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Dangerousness of the Delusional Misidentification of Children

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ABSTRACT: Misidentification syndromes have been studied from a variety of perspectives, including phenomenological, biological, and nosological approaches. More recently, misidentification syndromes have been studied from a psychiatric-legal perspective, especially with regards to the problem of dangerousness. Capgras syndrome and other syndromes of misidentification can lead to hostile mood and subsequent physical violence. Little attention has so far been devoted to children as the objects of the psychotic person's misidentification delusion(s). We provide a review of cases from the anglophonic literature that have children as the misidentified objects, add three new cases, and then discuss the relationship between misidentification and potential harm to these children.

KEYWORDS: psychiatry, mental illness, misidentification, dangerousness, violence

Misidentification syndromes have received increasing attention in recent times [*1,2*]. The best known of these syndromes is Capgras syndrome, also known as the syndrome of doubles. In this syndrome, the affected individual believes that another person, usually well-known to the individual, has a different psychological identity while the physical appearance remains the same as the original identity [*3,4*]. In contrast, in the Frégoli syndrome, the patient believes that another person changes his or her physical identity while the psychological identity remains the same [*5*]. In the syndrome of intermetamorphosis, the patient believes that the misidentified individual has undergone radical physical and psychological changes [*6*]. A patient suffering from the syndrome of subjective doubles believes that there are one or more physical duplicates of him or herself, but with a different psychological identity than that of the patient [*7*].

More recently, Signer has reviewed the evidence available in the psychiatric literature for misidentification delusions involving the self [*2*]. Signer designates misidentification syndromes of the self as "reverse" types in order to differentiate them from the misidentification syndromes involving others. In the syndrome of "reverse" subjective doubles, for example, the patient believes that he or she is changing in only psychological

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identity, while in the syndrome of "reverse" intermetamorphosis, the patient believes in radical changes in physical and psychological identity within the patient [*2,8*].

The misidentification syndromes are generally associated with paranoid thinking and hostility directed towards the misidentified object. In some cases, the level of hostility and paranoid ideation may lead to violence, including homicidal acts [*9,10*]. Patients suffering from misidentification syndromes can misidentify any person, including children. In particular, individuals including parents can misidentify children and consequently threaten or attack them or both [*11*].

We present three cases of individuals suffering from delusions involving misidentification and harmful behaviors towards child-victims. We then explore the possible linkages between the misidentification process and dangerous behavior towards the misidentified child.

Case One

Mr. A is a 20 year-old white male who received a psychiatric evaluation after he was charged with murder. At age 16 he began to abuse drugs, including amphetamine, marijuana, cocaine, phencyclidine, lysergic acid diethylamide (LSD), and alcohol. He continued to do so for several years. About one year before the alleged homicide, he began disrobing in public upon hearing voices ordering him to do so. Concurrently, religious and sexual themes predominated his thinking. Mr. A developed the delusion that he had changed or was changing mentally into a woman whom he had previously known. Because he thought of himself psychologically as a woman, he began insisting upon having a sexual reassignment operation to become a "full" woman. He developed a preoccupation with the devil, leading him to become active in a church congregation. Once while having sexual intercourse with a girlfriend, he thought she had psychologically become the devil. Mr. A also believed that one uncle had been replaced by an impostor who was a physical replica of the original but had a very different mind.

During the night of the homicide, Mr. A had become angry and violent towards his mother, believing that the devil had assumed the shape of his mother. Mr. A also thought that his 14-year old sister was psychologically the devil. His mother sustained severe cuts, including one deep stab injury near the kidney after Mr. A had attacked her with a knife. Mr. A's sister escaped unharmed, but he later acknowledged that he had also wanted to harm her.

After the attack upon his mother, Mr. A fled from her house and went to a friend's house. His friend was babysitting a four-year old girl and a three-year old boy. Mr. A's friend wanted to go to the store and asked Mr. A to care for the children temporarily. When Mr. A saw the sleeping girl, he thought she was only pretending to sleep and that the girl was psychologically the devil who intended to harm him. Mr. A reacted to this delusion by stabbing the girl several times with a kitchen knife, causing aortic, esophageal, and nuchal lacerations. The girl died secondary to internal hemorrhaging.

