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Echos, Doubles, and Delusions: Capgras Syndrome in Science and Literature

Shortly after the publication of his book *Awakenings* in 1973, Oliver Sacks received a letter from the Russian neuropsychologist Alexander Luria. Luria complimented Sacks on his book, praising it as a fine specimen of “romantic” science. Sadly, he wrote, today’s medicine is being dominated by “classical” science, in which clinical observation and convincing case histories have become something of a lost art. Luria must have thought of Sacks as the man with the other half of the amulet.

The dichotomy between classical and romantic science was to re-appear in the final chapter of Luria’s autobiography *The Making of Mind*, published posthumously in 1979. Classical neuropsychology, he wrote, aims at the reduction of psychological phenomena to the level of physiological or neurological processes. This reduction involves the use of advanced statistics and high tech instrumentation. The method of preference is quantitative and experimental. The end result of classical neuropsychological research is a set of general statistical relations between measurable parameters, presented in the form of graphs and tables. They will appear, typically, in specialist journals.

Romantic neuropsychology, Luria argued, does not aim at quantitative laws or generalizations, but at knowledge about individual persons through a process of narrativization. It respects the unicity of the patient and the subjectivity of his experience. Romantic neuropsychology emphasizes the vital importance of observation and description, rather than experimentation. Its natural product is the case history, portraying the patient in his social habitat, partially with literary means. Luria thought of his own two books *The Mind of a Mnemonist* (1968) and *The Man with a Shattered World* (1972) as written “in a more purely romantic style,” (178). Both are case histories of a single patient. On the final page of his autobiography he said that he regretted not having written more romantic studies.

Writing this in the 1970s, Luria was certainly right that in medicine romantic science had receded from center-stage. Another thirty years later we may say that physicians have come to live in what Meulenberg and Oderwald have called “a statistical universe.” (290) Medicine is a high tech science, experiment-driven, its

research is on groups of patients, its results are numerical, the format of presentation is a set of graphs or tables in specialist journals. Allowing for considerable margins, this switch can be dated in the mid-twentieth century. As a consequence, the history of many neurological or psychiatric diseases and syndromes shows two stages, dominated by disparate scientific styles. In *An Essay on the Shaking Palsy* (1817), James Parkinson, a London GP, described six individual patients with characteristic motor impairments and tremors. We learn about their background, their profession and what they themselves thought was the cause of their ailment. Today, medical publications on Parkinson's Disease typically deal with *groups* of patients. In his original 1885 paper on the "maladie des tics," Georges Gilles de la Tourette described his observations of nine individual patients. The early papers by Sergei Korsakoff, published in the late 1880s, likewise contain lengthy case histories on the consequences of dense amnesia, both for the patient and his family. In Alois Alzheimer's 1906 paper we learn quite a lot about the disorientation and despair of Auguste D., the "first Alzheimer patient." Well into the twentieth century the patient's perspective was part and parcel of medical discourse.

This is no longer the case. Today, articles in medical journals deal with diseases, not with patients. The elimination of the patient's perspective from medical science, however, does not imply its complete disappearance. It surfaced elsewhere. For one thing, patients have begun to speak for themselves. There are books on Parkinson's, Tourette Syndrome, Asperger Syndrome, even on the early stages of Alzheimer's, written by persons afflicted by these diseases and syndromes. They offer first-hand accounts of what it is like to suffer from the disease, of what it means for their personal life and their loved ones. On being diagnosed with — say — Parkinson's, many people will turn to first-person narratives authored by fellow-patients to read about their prospects.

