changing worlds & signs of the times

Selected Proceedings
from the 10th International Conference
of the Hellenic Semiotics Society

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E-BOOK (PDF)
Changing Worlds & Signs of the Times /
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DESIGN:
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PUBLISHER:
The Hellenic Semiotics Society
Ελληνική Σημειωτική Εταιρία

ISBN 978-618-82184-0-6

Changing Worlds & Signs of the Times

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A semiotic attempt to analyze delusions[1]

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Abstract

To show the relevance of semiotic analysis in determining mental disorder, I examine verbal expressions of two delusions: Thought Insertion and Capgras. First, I consider their context, namely the current polemic about mental disorder and DSM-V (2013). Second, I argue for an analysis of the subjective view of delusions in terms of self-perceived reality. Then, I examine delusional reports and the above-mentioned two monothematic delusions and rebut the view that delusions are false beliefs in favor of a semiotic interpretation of delusions as autobiographical narratives with an unreliable narrator in the passive voice. I suggest applying F. Schulz von Thun's (1983) model of communication for coordinating different viewpoints on delusions.

Keywords

delusion, delusional report, delusional self, mental disorder, false belief, perceived reality

Delusions – a sign of the times?

One of the signs of the times is the ongoing polemic about mental disorder, due to the new edition of (American) psychiatry's diagnostic manual, the DSM-V (May 2013). I argue that a semiotic approach is appropriate for interpreting delusional disorders and discussing the question whether the bottom line on mental suffering is, as psychiatrist James Davies puts it, "a realistic scientific picture" or "a convenient professional myth" (2013, 2801)? A recent publication in *Scientific American Mind* concurs: "a student's journal from "normal" to "schizophrenic" and back highlights shortcomings in how our society deals with mental health" (Longden, E., 2013, 34). Apparently the '*iatros tes psuches*' is not healing the *psyche*.[2]

Delusions are the first item on the list of the DSM-V's "key features that define the psychotic disorders" (2013, 87). In my analysis, I distinguish between two levels of interpretation: (1) definitions of delusions by the sciences (broadly speaking, from psychiatry to the humanities) and (2) the delusional self's view. I call level (1) the expert view. Level (2) subdivides into delusional reports – delusions as recognized and narrated by the subject experiencing them – and the delusional self's experience. In my view, delusional reports are *nested* like Russian dolls. The *nest* in question provides temporal continuity for the autobiographical self, which displays itself in narrative, as narrator, protagonist and author.

I argue for a two-step conception of delusional reports: the self's experience or perceived reality which is involuntary and could be qualified as an affective and partly cognitive process, on one hand, and the report of that perceived reality as an episode of the self's autobiography, on the other. The latter is voluntary and occurs on a self-reflective level, since it is coherently organized as a narrative. I take delusional reports as narratives with a nested perceived reality. It appears that the evidence in support of classifying delusions as false beliefs is put together by friends of the expert view, (1), rather than by the producers of delusional reports, i.e. the subjects experiencing delusions, (2). If you feel that a thought is being put into your mind, is that feeling evidence for a false belief? The expert view may ascribe you with a 'false belief', but how do you put together the evidence for holding a false belief? What are your grounds for putting together what you feel are alien thoughts, with accepting them as your false belief?

To illustrate this dilemma from another viewpoint, consider American psychologist David Rosenhan's (1969) experiment, published 40 years ago in *Science* under the title: "*On being sane in insane places*" (1973), recently cited in Ferris Jahr's (2012) presentation of the DSM-V[3]. Complaining of unfamiliar voices inside their heads, Rosenhan and 7 others were admitted to psychiatric hospitals, each with a diagnosis of schizophrenia. Although they told staff that their voices had gone away, "[d]octors forced them to accept antipsychotic medication [...]. [N]o one realized that these individuals were healthy—and had been from the start. The voices had been a ruse." (Jahr, 2012, 30).

