Eponymous Psychiatric Syndromes Revisited

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ABSTRACT

This report provides an anthology of psychiatric eponyms. Clinically, many of these described syndromes represent valid diagnostic constructs and may accommodate the atypical cases that defy the official diagnostic designation in the current classificatory systems in psychiatry.

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This report provides an anthology of psychiatric eponyms. Although the current trend in medicine in general is to toss aside eponymous syndromes, many of these eponyms are old names that die hard—they tend to outlive their obituarists. A brief description of these psychopathologic entities is provided, along with their historical background and updates from recent literature when available.

Although there is a general consensus within the currently available classificatory systems in psychiatry to provide a diagnostic lingua franca among clinicians, these systems sometimes overlook conspicuous and valid psychiatric constructs. This oversight is reflected in the endless expansion of residual categories to incorporate atypical cases that defy the official labels depicted in these manuals under rubrics like "other nonspecified disorders." This practice, in part, holds true for some of the syndromes described here.

PSYCHIATRIC EPONYMS

Capgras Syndrome

Capgras syndrome describes a delusional misidentification that a person closely related to the patient has been replaced by an impostor.[1] The patient accepts the resemblance but believes that 2 different people are present. The disorder can involve inanimate objects and is more common in women. The disorder was originally described by Capgras and Reboul-Lachaux in 1923 and is also called *l'illusion des sosies*.[1] Capgras syndrome is commonly associated with schizophrenia (based on delusional percept), mood disorders (eg, bipolar), and organic brain syndromes (eg, frontal lobe dysfunction, right hemispheric dysfunction). Psychoanalytically, the disorder was regarded as the result of the patient's ambivalent attitude toward the person implicated as an impostor. Ramachandran[2] postulates that a disconnection exists between the fusiform gyrus (concerned with face recognition) and the limbic system (concerned with emotions). In the book *Phantoms in the Brain: Probing the Mysteries of the Human Mind*,[3] Ramachandran and Blakeslee describe a patient with Capgras syndrome following traumatic brain injury (TBI).

De Frégoli Syndrome

In De Frégoli syndrome,[4] the opposite of Capgras´ syndrome, the patient identifies a familiar person in various other people he or she encounters. De Frégoli syndrome is less common than Capgras´ syndrome and is usually associated with schizophrenia. The disorder derives its name from Frégoli, an actor known for his great skill in changing his facial expression, and was described by Courbon and Fail in 1927.[4] Feinberg et al[5] hypothesized that interhemispheric disconnection of cortical areas allows each hemisphere to establish an independent image of an object. If one hemisphere cannot explain the perception received by the other hemisphere, the patient deals with this discrepancy by confabulating about the experience. Naguy and Al-Tajali[6] reported the case of an adolescent with Frégoli delusions post-TBI.

De Clérambault-Kandinsky Syndrome

De Clérambault-Kandinsky syndrome, also known as erotomania, the phantom lover syndrome, and *psychose passionelle*, is the delusion that an exalted yet inaccessible person is in love with the patient.[7] These patients are convinced that

Clinical Points

- Despite general consensus, the current classificatory systems in psychiatry cannot accommodate atypical or complex presentations that do not fit the official diagnostic labels, and the residual category of "other nonspecified disorders" is more of a redundant "wastebasket" diagnosis for such cases.
- Psychiatric eponyms, although they do not impact either the prognostication or the treatment of these cases, are historically intriguing and might be seen as valid diagnostic constructs that can fill the voids in these classificatory systems.

the object of their affection is in love with them when the supposed lover is not, has indirect conversations with the patient, and has to behave in a paradoxical and contradictory way. Of note, seeking a sexual relationship is not necessarily a feature of the disorder. The patient may stalk or pester the person he or she desires, which may manifest as persecutory delusions, causing the patient to become abusive. The disorder was originally described in 2 phases: hope and resentment.[8] The patient is typically a single woman. In the pure form, the disorder may be a projection of denied narcissistic self-love. Ellis and Mellsop[9] suggest operational criteria for diagnosis:

- Delusional conviction of being in a loving communication with another person
- This person has a much higher social status
- This person was the first to make an approach
- This person was the first to fall in love
- Sudden onset
- Love object is unalterable
- The patient provides an explanation for the paradoxical behavior of the person
- Chronic course
- No hallucination

De Clérambalt-Kandinsky syndrome is classified as (1) primary and (2) symptomatic. Pimozide, as reported by Munro et al,[10] is highly efficacious in treating this disorder.

