

Capgras Syndrome, Clinical Lycanthropy, and the Concept of Belief: A Critical Review of the DSM-5 Framework

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Monothematic delusions are false beliefs that fixate on a single theme while the patient's other reasonings and rationales remain largely intact. The DSM-5 classifies delusions as fixed beliefs that resist change despite contradictory evidence. Whether this classification is adequate in its purposes is contested in academia. This is due to how delusions may lack presentation of the fundamental profile of belief. This literature review specifically examines two conditions: Capgras syndrome, in which a person believes a familiar person has been replaced by an impostor, and clinical lycanthropy, in which a person believes they have turned into an animal. Within the literature, we will compare the two syndromes against four features attributed to belief: action-guidance, evidence-responsiveness, inferential integration, and affective coherence. These conditions guide actions selectively and with high convictions in the patients - and both respond poorly to counter-evidence. The claim that they are inferentially isolated, however, is not supported by the largest case series, which finds that Capgras rarely presents as a circumscribed delusion. This does weaken the leading argument against its doxastic status, though it does not settle the question, since co-occurrence among delusions is not the same as integration with ordinary belief. The evidence, now, favors a modest doxastic account. The DSM-5's classification appears broadly correct; though, its limitation is that a definition framed at the level of content and fixity is silent on the perceptual and affective anomalies that precede and sustain these conditions.

Keywords: monothematic delusion, Capgras syndrome, clinical lycanthropy, two-factor theory, predictive processing, doxasticism, belief, DSM-5, philosophy of psychiatry

Introduction

The DSM-5 is the primary reference for psychiatric diagnosis in the United States of America and is widely used internationally - giving physicians a shared glossary of terms that supports consistent diagnosis and comparable research. Few of its categories, however, have generated more debate than the definition of delusion.

The stakes are practical. A diagnosis shapes the treatment that follows it, and a definition that misidentifies the underlying problem can cause physicians to recommend the wrong scope of treatment. These same stakes are clearest for monothematic delusions. Unlike the polythematic disturbances seen in schizophrenia, where many false beliefs interlock, a monothematic delusion is characteristically narrow - fixating on a single theme while other reasoning logic remains intact. The distinction is one of degree, rather than kind, and monothematic themes are also reported within polythematic presentations^{1,2}.

This literature review examines two such conditions. In Capgras syndrome, a person believes that someone they are familiar with has been replaced by an impostor. In clinical

lycanthropy, a person believes they have transformed or are transforming into an animal. These two conditions differ substantially in evidentiary depth and frequency, and they are paired here deliberately rather than as joint representatives of monothematic delusion as a class. Capgras syndrome is the condition for which an anomalous first factor is best documented; clinical lycanthropy is one for which it is largely absent, since most reported cases are classified as primary delusions with no preceding perceptual disturbance. If both behave alike against the four features of belief despite this difference, the conclusion drawn does not depend on any particular account of what generates the delusion. Conclusions are scoped accordingly.

Reviews of the doxastic question already exist. What this review adds is not a new clinical finding but a change in the evidence base brought to bear on a philosophical dispute. The argument that monothematic delusions are too isolated to count as beliefs has been built almost entirely on single-case reports, and the large record-based series published since 2017 do not support the isolation those cases suggest. The observation that Capgras is rarely monothematic belongs to those series themselves; what is offered here is its application to the belief question.

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Features of Belief

In philosophy, a belief is generally understood as a mental state representing the world as being a particular way. There are four features that are commonly associated with paradigmatic belief:

- **Action-Guidance:** A belief guides behavior; someone who believes it will snow will dress for the cold.
- **Evidence-Responsiveness:** A belief forms and revises in light of what one perceives and can infer.
- **Inferential Integration:** A belief connects to other beliefs; believing all computers require electricity carries over to believing that a particular laptop requires electricity.
- **Affective Coherence:** A belief carries appropriate affect; believing one has slept through an examination should produce anxiety.

These four features are useful for a comparison, but are not settled criteria. The disagreements relating to them bear directly on what follows. There is no consensus that any is necessary for belief³, and mundane beliefs frequently are in violation⁴. People may hold political and religious commitments that resist counter-evidence, maintain beliefs inconsistent with others they also hold, fail to feel what their professed beliefs would warrant, or have an immovable bias. If violating these features disqualifies a state from a belief, a large number of ordinary convictions would be disqualified alongside clinical delusions.