A further spin on the question of false belief is provided by an unexpected source: unlike the expert-MD's, *patients* in the psychiatric wards to which Rosenhan and his colleagues were admitted, identified the newcomers as pseudo-patients. Unfortunately psychiatric staff was caught in the diagnostic belief-system of a mental institution (Richard Bentall (2009, 2010). Consequently, they "interpreted everything the pseudo-patients did in the light of their own presuppositions. [...] [O]nly the other patients seemed to recognize that the researchers were not who they pretended to be, some making remarks such as 'You're not crazy. You're a journalist or professor ... checking up on the hospital.' " (2010, 67). Bentall cites a recent case, with psychiatric staff interpreting a PTSD patient, Andrew, in an alarming analogy to the staff in Rosenhan's experiment. Andrew was classified as "excessively polite" – the psychiatric staff's problem being that "we're trying to work out whether his politeness is part of his normal personality or his illness." (2010, 112).

Coordinating different perceptions of reality

The message and its interpretation depend on who perceives and what is perceived – that is, how various perspectives of reality interact with each other. A semiotic model for analyzing how delusions are perceived is Friedemann Schulz von Thun's (1981) square of communication, also known as the four-ear-model (fig.1).[4] I take "reality" as designating *perceived reality*, synonymous with "view of life" or "view of the world", depending on an individual's socio-cultural context.[5] I try to specify a delusional self's perceived reality. In order to do that, I examine how delusions are communicated, because any communicative situation also projects a perceived reality, coordinated and located between a speaker (addresser) and a hearer (addressee). On Schulz von Thun's model, the communicative situation between a delusional self (sender) and an expert (receiver) comprises 8 different aspects: 4 from the sender's perspective and 4 from the receiver's perspective. Let's begin with the subjective perspective of the delusional self (the sender):

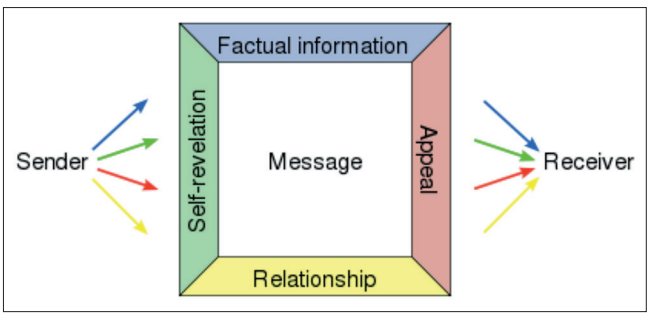

Figure 1. F. Schulz von Thun's model of communication.

1) self-disclosure: what the delusional self shows or reveals about itself; 2) appeal: what the delusional self intends or wishes to reveal about itself; 3) factual information: what the delusional self says about itself; 4) relationship: how the delusional self relates

to its addressee (how the self feels about, and what the self thinks of, the hearer). And how does the receiver perceive the sender, evaluating and reformulating the delusional self's perspective from the expert view? 5) he/she hears the delusional self's disclosure; 6) he/she hears the delusional self's appeal (what he/she wants to say); 7) he/she hears the factual information conveyed by the delusional self; 8) he/she relates to the delusional self and their relationship resonates into his or her interpretation. Now consider psychiatry's self-perceived reality. As psychiatrist Tom Burns (2013) explains, understanding and healing the *psyche* is the self-perceived endeavor of this science.

> "Psychiatry is firmly anchored in the belief that we can understand fairly well what is going on in another person's mind. [...] Psychiatry touches directly on that which is most human in us, the central core of our being – our identity or, if you wish, our 'soul'." (2013, xxi).

How does psychiatry touch the delusional self's perceived reality?

Analyzing the perceived reality in -and of- two delusions: *Thought Insertion* and *Capgras*

I analyze the perceived reality of two delusions, focusing on their narrational aspects in order to ground the claim that the delusional self is an autobiographical self with an unreliable narrator in the passive voice. 1) *Thought insertion delusion* – an unspecified bizarre delusion about alien thoughts coming into one's mind, or having thoughts that are not one's own and 2) the *Capgras* delusion – a delusional misidentification syndrome, where familiar people are replaced by impostors. Both cases are so-called monothematic delusions, namely delusions, which are "not entirely integrated with the rest of the patient's beliefs" (Coltheart, 2013, 103).

The narrational aspects in the perceived reality of delusions occur as a two-step process: i) the first step is the experience of the delusional self and ii) the second step is the delusional report. The objective of this two-step analysis is to extract the perceived reality as thought, felt and experienced – so as to rebut the traditional view that delusions are false beliefs. Thus, for example, thought insertions are a thought disorder, yet it also *feels* real to the person experiencing it. But that is not how medical psychiatry interprets delusions.

