Uludağ Üniversitesi Tıp Fakültesi Dergisi
Journal of Uludağ University Medical Faculty
50 (2) 313-315, 2024
DOI: https://doi.org/10.32708/uutfd.1478893

CASE REPORT

Capgras Syndrome Accompanying Schizophrenia: An Adolescent Case Report

Mehtap EROGLU

Ankara Bilkent City Hospital, Child and Adolescent Mental Health and Diseases Clinic Ankara, Türkiye.

ABSTRACT

In Capgras syndrome, the patient believes that the original person or objects have been replaced by identical ones (fakes). The syndrome rarely occurs in its pure form. It often accompanies psychotic illness and organic pathology. Capgras syndrome can occur in all age groups and is more common in women. In this article, the case of a 16-year-old female patient who applied to the hospital with complaints of aggression, harming her environment and wanting to have a DNA test will be presented. During her first admission examination, she was found to have Capgras delusions, and she was hospitalized and monitored in a psychiatric clinic. The patient, who was followed up with a diagnosis of early-onset psychotic disorder, was determined to be a case of CS accompanying Schizophrenia. Early-onset Schizophrenia is already a rare condition, and the onset of CS at this age is uncommon. Our case is valuable as it shows that CS, a rare condition, can also be seen in adolescence.

Keywords: Adolescent. Capgras. Schizophrenia.

Şizofreni ile Birliktelik Gösteren Capgras Sendromu: Bir Ergen Olgu Sunumu

ÖZET

Capgras sendromunda (CS), hasta orijinal kişi ya da nesnelerin tıpatıp benzerleri (sahteleri) ile yer değiştirdiğine inanır. Sendrom nadiren saf haliyle ortaya çıkar. Genellikle psikotik hastalık ve organik patolojiye eşlik eder. Capgras sendromu bütün yaş gruplarında ortaya çıkabilir ve kadınlarda görülme sıklığı daha fazladır. Bu yazıda saldırganlık, çevresine zarar verme ve DNA testi yaptırmak isteme şikayetiyle hastaneye başvuran 16 yaşında kadın hasta olgusu sunulacaktır. İlk başvuru muayenesinde Capgras sanrılarının olduğu görülmüş olup psikiyatri kliniğinde yatırılarak takip edilmiştir. Erken başlangıçlı psikotik bozukluk tanısıyla izlenen hastanın takiplerde erken başlangıçlı Şizofreni ile birliktelik gösteren CS olgusu olduğu belirlenmiştir. Erken başlangıçlı Şizofreni nadir görülen bir durumdur ve CS'nin bu yaşta başlaması da nadirdir. Olgumuz nadir görülen bir durum olan CS'nin ergenlik döneminde de görülebileceğini göstermesi açısından değerlidir.

Anahtar Kelimeler: Ergen. Capgras. Şizofreni.

Capgras syndrome (CS) is a rare disorder accompanied by persistent delusions described as part of the "Misidentification Syndrome" (MD)[1]. The main characteristic of the syndrome is the patient's temporary, repetitive, or permanent delusion that people close to them, such as their spouse, mother, or father, are not real and have been replaced by identical impostors[2]. The syndrome rarely occurs in its pure form. It is generally seen alongside various major psychiatric disorders, such as psychotic and mood disorders, and neurological disorders, such as traumatic brain injuries, epilepsy, stroke, and dementia[3]. Although a single holistic etiology has not yet been determined, biological and psychological factors are believed to have a combined effect on its possible etiopathogenesis[4].

Salvatore et al. reported that 14% of patients hospitalized with an initial episode of psychotic disorder were diagnosed with CS[3]. CS is associated with diagnoses such as brief psychotic disorder, unspecified psychotic disorder, delusional and schizoaffective disorders, Schizophrenia, bipolar I disorder, major depression with psychotic features, and most commonly schizophreniform disorder. The term 'First Psychotic Break' refers to patients who have at least one psychotic symptom not related to a general medical condition and who have not been in remission since the onset of the psychotic episode[5]. A patient diagnosed with a First Psychotic Break clinically may correspond to one of the diagnoses under the headings of "Schizophrenia and other