After his arrest, Mr. A repeatedly stated that he killed the girl and attacked his mother because he believed he was killing the devil. He did not perceive the girl or his mother to have changed in physical appearance, except that the girl's face and smile appeared strange. Mr. A told the police that he had sexual intercourse with the girl. However, no evidence of sexual abuse was found on necropsy. He also claimed to have ingested amphetamines two days prior to the alleged homicide. Laboratory tests, however, found no trace of illicit drug use. Physical examination, complete blood count, urinalysis, and blood chemistries revealed no abnormalities. During his initial psychiatric interview, he would only respond to the name Jennifer, as he believed himself to have become a woman. Nevertheless, he continued to request that he have sex and brain change surgeries as he thought he still remained physically a man. Mr. A was given DSM-III-R (Diagnostic

and Statistical Manual of Mental Disorders) diagnoses of schizophrenia, paranoid type, chronic and psychoactive substance abuse [*12*].

Case Two

Ms. B is a 32-year old Hispanic female who was psychiatrically evaluated after she was accused of killing her two-year old son. One month before the alleged crime, Ms. B began to experience intensification of her long-standing auditory hallucinations and delusional beliefs that her mind and body were being invaded. She no longer felt like herself because she had a different mind, which was evil. She sought medical attention for these disturbing symptoms. She received a physical examination and a computerized tomography (CT) scan. Both of these were unremarkable. Ms. B, however, received no psychiatric evaluation. Two weeks before she killed her son, the voices ordered her to kill her husband. While he slept, she pulled a knife close to his neck but decided not to kill him because she "was able to resist the voice" and because "I wanted a father for my child."

Soon thereafter, Ms. B heard a male voice telling her that her son was not her actual child. She said that the voice became more insistent, but she was usually able to convince herself that her son was her child. For brief periods of time, lasting no more than an hour, she became confused and believed her child had been changed by an "evil spirit." To convince herself that the child was truly hers, she frequently checked her child's voice and touched his body. This delusional state became more frequent until the homicide, at which point, she hung her son. He died via strangulation. Ms. B then left home, disrobed in a park, and tried to hang herself. However, the branch broke and she did not make another suicide attempt until a few days later. At that time, Ms. B tried to kill herself by overdosing on alcohol and pills.

The police arrested Ms. B a short time later. She acknowledged killing her child to the police. She was hospitalized after being found not competent to stand trial. Ms. B met DSM-IIIR criteria for schizoaffective disorder. She was treated with lithium carbonate, haloperidol, and nortriptyline. Her depression and auditory hallucinations subsided considerably. However, at times, especially at night, she continued to experience bodily intrusions and believed that a female presence threatened to take over her mind. She reported that unlike the past, the outside force could not take over and control her. On occasion, she heard voices encouraging her to kill herself, but she did not act on these commands. As she improved clinically, she began to deny that her child was dead. Ms. B currently believes that her child is alive and is being kept by her husband. She also believes that her family, her attorney, and the hospital staff are conspiring to hide the whereabouts of her son from her. During the hospitalization, her physical examination, complete blood count, urinalysis, and blood chemistries were within normal limits.

Ms. B was born in Mexico and raised there until age ten. At that time her mother died after a long illness, and an aunt raised Ms. B. This aunt physically and emotionally mistreated her. At age 14, Ms. B began to experience auditory hallucinations, paresthesias, depression, suicidal ideation, and delusions of influence. While living in Mexico, she twice attempted suicide, once by an overdose. At age 26, Ms. B married a man of similar age and sociocultural background. Although her family was aware of her psychiatric symptoms, she did not confide in her husband and thus did not inform him of her psychiatric problems. There was no known family history of major mental disorder.

At age 25, Ms. B and her husband emigrated to the United States. Two years later, she delivered a healthy son. She denied worsening of her psychotic symptoms postpartum. According to her husband she cared well for her son until shortly before her son's death.

Ms. B heard a female's voice for many years. At times, she thought that this voice belonged to a witch, or evil spirit, who wished to possess her. When the voice intensified,

she would also experience the voice as "an evil presence," which would come and lay beside her, caress her body, and tell her to kill herself, or else her body would be invaded by this outside force. Despite Ms. B's resistance, the evil presence would sometimes succeed in entering Ms. B's body at the same time she heard the voice telling her that this was happening. The voice also said, "You are not Ms. B, you are not Ms. B." Ms. B complained of losing time spans during which she did not know what she did.