This rationale is the central argument of doxasticism - derived from the Greek *doxa*, opinion or belief - which holds that delusions are beliefs and their irrationality differs in degree rather than in kind. The most developed version, termed modest doxasticism, concedes that delusions may be “poor” or “malfunctioning” beliefs while concurrently denying that this makes them non-beliefs⁵. A related account holds that delusions are malfunctioning beliefs: that they belong to the category, but fail to perform some of the characteristic functions⁶.

Several alternatives compete with these⁷.

Methods

The scope of the study is a literature review, and as such, sources were selected for their bearing on the conceptual question rather than through purely exhaustive screening. Due to the nature of the study, the analysis is interpretive rather than quantitative.

Search strategy: Literature sources for this review were identified through PubMed, Google Scholar, and JSTOR, spanning clinical psychiatry, cognitive neuropsychiatry, and

philosophy of mind. The date range of these publications, as these are relatively rare conditions, ranges from 1923 (the original description of Capgras syndrome) to 2025. Search terms included *monothematic delusions*, *Capgras syndrome*, *clinical lycanthropy*, *delusional misidentification*, *two-factor theory*, *predictive processing*, and *doxastic status of delusions*. Reference lists and citation networks of the large record-based Capgras series were researched to identify primary reports not returned by keyword searches. Searches were limited to English-language sources, with a notable exception as the 1923 French-language original, which was translated using Google Translate and not independently verified¹³. Foundational works were retained where the findings have yet to be superseded, since many of the most replicated results date from the 1990s.

Inclusion: Sources were only included if they were peer-reviewed clinical or psychiatric publications, recognized work in the philosophy of mind, or authoritative reference texts. Additional factors include whether the publications included clinical features, mechanisms, or conceptual status of monothematic delusions. Priority was given to primary reports, and to case series over isolated single-case reports, since the balance between these two source types bears directly on the argument developed in Section 4.2. A total of 37 sources met these inclusion criteria; eighteen report clinical or experimental data.

Extraction and appraisal: From each clinical source, five elements were extracted: author and year, design and sample size, condition, primary mechanism or measurement, and the finding bearing on the belief question. Each was then measured against the four aforementioned features, with features recorded as *present*, *poor*, *variable*, or *not assessed*. No overall numerical score was assigned, since the four features are not independent of each other and the sources were not designed to test them. Standardized risk-of-bias instruments were not used, as these instruments are designed to assess treatment-effect studies and do not apply to single-case reports or conceptual analyses. Where a claim solely rests on single-case evidence, this is stated, since the difference between isolated single cases and record-based evidence proves consequential in the review.

Results

The DSM-5 Definition

The DSM-5 defines delusions as fixed beliefs that resist revision even when there is clear evidence that directly contradicts them. These false beliefs rest on an incorrect inference about external reality - maintained despite near-universal disagreement and contradictory evidence¹⁴. The manual also distinguishes bizarre from non-bizarre delusions - with a delusion counting as bizarre when it is clearly implausible and not

Table 1 Competing accounts of the status of delusions, with the core claim and the principal difficulty of each.

Account	Core Claim	Principal Difficulty
Doxastic ⁵	Beliefs – irrationality here differs in degree, not kind	Incapable of explaining what is pathological rather than purely irrational
Imagination ⁸	Imaginings misidentified by the subject as beliefs	Fails to account for conviction or consistent action-guidance
Alief-like ⁹	A habitual and affect-laden state running contrary to beliefs	Aliefs coexist with a contrary belief – delusional patients do not present any
In-between states ¹⁰	Matches belief's dispositional profile only in part	Leaves the category itself underspecified / vague
Perceptual Inference ¹¹	Flawed perceptual inferences, closer to illusions	Explains onset well, but persistence or conviction not justified
Non-doxastic Acceptance ¹²	States adopted for a purpose without full endorsement	Sits poorly with the rigidity of the assertions (including sincerity)
Malfunctional Belief ⁶	Belief that fails selectively yet retains conviction	Requires a specification of belief's functions, itself contested

Measured against these frameworks and the DSM-5's own criteria, do our two conditions qualify as beliefs?

drawn from ordinary life. The DSM-5 de-emphasized this distinction relative to the DSM-IV, removing the special diagnostic weight bizarre delusions previously carried in Criterion A for schizophrenia. Monothematic delusions intersect at this boundary: they can appear to be bizarre in isolation even as reasoning remains intact elsewhere.

