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CAPGRAS' SYNDROME

by

ROBERT J. BERSON

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1982

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Abstract

CAPGRAS' SYNDROME

by

Robert J. Berson

Advisor: Professor Harold Wilensky

Capgras' Syndrome, the delusion of doubles, is a rare delusional phenomenon in which a person believes that identical doubles have replaced significant people in his life and/or that there exist identical doubles of himself. These delusional doubles are almost always believed to be malevolent. The delusion occurs in a variety of psychotic states, usually schizophrenia. It occurs in both women and men in a wide age range. This dissertation reviews early French reports by Capgras and his associates as well as over 100 cases reported in English. Previous efforts to explain the Syndrome have stressed both organic and psychodynamic factors. The Syndrome has been observed with many organic conditions, but the allegation of doubles is selective, the problem is not misrecognition but belief, thus psychodynamic factors must be significant. Psychodynamic explanations have emphasized four major themes:

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Oedipal problems in women, feelings of strangeness, intolerable ambivalence, and pathological splitting. An approach to the delusion based on object relations theory seems most comprehensive, because it is the manner in which images of self and others are internalized that appears to underlie the delusion. For Capgras' Syndrome to develop there must be paranoid characteristics, a psychotic state, and, I suggest, severe disturbances in early internalized object relations. The case presented here illustrates the application of an object relations approach to the history of a 32 year old woman who believed that her mother, uncle, and cousin (her only living relatives) had been replaced by doubles and that there were two doubles of herself. This woman experienced inadequate mothering in infancy, became an isolated and aloof adolescent, and suffered the onset of a schizophrenic illness in her mid-twenties, just after completion of medical school. Capgras' Syndrome is a frightening yet uncannily familiar phenomenon. The idea of doubles has long had a place in human religion and literature, and to make the Syndrome more conprehensible and thus more treatable it is appropriate to examine the use of the idea of doubles in fiction. It is also useful to build a continuum from the psychotic delusion of doubles through the neurotic "family romance" toward a recognition of similar dynamics in normal life.

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Man's best friend is not the noble dog, but the reference librarian. I wish to thank the following friends for their help: first, the staff of the Bolling Medical Library of St. Luke's Hospital, Nancy M Panella, Chief Librarian, Marlene Horowitz, Carroll H. Otis, and especially Robert J. Garrett whose great efforts unearthed great finds and whose interest and humor lessened my load; second, the staff of the Esther Raushenbush Library at Sarah Lawrence College, Rose Ann Burstein, Head Librarian, Phyllis N. Byan, Margaret Haag, Jeanne L. Schwarz, Margaret S. Protzman, Judith Kicinski, and Stephanie S. Pfaff; and third, Ellen H. Poisson, Senior Assistant Reference Librarian, Samuel J. Wood Library, Cornell University Medical College.

I would also like to thank the members of my supervisory committee, Harold Wilensky, Arthur Arkin, and Laurence Gould, and the outside readers, Paul Nassar and Paul Wachtel. Their interest and support have been deeply appreciated.

This is the second dissertation which Robin, Jessica, and William have had to endure. For them, apologies, gratitude, and love.

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I

Introduction

In early July of 1979 a young woman was admitted to the psychiatry service of the large urban hospital where I had begun my interneship in clinical psychology. She said that her mother had died earlier that week and that she had become "despondent" and tried to jump out a window (she was restrained by a friend) after hearing voices telling her to join her mother. She resisted the idea of hospitalization at first, but with minimal persuasion she agreed to a voluntary admission. The woman, Ms. F., said she was a single, Jewish woman of 32 who had lived alone with her mother since her father's death seven years before. She told us that her parents had been hidden during the Holocaust, she herself had been born in 1947 in Austria, and the family had come to the United States in 1949. She said she had attended a public high school and city college, then worked for a credit firm until her father's death, when her inheritance enabled her to stop working. Since then, she said, she had occupied herself by visiting museums, attending concerts, and reading. There were no siblings and no living relatives. "I am used to my

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solitude," she said in response to a question, "and I feel all will be well--I feel an inner strength. . .I have no functional problems, the voices were a transient aberration; the admission was inappropriate." She was dirty and unkempt, her mood depressed and her affect strikingly flat. She was fully oriented, alert, and clearly well educated. There were no obvious defects in memory or cognition. She was diagnosed as suffering a psychotic depression and started on a low dose of neuroleptic medication.

For several days she repeated her story to a sympathetic staff. Then, with no apparent reason, she began to tell a different story. She told us that she had graduated from a local medical school, had during her residency unwillingly become part of a five-year psychoanalytic film study in which her entire life had been filmed, had sued for invasion of privacy and had been awarded five hundred million dollars, but had then been "incarcerated" at a nearby state hospital by the "film director-psychologists" who wanted the money for themselves. She had escaped from the hospital, lived with a man she picked up on the street, then come to the West Side of Manhattan where she "engaged in sexual deviancy with several men for the profit of the film director-psychologists."

We on staff were convinced that the story of filmed studies and law suits was delusional, but we gradually were struck by an awareness that we had believed the first story

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without obtaining any evidence other than the words of Ms. F. herself. When we discovered that she had given a false address, we realized that there were two "crazy" stories and that we knew nothing of our patient's "real" life. It was at about that time, a week or so after her arrival on the ward, that Ms. F. added that the "film director-psychologists" had put a "double" in her place to collect the five hundred million dollars and that while her "real mother" had died long ago, an "imposter mother" was alive, living in a nursing home, and was a "double" of her real mother. It was at this point that we realized that our patient suffered from the delusion of doubles first described by Capgras and Reboul-Lachaux in 1923.

In this essay I will attempt to achieve an understanding of Capgras' Syndrome through a review of the literature and a discussion of the patient I treated. I will first define the syndrome, review the psychological literature, and present the explanatory hypotheses that have been suggested. In discussing the explanatory hypotheses I will indicate their inadequacies and suggest an explanatory hypothesis based in object relations theory. I will then present the data of the case of Ms. F., concluding with an application of the object relations approach to her illness. Finally, I will attempt to place Capgras' Syndrome in a broader context, looking for its roots and analogues in both normal and neurotic experience and in fiction as well, and examining the implications of my inquiry for both further research and effective treatment.

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There are significant limitations to this study. Capgras' Syndrome is a relatively rare phenomenon (See Appendix for a list of cases reported in English language literature), and I am able to discuss only one case in detail. The data for my case are themselves limited, for my patient was as highly guarded as she was severely ill, and the external sources of data I eventually encountered were so deeply distressed by Ms. F.'s illness that I decided not to press them. The data from the professional literature are often sparse as well, especially with regard to information about the early life experiences of the patients described. Thus I must construct a hypothetical argument on less than adequate data. Recognizing these limits, however, I believe that a heuristic essay thoroughly examining, as I have done, as much of the literature as possible, can provide the basis for the better understanding and treatment of patients presenting the delusion of doubles.

Ms. F. was one of the first patients of my interneship year. The tragedies of her history, her illness, and her death made my experience with her an unforgettable encounter. (See Chapter III.) It became an absorbing personal commitment to try to learn about the Syndrome, to uncover especially the earliest reports, and to struggle with the explanations offered--explanations at first so convincing, but then so obviously incomplete. I felt I owed it to her at least to understand better. There is another reason

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as well for this essay. The tragic waste of life, influenced at least in part by the horror of the Holocaust, should not be permitted to go untold. The story should be spoken.

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II

Capgras' Syndrome

"The Capgras' Syndrome," write Enoch, Trethowan, and Barker (1967), "is a rare, colorful syndrome in which the patient believes that a person, usually closely related to him, has been replaced by an exact double."(p.1) The syndrome is indeed rare--I have been able to discover, utilizing computer searches as well as texts, only about 124 case reports in the English language literature. (See Appendix.) Foreign language sources are harder to unearth, but I have obtained the first three case reports by Capgras and his associates as well as French accounts of approximately 25 cases reported from 1923 to 1962. Citations in the more recent French papers indicate that the total number of cases in the French literature is also small--I have located citations indicating approximately 50 reports. (An indirect indication of the rarity of the syndrome may be taken from the eagerness with which so colorful a syndrome is reported: the appearance of the syndrome is so dramatic that nearly everyone who has had contact with it seems to write an article; most of the articles are unimpressive, offering little more than description, and some of the articles report cases that fail to meet the descriptive diagnostic criteria. Lansky (1974) comments: "The

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clinical presentation is so striking it is unlikely that the syndrome occurs frequently and is overlooked."(p.363) If so eagerly reported a syndrome has produced so few published articles, one may, I think, assume its relative rarity.)

Arieti and Meth offer the following definition and description of Capgras' Syndrome in the first edition of The American Handbook of Psychiatry (1959):

> The phenomenon (or syndrome) described by Capgras is the following: the patient will claim, on meeting someone he knows well, that the person is a double or an impostor who has assumed this person's appearance. For example, the mother of a female patient comes to visit the patient at the hospital. The patient claims that this visitor is not the mother but either a double of her or an impostor who has tried to assume the appearance of the mother in order to deceive the patient. The phenomenon is this complicated type of misidentification, much more characteristic and specific than the usual misidentifications occurring in schizophrenia. (Vol. I,p.548)

The descriptions offered both by Enoch, Trethowan and Barker and by Arieti and Meth are incomplete, for the first patient described by Capgras not only claimed that there were doubles of significant other people in her life, but also claimed that there were doubles of herself.(Capgras and Reboul-Lachaux, 1923) One reason for this descriptive incompleteness may lie in Arieti and Meth's use of sources. Arieti and Meth cite a report in Annales Médico-Psychologiques which is actually a two paragraph summary of a full ten page report in the Bulletin de la Société Clinique de Médicine Mentale. The summary does not mention the patient's belief in doubles of herself; the full paper speaks at length

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about this symptom. Many other authors whose papers I have read also cite the summary rather than the full report. While most patients claim that there are doubles of others, some--including the original patient--claim that there are doubles of themselves as well. It might be wise, then, to define the Capgras' Syndrome as the delusional belief in the existence of identical doubles of others and/or of oneself.

The first report of a patient with this delusion is the report of Capgras and Reboul-Lachaux (1923) already mentioned. (Earlier descriptions of the delusion by Bessiere, Janet, and Magnan are reported by Todd, Dewhurst, and Wallis, 1981.) Capgras and Reboul-Lachaux entitled their report "L'Illusion des 'Sosies' dans une Délire Systematisé Chronique" or "The Illusion of Doubles in a Chronic Systematized Delirium." (*Sosie* is the French word for double. It is derived from the name Sosia; Sosia was the servant of Amphitryon in Plautus' play *Amphitryon*, in which Mercury impersonated Sosia. In Greek mythology impersonations and transformations are not uncommon. Indeed, Zeus himself impersonated Amphitryon in order to sleep with his wife Alcmena; Alcmena conceived by Zeus her son, Heracles.) Capgras and Reboul-Lachaux chose to speak of the phenomenon "after the manner of the patient"(p.12) who herself used the word "sosie."

The patient was a woman of 53 at the time of the report. She had married at 29 and had one living child,

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a daughter of 20; four other children had died at birth or in infancy. Her husband stated that she had been in a "nervous state" beginning three or four years after their marriage (she would have been 33 or 34 and had lost two children); her state became more severe after the deaths of her twin sons when she was 37. Her early symptoms included hearing the moaning of children from under the ground, which led to a belief that there were hidden caverns beneath the streets of Paris filled with kidnapped children. Several years later she told her husband that he was an impostor, a double. Little is told of her early history (a difficulty with most case reports of Capgras' Syndrome), save that she had attended school to the age of 14, then worked as a seamstress. Her delusions seemed to have been systematized and fixed from about the age 44 on. These delusions consisted of ideas of grandeur (that she was the kidnapped daughter of aristocrats), ideas of persecution (her princely fortune was being stolen, people were trying to poison her), and the belief in doubles.

In addition to believing that her husband had been replaced by a double, she asserted that three of her dead children had not died but had been carried away and replaced by (dead) doubles. (The other child had been poisoned, she said.) Furthermore, doubles had replaced her concierge, her domestic servants, tenants in her building, and so on. Police officers too had been replaced by impostors (frustrating her efforts, she claimed, to bring these matters to

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the attention of the authorities) as well as doctors, staff, and patients in the hospital. In addition, she asserted that "she (herself) had two or three doubles of which she knew."(p.8) These doubles of herself were part of the plot to forge her papers and steal her fortune and to have her held in captivity. "How is it possible that such an illusion be born and develop?" ask Capgras and Reboul-Lachaux.(p.13) To answer their question, they argue persuasively that for this patient a long period of anxiety and agitation (following the deaths of her children) brought about her first delusions and hallucinations which in turn produced a "feeling of strangeness" ("sentiment d'étrangété.") The feeling of strangeness did not distort either perception or memory, however, and so well-known and well-remembered people were recognized accurately but in association with a profound and pervasive feeling of strangeness. In order to make sense of this, the patient concluded that the people she saw were impostors. "The illusion of doubles, for her, is thus not, to speak correctly, a sensory illusion, but the conclusion of an affective judgment."(p.14) Capgras and Reboul-Lachaux do not specifically explore the symptom of belief in doubles of the self except to say that too fits into the general delusion of persecution as the patient tried to explain why she was hospitalized and why she was unable to claim her ancestral inheritance. Of significance in their understanding of the formation of

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the delusion was the patient's "paranoid disposition. . . very marked inclination to distrust and minute investigation of the slightest details."(p.14)

The second case of the delusion reported in France is described in a short paper by Halberstadt (1923). "Doctors Capgras and Reboul-Lachaux have had the merit of recently calling attention to a new clinical syndrome to which they have given the name of illusion of doubles."(p.728) writes Halberstadt. His patient was a 41 year old woman, married, with a son of 20. At 24 she had a hysterectomy, afterward becoming "neurasthenic," melancholic, and eventually suicidal. Several years later she had developed ideas of grandeur, bought things at random, and made large gifts of money. By her late 30s she was aloof, hostile, and irritable; she expressed paranoid delusions of people trying to poison her, spoke at times in neologisms, and suffered from auditory hallucinations, thought insertion, and thought broadcasting. She asserted there were doubles of her husband, son, doctor, and nurses. Halberstadt does not speak at length about a belief in a double of the self, but notes that his patient believed that "All the world has a double, she like the others."(p.729) Halberstadt attributes the development of the delusion to "transitivism," a state in which the external world appears changed, and to regression to primitive, pre-logical modes of thought, in a patient with a paranoid suspiciousness. Halberstadt,

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however, notes that he offers his observations with reservations, as a hypothesis rather than explanation. "It is," he writes, "extremely difficult if not impossible to 'explain' the genesis of all delusions. The mentality of the _aliéné_ is not in all ways similar to that of the normal man, his manner of creating and coordinating concepts is not ours, contradictions and implausabilities do not shock him." (p. 732)

Capgras reported his second case of the delusion of doubles in 1924 (Capgras and Carette, 1924). The patient was a woman of 33 who had been psychotic for eight to ten years at least. This woman had always loved her father more than her mother; she idealized him and was attentive to his physical and emotional state. She willingly broke off her only emotional attachment to a young man because her father disapproved. She hated her mother, however, for the mother was critical, pointing out her homeliness and masculine traits. The patient was from adolescence on obsessed about her appearance and its effects on others; at 18 she became withdrawn, seeking solitude in which she ruminated about the hateful mother who had caused her such pain; eventually she became irritable and antisocial and her agitation and threats necessitated hospitalization. For six years her thoughts concentrated on "tenderness toward the father, hatred toward the mother."(p.60) Her feelings toward her father

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> constituted the principal concern of the patient, which she analyzed without cease and of which she spoke the most abundantly. She acknowledged with the most naive shamelessness her love for her father. In periods of calm this love appeared almost filial. It expressed itself most often in a melange of sentimental tenderness, of eroticism and of jealousy, ordinarily placid enough and without a truly passionate character. But if, upon the influence of a commonplace annoyance, there occurred a crisis of excitation, immediately the sensuality awakened and Blanche overpowered with obscene insults the father who did not respond to her desires and the mother who was her rival. (p.60)

"The exteriorization of the Oedipus complex was entirely spontaneous," write Capgras and Carette, "without the least intervention of psychoanalysis."(p.61) The general "psychic enfeeblement" (what we might call weakening of the ego?) of the psychotic illness led, they believe, to the eruption of Oedipal impulses into consciousness.