There is yet a second place where the patient's perspective has surfaced. *Novelists* have begun to speak for patients. The narrator in *The Suspect* by Michael Robotham suffers from Parkinson's. His account gives the reader a chilling sense of what it must mean to live in an ever slower and stiffer body and to stare at a stone face in the mirror. In *Motherless Brooklyn*, Jonathan Lethem has Lionel Essrog, aka "freakshow," tell us about the hectic in the mind and behaviour of someone afflicted with Tourette Syndrome. Christopher Boone, the narrator in Mark Haddon's *The Curious Incident of the Dog in the Night-Time*, gives us an account of the ritualistic and obsessive thoughts in an autistic mind. And even if the narrators are not the ones afflicted, novelists may still present convincing descriptions of the thoughts and

behaviors of patients. Ian McEwan did this with a man suffering from Clérambault's Syndrome in *Enduring Love* and with Huntington's Disease in *Saturday*.

Richard Powers did it with Capgras Syndrome. The main character in *The Echo Maker* is Mark Schluter, a 27-year-old truck driver for Iowa Beef Productions somewhat reminiscent of "the dude" in *The Big Lebowski*. After his truck jackknifed off a country road he sustained severe brain damage. When his condition slowly ameliorates it appears that he suffers from Capgras Syndrome, a rare disorder characterized by the delusional idea that persons near and dear to the sufferer are replaced by doubles. As the story unfolds, Mark comes to be treated by two neurologists, first by Dr. Hayes, working in the hospital where Mark had been admitted after the accident, and later by Dr. Weber, a world famous neurologist, invited over by Mark's sister Karin.

I will argue that by introducing these two doctors, Richard Powers presented himself with the splendid opportunity to pitch against each other two stages in the history of Capgras Syndrome. In *The Echo Maker* these two perspectives figure as contemporary scientific styles, Dr. Weber typifying the period 1923 until the 1980s and Dr. Hayes typifying the present mainstream view on Capgras Syndrome. What Powers has done is cleverly collapsing the history of Capgras Syndrome in a clash between two doctors, as if the controversy were still very much alive today. In Powers's novel one hears echos of the syndrome's past.

I. Joseph Capgras and Mme. M.

Joseph Capgras (1873-1950) was a Paris psychiatrist, working mainly in Maison Blanche and later in the Sainte-Anne-hospital (Luauté). The woman that would go down medical history as "the first Capgras patient" was a certain Mme. M., a 53-year-old seamstress. In the final year of World War I she had been admitted to Maison Blanche, where she came under the care of Capgras. She was intensely delusional, claiming that she wasn't really Mme. M., but a descendant of king Henri IV, heiress to an immense fortune. She said that her father had made a deathbed-confession that he had snatched her as a fifteen-months-old from her cradle in a family of nobility. Her true name, she said, was Mathilde de Rio Branco. A second delusional theme was that her daughter and husband had been replaced by what she called "sosies," impostors who were the spitting image of her loved ones but impostors nevertheless. In 1923, Capgras and his colleague Reboul-Lachaux published a case study on Mme. M., indicating that her delusions of grandeur were a case of "folie raisonnée," a concept of their own finding, meaning that the delusions were bizarre, but internally consistent (Capgras and Reboul-Lachaux; Ellis et al.). The authors explained that the "illusion des sosies," as they dubbed it, was caused by

an “identification agnosia.” That is, Mme. M. had no trouble recognizing faces, she just failed to identify these faces as the faces of her dear ones. The idea of “doubles” was in a sense a natural consequence of recognizing a face but not experiencing the warmth and familiarity that comes naturally with seeing this face. Her implicit reasoning seemed to be that if she didn’t warm to her daughter emotionally, then it couldn’t really be her daughter. Capgras and Reboul-Lachaux argued that doubles were a creation of a “logique des émotions.” A few years later a Paris colleague proposed to rename the “illusion des sosies” into Capgras Syndrome.

If Capgras had simply published his 1923 explanation and left it at that, he would still be revered as the first psychiatrist who had a clear incling on the most probable explanation. Unfortunately, his initial article was followed by a series of articles championing psychoanalytical explanations. In 1924 he published a case study of a woman who claimed that her father was a double, due, Capgras assumed, to her incestuous desire towards him, a desire so taboo that it forced her to conclude that it couldn’t really be her father (Capgras and Carrette). This set the stage for a series of Freudian explanations for doubles, for instance by arguing that creating a double is a subconscious way of handling mounting tensions between ambivalent feelings: all hostility is projected on the impostor, whereas the lost dear one tends to be idealized.