Delusions as false beliefs: a review

On psychiatry's official view, delusions are abnormal and false beliefs (Oxford Handbook of Psychiatry (2013, 90) and the DSM-IV (1994, 765). The Oxford Handbook of Psychiatry defines a delusion as "an abnormal belief which is held with absolute subjective certainty, which requires no external proof, which may be held in the face of contradictory evidence; and which has personal significance and importance to the individual concerned. Excluded are those beliefs, which can be understood as part of the subject's cultural or religious background. While the content is usually demonstrably false and bizarre in nature, this

is not invariably so." DSM-IV defines a delusion as "a false belief based on incorrect inference about external reality and firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g. it is not an article of religious faith)." (1994, 765).

On both definitions, delusions are beliefs, albeit false or abnormal ones, but a belief is not considered delusional "if it is culturally acceptable" (Mullins & Spence, 2003, 293). Yet the question remains, whether thought insertion is "solely an abnormal belief or may also be an experience" (ibid). By contrast, DSM-V revamps the view that delusions are false beliefs: "*Delusions* are fixed beliefs that are not amenable to change in light of conflicting evidence. [...] The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity." (2013, 87).

First-person perspectives are expressed in statements such as: "my best friends have been replaced by impostors" or "I don't exist" or, "the houses are sending me messages". I suggest that the 'delusions are false beliefs' view boils down to an attribution of belief from a third-person perspective. Analyzing how first- and third- person perspectives are coordinated can clarify why and when a delusion is reported. In addition, I suspect that the attribution of belief view is based on some sort of normative grid for distinguishing between 'true' and 'false' beliefs. A false belief would be one that deviates from the norm. If my suspicion is correct, this attribution may not even produce a sufficient explanation of why some people have delusions. Although delusions involve misinterpretation, the interpretation of the delusional self's reality in terms of false beliefs may itself be a misinterpretation. In delusions, there are no clear borders between what 'seems to be' and 'what is' and that is a semiotic problem: how to interpret reality.

According to another view, the attitude view, delusions are affective disturbances rather than belief states (Bayne, 2009; Fernandez 2010, 2013).[6] A delusion is an attitude or standpoint regarding reality and, rather than a belief, a *delusional attitude* is an acceptance (or a refusal), grounded on cognitive and personal or sub-personal perceptual responses and/or affective disorders of the self. On the attitude view, a delusion itself is not a belief, though it may ground one. Or, as philosopher of psychology Keith Frankish (2011, 26) puts it, "it may be that delusions, rather than being beliefs that fail to conform to the standards of rationality for belief, are non-doxastic acceptances that were never meant to conform to them. Perhaps patients adopt delusions because they answer some emotional or other psychological need [...]." In addition, psychoanalytical theory emphasizes the importance of motives as doxastic forces. This view is supported by cognitive psychologists, like McKay, Langdon & Coltheart (2005), who claim that motivational factors may determine whether beliefs formed are congruent with wishes (a subject's perceived reality) or reality (the experts') perceived reality. Addressing the question, "why

do subjects have delusions?" Following Gerrans (2013), I assume that having a delusion has something to do with how things *feel* – in particular regarding mood disorders – and *seem*, rather than are, and how the self views its history. Hence I focus on the delusional self's autobiographical narrative and the subjective adequacy of delusional reports.[7]

I argue that delusions are not false beliefs because the experiencing self does not interpret its delusion as a false belief, rather it experiences an unexpected event. According to child psychologist Renée Baillargeon et al, "false-belief understanding provides evidence for a sophisticated (and possibly uniquely human) ability to consider the information available to an agent when interpreting and predicting the agent's actions – even if this information is inaccurate and incompatible with one's own" (2010, 110).[8] If we combine this view with the stance that delusions are attitudes, the upshot would be that (i) the delusional self does not understand that it is experiencing a false belief and (ii) a delusional report explains an unexpected event by narrating it and thereby binding it in a context. Lastly (iii), false-belief understanding as outlined by Baillargeon might inform the expert view on which false beliefs are ascribed to delusional selves.