> Nevertheless the psychic deficit and the correlative diminution of the moral sense did not entirely abolish the Censorship. This latter, henceforth incapable of repelling the Oedipus complex, concealed it under the influence of modesty and unconscious shame which subsisted in spite of the shamelessness of the utterances, with the aid of a new conception, the illusion of doubles, which is, in effect, contemporaneous with the erotic acknowledgement. At the same time that she declared her incestuous desires to her father, Blanche took him for a stranger of the same appearance: she built then a small delirium from which it followed that her parents had sold their clothing and furniture to the doubles with whom she lived and who came later to see her in the asylum. It was thus not to her true father but to a double of him that she had made her voluptuous demonstrations. (p.61)

The invention of the double was a final effort of "the Censorship," which could no longer repress the Oedipal impulses entering consciousness, but could make them acceptable by displacing them from the father to a stranger, a

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double who "looked like" her father. The patient, "far from seeking to veil her desire, was irritated at not being able to satisfy it." (p.62) She sought to have the "double" divorce the other woman and marry her. In distinction from the first reported case, write Capgras and Carette, the delusion of doubles in this second patient was precipitated not by a feeling of strangeness, but by "a sudden insight provoked by unconscious shame."(p.62) The patient asserted that the truth of her beliefs had been confirmed by invisible voices and that invisible spirits had put the appearance of her parents on the strangers who came to see her.

The fourth case of the delusion of doubles appears in a brief report by Dupouy and Montassut (1924). Their patient, also a woman (age not given), suffered from a psychotic illness of at least six years' duration, marked by auditory hallucinations (commenting, accusing, insulting, and menacing) and by the delusion of doubles. She believed that all her friends had been replaced by doubles and that a "woman of bad life" had taken her place as well.

> 'How else explain all the filth I hear? I do nothing bad, conduct myself without scandal. Why do they accuse me of having made revels with soldiers, why do they dirty me? I think that all of that happens to a double I have at home, who dresses herself in my clothes and who passes for me.'(p.343)

Dupouy and Montassut see the delusion, in their case, as a defensive process compensating for the difficulties of the psychotic illness; it permits the patient to make sense

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of her hallucinations and of the changes in her friends' responses to her.

Capgras reported his third case in 1925. (Capgras, Lucchini, and Schiff, 1925) This patient was a woman of 30 suffering from general paresis. She reported disagreeable body sensations, auditory hallucinations, and a feeling of strangeness: "Everything appeared changed to her. She herself was totally changed."(p.210) In addition she suffered hypnogogic phenomena: she visualized herself engaging in obscene acts with little men. And finally, she believed that her lover had been replaced by a double; she later asserted that members of her family had also been doubled. Capgras, Lucchini, and Schiff assert that the feeling of strangeness originated in this woman as she began to notice the emaciation caused by her syphilis, that the feeling of strangeness did not bring about a state of depersonalization, but rather elicited the delusion of doubles in an effort to combat the danger of depersonalization: "The illusion of doubles appears to us here as an extreme attempt made by the mind of the patient to struggle against the grave menace of depersonalization constituted in the feeling of strangeness."(p.214) Trying to make sense of the indefinable feeling of strangeness which attacked her, a sensation based in an awareness of an insidious physiological process (see Hollos and Ferenczi, 1925), this woman reacted by creating the double and thus explaining the vague changes she was experiencing.

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> The world (beings and landscapes) had changed around her. She herself had changed, and had to struggle to preserve the sense of herself. Her critical intelligence remained nonetheless strong enough to note the characteristic differences, and she built her illusion of the double as the only rational explanation of the change. (p.214)

For this patient the belief in doubles was an intellectual conclusion, made after acute observation of changed details, which adequately explained changed conditions. Her lover, for example, had in reality left her, then returned to live with her. The patient said, "The true Marcel did not desire me and the new /Marcel/ wants to resume relations with me, so he is no longer the same, he has been changed." (p. 214)

Capgras, Lucchini, and Schiff make two observations in this report which are of theoretical importance. First, comparing this patient to Capgras' two previous reports and to that of Halberstadt mentioned above, they note that the process leading to the delusions seems to differ from case to case; no single pattern emerges. They note, however, that at first the doubles are always of people to whom the patient has strong affective ties. The affective factor is important:

> Transformed into doubles were only those people to whom the patient was tied with intense affective sentiment such as, for example, her lover and an aunt who was very dear to her. (p.215)

(In all these early cases the first claims about doubles referred to intimates: children, parents, lover. Where the illness was of long duration, as in Capgras' first

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patient, the delusion seems to have generalized, including police and doctors, for example.) The second observation of importance comes in the effort of Capgras, Lucchini, and Schiff to relate the delusion of doubles to "normal" psychological phenomena. Recognition of others is a complex process, and we all experience ephemeral false recognitions and misrecognitions. "Who among us," they ask, "has not happened to encounter a friend having changed in some commonplace way the habitual aspect of his appearance and said to ourself: 'this is not he, as I know him, but someone who resembles him greatly. . .'?"(p.214)

I will not speak at length of other early French papers. (I have located references to approximately 50 cases reported in French journals from 1923 to 1936 and have read about half of those cases.) Of minor historical interest is the fact that the delusion of doubles was first called "Capgras' Syndrome" by Dupouy and Montassut in their 1924 paper (the fourth reported case) although Jacques Vie (1930) and Todd, Dewhurst, and Wallis (1981) assert that the honor was awarded by Lévy-Valensi in his paper of 1929. Also of interest is the fact that all of the 25 to 30 patients reported from 1923 to 1936 seem to have been women; the first man with the delusion is reported by Brochado in 1936.

Two French surveys do call for mention. Vie (1930) reviewed the cases of ten patients suffering from errors of recognition. He distinguished defects of memory from

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delusional errors and within delusional errors he distinguished positive doubles, in which non-existent similarities are asserted, from negative doubles, in which non-existent differences are asserted. An example of the assertion of positive doubles comes from a case in which a woman habitually engaged in sexual activities with many men and asserted, "They look different, but are my husband." (p.236) Vie writes that delusions of positive doubles represent a more "advanced degree of mental dissociation" than that which is found in Capgras' Syndrome, which is for Vie a delusion of negative doubles found in hallucinatory psychosis, paranoid dementia, confusional states, depression, general paresis, manic states, and so on. "The prognosis is, then, as variable as those of the states in which it finds itself inserted. . ."(p.231) Since the patients never see the double and the original at the same time, the syndrome is not an illusion, but an "hypothesis capable of explaining the changed attitudes of those close to [the patient]."(p.232) The delusion begins as a plausible explanation; that explanation, once adopted, becomes the central theme of the delusion. He concludes:

> The syndrome of doubles, whether it presents itself in a positive or negative form, does not carry in itself any special prognostic indication. Its gravity is that of the state which serves as its base. However, one can consider it as the interpretation of a profound blow to the conscious personality; it rests in general on substantial troubles in the feeling of self, primordial base of affectivity; the feeling of strangeness, of physical and moral change seeming so paradoxical to the patient that he is unable to restrain

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> himself from referring it onto the environment or from attributing it to some unwonted action of the environment upon himself. (p.236)

A year after Vie wrote his paper, Larrivé and Jasienski (1931) also published a review of the syndrome. They follow Vie in distinguishing Capgras' Syndrome, a delusion of negative doubles, from delusions of positive doubles in which there are affirmations of imaginary resemblances. Capgras' Syndrome, they argue, is "characterized by the refusal to admit, in the presence of known people, their true identity,"(p.502) and to explain changes in relationships by the imposition of doubles. In addition, only patients with Capgras' Syndrome use the characteristic word "double" (<u>sosie</u>).

> The syndrome signifies a psychological reaction towards the affective modifications which accompany the psychosis, a correction brought by the patient to the bizarre sensations and to the feelings of strangeness which invade him. (p.503)

Summarizing the divergent psychological explanations offered by previous authors for the onset of the syndrome, Larrivé and Jasienski conclude that there is no single, simple psychological explanation.

> In fact, the illusion of doubles appears secondarily, in the course of a psychosis. It is a defensive reaction which is opposed to diverse troubles which threaten one or another element of mental synthesis. (p.503)

Larrivé and Jasienski argue that the syndrome does not involve perceptual or memory problems, but rather represents the <u>least</u> unreasonable explanation a psychotic patient can

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offer to make sense of his experiences. They note that the delusion seems to occur most often in the context of chronic paranoid delusions and that all reported cases have been of women. The new case they report is that of a paranoid woman of 52 who claimed that there were doubles of (in order of assertion) her lover, her sisters, her brother-in-law, and her self. In their case, as in most others, there was no sign of intellectual impairment or of neurological problems; their patient, except for her paranoid illness, was in excellent health.

These early French descriptions leave us with the following impressions: Capgras' Syndrome is best described as a delusion in which the person believes in the existence of identical doubles of significant others and/or of himself. The delusion can occur in a variety of psychotic states (most often in paranoid schizophrenia) of both organic and functional origin and can be accompanied by a wide range of other symptoms. It is not an illusion, for no perceptual functions are impaired, nor an hallucinatory experience like autoscopy, and it is not a defect in memory. When the delusion is of doubles of others, the patient asserts that the real person has been replaced by an identical double, although slight changes in appearance or behavior are alleged to give evidence of the imposture; when the delusion is of doubles of the self, the patient asserts that impostors in his image are at work in the world interfering with his life by ruining his reputation or by

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claiming his wealth and property, etc. The prognosis for the syndrome is basically that of the psychotic illness. Explanations for the delusion vary with the particular history of each case, although it is clear that those who are doubled are always (at least initially, before the delusional system becomes all-encompassing) people to whom the patient is tied with strong affective bonds.

These early observations, acute and compassionate, are not significantly altered by more recent studies. The early reports present the basic phenomenological descriptions and present the basic outlines of the main explanatory hypotheses that have been offered. Like later reports, however, they provide very little information about formative experiences in the early life of the patients who are described. More recent studies, to which I will now turn, present us with two major questions: first, the relationship of Capgras' Syndrome to organic aetiology; and second, the need to develop an adequate psychodynamic hypothesis..

A number of authors have attributed the symptoms of Capgras' Syndrome to organic causes. In the approximately 20 to 25 papers arguing for organic causality, a wide variety of observations of organic conditions has been made. These include:

alcoholism (MacCallum, 1973);

basilar migraine (MacCallum, 1973);

brain tumor (Todd, Dewhurst, and Wallis, 1981);

cerebral atrophy (Gluckman, 1968; Nillson and Perris,1971);

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decreased platelet monoamine oxidase activity (Sullivan et al.,1978);

diabetes (MacCallum,1973);

EEG abnormalities (Christodoulou,1977,1978a,1978b; Malliaria and Christodoulou,1977; Kiriakos and Ananth, 1980);

head trauma (Fialkov and Robins, 1978; Weston and Whitlock, 1971);

low folic acid (MacCallum, 1973);

malnutrition (MacCallum, 1973);

myxedema (Madakasira and Hall, 1981);

organic brain syndrome (Goldfarb, 1974; Goldfarb and Wiener, 1977; Todd, Dewhurst, and Wallis,1981);

post varicella encephalitis (Nikolovski and Fernandez, 1978);

prosopagnosia (Granacher, 1978; Hayman and Abrams, 1977; Schraberg and Weitzel, 1979);

pseudohypoparathyroidism (Hay, Jolley, and Jones, 1974; Preskorn and Reveley, 1978);

right cerebral hemisphere dysfunction (Hayman and Abrams, 1977; Nillson and Perris, 1971);

temporal lobe epilepsy (Chawla and Virmani, 1977);

toxicity (MacCallum, 1973; Waziri, 1978).

The very variety of organic factors listed would tend to suggest that no one of these conditions could be <u>the</u> direct cause of the delusion of doubles. Some authors, however, make strong assertions of the <u>necessity</u> of organic conditions in producing the delusion. Waziri (1978), for example, in discussing one case in which neuroleptic toxicity seemed to precipitate the delusion, dismisses psychodynamic theory:

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"In explaining these symptoms one could invoke one of several facile psychodynamic explanations."(p.257). Because his patient demonstrated signs of organicity which "would tend to make psychodynamic explanations inadequate if not spurious,"(p.357) Waziri emphasizes brain dysfunction:

> Capgras' symptoms appear in individuals who have a brain dysfunction (probably involving the parietal lobes) as well as a psychosis. Neither the brain dysfunction nor the psychosis are [sic] sufficient basis for the Capgras' symptoms, but the simultaneous presence of both is necessary to produce these symptoms. (p.358)

Waziri's patient, a 30 year old woman with a 22 year psychiatric history, left his care with a diagnosis of chronic undifferentiated schizophrenia. While he thoroughly documents early physical problems, he says little of her early interpersonal experiences. He does mention that at eight she sought care for a number of problems and received a diagnosis of conversion reaction; that she was hospitalized for six months in her early 20s, displayed paranoid tendencies, sustained a marriage for only three months, and came into his care suffering hallucinations and delusions as well as Capgras' Syndrome. (Waziri has not read Capgras' paper: he refers to it, with inaccurate data, as cited in another work.) Even if the delusion of doubles was triggered by neuroleptic toxicity--her Capgras' symptom disappeared when Mellaril was discontinued--this woman clearly had major problems in living as well. Waziri concludes that authors who have reported Capgras' Syndrome as a functional

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phenomenon have simply not discovered the organic components in their patients.