Thus, Capgras Syndrome, as originally conceived, was a *female* disorder, part of the general diagnosis of hysteria. For the first fifteen years or so all case studies featured women. The first case of a male Capgras patient, in 1936, was published as *something of a discovery*, this case was so anomalous that the author hinted at latent homosexuality (Murray). Taking the long view on Capgras, one will find that the patient population developed from exclusively female to an ever smaller but still robust female overrepresentation of 2 to 1 today (Berson; De Pauw).

In most cases of Capgras Syndrome the doubles are part of a system of paranoid delusions. This is one of the reasons why every effort of loved ones to convince the patient that they aren’t doubles, but still truly their son, daughter or husband, meets with hostility. It may, in fact, make matters worse: the patient will weave their efforts into his paranoid system. In *The Echo Maker* this happened to Karin: when she began to talk about things that only she and Mark knew about, he became instantly suspicious, for this could only mean that this impostor woman had extorted private information from the true Karin — apparently there were more people involved in the plot than he first suspected. Hints at intimacy by loved ones tend to fuel the paranoia. Sadly, this also implies that the status of being a double is not without risk. There are cases on record in which the patient actually killed the double. In

Missouri a Capgras patient was convinced that his stepfather had been replaced by an alien and decapitated him to look for the batteries and microfilms (Blount).

In most cases, however, Capgras patients react less drastically to the substitution of their loved ones by doubles. An elderly woman was convinced that her daughter had been switched for a double, but since this double seemed to be a kind woman she decided not to confront her with the deception. Another woman tried to make the best of the new situation, now pouring three cups of tea, one for herself, one for the double and one for her husband, should he suddenly return. But most patients are angry and worried about the fate of their loved ones. Are they being held captive somewhere? Will they ever return? It is entirely natural, within the internal narrative logic of the delusion, to interpret a forced stay in the institution as a further proof that the true friends and relatives have disappeared. As Mark put it: "My sister wouldn't have left me in here to rot." (77).

II. Capgras Syndrome: A Gestalt Switch

Until the 1980s the accepted view was that Capgras Syndrome was a *psychiatric* disorder. The double was typically part of a paranoid delusional system, symptomatic of schizophrenia. If there were organic lesions these were thought to be accidental and could be explained in terms of co-morbidity. They were seen as essentially unrelated to the primary disorder of paranoid delusions. As a consequence, many psychiatrists saw no reason to keep track of any organic disorders in cases of Capgras. Looking back, there were good reasons to think of Capgras in terms of psychodynamic causes. Capgras expressed itself in a change of affect toward loved ones and *only* loved ones. Precisely this strange selectivity — why is it that a husband is replaced by a double and not, say, a neighbor? — could not be fitted in any of the known neurological theories on face recognition.

Today's accepted view is that Capgras Syndrome is a *neurological* disorder. It has, as its primary cause, an organic lesion, and the delusion is an *effect* of this lesion. Even in cases where no lesion can be found it is assumed that there is some form of hidden cerebral damage, undetectable by present diagnostic instruments. Today, the default with Capgras Syndrome is that it is caused by an organic lesion.

Comparing the earlier and the later view, one will find that this is one of those exemplary Gestalt switches in science, with a reversal of figure and background (Draaisma). Before the 1980s the symptom of experiencing doubles was primary and organic disorders were seen as accidental, as background; after the 1980s the delusion was seen as secondary, the effect of a primary organic disorder. So what happened in the 1980s? What caused Capgras Syndrome to switch from psychiatry to neurology?

