

## CASE REPORT

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### A Case Study of Spousal Homicide and Delusional Misidentification Syndromes

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**ABSTRACT:** We present the first published case of spousal homicide caused by delusional misidentification syndromes (DMS). The patient's subsequent twenty year history of progressive DMS, and its various clinical manifestations, is discussed. Both organic and psychodynamic factors were pathogenetically involved, and are understood in the context of four psychodynamic themes and certain violence risk factors.

#### KEYWORDS:

The continuing increase of homicides in the United States is well documented. According to Federal Bureau of Investigation figures [1], the national homicide rate increased 23% from 1987 to 1991. At least half of the homicides in 1991 were committed by someone related to or acquainted with the victim. According to Silverman and Mukherjee [2] who studied intimate homicides, most homicides can be characterized as a "social event" between victim and offender. Gillis [3] proposed that even in the most loving relationships the potential for hatred, anger and violence, even homicide, may be present. When these dormant, potentially aggressive emotions become activated in a psychotic individual who has lost his ability to grasp consensual reality, the risk of violence likely increases and overrides some other predictive factors [4]. Swanson et al. [5] recently found a small but significant relationship between a diagnosis of any mental disorder and self-reported violence in a large epidemiological study.

One such group of mental disorders, delusional misidentification syndromes (DMS), are fixed and false beliefs held by a patient regarding the existence of identical doubles of oneself and/or significant others. Christodoulou [6] divided DMS into four basic sub-

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types. First, *Capgras syndrome*, the original misidentification syndrome [7], involves a belief that a familiar person, usually someone emotionally close to the patient, has been replaced by a physically similar double or imposter. Second, *Fregoli syndrome* is characterized by a stranger identified as a familiar person [8,9]; although physical characteristics are different, the patient believes the psychological identity is a known person. Third, in *intermetamorphosis syndrome*, a patient believes both physical and psychological identity of another person have changed into someone else entirely [10,11]. And fourth, *subjective doubles* is the delusional belief that a stranger has been physically, but not psychologically, transformed into the patient's own self [12]. Although other misidentification syndromes have been identified [13-16], they can be conceptualized as variants of these four subtypes [6]. Despite clinical literature on delusional misidentification syndromes, there is no reference to them anywhere in the DSM-III-R, including the category that would be most appropriate, namely Psychotic Disorder Not Otherwise Specified.

Patients suffering delusions of doubles<sup>3</sup> are most often diagnosed with paranoid schizophrenia, schizoaffective disorder, major affective disorder with psychotic features and/or organic brain (mental) disorders [6,13,17,18]. Christodoulou [6] stressed the presence of paranoia for "without this paranoid component, nondelusional misidentifications are simply misidentifications—neurological rather than psychiatric" (p. 65). Berson [17] identified psychodynamic factors such as pathological splitting of internalized object relations which, when combined with psychosis, paranoia, and a precipitant, may predispose a delusional misidentification syndrome. Misidentification delusions which lead to violence have also been investigated. Silva et al. [19] reported a series of eight patients who suffered from DMS in which the misidentified persons included prominent political figures. DePauw and Szulecka [20] reported four case studies of physical violence associated with misidentified delusions. Driscoll et al. [21] described two cases of violence in a mania-induced misidentification delusion, one of which involved a man who attempted to kill his wife by strangulation and multiple stabbings. Several other authors [22-25] reported case studies in which misidentification delusions precipitated violence.

We present the case of a patient with delusional misidentification syndromes who was found not guilty by reason of insanity for stabbing his wife to death. In our review of the literature and according to Silva<sup>4</sup> this is the first published case study of misidentification syndromes and spousal homicide.