It is, of course, appropriate to be alert for organic conditions in psychotic patients, but among authors who discuss organic factors as contributing to Capgras' Syndrome there is much contradiction. In distinction, for example, to Waziri's (1978) observation that the delusion of doubles disappeared along with the toxic psychosis, we must consider Christoudoulou's (1978) conclusion, based on studies of 11 Capgras patients, and in agreement with Enoch, Trethowan, and Barker (1967), that "the progress of Capgras' syndrome does not necessarily follow the course of the associated psychosis." (p.70) Christodoulou (1977) in turn observes that "an organic cerebral dysfunction probably contributes to the pathogenesis of the syndrome," (p.562) and cites substantial differences in Verbal over Performance scores on the WAIS as giving evidence (along with a variety of EEG abnormalities) of cerebral dysfunction. Shraberg and Weitzel (1979), referring specifically to Christodoulou (1977), report _no_ significant differences between Verbal and Performance scores in their two cases.

Shraberg and Weitzel (1979) postulate that Capgras' Syndrome is

> a peculiar but particular neuropsychiatric disorder involving the behavioral expression of an acquired integrative defecit (i.e., a disorder of facial recognition) in the presence of a psychopathological

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> condition (schizophrenia, paranoid states, or even depression). (p.315)

This disorder of facial recognition is prosopagnosia, a disorder which Hayman and Abrams (1977) also postulate lies at the basis of Capgras' Syndrome. The contention that prosopagnosia is the root of the delusion of doubles must be challenged, however, on the basis of literature discussion that entity itself. "Prosopagnosia," writes Meadows, (1974), "is the specific inability to recognize familiar faces." (p.489) Cohn, Newmann, and Wood (1977) concur, saying prosopagnosia is a "failure to recognize previously well known faces." (p.178) A male patient with prosopagnosia, for example, will not be able to recognize his wife in a "line-up" with three or four other women, but will immediately recognize her voice--and show no delusional thinking or paranoid distrust. This is clearly different from Capgras patients who suffer _no_ failure of recognition, but rather attribute delusional difference of identity to the instantly recognized facial image.

Most authors who observe organic conditions in patients with Capgras' Syndrome recognize as well the power of psychopathology. Gluckman (1968) for example, documents cerebral atrophy but recognizes psychodynamic significance in the partucular psychology of his patient. Nikolovsky and Fernandez (1978) observed a pathological solution to the problem of ambivalence in

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their post-varicella encephalitis patient. The patients of Shraberg and Weitzel (1979) presented in addition to organic factors diagnoses of schizophrenia and paranoid personality. Christodoulou (1977) comments about his eleven Capgras patients:

> It is probably worth noting that, irrespective of diagnosis, the clinical picture of almost all patients was dominated by a marked paranoid component. (p.561)

Organic explanations which ignore dynamic contributions are inadequate. Chawla and Virmani (1977) for example, describe a patient whose Capgras' Syndrome they attribute to temporal lobe epilepsy. Their patient accused his father and one brother of being doubles. He did not include his mother or six other siblings in the delusion. But temporal lobe epilepsy should not be able to discriminate among individuals if its effect is to create misrecognition. This, perhaps, is the strongest point to be made regarding the necessity of a psychodynamic component to the formation of the delusion of doubles: the allegation of doubling is always <u>selective</u>, it is not general. <u>Particular</u> people are believed to have been replaced by doubles while others are accepted as being who they are. There is not a problem of "misrecognition," as some authors would have it, nor is there a perceptual problem, but rather there is a problem of belief, a delusion. While organic conditions may well

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play a part in the origination or continuation of a psychotic state, the particular content of psychotic delusions contains psychological meanings, meanings to be sought not in lesions, but in the psychodynamics of the individuals involved. In addition to their individual psychology, some commonality must link those patients who develop the Capgras' Syndrome. There must be some similar psychodynamic preconditions which can, in certain situations, lead toward the delusion of doubles.

Efforts to formulate psychodynamic explanations for Capgras" Syndrome have clustered around four basic themes emphasizing: 1) Oedipal problems in women (and in "latent homosexual" men), 2) feelings of strangeness and other affective problems, 3) problems with ambivalence, and 4) pathological splitting. Little has been added to the descriptive, phenomenological accounts by Capgras and his associates; indeed, many of the efforts to explain the syndrome hark back to Capgras' own efforts to find psychological meaning in the delusions of his three patients. I will now examine each of these four basic psychodynamic themes as they appear in the English language reports I have been able to obtain. (See Appendix for a list of those cases.)

In what appears to be the first discussion of Capgras' Syndrome published in English, Coleman (1933) reviews the French reports, then presents the case of a woman of 50

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who asserted that letters from her daughters were not genuine, but facsimilies written by someone else. This patient seems not to have claimed that her daughters themselves had been replaced by impostors, nor that there were doubles of herself, but Coleman suggests that the psychological mechanism is like that of the previous French reports. He adopts the notion in Capgras' initial report (Capgras and Reboul-Lachaux, 1923) that the origin of the syndrome rests somehow in feelings of strangeness; he elaborates on that notion by speaking of disorders in "coenaesthesia," the normally unconscious feeling of the ongoing life-functioning of the organism, which accompanies all processes of perception and of which a person becomes aware only when perceptual sensations begin, for some reason, to seem strange. Colemen then notes that all case reports have been of woman patients. (I have read, or found citations to, a total of 21 reported cases in the French literature from 1923 to 1933; all were of women.) Coleman concludes: "Presumptive evidence would suggest that no male cases have been described because the syndrome does not occur in men and that the mechanism is peculiar to women."(p.49) To explain this sex bias he observes that

> Men are on the whole more objective, and tend to take the outer world very much for granted. Women, on the contrary, are more subjective, and their whole attitude towards the environment is colored by a mistrust of the reality and absolute significance of the object,

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> with a resultant tendency to correct their objective findings by a subjective evaluation. (p.49)

He supports this supposition by referring to Freud's 1931 paper, "Female Sexuality." For women, but not for men, argues Coleman, the resolution of the Oedipal complex requires the transfer of libidinal aims from mother to father, with concomitant growth in hostile feelings toward the mother, Coleman concludes that

> Whatever the reason, the significant fact is that at a certain state in the little girl's life it is forced in upon her consciousness that she has been deceived in her object love; she finds herself hating where she had formerly only adored. Such a dramatic upheaval, requiring a complete reversal of former evaluations, would colour all subsequent reactions, and account for much that is distinctive in female psychology. "Things are not what they seem"--"I have loved where I should have hated"; such are the impressions induced by this experience. From then onwards her attitude is characterized, not by ambivalence, but by a mistrust of the object; it may not be what it appears. And if at any time psychic disintegration occurs, it will be the object and not the self that will be found to be at fault....The female from infancy onward has had her faith in her object-love shattered. The mother being proved false in the beginning, all subsequent love-objects carry the same pattern. People are not what they seem; deception has occurred before and may occur again. The psychotic woman, rather than doubt the genuineness of her own feelings, decomposes the object and postulates the existence of doubles. (p.50-51)

In a second paper Colemen (1934) reviews doubles in literature and notes that almost all stories or novels on this theme are about doubles of the self of a male character; only one novel, Dostoevsky's The Possessed, contains a scene in which a character, a woman, claims that doubles of others (in this case a husband) exist. Colemen writes,

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> So far, then, it has been established that in an unbalanced mental state, subjective decomposition is liable to occur in men with the postulation of a double self. In women, on the contrary, under psychic stress decomposition of the object is the more likely mechanism, the resulting syndrome being the "Illusion of Doubles." (p.271)

The proposition that Capgras' Syndrome afflicted women only was challenged in 1936 in a report by Murray. Murray (1936) describes a male patient of 32 who after several years of hospitalization for schizophrenia asserted that his parents were doubles. As a child this man had been shy and solitary. "The father regards his son with soft sentimental feelings, and has always been inclinced to 'mother' him." (p.63) As a young man he was reserved, obsessional, and hypochondriacal. He gave up work and hobbies, began to hallucinate, and developed paranoid delusions. Murray accepts Coleman's notions of Oedipal development and (fitting case into theory, perhaps) concludes that this case of Capgras' Syndrome in a male can be explained by the presence of "latent homosexuality."

> Reviewing the history of the case described here there are certain features which strongly suggest a latent homosexuality. The patient is physically well developed, but of exaggerated complexion, the "milk and roses" type. His known difficulty in attaining adequate heterosexual adjustments and the revealing nature of the hallucinatory content, "Nancy boy," show that there is a difficulty of this order present.
>
> If we consider that the course of development of infantile sexuality in homosexual males follows the lines of that already described in the female, we can see an explanation of the occurence of Capgras' Syndrome in the case described. (p.66)

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(It should be noted that in the same year as Murray wrote, Brochado [1936] also presented the case of Capgras' Syndrome in a male patient, but without any special comment.) The Oedipal hypothesis disappears from the literature by the early 1940s as Davidson (1941) reported Capgras' Syndrome in two men where homosexuality was not an issue. Subsequently, many cases have been reported in men; of the 124 cases I have listed in the Appendix, 70 are of women, 51 are men (3 reports do not specify sex). If the problem were Oedipal, it would be seen much more often in psychotic women; if it were restricted to women, we'd not see it in men. As an explanatory hypothesis, then, it is grossly unsatisfactory.

Davidson's patients, both men at Manhattan State Hospital, claimed that their wives were doubles. He writes that the alleged "differences" between the "double" and the "real wife" which were mentioned by these men were inventions in support of the delusion, not perceptual problems. His efforts at explanation present a melange of positions: he notes that the dynamics of reported cases are quite different, but then tries to find common qualities through a combination of the ideas of "feelings of strangeness," a "double attitude toward the present and toward past experiences," "depersonalization and derealization," "coenesthesia;" "projecting and identifying mechanism,""and regression to a magic form of thinking." (pp. 519,520,521)

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Other authors present more economical explanations predicated on the importance of the feeling of strangeness and related affective states. The basic notion here is that the patient becomes aware of changes in his customary affective responses to significant people in his life. These changes in affective response can be triggered by actual alterations in interpersonal life. Haslam (1973), for example, presents a case of Capgras' Syndrome in a schizophrenic woman who developed the delusion that her fiance had been replaced by a double--at the time he, in actuality, had developed a schizophrenic illness. Unable to accept the changes in him, suggests Haslam, she declared him to be an impostor. Siomopoulos and Goldsmith (1975) report a case like that of Capgras' third patient (Capgras, Lucchini, and Schiff, 1925), in which a paranoid schizophrenic man, frustrated in his ambitions as well as by his illness, developed Capgras' Syndrome. They write:

> We assume that the patient with the typical Capgras' Syndrome, after experiencing unacceptable changes in himself and his conditions of living, projects them onto persons closely related to him (probably the ones he considers responsible for these changes) to the effect that the initial 'I have changed, I am not the person I used to be' becomes 'He has changed, he is not the person he used to be,' and subsequently, through the processes of denial and rationalization, 'He is not the real one, he is an impostor.' (p.756)

(Other authors as well discuss the feeling of strangeness, for example: Bankier, 1966; Merrin and Silberfarb, 1976; Mikkelson and Gutheil, 1976.) Whatever the origin of the shift in feelings, it is misunderstood, transformed, and

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the result is the assertion of the existence of doubles. "Things are different with me and him," the patient may think, "I've never felt this way with him, so it can't be him, he is an impostor who looks identical: a double."

The notion that feelings of strangeness, especially in close relationships, may lie at the heart of Capgras' Syndrome reminds us of the importance of the actual experiences and relationships of those who develop the delusion, but we are left with the question of why such emotional changes, which occur frequently, should produce the specificity of the rare delusion of doubles rather than a variety of other responses. Hypotheses stressing the problem of ambivalence attempt to deal with that question.

Todd (1957) presents a discussion of seven cases of Capgras' Syndrome, five in women, two in men, and his discussion offers a number of provocative observations. Citing anthropological evidence, primarily from Crawley (1914), he notes that ideas of doubles are common in primitive cultures where often the soul is believed to be an exact replica of the person. Some cultures believe that shadows, reflections, and dream images are the visible forms of the soul. Todd also notes the Greek story of Amphitryon, and he observes that dualism, or the belief in polar opposites, is a basic motif of primitive philosophy. He concludes that "the disintegration of the personality doubtless sets free primitive modes of thought, which include the tendency to think in terms of doubles and

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dualism." (p.263) Todd asserts that in Capgras' Syndrome the patient splits the object of his delusion into debased and sanctified images and thus "offers an effective solution to the problem of ambivalent emotions, a Jekyll-prototype being differentiated from a Hyde-double, or more rarely, vice versa."(p.264) Noting that the person "doubled" is always linked to the patient by intimate emotional bonds, Todd sees the syndrome being determined by an interaction of factors: first, the psychotic regression to primitive thinking and belief in dualism; second, a paranoid state; third, the presence of marked ambivalence.