There are several factors to consider. One of them is that there were incidental reports on cases of *acute* Capgras Syndrome, for instance after a car accident or other causes of brain trauma. This seemed inexplicable against a background theory of psychodynamic etiology, which generally develops on a different time scale. A second factor has been the rise of the organic orientation in psychiatry in general. This alerted psychiatrists to the idea that sometimes organic disorders were not simply accidental or cases of co-morbidity and encouraged them to at least start registering the presence or absence of organic disorders in cases of Capgras. But certainly the single most important factor has been the articulation of a neurological theory that was able to explain the enigmatic selectivity of face recognition in Capgras Syndrome. The result has been that today Capgras is seen as the effect of a wide range of etiological factors, all of them organic. In terms of co-morbidity, Capgras is connected to epilepsy, Parkinson's, MS, brain tumour, migraines, alcoholism and especially Alzheimer's Disease (Bourget and Whitehurst). Which theory, then, turned Capgras into a neurological disorder?

In the domain of face recognition, there is a well-known disorder called "prosopagnosia," in which patients fail to recognize faces. In 1985 this disorder was immortalized by Oliver Sacks in the title chapter of *The Man Who Mistook His Wife For a Hat*. He described a musician who saw faces where there weren't any faces — causing him to give parking-meters a friendly pat on the head or to put out his hand to introduce himself to a grandfather's clock — but failed to recognize real faces, not even that of his wife. The cause of this disorder is often a stroke or a tumour, as was the case with Sacks's patient. For a long time it was thought that prosopagnosia couldn't have anything to do with Capgras Syndrome. For one thing, the population of patients suffering from these two disorders are very different. Prosopagnosia patients are mostly elderly men. Capgras patients are mostly women, of no particular age, even children can have Capgras Syndrome. A second reason to think that these disorders were unconnected was that the selectivity that defines Capgras is absent in prosopagnosia: the latter disorder is an impairment in recognizing faces in general, not of loved ones in particular.

This changed in 1984, when it was discovered that in prosopagnosia certain autonomic reactions to familiar faces are still intact (Bauer). It appeared that patients reacted with a Galvanic Skin Response (GSR) — of lie-detector fame — to photographs of faces of familiar persons. So there had to be a brain circuit that was still operating, recognizing faces in a way that was inaccessible to the patient. It was hypothesized that face recognition requires the concerted effort of two separate systems, one system for *visual* recognition and a second system for

emotional recognition. These two systems operate independently in the sense that damage to the visual system doesn't automatically impair the emotional system and vice versa, their relation being what neurologists call a "double dissociation."

Taking their lead from this two pathways theory on face recognition, two British neuropsychologists, Hadyn Ellis and Andrew Young, argued that Capgras Syndrome could very well be the *reverse* of prosopagnosia, with visual recognition still intact, but the second circuit, processing emotion, blocked or damaged. In that case one would predict that Capgras patients will fail to show autonomic responses to familiar faces — which turned out to be the case. What is wrong with a person suffering from Capgras is that he perfectly recognizes his loved ones, but has no longer the familiar response of warmth and sympathy to match their face — an explanation that is indeed reminiscent of what Joseph Capgras suggested in the first place, but which could now be tested experimentally.

This was a very elegant theory, seducing many to think of Capgras Syndrome as a disorder involving damage to — probably — the amygdala or the pathways leading to or from the amygdala, a disorder, therefore, of destructed circuits or severed connections. In the last five years or so, however, it turned out that there were a few loose ends. First, there are several other psychiatric conditions in which patients fail to show galvanic skin responses and not all of them lead to Capgras-like symptoms. Second, sometimes the trigger for Capgras Syndrome seems to have a decidedly *psychological* nature. It is hard to imagine that — say — a divorce could lead to the kind of brain damage that is assumed in the neurological explanation. Third, there have been cases in which the trigger for Capgras Syndrome was non-visual. A woman in Germany became convinced that her daughter, who had moved to America, was replaced by a double, a suspicion that originated from phonecalls (Dietl et al.). And finally, there are cases of *blind* Capgras patients. A blind Brazilian woman insisted that her husband was a double: she said she found out about the deceit because this man was a little fatter than her real husband and smelled differently (Dalgalarondo et al.). If the two pathways theory still holds, it cannot be a matter of visual recognition only.

