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CASE REPORT



## A misidentification ritual in a patient with obsessive-compulsive disorder: clinical and pharmacotherapeutic implications

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### ABSTRACT

Misidentification of self, others, places, time, and objects occurs in a large number of medical or psychiatric conditions. Misidentification syndromes have been rarely reported in patients with primary non-psychotic conditions. The subjects with obsessive-compulsive disorder (OCD) may present unusual and rare symptoms. In this case report, we present an OCD patient who exhibited a misidentification ritual to decrease his anxiety arising from horrific images of someone assaulting his wife and children. He substituted the face of assailant with the faces of three different previously known individuals. For this case, we supposed that this ritual was related to an autogenous obsession and also was associated with schizotypal personality traits. To our knowledge, this is the first case exhibiting misidentification rituals related to non-delusional violent images in a patient with OCD.

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### KEYWORDS

Obsessive-compulsive disorder; delusional misidentification syndrome; autogenous obsessions; schizotypal traits

Misidentification of self, others, places, time, and objects have been reported in several medical or psychiatric conditions [1]. Misidentification syndromes are currently often understood as cognitive disorders of either the “sense of uniqueness” [2] or the recognition of People [3].

Delusional misidentification syndromes (DMS) are a group of phenomena including Fregoli and Capgras syndromes, the syndrome of intermetamorphosis, the delusion of subjective doubles, and reduplicative paramnesia. In all of these, the patients misidentify or reduplicate familiar individuals, objects, places, or events supposing that they have been replaced or transformed [4,5]. DMS were diagnosed mainly in patients with paranoid schizophrenia [6], or mood disorders [7]. They can also result from epilepsy, cerebrovascular accident, head injury, brain tumours [8–10], neurodegenerative diseases such as Alzheimer’s disease [11–13] or Lewy body dementia [14], multiple sclerosis [15], Parkinson’s disease [16], metabolic [7] and infectious diseases [17].

Obsessive-Compulsive Disorder (OCD) is characterized by repetitive and intrusive thoughts, images, and impulses (obsessions) and repetitive acts (compulsions) that cause significant distress and impairment. OCD commonly includes themes of contamination, doubts, urges, images, fear of harming others, religious, or sexual obsessions. In response to these obsessions, patients may act a variety of compulsions or neutralizing responses, such as washing, checking, arranging, counting, and orderliness as

well as avoidance of situations that provoke the obsessions [18]. Since OCD included multiple symptoms, there has been a great effort in identifying more homogeneous subtypes [19]. Obsessions are also associated with various forms of neutralizations, which may lead to different clinical manifestations of OCD. Autogenous obsessions are quite aversive and unrealistic thoughts, images, or impulses that are perceived as threatening towards self or others include sexual, aggressive, and immoral thoughts or impulses. They are usually perceived as ego-dystonic and unacceptable, and associated with efforts to remove or control the thoughts. In contrast, reactive obsessions are perceived as relatively realistic and cause specific actions aimed at preventing their negative consequences and include intrusive thoughts about contamination, mistakes, accidents, and asymmetry. Lee et al. [12] reported that autogenous obsessions would be more highly associated with schizotypal personality features such as magical thinking and unusual perceptions. Misidentification syndromes have been rarely reported in patients with non-psychotic conditions [20,21]. In this paper, we presented a patient who exhibited a misidentification ritual during the course of OCD. We noted that the patient developed his mental ritual in the form of misidentification to decrease his anxiety arising from horrific images of someone assaulting his wife and children. He substituted the face of assailant with the faces of three different previously known individuals consecutively.

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## Case presentation

The patient was a 33-year-old, married man admitted in psychiatry ward suffering from substitution of some unfamiliar faces who seemed to be dangerous for his wife and children, with consecutively three different previously known person faces. He stated that when he met a foreigner, he intrusively imagined that this individual would harm his children, and would rape his wife. Unless he did not substitute his face with another three well-known and loved faces, he would not decrease his anxiety. He stated that these mental rituals continued throughout the day, even when he was alone. He recognized that these obsessions and compulsions were aversive, irrational, and unacceptable.