The notion that Capgras' Syndrome represents a psychotic solution to the problem of ambivalence has been accepted by a variety of authors: Arieti and Meth (1959), Dally and Gomez (1979), Enoch, Trethowan, and Barker (1967), Meissner (1977), Moskowitz (1972), Nikolevski and Fernandez (1978), and Vogel (1974), for example. In his presentation of five cases of Capgras' Syndrome, Vogel (1974) describes the process as follows:

> Repression finally fails and is no longer successful in binding the patient to her strongly ambivalent feelings in regard to her love object. She begins to feel that she hates as well as loves this emotionally important individual. This realization is the *fons et origo* of the special and qualitatively unusual features found in the syndrome.(p.923). . . The love object is split into a good and bad individual who, of course, outwardly resemble one another almost exactly.(p.924) . . .The Capgras Syndrome rather elegantly shows the major use of the defense mechanisms of ambivalence, concretization of mental representations, splitting of the object, displacement, projection, and identification--or rather, misidentification. In very visible

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> fashion, under the threat of disintegrating forces, the ego makes a desperate psychotic effort to maintain some relationship with its love object. (p.924)

In the first edition of the American Handbook of Psychiatry (1959), Arieti and Meth suggest that the double is always an important person, that the patient in some way rejects that person, but that the patient cannot allow himself to be conscious of that rejection because of guilt or ambivalence, and so displaces his rejecting feelings onto the "double" in "an unusual form of psychotic displacement" (p.549) that has "not yet been fully explained."(p.550) Enoch, Trethowan, and Barker (1967), modifying Enoch's (1963) earlier emphasis on affect change, conclude, "Two fundamental opposing views of the same person are present, and this ambivalence is the basis of the psychopathology of the condition."(p.8) They suggest that the invention of the "double" allows the patient to express his hostility without risking the guilt that would ensue from such expressions directed at a loved person. Meissner (1977) concurs, stating, "The origins of this doubling of the object seem to lie in the patient's intolerable ambivalence toward the significant love object."(p.424) And Nikolevski and Fernandez (1978) conclude their report by stating:

> The delusion of doubles in its psychodynamic aspects is the psychotic solution to the problem of ambivalence; it is an unusual defense reaction, a desperate and ultimate attempt at coping with an intolerable intrapsychic conflict. (p.41)

The suggestion that Capgras' Syndrome is a psychotic solution to the problem of ambivalence, however, leaves us

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with questions about why the ambivalence should be so intolerable in these patients and why their response is to split the object into "real" and "impostor" rather than to institute some other psychological "solution." The key may lie in the word "split," for if the significant people in the patients' lives have in some sense never been accepted in normally integrated ambivalence, then perhaps ambivalence when felt becomes intolerant. It is to the concept of splitting, then, that we must next turn.

The concept of splitting has recently been put forward as an explanatory hypothesis capable of illuminating the Capgras' Syndrome. (Arieti and Bemporad, 1974; Cavenar, Maltbie, and Petty, 1977; Dally and Gomez, 1979; Lehmann, 1980; Mikkelsen and Gutheil, 1976; Moskowitz, 1972,1973.) In the second edition of the American Handbook of Psychiatry Arieti and Bemporad (1974) write, "This syndrome seems to represent in a dramatic fashion what Melanie Klein proposed as the early infantile solution to ambivalence, the 'splitting' of the parent into good and bad imagos." (p.714). Lehmann (1980) in The Comprehensive Textbook of Psychiatry, III writes that in the Capgras' Syndrome "The splitting of a person who constitutes an important libidinal object into his good and bad parts--a basic psychodynamic mechanism--is transduced into perceptual reality by the patient."(p.1993) The notion of splitting, which

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I will discuss in greater detail below, is of particular use in thinking about the delusion of doubles for two principal reasons: first, the concept of splitting allows for the theoretical linkage of the affect state and ambivalence hypotheses (see, for example, Dally and Gomez, 1979); and second, the concept of splitting can be anchored in developmental stages (Lehmann, 1980; Mikkelsen and Gutheil, 1976; Moskowitz, 1972), thus allowing for understanding of both normal and pathological phenomena.

Moskowitz (1972), who has reported the only successful psychotherapeutic treatment of Capgras' Syndrome (all other successes are attributed to chemical or convulsive treatments), notes:

> Capgras' Syndrome, then, is a complicated situation in which "delusional" belief, usually paranoid, is linked to an affective response--a feeling of strangeness-- which results in the conviction that a familiar person is a look-alike impostor.(p.59) The splitting of an ambivalently held object into good and bad (impostor) parts is represented in the distortion of perceptual reality. It is a mechanism whereby the undesirable parts of the particular object may be rejected without incurring as much guilt as in rejecting the total object. (p.61)

The internalized object is split--I shall suggest how below--into a "good," consciously acknowledged, image and a "bad," repressed and unconscious image. Those images persist until a change in the interpersonal relationship triggers a significant affective shift. Two responses ensue: first, the patient concludes that "He/she wouldn't make me feel that way--he/she is different, a double;"

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and second, the patient experiences feelings that cannot be addressed to the consciously held object but that force their way into awareness--"I hate him/her, but I wouldn't feel that way to the 'real' him/her because he/she is so good." (The patient may additionally conclude that expressed hostile feelings might provoke massive retaliation.) The dilemma is resolved by declaring that a double, an appropriate target for negative feelings, has replaced the good real person. This pathological process, Moskowitz (1972) argues, has its roots in the normal developments of the separation-individuation stage. I should note here that the "double" in Capgras' Syndrome is most often a negatively regarded figure, but the concept of splitting would also allow for negatively regarded real objects and dissociated positive feelings which, when they press into awareness, produce anxiety. (See, for example, Christodoulou's [1978] description of positively regarded doubles.)

An object relations approach was taken by Moskowitz (1972) in his treatment of a 12 year old boy who displayed Capgras' Syndrome. Because Moskowitz reports the only detailed account of a <u>psycho</u>therapeutic treatment of the syndrome, including information about early interpersonal experiences of a patient, it is useful to summarize his experience. The boy whom Moskowitz treated became frightened that his parents and younger brother had been replaced by doubles, whom he called "aliens" and whom he likened to

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the extra-terrestrial "invaders" of a then-popular television show. "Small differences in the usual expected appearance or action of a family member would elicit anxiety."(p.46) The immediate families of both parents included relatives with severe mental illness; the mother expressed reservations about two such people marrying and having children and, in addition, endured three unsuccessful pregnancies before the birth of this boy.

The boy was named after a schizophrenic uncle who died a suicide. He was raised according to rigid guidelines by his mother, the father deferring entirely to his wife. When he was 15 months old the mother spent eight days away from home to give birth to her second child. The boy then developed gastro-intestinal problems which continued until he was four. He also showed other forms of regressive behavior, including delayed toilet training, sitting to urinate, and use of a pacifier. During the years before he came into Moskowitz's care he was a guarded and unspontaneous child. The boy seemed to feel a conflict related to "the rigid disciplining mother and the concerned protective mother."(p.52) He called both parents "fakes."

> David's preoccupation with doubles, fakes, and 'aliens' continued intermittently throughout the entire period he was in treatment. It would become more apparent and troublesome when David felt angry or resentful toward people in his family or toward me. As I became familiar with the pattern I began reminding him of the affect just preceding his reaction. Initially

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> he denied any connection. Later he agreed that he had negative feelings toward the person whose identity had seemed to change. (p.53)

The boy included Moskowitz in the delusion, but Moskowitz was able to use this to demonstrate even more clearly "that feeling states might produce psychic phenomena" and to increase the boy's insight.

The patient Moskowitz treated seems to have had the kind of early disruptions in object relations which could provoke split internalized object-representations: a mother whose "concerned protective" image could hardly be reconciled with a "rigid disciplining" image; a mother who left him at 15 months with a father who had previously had almost nothing to do with his care. While Moskowitz does not offer his suggestions about what events might have precipitated the initial development of the delusion, he does indicate clearly that changes in feeling states seemed to trigger the intermittent belief that the parents had been replaced. (See also the three similar examples, one from Bettelheim [1976], two from my own experience, in Chapter IV.) The success of the therapy seems to have lain in Moskowitz's ability to help the boy recognize how these contrasting affective states, triggered by some interpersonal interchange, elicited ideas of the protective, reassuring "reality" or the hostile, frightening "imposture" of the parental figures.

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To understand adequately the process of splitting and its applicability to the Capgras' Syndrome, one must enter the sometimes convoluted realms of "object relations theory," the psychoanalytic theory of how we internalize representations or images of significant others and of ourselves and how we integrate those internalized representations and are affected by them. I have found that that the works most useful for my thinking about the delusion of doubles are those of Otto Kernberg (1972,1975, 1976). Kernberg argues that earliest experiences are internalized according to their affective valence: positive experience (instinctual gratification, satiation, loving mother-child interaction) has at the start a globally "good" affective character which is internalized along with initially undifferentiated self-representations and object-representations; while negative experience (frustration, rage, anxiety-laden or hostile mother-child interaction) is internalized around a "bad" affective tone and its associated self- and object-representations. In very early infancy, then, a "good" internal object composed of undifferentiated self- and object-representations is separately internalized, or split, from a "bad" internal object. It is because of the opposite affective states that these early internalized representations are kept apart, at first simply because they occur separately and the infantile ego is as yet incapable of integrating them, and later because of anxiety. Each new experience brings

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with it an image of self and an image of object, with an affect state linking them. Gradually, as the ego begins to distinguish self and not-self, the self-representations begin to fuse and a differentiation of self-image from object-image occurs in the core "good" self-object image.

To the normal splitting of earliest infancy is added the defensive splitting which begins at about three or four months, peaks at six to twelve months, and then diminishes during the second year. Defensive splitting is utilized to keep apart the libidinally invested and aggressively invested self- and object-representations in order to protect the ideal, good relationship with the mother from "contamination" by the "bad" self-representations and representations of her. In normal development, good and bad self-representations are integrated into a realistic self-concept, and good and bad object-representations are integrated into a total object-representation: the infant has learned that he and mother are separate and now recognizes that the "good" and "bad" mother are one and the same, sometimes interacting with him in satisfying and happy ways, sometimes bringing frustration and unhappiness. With self differentiated from object and with the integration of self-images and object-images, it is possible for ideal self-images to coalesce with ideal object-images into an "ideal self" as precursor to the superego. Repression replaces splitting as a defensive process, and the child

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grows toward healthy ego-identity.

Splitting, then, is a normal developmental process in earliest infancy, a normal and diminishing defensive process in the first two years of life. Splitting is not only of affect states but of object-images and self-images as well, and because internalizations are crucial to the organization and integration of the ego, the process of splitting splits the ego as an organization. "This active separation by the ego of positive and negative introjections, which implies a complete division of the ego, and, as a consequence, of external reality as well, is, in essence, the defensive mechanism of splitting."(Kernberg, 1976, p.36) As has been mentioned, in normal development the defensive process of splitting diminishes in the second year of life and is eventually superceded by repression, but in pathological situations splitting can be maintained; it becomes a "pathological dissociation of polar opposite ego states in order to prevent an all-pervasive anxiety and fear of destruction." (Kernberg, 1972, p.239) If splitting becomes excessive, pathological, then the split-off, hostile "bad" representations are never allowed to fuse with their "good" counterparts, but rather

> the most frightening units involving self and object images under the influence of primitive affect are repressed and this interferes with their ultimate differentiation and integration within the total personality. Primitive unrealistic self- and object-representations remain relatively unchanged in the id, and so do their correspondingly primitive, overwhelming affect dispositions. (Kernberg, 1976, p.70)

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Initially split then repressed "bad" representations, originally internalized in primitive, infantile form, remain out of consciousness; while idealized "good" self- and object-representations are accessible to consciousness. But why should defensive splitting become pathological? "Environmental factors, particularly severe chronic frustrations in early childhood, appear as the predominant etiological factor." (Kernberg, 1972, p.242) Pathological disruption of personality development occurs, in Kernberg's view, from distortions in the internalization of interpersonal relations. "Early maternal deprivation determines abnormal personality development through the intermediate variable represented by faulty internalized object relations." (Kernberg, 1972, p. 233)

I would suggest (along with Moskowitz, 1972; Arieti and Bemporad, 1972; and Lehmann, 1980), that pathological defensive splitting of internalized object-representations is at the psychodynamic root of the Capgras' Syndrome. In brief, the patient who develops the delusion of doubles has suffered early maternal deprivation of the sort that prohibits the normal fusion of "good" self-representations with "bad" self-representations and "good" object-representations with "bad" object-representations. Defensive splitting increases, rather than diminishing with maturity, and images of people who enter the life of the patient are continually fragmented into "good" and "bad" internalized

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representations. An idealized "all good" self-representation is accessible to consciousness, as is an "all good" object-representation, while the split "all bad" images are dissociated and unconscious. Later in life some event precipitates the awareness of previously unconscious images and associated feelings. The event may be a sudden affective shock caused by changes in an important interpersonal relationship (emotional disappointment, a rejection, or a genuine alteration in the other) at which point the patient is unable to integrate his newly conscious bad feeling because his image of the other has excluded the possibility of mixed or ambivalent responses. The negative affect, fear, and anxiety elicit the "bad" representations hitherto split and repressed, and the patient concludes that the person with whom he is dealing cannot be the person he has always known. So different are the images and feelings that the patient can conclude that the other person is therefore a double. A similar pattern could develop if the precipitating affective change were to occur within the patient himself, due to depersonalization, "feelings of strangeness," or the onset of a psychotic illness. The patient again feels unfamiliar and uneasy in the presence of a significant other and the rise to consciousness of previously unconscious bad representations stimulates the delusional elaboration. A variation might be that the patient senses that he is no longer the person

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he once was, rejects that feeling because his all-good self image cannot integrate it, and concludes that it is the other who is causing him to feel different, that the other person has changed.

The concept of splitting, then, seems able to encompass feelings of strangeness, affective changes, and problems of ambivalence, and is thus the most useful construct with which to approach the delusion of doubles. It would seem that for the development of Capgras' Syndrome a convergence of three phenomena would be necessary, if we are to explain both the process of the delusional formation and the relative rarity of its occurrence. These phenomena are: first, strong paranoid characteristics, noted by Capgras and Reboul-Lachaux (1923) in the first report as well as by Christodoulou (1978) more recently; second, the presence of a psychotic state, induced by organic or functional conditions; and third, a history of disturbed early object relations leading toward unintegrated, internalized self- and object-representations and the pathological defense mechanism of splitting.

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III

The Case History

The family of Dr. F. (for she was, in addition to everything else, a fully qualified physician) had suffered dreadfully during the Holocaust. Her father, a rabbi and school teacher, and her mother, the principal of a religious school, were hidden by a Christian woman who had worked as their housekeeper in a town near the Polish-German border. They were childless at the time, having tried unsuccessfully for many years to conceive a child. While in hiding, however, Mrs. F. became pregnant. By subterfuge she was able to enter a local hospital and there gave birth to a boy, but she was recognized by a non-Jewish former neighbor and fled back to the housekeeper's basement with the just-born child. The F.'s protector, however, was herself childless, and the infant's crying if overheard posed a lethal threat of detection to all. The housekeeper took the boy to a convent to be cared for by nuns, but the nuns gave him up for adoption to a farmer. The good housekeeper continued to hide the F.'s and made weekly trips to the farm where their son was being raised, ostensibly to buy or beg food, actually to observe the boy's progress and report to the hidden parents.

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After Russian troops drove the Nazi forces back, Mr. F. understandably but rashly ran to the farm where his son, now a toddler, was living. He claimed his son, but the irate farmer drove the distraught father away with threats of death. The next day Mr. F. contacted Russian troops and managed to convince them to go with him to the farm. The farmer showed them a freshly dug grave and told them the boy was dead. No one was ever to know if the boy indeed had died or if he had been hidden elsewhere.

