Characteristics of dysthymia

Both patients had facial features reflecting chronic tormenting depressive disorder and the posture and gait portrayed the same mental disorder.

The symptoms of dysthymia in both cases are summarised in Table 1.

Discussion

Both our patients fulfil the key characteristics of dysthymia according to both ICD-10 and DSM-III-R descriptions and Akiskal's main clinical manifestations (Burton & Akiskal, 1990).

People with mental handicap appear to suffer from a higher incidence of psychiatric disorders than the general population. The results of recent studies of the prevalence of such disorders vary and there is a need for futher research. There is a moderate amount of literature available now on depressive disorders in mentally handicapped people and this is growing rapidly. A textbook on this topic was recently published (Dosen & Menolascino, 1990). However, there do not appear to be any publications relating to dysthymia and mental handicap. Nevertheless, as there is a prevalence rate of over 3% in the general population (Angst, 1992), we feel that there must be many cases of dysthymia among the mentally handicapped.

It is important, therefore, that early diagnosis is established and treatment with antidepressants and psychotherapy instituted. This will prevent or ameliorate the symptoms of this chronic debilitating mental disorder.

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*J. Jancar, MB, BCh, BAO, FRCPsych, DPM, *Honorary Consultant Psychiatrist, Stoke Park Hospital, Stapleton, Bristol BS16 1QU*; I. J. Gunaratne, MB, BS, MRCPsych, *Senior Registrar, Stoke Park Hospital, Stapleton, Bristol BS16 1QU*

*Correspondence

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Delusional Gross Replacement of Inanimate Objects

PURA M. CASTILLO and CAROL W. BERMAN

Three cases of a misidentification syndrome are presented. In this syndrome, which may be Capgras' or a new syndrome that we refer to as delusional gross replacement of inanimate objects, patients believe that their new possessions are replaced by inferior copies of the original objects by identified individuals. The patients believe that these individuals want to enhance themselves at the patients' expense, and feel persecuted by them.

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Capgras & Reboul-Lachaux (1923) described a 53-year-old woman who believed that her husband, children, neighbours and herself had been replaced by identical doubles as part of a plot to steal her property. The paper also mentioned the patient's belief that the prefecture building was replaced at least ten times. Nevertheless, replacement of an object (i.e. the building) has not been considered as the definition of Capgras' syndrome (Kaplan & Sadock, 1989). Hence, authors in the field expanded upon Capgras' syndrome and defined other syndromes to include objects and places being replaced (Courbon & Tusques, 1932; Enoch & Trethowan, 1979; Rastogi, 1990). This Capgras' case is the first instance

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of a syndrome that was later classified under misidentification syndromes (Christodoulou, 1976).

Pick (1903) described a 67-year-old woman with depression who asserted that there were two identical clinics in which Pick had been, and two professors of the same name (Pick) were the heads of these clinics. Pick called this syndrome 'reduplicative paramnesia', considering it a neurological phenomenon.

Courbon & Tusques (1932) described a 49-year-old woman with melancholic depression and ideas of persecution, who believed that her new coat was replaced by an inferior one. Also her young hens were changed into old ones. Coleman (1933) reported the case of a 50-year-old woman with involutional melancholia who believed that her daughter's letters were changed by facsimiles. Enoch & Trethowan (1979) cite a case of a 22-year-old schizophrenic university student who believed her watch was replaced by a clever copy by the police. Anderson (1988) described a 74-year-old man who thought that his wife and nephew had replaced more than 300 household items by identical but inferior doubles over ten years. Abed & Fewtrell (1990) described a 55-year-old woman with an acute psychotic episode who believed that some familiar household objects had been replaced by near-identical duplicates. Rastogi (1990) reported "a particularly rare variant" of Capgras' syndrome where a 57-year-old patient believed that her spectacles were replaced by an exact replica.

All three of the following cases were women aged 74–94, without previous psychiatric histories, who were referred by their specialists in internal medicine for the first time to the psychiatry clinic in the geriatrics department.

In our patients, dementia testing gave results within normal levels. This testing consisted of: Mini Mental Status (Kaplan & Sadock, 1989); complete blood counts; liver function tests; electrolytes; kidney function tests; thyroid function tests; venereal disease research laboratory test; B_{12} level; folate; rheumatoid factor; electroencephalograms; and computerised tomography (CT).

The delusions of replacements were present without hallucinations, disorientation, cognitive decline or any other significant symptoms except for paranoia.