His first obsessive-compulsive symptoms emerged when he was eight years old with ordering/symmetry obsessions and compulsions. He reported that he put his school materials on his desk always in the same order. He also exhibited touching rituals. He was concerned about her parents' safety and had to touch objects many times to forget these unwanted thoughts. Five years later, he began to substitute the faces of subjects he thought as harmful, with three previously known people. During his adolescence, he started to take out the trash to neutralize his ordering obsessions. At 20 years old, he was administered a treatment of fluoxetine, sertraline, and quetiapine with a diagnosis of OCD. He described a full remission for the next eight years. Three years ago, he again started to take out the trash to decrease his ordering obsessions. He was prescribed 60 mg/day of fluoxetine and 100 mg/day of sertraline. When he discontinued his drugs six months later, the misidentification rituals emerged as well as an exacerbation of ordering/symmetry obsessions and compulsions. Since he thought that a coworker in his workplace would assault his wife and children, he began to substitute this man's face with the faces of three well-known and loved individuals in order to expel these intrusive and irrational thoughts.

By psychiatric interview, the patient had current obsessive fears related to a person in his workplace who would assault his wife and children, and mental rituals in the form of misidentification. He substituted this man's face with the faces of three well-known and loved individuals in order to neutralize or reassure himself concerning his unwanted thoughts. At this interview, a Diagnostic and Statistical Manual of Mental Disorders, 5th Edition [22] (DSM-5; APA, 2013) diagnosis of OCD was confirmed. His current mental examination revealed no delusions and hallucinations. He had no family or personal history of tic disorder, and comorbid diagnoses of other psychiatric disorders. His brain magnetic scan, EEG, and biochemical tests were unremarkable.

His pretreatment total Yale-Brown Obsessive Compulsive Scale [23] score was "38" or "severe symptoms," "18" points for Obsessions "16" points for Compulsions. OCD symptom clusters identified intrusive violent images, ordering/symmetry obsessions and compulsions, and mental misidentification rituals. In the past, he had ordering/symmetry obsessions and compulsions, and touching rituals. Our patient tended to have schizotypal personality traits with a total score of 32 in Turkish version [24] of the Schizotypal Personality Questionnaire [25].

Our patient had early onset multiple obsessions and compulsions. He had a high pretreatment score of Y-BOCS. He reported some prominent schizotypy traits which might be related to autogenous obsessions. Previous studies reported a good response to low-dose antipsychotic agents when added to selective serotonin reuptake inhibitors in OCD patients with schizotypal traits [26]. For these clinical reasons, we decided to administer a combination of antidepressants and low-dose of antipsychotic agents to our patient. He was started 75 mg/day of clomipramine, 100 mg/day of sertraline, 5 mg/day of aripiprazole, and 2 mg/day of haloperidol. Twelve weeks later, his Y-BOCS total score decreased to 12. Although we planned to add cognitive-behavioural therapy to his ongoing drug treatment, the patient could not participate in the treatment protocol because of personal reasons. His OCD remained stable and no metabolic or neurological side effects were observed during follow-up period. He already does not have any affective or psychotic symptoms since then. The patient was on a regular follow-up schedule for six months, and his condition remained stable, with the same treatment regimen.

## Discussion

The presentation of OCD is sometimes unusual and can mimic other disorders. Previously, it was reported that a 35-year-old married woman with OCD had doubts about whether her husband, her parents, her cat, and even the city that she lived in had been replaced by identical-appearing duplicates [27]. Here we presented an OCD patient exhibiting misidentification rituals related to a horrifying and threatening obsession. Our case repeatedly misidentified persons and places in order to expel and thus to control his aversive, fearful, and unacceptable obsessions. As suggested in some of the previous studies [28,29], our case also reported that feared consequences would occur if he did not perform his compulsions. Thus, we considered his obsessions as autogenous, since the patient perceived them as ego-dystonic and unacceptable, and misidentification ritual occurred to remove or control the intrusive thoughts. Our case would be interesting to present his misidentification ritual as a

symptom in OCD. We supposed that misidentification ritual might be related to an autogenous obsession and therefore might be associated with schizotypal personality traits.