Several days later the farmer reported to a different group of Russians that Mr. F. had been a Nazi collarborator. Mr. F. was arrested and sent to a Russian labor camp near Minsk, sentenced to five years at hard labor. Such horror upon horror seems inconceivable, but as Krystal and Niederland (1968) point out, "Survivors of disasters and persecutions are suspected of unfair play, collaboration with the enemy, or harlotry."(p. 343) In the labor camp fate played yet another trick: Mr. F. was noticed and interrogated by a Russian officer, also Jewish, who believed his story. The officer ordered Mr. F. to the camp infirmary for several weeks of rest, then called him back and told him that papers had been prepared indicating that he had "died" while in the camp--and he could return home and try to find his wife. Mr. F. was reunited with his wife, and they made their way to a displaced persons center in Vienna. There, in the spring of 1947, Mrs. F. gave birth to a second child, her daughter, Dr. F.

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I was unable to investigate thoroughly the Holocaust experiences of Dr. F.'s parents (her father had died in 1971; her mother, a broken woman, lived in a nursing home), but I was able to obtain some information about their home life from Dr. F.'s uncle and from her cousin, also a physician about her age. We know too, from an extensive literature, the nature of the effects of the Holocaust on the survivors and on their children. It is to that literature that I now must turn.

Numerous authors (Eitinger, 1962; Krystal and Niederland, 1968; Ledere, 1965; Niederland, 1964b, 1968; Trossman, 1968) have described the "survivor syndrome" which afflicts so many who endured internment, terror, torture, and humiliation during the Holocaust. The syndrome includes: chronic anxiety and depression; sleep disturbances, including insomnia and nightmares; psychosomatic symptoms; chronic fatigue; disturbances of cognition, memory, and concentration; irritability, emotional lability or moodiness; obsessive ruminations, moroseness and apprehensiveness; social isolation, withdrawal and inability to enjoy life; and survivor guilt. Few, if any, survivors seem to have escaped one or more of these symptoms. Several authors (Niederland, 1964b; Eitinger, 1962) comment on the troubling memories that enter the consciousness of survivors in association to harmless or even benign experiences. Eitinger (1962), for example, writes of such painful associations,

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> They can occur in any connection whatsoever, from seeing a person stretching his arms and associating this with fellow prisoners hung up by their arms under torture, to seeing an avenue of trees and visualizing long rows of gallows with hanging corpses. Children playing peacefully may suddenly and without apparent cause call to mind other children, emaciated, tortured, murdered. (p. 372)

While most authors write primarily of survivors who were incarcerated in Nazi camps, it is important to bear in mind that the terror and torment were no less traumatic for those who survived in ghettos or in hiding. Ostwald and Bittner (1968), for example, in writing of their subjects who survived in hiding, declare:

> From the accounts available to us, we can say that the fugitive existence of those who escaped the Nazi dragnet and subsisted in forests and bunkers was as suffused with terror and martyrdom as was the life of concentration camp inmates. (p. 89)

Venzlaff (1964), writing of those who survived in hiding, notes

> a striking resemblance of the mental disorders in such persecuted persons, who were not in prisons and not in concentration camps, with those mental disorders which we could find in patients who very often spent many years in concentration camps, ghettos, or work camps, under severe and somatic strain. (p. 178)

If the survivor syndrome was present, even to a moderate degree, in Dr. F.'s parents, we need to explore the effects on Dr. F., for as Lipkowitz (1973) writes, "It must be anticipated that the psychic scarring of the survivors will have noxious effects upon the development of their children." (p.141) I have reviewed some of the literature on children of Holocaust survivors (Borocas and

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Borocas, 1973, 1980; Epstein, 1977, 1980; Fogelman and Savran, 1980; Freyberg, 1980; Klein, 1973; Krystal and Niederland, 1968; Lipkowitz, 1973; Rakoff, Sigal, Epstein, 1967; Sigal and Rakoff, 1971; Sigal, Silver, Rakoff, and Ellin, 1973; Trossman, 1968) and can summarize some of the effects on parenting and child development attributed to the massive psychic trauma experienced by the survivors. Of most importance, perhaps, in terms of parent-child relations are what Niederland (1968) has observed, after clinical observations of some 800 survivors, as

> Tendency to isolation, withdrawal, and brooding seclusion; tenuous and unstable object relations, with marked ambivalence notable in lasting disturbances of object relations. (p.313)

Survivor parents are described as being over-protective and overly anxious about the health and well-being of their children. They are frightened that something terrible will happen to them, and are often beset by persecution dreams in which their children are victimized. Their worries engender anxiety and mistrustfulness in their children. (Borocas and Borocas, 1973; Freyberg, 1980; Krystal and Niederland, 1968; Trossman, 1968) The mothers are described as withdrawn, depressed, fearful, uncommunicative; they are bound to their past and often unable to respond adequately to their growing children.

> Because of their total preoccupation with tormenting memories and with an unending re-living of their traumatic past, the parents have few emotional resources left over to meet any but the most routine psychological pressures. The continually changing emotional needs and their children's requests for attention and care are either ignored or dealt with as unfair demands. (Rakoff, Sigal and Epstein, 1967, p. 24)

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While the considerations mentioned above apply to a wide sampling of survivor parents, a special tragic edge is added to the pain of those who lost children during the Holocaust while managing to survive themselves. Speaking of this issue, Ostwald and Bittner (1968) note, "Those who lost children as a result of the persecution were among the saddest and most guilt-ridden patients in our sample." (p.88) Niederland (1968) notes that chronic depressive states correlate highly with the specific trauma of the loss of a child, and Krystal and Niederland (1968) observe that in their sample "Survivor guilt was specifically strongly correlated to the loss of children, both in incidence and severity (X^2=54.30; f=26, reliable at the .001 level."(p.331) Often survivors who lost a child feel that they have sacrificed that child to save their own lives. (Klein,1973)

We know that, in general, women who have survived the Holocaust have had difficulties as mothers. Krystal and Niederland (1968) write of their sample:

> Of the women in this series, only 2 per cent were considered completely successful in their function as wives and mothers, and 45 (49 per cent) of all women were grossly inadequate as housekeepers and mothers. (p.332)

Most of the authors studying parent-child interaction find difficulty occurring in pre-Oedipal stages of development. Klein (1973), commenting on the child's anal phase experiments with autonomy and separation, notes that "The child's strivings create anxiety, aggression, and feelings of help-

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lessness in the mother," and adds that "the fearful attitude of the parents is shared by the children and is manifested in the difficulty of both separating from each other." (p.406) Freyberg (1980) argues that children of Holocaust survivors rarely achieve a complete traversing of the separation-individuation process described by Mahler (1972). Freyberg notes that the child striving toward autonomy needs its mother's love and support, but that survivor mothers fear and disapprove of those strivings and so engender depression and axiety about the loss of the mother in their children.

> It is at this crucial juncture of the individuation process that the mourning, grieving, affect-lame, guilty, and overwhelmed survivor mother has difficulty gratifying her child's need for emotional responsiveness and availability. (p. 91)

In a world she feels is unsafe, the survivor mother responds negatively to the child's efforts at separation. The child in turn responds to the mother's anxiety and becomes highly ambivalent about autonomy and separateness; the frightening anger engendered by the mother's inability to gratify must however be repressed; the child cannot individuate, for it is too much a loss for the parents, too great a risk for itself. Lipkowitz (1973) summarizes:

> Burdened by guilt, tension, and fear, she /the mother/ cannot assist in another separation. In addition, from Erikson's point of view the chronically depressed and withdrawn mother cannot inspire basic trust, without which the capacity to accept the reality that symbiosis with the mother cannot be maintained will not develop. . . Unable to tolerate separation, the concentration camp mother cues for symbiosis,with expected results. (p.152)

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Krystal and Niederland (1968) agree with Freyberg (1980) and Lipkowitz (1973). They note in addition that survivors have great difficulty expressing aggression as well as in nurturing and responding to children, and they conclude:

> The repression of aggression tends to produce problems of aggression in the next generation. The impairment of the ability for nurturing of the children tends to produce depressions in the next generation. Both problems tend to promote symbiotic relationships and interfere with the individuation of the youngster. . . .the irreparable loss is that of faith and trust in one's fellow man and in the essential benign nature of the world. The disturbance here is so profound that the benign introjects become unavailable as patterns for mothering and nurturing behavior. . . .The survivors form abnormal families and communities. The families tend to be sado-masochistic and affect-lame.(p.346)

This devastating pattern of child-rearing and family life produces, of course, devastating effects upon the children.

In speaking of the children of survivors Ostwald and Bittner (1968) write, "Their environment looks tense, dreary, and emotionally impoverished."(p.93) Fogelman and Savran (1980) note that the children are over-protective toward the parents and have a guilt-ridden attitude toward their parents who have suffered so much; they feel a need to identify with their parents' suffering, yet feel they cannot talk about Holocaust atrocities for fear of hurting their parents or discovering some shameful way in which their parents survived. The children fantasize about compensating their parents and replacing lost relatives (for whom they are often named), and they struggle with the problem of identifying with and mourning for people they never knew. "Many of them spoke of an overwhelming burden of

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responsibility to fulfill their parents' needs and to replace dead siblings or other relatives." (p.104) Freyberg (1980) writes of similar patterns in which rage triggered by unmet needs for emotional relatedness is repressed and a consuming concern for the well-being of the parents leads the child to assume responsibility for parental health and happiness. On both conscious and unconscious levels, notes Lipkowitz (1973), the children feel "After all they have been through, how can I hurt them any more?"(p.147) The children, then, strive for parental love and approval by being over-protective, by fulfilling the felt or stated expectations of their parents, by being good and successful and by trying to repress whatever anger they sense within themselves--and this in the context of anxiety ridden,symbiotic ambivalence caused by incomplete individuation.

The patient who came to our psychiatric service bore the scars not only of her schizophrenic illness, but also of the cataclysmic historical trauma of the Holocaust as experienced by her parents. Her developing the delusion of doubles can best be understood by object relations theory, but much of the content of her delusional system reflects the personal and cultural nightmare of terror and despair that had been the lot of her parents; and even the original disruptions in the mother-child relationship which laid the basis for the delusion are at least in part the result of the massive psychic trauma of survivors. I will now present the case material and follow with an object relations analysis.

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That Dr. F.'s parents suffered irreparable psychic harm can be assumed by extrapolating from the survivor syndrome--but I also obtained confirmation in the recollections of Dr. F.'s cousin. The cousin described Dr. F.'s father as a "timid scholar-type" who spent his days "reading at home in his slippers" and who "over-protected" his daughter; he described Dr. F.'s mother as a woman whose "spirit was broken during the war" and whose visits he dreaded because of her "morbid preoccupation with death and dying." Dr. F., by contrast, described her father as "an administrator type, organized, forthright," and described her mother as "a homemaker, kind and helpful." The cousin described Dr. F.'s home as dark and dreary; the parents as apprehensive, fearful, and mistrustful; Dr. F. as a child as isolated, aloof, and lonely. Dr. F. described a "happy, stable home." The small apartment in which Dr. F. lived with her parents was in an old building in a decaying neighborhood; for ten or fifteen years preceding her hospitalization with us, Dr. F. and her parents were the only Jewish family in the area and the only English-speaking people in the building. Dr. F. once said, "I was always considered an adult--and I did not have equivocal feelings--I wasn't a child *per se*. . ." In four months of hospitalization she mentioned only one childhood experience of pleasure: a birthday party when she was eight--but she was unable to recall the names of any of the playments she'd invited. Speaking of her school years, she said,

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"I was a model student." I know from her cousin that she worked at after-school jobs from the time she was thirteen by passing for eighteen; I know too that she was regarded as odd by schoolmates, even at the special public school for exceptionally bright children to which she was admitted. Withdrawn, isolated, and lonely, living with morbid, preoccupied, psychically scarred parents in a dingy apartment in a decaying neighborhood; diligent, hard-working and intelligent, aloof, arrogant, and with touches of grandiosity--this is the picture of Dr. F.'s childhood I obtained from her cousin and uncle. It is the picture of a fragile, brittle, withdrawn young woman, a young woman described by her cousin as "a pre-morbid personality, a grandiose personality."

After graduating from her prestigeous high school, Dr. F. attended a public college and subsequently enrolled in a local medical school. About the time of her graduation her father died. She said that she had been at his bedside when he died but had had no special reaction: "He was simply deceased." She spent an internship year on the West Coast and it was there that psychological problems seem to have become manifest. She referred vaguely to difficulties working under the supervision of others, but refused to elaborate. She returned East for a residency in opthamology and encountered real difficulty. She reported that she got into trouble because she made comments about sexual

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behavior in a discussion with other residents, comments that were maliciously misinterpreted to her supervisors. Her cousin told me that she had begun then to hear voices, that her then-boyfriend had concluded she was too "odd" and there had been an "acrimonious break." Shortly thereafter Dr. F, left the residency program.

Somewhere in this period Dr. F.'s mother attempted suicide by hanging. Dr. F. said that she had cut her mother down, but the story is confused. Dr. F. did obtain a second year residency at an Ivy League institution and it was there that the psychosis became virulent. Dr. F. claimed that her problems started because "I was too perfect. . ." She apparently stood up during lectures to denounce people. He cousin, a resident in the same city at the time, was called and he reports arriving to find Dr. F. "on all fours" listening to the sounds from the radiator. She was taken to New York and hospitalized for the first time. That summer she traveled to India to seek a residency, but returned home, unsuccessful, in the fall. She then went to a western state to seek a residency. She was arrested there for theft of service after refusing to pay a hotel bill. Her uncle wired money to the hotel and arranged for transportation back to New York, but Dr. F. flew instead to a southern city. There was again trouble with police, and this time the uncle flew down and took Dr. F. from what he called "a hang out place," what the cousin called "a brothel." There followed a period of

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hospitalizations and arrests. Dr. F. declared that it was in 1975 that her uncle was killed and replaced by a double, but he reported that she confronted him directly with this belief only three years later, in 1978, during a long stay in a state hospital to which she was "abducted."

Just before Dr. F.'s stay in the state hospital her mother had to be hospitalized again after what the uncle described as months of refusing to eat, change clothes, or leave the house. The mother was discharged to a nursing home. While at the state hospital Dr. F. refused to eat and at one time was tube fed. While out on a "grounds pass" she left the hospital. Dr. F. met a man with whom she lived for five weeks until voices told her that he had been replaced by a double and she left his apartment. For several days, she said, she picked up men on the streets, "indulging in sodomy for money." She decided to seek hospitalization because her voices told her that the "psychologist film-directors" were planning to put her into films of sexual exploitation: there would be "dogs upon my naked person," she would be "forced to eat my own excrement," and they would "insert huge dildoes into my vagina." She came into my care, then, to escape the sadistic tortures she anticipated.