III. Dr. Hayes and Dr. Weber

After the accident Mark is under the care of Dr. Hayes, a neurologist in the Good Samaritan Hospital in Kearney, Nebraska. Dr. Hayes is hardly a rounded character in the novel. We don't learn much about him, he is simply there to represent modern neurology, and this he does very well. He's the man with the answers. He knows all about the three-part brain — the reptilian brain, the mammalian brain and the human brain, he knows that in cases of coma the fifteenth day is the point of no return. And

he knows what is wrong with Mark. To Karin he explains the damaged neurological circuitry behind Capgras Syndrome: “The part of his brain that recognizes faces is intact. So is his memory. But the part that processes emotional association has somehow disconnected from them.” (61) There isn’t much he can do about that, Capgras is the kind of condition that will either stay or improve spontaneously.

But no such thing happens and after weeks and months of rehabilitation Mark still thinks that Karin is doubled by an impostor, who, by this time, goes by the name of K2. That’s where Dr. Gerald Weber enters the novel. Karin chances upon his books and finds them fascinating. He is a famous New York neurologist, modelled, in a not very covert way, on Oliver Sacks. In contrast to Powers’s handling of the Dr. Hayes character we learn quite a bit about Dr. Weber. He has a face, to start with, he is a man with gentle, contemplative eyes, “a cross between Charles Darwin and Santa Claus.” (101) He writes books with fancy titles like *Wider Than the Sky* or *The Three-pound Infinity*. These books contain case histories, emphasizing individual’s stories rather than medical wisdom. They also celebrate the brain’s plasticity and “neurology’s endless ignorance” (93). Apparently he is a neurologist who still does house calls, for he visits his patients in their own surroundings, spends time with them, talks with them. He is the man with the questions. He is, in every respect, the reverse of Dr. Hayes. Though it seemed the longest of shots, Karin writes him a letter, persuading him to come down to Nebraska.

Soon after, the focalization shifts to Dr. Weber in his New York apartment. Reading Karin’s letter he is tempted by the possibility of personally examining such a rare case of Capgras Syndrome after closed-head injury. One of the pivotal scenes in the book, as far as matters neurological are concerned, is the professional conversation between Hayes and Weber. Weber travels to Nebraska and consults Dr. Hayes, who is, after all, Mark’s neurologist. Hayes is delighted that such a celebrity in the profession should turn up in his office in Kearny, Nebraska. Within a few minutes he has asked for autographs in Weber’s last two books and he is eager to share his thoughts on Mark’s condition. He invites Weber to the light box to show him a couple of scans of Mark’s brain in cross section. That is where it becomes clear that these two neurologists are worlds apart. The young neurologist indicates all kinds of cerebral structures, whereas Weber can’t help thinking how scans like these remind him of butterflies:

Hayes traced over the surreal art. Each shade of gray spoke of function or failure. This subsystem still chattered; this one had fallen silent. “You see what we’re dealing with, here.” Weber just listened to the younger man stepping through the disaster. “Something that looks like possible discrete injury near the anterior right fusiform gyrus, as well as the anterior middle and inferior temporal gyri.”

Weber leaned toward the light box and cleared his throat. He didn't quite see it.

"If that's what we're looking at," Hayes said, "it would fit the prevailing understanding. Both the amygdala and the inferotemporal cortex intact, but a possible interruption of connection between them."

Weber nodded. The current dominant hypothesis. (131)

But Weber is not convinced. He says that he has seen cases with bilateral damage to the amygdala without Capgras-like symptoms. He doesn't doubt that lesions contribute to Mark's condition, but there is still need for a more comprehensive explanation. Hayes reacts with incredulity: "Something more than neurons, you mean?" And then Weber is ready to state *his* creed:

There is a higher-order component to all this, too. Whatever lesions he has suffered, he's also producing psychodynamic responses to trauma. Capgras may not be caused so much by the lesion *per se* as by large-scale psychological reactions to the disorientation. His sister represents the most complex combination of psychological vectors in his life. He stops recognizing his sister because some part of him has stopped recognizing himself. I have always found it worthwhile to consider a delusion as both the attempt to make sense — as well as the result — of a deeply upsetting development.