Several studies have examined the beliefs in relation to OCD symptom dimensions. Forbidden thoughts were associated with the over importance and need to control thoughts [30–33]. Some patients with OCD interpret normal intrusive thoughts as indicative of harm or danger and feel responsible for preventing harm to themselves or others. Therefore, they would engage in compulsions to prevent harm that would temporarily decrease his anxiety [30]. Our patient repeatedly misidentified persons and places in order to expel and thus control his unwanted thoughts. The association between forbidden thoughts and misidentification rituals in our case report might represent an example of an overlap between responsibility and threat in OCD patients. Cognitive models propose that subjects with OCD acknowledge the occurrence and content of their obsessions as significant and meaningful, on the basis of particular dysfunctional beliefs [34–36]. The Obsessive-Compulsive Cognitions Working Group [34] originally defined that false beliefs regarding inflated responsibility, perfectionism and certainty, and importance/control of thoughts are effective in developing OCD. An OCD patient requires compulsive behaviours to eliminate the anxiety caused by obsessive thoughts because of extreme perfectionism and exaggerated responsibility. Calamari et al. [37] identified 5 symptom-based clusters in a sample of 106 OCD patients: (a) harming, (b) hoarding, (c) contamination, (d) certainty, and (e) obsessionals. They reported that their certainty subgroup displayed great certainty regarding many issues, sometimes to prevent harmful outcomes. In addition to the harming, contamination, hoarding, and symmetry clusters which were described by previous authors [19,38], Abramowitz et al. [39] reported that mental rituals were also included in this cluster. The patients in this group tended to use mental and checking rituals to neutralize or reassure themselves concerning their unwanted thoughts. According to this model, our patient used misidentification as a mental ritual to decrease his anxiety caused by unacceptable thought.

In summary, we presented a case with OCD who exhibited a misidentification ritual related to harm and sexual obsessions. Clinicians should be aware of any interesting and different obsessive-compulsive symptoms which might be related to schizotypal traits in OCD. Future studies should be performed to identify the rates and symptom dimensions of misidentification phenomenon in OCD.

### Disclosure statement

No potential conflict of interest was reported by the authors.

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### References

- [1] Nagaratnam N, Irving J, Kalouche H. Misidentification in patients with dementia. *Arch Gerontol Geriatr*. 2003;37:195–202.
- [2] Margariti MM, Kontaxakis VP. Approaching delusional misidentification syndromes as a disorder of the sense of uniqueness. *Psychopathology*. 2006;39:261–268.
- [3] Ellis HD, Lewis MB. Capgras delusion: a window on face recognition. *Trends Cogn Sci*. 2001;5:149–156.
- [4] Abed RT, Fewtrell WD. Delusional misidentification of familiar inanimate objects. A rare variant of Capgras syndrome. *Br J Psychiatr*. 1990;157:915–917.
- [5] Feinberg TE, Roane DM. Anosognosia, completion and confabulation: the neutral personal dichotomy. *Neurocase*. 1997;3:73–85.
- [6] Odom-White A, de Leon J, Stanilla J, et al. Misidentification syndromes in schizophrenia: case reviews with implications for classification and prevalence. *Aust N Z J Psychiatr*. 1995;29:63–68.
- [7] Christodoulou GN, Margariti M, Kontaxakis VP, et al. The delusional misidentification syndromes: strange, fascinating, and instructive. *Curr Psychiatr Rep*. 2009;11:185–189.
- [8] Fleminger S, Burns A. The delusional misidentification syndromes in patients with and without evidence of organic cerebral disorder: a structured review of case reports. *Biol Psychiatr*. 1993;33:22–32.
- [9] Horikawa H, Monji A, Sasaki M, et al. Different SPECT findings before and after Capgras' syndrome in interictal psychosis. *Epilepsy Behav*. 2006;9:189–192.
- [10] Collins MN, Hawthorne ME, Gribbin N, et al. Capgras' syndrome with organic disorders. *Postgrad Med J*. 1990;66:1064–1067.
- [11] Assal F, Mendez MF. Intermetamorphosis in a patient with Alzheimer's disease. *J Neuropsychiatr Clin Neurosci*. 2003;15:246–247.
- [12] Lee H-J, Cogle JR, Telch MJ. Thought–action fusion and its relationship to schizotypy and OCD symptoms. *Behav Res Ther*. 2003;43:29–41.
- [13] Josephs KA. Capgras syndrome and its relationship to neurodegenerative disease. *Arch Neurol*. 2007;64:1762–1766.
- [14] Marantz AG, Verghese J. Capgras' syndrome in dementia with Lewy bodies. *J Geriatr Psychiatr Neurol*. 2002;15:239–241.
- [15] Sharma A, Garuba M, Egbert M. Capgras syndrome in a patient with multiple sclerosis: a case report. *Prim Care Companion J Clin Psychiatr*. 2009;11:274.
- [16] Roane DM, Rogers JD, Robinson JH, et al. Delusional misidentification in association with Parkinsonism. *J Neuropsychiatr Clin Neurosci*. 1998;10:194–198.
- [17] Crichton P, Lewis S. Delusional misidentification, AIDS and the right hemisphere. *Br J Psychiatr*. 1990;157:608–610.
- [18] Rachman S. A cognitive theory of obsessions. *Behav Res Ther*. 1997;35:793–802.
- [19] Leckman JF, Grice DE, Boardman J, et al. Symptoms of obsessive-compulsive disorder. *Am J Psychiatr*. 1997;154:911–917.
- [20] Shafran R. Cognitive-behavioral models of OCD. In: Abramowitz JS, Houts AC, editors. *Concepts and*