Case Three

Ms. C is a 32-year old white female who was arrested for kidnapping Abel, the six-year old son of Mr. and Mrs. D. Ms. C had been renting a room from the D's. A few days before abducting Abel, Ms. C became "aware" that he was her son. She believed that the D's had decided to adopt Abel and had refused to acknowledge that she was his true parent. Ms. C further believed that Mr. and Mrs. D had named her son, "Wino," in order to turn him into an alcoholic child. She saw Abel as looking physically the same as her "son," though she explained that Abel had refused to go with her because he had last seen her three years ago. On the day of the kidnapping, she took Abel away when the D's were not home. Ms. C eluded the police for two days. When she was finally arrested, Abel was found physically unharmed. At the time of her arrest, Ms. C repeatedly asked the police why they were taking her son away. She later confessed to the police that she had been planning to take Abel to another city where the D's would not be able to find them.

Ms. C has a history of verbally threatening to take children from previous neighbors. She once believed that a seven year-old daughter of another couple was her daughter. She delusionally believed that this girl's parents had been plotting to turn her daughter into a prostitute and therefore had to rescue the girl. Ms. C did in fact attempt to take the girl but was stopped during a physical altercation with her parents. Ms. C has five children, who are all being raised by family members in other cities. Her children had been taken from her because of her inability to care for them due to her psychotic thinking of at least seven years duration. Ms. C does not live in one place for very long and changes addresses frequently. She refused to reveal how she financially supported herself. Ms. C has no known history of serious head injury or other major medical problems.

Her mental status examination revealed that her short-term memory was impaired, her mood anxious and depressed, and insight and judgement poor. Physical examination found no abnormalities. Her complete blood count, routine blood chemistries, and urinalysis were within normal limits. She met DSM-III-R diagnostic criteria for schizophrenia, paranoid type, chronic.

Ms. C was treated with antipsychotic medication for ten months. At that point, she no longer believed that Abel was her son but continued to believe that one of her daughters had been taken away from her by a couple who had tried to pose as her parents.

Discussion

All three patients suffered from misidentification syndromes. Mr. A's case exemplifies a misidentification syndrome of others in which he believed that the psychological identity of the child victim, his mother, his sister, and his girlfriend had been replaced by the mind of the devil. He thought that the physical bodies of the misidentified persons were unchanged, except possibly for that of his mother, in whom the devil might have assumed a physical form identical to his mother's. He also believed that one uncle had been replaced by an impostor as this uncle had a different psychological identity, but his physical appearance remained unchanged. Mr. A's misidentification delusions qualify him as

suffering from Capgras syndrome because the physical appearance of the misidentified persons remained unchanged, while the psychological identity was radically different from the original [*1,4*]. Mr. A also suffered from the syndrome of "reverse" subjective doubles because he believed that he was psychologically changing or was changed into a woman while retaining his male physical identity [*2,13*].

Ms. B presents with the same two types of misidentification syndromes as Mr. A. First, she had suffered from a long-standing misidentification syndrome of the self in which she believed that at times she had become an "evil presence" with a mind very different from her own. Although she did not perceive her bodily structure as having changed, she believed an evil spirit inhabited her body. This presentation is consistent with the syndrome of "reverse" subjective doubles [*2,13*]. Ms. B also believed that her child at times had been replaced by a changeling that looked physically identical but was psychologically different from her child. This latter misidentification delusion is consistent with Capgras syndrome [*1,4*].

In the case of Ms. C, she had initially acknowledged Abel as the son of the couple, but when she became delusional, she thought that Abel was psychologically her son while his physical appearance remained unchanged. This presentation is consistent with Capgras syndrome [*1,4*]. This case of misidentification is different from many cases of misidentification syndrome because Ms. C harbored essentially positive and protective thoughts towards the misidentified child, in contrast to the hostility and suspicion which most of delusional persons harbor toward the misidentified person. The misidentification provided a rationale for enabling her to take a child she liked and wanted in order to replace her own children who no longer lived with her. The misidentification in this case changes an otherwise harmful act into a benign protective one in Ms. C's mind, enabling her to carry out an otherwise forbidden action. It should be pointed out that she physically restrained the child at the time of the abduction. In addition, Ms. C's belief about the girl she had attempted to steal was also associated with a Capgras delusion [*1,4*]. Though no actual physical harm came to the child, the potential for serious physical harm could have been significant. Moreover, the abduction may later give rise to significant emotional difficulties for the child.

