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CASE REPORT

Capgras Syndrome Comorbid With Paranoid Schizophrenia: A Case Report

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ABSTRACT
Capgras syndrome, Fregoli syndrome, reduplicative paramnesia, and intermetamorphosis syndrome are classified under the delusional misidentification syndromes (DMS),. The common characteristic of the delusional misidentification syndromes is individuals' identification of people, objects or events as disguised. Among these syndromes, the most common one is the Capgras syndrome. The main feature of this syndrome is a delusional belief that the closest people around the individual, such as the spouse, mother or father, are not genuine but in fact impostors. This belief can be temporary, repetitive or persistent. In some cases places, animals or objects as well as people can be misidentified. In this case report, we present a patient with Capgras syndrome comorbid with the diagnosis of paranoid schizophrenia, who displays aggressives behavior against the family members. The case is presented with the consideration that it may provide contributions to the literature as it is a rarely seen disorder, which may be overlooked in the clinical practice of psychiatry.
Keywords: Antipsychotics, capgras syndrome, delusional misidentification syndromes, delusions, paranoid schizophrenia

INTRODUCTION

The common feature of the delusional misidentification syndromes is the differentiated identification of humans, subjects or events by the patient (1). Capgras syndrome, reduplicative paramnesia, Fregoli syndrome and intermetamorphosis belong to the delusional misidentification syndromes (1). During the past 90 years, delusional misidentification syndromes (DMS), especially the Fregoli and Capgras syndromes, have posed challenges to clinical psychiatrists due to a lack of comprehensive understanding of the syndromes and a lack of effective treatment. The most common andwell-known of these dissociation and identification disorders is the Capgras syndrome (1). This syndrome was first described by Jean-Marie Joseph Capgras and Reboul-Lachaux in 1923 (2). Capgras syndrome is characterized by the delusion that a friend, spouse, parent, or another close family member has been replaced by an identical impostor (3). The main symptom is the patient having a transient, recurrent or persistent delusional belief that well-known people such as the spouse and parents are not real and are replaced by identical impostors (4). In some cases, the delusional misidentification may be towords a place, person, animal or object (4). Although the exact prevalence of the Capgras syndrome is not clear, it is reported to be up to 4% among the psychotic patients with being relatively more common in patients with paranoid schizophrenia (5).

In this case report, we a patient with Capgras syndrome who had been followed up with the diagnosis of schizophrenia and had recurrent violent behaviors against his family. We believe that this case report will contribute to the literature since the Capgras syndrome being relatively rare and its symptoms could easily be neglected in patients with schizophrenia by clinical psychiatrists.

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CASE PRESENTATION

The patint was a 34-year old male who was living in a village. He was a high-school graduate who had dropped out of the 2nd class of the Anadolu Universities Online Edication Program and had served as a swat team member in the Turkish Armed Forces. He had worked as a safety officer between 2009 and 2014. He was currently unoccupied. He was referred to the ER as a legal case by the local gendarmerie due to his homicidal action against his family. He claimed that his parents were in fact his stepparents and his real parents were replaced by them. He had the story of occasional violence against his parents. In the last few months, he withdrew from the social life, did not leave home and was living alone. Regarding his medical history, the ages of learning to walk and talk were considered normal and no labor complication history was present.

He had been under follow-up with the paranoid schizophrenia diagnosis but did not have compliance with medication. He had not been using his medication for last three months and did not present for any follow-up visits to the hospital. His medical treatment consisted of quetiapine (400 mg/day), amisulpride (400 mg/day), and clozapine (200 mg/day). The psychiatric examination was as the following; he was conscious, fully oriented, looked older than his age and avoided eye contact. The patient's speech was at the normal speed. He had a dysphoric mood and labile affect. His intelligence and cognitive functions were within normal range. He had no history of drug abuse or any chronic diseases. Regarding the thought content, in addition to his delusions related to the Capgras syndrome, he also had delusions of persecution and reference. He had associative looseness in his thought process. His insight was impaired and the reality testing skills were impaired. The results of the routine laboratory analysis, ECG, EEG and cranial MRI which were performed to exclude the possible organic etiological causes, were all normal. The physical and neurological examinations did not reveal any abnormal findings. There were no reported history of psychiatric disorders in his family. The treatment with quetiapine was initiated with the dosage being raised up to 600 mg/day gradually. In order to gain the treatment compliance and prevent the persistent exeternalization demands of the patient, paliperidone palmitate was administered via intramuscular injection 150 mg on the first day and 100 mg on the eighth day. Maintenance dose of paliperidone palmitate was recommended as 100 mg/once monthly. No side-effects were observed. The patient was cooperative during the hospitalization period and had a good relationship with other patients. In the 4th week of the hospitalization, he his delusions had partly vanished and his delusions about his parents being his stepparents had disappeared. In his follow-up exam; the patient had been using depot antipsyhotic paliperidone palmitate (100 mg/month) and quetiapine (600 mg/day) for one year and his delusions about his parents being stepparents had completely disappeared. His functionality has improved, his social relations has increased and he has started to help with the family chores.