As I mentioned at the beginning of this paper, Dr. F. told a story of her mother's "recent death." I now believe she told that story to gain admission and thus "safety" from her persecutors. In hospital she soon revealed her

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genuine belief which proved resistant to both antipsychotic medication and to psychotherapy. Dr. F. informed us early, "I am not a paranoid schizophrenic with a delusional system," adding condescendingly, "It's very complicated, you wouldn't understand." She did enact at least part of what she had described as her behavior just prior to hospitalization by suggesting to the Director of In-patient Psychiatry and later to her social worker that they engage with her in sodomy.

Dr. F. began to ask for discharge within a week of admission, claiming "all is well." When it appeared that long-term care would be required she began to increase her participation in ward activities, asking the dance therapist to be sure to note in the chart that she had "participated fully" and telling her nurse "I want you to see that my personal perimeters are in good order." She was able, under the threat of involuntary long-term hospitalization, to convince the Director that she was aware she had delusions and was able to control them, and to tell her therapist she understood she had "irrational fears." Within a few days of convincing staff that she was able to recognize and control the delusion, she horrified a young woman medical student, who had a noticeable physical handicap herself, with an account of the tortures she was sure she would undergo: they were going to "stenose" her intestines, cut out her eyes, and shove hair brushes into her vagina; her teeth were to be pulled out without anesthesia, her

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legs were to be cut off in slices, and they were going to create "a huge anal-vaginal fistula;" she would be beaten with broomsticks, her head would be twisted to the side and her vertebrae fused, and rubber male genitals would be surgically attached, making her "appear a hermaphrodite."

The delusion of doubles displayed typical forms reminiscent of Capgras' first patient, as well as some particular elaborations. The principal double was that of her mother, and Dr. F. could give the exact date--July 4, 1974--when her mother had been "killed." That time coincides roughly with the period of her trip to India, the time also when she demanded more money for the trip from her mother and the mother for the first time refused. Her uncle, she said, had been killed a year later, at the time when he was involved in getting her admitted to the state hospital. After some six weeks in hospital she declared that her therapist had been replaced by an imposter; shortly thereafter she declared the social worker a double as well. Toward the end of her stay with us, as preparations were begun for her transfer to a state facility, she asserted that there were doubles of everyone on the floor, and indeed that there was an identical, mirror image world on the other side of our locked doors.

Dr. F. spoke also of doubles of herself. One double, who had collected the five hundred million dollars was on a "cruise to nowhere" taking Dr. F.'s place, because Dr. F.

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was "channeled for the Presidency." (When questioned some time later about the significance and responsibility of the Presidency, Dr. F. said that it was really the Vice-Presidency for which she was headed--first.) The second double of herself, she said, was in other areas of the hospital getting Dr. F. into trouble--by indulging in sexual activity with male staff members and biting their penises to convince people that Dr. F. was homosexual. Both of these doubles were part of the plot of the "film director-psychologists" of the original "psychoanalytic study," but she was the "real" Dr. F. and could prove it by identifying people in photographs whom only the real Dr. F. could have known. She begged us to contact the President and the Mayor (and I believe she wrote letters to the President) but she also said that if we were to let her meet the Mayor we'd probably put in a double of him too.

Dr. F. responded to antipsychotic medication by gaining more control over the outpour of her delusional system, but not, it seems, over the delusions themselves. When she had convinced staff that she could control her delusions, we began to plan for discharge. (We had also sought legal consultation and had been told that we needed to try less restrictive forms of treatment before considering involuntary long-term care.) We were exploring a "half-way house" for residence and a day-treatment center for out-patient therapy when, on a day pass she was supposed to use to attend the day center, Dr. F. was stopped from climbing

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into the East River. She denied suicidal intent but refused to explain the incident other than to say there had been "a misunderstanding." She had withdrawn money from her bank accounts and sent thousands of dollars, unowed, to the Internal Revenue Service; she had over $9,000 in cash and bank checks on her person. Clearly, long-term care was required, and we began proceedings. A few days later, now restricted to our locked ward and on fifteen minute checks, Dr. F. committed suicide by drowning herself in the bathtub.

Dr. F.'s delusional system of doubles reflects, I believe, a pathology of internalized object relations which lay dormant until activated by the onset of her schizophrenic illness and which was precipitated by the altercation with her mother over money early in her illness. Both the evidence I obtained from her uncle and cousin and the research literature on Holocaust survivors point toward the kind of mother-child interaction that would lead to pathological splitting of internalized object representations. For example, Dr. F.'s uncle told me that her mother was obsessed by the thought that she had sacrificed her son in order to save her own life. As has already been mentioned, Holocaust survivors who lost children seem to have been especially beset by guilt. We know that Mrs. F. was morbid and brooding, dispirited, a shadow of the active, effective professional she had been before the war. It

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seems reasonable to suppose that she, like so many survivor mothers, was emotionally unavailable, anxious, watchful, and mistrustful. I can hypothesize that the earliest, split internalized object representations were never integrated, and the split-off "bad" mother images lay dormant in the unconscious while an idealized "good" mother image was tenaciously maintained. Dr. F. always described her parents in a totally positive light: her parents were perfectly good, there were never any family problems, she had an ideal childhood.

Her illness seems to have begun during her internship year--at the time, significantly, of her first separation from home. The delusion of doubles came, she indicated, about two years later--at least she dated her mother's "death" at that time. The precipitating event seems to have been an argument over money as Dr. F. erratically sought residency programs. Dr. F. demanded money from her mother, the mother refused. Dr. F. struck her mother during this argument; indeed, it was a discussion of this incident which first uncovered the delusion of doubles. When asked, early in her hospitalization, if she had ever been angry at her mother, she replied, "Yes." Did they ever fight? "No comment ...yes...the real E.F. hit her mother, not this one. . .no, it was the false E.F. who hit her mother, not me. . .I sound like a paranoid schizophrenic with a split personality, but I'm not." A day later she said, "E.F. is not proud of hitting her mother," and added

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later, "The false E.F. hit her mother. . .the true E.F. struck an imposter mother." The altercation, I believe, stimulated an upsurge of rage at the mother, rage which elicited the previously unconscious, aggressively charged "bad" mother images. At the same time there occurred a marked affective shift in which Dr. F. wondered, shocked, that her mother had refused her---"My mother wouldn't refuse me, how can this be happening?" The affective strangeness combined with the unfamiliar rage and its concommitant anxiety, guilt, and fear and with the formerly dissociated "bad" mother image produced first a feeling that "this can't be my mother," then the delusion that there was an imposter mother, a malevolent, frustrating person who rightly warranted the anger. Once the delusion of the first double was accepted, other important people, especially as they too frustrated Dr. F., would "logically" become part of the system. Dr. F.'s uncle, for example, was told he was a double at the time he was arranging Dr. F.'s commitment to a state hospital. The man with whom Dr. F. lived for several weeks after leaving the state hospital became a double only when he began worrying about her and attempted to contact her family. The belief that her therapist had a double developed only after discussions began about long-term care, and the social worker was replaced only when he refused to facilitate her effort to obtain a new Social Security number under a false name. The para-

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noia explains the inclusion of frustrating people in the broad plot, but only the pathological process of splitting of representations adequately describes the allegations of replacement by doubles.

Doubles of the self seem less common in Capgras' Syndrome than doubles of others (although Capgras' first patient believed there were doubles of herself,as did the patient of Dupouy and Montassut). I have noted eight cases in the English reports (see Appendix) in which the delusion included doubles of the self. Again, an object relations perspective may serve to help us understand that phenomenon. Just as internalized images of the mother were split, so too were self-images. The narcissistic, idealized self-images--the "model student," the "too perfect" resident--were consciously held and fiercely maintained. (Dr. F.'s cousin said she had as a young woman always been "aloof" and "grandiose;" she could, even when I knew her, be remarkably condescending.) As illness took hold and she felt herself changing, and as she encountered rejection in her search for a residency, she protected that idealized image by asserting the existence of doubles. The second double, the imposter she believed was sexually active in the hospital in order to get her into trouble, represented projected aspects of the "bad" self-representations which had originally been split and repressed but which returned to consciousness in the course of the schizophrenic illness.

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Conscious but unacceptable, those "bad" attributes could be externalized and disavowed in the form of a second double, the imposter biting penises.

An additional dimension in the "choice" of the delusion of doubles may have come from the family tragedy: Dr. F.'s brother was "dead" but probably alive, somewhere in Eastern Europe, unaware himself of his true identity; and Dr. F.'s father had been declared "dead" in order to return him to life with his wife. Dr. F. was aware of the family story, although she professed little interest in her parents' suffering. I wonder too whether some of her fantasies of torture she expected to undergo were derived from Nazi "medical experiments" about which she may have known. (See Trials of War Criminals. . . , 1946-1949.) Indeed, when I expressed some sympathy for her parents, Dr. F. replied, "It's what happened to them, not to me--for me it's much worse: no one has ever undergone such torture as I will undergo." It may have been fear of those tortures, which she expected to occur should she be sent to a state hospital, which drove her to take her own life.

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IV
The Delusion of Doubles in Broader Context

The delusion of doubles is frightening, yet familiar. It is alien and horrifying, yet we somehow recognize its closeness to ourselves. It is uncanny. "The uncanny," wrote Freud (1919), "is that class of the terrifying which leads back to something long known to us, once very familiar."(p.369) To understand the delusion of doubles adequately, we must acknowledge its familiar as well as its frightening aspects; we must seek to set the delusion into the context of normal and neurotic phenomena, as well as to describe it in its psychotic extreme. We must search, then, for phenomena in the broad range of human experience which can offer fuller understanding of the origins of the ideas of doubles and the expression of those ideas in normal life, in neurotic distress, and in the creativity of fiction as well. Only such a contextual effort can provide the necessary beginning for the understanding of the phenomenon and for psychotherapeutic treatment of its devastating pathological form.

There must be both intra-psychic experiences and environmental-experiential factors to give shape to the idea

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of doubles. The object-relations theory approach I have suggested may provide the necessary intra-psychic patterns for the delusion of doubles. There are patterns as well in normal human interactions and experiences. The obvious experiential templates for the delusion of doubles are twins, family resemblances, chance similarities in appearance, and shadows and reflections. Crawley (1914) discusses the importance in many primitive cultures of shadows and reflections as images of the soul, and of the belief in ancient Egypt and elsewhere that the soul is an identical image of the body, released at death or, in some cultures, at sleep. To cast no shadow or no reflection would be to be soul-less. (In the film "Dracula," van Helsing confirms his belief that the count is a vampire by noting his lack of reflection in a mirror.) Identical twins are startling, and there are often "look-alike" contests seeking doubles of prominent figures in politics or entertainment.

Ordinary language hints at a familiar toying with questions of identity and identical images. We say, "I am not myself today," or "He was beside himself." When startled by an uncharacteristic act by a well-known person we may ask, incredulously, "How could he, of all people, do something like that?," and we might even add, "It can't be he!" We speak of people putting up a "false front" and often say of others (or feel of ourselves) that it is possible to live a "double life." Capgras, Lucchini, and Schiff (1925) asked, "Who among us has not happened to

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encounter a friend having changed in some commonplace way the habitual aspect of his appearance and said to ourself 'This is not he, as I know him, but someone who resembles him greatly. . .'?"(p.214) Indeed, some of us may have acted in our lives much like Doestoevsky's Golyadkin in The Double (1866). Golyadkin, riding in a rented carriage, a mode of transportation far above his station as a clerk, passes his department head, also, but appropriately in his case, in a carriage.

> Seeing that concealment was quite out of the question since Andrey Filippovich, having recognized him, was now staring hard at him, his eyes nearly popping out of his head, Mr. Golyadkin coloured up to his ears.
> "Shall I bow? Shall I make some response? Shall I admit it's me, or shan't I?" thought our hero in indescribable anguish. "Or shall I pretend it's not me, but someone extraordinarily like me, and just look as if nothing had happened? It really isn't me, it isn't me, and that's all there is to it," said Mr. Golyadkin, raising his hat to Andrey Filippovich and not taking his eyes off him. (p.19)

Experiences such as that of Golyadkin seem quite familiar and understandable, for who has not wished at some time or other to be recognized not as himself but to be taken only as someone looking very much the same?

There is an extensive literature on the concept of the double in fiction. (See Guerard, 1967; Rogers, 1970; Rosenfield, 1963; and Tymms, 1949, for example.) Literary criticism uses the term "double" with a far broader definition that I would suggest is useful. The double, for the literary critics, includes the autoscopic image, the identical look-alike, and a wide range of non-similar charac-

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ters who can be seen as foils to the protagonist, representing hidden dimensions of his personality or projected fragments of his shattered psyche. Critics like Rogers (1970), for example, tend to see most conflict as intrapsychic, with various characters representing ego, id, and superego and with Oedipal dramas as the heart of literary imagination. It is important to bear in mind this wide definition of doubles when considering the possible contributions of fiction to our understanding of Capgras' Syndrome, for while literary usage does illuminate the delusion of doubles, it is not directly analogous.

Rosenfield (1963) notes that from the Classical world through the Renaissance doubles were used as either diverting look-alikes in comedy or as instructional, allegorical opposities in morality plays. The Romantics, she notes, used doubles in fairy tales, but only moderns deliberately use the structure of the double to portray ". . .the conflict between the conscious and the unconscious life, the constant menace of personal disintegration which apparently threatens us all, and the loss of identity consequent both upon mental disorder and the necessity that the character mask his internal life by creating roles to play."(p.343)

Perhaps the most famous use of doubles in Classical literature occurs in Amphitryon, by Plautus (ca.200B.C.) In the prologue Mercury tells the essentials of the play, and the outline of the original Greek myth.

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> He /Jove/ began carrying on an affair with Alcmena behind her husband's /Amphitryon's/ back. He borrowed her husband's looks for himself, made love to her, and made her pregnant /with Hercules/ on his own. I want you to get Alcmena's situation straight: she's pregnant by both of them, by her husband and by almighty Jove. . . .I've changed myself to look like Sosia, Amphitryon's servant, who's off at the front with his master. (p.5)

The action of the play takes off as the real Amphitryon returns home from war with his real servant, Sosia. Marital strife and the multiple beatings of Sosia provide the occasion for comedy. At one point Sosia, desperate but convinced that there are two of him, insists to Amphitryon, "I tell you I'm in that house over there and also beside you here."(p.31) A happy ending is achieved when Jove reveals his adventures to Amphitryon and all the mortal beings are reconciled.