### Case Study

Mr. A was a 54-year-old Hispanic male born and raised in his native land by his mother, maternal aunt, uncle, and grandmother. His father was in the armed forces and absent during much of the patient's younger years. Mr. A's childhood was marked by loneliness and frequent beatings by all caregivers. He performed poorly in school and repeated several grades. At age 13 he and his mother joined his father in the United States. He dropped out of high school at age 19. At age 25 he enlisted in the Army and served a brief tour of duty in Vietnam in a noncombatant role. He fell in love with a Vietnamese woman and went AWOL in search of her. After being apprehended, he was court-martialed and reduced in rank. Subsequently he suffered a severe depression that led to a suicide attempt by shooting himself in the stomach with a .45 semi-automatic

<sup>3</sup>These disorders do not involve auditory or visual hallucinations of the self as another person, such as would be evident in autoscopy, a rare psychotic disorder.

<sup>4</sup>Silva, J. A., Personal Correspondence, March 11, 1992.

pistol. As a result, he spent four months in a military psychiatric hospital where he was treated with chlorpromazine and eventually given a 60% disability pension.

Upon his return home Mr. A completed high school, learned a trade and found employment at a large construction business. He developed a "common law" relationship with "Maria," and lived with her several years. He was often brutal to this woman, locking her inside the apartment with a padlock while he was working, and beating her when he was intoxicated with alcohol. During their relationship she bore four children, all of whom he denied fathering though reports indicate otherwise. He continued to receive chlorpromazine through outpatient services at the Veteran's Administration.

At age 35 he eventually married another woman, "Nina," whom he had known as a child. Their relationship was rekindled when they met while she was visiting the area. Mr. A planned to visit her one month later at her home in St. Louis, where she worked as a teacher. He later called and asked her to marry him, though his parents may have helped arrange the union. Mr. A and his mother flew to St. Louis, but she was not present at the civil marriage ceremony. Nina stayed in St. Louis two months before moving to the west coast. During that time Mr. A sent her letters actually authored by his father. When she arrived from the mid-west, she and Mr. A lived with his parents briefly before moving into an apartment financed by his mother. Two weeks after they lived together he began to believe they were not actually married, in part because of his incorrect middle initial on one of the marriage certificates. He wanted to remarry in a Roman Catholic Church and became suspicious of Nina's real identity when she refused. He began to believe she had tricked him, and that she and his father were having sexual relations. He was involuntarily hospitalized after becoming verbally aggressive toward his family, physically violent, and threatening to kill his father whom he accused of having illicit sexual relations with his wife. He was discharged against medical advice three days later.

Nina requested an evaluation of Mr. A's mental health by the court system and was informed that the marriage should be annulled due to his psychiatric instability. Mr. A had discontinued treatment at the VA clinic and remained noncompliant with his medication.

On the morning of the killing, five months after the wedding, Mr. A and his wife consulted an attorney regarding annulment of their marriage since Mr. A continued to insist it was invalid. He began to believe his wife was an imposter and therefore, he should not be married to her. When they returned home, his mother and aunt arrived at the apartment. Mr. A later stated that "she (mother) talked to me like a kid—and made me nervous." His mother, worried about Nina's safety, contacted the apartment manager who then called and informed the police that Mr. A was holding his wife hostage and had threatened to kill her with a knife should any uniformed officers come on the premises. The manager let two plainclothes policemen and two uniformed policemen into the apartment with the master key. Mr. A had seen the officers through the window. When they entered, Mr. A ran from the kitchen to the bedroom and closed the door with what appeared to be a knife in his hand. They heard a scream and opened the bedroom door to find Mr. A and his wife struggling on the floor, both with stab wounds. The apparent weapon used was a 10 inch stainless steel chef's knife with a six inch blade and a wooden handle.

When questioned by police immediately after the stabbing, Nina stated, "He didn't mean to hurt me. He's afraid someone was going to get him." She was taken by ambulance to a local hospital emergency operating room where, upon arrival, she was conscious and communicative, though part of her intestine was protruding from the wound. During exploratory laparotomy, findings of a lacerated infrarenal inferior vena cava, a through-and-through laceration of the pancreas, a laceration of the mesenteric colon, and a massive hemoperitoneum were observed. She was hypotensive throughout

the surgical procedure. Blood volume loss was partially controlled by administration of four pints of A positive blood. Following the surgical procedure at the time of closure of the wound, bradycardia became evident. She then entered into cardiac arrest. Resuscitative measures were attempted for approximately 30 minutes without success. She was subsequently pronounced dead.