Case reports

Case 1

B, a 94-year-old woman known to our medical clinic for 11 years, was referred to the psychiatry division with complaints of anxiety and preoccupation with her medical problems and her living conditions. She denied having any psychiatric problems before her referral. At interview she was talkative; her complaints were focused on the adult living facility where she resided. According to the patient, the administrator at her residence was changed a few months before she started having problems. B described the previous administrator as a lady of quality, in her 60s, who was full of "compassionate care". She called the new administrator, a woman in her 40s, a "social climber, full of sex appeal for men". The patient stated several times that "the new administrator has no business caring for the elderly". The initial diagnosis at this time was adjustment disorder with mixed emotional features.

Two years later B was admitted to hospital for the evaluation of dizziness and chest pain. She agreed to be admitted, and a few days after her admission and before completing the evaluation she signed out against medical advice for no apparent reason. After her discharge she went to a medical clinic voluntarily and requested to see a psychiatrist. She wanted to explain to the psychiatrist about her self-discharge. She explained to us that before going to the hospital she left her key with her best friend with special instructions not to give it to anyone. She stated that she was doing well until her friend came to visit her at the hospital and told her that the administrator of the residence was requesting B's room key from her. B felt that her friend was being harassed and that made her decide to go home and take care of her belongings since she thought that the administrator was trying to steal them.

On her return from the hospital she noticed and complained that several of her best pieces of clothing and jewellery were missing. Later she alleged that these items had been replaced by old, oversized, low-quality pieces of clothing and jewellery. At this point she was treated with a neuroleptic. She accused the administrator of being a thief and opportunist who preyed on the hospitalised elderly, scheming to steal their money or their belongings. She became compulsive about changing her locks and tried to hide her belongings, while expressing her belief that such attempts were in vain since she believed that the administrator had a master key. There were three or four changes of locks before the patient gave up and became resigned to her clothes being exchanged. This occurred after her dose of thioridazine was increased from 25 mg to 50 mg twice a day.

During the next six to nine months B came to the clinic only three or four times and was given a month's supply of medication at each visit. It was thought that she was not compliant with medication or treatment. Every visit was similar to the previous one in that the patient complained about the changes in her residence. The patient's cognitive functioning was good. CT showed cerebral atrophy normal for her age. We did not find any mood disorder. Her vision and other senses except for hearing, which was mildly decreased, were intact. No hearing aid was necessary.

She discontinued her medication but in a year's follow-up had no more delusions. Her final diagnosis was paranoid delusional disorder.

Case 2

C was a 74-year-old woman who was referred to us after she began to complain bitterly that her belongings were

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replaced by old and inexpensive ones by her neighbour. She was resistant to giving information about her psychiatric history but it was known that she had had psychosomatic complaints.

On interview C was composed and eloquent although she admitted to feelings of anger and anxiety. She denied ever experiencing feelings of this kind until her neighbour, a lady also in her 70s, moved in, with a daughter in her 50s. Since then the patient had noticed things missing from her terrace, which was divided only by a small piece of plywood from her neighbour's terrace. After that the patient noticed that several pieces of linen were missing and found old pieces of rags in her wardrobe and drawers. She stated that she later realised that these rags were the replacements for her good linen.

At the time the patient claimed that she did not know who the culprit was but she changed her locks and added extra ones. One day the patient saw the elder of her neighbours looking younger and sexier, wearing what looked like some of the patient's best sweaters. She also noted that this lady was on "very friendly" terms with the landlord. During the next few months C began to observe this closely and came to the conclusion that, although already rich, pretty, and with very good taste in clothes, she was enhancing her appearance with C's clothing. C also believed that the use of her clothes would help the neighbour attract the landlord, who was possibly allowing her to use a master key to gain entrance into C's flat. The neighbour and her daughter would loiter in the lobby downstairs so that they would know when C was entering or leaving the building. The mother or daughter would go upstairs and steal objects in her flat while the other waited downstairs. C, although angry, anxious and emotionally disturbed by these events, never thought of denouncing the neighbour to the authorities because she was afraid of losing her flat.

The diagnosis was paranoid delusional disorder. We tried treating her with thioridazine (25 mg at bedtime) but she complained of restlessness and other side-effects, took the medication only twice and then refused it. She expressed several times in therapy that she was resigned to her fate and misfortune, recounting again and again her love for "beautiful living, beautiful objects and beautiful clothing". After four or five psychotherapy sessions C never returned for treatment. The CT scan was normal for her age.