Regarding delusional experiences, Baillargeon's view entails the claim that the delusional subject does not self-attribute a false belief because the delusional episode it experiences is an unusual occurrence in a cognitive process, nor would it interpret the delusion as false belief unless it retrospectively adopted the addressee's viewpoint. Looking back, reconstructing its autobiographical account of a delusional experience by binding it in a narrative context in which said delusional experience becomes an episode, the delusional subject may self-attribute a false belief if that is how it has come to understand its experience. This is how, as Philip Gerrans (2013, 23) puts it, "delusions are empirical beliefs. That is, hypotheses that explain perceptual and sensory information." From a semiotic viewpoint, the subjective perspective provides evidence for a causal explanation as an autobiographical narrative, in which the delusional experience appears as an episode. As Gerrans points out, "a mind which is limited to decontextualized processing is not very useful for acting in the world." (2013, 91). All the more reason to fruitfully communicate with such a mind, and come to understand it.

Perceived reality in and of the thought insertion delusion

Thought insertions are a *thought* disorder – that is, a cognitive disorder, which is a psychotic disorder. As schizophrenic patient and professor of law & psychiatry Elyn Saks (2007, 302) explains: "Schizophrenia is an example of a disorder that affects thinking, and so it is referred to as a thought disorder. [...]. The DSM places schizophrenia among the thought disorders characterized by psychosis. Psychosis is broadly defined as being out of touch with reality [...]." Even though it is a *thought* disorder, thought insertion it also *feels* real to the reporting self. The delusion of thought insertion is also called 'loss of boundary delusion', since it seems to be "more about the interface between internal

and external reality" (Langdon & Bayne, 2010, 321). We may note that Elyn's perceived reality is not shared by her interlocutors, as she points out, emphasizing that people with a thought disorder like hers "aren't in any hurry to tell the world about themselves" because of "the stigma: schizophrenics are violent and threatening. [...]. Yet, "the schizophrenic mind is not split, but shattered." (2007, 303-4). I suggest that a semiotic and narratological analysis might provide fresh insights into some aspects of a shattered perceived reality and how it is communicated.[9]

The delusional report is a first-person narrative of an episode in which the autobiographical narrator is a passive voice rather than an active producer. An autobiographical (autodiegetic) narrator is a first-person narrator who is both author and protagonist of his/her narrative and, as the latter's agentive owner, he/she she uses the active voice. A delusional narrator lacks the privilege of self-perceived agency and self-ownership and hence her experience occurs in (and is reported in) the passive voice: a different structure of reality is interfering with her perceived self: an event walks onto her self-reflective timeline and shifts the latter into a different format. Listen to Elyn Saks' experience: "As I walked along, I began to notice that the colors and shapes of everything around me were becoming very intense. And at some point, I began to realize that the houses I was passing were sending messages to me: *Look closely. You are special. You are especially bad. Look closely and ye shall find. There are many things you must see. See. See.*" (Saks, 2007, 27).

Therefore, a delusion becomes a delusional episode of a subject only if it is fitted into the narrative structure of its autobiography, thereby gaining meaning. Put differently, a delusion is embedded in the autobiographical self's narrative when the latter re-tells or reports a real-time character-centered *reality show*. To take Elyn's case, she reports that the houses she was passing were sending her messages: the delusion emplots itself on its narrating subject as a mental content and real occurrence in two steps: first, for her, it is a real occurrence because she is experiencing it, which is why the episode is emotionally salient. Second, since the delusional episode is conspicuous and pertinent to the self, it becomes an episode in her autobiographical narrative – but the self does not relate itself actively to this episode. Rather, this episode is a mental content appearing as an unauthorized occurrence in her narrative, as is made explicit in Elyn's reports: "I didn't hear these words as literal sounds, as though the houses were talking and I was hearing them; instead, the words just came into my head – they were ideas I was having. Yet I instinctively knew they were not *my* ideas. They belonged to the houses, and the houses had put them in my head." (2007, 27).

L. Sass (2000, 53) and J. Fernandez (2013, 174) argue that delusional selves with thought insertions experience hyper-reflexivity, namely self-attribution without self-ownership. Subjects of thought-insertions attend to their own delusional states by focusing on their own experiences as witnesses, rather than being aware of them as their own. Put differently, the delusional self seems to have a temporal consciousness,

which does not spread over time: it lacks temporally extended consciousness. Thus we could explain the delusional self's timeout which, in the delusional report appears as a slowing-down of the narrative, as in Elyn's report: "As I walked along, I began to notice that the colors and shapes of everything around me were becoming very intense."