Mr. A reported that when he heard the police knock he "got scared" and "didn't know what was going on." He stabbed his wife then tried to kill himself by stabbing himself in the abdomen and wrist. He sustained a one-half in. wound in the upper abdomen, and a 1 in. laceration on the middle finger on the inside of the left hand between the knuckle and the first joint. Mr. A also underwent laparotomy due to a severed mesenteric artery and punctured colon and small intestine. While in the hospital recovering he was unable to give a clear account of the instant offense. He appeared paranoid in thinking others were looking at him, talking about him and laughing at him in a derogatory fashion. He maintained numerous bizarre delusions surrounding the circumstances of his marriage and tended to misidentify his dead wife. He repeatedly referred to her as "the girl," claiming that his wife was not dead and that he would not believe it until he saw her body.

Mr. A was psychiatrically hospitalized for approximately 10 days following his release from the medical hospital. Psychiatrists believed there was a "possibility" of a well established delusional system. Results of the WAIS given Mr. A at this time indicated a full scale IQ of 61, although various clinicians over the years estimated his IQ as borderline mentally retarded (70 to 79). The Rorschach test interpretation suggested a personality disorder, explosive type. The staff psychiatrist deferred a diagnosis, but stated the additional diagnosis of schizophrenia, paranoid type, needed to be ruled out. He subsequently was diagnosed with paranoid schizophrenia.

Mr. A spent several months at state forensic hospitals as incompetent to stand trial. He was treated with haloperidol, trifluoperazine, and benztropine. He was eventually found not guilty by reason of insanity of one count of first degree murder. He remained at a state maximum security forensic hospital for more than 15 years. He was released to outpatient status on two separate occasions, but required revocation and re-hospitalization secondary to dangerousness and legal problems. Mr. A was discharged from the state hospital for a third time. He received psychiatric and psychosocial services as a condition of release into the community [26]. In addition to weekly individual and group therapy, Mr. A received fluphenazine decanoate 3.25 cc every two weeks.

Mr. A refused to cooperate with psychological and neurological testing. While incarcerated he experienced what may have been a seizure; he apparently lost consciousness and was found sitting on the floor. An EEG performed shortly thereafter was abnormal. He refused other followup diagnostic procedures. It was suggested that borderline intellectual functioning with abnormal EEG could indicate cortical structural defects that exacerbated his emotional instability.

Psychiatric evaluations over nearly 20 years indicated a progressively more complex and well documented account of Mr. A's various misidentification syndromes. Prior to the homicide he believed his wife was an imposter. The following year he reported that the victim was not his wife, that she was not dead but actually married to another man. Five years later, Mr. A reported that his mother was an imposter, a "clone." After another five years he identified two Hispanic women unknown to him, as his wife or impersonating his wife. He believed they were taking advantage of him. Then three years later, he elaborated the misidentified characteristics of his wife. The woman he killed was actually younger and shorter than his wife. After admission to the outpatient program, Mr. A's delusional beliefs, particularly his various DMS were well monitored. He maintained that both his parents, whom he referred to as "stepparents," sister, and brother were imposters. They "went away" while he was in Vietnam. He continued to believe

unfamiliar women he encountered were either his wife or his ex-girlfriend. He accused outpatient staff of being extended family members. In addition to his DMS beliefs, Mr. A had numerous other fixed and transitory delusional beliefs. He required intense supervision in the community, and his delusional beliefs were constantly explored for the possibility of new and potentially dangerous delusional thoughts.