The DSM-5-TR, published in 2022, revised the surrounding text but did not substantively alter the delusion criteria, which is why this review refers throughout to the DSM-5 definition.

Capgras syndrome

Capgras syndrome is the delusion that a familiar individual has been replaced by a physically identical impostor. This is distinct from another syndrome, Fregoli syndrome, in which different strangers are believed to be a single familiar person in disguise.

The condition was first described in publication in 1923¹³. The original case was a woman known as Madame M., who maintained that her husband, daughter, and neighbors had all been replaced by look-alikes, a claim she folded into an elaborate and persecutory narrative.

The leading account proposes that Capgras represents the reverse dissociation of prosopagnosia: intact overt facial recognition alongside an absent covert autonomic response and a missing affective familiarity signal¹⁵. In this view, the recognized face fails to trigger the usual sense of familiarity, and the impostor hypothesis emerges as an explanation for the lacking emotional response.

Three independent groups have found the predicted auto-

nomic deficit. The first reported an absent skin-conductance response to familiar faces in a single case¹⁶. A second compared five Capgras patients with five general-public and five medicated psychiatric controls: finding no autonomic discrimination between familiar and unfamiliar faces while orienting responses to tones remained normal; this indicates that the hypo-responsiveness is specific rather than global¹⁷. A third confirmed the finding a decade later¹⁸. Functional imaging has since shown reduced activity to familiar faces in extended face-processing regions alongside a right prefrontal lesion¹⁹.

The convergence is genuine, yet the combined sample across all three studies is only seven patients. Furthermore, it has been argued that the familiarity deficit is not solely autonomic and that the evidence has been interpreted more strongly than it truly supports²⁰.

These isolated cases are often cited to drive the perspective that Capgras syndrome is a narrow, circumscribed delusion. One such report describes a 24-year-old man admitted with suicidal ideation who believed his mother and family were government impostors sent to elicit military confessions - a case in which circumscription is claimed but comorbidity is present²¹.

Three record-based series challenge the circumscription perspective directly:

- The first identified 84 individuals from a 250,000-record database. Capgras was not monothematic in the majority of presented cases - with misidentification extended beyond close relatives in a substantial minority - and neuroimaging showed no predominant right-hemisphere damage²².

- A replication in an independent database identified 34 cases: 20.6% of these involved misidentification of people other than family members. Here, Capgras typically did not present as monothematic, and once again, no right-hemisphere bias was present. In addition, there was no evidence of association with physical violence²³.
- A systematic review of 255 published cases found a wide diagnostic range²⁴.

The absence of right-lateralization in psychiatric samples contrasts with the lesion cases - where right-lateralized pathology predominates²⁵. This suggests that lesion-derived and psychiatric Capgras may not share a single substrate.

Clinical lycanthropy

Clinical lycanthropy is an elaborate delusion that involves perceived bodily changes and animal-like behaviors. Historical cases, such as Jean Grenier (1603) and Manuel Blanco Romasanta (1852) are frequently cited, but both cases were assessed under legal and medical frameworks that do not permit clinical coding. As such, they will not be regarded as evidence in this publication. Clinical lycanthropy is often classified as a delusion that is not only rare, but also heavily shaped by available cultural idioms. Lycanthropy is examined here as a contrast to Capgras rather than as a second body of comparable evidence: the literature is far smaller, and no experimental measure of affective response exists.

A systematic review examined 56 original case descriptions of supposed animal metamorphosis published since 1850²⁶. However, only 13 met the strict criteria for clinical lycanthropy proper. The remainder were variants of clinical zoanthropy. Across the full set of 56 cases, 47 of them were identified as primary delusions and 9 as secondary delusions that arose from somatic or visual hallucinations due to altered background body awareness (coenaesthesia). The somatic-interpretation model therefore applies to a small minority of zoanthropy cases - because the split is not reported separately for the 13 lycanthropy-proper cases, the parallel with the affective deficit in Capgras cannot be quantified and should be regarded as weaker than commonly assumed.

