




CASE REPORT

Serial killing in schizophrenia

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Abstract

Serial criminality, although rare, has always aroused the interest of researchers in criminology, psychiatry, psychology, and sociology. We report the case of a patient, suffering from a chronic psychotic disorder, having committed several murders over a period of 9 years, underpinned by a delirium of misidentification of Frigoli syndrome.

KEYWORDS

delusional misidentification, frigoli syndrome, homicide, psychosis, serial killer

1 | INTRODUCTION

Serial criminality, although rare, has always aroused the interest of researchers in criminology, psychiatry, psychology, and sociology. Arousing fear, revolt, incomprehension but also fascination and interest, serial killers continue to make headlines and inspire the most appalling of successful “thrillers.” Reading the clinical stories of the murderers often reveals absurd, horrific, monstrous, and incomprehensible homicides. They are often out of proportion to the avowed causes, or even without apparent motive.

Although re-offending murderers have always existed, individualizing the concept of the serial killer and developing a ubiquitous definition still poses challenges. The typology of serial killers is vast and complex. Several classifications exist with distinctive criteria often belonging to different fields. One of the most common classifications that are widely used by the Federal Bureau of Investigation is the one proposed in 1980 by Hazelwood and Douglas¹ and which differentiates between organized killers and

disorganized. “The organized killer is an egocentric, amoral and manipulative individual who methodically commits his murderous crimes,” versus “the disorganized killer is a lonely individual, experiencing feelings of rejection, committing murderous acts out of opportunity.” Bénézech² presents a dichotomy of serial killers in relation to rational and psychopathological motivations. He differentiates schematically between the psychopathic murderer and the psychotic murderer, yet this taxonomy is only indicative of the fact that some criminals fall in between.

We report, in this work, the case of a patient, suffering from a chronic psychotic disorder, having committed several murders over a period of 9 years, underpinned by a delirium of misidentification of Frigoli syndrome.

2 | OBSERVATION

A patient was involuntarily hospitalized, at the age of 34, in the forensic psychiatry department at the hospital Razi,

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Tunisia, following dismissal for dementia after having committed eleven murders, over a period of 9 years. He came from a non-consanguineous marriage. His family lived with his maternal grandparents when he was born and their socio-economic conditions were precarious. He was the second child of 4 boys and 2 girls. He left school before completing the first year of primary school. He started working at the age of 10 and has done several small jobs with professional experience marked by instability. His parents were divorced and his father remarried and had another son. The patient is single and has not done military service.

The patient was brought up by his maternal grandparents who spoiled him. They were complacent and permissive to him. The family, of rural origin, moved to the city for economic reasons. The patient was 6 years old at the time. The moving continued as a result of the father's unstable work.

Instability and violence reigned within the patient's family. The older brother was placed in an adoption center from an early age and the patient himself was violent with all the members of his family.

He described his mother as being ambivalent. She was protective, fusional, and violent at the same time. His father had a criminal record and was an alcoholic. The patient described him as being extremely violent, even sadistic.

The patient reported violence from his older brother, his mother, and especially his father. Until pre-adolescence, the patient slept in the same bed with his two parents. After the separation of the latter, the patient reports having continued to sleep on his father's side and says he noticed that the latter was hiding knives under the bed.

The patient was a very unstable, aggressive child. During his childhood, there was the notion of cruelty to animals, then, during adolescence, the notion of erotic-themed fantasies with women, men, and adolescents. He was allegedly sexually abused as a teenager. His attacker was in his 50s and was reportedly sentenced to 5 years in prison. When he was an adolescent, he went almost daily to the cinema to watch erotic films as well as horror films. Social relations were very disturbed and generally poor, with an inability to form lasting relationships, or reduced to aggressive and purely utilitarian behaviors. He assaulted all members of his family except the father, repeating each time that his father scared him very much, and that he had a terrifying and scary image of him. His female relationships were almost non-existent. He did not have any addictive behaviors, according to him.

Before his arrest for a series of murders, he was jailed twice: the first at the age of 14 in a correctional prison for a year following an act of physical violence and the second age 20 years for 8 months for attempted rape.