Date Received: May 05, 2024
Date Accepted: July 25, 2024

Dr. Mehtap EROGLU
Ankara Bilkent City Hospital,
Child and Adolescent Mental Health and Diseases Clinic
Ankara, Türkiye.
Phone: 0312 552 60 00-dahili 422516
E-mail: drmehtap.eroglu@gmail.com

Author's ORCID Information:
Mehtap EROĞLU: 0000-0002-5879-9412

psychotic disorders, 'bipolar and related disorders' and 'depression disorders, according to the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) diagnostic system[6]. Schizophrenia is a psychiatric disorder characterized by delusions, hallucinations, unorganized behavior, negative symptoms, and social dysfunction[6].

The frequency of CS is 0.17/100.000 in adolescents[7]. A literature review provides case reports describing CS and related conditions. However, there are limited data on adolescence in Turkey and the number of case reports is low. In this article, the evaluation and treatment of Capgras syndrome accompanying early-onset schizophrenia in an adolescent case is presented.

Case presentation

The 16-year-old female patient came into our outpatient with anxiety, irritability, introversion, social isolation, and decreased academic performance that had been going on for about 2-3 months. Her history shows she had not previously suffered similar complaints and had been academically and socially well-adjusted. Her family did not describe any stressor factors. Her history of development and birth were normal. She did not have any organic disorder and had no previous psychiatric admissions. Her family also did not have any psychiatric disorders. Her psychiatric examination was normal except for presenting as mildly anxious and depressed. She was diagnosed with Mixed Anxiety-Depressive Disorder and started Aripiprazole 5mg/day and Sertraline 50mg/day.

When she urgently came back into hospital after five days from her first visit, she was irritable and delusional, stating that she was a pharmacist and had a separate house. Her clinical condition was evaluated as "First Psychotic Break", and admission to the psychiatry service was recommended. The family refused admission. Outpatient medical treatment was planned with Risperidone 2 mg/day and Lorazepam 5 mg/day. However, the patient did not present to the hospital for her follow-ups. She presented to hospital forty days later with the complaint of aggression and causing damage to her surroundings. She was agitated, persecuted her family, swearing constantly, and had auditory hallucinations. She stated that her father was not her birth father, that the person there with her was not her mother and that she had been replaced, that someone else was her father and that the person who introduced himself as her father had sexually assaulted his mother. She also asked for a DNA test to be done. It was revealed that she had not been using the prescribed medical treatment. The first complaints that prompted the family to present to the psychiatry outpatient were evaluated as "Pre-Psychotic Phase," and the status with the onset of delusions was assessed as "First Psychotic Break," and the patient was admitted to the psychiatry service.

During hospitalization, the treatment was arranged with Risperidone 3 mg/day and Lorazepam 5mg/day orally, with Risperidone 25 mg/day intramuscular depot injection given every 14 days. Physical and neurological examinations were normal. EEG and MRI conducted during hospitalization were normal, and the determination of substances in the urine was negative. Routine laboratory tests (including TFT, B12, and Folate) were within normal range. Risperidone was increased to 4 mg/day as there was no change in symptoms in the clinical follow-up, but the dose was reduced to 3 mg/day due to nosebleeds. The treatment produced no changes in the content of delusional thoughts; therefore, on the tenth day of hospitalization, Olanzapine 5 mg/day was added to the treatment and the dose was increased to 15 mg/day within a week. After one week of treatment with Olanzapine 15 mg/day, the patient's irritability decreased, Capgras delusions were still present but coming up less in her speech, and she accepted that her mother was her mother, but the delusional content about her father continued. After one month of hospitalization, she was less irritable and agitated, the prominent and persistent Capgras delusional content in her thoughts had decreased. She was discharged with partial remission and was followed up closely as an outpatient. The discharge treatment was set as Olanzapine 15 mg/day and Risperidone 3 mg/day oral treatment, with Risperidone Consta 25 mg/day IM every 14 days.