Othello Syndrome

Othello syndrome is also known as morbid jealousy, scrupulosity delusions, and conjugal paranoia and describes the delusion of infidelity on the part of a sexual partner.[11] Normal phenomena are interpreted to fit the conviction, with a desire to find proof or extract a confession, and may culminate in aggressive behavior and even murder. Othello syndrome has been tied to alcoholism (in jealous insecure personality), organic or functional psychosis, paranoid personality, impotence, and punch-drunk syndrome.[11] It is more common in cohabitants and homosexuals.[11] Historically, Othello syndrome has been thought of as projection of one's own desires for infidelity, suppressed homosexuality, or feelings of inadequacy.[11] Easton et al[12] opine that Othello, in the play by William Shakespeare, was deceived rather than deluded about Desdemona's alleged infidelity and hence did not have the syndrome, and the term (Othello syndrome) is a misnomer to be abandoned.

Ekbom Syndrome

Ekbom syndrome is also known as delusional parasitosis and describes the delusion of infestation.[13] It is often associated with tactile hallucination (formication) in cocaine misuse, dementia, alcohol withdrawal, thalamic lesions, and cerebrovascular insufficiency. The disorder is seen in affective psychosis, delusional disorder, paranoid schizophrenia, anankastic or paranoid personality disorders, neuroses, and organic brain syndrome. Recently, a debatable diagnostic entity known as Morgellons disease[14] was introduced describing a dermatologic disorder characterized by a crawling or stinging sensation, finding fibers on skin, and various rashes or sores. This entity is mostly believed to be a manifestation of delusional parasitosis.

A related syndrome is delusory cleptoparasitosis[15] in which the individual believes the infestation is in their dwelling. Another, yet different, Ekbom syndrome is restless legs syndrome (RLS),[16] sometimes known as Allison jitter leg. The National Institutes of Health criteria for diagnosis of RLS[16] are as follows:

- Urge to move limbs with/without sensations
- Improvement with activity
- Worsening at rest
- Worsening at night

RLS may be primary or secondary to iron deficiency, neurodegenerative disorders, or drugs. A link between RLS and periodic limb movement disorder with attention-deficit/hyperactivity disorder in children has been shown.[17] Iron insufficiency and the dopaminergic system have been implicated in the development RLS.[17]

A third syndrome bearing the name of Ekbom is pleurothotonus or Pisa syndrome, which has been described as antipsychotic-induced extrapyramidal symptoms.[18]

Cotard Syndrome

Also known as *délire de négation généralisée*, Cotard syndrome describes nihilistic delusions.[1] The disorder is typically seen in psychotic depression with hypochondriasis, especially in the elderly. Delusions are bizarre and dramatic. Cotard syndrome has been considered to be the psychotic form of depersonalization and derealization.[1] Currently, it is viewed as a disconnection syndrome (not unlike Capgras syndrome). In 5 studies,[19] electroconvulsive therapy was found to be a highly effective treatment modality.

Couvade Syndrome

Couvade syndrome is sometimes known as sympathetic pregnancy.[20] It describes a man developing anxiety and nonspecific physical signs of pregnancy when his wife is pregnant and is common during her third to ninth month. The patient is not delusional since he does not believe that he

is pregnant (ie, metamorphosis sexualis paranoia). Instead, it is more akin to conversion disorder in which anxieties about the wife's pregnancy are converted to physical symptoms. Couvade syndrome has been regarded as deep empathy with a partner or fetus, ambivalent parenthood, overidentification with one's wife, expression of jealousy of attention paid to the wife, or frustrated creativity.[20] It may be classified as hysteria-allied or culture-bound syndrome. Budur et al[21] reported a Couvade equivalent in a twin sister rather than in a spouse. The name was originally coined by Sir James Young Simpson (an obstetrician).[20] Churchwell[22] addresses the expectant father's hormonal shift as a central etiologic component (increased estradiol and prolactin and decreased testosterone), but this theory has been largely debunked by failed hormonal treatments.[23]

Ganser Syndrome

Ganser syndrome is also known as "approximate answers" syndrome or *vorbeireden*.[24] It describes patients uttering absurdly wrong, but almost correct, answers to questions that are inconsistent. There may be hysterical conversion symptoms, pseudohallucinations, changeable clouding of consciousness, or subsequent amnesia. Ganser syndrome often has a sudden onset and is stress related and usually resolves when stress subsides. Ganser syndrome is regarded as a dissociative disorder. It is often seen in forensic settings and was first described in 1898 in 4 criminals.[24] It might be seen in a hysterical twilight state, a postictal state, depression, or dementia. It is akin to the "buffoonery state" of acute or catatonic schizophrenia or faxenpsychosis and is also known as balderdash syndrome. One hypothesis is that genuine psychosis underlies the disorder, while another is that it is the result of malingering; over the years, opinions have seemed to shift from the first hypothesis to the second.[24]