- controversies in obsessive-compulsive disorder. New York (NY): Springer; 2005. p. 229–260.
- [21] Taylor S. Cognition in obsessive compulsive disorder: an overview. In: Frost RO, Steketee G, editors. *Cognitive approaches to obsessions and compulsions: theory, assessment, and treatment*. Oxford: Elsevier; 2002. p. 1–12.
  - [22] American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington (VA): American Psychiatric Association; 2013.
  - [23] Goodman WK, Price LH, Rasmussen SA, et al. The Yale-Brown Obsessive Compulsive Scale. I. Development, use, and reliability. *Arch Gen Psychiatr*. 1989;46:1006–1011.
  - [24] Sener A, Bora E, Isik T, et al. The reliability and validity of Schizotypal Personality Questionnaire (SPQ) in Turkish students. *Bull Clin Psychopharmacol*. 2006;16:84–92.
  - [25] Raine A. The SPQ: A scale for the assessment of schizotypal personality based on DSM-III-R criteria. *Schizophr Bull*. 1991;17:555–564.
  - [26] Bogetto F, Bellino S, Vaschetto P, et al. Olanzapine augmentation of fluvoxamine refractory obsessive-compulsive disorder (OCD): a 12-week open trial. *Psychiatr Res*. 2000;96:91–98.
  - [27] Stein RM, Lipper S. An obsessional variant of Capgras symptom: a case report. *Bull Menninger Clin*. 1988;52:52–57.
  - [28] Foa EB, Goldstein AJ. Continuous exposure and complete response prevention in the treatment of obsessive-compulsive neurosis. *Behav Ther*. 1978;9:821–829.
  - [29] Lelliott PT, Noshirvani HF, Başoğlu M. Obsessive-compulsive beliefs and treatment outcome. *Psychol Med*. 1988;18:697–702.
  - [30] Tolin DF, Brady RE, Hannan S. Obsessional beliefs and symptoms of obsessive-compulsive disorder in a clinical sample. *J Psychopathol Behav Assess*. 2008;30:31–42.
  - [31] Tolin DF, Woods CM, Abramowitz JS. Relationship between obsessive beliefs and obsessive-compulsive symptoms. *Cogn Ther & Res*. 2003;27:657–669.
  - [32] Wheaton MG, Abramowitz JS, Berman NC, et al. The relationship between obsessive beliefs and symptom dimensions in obsessive-compulsive disorder. *Behav Res Ther*. 2010;48:949–954.
  - [33] Julien D, O'Connor KP, Aardema F, et al. The specificity of belief domains in obsessive-compulsive symptom subtypes. *Pers Individ Dif*. 2006;41:1205–1216.
  - [34] Obsessive Compulsive Cognitions Working Group. Cognitive assessment of obsessive-compulsive disorder. *Behav Res Ther*. 1997;35:667–681.
  - [35] Salkovskis PM. Obsessional-compulsive problems: a cognitive-behavioural analysis. *Behav Res Ther*. 1985;23:571–583.
  - [36] Salkovskis PM. Cognitive-behavioural factors and the persistence of intrusive thoughts in obsessional problems. *Behav Res Ther*. 1989;27:677–682.
  - [37] Calamari JE, Wiegartz PS, Janeck AS. Obsessive-compulsive disorder subgroups: a symptom-based clustering approach. *Behav Res Ther*. 1999;37:113–125.
  - [38] Baer L. Factor analysis of symptom subtypes of obsessive compulsive disorder and their relation to personality and tic disorders. *J Clin Psychiatr*. 1994;55 Suppl:18–23.
  - [39] Abramowitz JS, Franklin ME, Schwartz SA, et al. Symptom presentation and outcome of cognitive-behavioral therapy for obsessive-compulsive disorder. *J Consult Clin Psychol*. 2003;71:1049–1057.