DISCUSSION

Although Capgras syndrome is a very rare disorder, recent studies have demonstrated that its incidence is higher than the expected. 315 cases had been reported till 1987 in the literature (6). In a study performed in a psychiatry clinic, the annual prevalence of the Capgras syndrome was reported to be 2.5% (7). In a retrospective study, the annual rate of the Capgras syndrome was found to be 0.14% among patients who applied to the psychiatry service (8). Our case had been followed-up with the diagnosis of paranoid schizophrenia for 4 years. In the light of this information, it may be claimed that in some patients who had been followed-up with the diagnosis of paranoid schizophrenia, no differential diagnosis had been taken into account.

Tendency to violence and delusional disorders are more common in paranoid schizophrenia and undifferentiated psychosis compared to other psychiatric disorders (9). Violent behavior is frequently reported in the Capgras syndrome. In a forensic psychiatry study, Capgras syndrome was found to be more frequent in cases who had committed either homicide or violence-related crimes (10). It was reported that the victims of the violence were usually the family members of the perpetrators and lived in the same house with the patient (10). Crimes of violence are more frequent in male patients with the

Capgras syndrome (11). The rate of commiting crimes is significantly higher among the untreated patients of the Capgras syndrome (11). Delusions of persecution is very common in the Capgras syndrome (11). Our patient had also persecutory delusions and he had been involved in several legal incidents due to the violence he had committed against his parents. It has been reported that the violent behaviors and the recurrent criminal behavior may be prevented with an appropriate forensic psychiatric follow-up (12). Although most of the therapeutic principles are rather the same, this syndrome should be also be taken into consideration in patients who have chronic psychotic disorders. Capgras syndrome should be considered in the differential diagnosis and the awareness of the family members should be raised.

As the number of the Capgras syndrome cases being rather limited, no studies on the treatment of this syndrome is published. There is very limited data about the treatment of Capgras syndrome in the literature. In most of the reported cases, antipsychotic agents were used as the first line therapy. Depot antipsyhotics, pimozide, trifluoperazine and haloperidol were the most commonly used medications in these studies (13). As our patient did not comply with oral antipsychotics treatment, we preferred the administration of parenteral paliperidone palmitate (100 mg) and quetiapine (600 mg/day) and our treatment was able to achieve remission. During the one-year follow-up period, the patient had good compliance with the treatment and presented to the outpatient clinic by himself for his follow-up visits and was not hospitalized during this period.

Capgras syndrome is usually not represents as a single disorder. In the majority of cases, paranoid schizophrenia is comorbid. Other comorbid disoreders are schizoaffective disorder and psychotic mood disorder (1). In 25-40 % of the Capgras syndrome cases the etiology might be an organic disorder such as the endocrine disorder, brain tumors, delirium, dementia, lithium intoxication, epilepsy, hepatic encephalopathy, Parkinson's disease, nephrotic syndrome, and migraine (1). In our patient, paranoid schizophrenia accompanied the Capgras syndrome. We did not detect any abnormal findings in laboratory analyses and on the magnetic resonance imaging (MRI) of the brain. Capgras syndrome was diagnosed in our patients since there were no organic lesions to explain the etiology of the psychiatric findings.

We believe that our case report will contribute to the literature, as no specific treatment being determined for this syndrome in the literature and the symptoms of our case proceeding into the remission with the chosen treatment. In conclusion, in patients with chronic psychotic disorders, Capgras syndrome should be considered in the differential diagnosis and the importance of the psychoeducation of the family members along with the medical treatment should be noted.

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