In Elyn's account, we notice that the narrator's present perfect is invaded by a change in format - retold in the present continuous. This retelling of the delusional episode stays with the story, that is, it occurs without slowing down the report and the shift in mood is indicated by a shift in verbal aspect: from perfect to continuous. By the time Elyn reaches her parents' house, the delusional episode has passed, but it has left a scary mark in her mind: " – one, maybe two hours later – I was tired, hot and very frightened. Immediately, I told my mother what had happened on my long walk and how scary it had been to have those thoughts from the houses in my head." (2007, 27).

Gerrans (2013, 89) interprets the delusional self's subjective presence time as a mental time travel network in screensaver mode. This screensaver mode is the delusional self's default mode – which is Gerrans' explanation of why delusions are formed. Roughly, mental time travel is a result of a cognitive simulation process, in which the self relates episodic memory to future decisions by means of a narrative providing an autobiographical framework for its experience. This autobiographical framework, Gerrans notes, is "characterised by subjective adequacy rather than truth, accuracy, public acceptability or verification." (ibid). I agree with Gerrans' view of subjective adequacy – of the delusional self's state as well as of its delusional report, though I believe the distinction between the two steps is worth mentioning. However, mental states, whether delusional or not, notoriously fall short of corresponding to 'facts' (whatever these turn out to be). In Gerrans' own words: "The stories people tell to themselves about themselves or others in order to cope with experience are often at odds with objective accounts of the causes of their experience." (2013, 89).

On another view, held by Christoph Hoerl (2013, 12-13), "there is a specific breakdown in schizophrenic patients' reasoning abilities [...]." They lack "a certain sense that certain thoughts, which come into their minds are still theirs to consider, because the ability to take relevant alternatives into account is disrupted." If this is true, Hoerl continues, it may explain why "the patients also don't experience themselves as having settled the issue. They are mere bystanders to the occurrence of those thoughts, and thus may form the impression that those thoughts have been imposed on them by an outside agency".

Hoerl (2013, 23) advances the claim that patients with thought insertion delusions lack a sense of active participation. His claim dovetails with my view, that the delusional self is an unreliable autobiographical narrator in the passive voice. He argues that for a thought to belong to me, first, it must be the product of my background beliefs, desires and interests. Second, "it must play a certain role in affecting the future background of beliefs, desires and interests I have, where this is determined by the active use I make

of that thought." Since the delusional self cannot identify certain thoughts as belonging to its psychological history or does not recognize them as its own, it also does not 'own up' to or acknowledge these thoughts as belonging to its future background of desires, beliefs and interests. Although retrospectively emplotted in a delusional report, the insertion of thoughts is not homogenous with the delusional self's spatio-temporal extension. "'[T]hey were being put into me into my mind', 'very similar to what I would be like normally'", says delusional patient Allison Bolger (1999).

On the other hand, a delusional subject's way out of suffering from voices may be to re-appropriate them or interpret them as a part of her. Psychology student Eleanor Longden (2013) explains how learning to listen to the voices in her mind helped her to accept them. Once she had learnt to accept them as a response to abuse, the voices ceased to torment her. Acknowledging ownership of her aggressive voices and allowing them to participate in her mental life, Eleanor could live with them, having "learned to interpret them in a constructive way." (2013, 38). This case is a good example of a semiotic approach to thought insertion delusion: listening and interpreting the voices she hears enabled Eleanor to recover from her thought disorder.[10]

Perceived reality in and of Capgras delusion

The Capgras delusion is a "delusional misidentification syndrome" (DMS-IV), also called a delusional denial of identification (Christodoulou, 2009). Neuroscientist V.S. Ramachandran (1998) calls Capgras "one of the rarest and most colorful syndromes in neurology" (1998, 1856). Capgras occurs in paranoid hallucinatory schizophrenia, as well as in neurological disorders – which is why neuroscientists like Ramachandran (1998) and Christodoulou (2009) suggest that it has an organic base, "although frequently seen in psychotic states" (1998, 1856). The syndrome is named after French psychiatrist Jean-Marie Joseph Capgras (1873-1950), who first described this disorder in 1923, on the case of patient Mme. M., who complained that 'doubles' had replaced her husband and other people close to her. Capgras and his co-author Jean Reboul-Lachaux consequently called the disorder "*l'illusion de sosies dans un délire systematisé chronique*" (*the 'doubles' illusion in a systematized chronic delirium*) (1923, 11: 6-16). Interestingly, the term 'double' (*sosie*), was the patient's own ascription when reporting her perceived reality and Capgras, the treating psychiatrist, used it for designating the syndrome which was ultimately named after him.