Review of the Literature

The association of misidentification syndromes to children as misidentified objects has been previously noted in the literature [*4,11,14–28*]. Of the 18 reported cases in the anglophonic literature, only nine cases provide information on the age of the misidentified child as well as other information of forensic interest. The information regarding these nine cases and the twelve misidentified children is given in Table 1. The average age of the misidentified child is 4.8 years. Of the twelve children, nine were males, two were female, and the gender of one was unknown. Whether the preponderance of males in this small sample is significant remains unanswered. Eight of the twelve were sons and two were daughters misidentified by a delusional parent. The child of unknown gender was also misidentified by his or her parent. The remaining boy was misidentified by a stranger. This latter case is discussed in more detail below [*24*]. The average age for the nine individuals who misidentified children was 31. All were female. While the sample size is small, this gender trend is consistent with the observation that persons afflicted with misidentification syndromes tend to misidentify persons with whom they are emotionally close in that in Western culture, that is, women who generally provide the majority of child care are both proximate to children in both the physical as well as affective sense. These nine women also misidentified other family members: six husbands and one parent. In four cases, they misidentified themselves. Hospital staff and other patients were misidentified in one case. Of the twelve misidentified children, eleven were objects of a

TABLE 1—*Cases of delusional misidentification of children in the literature.*

Reference	Age(s) of Misidentified Child	Child's Gender	Relation to Patient	Quality of Relationship towards Child
16	<1	unknown	offspring	"strongly charged" negatively
4	7	female	daughter	suspicious and hostile
	4	male	son	
18	12	male	son	suspicious and hostile
	10	male	son	
21	3	male	son	no evidence of suspicion
	1	male	son	or hostility
23	<1	male	son	suspicious and hostile
24	4	male	son	suspicious and homicidal
11	4	male	stranger	suspicious and hostile
25	10	male	son	suspicious and hostile
27	<1	female	daughter	suspicious and hostile

Capgras delusion and one was an object of an intermetamorphosis delusion. Diagnostically, three suffered from paranoid schizophrenia. Other diagnoses included depression and atypical psychosis (including postpartum psychosis). The relationship between postpartum psychosis and misidentification delusions is discussed below.

Relevant Forensic Psychiatric Case Studies

Misidentification delusions involving a parent's own child have been previously reported. The postpartum period is a critical time in which the mother accepts and properly identifies her newborn child as her own. Cohn and colleagues reported the case of a woman suffering from postpartum psychosis, in which she believed that her newborn child had been switched in the hospital nursery [*16*]. In another case involving postpartum psychosis, a mother believed that her newborn son had been replaced, and she refused to care for the impostor [*23*]. Nilsson and Perris also reported a case of postpartum psychosis of a woman who believed that her three-year old son had been replaced and that her newborn was also a changeling [*21*].

The idea of misidentification of one's child is not confined to psychotic persons, but is a widely disseminated cross-cultural motif. The idea that demons and other evil spirits were responsible for changelings has been noted in cultures such as the Cherokee and Shoshone Indians of North America as well as the Yoruba tribe of Africa [*29*]. In Western Europe, the idea of the changeling finds pervasive expression in mythology as well as in literature. Mythology and fairy tales from Scandinavian countries contain the changeling motif. In many of these stories, it was assumed that if a child was correctly identified as a changeling, then battering, kicking, or displaying other forms of physical aggression toward the changeling may indeed bring the real child back. For example, in the Swedish fairy tale, "The Changeling in the Oven," a woman was advised to throw her baby into a hot oven because she believed it was a changeling. The woman reluctantly followed this advice and her real baby was returned unharmed [*30*]. The delusional misidentification of a child as exemplified by Case 2 represents a delusional form of the universal changeling motif.

Some who harbor a misidentification syndrome involving their children may also entertain homicidal ideas towards them. In a case reported by Silva and associates, a 24-year old woman believed that her four-year old son was transforming into his mother. She also thought her son was making sexual advances and thought of burning his hand

and killing him. Fortunately, she obtained psychiatric intervention before actually harming her son [*11*]. In another case, a 40-year old woman was hospitalized after attempting to choke her misidentified son [*26*]. In cases reported below by Resnick [*31*] and Meyers [*24*], the misidentification process is associated with completed homicides.

Resnick described the case of a woman who killed her nine-year old daughter, her six-year old son, and her mother [*31*]. Around the time of the killings, the woman recalled having seen her face assume a demonic appearance. She perceived that her lips turned purple, her facial skin turned yellow and green, and her eyes acquired a glowing, deep yellow mustard color. The woman ascribed her facial changes to her transformation into a devil. At the time of the killing, she also believed that she was possessed. This presentation suggests that the woman suffered from a misidentification syndrome of the self with altered physical and psychological identities [*32*].