After a beat, Hayes nodded. "I'm ...sure it's all worth thinking about, if that interests you, Dr. Weber." (132)

Weber is prepared to agree that the days of psychoanalysis are over, clearly Mark's condition doesn't follow from some incestuous desire. Still, he feels he owes Mark "more than a simple, one-way, functionalist, causal model" (133), and says so to Dr. Hayes. The two doctors finish their conversation with professional politeness, but this brief encounter exposed the incommensurability of their perspectives.

Many of the differences of opinion can be summarized in terms of Luria's dichotomy between classical and romantic neuroscience. For Hayes, explaining Mark's delusions is a matter of reduction to the level of damaged circuitry. Whatever there is in terms of "something more than neurons," is irrelevant to understanding his condition. The cerebral injury is at once detected, proven and shown by brain imaging technology, the icon of high tech medical science. Scans are measurements visualized, persuasive arguments for quantitative science. Mark, as a person, a self, is eclipsed by technological representations of the damage in his brain. Weber, on the other hand, insists that a psychological link should be inserted between the injury and its expression in the behaviour of the patient. This requires observation rather than experimentation, and conversations rather than measurements. His own research on Mark's condition is very low tech. He presents a few paper-and-pencil-tests and asks him to do the Benton Facial Recognition Test. During one of their conversations Weber produces a portable GSR-device. This is as close as he comes to an instrument-aided assessment.

Of course the methodology was all wrong. There should have been a separate device operator and reader. His calibration trials were primitive at best. No randomizing, no double blind. No controls. Nothing in Karin's pictures gave him any baseline. But he was not sending this data to a refereed journal. He was just getting a rough sense of this shattered man, of Mark's attempts to tell himself back into a continuous story. (143)

The session with the GSR-device is a mockery of an experiment, it proves, in fact, that Weber isn't an experimentalist at all. What he really aims at is Mark's story, the personal expression of his reaction to the cerebral damage he suffered. This is the type of diagnostics that suits him. It is also his claim to fame. Weber reflects: "For twenty years, he'd built a reputation on exposing the inadequacy of all neural theory in the face of the great humbler, observation" (145).

IV. The Lure of Romantic Science

By introducing Dr. Weber as a somewhat anachronistic neurologist in a discipline dominated by the conventions and values of classical science, Powers has been able to capture some of the earlier thoughts on Capgras Syndrome. There is, however, a puzzling aspect in Powers's handling of Weber and Hayes. The Hayes characterization can be summarized in the terms Weber reserves for his type of diagnosis: flat, one-dimensional, linear, simplistic. Powers didn't give him a life, a first name. He is anonymous, a blank, the type of mainstream neurologist completely interchangeable with his colleagues in the next-door hospital. Powers lets Weber represent the subtler position, his is the sophisticated view on Mark's condition. Yet the persiflage of Weber and his romantic style of practising neurology is viscous and hostile. Towards the end of the novel, Powers lets him come to think of himself as a charlatan, a fraud, someone who invades his patient's privacy, writing bestsellers at the expense of other people's misery. There is an intense ambivalence in the Weber character that many readers will experience as a conflict in their "logique des émotions."

The Echo Maker represents a type of narrative that has disappeared from present medical discourse. It gives a voice to a delusional mind. Like Weber, the novelist is after the story of the patient. He may even draw a wider circle around the patient, a circle that includes family and friends. What Powers does superbly well is showing the devastating effect Capgras Syndrome may have on the patient's loved ones. Karin has to live with the various versions of herself: as she was before Mark's accident, as she is now, as she is in Mark's memory, too much to be integrated in a single self. It also affects those who interact with Mark on a professional level. Even Dr. Weber can't keep himself together — which, incidentally, testifies to his sensitivity. Dr. Hayes experiences no troubles whatsoever. When he flies back to

New York, having failed in his attempt to help Mark or Karin, he doesn't even want to be himself. The man in the seat next to him asks:

"Don't I recognize you?"