Shakespeare's A Comedy of Errors (1593?) also uses the device of doubles to achieve comedic effects. Again both masters and servants are doubled, in this case by two sets of identical twins, separated in infancy and brought together, unknowingly, in maturity. Wives and servants, friends and creditors are confused, servants are beaten, and devoted wives are maligned and disheartened until, at last, the two sets of twins are finally brought together at the end of the play. Confronted with two sets of confusing identical twins put before him, the Duke of Ephesus asks:

> One of these men is genius to the other;
> And so of these. Which is the natural man,
> And which the spirit? Who deciphers them?
> (Act V, scene i)

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All is explained, and all forgiven, as reunited families recognize their kinship, and fears of enchantment, of magical bewitching, vanish as the natural twinship is revealed.

As Plautus toys with divine dissemblance and Shakespeare employs twins, other authors utilize other forms of doubling in their works. I will discuss briefly several of the works which seem most useful in thinking about the delusion of doubles. Andersen's fairy tale "The Shadow" (1835?/1936) uses the notion of the shadow as double and also introduces the theme of the double taking over the original. In Andersen's story a student from a cold northern country visits a hotter southern country. A vision of a beautiful maiden on the balcony across the street prompts the student to send his shadow into her dwelling--and the shadow does not return. The student "returned to his cold fatherland and he wrote books about all that was true, and good, and beautiful in the world," (p.341) but one day he was visited by his shadow, a shadow grown solid, knowing, and powerful. The student asked the shadow where he had been and what he had learned.

> 'I saw the most incredible, unheard-of things among all ranks and classes. I saw,' continued the shadow emphatically, 'what none must know, but all would so much like to know--<u>their neighbors' secret evil deeds</u>.'(p.345)

The now rich shadow convinces the student to act as <u>his</u> shadow, indeed shows off his intelligent "shadow" as a way to win favor with the rich and the aristocratic.

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When the shadow has won the hand of a princess, the scholar tries to stop the deceit, but the shadow, declaring "My shadow has become crazy,"(p.350) has the scholar imprisoned and killed.

Two stories by Guy de Maupassant describe phenomena related to the sense of being taken over by a "double." In "The Horla,"(1880s/1923) the narrator wonders if there are two beings dwelling within him and declares, "Somebody possesses my soul and governs it. Somebody orders all my acts, all my movements, all my thoughts."(p.249) Determined to destroy the evil presence, the narrator burns down his house, then realizes that the presence is still with him--to destroy it he must kill himself. In "He"(1880s/1923) the narrator decides he must marry, not because he is in love but because he is frightened of being alone. ". . .I am afraid of myself, afraid of that horrible sensation of incomprehensible fear. . .Above all, I am afraid of my own dreadful thoughts, of my reason, which seems as if it were about to leave me, driven away by a mysterious and invisible agony."(p.154) The narrator wanders in the streets to escape his terrifying aloneness, and on entering his apartment notices a figure sitting in his chair--but he touches the figure, and no one is there. Maupassant himself apparently experienced autoscopic phenomena (see Todd and Dewhurst,1955), and the narrator of this story becomes obsessed with the idea of seeing "him"(self)

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again, obsessed to the point of being convinced that if he were to marry this other self would not reappear.

The idea of a "double," dangerous and different from the surface, social self, takes poignant form in Stevenson's "Dr. Jekyll and Mr. Hyde" (1886/1979). The inner, hidden demonic persona of Mr. Hyde exerts an irresistible pressure to emerge, and in emerging overwhelms the civilized Dr. Jekyll. "All things therefore seemed to point to this: that I was slowly losing hold of my original and better self, and becoming slowly incorporated with my second and worse."(p.89) In the chapter entitled "Henry Jekyll's Full Statement of the Case," Stevenson has Dr. Jekyll reveal the history of his disastrous experiment. The portrait of a soul divided is apt and moving.

> I was born in the year 18__ to a large fortune, endowed besides with excellent parts, inclined by nature to industry, fond of the respect of the wise and good among my fellow-men, and thus, as might have been supposed, with every guarantee of an honorable and distinguished future. And indeed, the worst of my faults was a certain impatient gaiety of disposition, such as has made the happiness of many, but such as I found it hard to reconcile with my imperious desire to carry my head high, and wear a more than commonly grave countenance before the public. Hence it came about that I concealed my pleasures; and that when I reached years of reflection, and began to look round me and take stock of my progress and position in the world, I stood already committed to a profound duplicity of life. Many a man would have even blazoned such irregularities as I was guilty of; but from the high views that I had set before me, I regarded and hid them with an almost morbid sense of shame. It was thus rather the exacting nature of my aspirations, than any particular degradation in my faults, that made me what I was and, with even a deeper trench than in the majority of men, severed in me those provinces of good and ill which divide and compound man's dual nature. In this case, I was driven to reflect deeply and inveterately

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> on that hard law of life which lies at the root of religion, and is one of the most plentiful springs of distress. Though so profound a double-dealer, I was in no sense a hypocrite: both sides of me were in dead earnest; I was no more myself when I laid aside restraint and plunged in shame, than when I labored, in the eye of day, at the furtherance of knowledge or the relief of sorrow and suffering.(p.81)

Dr. Jekyll struggled, then, not to repress one or the other aspect of himself, but rather to separate the two, so that each part might pursue its own natural inclinations. We feel, with Jekyll, the torment of his divided self, for we can easily recognize in ourselves the conflicts of impulse and prohibition.

Poe's short story "William Wilson"(1839/1950) presents one of the few literary accounts of an identical double of the self, and thus a clearer analogue to one form of Capgras' Syndrome. Poe's narrator opens with mention of his "later years of unspeakable misery and unpardonable crime,"(p.39) thus setting a contemporary frame around incidents from his past. As a child, says the narrator, he was "self-willed, addicted to the wildest caprices, and a prey to the most ungovernable passions."(p.40) To his school came a new boy, a boy who shared his rather common name. The namesake provokes anxiety in the narrator, but his feelings are mixed.

> They formed a motley and heterogeneous admixture--some petulant animosity, which was not yet hatred, some esteem, more respect, much fear, with a world of uneasy curiosity. To the moralist it will be unnecessary to say, in addition, that Wilson and myself were the most inseparable of companions.(p.45)

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The namesake imitates the narrator in dress, gesture, voice, and manner and takes on a patronizing role, the role of the giver of moral advice. The moral interference of the double continues at Eton, when the narrator is drunk and carousing but the double appears and produces instant sobriety. Again, at Oxford, as the narrator is cheating at cards the double appears and the fraud is exposed. Forced to leave Oxford, the narrator flees to the Continent, but at each moment of crime or debauchery the double appears ". . .to frustrate those actions which, if fully carried out, might have resulted in bitter mischief." (p.57) Indeed, the narrator, while frustrated, nonetheless feels "deep awe" as he regards "the majestic wisdom, the apparent omnipresence and omnipotence of Wilson. . ."(p.58) At last, in Rome, as the double frustrates a seduction, the narrator is driven to a final rage and, drawing his sword, runs the double through. He then beholds

> mine own image, but with features all pale and dabbled in blood. . .It was Wilson; but he spoke no longer in a whisper, and I could have fancied that I myself was speaking when he said:"You have conquered, and I yield. Yet, hence forward art thou also dead--dead to the World, to Heaven, and to Hope! In me didst thou exist--and, in my death, see by this image, which is thine own, how utterly thou hast murdered thyself!" (p.60)

In the killing of the double, of the moral self, all hope dies. The double's last words return the reader to the narrator's opening lines:

> Oh outcast of all outcasts most abandoned!--to the earth art thou not forever dead? to its honors,

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> to its flowers, to its golden aspirations?--and
> a cloud, dense, dismal, and limitless, does it not
> hang eternally between thy hopes and heaven?(p.39)

For the narrator Wilson, as for Dr. Jekyll, all hope fades when the self-observing moral agency succumbs to the unbridled passions.

Poe makes two observations which are striking in the context of Capgras' Syndrome. First, he shows how the moral, self-observing agency, the superego, is both admired and resented, and how the "good" and "bad" in conflict can become unstuck. Once "inseparable companions," the narrator and the double become increasingly dissociated. But perhaps these aspects of the self were never fully bound in William Wilson, and this is the second point to note. The narrator recalls an altercation with his double at school and remembers:

> . . .I discovered, or fancied I discovered, in his accent, in his air, and general appearance, a something which first startled, then deeply interested me, by bringing to mind dim visions of my earliest infancy--wild, confused and thronging memories of a time when memory herself was yet unborn. I cannot better describe the sensation which oppressed me than by saying that I could with difficulty shake off the belief of my having been acquainted with the being who stood before me, at some epoch very long ago--some point of the past infintely remote.(p.49)

Poe seems to allude here to an obscure awareness of the tumultuous images of split good and bad self-representations, images of warring affect, recognizable but irreconcilable; images split and dissociated, images never cohering and thus always susceptible to fragmenting.

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If Poe delineates an ultimate dissolution of poorly integrated self-representations, Joseph Conrad, in "The Secret Sharer"(ca1902/1981) presents a study of reintegration of dissociated aspects of the self. Conrad's narrator takes his first command of a sailing ship, feeling some prescient intimation of an arduous enterprise to come. "But what I felt most," he says, "was my being a stranger to the ship; and if the truth must be told, I was somewhat of a stranger to myself."(p.138) New to the position of command, new to the ship, the narrator is as unknown to his crew as they to him. "They [the crew] had simply to be equal to their tasks; but I wondered how far I should turn out faithful to that ideal conception of one's own personality every man sets up for himself secretly."(p.138) Ruminating on deck in the stillness of the tropical air, the captain reveals a bit of how he happened--how he chose?--to become a stranger to himself.

> And suddenly I rejoiced in the great security of the sea as compared with the unrest of the land, in my choice of that untempted life presenting no disquieting problems, invested with an elementary moral beauty by the absolute straightforwardness of its appeal and by the singleness of its purpose.(p.141)

In his first act as captain, the narrator takes a watch on deck--then worries what effect his untraditional behavior will have on his crew. And then the security and elementary moral beauty of the sea are broken.

The captain spots Leggatt floating naked by the side of the ship, speaks to him, and brings him secretly aboard.

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The captain notes a subtle change in himself, a change somehow stimulated by the words of Leggatt: "The voice was calm and resolute. A good voice. The self-possession of that man had somehow induced a corresponding state in myself.(p.144) The captain frequently notes that he and Leggatt do not look alike, yet just as frequently, and often in the same sentence, calls Leggatt his "double" or his "other self." Leggatt has escaped from imprisonment on his own ship: he had, in a fit of temper, killed a man who was endangering the entire ship. The murder was not intended, the victim was a worthless, surly fellow, but a crime was done; Leggatt, imprisoned, chose escape over trial. For the irresolute captain listening to the determined Leggatt, "It was, in the night, as though I had been faced by my own reflection in the depths of a somber and immense mirror."(p.146) The captain hides Leggatt in his cabin, clothes him, feeds him--and by his unusual behavior further strains relations with his crew. To give Leggatt the best chance to escape the captain brings his ship dangerously close to an island shore; now resolute himself, he holds his course, leaves Leggatt to his freedom and his fate, and catches at last the off-shore wind that moves his ship to safety. For Conrad's captain, Leggatt, the secret sharer, represents the untested, dissociated aspects of himself. In the crisis of hiding a wanted criminal the captain sees dimensions of himself in the other and allows those hidden parts to rejoin the functioning self.

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Doestoevsky's short novel The Double (1866/1958) presents the story of a petty clerk tormented by his double. At the beginning of the story it is clear that Golyadkin is in the process of psychotic decompensation. He spends inordinate time in narcissistic preoccupation before the mirror, suffers from vague paranoid delusions and ideas of reference, endures periods of agitation, and acts inappropriately. Like William Wilson, Golyadkin initially feels warmly toward his double: "Mr. Golyadkin felt no hatred, enmity or even the slightest unfriendliness towards him--quite the reverse, it would seem."(p.79) The double works in the same office, gradually usurping Golyadkin's position, turning colleagues against him, and causing mischief and ridicule. Golyadkin questions the reality of the double, even sees his doctor, but his illness grows and his frantic efforts to assert himself bring even more disastrous responses. Eventually he is carried away to an asylum at the direction of his doctor: "This wasn't Dr. Rutenspitz! Who was it? Or was it him? It was! Not the earlier Dr. Rutenspitz, but another, a terrible Dr. Rutenspitz!"(p.254) Perhaps Golyadkin displays here the process of generalization of the delusion of doubles noted in several case reports mentioned above, as the belief in one persecuting double expands to include belief that others too have been impersonated. The double here represents what Golyadkin wishes he himself were like: the double is younger, more charming, more socially adroit and socially accepted.

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The double while imbued with "good" attributes none-the less foils the original, as do nearly all doubles reported in the clinical literature.

Doubles in literature seem then to appear in a number of forms: the felt but unseen "possessor;" the seen identical image; the seen but distinctly different-appearing image representing a divided aspect of the self. Each of these works is the story of a double of a self, not a story of doubles of others. (There are also, of course, stories of identical twins, known and unknown to each other, who represent good and evil; there are "science fiction" stories of duplication, like "Invasion of the Body Snatchers," but these latter seem usually of a "lower order" of literary endeavor, romances, adventures, or thrillers.) The general pattern in these works of fiction emphasizes the "trench" in Jekyll's words, cited above, which severs "those provinces of good and ill which divide and compound man's dual nature." The double seems usually to possess some dissociated, split-off aspects of the self, aspects often charged with unbridled passion, as with Jekyll or Andersen's scholar, though at times representing acceptable characteristics (Leggatt) or conscience (William Wilson). The double is usually capable of observing the original, of knowing all about him, and of judging him. Often then, the double seems to represent some notion of a superego, either in its critically judgmental aspect of conscience (William Wilson) or, less frequently, in its

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more benevolent aspect as ego ideal (Leggatt).

I have tried to indicate the every-day ways (twins, reflections, etc.) in which the idea of doubles can become the theme of delusion and I have tried to present some of the expressions of that idea in works of fiction. But it is not only in delusion or fiction that the idea of doubles becomes lively, it is also in moments of our ordinary growth and development. I would like to present three sketches of Capgras-like phenomena in non-psychotic children to indicate something of the place of the idea of doubles in development. Two cases are of people I have encountered; one is discussed by Bruno Bettelheim.

Bettelheim, in his The Uses of Enchantment (1976), discusses the echoes in fairy tales of the splitting of object representations. When kind grandmother suddenly reprimands and humiliates the child for bedwetting, for example,

> To the child, Grandma is no longer the same person she was a moment before; she has become an ogre. . . Unable to see any congruence between the different manifestations, the child truly experiences Grandma as two separate entities--the loving and the threatening. She is indeed grandma and the wolf. By dividing her up, so to speak, the child can preserve his image of the good grandmother. (pp.66,67)

Splitting of one person into two in order to keep the good image uncontaminated is a device not only of fairy tales, but also of many children confronted with "a relationship too difficult to manage or comprehend."(p.67) Bettelheim tells of a college student who remembered an experience

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she had when aged five.

