the place where the girl's dead body was retained.

Risperidone was initially trialled but withdrawn due to a pronounced akathisia. Quetiapine was used as an alternative. Despite quetiapine being administered at a rather high dosage (900 mg/d), combined with carbamazepine to reduce the impulsive aggression and diazepam for minimizing anxiety, the delusional syndromes remained unaffected.

The patient's main delusional topic was the loss of his identity. He claimed to be someone else, to come from somewhere else and to have another social origin. For example he assumed that he had a German family instead of his Hungarian background. One day he met a 20-year old female patient with a first episode of a schizoaffective disorder, who had the delusional idea to find a "brother". As he was searching for a "family" they bonded and he assumed her family name for the next days. They walked hand in hand telling everyone that they were siblings. Frequently the patient demanded a DNA-analysis to verify his idea. The patient insisted that his parents were not his parents anymore. He often became tense and angry when someone called him by his real name.

After some weeks he perceived the girl's dead body in the immediate vicinity. He appeared to be agonised about this delusion and was looking everywhere for the body. On the day of his discharge he himself believed he would die. He was told that his father would come to take him home (indeed he came from Hungary with some other family members to pick him up), but the patient thought God would take him to heaven.

When his family arrived he initially recognized them but maintained that they had been replaced by physically identical persons. He was convinced that they had been replaced by doubles and thus he was uncertain whether to join them. Due to these delusional misidentifications it was initially not possible to convince the patient to go back to Hungary. Only the costs the family had to pay due to his stay in a German hospital convinced him to finally join them.

## Discussion

Our patient meets all criteria for Erotomania (Ellis and Mellsop, 1985). He had the delusional conviction of being loved by the German girl. The delusional belief occurred suddenly and took a chronic course for more than one year. As the delusion had its origin in an underlying mental disorder and occurred during this disorder it is a secondary erotomania, which is most common (Mullen and Pathé, 1994). According to Goldstein and Laskin (2002) there is a potential risk for violent behaviour by erotomaniac patients. In their forensic sample, 57 % of the patients were involved in violent situations (threat, persecution, rape, homicide). Most of them were male and many had a primary diagnosis of schizophrenia or a personality disorder. Another problem connected with erotomania is the manifestation of a chronic state.

The patient suffered from multiple delusional misidentification syndromes: Misjudging the neighbour's daughter for the girl in search for manifests a Fregoli Syndrome. The patient delusionally believed that the German girl could assume a different physical identity (neighbour's daughter) while retaining her psychological identity. Only few cases of a simultaneous appearance of Fregoli syndrome and erotomania (Collacott and Napier, 1991; Wright et al., 1993; Brüggemann and Garlipp, 2007) or Fregoli and Capgras Syndromes (Papageorgiou et al., 2002; Lykouras et al., 2002) or a combination of the three (Mann and Foreman, 1993) have been described. The Capgras syndrome in our patient was obvious when he misjudged his parents as being replaced by doubles. The induced delusional disorder is a phenomenon mainly occurring in a family when one member has a genuine psychotic disorder. In the present case two persons appear with a similar delusion and they reciprocally aggravated their ideas. To our knowledge this symptom has not been reported in literature, we named it "reciprocal induced delusion", a type of *folie simultanée*.

Some of the patient's main delusional topics were death, dead persons or his own dying. This phenomenon is often described as nihilistic delusion or Cotard's Syndrome. Current evidence regarding Cotard's Syndrome is based mainly on case studies and therefore no clarity can be obtained about the various aspects of this syndrome (Van den Eynde et al., 2008).

The phenomenology and progression of the current case suggest that all these delusions may have a common origin and that a general conception in a fundamental identity change, possibly also triggered by the migrational background, is the most important defining element of the course of these delusions (Silva and Leong, 1992). We assumed that the Erotomania was the original delusion and all other delusions can be seen as consecutive delusions ("Wahnarbeit").

The patient came to Germany with the intention to look for the girl he was convinced of loving him. After months of futile search he misjudged a neighbour's daughter in the sense of a Fregoli syndrome. On the psychiatric ward he finally became completely insecure of his whole identity and developed a systematised delusion with *folie simultanée*, a Capgras syndrome and nihilistic delusion. These syndromes

might also have been triggered by the foreign surroundings the patient had to adjust to. Although his German was good, he was far away from his family and his cultural background. This fact might also enhance such pronounced pathology, although there are up to now no clear scientific results pointing in this direction (Assion, 2005).

Delusional syndromes are often associated with organic brain affections (Fricchione et al., 1995). As an EEG or cranial CT could not be realized due to non-compliance of the patient an exclusion of organic causes could not be fully made.

Regarding the treatment of delusional syndromes sufficient pharmacotherapy is essential (Segal, 1989). Antipsychotics, mood stabilizers and antidepressants were used to treat DMS with variable results (Silva et al., 1996). Our patient was treated with an antipsychotic, carbamazepine and a benzodiazepine. This combination was successfully used in therapy of DMS (De Leon, 1992; Aziz et al., 2005). But probably due to a relative short observation period of six weeks our medication had no effect on the psychopathology in our patient. The primary aim of the therapy was the patient's stabilisation by organising his return to Hungary. Thereby not only the cultural aspect as a disease triggering factor but also the factor of the threat to others, especially the neighbour's daughter, was reduced.

The danger to others is one of the main problems associated with delusional misidentification syndromes as well as erotomania. Although patients with dangerous delusional misidentifications were less likely to harm people than psychotic patients without delusional misidentifications (Silva et al., 1995), our patient could not distance himself from stalking the girl and he had to be detained in a closed psychiatric ward.

To summarize this case report shows an extraordinary combination of different rare delusional syndromes and the therapeutic difficulties associated with them. The risk of becoming a threat to others has to be assessed and an effective medication dealing with the underlying mental disorder should be established, e.g. a combination of neuroleptics and mood stabilizers. Constant psychotherapeutical approaches may support the decrease of the symptomatology and other factors supporting the symptomatology – like in this case migrational aspects – should also be dealt with.

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