Case 3

D, a 78-year-old woman, was referred to us after she complained to a community agency about a young female neighbour. D felt that the neighbour was persecuting her and spreading rumours about her reputation in order to get easier access to her flat. The neighbour had replaced her beautiful gauze and silk dresses with rags. The patient said she was afraid to look in her wardrobe after an outing because she knew good clothing would have been replaced by rags.

She was treated with small doses of haloperidol but seemed to comply poorly with medication and after 18 months complained of agitation and feeling harassed by the same neighbour who had moved away six months previously but who, D believed, was still spreading rumours and exchanging D's gauze and silk clothes for rags. She did not think any items had been removed but her fear of theft or replacement of her clothes was so strong that she was afraid to leave her flat. A social worker found that her wardrobe was indeed full of rags and her whole flat in shambles but at this point the patient stopped medication and attendance at the clinic.

Discussion

These three patients believed that their new, high-quality goods were replaced by inferior copies of the articles by individuals by whom they felt persecuted. The motive appeared to be enhancement of these individuals at the patients' expense. We contend that this condition presents as a syndrome with distinctive characteristics coexisting with paranoid disorders.

Various authors have described the replacement of objects by their doubles as Capgras' syndrome, Frégoli syndrome (where the patient recognises different people as a single person), intermetamorphosis (where the patient thinks that an individual has been transformed both psychologically and physically into another person) or reduplicative paramnesia (Courbon & Fail, 1927; Anderson, 1988). We suggest that the gross replacement of objects by inferior copies without the replacement of people or places (Coleman, 1933; Abed & Fewtrell, 1990; Rastogi, 1990) may be a distinct category. The new category, which we would like to call delusional gross replacement of inanimate objects syndrome, would expand and clarify nosology and allow clinicians and researchers to differentiate these syndromes.

In reduplicative paramnesia (Pick, 1903), the patient believes that a place or a person has been duplicated. Duplication means the patient sees an identical double but there is no replacement of the place or person.

In the descriptions of Coleman (1933), Rastogi (1990) and Abed & Fewtrell (1990) there are replacements of objects which are not necessarily inferior, without replacements of people or places. The patients of Courbon & Tusques (1932) and Anderson (1988) believed in the gross replacement of objects with inferior ones but they also include replacement of people. Our syndrome deals with replacement of objects without either duplication or identical replacement, or replacement of people. Therefore, the syndrome is distinct from both delusional misidentification of inanimate objects and from reduplicative paramnesia.

It seems there is a spectrum of replacement, from people and objects being exactly duplicated, like Capgras' syndrome, through to objects being duplicated by exact replicas without people being

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involved, or replacement with grossly inferior copies like our cases.

It is interesting to note that in all three cases these patients are living alone and suffering from a paranoid disorder. B, C and D all became concerned with another woman replacing their superior clothing and articles with inferior objects. The culprits all use the patients' clothing to attract men. Here we have Oedipal triangles of B, the administrator and "men", or C, her neighbour and the landlord; or D, her neighbour and the neighbour's boyfriend. The other women are seen as seductive and the men are attracted to them and not to the patients. B, C and D are all losing the men as well as their belongings to "the other woman". These rival women may have triggered paranoid reactions.

Another psychoanalytical explanation may be that these patients are defending against loss. Their beautiful clothing and jewellery are replaced by rags. In a way this is symbolic of how they have grown old.

Alternatively, perhaps they are splitting the good and the bad object (Berson, 1983) and viewing their good objects in an idealised form that would be unable to age and turn into rags. The rags must be bad objects that have no relationship to the good objects. Therefore, good beautiful objects do not disintegrate but rather they are magically replaced by rags. Capgras' syndrome has been explained by this splitting.

Misidentification syndromes have also been associated with organic conditions (McCallum, 1986). However, we ruled out organic factors in our patients.

If considered only variants of Capgras' syndrome, all the aspects of our cases are not fully explained. For example, a person by whom the patient feels persecuted and who has a motive to enhance herself at the patients' expense does not occur in Capgras' syndrome. Also there is no replacement of people in any of our three cases. Thus, we believe that this syndrome is representative of the misidentification syndromes although we have not been able to determine into which category it falls.

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Pura M. Castillo, MD; *Carol W. Berman, MD, *Department of Psychiatry, New York University Medical Center, 550 First Avenue, New York, NY 10016, USA*

*Correspondence: *866 United Nations Plaza, Suite 473, New York, NY 10017, USA*

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