Munchausen Syndrome

Munchausen syndrome, in which an individual is motivated by the sick role, is classified as fictitious disorder or thick file syndrome.[25] In Munchausen-by-proxy, a caregiver makes up or causes an illness or injury in a person under his or her care. Patients with Munchausen syndrome gain multiple hospital admissions via deception and feigning illness. These patients may hope for a laparotomy (laparotimophilia migrans) or present with bleeding (hemorrhagica histerionica), false heart attacks (cardiopathia fantastica), or curious fits (neurologica diabolica). Patients present with plausible, often dramatic scenarios that include extensive pathological lying (pseudologia fantastica) with lack of personal rapport. The mean age at presentation is 36 years, and men and women are equally affected.[25] Symptoms are intentionally generated voluntarily (pathomimicry) and might be seen as hysterical behavior in severely disordered personalities. There are no external incentives (eg, malingering). The syndrome was described by Asher in 1951, deriving its name from Baron von Munchausen, who was famous for his excellent story telling (of his travels).[25] The syndrome is commonly associated with personality disorders, especially borderline personality disorder.

Klüver-Bucy Syndrome

Klüver-Bucy syndrome describes a constellation of placidity (tameness), hyperorality, hypersexuality, visual agnosia, hypermetamorphosis, and memory defect.[26,27] It is organic in nature and typically seen in bitemporal lesions (eg, frontotemporal dementia, Alzheimer's disease, brain tumors).

Waxman-Geschwind-Gastaut Syndrome

Waxman-Geschwind-Gastaut syndrome describes the interictal personality (eg, epileptoid personality) and remains a debatable entity.[28] The syndrome has been linked to chronic temporal lobe epilepsy and manifests religiosity, hypermoralism, hypergraphia, hyposexuality, viscosity, rigidity, egocentricity, seclusiveness, pedantism, obsessionalism, and circumstantiality.[28]

Diogenes Syndrome

Also known as squalor syndrome, Diogenes syndrome describes gross self-neglect in elderly reclusive individuals.[29] Typically, patients live in filthy conditions, refuse any offers of help, may hoard rubbish, and are seemingly unconcerned, apathetic, and socially withdrawn. Diogenes syndrome might be seen as end-stage personality disorder in Alzheimer's disease and schizophrenia. Frontal lobe dysfunction may be a cause.[29] The syndrome name derives from Diogenes of Sinope (ancient Greek philosopher); the name is believed to be a misnomer, and Plyushkin syndrome may be more appropriate.[29]

Kempf Syndrome

Kempf syndrome refers to homosexual panic and manifests as an acute severe episode of anxiety related to the fear (may be of psychotic intensity) that one is about to be attacked sexually by another person of the same sex or that one is thought to be homosexual by fellow coworkers.[30] The syndrome is typically precipitated by loss of someone of the same sex to whom the patient was emotionally attached.[30] It may appear as the first acute episode of schizophrenia disorders and is more frequent in men than in women.[30]

Kempf syndrome is most often seen in those with schizoid personality disorder who insulate themselves from physical intimacy. A breakdown often occurs in a situation involving enforced intimacy with the same sex such as in dormitories and military barracks.[30] The syndrome was common during mass mobilization of World War II when barracks with communal showers, often without doors or cubicles around toilets, provided little privacy.[30]

Charles Bonnet Syndrome

Charles Bonnet syndrome is an organic brain syndrome of the elderly that involves vivid episodic isolated visual (pseudo) hallucinations.[31] It might be persistent or repetitive, elementary or complex, and amusing or distressing and may

be associated with visual impairment. There is no evidence of associated psychotic features. The syndrome may persist for 12–18 months. Sensory deprivation has been implicated as a possible cause.[31] Reaction of the visual cortex to a lack of visual stimulation produces a release phenomenon. Absence of ocular sensory input leads to a lack of stimuli in the occipital cortex and visual association area.[31] Cortical input from other areas (eg, memory association areas) closely involved with the occipital lobe are hypothesized to fill in for the sensory deficit, producing the hallucinogenic effect.[31] Gabapentin has been used in trials with some success.[32] Charles Bonnet syndrome is also referred to as visual release hallucinations and was first noted by Charles Bonnet in his grandfather.[32]

Blocq Syndrome

Blocq syndrome describes the inability to stand or walk in a normal manner and is also known as *astasia-abasia*.[33] Gait in these patients is bizarre and is not suggestive of any organic lesion. Patients tend to sway or almost fall with recovery at the last moment. As such, it is classified with conversion disorder. Neurologic causes should be excluded first. Another Blocq syndrome is abulia,[34] which is usually part of the negative domain of schizophrenia.[33]

CONCLUSION

This list of psychiatric eponyms is not all inclusive. This report highlights some of the more common syndromes that clinicians encounter in clinical practice with an update from recent literature. Although these psychiatric eponyms are largely of historical interest and more appealing to academicians, clinicians should use these diagnostic labels in circumstances that fit the phenomenology more aptly than the redundant category of "other nonspecified disorders" in the current classificatory systems.

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