Weber flinches, a lopsided phantom grin stolen from one of his patients. "I don't think so."

"Sure, the brain guy."

"No," Weber says.

The stranger examines him, suspiciously. "Sure. The Man Who Mistook His Life for a..."

"Not me," Weber insists. "I'm in reclamation." (449)

Towards the end of *The Echo Maker* it is perfectly clear that Capgras is more than a disorder contained within the individual, it has an essential social dimension. This brings us — full circle — to the very beginning of the book: a sentence from Luria that graces *The Echo Maker* as its motto. It reads: "To find the soul it is necessary to lose it." If one reads the sentence in its context, it is clear that Luria (1982) hinted at the essentially *social* nature of the self. The sentence leading up to the motto reads: "To discover the sources of free action it is necessary to go outside the limits of the organism, not into the intimate sphere of the mind, but into the objective forms of social life; it is necessary to seek the sources of human consciousness and freedom in the social history of humanity. To find the soul it is necessary to lose it." (23) In these lines Luria articulates a view that is central to his own work, as it is to *The Echo Maker*, in which the main protagonists are struggling with their identities and desperately try to find their souls by weaving their selves into the fabric of social life.

Works Cited

- Bauer, Russell M. "Autonomic Recognition of Names and Faces: a Neuropsychological Application of the Guilty Knowledge Test." *Neuropsychologica* 22 (1984): 457-69.
- Berson, Robert J. "Capgras' Syndrome." *American Journal of Psychiatry* 140 (1983): 969-79.
- Blount, G. "Dangerousness of Patients with Capgras Syndrome." *Nebraska Medical Journal* 71 (1986): 207.
- Bourget, Dominique and Laurie Whitehurst. "Capgras Syndrome: a Review of the Neuro-Physiological Correlates and Presenting Clinical Features in Cases Involving Physical Violence." *Canadian Journal of Psychiatry* 49 (2004): 719-25.

- Capgras, Joseph and Jean Reboul-Lachaux. "L'illusion des 'sosies' dans un délire systematisé chronique." *Bulletin de la Société de Médecine Mentale* 11 (1923): 6-16.
- , and Paul Carrette. "Illusion des sosies et complexe d'Oedipe." *Annales Médico-Psychologiques* 82 (1924): 48-68.
- Dalgalarondo, Paulo, Giane Fujisawa and Claudio E.M. Banzato. "Capgras Syndrome and Blindness: Against the Prosopagnosia Hypothesis." *Canadian Journal of Psychiatry* 47.4 (2002): 387-88.
- Dietl, Thomas, Alexandra Herr, Hans Brunner and Elisabeth Friess, "Capgras Syndrome — Out of Sight, Out of Mind?" *Acta Psychiatrica Scandinavia* 108 (2003): 460-63.
- Draaisma, Douwe. *Disordered Minds*. Cambridge UP, forthcoming.
- Ellis, Hadyn and Andrew Young. "Accounting for Delusional Misidentifications." *British Journal of Psychiatry* 157 (1990): 239-48.
- , Janet Whitley and Jean-Pierre Luauté. "Delusional Misidentification. The Three Original Papers on the Capgras, Frégoli and Intermetamorphosis Delusions." *History of Psychiatry* 5 (1994): 117-46.
- Haddon, Mark. *The Curious Incident of the Dog in the Night-Time*. New York: Doubleday, 2003.
- Lethem, Jonathan. *Motherless Brooklyn*. New York: Doubleday, 1999.
- Luauté, Jean-Pierre. "Joseph Capgras and His Syndrome." *Bibliotheca Psychiatrica* 164 (1986): 9-21.
- Luria, Alexander. *The Mind of a Mnemonist*. Cambridge, MA: Harvard UP, 1968.
- . *The Man with a Shattered World*. New York: Basic Books, 1972.
- . *The Making of Mind*. Cambridge, MA: Harvard UP, 1979.
- . *Language and Cognition*. New York: Wiley, 1982.
- McEwan, Ian. *Enduring Love*. London: Cape, 1997.
- . *Saturday*. London: Cape, 2005.