## Discussion

Mr. A's initial delusional misidentification syndrome progressed to a broader delusional belief system involving several DMS and incorporating many familiar and unfamiliar people. Some of his misidentification delusions also changed subtypes. The presence of multiple and progressive delusions is not unique. Christodoulou [6] stated that subtypes often co-exist as in Capgras' [7] original article. Mr. A exhibited Capgras syndrome at the time of the instant offense. Although his wife's physical characteristics remained constant, her psychological identity changed. He believed that his wife had married another man and he was living with an imposter. A Capgras variety delusion can also be attributed to Mr. A identifying his mother as a "clone" six years later. Physical attributes remained while psychological characteristics changed. With the next reported misidentification, that is, the two Hispanic women he mistook for his wife, we see the introduction of Fregoli Syndrome, which broadened his DMS. He believed these unfamiliar women had the psychological identity of his wife. With his family members, he again held the Capgras variety of DMS. However, he also began to distinguish various physical characteristics of his mother, specifically that her skin was lighter, she no longer had moles that he remembers, and she was shorter in stature in his delusional beliefs. This change from purely psychological differentiation to emphasis on physical differences suggested intermetamorphosis syndrome. He apparently made similar alterations in the delusional belief of his dead wife, namely that the woman he killed was shorter, heavier, younger, and of a different ethnic background than his wife, which again illustrates an intermetamorphosis DMS. Mr. A exhibited three of the four primary subtypes of DMS. Table 1 illustrates the chronology of DMS in Mr. A.

Christodoulou [6] discussed ten pathogenic hypotheses regarding DMS and concluded that explanatory attempts can be reduced to either organic or psychodynamic. Neither fully explain DMS and the genesis is probably a combination of organic and psychodynamic factors. Berson [17] added that the selectivity of the delusions, that is the patient's belief that only some people in his environment are impostors, provides additional evidence that organic factors alone are inadequate. In our case, we primarily focus on psychodynamic issues since data concerning organic etiology is sparse due to Mr. A's uncooperativeness.

TABLE 1—Chronology of DMS in patient A.

Time	Object of delusion	Syndrome
At homicide	Wife	Capgras
+ 6 years	Mother	Capgras
+ 11 years	Hispanic women	Fregoli
+ 12 years	Wife	Intermetamorphosis
+ 15 years	Family members	Capgras
+ 16 years	Mother	Intermetamorphosis
+ 17 years	Clinicians	Fregoli, Intermetamorphosis

*Organic Factors*

Organic factors contributing to DMS have received numerous clinical and laboratory investigation. Christodoulou [6] noted that a variety of psychiatric experiences, such as depersonalization or derealization, false memories of familiarity, reduplicative paramnesia, and autoscopy, can be attributed to cerebral dysfunction. However, a strong paranoid factor is necessary for these experiences to develop into DMS. Joseph [13] found that modern brain scanning techniques in addition to abnormal electroencephalography (EEG) have revealed consistently similar findings indicative of organic cerebral dysfunction in DMS patients. Christodoulou [27] also found similarities between patients suffering from DMS and those suffering from epileptic psychosis. He proposed that these patient groups often share marked EEG abnormalities and, therefore, may both be suffering from "epileptic" psychosis. This should be treated as a very tentative hypothesis since EEG abnormalities may, or may not, manifest in a variety of psychotic symptoms. Mr. A's abnormal EEG was consistent, however, with Christodoulou's theory linking psychosis and epilepsy.

*Psychodynamic Factors*

Berson [17] emphasized four psychodynamic themes to explain DMS: unresolved oedipal issues, affective issues focused primarily on feelings of strangeness, attempted resolution of feelings of ambivalence, and pathological splitting of object representations. We will discuss the patient in light of each of these constructs.

*Oedipal and Pre-Oedipal Conflicts*—Evidence for this construct is found in several areas, including Mr. A's many expressed homosexual fears. In his outpatient living situation he reported that male residents had sex with him during the night without his consent and without awakening him. He also recalled similar experiences at the hospital. When he moved to a single room these articulated fears diminished and his general anxiety level decreased. These psychotic homosexual fears may be rooted in early actual submissive experiences to a same sex aggressive object during the initial phases of separation-individuation. The patient's history suggested such early abuse [28].

Mr. A's reported "nervous" reaction to his mother talking to him like a child the day of the homicide may have been symbiotic anxiety [29]. The stabbing would then be a displaced violent reaction against the regressive pull, and consequent anxiety, to return to a symbiosis with the maternal object.