Meyers described a case of a woman who killed a four-year old black boy because she believed that blacks were radically different beings from whites [*24*]. She thought that whites were extraterrestrial beings and that darker-complexioned races were to be cannibalized as food. For this reason, she championed the genocide of nonwhites. The idea that whites were from a different planet than blacks suggests that she viewed blacks as different beings.

Misidentification and Violence

The case of Ms. B and that described by Resnick strongly suggest that the misidentification process can overcome normal human caring behavior even to the point of overriding the normal maternal desire to protect her own child with resultant killing of the child [*31*]. This is exemplified by Ms. B, who before the homicide was reported to have been a competent parent. Ms. B perceived the double of her child with fear, perplexity, and mistrust. Given that the psychotic misidentification process represents an extreme breakdown of the human recognition process towards its own kind, and that previous studies suggest that individuals with misidentification syndromes may be significantly associated with violent behaviors, then it is possible that the study of misidentification syndromes may shed light on the nature of dangerous behavior by psychotic persons in general [*9,10,33*].

The misidentification process can facilitate violent behaviors because individuals who misidentify others, especially their relatives, no longer view the misidentified person as one of their own. Some misidentification delusions can therefore be conceptualized as a dehumanization process that facilitates aggression towards the misidentified persons. Psychotic persons who delusionally misidentify others and also display hostility towards them may demonstrate more violent acts than those psychotic persons who only display nonmisidentification delusional concerns associated with aggression.

Psychodynamically, it is likely that extreme hostility that the person cannot accept initiates the misidentification process. Because directing such anger towards a loved one is viewed as unacceptable, the individual may resort to the primitive ego defense mechanism of splitting to cope with intensely unpleasant effects. The identity of the loved one is protected as the good object who has been replaced. The misidentified hated individual becomes the bad object [*1*].

In most people with misidentification syndromes, the delusion enables the individual to cope with strong unpleasant effects but does not lead to action. Besides splitting, the co-occurring defense mechanisms of projective identification and psychotic denial are likely to play significant roles in the genesis of violent acts perpetrated by persons suffering from misidentification syndromes. In projective identification, a dissociated impulse that is projected onto another person is simultaneously experienced by the person himself. Psychotic denial serves to protect the individual from perceiving himself as having un-

acceptable effects as well as facilitating splitting and projective identification. While the misidentification delusion allows the individual to act out metaphorically unacceptable anger, in individuals such as those described in this paper, at a particular point, the splitting mechanism can not contain the anger when the projective identification mechanism permits increasing amounts of anger to be experienced. Anger towards a child could especially lead to violent action insofar as the child may be perceived as least capable of retaliating and therefore as least dangerous. This psychodynamic formulation may help explain the development of violence perpetrated by misidentification syndrome patients. However, in overcoming the usual parental caring and concern for one's own child, an extremely high amount of anger is needed to overload the tenuous equilibrium state provided by the aforementioned primitive psychological defense mechanisms in forming the misidentification delusion.

Returning to the misidentification syndromes, those persons suffering from syndromes that involve both physical and psychological misidentification, such as in the syndrome of intermetamorphosis, may be more hostile toward others than those in which the psychotic person misidentifies others only psychologically, such as in Capgras syndrome. This is likely to be true because witnessing the same physical appearance as the original may remind the psychotic person of the original person, thereby inhibiting serious aggressive behaviors.

The case of Ms. C, however, illustrates that not all cases of misidentification may be interpreted along the lines of overt aggression towards the misidentified child. In her case, the kidnapping is a potentially physically harmful act as well as a psychologically harmful behavior. From her own perspective, Ms. C was protective towards the misidentified child. This misidentification allowed her to act out a wish. Such misidentification without negative feelings has been previously observed [*34*]. The misidentification most likely provided a rationale for taking and "protecting" a child Ms. C wanted for herself. The misidentification enabled her to believe her actions would benefit the child rather than result in anything harmful, thereby making it possible for her to carry out the kidnapping.

From a forensic psychiatric perspective, it should not be underappreciated that children can be recipients of harmful acts when psychotic persons delusionally perceive them as inauthentic or having different identities. Given the propensity for individuals suffering from misidentification syndromes to experience anger and suspiciousness towards the misidentified person(s), these patients need careful assessment for their potential for dangerous behaviors.

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