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Obsessions in OCD Mimicking Capgras: A Case Report

Ricky Chu
Rowan University

Alexander Swartz
Rowan University

Helen Yi
Rowan University

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Ricky Chu, DO, Alexander Swartz, OMS-3, Helen Yi, MD

Psychiatry, Rowan University School of Osteopathic Medicine

Background and Significance

Obsessive Compulsive Disorder (OCD) is a mentally debilitating condition that can present in a multitude of ways and its manifestations can vary within the diagnosed patient population. OCD can be diagnosed with the presence of either obsessions or compulsions and does not require both[1]. Sometimes, OCD can affect a patient in a way that mimics delusional misidentification syndromes[2]. In these cases, a patient's ego-dystonia can be a key distinguishing feature in diagnosis[3]. In one specific delusional misidentification syndrome, Capgras, a patient possesses fixed beliefs that a known person (or sometimes object) is an imposter[4]. And even though the textbook OCD presentation differs from that of Capgras Delusion, there can be overlapping similarities. As such, a patient's insight and ego- dystonia into these preoccupations may help to point the diagnosis towards an obsessional form of OCD, a critical recognition for proper treatment. This case will highlight the importance of recognizing the distinction between obsessions and delusions to appropriately treat a patient with OCD with primarily obsessions.

Case Presentation

Patient DW was a 56 year old female who initially presented to the emergency department for a stroke evaluation and later told the ED physician that she had been having suspicions that her husband and daughter were not really who they said they were. Following a negative stroke work up including lab-work and an unremarkable head CT, she was subsequently admitted to the inpatient psychiatric unit under the pretense of a possible delusional disorder.

After admission, she continued to explain that despite being married for 20 years, she had been having these doubts for 2 months now and also questioning whether her husband was poisoning her as well. The unique aspect of DW's presentation, however, was that she appeared to have good insight and acquiesced that these thoughts made no rational sense. She explained that while she rationally knew that her husband and daughter were who they said they were, she just could not shake these recurrent thoughts of doubt from popping into her head.

OCD vs. Capgras Delusion

Obsessive Compulsive Disorder	Capgras Delusion
Intrusive thoughts +/- routines to alleviate anxiety	Misidentification syndrome where people or objects are thought to be imposters
Thoughts are unwanted and anxiety-provoking	Thoughts are persistent and in harmony with own beliefs
First line treatment: CBT +/- SSRIs	First line treatment: Therapy +/- antipsychotic

Case Presentation cont.

With her history of generalized anxiety prior to this new presentation, she also noted that she had been on Cymbalta in the past with good effect for her anxiety. And since her thoughts were not fixed and she, herself, admitted they could not be true, the differential moved away from delusional disorder and towards OCD. As such, Cymbalta was restarted and titrated up while she continued on a low dose of Seroquel that was started in the emergency department. Over the next 2 weeks, she slowly began to improve, reporting that her thoughts became less frequent and decreased in intensity.

Discussion

We reported here on a patient with OCD whose recurrent, persistent thoughts were that her family members were imposters. On the surface, this case initially seemed to suggest that the patient held delusions consistent with those found in Capgras Syndrome. However, if that were true, we would expect the patient's beliefs to be firmly held[4]. In her case, she understood that her beliefs were irrational and agreed to the fact that her husband and daughter were not imposters. This highlights the importance of attention to the patient's insight and associated anxiety to help make the correct diagnosis when presentations of OCD and Capgras Syndrome may have overlapping characteristics.

Furthermore, while we classically think of OCD in terms of both an obsession and a compulsion, it is important to keep in mind that there are different subtypes of OCD. For our patient discussed above, her OCD appeared to manifest as primarily obsessions, in which she did not engage in any outward rituals or compulsions. However, it is possible that those whose diagnoses favor primarily obsessional qualities have mental rituals that act as compulsions[5].

While there may be an overlap in certain medication indications such as using SSRIs in both major depressive disorder and generalized anxiety, recognizing the interface between OCD and delusional disorder is important as treatment can differ greatly.

Conclusion

Psychiatrists must be able to recognize that OCD may be mimicking Capgras delusion in order to properly treat an affected patient. Without proper diagnosis of OCD in such scenarios, underlying patient anxiety and anguish will be prolonged. In this case, effective recognition of the condition led to initiation of the correct treatment regimen, thereby furthering alleviation of its debilitating anxiety.

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