Prior to the instant offense Mr. A believed his father had a sexual relationship with his wife, and therefore, came to see his wife as a maternal object. Mr. A wanted to defeat his father for sole possession of the mother figure, as he actually had as a child when his father was overseas. The arrival of the police at the door of the apartment may have stimulated unconscious fantasies of the father figure arriving to punish the son, an Oedipal triangulation just prior to the killing.

*Affective Responses and Feelings of Strangeness*—This construct suggests that a patient attributes his own changed feelings toward significant others to actual changes in the other. Christodoulou [6] and Berson [17] both address this issue, yet differ in their opinions on the central question of perceptual defects. Berson [17] believed that DMS should be seen as problems in beliefs, and need to be differentiated from defects of perception or memory. Christodoulou [6] believed perceptual defects were primary in development of DMS, particularly experiences of depersonalization and derealization, which he proposed may be identical to feelings of strangeness. More theoretical and empirical work needs to be done on the general demarcation between unusual affective and perceptual experiences. During outpatient treatment Mr. A's affective response to

those he identified as doubles was neutral. He expressed no strong negative or positive emotion toward the imposters.

*Ambivalence*—Berson [7] suggested that DMS, in particular Capgras syndrome, may be a psychotic solution to problems of ambivalence. Ambivalence, by definition, means that two opposing views, or feeling states, are held simultaneously by the individual. We do not think that the patient developmentally reached this level of personality, since, after years of clinical work, he remained unable to express mixed feelings toward significant persons at the same time.

*Internal Splitting of Objects*—Misidentification delusions become psychotic defenses against internalized objects and their negative affects. They prevent split off feelings from entering awareness. For example, on the morning of the crime, Mr. A was angry at his mother because she “talked to me like a kid—and made me nervous.” His anger was then displaced onto his wife. He believed that his wife was like his mother in that she was having sexual relations with his father. His wife was also an imposter, not whom she said she was, which again is a psychotic defense against object relatedness. In another example, Mr. A attributed his parents “going away” to his experience of being in Vietnam. His anger at them for their lack of support, as well as the stress of this wartime experience, precipitated a defensive delusion of Capgras type. We think that his vocalized delusional beliefs regarding his outpatient treatment staff, particularly the program manager whom he misidentified as his uncle, suggested that he saw himself in a similar relationship, namely that the staff “beat him up” by opposing his release from the state hospital for several years, and his fear that he would again be “beaten up” by the staff and returned to the hospital. He repeated expressed fears of being revoked.

#### *Spousal Homicide and DMS*

We draw on the Silva et al. [21] psychodynamic explanation to better understand the connection between DMS and violence. An individual first develops unrestrained anger toward an object. He finds this anger overwhelming and uses denial, an ego defense, to rid himself of it. Eventually this defense proves inadequate and the unacceptable anger threatens to re-enter consciousness. The individual then uses splitting, another ego defense, to protect the good object from being destroyed or harmed by his anger. The disowned anger is then projected onto the imposter, or double. The anger at the double, which continues to build, is now believed to be warranted. The individual through the use of projective identification believes the imposter object is becoming exceedingly dangerous to him. He subsequently fears the object and finds it necessary to control the imposter at all costs [30]. We see Mr. A's attempt at controlling his wife just prior to the instant offense. Unfortunately, Mr. A's ego defenses were insufficient to contain his intense emotion, and his anger resulted in the death of his wife, the misidentified object. Although Silva et al. [21] focused on Capgras syndrome psychodynamics, they contend that the use of defense mechanisms in Capgras variants (other DMS) is similar. Silva et al. [21] also stressed that an individual with an unremitting delusional belief is already unstable psychologically, and any minute environmental stressor places him at increased risk for assaultive behavior, especially given the often close proximity of the object. The stressors of a recent marriage and close proximity to his parents also contributed to Mr. A's homicidal violence.

#### **Conclusion**

DMS may be a causal factor in certain cases of homicidal violence. The nature and course of these delusional syndromes, not yet recognized in the DSM series, may include

the four subtypes. Both organic and psychodynamic factors usually contribute to etiology, and DMS patients with a history of violence toward self or others should be intensively treated to attenuate further risk.

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