The Capgras delusion as a false belief

Today, the Capgras delusion is commonly considered a 'belief that familiar persons or objects have been replaced by doubles' and is classified as an unspecified non-bizarre delusion. Thus the Oxford Handbook of Psychiatry (2013) gives the following definition: "Capgras Syndrome. A type of delusional misidentification in which the patient believes

that a person known to them has been replaced by a 'double' who is to all external appearances identical, but is not the 'real person'." (2013, 88). A delusional misidentification is the opposite of déjà vu – loved ones have been replaced by doubles and the originals are no longer available. The experience of Capgras syndrome is sometimes compared to the plot of "Invasion of the Body Snatchers," directed by Don Siegel, (1956). In this movie, a doctor returns to his small town and discovers that some of his neighbors have been supplanted by aliens.

Note that Capgras and Reboul-Lachaux defined the syndrome as an *il*lusion, that is, a misinterpreted perception of a sensory experience. A *de*lusion, by contrast, is propositional and involves a breakdown in belief, at least according to the expert view. "Mme. M. believes that her husband has been replaced by a double" ascribes to the subject (Mme. M.) a belief of (or an attitude towards) a proposition "that her husband has been replaced by a double". By ascribing a belief to Mme. M., friends of the doxastic view assume that she regards this proposition as true. The common question regarding illusions and delusions such as Capgras is, whether believing is seeing. Capgras is classified as 'non-bizarre', which denotes delusions about situations that could occur in real life, such as being followed, deceived, having an infection – or failing to identify your husband and feeling certain that he has been replaced by an impostor. So here the relation between believing and seeing is questioned, unlike thought insertion delusion which is, as its name indicates, a *thought* disorder involving situations unlikely to occur in real life – such as houses sending you messages.

Whereas illusions question the nature of our perceptual experience, delusions (thought insertion, Capgras and others) question the nature of our experience *per se*. That is why the doxastic view may be an easy way out of the general problem – but it doesn't solve the general problem. Even if we take the DSM's weaker version, namely that delusions are "incorrect inferences about external reality" (DSM IV, 1994, 765), there is a dissonance between the subject's belief and the expert's belief (or truth). In order to ferret out the doxastic or inferential view's fallibility, let's examine it with regard to Capgras. Consider a neutral phrasing: a delusional subject takes her husband and her brother to have been replaced by impostors. These latter resemble her husband and her brother: they look just like them but they are not - and the originals have gone.

On the expert view that delusions are false beliefs, the Capgras patient is convinced that her husband and her brother are gone and have been replaced by doubles or impostors – and that this is true. This belief is abnormal and not accounted for by her cultural background or level of intelligence. Her thought (or maybe the content of her thought) is false. Despite evidence to the contrary, such as her husband identifying himself, or her brother telling her about their childhood, she holds onto her false belief and is convinced of its reality. Sustaining a variant of the doxastic view initiated by Locke, namely that delusions are errors of the imagination and these errors ground false beliefs, philos-

opher A. Egan (2008, 263-80) argues that delusions are *bimaginations* or in-between states that may not influence a patient's overall reality or worldview. Although a person who suffers from Capgras delusion might act differently toward her friends and family, she might not draw all the inferences that her delusional thoughts demand. So, says Egan, the delusion is *circumscribed* like imagination. Consequently delusions are *bimaginations*, which are doxastic malfunctions – providing imaginations are considered as non-sensory. (2008, 263-6).

