

## Chapter 5

- This chapter deals with Capgras and other misidentification syndromes. Hirstein claims that Capgras patients confabulate. But, is this stretching the application of the term too much? After all, not every case of strange false belief is a confabulation.
  - Hirstein justifies this inclusion, in large part, because Capgras patients resemble other confabulators in that they are insensitive to the correction and doubt presented by their cultural peers. Hirstein also claims that they share a *mind-reading* problem (i.e., a deficit in representing the mental states of others).
- Capgras patients also commonly have damage to the orbitofrontal cortex. Significantly, this also affects mind-reading abilities. See §5.2 for discussion.
  - 4 different types of mind-reading/simulation: understanding the i) perceptions, ii) actions, iii) beliefs, and iv) emotions of others.
  - Mind-reading deficits cannot explain why a confabulation is told in the first place. But, they might explain why confabulators do not respond appropriately to correction and doubt.
- Capgras patients sincerely avow that someone close to them has been replaced with an impostor. Sometimes they even act on this. They often point out minor differences between the “impostor” and the “actual person”. They also confabulate as to why they keep up relationships with impostors.
- Hirstein briefly explains various misidentification syndromes: Fregoli’s syndrome, Cotard’s syndrome, the illusion of subjective doubles, intermetamorphosis, and DeClerambault’s syndrome. (116–117)
- There are two components to misidentification syndromes:

As with the other confabulation syndromes we have seen, many authors believe that there are two components to a delusion of misidentification: one approach is typical. Ellis et al. stated “first [there is] a disturbed perceptual/cognitive stage which may take a variety of forms; and second a corruption to the subsequent decision stage that is comparatively uniform across delusions”. (117–118)

- Hypothesis: Capgras is the mirror image of prosopagnosia. With Capgras they recognize the face, but lack the emotional response.
- In §5.4 Hirstein explores Frith’s suggestion that many delusional disorders involve mind-reading deficits. Hirstein extends the suggestion to confabulation.
  - But, does this sound plausible?

Constructing a “solution” to explain their strange experience seems to help these patients regain their cognitive equilibrium. The misidentification “rationalizes” a conflict between present “feelings of unfamiliarity and any preserved memories for a person by splitting the person’s identity with an invented double”. (126)

- Hirstein presents a helpful figure on p. 127.
- 3 challenges to the mind-reading approach to misidentification syndromes: the dog problem, the house problem, and the friends and family problem.
- Summary:

The Capgras’ patient is looking at someone who visually resembles his father, but who appears to have a different mental life, a different personality, with different dispositions to do different things. (133)

Q: Is this a plausible articulation/explanation of the phenomenon?

## Chapter 6

- anosognosia: unawareness (or denial) of illness — e.g., denial of paralysis or left-side neglect. These denials are often confabulatory.

asomatognosia: lack of body knowledge. These are also supported by confabulations.

◦ For such people, sometimes the truth is briefly recognized — when it is directly pointed out — but then confabulations return soon after. (137)

◦ Interesting study: If given a “safe” reason for paralysis, these patients will admit to it.

If patients who denied paralysis were given a nonthreatening reason for being paralyzed, the denial abated, as shown by an injection experiment ... (138)

• Anosognosia is not plausibly a purely psychological problem — it is also a neurological problem. Right hemisphere damage impacts emotional responses, and this contributes to understanding the lack of concern about such damage.

• §6.3 is on the neuroscience of denial. You can skim this.

• Those with Anton’s syndrome often confabulate answers or excuses. Again, damage to the orbitofrontal cortex is often present.

• Q: Why is the monitoring problem often limited to a small domain of confabulation? (147)