Meulenberg, Frans, and Arko Oderwald. "Wat wil het geval...? Gevalsbeschrijvingen in medische wetenschap en journalistiek." *Medische publiekscommunicatie. Een panorama*. Eds. Frans J. Meijman and Frans Meulenberg. Houten: Bohn, Stafleu, Van Loghum, 2002.

Murray, J.R. "A Case of Capgras Syndrome in the Male." *Journal of Mental Science* 82 (1936): 63-66.

Pauw, Karel W. de. "Psychodynamic Approaches to the Capgras Delusion: a Critical Historical Review." *Psychopathology* 27 (1994): 154-60.

Powers, Richard. *The Echo Maker*. New York: Farrar, Straus and Giroux, 2006.

Robotham, Michael. *The Suspect*. London: Time Warner Books, 2004.

Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*. London: Picador, 1985.

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make compatible the rhetorical-narratological interest in formal and stylistic characteristics with the study of the interaction of various discourses, media and contexts.

LUC HERMAN AND BART VERVAECK, "Capturing Capgras: *The Echo Maker* by Richard Powers" / 407

This essay deals with focalization and narration as the two central means used in Richard Powers's novel *The Echo Maker* to capture the 'deranged' mind of Mark Schluter, the central character who suffers from Capgras and paranoia. The cognitive neurologist, Dr Weber, regards his science as a form of storytelling, but as a narrator he refuses to enter the minds of his characters (i.e., patients). This turns him into an unreliable narrator and makes it impossible for his patients to become the tellers of their own life stories. They are separated from their own history, which is exactly what happens in Capgras. This condition is all about the gap between seeing (a loved one) and feeling (nothing for that person). As a focalizing subject, Mark is unable to find the right balance between, on the one hand, an exaggerated form of empathy and mindreading (paranoia) and, on the other, a total lack of empathy (Capgras). To some extent, all characters have problems with empathy and mindreading. The novel turns Capgras into a 'contagious' disease and a symptom of our present day condition. To illustrate the interaction between focalization and narration this essay concludes with an analysis of Mark's initial, hallucinatory experiences, just after his fatal accident. In the beginning he identifies himself with the cranes, birds that represent history and continuity. Then he tries to free himself from that identification and gain a separate identity. But in so doing, he dissociates himself from his past, which is retold and rewritten so drastically that it can no longer be felt and relived.

DOUWE DRAAISMA, "Echos, Doubles, and Delusions: Capgras Syndrome in Science and Literature" / 429

Mark Schluter, the main protagonist in Richard Powers's *The Echo Maker* (2006), suffers from Capgras Syndrome, a disorder characterized by the patient's delusional belief that his near ones are replaced by doubles. Since its initial identification in 1923, Capgras Syndrome has had a two-stage history. Until the 1970s the delusion was explained in terms of psychodynamic forces, assuming, for instance, that creating a double was the patient's subconscious way of handling mounting tensions between ambivalent feelings towards his near ones. As a rule, these explanations were based on case histories, which were dealt with as narratives. In the 1980's, however, Capgras Syndrome came to be seen as caused by a neurological deficit, severing the connection between visual and emotional recognition of familiar faces. This explanation originated from research on the neurological representation of face recognition. In my paper I argue that by introducing *two* doctors for Mark – the one, Hayes, a modern, experimentally oriented neurologist; the other, Weber, an old-school neurologist versed in case studies – Powers succeeds in collapsing chronologically disparate stages in the history of Capgras Syndrome into a contemporary clash between two scientific styles. In this way Powers seems to present the best of both worlds: a narrative orientation to give a voice to the perspective of a patient struggling with his identity, and a state of the art neurological account of the organic lesion causing the loss of identity in the first place.