Case Report

MY DAD IS DHONI – REPORT OF AN UNUSUAL CASE OF DELUSIONAL MISIDENTIFICATION SYNDROME

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ABSTRACT

Delusional misidentification syndromes are a group of symptoms seen in different forms in diverse neuropsychiatric conditions. Most reported cases are of adults with psychotic or organic disorders. Here we report a case of a variant of delusional misidentification syndrome in an adolescent boy with subnormal intelligence. During a manic episode, he developed a delusion that it was his father who was playing in disguise as Indian cricket team captain all these years, and also identified his sister as his wife.

Keywords: Manic episode, Capgras syndrome, intermetamorphosis

INTRODUCTION

Delusional misidentification syndromes (DMS) include delusional beliefs that the people, objects, or places around the patient change or are made to change with one another. They have in common the concept of the double.[1,2] The first described and most studied syndrome among these is the Capgras' syndrome described by Capgras and Reboul-Lauchaux in 1923. In this, the patient believes that a person, usually closely related to him, is replaced by an exact double. Other syndromes described in this category are Fregoli's syndrome, syndrome of intermetamorphosis, and the syndrome of subjective doubles.

Many cases of DMS, its atypical forms, and cases presenting with a 'mixture' of types of DMS have been described in the literature.[3] Most of the reported cases are of adults with psychotic or organic conditions. Here, we describe a case of delusional misidentification syndrome in which an adolescent in his first episode of mania held a delusion that it was his father who was playing in disguise as Indian cricket team captain all these years.

CASE REPORT

A 15 year old boy, studying in 10th standard, with history of poor academic performance and family history of alcohol

Please cite this article as: Vinuprasad VG, John TR. My dad is Dhoni – Report of an unusual case of delusional misidentification syndrome. Kerala Journal of Psychiatry 2015; 28(1):38-41.

dependence in father, was first brought to us with symptoms of decreased sleep and worries about his disagreements with his father, who had been compelling him to become the priest's assistant in the church, resulting in strained relationships.

His birth and early development were uneventful. Physical examination, including neurological examination, was normal. After detailed evaluation, he was diagnosed to have moderate depressive episode without somatic syndrome according to ICD-10 criteria, and was started on escitalopram 10 mg/day and clonazepam 0.75 mg/day. His IQ assessment revealed borderline intelligence. His depressive symptoms improved within two weeks. Immediately after that, however, his mother noticed him to be more talkative, unusually confident and playful most of the time, and riding bicycle at a higher speed.

One day during this phase, while watching cricket on television, he told his mother that all these years his dad has been playing in disguise of MS Dhoni, the captain of Indian cricket team. He substantiated this argument by pointing out that on that particular day Dhoni was not playing and his dad was at home. Repeated attempts by his mother to challenge this belief did not succeed. He also started saying that he is already married, and identified his 12-year old sister as his wife. When asked about his sister, he told that she is married and staying elsewhere. He also blamed his mother for hiding these matters from him. Nonetheless, he did not show any inappropriate behavior towards the sister.

He was brought to our OPD within one week of onset of these symptoms. During the interview, he appeared more confident and euphoric. There were no depressive symptoms. He was talking about his father in a funny way, rather than in a tensed manner. There were no abnormalities of perception.

After this evaluation, his diagnosis was changed to bipolar affective disorder, current episode mania with psychotic symptoms, according to ICD-10 criteria. Escitalopram was stopped, and he was started on sodium valproate 600 mg/day and olanzapine 10 mg/day. His symptoms slowly improved on this regime. On our last assessment, done after a month of the manic switch, he was seen to be maintaining well. When asked about his previous belief, he reported that although he was sure about it when he was ill, now he does not believe so. However, he added that there is a chance that his old belief might be true.

DISCUSSION

Though described as "syndromes" in literature, DMS denote a group of symptoms which exist in different forms in various neuropsychiatric conditions. They are most commonly associated with schizophrenia, but are also seen in organic brain diseases and bipolar disorders.[2] In a review of 260 case reports of delusional misidentification, 174 patients had a Capgras delusion (66.9%). Associated diagnoses were: schizophrenia, usually paranoid type (127/174, 73.0% of Capgras cases), dementia or other organic mental disorders (46/174, 26.4%), mood disorders (29/174, 16.7%).[5] Silva et al. have reported a series of three cases of DMS in manic episodes.[6]

In this patient, though the delusion was seen during the manic phase of bipolar disorder, he did not seem to completely give up the delusion even after the resolution of mania. This scenario might have happened due to his subnormal intelligence. Also, most reported cases are of adults, and the

symptom of delusional misidentification is rare among adolescents.[4]

Among the many classical and variant cases of DMS reported, we were unable to find a similar case where a familiar celebrity exchanged identity with a close relative. Our patient manifested delusion of intermetamorphosis syndrome, where there is delusion of exchange of identities. Besides, he also had a Capgras' like delusion because he believed that his sister had been replaced by his wife.

Most of the previously reported cases involved themes comprising a close relative or object, as in this case, where the characters are his father, sister, and favorite team's captain. A similar report is available about an adolescent girl with schizoaffective disorder who displayed Capgras syndrome, metamorphosis, reverse intermetamorphosis, misidentification of reflection, and reduplicative paramnesia.[7]

Though the neurological substrates of DMS have been extensively studied, no specific area/mechanism have been identified so far. Dysfunctional facial recognition and disconnection between right frontal and temporolimbic areas have been postulated.[8] A psychodynamic explanation that focuses on definition of identity too has been postulated as a mechanism behind the origin of DMS.[9] Being brought up by a dominant father, who demands complete submission even from an adolescent son, might have resulted in alterations in this patient's concepts of identity. Fathers' habit of alcohol consumption and resultant disrupted family environment too could have been a contributing factor.

Zanker reports that most cases of DMS are refractory to treatment with available antipsychotics.[10] This indicates that the presence of DMS is an indicator of symptom severity and unfavorable prognosis. In this patient, however, the acute symptoms remitted with olanzapine. It would be worthwhile to keep the patient in follow-up to trace the future course of his delusions.

We were unable to get neuroimaging or projective tests done in this patient due to financial reasons, and this limits our ability to make further conclusions regarding the etiology in this case. Previous reports of DMS in adolescents have not demonstrated any specific or consistent structural brain lesions though.

To conclude: DMS can present in a variety of forms in many neuropsychiatric conditions. This case report reveals that being adolescent and a diagnosis of mood disorder is no exception. Detailed clinical evaluation can reveal unusual and interesting phenomenological dimensions in these patients. Follow up of reported cases for longer duration might throw light on the course and resolution of these symptoms.

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Source of support: None *Conflict of interest:* None declared *Consent:* Informed written consent was obtained from patient's mother for reporting this case.