Mechanistic accounts

One-factor theory holds that our delusions are, in fact, normal and rational inferences drawn from abnormal perceptual experiences²⁷. Meanwhile, two-factor theorists present that a second factor - a belief-evaluation failure - is necessary to explain why implausible hypotheses are not summarily rejected^{28,29}.

Predictive-processing accounts hold that delusions arise when the brain's hierarchical generative model mis-weights prediction errors. Aberrant prediction-error signals have been

shown to track delusion severity in psychosis³⁰, and delusions have been treated as errors in learning and memory³¹. These align with the two-factor theory when factor two is formalized as an abductive or Bayesian evaluation failure. The two-factor model has been challenged with the rationale that cognitive penetration of perception blurs the separation between modular perception and evaluation²⁰.

All mechanistic accounts locate the pathology in perceptual, affective, or inferential processing rather than based on propositional content.

Coding against the features of belief

Source names are retained in Table 2 as each row can be identified by the study it summarizes. Seven of the eighteen clinical sources were excluded from feature coding because their samples were not condition-specific; these inform Sections 3.5 and 4.2 narratively instead.

Action-guidance - present but selective: Lycanthropy leads to growling and ingesting raw meat, while Capgras leads to wariness or hostility towards the supposed double. Patients, however, do not reliably take all the actions the claim would warrant - for example, a Capgras patient rarely reports the replaced relative as a missing person.

Evidence-responsiveness - poor: Both conditions persist in spite of contradictory evidence. Reasoning tasks demonstrate a jumping-to-conclusions bias³² and a bias against disconfirmatory evidence^{33,34}, with the deficit due to misjudged evidential value rather than sampling cost³⁵.

Inferential integration - contested: Single cases do suggest theme-specific isolation. The record-based series show Capgras syndrome is rarely circumscribed and is typically embedded in broader psychiatric pictures.

Affective coherence - anomalous in Capgras: Capgras syndrome cases often document an absent or reduced covert autonomic response. However, this is not yet applicable in clinical lycanthropy due to a lack of tests.

The two conditions against the two-factor model

The four features are properties of the resulting state, and the two-factor model concerns how that is produced. Mapping one onto the other separates the two conditions.

In Capgras syndrome, factor one is identified and measured: the absent covert autonomic response is the same finding recorded as anomalous affective coherence in Table 2. In clinical lycanthropy, factor one is not established. Only 9 of the 56 reported cases were classified as secondary to a somatic or visual disturbance.

Factor two, the failure to reject an implausible hypothesis, is not directly measured in either condition. The reasoning-bias evidence above is drawn from polythematic and non-clinical

Table 2 Clinical sources coded against the four features of belief.

Source	Design (n)	Action-guidance	Evidence-responsiveness	Inferential integration	Affective coherence
Capgras & Reboul-Lachaux ¹³	Single case (1)	Present	Poor	Embedded	Not assessed
Hirstein & Ramachandran ¹⁶	Single case, exp (1)	Present	Poor	Reported isolated	Absent autonomic response
Ellis et al. ¹⁷	Case-control (5+10)	Not assessed	Poor	Not assessed	Reduced autonomic response
Brighetti et al. ¹⁸	Case-control (1+10)	Not assessed	Poor	Not assessed	Reduced autonomic response
Blom ²⁶	Systematic review (56; 13 proper)	Present (growing)	Poor	Elaborated	Not assessed
Thiel et al. ¹⁹	Single case, fMRI (1)	Present	Poor	Reported isolated	Altered familiarity response
Darby & Prasad ²⁵	Review (61)	Present	Poor	Variable	Not assessed
Bell et al. ²²	Database series (84)	Present	Poor	Not circumscribed	Not assessed
Chhaya ²¹	Single case (1)	Present (wary)	Poor	Claimed isolated; comorbid	Not assessed
Currell et al. ²³	Database series (34)	Present	Poor	Typically not monothematic	Not assessed
Pandis et al. ²⁴	Systematic review (255)	Present	Poor	Variable	Not assessed

samples - therefore it can only be applied by extension. The two conditions therefore diverge on factor one while coding identically across all four features of belief. This is what makes the doxastic conclusion robust: it does not rest on the presence of any specific generating anomaly.