The patient was hospitalized in a general psychiatry department a year before his murderous act, of running away and aggression. He had, among other things, tried to put out the eye of one of his brothers and had threatened

to cut his mother's throat. The diagnosis retained was that of paranoid schizophrenia. The patient escaped from the hospital after 1 week.

He was arrested 10 years later for a series of murders for which he was deemed irresponsible, hence his admission to the forensic psychiatry department.

Regarding his criminal history, he had committed 11 murders and one attempted homicide. His first crime was at the age of 25 and the murderous activity continued over a period of 9 years. The last crime was committed during the day in front of passers-by, and was followed by an attempted homicide of the police officer who was chasing the patient to arrest him.

He had reported killing older men. The crimes were committed according to a stereotypical *modus operandi*. The weapon used was a weapon of opportunity represented by a stone with which he was beating down on the victim's heads. The murder was accompanied by an act of post-mortem emasculation on its victims by means of a knife. Indeed, he always kept this weapon on him, which gave him a feeling of power as he mentioned with a big smile. He killed his victims almost always at night or at dawn, in cemeteries or near mosques. After the emasculation of the victim, he placed the sex organs of the victims in their mouths. There was no concealment of the body, of the weapon used, or of the evidence of the crime. When the patient spoke of his crimes, anxiety was associated with it, while at the evocation of the acts of emasculation a smile appeared on his face evoking pleasure. The motive for the crimes reported by the patient was revenge; he is convinced that his victims are in fact the aggressor who allegedly abused him as a child. In the evening, he saw them again in his hallucinations making indecent proposals to him, a fury of destruction then fell on them and he attacked them the next day in their sleep and killed them. These are tramped men living in the streets. In his visual hallucinations, he also saw naked men and women, fire, crushed heads, blood, a mixture of erotic scenes, and scenes of extreme violence and horror.

He also had imperative auditory hallucinations ordering him to kill and put out his victim's eye, intrapsychic hallucinations, Quranic verses, and tales of the president were coming out of his chest, head, and stomach.

Thus, the psychiatric examination revealed a delusional paranoid syndrome, a Frigoli syndrome, a mental automatism syndrome, visual hallucinations, auditory and intra-psychic, and disorganization. The diagnosis retained was paranoid schizophrenia. The projective tests brought out in addition to the psychotic structure, the perverse dimension through the inability of the subject to consider an enjoyment without sadism or sexuality without aggressiveness. The physical examination and the paraclinical explorations did not show any organic disorder.

3 | DISCUSSION

The reported case corresponds well to a serial killer type repeating offender, having committed more than three homicides, in different places, over a period spanning many years, with no apparent motive, but often an identical criminal scenario over one particular profile of victims. All homicides committed are supported by delusional identification activity of the Fregoli illusion type.

The delusional identification syndromes (DIS) are complex psychotic phenomena that may be present in several neurological disorders essentially neurodegenerative or psychiatric such as schizophrenia, delusional disorders, bipolar disorders, and schizoaffective disorders.³

In the context of DIS, the subject identifies people, places, objects, or events poorly or doubly.^{4,5} The common theme of these syndromes being the exact resemblance to the other, the lookalike or the double.³

DISs include the syndromes of capgras, fregoli, self-identification, disorientation of places, subjective doubles, intermetamorphosis, and duplicative paramnesia.

DISs are also considered as specific factors of passage to the aggressive act and violence. Indeed, they are characterized by hostility toward poorly identified objects, which would entail a significant danger toward others.^{6,7} The prevalence of DIS is estimated at 3% in the general psychiatric population.⁸ However, some authors believe that these are under-diagnosed disorders. This is due to the absence of systematic clinical screening as well as the absence of reliable and standardized diagnostic criteria.^{3,9}

Fregoli syndrome is defined by the delusional belief that one or more familiar people, usually persecutors of the subject, change their appearance repeatedly (ie the same person performs many different disguises). The Fregoli illusion can also involve animals, inanimate objects, or even places.¹⁰ In our case, we consider that the Fregoli syndrome was the predisposing factor of passage to the aggressive act.