> One day in a supermarket this girl's mother suddenly became very angry with her, and the girl felt utterly devastated that her mother could act this way toward her. On the walk home, her mother continued to scold her angrily, telling her she was no good. The girl became convinced that this vicious person only looked like her mother and, although pretending to be her, was actually an evil Martian, a look-alike impostor, who had taken away her mother and assumed her appearance. From then on, the girl assumed on many different occasions that this Martian had abducted her mother and taken her place to torture the child as the real mother would never have done.
>
> This fantasy went on for a couple of years until, when seven, the girl became courageous enough to try to set traps for the Martian. When the Martian had once again taken Mother's place to engage in its nefarious practice of torturing her, the girl would cleverly put some question to the Martian about what had happened between the real mother and herself. To her amazement, the Martian knew all about it, which at first just confirmed the Martian's cunning to the girl. But after two or three such experiments the girl became doubtful; then she asked her mother about events which had taken place between the girl and the Martian. When it became obvious that her mother knew about these events, the fantasy of the Martian collapsed.(p.67)

Bettelheim concludes that at the time this girl needed to feel secure that her mother was totally good and thus incapable of inflicting such painful criticism, she was able to rearrange reality via the delusion of the Martian and so preserve her belief in her mother's total goodness. When more secure in herself she was able to test the fantasy and integrate the double image of her mother.

A similar quality of thought appeared in a three year old boy whom I met last summer. Just before I met him, his parents told me, he had begun to say things like "I don't want two daddies, a nice daddy and a nasty daddy." He seemed also to be having nightmares of "two daddies." (It should

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not be difficult to imagine the enthusiasm with which I responded to this encounter.) The boy offered little additional data; he was very bright, but late in language acquisition. His vocabulary was limited and he was reluctant to talk about these unsettling experiences. I did discover, however, that a few days before he first complained of two daddies his father had, for this first time, inflicted a corporal punishment, and the father acknowledged he had been in a towering rage at the child. The parallel to Bettelheim's girl is obvious. In both cases a sudden change of attitude on the part of a parent is so shocking, so alien, that it threatens the child's entire world view and can "only" be explained by the "fact" that two persons, not one, are involved.

The second Capgras-like case I encountered was reported by a 24 year old college student who spontaneously recalled while in treatment that when he was about five he had begun to believe that his mother was occasionally replaced by an identical double. His conviction, he recalled, was complete: on many occasions, roughly between his fifth and tenth years, his mother would leave home and an identical double would return. He knew it was a double because, even though identical, she <u>felt</u> different to him: she was hard, cold, angry; she treated him differently. Looking back, the young man realized that the delusion began shortly after his parents' divorce and occurred always after

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what must have been his mother's going out on dates which went badly. Again the parallel with Bettelheim's case is clear. At a time when this boy especially needed the complete support and security of a loving mother, her strained and changed demeanor could not be tolerated because of the risk it posed to his good image of her. The unpleasant mother, then, was believed to be a double, an impostor, a person who did not love him and whom, in turn, he could reject without losing his inner bond to his "real," loving mother.

The argument I have presented in this chapter tries to indicate that the Capgras' Syndrome, the psychotic delusion of doubles, should appear not as a bizarre, exotic, alien entity, but rather as the extreme expression of phenomena familiar to us all. In our development as a species as well as our development as individuals we note the striking possibility of similarity in twins, reflections, and chance resemblances. Our literature is rich with the idea of doubles as comedic devices and allegorical reminders as well as in depictions of our potential for psychic dissolution and our capacity for doing ill as well as good. Our fairy tales enact the splitting up of good and bad, and echo the normal childhood devices of preserving good images by postulating bad impostors. (Folklore is rich with stories of "changelings," and as late as the early twentieth century there are accounts of children left to die on dungheaps because their parents believed they were changelings.

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/Briggs, 1967/) The "family romance" of the neurotic (Freud, 1909) portrays, according to both Bettelheim (1976) and Fenichel (1945) a similar if somewhat less dramatically conceived role. Rank (1909) notes also the presence of the family romance in myths of the birth of the hero. Freud (1909) compares the "family romance" to historical intrigues; indeed, in 1688 the birth of a potential Catholic successor to the throne of England brought with it a wide-spread belief that the infant was "supposititious," a changeling in the royal family. (See Berson, 1968) Folklore and history, then, echo literature and psychoanalytic theory. The three cases sketches I have presented in this context should, I hope, convey in yet another way the familiarity with which we ought to greet the notion of doubles.

Perhaps a more familiar response to Dr. F.'s delusion of doubles would have made possible some real treatment. It is hard to know. Certainly by the time I met her, her disease had taken a heavy toll, the delusion of doubles and the fear of mutilating torture preoccupied her totally. Earlier, perhaps, some recognition of the syndrome, some sense of its relation to us all, might have fostered better care. It is my hope that this discussion of the delusion of doubles may help engender a better response to those who suffer it. Those authors who posit potential organic causes for the syndrome urge greater diligence in organic work-ups. I would urge as well greater attention to early object relations, to one-sided images of self and others,

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and to interpersonal experiences of sudden, startling changes in emotionally rich relationships. If the idea of doubles is, as I have tried to demonstrate, a more familiar, understandable phenomenon than we had thought, it is nonetheless most horrifying, cruel, and awful when it takes psychotic form. What is richness in literary metaphor, what is transitionally adaptive in childhood dilemmas, what brings mirthful confusion in drama or twin-play, is also capable of wreaking devastation and tragic destruction as Capgras' Syndrome, the delusion of doubles.

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Appendix

Cases of Capgras' Syndrome Reported in English

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SOURCE	# CASES	SEX	AGE	PRINCIPAL DOUBLES	DIAGNOSIS
Alexander, Stuss, Benson (1979)	1	M	44	wife, children, home	brain trauma + psychosis
Arieti and Meth (1959)	1	F	ng	parents	paranoia
Ball and Kidson (1968)	1	M	26	father, priest	paranoid schizophrenia
Bankier (1966)	1	M	29	wife	paranoid schizophrenia
Bland (1971)	1	F	38	daughter, husband	schizophrenia
Blum (1974)	2	F	ng	husband	ng
		F	ng	husband	ng
Cavenar, Maltbie, Petty (1977)	3	F	42	ex-husband	paranoid schizophrenia
		M	28	grand parents	paranoid schizophrenia
		M	26	parents	paranoid schizophrenia
Chawla and Virmani (1977)	1	M	26	father, brother	temporal lobe epilepsy
Christodoulou (1977, 1978a, 1978b)	12	F	47	husband, children	paranoid schizophrenia
		M	67	son	involutional depression
		F	52	daughter	involutional drpression
		F	43	father, employers	paranoid schizophrenia
		F	35	husband, domestic animals	paranoid schizophrenia
		M	40	wife, mother, children	paranoid schizophrenia
		F	64	children, husband	involutional depression
		F	50	husband, sisters	paranoid schizophrenia
		F	60	daughters	involutional depression
		F	43	husband	paranoid schizophrenia
		F	28	therapist	organic psychosis
		F	18	self	paranoid schizophrenia
Cohen, Rosenblatt, Faillace (1977)	1	F	25	husband, child	postpartum psychosis
Coleman (1933, 1934)	2	F	50	letters from daughter	acute depression
		F	55	husband, sisters	unsystematised delusional insanity
Crane (1976)	1	M	27	parents, children	schizophreniform psychosis
Dally and Gomez (1979)	1	M	58	wife, daughter, son-in-law	depression

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Davidson (1941)	2	M	30	wife	paranoid schizophrenia
		M	73	wife	paranoid schizophrenia
Enoch (1963)	10	M	50	wife, brother	paranoid schizophrenia
		M	57	wife	paraphrenia
		M	37	parents	paranoid schizophrenia
		M	41	wife	paranoid schizophrenia or psychotic depression
		M	34	mother	paranoid schizophrenia
		M	73	son, brothers	manic-depressive psychosis
		F	66	sons	paraphrenia
		F	38	husband, children	paranoid schizophrenia
		F	31	husband	schizophrenia or manic-depressive psychosis
		F	57	sister, mother	paranoid schizophrenia
Enoch, Trethowan, Barker (1967)	3	M	50	wife, daughter	paranoid schizophrenia
		F	30	husband	paranoid schizophrenia
		F	40	husband	endogenous depression
Eppel and McCormick (1975)	1	M	20	mother, siblings	paranoid schizophrenia
Faber and Abrams (1975)	1	M	36	mother	chronic undifferentiated schizophrenia
Fialkov and Robins (1978)	1	F	43	self, husband, children	paranoid schizophrenia + brain trauma
Gluckman (1968)	1	F	61	self, husband	paranoid schizophrenia + cerebral atrophy
Goldfarb (1974)	1	M	69	wife	organic brain syndrome + paranoid state + depression
Goldfarb and Weiner (1977)	2	M	78	wife	organic brain syndrome
		F	78	husband	organic brain syndrome
Haslam (1973)	1	F	32	fiance	paranoid schizophrenia
Hay, Jolley, Jones (1974)	1	F	57	sister, brother-in-law	pseudohypoparathyroidism

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Hayman and Abrams (1977)	2	M	37	ex-wife, siblings, therapists	prosopagnosia (right parietal lobe lesion)
		F	51	sons	prosopagnosia (right parietal lobe lesion)
Hicks (1981)	4	M	16	mother	schizophrenia
		ng	ng	ng	schizophrenia
		ng	ng	ng	schizophrenia
		ng	ng	ng	psychotic depression
Karkalas and Nicotra (1969)	2	F	69	husband	ng
		F	43	husband, children	paranoid schizophrenia
Kiriakos and Ananth (1980)	13	7M 6F	ng	not individually specified 3 spouse 4 parent 4 sibling 1 close cousin 1 therapist	not individually specified 11 schizophrenia 1 borderline personality organization 1 hysterical psychosis (4 with EEG abnormalities)
Lansky (1974)	1	M	24	wife, therapist	schizophrenia, possible brain lesion
MacCallum (1973)	5	M	71	wife, brother	toxicity, anoxia
		M	45	wife, children	alcoholism
		F	28	mother, nurses	basilar migraine
		F	44	therapists, hospital	low folic acid
		F	75	domestic worker	malnutrition
Madakasira and Hall (1981)	1	F	68	son	myxedema
Merrin and Silberfarb (1976)	1	F	52	husband, therapist ?	paranoid schizophrenia
Mikkelsen and Gutheil (1976)	1	F	44	husband, mother, sister, therapist, self	paranoid schizophrenia
Minns (1970)	1	F	42	mother, brothers, neighbors	paranoid schizophrenia
Morrison (1980)	3	F	37	husband	paranoid schizophrenia
		F	29	husband, children	psychotic depression
		M	17	parents	schizophreniform psychosis

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Moskowitz (1972)	1	M	12	parents, brother	ng
Moskowitz (1975)	1	M	ng	parents	ng
Murray (1936)	1	M	26	parents	ng
Nikolovski and Fernandez	1	F	15	parents	post varicella encep-alitis
Nilsson and Perris (1971)	1	F	26	husband, children	post partum depression + right temporal lobe atrophy
Prabhu (1973)	1	M	18	mother, brother	paranoid schizophrenia
Preskorn and Reveley (1978)	1	F	24	husband	pseudohypoparathyroidism
Rosenstock and Vincent (1978)	1	F	15	parents, grandparents, therapist	paranoid schizophrenia
Schlesinger (1975)	1	M	39	wife, daughter, in-laws	episodic depression
Shraberg and Weitzel (1979)	2	F	40	children, therapist	prosopagnosia + retard-ation + epilepsy + schizophrenia
		F	57	husband	prosopagnosia + paranoid personality
Sims and White (1973)	1	F	32	mother, ex-employer	paranoid schizophrenia
Siomopulos and Goldsmith (1975)	1	M	34	self	paranoid schizophrenia
Steiner (1975)	1	F	56	son, husband	paranoid schizophrenia
Stern and MacNaughton (1949)	2	F	42	father	paranoid schizophrenia
		M	59	wife	manic depressive illness
Sullivan, et. al. (1978)	2	M	26	parents	decreased platelet mono amine oxidase + paranoid schizophrenia
		M	28	grandparents	decreased platelet mono amine oxidase + paranoid schizophrenia

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Thompson, Silk, Hoover (1980)	1	M	32	wife, children, self, cities	paranoid schizophrenia
Todd (1957)	7	M	29	wife	schizo-affective psychosis
		M	47	brother	chronic hypomania
		F	54	daughter, therapist	paranoid schizophrenia
		F	17	parents	paranoid schizophrenia
		F	65	husband.	manic depressive illness
		F	48	husband	paranoid schizophrenia
		F	38	husband	schizo-affective psychosis
Todd, Dewhurst, Wallis (1981)	3	M	56	wife	paranoid schizophreniform psychosis + brain tumor
		F	68	daughter, therapists	paranoid schizophrenia + organic brain disease
		F	41	husband, step-sons, parents, self	paranoid schizophrenia
Vogel (1974)	5	F	35	husband	paranoid schizophrenia
		F	52	mother	paranoid schizophrenia
		F	ng	husband	paranoid schizophrenia
		F	53	brother, sisters	paranoid schizophrenia
		F	36	son, husband	paranoid schizophrenia
Wagner (1966)	1	F	21	self, ex-lover	paranoid schizophrenia
Waziri (1978)	1	F	30	parents	neuroleptic toxicity + brain dysfunction
Weinstock (1976)	1	M	32	parents	paranoid schizophrenia
Weston and Whitlock	1	M	20	parents, siblings	brain trauma

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TOTALS*:	# CASES	SEX	AGE			PRINCIPAL DOUBLES	DAIGNOSIS
	124	70F		male	female	57 spouse	78 schizophrenic illness
		51M	0-10	0	0	38 parents	54 paranoid schizophrenia
		3ng	11-20	5	4	3 grandparents	24 schizophrenia, schizo-
			21-30	12	9	30 children	phreniform psychosis,
			31-40	10	12	22 siblings	paraphrenia, etc.
			41-50	6	14	12 therapists, staff	2 schizo-affective psychosis
			51-60	4	12	10 others	17 affective disorders
			61-70	2	7	4 inanimate objects	1 borderline personality disorder
			71-80	4	2	8 self	1 hysterical psychosis
			ng	8	10		28 organic conditions
							(many with concurrent func-
							tional psychotic diagnoses)
							6 ng

*Numbers will not match because some patients received multiple diagnoses, some patients allege more than one double, some data are not given, etc.

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