The first 3-month follow-ups after discharge showed that social isolation, and shallowness of mood persisted, albeit diminished. In the following two months, her functionality gradually increased, although it did not reach the period before the disorder, and emotional participation was still insufficient. Consequently, the clinic state continued with partial recovery. The case was finally diagnosed as Schizophrenia as the symptoms still partially persisted after more than six months from the initial diagnosis, and the patient could not attain the level of functionality she had before the disorder.

The consent was obtained for publication from the patient and her family.

Discussion and Conclusion

CS rarely occurs on its own. It often accompanies a psychotic disorder but can also occur due to organic causes. Although organic factors are reportedly responsible in 25-50% of cases with CS, no organic etiology was detected in our case. Additionally, 60-75% of all MDs indeed occur alongside psychiatric disorders, and no underlying organicity is detected[8].

75% of MD cases are women. The age of onset varies between 12 and 78 years[9]. Based on these data, our case was consistent with the literature.

In treating CS, it is essential first to investigate the underlying organic etiologies. The underlying psychiatric disorder should be treated after this condition is ruled out. There are studies in the literature on olanzapine, risperidone, quetiapine, haloperidol, pimozide, trifluoperazine and depot antipsychotics[10]. Medical examinations in our case ruled out possible organic etiologies and alcohol-substance use disorder. Our case was considered a "First Psychotic Break" during the initial evaluation phase. The treatment was arranged as a single oral and depot antipsychotic (Risperidone), and when the desired efficacy was not achieved, it was rearranged as a dual antipsychotic (risperidone+ olanzapine). Eventually, the patient was diagnosed with CS accompanying Schizophrenia.

This case report determined that the patient, observed with a diagnosis of early-onset psychotic disorder, showed clinical symptoms of CS accompanying Schizophrenia. Early-onset Schizophrenia is already a rare condition, and the onset of CS at this age is uncommon[7]. Our case is valuable as it shows that CS, a rare condition, can also be seen in adolescence.

Ethics Committee Approval Information:
Since this is a case report, there is no need for ethics committee approval. Consent was obtained from the patient and the family.

Researcher Contribution Statement:
Idea and design: M.E.; Data collection and processing: M.E.; Analysis and interpretation of data: M.E.; Writing of significant parts of the article: M.E.

Support and Acknowledgement Statement:
This study did not receive any specific grant from the public, commercial, or not-for-profit funding agencies.

Conflict of Interest Statement:
The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper. None of the authors have any conflicts of interest or financial ties to disclose.

References

1. Cipriani G, Vedovello M, Ulivi M, Lucetti C, Di Fiorino A, Nuti A. Delusional misidentification syndromes and dementia: a border zone between neurology and psychiatry. *American Journal of Alzheimer's Disease & Other Dementias®.* 2013;28(7):671-78.
2. Edelstyn NM, Oyebode F, Barrett K. The delusions of Capgras and intermetamorphosis in a patient with right-hemisphere white-matter pathology. *Psychopathology.* 2001;34(6):299-304.
3. Salvatore P, Bhuvaneswar C, Tohen M, Khalsa H-MK, Maggini C, Baldessarini RJ. Capgras' syndrome in first-episode psychotic disorders. *Psychopathology.* 2014;47(4):261-69.
4. Gibson R, Lowe G, Morgan K, Henry M, De La Haye W, Irons A. Capgras syndrome presenting in an adolescent girl in the Caribbean. *West Indian Medical Journal.* 2013;62(1).
5. Breitborde NJ, Srihari VH, Woods SW. Review of the operational definition for first-episode psychosis. *Early intervention in psychiatry.* 2009;3(4):259-65.
6. Association AP. Diagnostic and statistical manual of mental disorders. *Text revision.* 2000.
7. Förstl H, Almeida OP, Owen AM, Burns A, Howard R. Psychiatric, neurological and medical aspects of misidentification syndromes: a review of 260 cases. *Psychological medicine.* 1991;21(4):905-10.
8. Devinsky O. Delusional misidentifications and duplications: right brain lesions, left brain delusions. *Neurology.* 2009;72(1):80-87.
9. Christodoulou GN. The delusional misidentification syndromes. *Bibl Psychiatr.* 1986.
10. Enoch D, Puri BK, Ball H. *Uncommon psychiatric syndromes.* Routledge; 2020.