Little literature has examined the relationship between violence and Fregoli syndrome. These are usually case studies or retrospective descriptive studies with small populations.

Some studies have classified Fregoli syndrome as a specific risk factor for violence against the misidentified person.¹¹ Indeed, under the effect of the delusional activity, the affected subjects look at the misidentified subject with suspicion and hostility, which can contribute to growing ideas of persecution as well as an aggressive attitude within the framework of preventive self-defense.¹² Physical assault can progress to homicide.¹³

Other studies took a more global view and took into account other confounding risk factors for a violent act out. Within the framework of these studies, the authors put the question: Are the subjects suffering from Fregoli syndrome within the framework of any confused psychiatric

pathology more violent than the subjects not affected by these delusions?³ It has been shown that, apart from delusional misidentification, there are other risk factors for an aggressive act, namely: a history of physical violence,¹⁴ anger, targets of violence being close relatives, and attachment figures being significantly higher,¹⁵ the masculine gender (in 70% of cases),¹³ delusional themes of erotomania^{16,17} or jealousy,¹⁸ substance abuse,^{19,20} as well as impulsivity and dissociation.¹¹

Statistically, schizophrenia is the first etiology in which occurs Fregoli syndrome,^{21,22} and which is the case of our patient.

The literature has proposed three explanatory models of Fregoli syndrome (neurobiological, psychoanalytic, and cognitive).

Neurobiologically, it is believed that Fregoli syndrome is associated with some degree of objective impairment of facial recognition. It is caused by a fault in the identification process leading to the inability to assign an identity to a specific person. It is a hyperactivity of the cerebral cortex, in particular of the right hemisphere, which can explain the hyper-familiarity in Fregoli syndrome.²³

The psycho-analytical explanatory model of Fregoli syndrome is based on the splitting of parental figures into good and bad objects according to the theory of Mélanie Klein.²⁴ In addition, this syndrome is defined by the meeting of three instances being: the "sick" subject under the effect of delusional ideas, the alter (the third person well known to the patient), and the alias (the disguised impostor, present in a significant way in delirium).¹⁰

The cognitive explanatory model proposed that non-recognition in the context of Fregoli syndrome leads to the absence of a feeling of familiarity given the impossibility of successively integrating a person's memories accompanied by episodic experiences, thus generating delusional duplicates according to the subject's needs and motivations.²⁵

Currently, there are no specific recommendations for the treatment of DIS. A review of the literature on 84 clinical cases of DIS concluded that antipsychotics have been widely used, primarily: olanzapine, risperidone, aripiprazole, quetiapine, haloperidol, and clozapine.²⁶ The efficiency of antipsychotics remains controversial given the absence of randomized studies. Some studies have often noted the persistence of delusions despite antipsychotics.²⁷

Hypnosis has also proved its effectiveness among half of the subjects followed for Fregoli syndrome.²⁸ Some authors believe that hypnosis is used to recreate bad mirror identification, which would make it possible to keep delusional ideas at bay.²⁹

Finally, electroconvulsive therapy constitutes a particularly effective therapeutic alternative in Fregoli syndrome, mainly in the context of postpartum mood disorder.³⁰

The literature does not provide enough data concerning DIS in general and Fregoli syndrome in particular. This being explained by the absence of standardized diagnostic criteria, therefore a limited number of works on the subject³¹ and variability of definitions from one publication to another; which complicates the generalization of the results.²⁷

4 | CONCLUSION

This illustration of the serial killer emphasizes the dangerousness of delusional identification syndrome. Early identification and treatment are primordial to prevent violent behaviour.

AUTHOR CONTRIBUTIONS

GH and HBA: conceived the ideas and led the writing. NM, LB, and RF: involved in writing. RR: did the editing.

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CONFLICT OF INTEREST

All authors declare that they have no conflicts of interest to disclose.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL

An informed consent publication was obtained from the patient.

CONSENT

Published with the written consent of the patient.

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