Discussion

Conviction and belief status are separable

Conviction in both conditions is deeply entrenched. For example, in clinical lycanthropy, patients do not report feeling as though they are a wolf; they report being one. Meanwhile, in Capgras syndrome, the impostor claim is asserted with a certainty that exceeds what most people express about ordinary factual matters.

This may appear to be a definitive answer, but conviction in itself is a phenomenological property: how a state feels from the inside and how confidently it is asserted. By contrast, belief status is a functional property concerning what the state does within a person's cognitive economy. These are not the same. A patient may assert with absolute certainty that his

mother has been replaced by a look-alike, yet fail to report her missing or search for her whereabouts. Conversely, a person may believe something functionally - acting on it and reasoning from it - while feeling no particular certainty about it at all. Since the DSM-5 definition leans heavily on firm and stubborn persistence, it inherits this conflation.

What the case series do and do not show

The strongest argument against doxastic status is inferential isolation: if the impostor claim does not propagate through the patient's other commitments, it does not behave as a belief. Two record-based series find that Capgras syndrome is typically *not* monothematic^{22,23}, which removes the empirical premise that the argument would require.

This, however, does not settle the matter. Co-occurrence with other delusions is not the same as integration with the typical web of belief. A patient with Capgras plus persecutory delusions may demonstrate that delusions cluster together - not that the impostor claim connects to non-delusional reasoning. What the series do establish is narrower, but still substantive: the picture of a single isolated false belief in an otherwise

intact cognitive system is an artifact of the single-case literature, and any argument built on that foundation inherits the artifact.

The same pattern of reporting bias occurs elsewhere as well. Single-case reports have supported claims of high forensic risk in Capgras³⁶, while the record-based series find no association with physical violence²³. Where single cases and series diverge, the series should be preferred.

Assessment of the DSM-5 Framework

The DSM-5's framing around persistence and resistance to evidence has clear clinical utility - supporting rapid identification and early intervention. Yet, the argument that delusions are non-beliefs because they violate integration or evidence-responsiveness ultimately fails. This is because ordinary beliefs violate the same norms. Modest doxasticism⁵ remains the most defensible position: delusions belong to the category of belief while functioning poorly within it. The malfunctioning belief account⁶ is not a competitor, but a more specific version of the same claim, as it identifies which functions fail. It is adopted here only where that specification is needed, as it carries a cost modest doxasticism does not: requiring a settled account of what belief's characteristic functions are, which remains contested.

The DSM-5's real limitation is that it is etiologically silent. Framed at the level of content and fixity, there is no information regarding the perceptual and affective anomalies that all mechanistic accounts identify as the source of the pathology.

Implications for treatment

Where a delusion is sustained by an ongoing affective or perceptual anomaly, disputing the content targets the wrong mechanism. Care should instead characterize factor one - affective, somatosensory, or inferential - and recognize that Capgras syndrome is usually embedded within a broader psychotic or neurodegenerative picture. Then, proceed with a broad diagnostic assessment given the documented heterogeneity²⁴ and, in neurodegenerative contexts, the distinct pharmacological considerations that apply³⁷.

Limitations

Monothematic delusions are rare, and as a result, there is only a small primary literature that is heavily reliant on retrospective series and isolated case reports. The evidence is markedly asymmetric. Capgras has experimental data; clinical lycanthropy rests on only 13 cases meeting strict criteria, none tested for affective coherence. This asymmetry is why lycanthropy is treated as a contrast case rather than as independent support, and it means the affective-coherence comparison between the two conditions remains open rather than

resolved. Experimental reasoning paradigms draw on polythematic or non-clinical samples, thus their bearing on monothematic cases is indirect. As such, the review is narrative and interpretive, rather than quantitative.

Conclusion

Monothematic delusions are best classified under a modest doxastic model: they are genuine beliefs that function poorly, rather than states belonging to some other category. While the DSM-5 correctly categorizes delusions as beliefs, its content-based and fixity-focused definition is etiologically deficient and mistakenly treats high subjective certainty as proof of belief status. Crucially, clinical evidence has undercut the empirical premise that these delusions exist in a perfectly circumscribed, isolated vacuum. Consequently, effective treatment should target the underlying perceptual or affective disturbance rather than unproductively challenging the delusional content directly.

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