

Capgras delusion: An interactionist model

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Abstract

In this paper I discuss the role played by disturbed phenomenology in accounting for the formation and maintenance of the Capgras delusion. Whilst endorsing a two-stage model to explain the condition, I nevertheless argue that traditional accounts prioritise the role played by some form of second-stage cognitive disruption at the expense of the significant contribution made by the patient's disturbed phenomenology, which is often reduced to such uninformative descriptions as "anomalous" or "strange". By advocating an interactionist model, I argue that the delusional belief constitutes an attempt on the part of the patient to explain his/her initially odd and somewhat disturbed phenomenal content (which I refer to as a sense of estrangement) and, moreover, that the delusion then structures the patient's experience such that what he/she perceives *is* an impostor. This fact is used to explain the delusional belief's maintenance and resistance to revision. Thus, whilst accepting that second-stage cognitive disruption has a part to play in explaining the Capgras delusion, the emphasis here is placed on the role played by the patient's changing phenomenal content and its congruence with the delusional belief. Unlike traditional two-stage models, which posit a unidirectional progression from experience to belief, the interactionist model advocates a two-way interaction between bottom-up and top-down processes. The application of this model to other delusional beliefs is also considered.

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1. Introduction

Over the past decade or so, much discussion on the Capgras delusion—the belief that relatives and/or significant others have been replaced by an impostor (Capgras & Reboul-Lachaux, 1923)—has focused on the extent to which abnormal phenomenology can account for the formation of delusional belief (Bayne & Pacherie, 2004b). In line with this debate, I will argue that approaches which take into account the patient's disturbed phenomenology either (i) overemphasise the extent to which the anomalous nature of the experiential content can cause directly the delusional belief (indicative of a one-stage account), or (ii) assign such content a peripheral role in favour of some form of cognitive disruption. The marginalisation of disturbed phenomenology (as noted by ii) is particularly pronounced in two-stage models in which experiential

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content receives fairly cursory treatment and is described simply as “anomalous” or “bizarre”, or as a “strange feeling” that alludes to something being “not quite right”. In addition, and of equal importance to this paper, is the fact that each of these general approaches posits a causal explanation that is unidirectional in so far as it maps the causal progression exclusively from anomalous experience to delusional belief.¹

It is my contention that the phenomenology of the Capgras patient has a much greater role to play in explaining the condition than two-stage models thus far allow. Having said that, it is not my intention to overburden the patient’s disturbed phenomenology with an explanatory role it cannot accommodate. What I propose is a two-stage model that features a two-way interaction between bottom-up and top-down processing rather than the more typical unidirectional aetiology found in other approaches. The significance of this *interactionist* model is that it transforms the nature of the patient’s experiential content from something “anomalous” (what, in Section 5, I refer to as ‘estrangement’) into a full-blown ‘impostor’ experience. In other words, the interactionist model, much like the more traditional two-stage model, posits that the Capgras patient forms the delusional belief that the woman in front of him (his wife) is an impostor through a combination of disturbed phenomenology and cognitive deficit but, in addition, makes the bolder claim that the belief is maintained because the patient, upon forming the delusional belief, experiences his wife *as* an impostor.²

To help present the case for the interactionist model, it is necessary to provide some detail (however brief) on current thinking about the Capgras delusion. In Sections 2–4, I will outline issues relating to one- and two-stage models, neurological dysfunction in the Capgras patient that is said to ‘mirror’ prosopagnosia, evidence for reduced autonomic arousal and the implications this has for the patient’s underlying phenomenology. A more detailed analysis of the patient’s experiential content—beyond merely “anomalous”—will also be undertaken (see Sections 5–8) lending support for the two-way causal interaction proposed above. Finally, in Section 9, the model’s application to other cases of delusional misidentification will be discussed.

2. The One-stage Model: Emphasising the role of phenomenal content

As a proponent of the one-stage model, Maher (1974, 1988, 1999) (see also Gerrans, 2002a) argues that delusional beliefs are the product of a rational process. In other words, they are indicative of the patient’s *reasoned* attempt to make sense of his anomalous experience, or what Gerrans (2000) refers to as a “deeply disturbing and intractable phenomenal state” (p. 116). As such, defective reasoning should not be considered the primary protagonist in the formation of delusional beliefs; rather, we should look to the nature and intensity of the phenomenal experience the belief is trying to explain.

Critics have been quick to point out, however, that the one-stage model has difficulty explaining the specific content of the delusional belief (Young & de Pauw, 2002). It suggests that such content is implicitly contained within the patient’s phenomenal experience, to the effect that it (the experience) determines, exclusively and exhaustively, what the belief is about. In other words, the anomalous experience must be ‘powerful enough’ to insure that one and only one conclusion (belief) can be drawn by the patient. In the case of the Capgras delusion, this means that whatever the husband experiences when in the presence of his wife, it alone leads him to conclude that she has been replaced by an impostor. Klee (2004) considers it implausible that “raw perceptual experience contains its own intrinsic thematic content” (p. 26). It is therefore unlikely that the husband’s delusional belief that his wife is an impostor is derived solely from an experience with intrinsic ‘impostor wife’ properties.³

What is problematic, then, is that neurological damage could be capable of producing something as specific as an ‘impostor wife’ experience. I agree; yet I endorse the view that the husband perceives his wife as an impostor. To explain the seeming contradiction, my position differs from Maher’s one-stage account not

¹ See Davies and Coltheart (2000) for a detailed example of this. Their EHBC account proposes a progression from experience to hypothesis to belief to circumscription.

² The use of the masculine pronoun throughout this paper is for convenience only and in no way suggests a male clinical prevalence or any other bias.

³ In response, Gerrans (2002b) argues that beliefs do not constitute the simple reporting of an experience’s intrinsic content. As such, they do not constrain the belief—the experience can be interpreted differently. Gerrans, like Maher before him, simply requires that the interpretation and subsequent belief formation be within the normal parameters of rational processing.

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