However that may be, I think that regarding delusions as kindred to imagination while sustaining a non-sensory view of imagination, may be problematic, for precisely the same reason that the doxastic view is problematic. Let's consider the Capgras delusion once more, beginning with a schizophrenic person's account:

"As I dropped my levels [of Zyprexa] [...] I faintly sensed the fog drifting in, the early signs of disorganization beginning. I [...] struggled with the urge to jump out of my chair and scream at the terrifying creatures hovering in the air around me. [...] my sickness took a new, horrific turn. For some reason, I decided that Kaplan and Steve were impostors. They looked the same, they sounded the same, they were identical in every way to the originals – but they'd been replaced, by someone or something. Was it the work of alien beings? I had no way of knowing, but I was terrified." (Saks, 2007, 295).

The patient is Elyn Saks, the law & psychiatry professor whose lucid account first gave us insight into thought insertion delusion and now into Capgras delusion. Capgras appeared a couple of weeks after Elyn had been reducing her dosage of a second-generation antipsychotic medication called Zyprexa (olanzapine) which, despite known side-effects, has been successfully promoted by its manufacturers since 1996.[11] If Capgras is a false belief, the grounds of that belief are not just irrational but non-cognitive and unconscious because they occur on neuroanatomical and biochemical levels. Elyn experienced a Capgras delusion as a follow-up of her attempt to cut down on the Zyprexa, which had kept psychotic episodes at bay, allowing her, for long periods of time, to live "as other people did" (2007, 281). She lowered the dosage because she was concerned about side effects (2007, 293). At first, she had hallucinatory symptoms: sensing terrifying creatures hovering in the air around her, creatures of which her entourage was blissfully unaware. Then she discovers that the two most important people in her life are gone and have been replaced by doubles. "Much later I learned that what I was experiencing was called "Capgras Syndrome". [...] In my mind, the people I so depended on were simply gone, and the two who remained were not who they said they were. Therefore, I could not trust either of them." (2007, 295).

Can an unconscious mental state resulting from biochemical and neuroanatomical processes which gives rise to a conscious experience of a terrifying reality, be called an incorrect *inference* about external reality? An inference is obtained by reasoning, but where is the reasoning and what is the evidence? Elyn does not doubt the truthfulness of her

mental state - she is convinced that the delusion is real because, for her, it is real – it is the reality she senses, perceives and experiences – that is, the evidence from which she infers ("decides") that Kaplan (her psychiatrist) and Steve (her best friend) are impostors.

The Capgras delusion as an affective disorder

Consider some neuroanatomical evidence provided by neuroscientists who, unlike their philosopher-colleagues, do not classify the Capgras delusion as a false belief, but consider it as an affective disturbance, or a disconnection between perceptual and affective processes, which the Capgras subject tries to explain away by identifying familiar persons as impostors. Their views are variants of the so-called two-factor account by Ellis & Young (1993, 1997, 1999), according to which the perceived person 'looks like' but does not 'feel like' the family member in question, hence the Capgras patient interprets them as some kind of impostor. Hence the interpretation (or the belief, if you like) is formed on shaky evidence. Rather, they are formed by a motivation to make sense of what is happening to them. To put it as McKay, Langdon & Coltheart do, motives are important causal forces *doxastically*, i.e., relating to belief (2007, 312). On their view, the Capgras delusion is not merely a misguided attempt "to make sense of an unpleasant experience – it is a motivated attempt to avoid the upsetting implications of the experience." (2007, 319). Various stripes of this two-factor model is sustained by various neuroscientists and philosophers of neuroscience, such as Ramachandran (1998), Frith (2005), Coltheart et al. (2007), Corlett et al. (2010) and Gerrans (2013). On Corlett's (2010, 360) view, Capgras constitutes a precedent for experience and is a defense reaction or "a means for explaining it away".

Yet, as McKay, Langdon and Coltheart (2007) argue, Capras may be more than making sense of anomalous perceptual information – it may be a motivated attempt to avoid the upsetting implications of the experience." If this is so, the belief-formation system of Capgras subjects is "unduly biased toward the satisfaction of such motivational constraints" (2007, 319). But we are dealing with a delusional *autobiographical* self and the motivational constraint in this case would be the coherence of its narrative. Unreliable though its narrator may be, the delusional self is working on a coherent account, in which what it feels fits with what it sees. Hence the subject does not only frame a delusional event as a story, but emplots it by curtailing the 'before' and 'after' to fit around the delusional episode. The self develops the ability to account for itself as agent or as undergoer. The delusional self has a passive voice because it is an undergoer – yet it self-reflects, self-augments and looks for temporal continuity, unity and coherence – an identity across its life, which comprises its delusional experience. Consequently, a delusional report will be biased.

