Editorial
Άρθρο σύνταξης

Delusional misidentifications in a procrustean bed

Psychiatriki 2018, 29:15–16

The Delusional Misidentification Syndromes (DMSs) are characterized by defective integration of the normally fused functions of perception and recognition.[1] The classical sub-types are: the syndromes of Capgras,[2] Fregoli, Intermetamorphosis (mentioned in 3) and Subjective doubles.[4] These syndromes occur in a clear sensorium and should be differentiated from the banal transient misidentifications occurring in confusional states and in mania and from the non-delusional misidentifications (e.g. prosopagnosia).

Joseph Capgras, who described the best-known sub-type, was indecisive on its pathogenesis. In his original report[2] he defined the syndrome as "agnosia of identification" produced by a conflict between affective accompaniments of sensory and mnemonic images. In his subsequent two publications, he considered the syndrome as a restitution delusion and as a psychopathological mechanism to hide incestuous desires. For more details see the chapter by J.P. Luauté in a volume on DMS.[3]

Psychodynamic approaches are, essentially, variants of the formulation that DMSs result from ambivalent feelings resolved by directing hate feelings onto an imagined double in order to retain the original intact (and thus avoid guilt). These views have been voiced by David Enoch [relevant chapter in (3)] and with variations by many other investigators reviewed by Oyebode.[5]

Regression to archaic modes of thought (like thinking in terms of doubles and dualisms) due to personality disintegration produced by psychotic illness is a fascinating hypothesis by John Todd [mentioned in (1)]. However, if this was the case, DMS should be much more frequent.

Mayer-Gross and Ackner (mentioned in 9) had observed that when there is a delusional development, depersonalization-derealization experiences tend to be included within the delusional system. Such experiences usually precede or coincide with the onset of DMS.[6] In view of this, Christodoulou[1,6] suggested that DMSs may represent delusional evolutions of depersonalization–derealization experiences. Similar mechanisms were proposed for false memories of familiarity, reduplicative paramnesia and autoscopy.

Cerebral “dysrhythmia” has also been noted in patients with DMS.[7] In view of clinical and prognostic similarities of DMS patients with patients suffering from psychotic states occurring in an epileptic setting, many of these patients have been considered as suffering from broadly speaking "epileptic" psychoses.[7] Joseph [mentioned in (6)] suggested that organic causes produce disconnection between right and left cortical areas that decode afferent sensory information. This results in the creation of a separate image in each hemisphere leading to an awareness of two, physically identical images.

Ellis and Young [mentioned in (1) and (6)] have maintained that DMS may result from defects at different stages of an information processing chain. More specifically, the Capgras Syndrome appears when the route for unconscious recognition is damaged. Similar mechanisms have been proposed for the rest of the subtypes.

Margariti and Kontaxakis[8] have considered that in DMS there is disruption of the ability to recognize identities rather than superficial appearance. Others have maintained that DMSs are multimodal neuropathologies and cannot be linked to a single cognitive defect.

Lastly, in view of the marked organic abnormalities detected in all DMS subtypes, DMSs have been linked with a great number of organic conditions [reviewed in detail by Oyebode (5)].

According to Greek mythology, Procrustes was a bandit who stretched or amputated the limbs of his guests to fit his iron bed. The DMSs do not deserve such treatment. Submitting them to the procrustean bed of uniformity should be avoided.

People develop DMS for a variety of reasons. Most subjects have right hemisphere dysfunction but not exclusively. Their condition is associated not with one but with diverse phenomena (depersonalization – derealization, prosopagnosia, false memories of familiarity, autoscopy, reduplicative paramnesia etc.) similarities with psychotic phenomena associated with epilepsy have been suggested but this refers to some patients only. Additionally, the charged emotional relationship of the patient with the misidentified person(s) is neither necessary nor sufficient.

Diagnostically speaking, many roads lead to DMS, ranging from the monosymptomatic and monothematic one (considered as *par excellence* DMS) to that associated with disorders mainly of the schizophrenic or organic spectrum. DMS can also be reached by a more "superficial" road, the one of depression, in which the delusion is secondary and often dependent on the self-depreciation ideation. Speculating on these syndromes is a fascinating journey in psychopathology but, although in most cases an organic contributor is present, yet the great diversity of conditions in the setting of which DMSs occur renders the possibility of a unifying hypothesis unlikely.

Key words: Delusional misidentification syndromes, Capgras, Frégoli, Intermetamorphosis, syndrome of subjective doubles.

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