Likewise, Chris Frith (2005) argues that delusional patients – with thought insertion delusion as well as Capgras, form delusions in order to make sense of their experience.

Thus a subject with thought insertion delusion might advance the explanation that their thoughts or actions are under the control of alien forces in order to make sense of their experiences of loss of control. A Capgras subject might explain her lack of familiarity with her best friend by putting the available evidence together as: "my friend has been replaced by an impostor". And if there is a certain kind of experiential evidence that grounds delusional beliefs, says Frith (2000, 2005), then it is no longer obvious that these delusions *are* held, despite what constitutes incontrovertible proof or evidence to the contrar.[12] In addition, Frith's neuroanatomical research shows that delusional selves lack intentional binding, which is a marker of agency (2005, 173). Lack of agency accompanies lack of ownership, Gerrans agrees. "Capgras patients with dorsolateral lesions are stuck with the intractable default thought and its prompt to action but cannot decontextualize, or if they can, cannot produce an autobiographical narrative which incorporates the non delusional alternative. They cannot 'make it theirs' so to speak." (2013, 96).

Conclusion

This upshot, namely that a delusional self's experience does not provide grounds for the claim that it holds a false belief because its attempt to make sense of that experience coheres with its affective, perceptual and conceptual reality, also corroborates my claim that delusional subjects are autobiographical selves with an unreliable narrator in the passive voice – they are undergoers. Frith explains that" [t]he idea of agency is intimately concerned with cause and effect; my desire causes my action", since, [w]hen our action causes an event there is an 'intentional binding' whereby the cause and its effect are drawn together in perceived time." (ibid). Since the delusional self experiences a timeout, cause and effect are not drawn together in its perceived time. So it may well self-ascribe a false belief, but that self-ascription has little epistemological value, except from the expert's view. Karl Jaspers ([1913]), 1963 93), issued a century-old warning: "To say simply that a delusion is a mistaken idea which is firmly held by the patient and which cannot be corrected gives only a superficial and incorrect answer to the problem. Definition will not dispose of the matter."

Endnotes

1. A shorter version of this paper was presented at the 10th International Conference on Semiotics organized by the Hellenic Society of Semiotics in Volos, Greece 4-6 October, 2013. My thanks go to Boriana Piryova for helpful comments.
2. Cf. also Joanna Moncrieff (2013) who provides an incisive account of what she calls the "drug-centered model" of mental health care and its historical roots.
3. N.B. The history of this problem goes back to T. Szasz's (1957) observations on using drugs in mental health care, R.D. Laing's (1965, 1967) antipsychiatrist view that psychosis is "a sane

response to an insane world" and Szasz's (1970) extreme stance that psychiatric diagnoses are disguised political judgments on varieties of human behavior, which do not fit the 'norm'.

4. http://www.schulz-von-thun.de/index.php?article_id=71&clang=0 A parallel between Schulz von Thun and communication models by Bühler (1932), Jakobson (1960), Buber (1963) and Greimas (1966) is easily made.
5. According to DSM-V itself: "Ideas that appear to be delusional in one culture (e.g. witchcraft) may be commonly held in another" (2013, 108).
6. 'Attitude' is an important concept in social psychology, denoting a person's expression of favor or disfavor toward something. According to G. Allport (1935, 789-844): attitudes are formed from a person's past and present.
7. There are other alternatives to the 'delusions are false beliefs' account. Following John Locke (1689), G. Currie & I. Ravenscroft's (2002: 170-175) consider delusions as disorders of the imagination. Cf. also T. Gendler (2008, 2010) and A. Egan (2008).
8. Baillargeon, R., R. Scott, and Z. He, (2010, 110-118).
9. N.B. The title of Elyn's book refers to a line in a poem by W.B. Yeats (1919): "Things fall apart; the centre cannot hold".
10. Cited by Hoerl (2013, 4).
11. Cf. http://www.drugs.com/zyprexa.html ; http://www.rxlist.com/zyprexa-drug.html.
12. Frith, Chris (2005, 169–175).

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