UNDERSTANDING DELUSIONS: A PHENOMENOLOGICAL CRITIQUE OF THE COGNITIVE-BEHAVIORAL CONCEPTUALIZATION OF DELUSIONS

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Abstract

Theorists of cognitive-behavioral therapy (CBT) for schizophrenia claim that understanding aberrant experiences, such as the delusions found in persons with schizophrenia, is possible partly because delusions and non-delusional beliefs are continuous. This assumption of continuity runs contrary to the views of phenomenologically-oriented psychopathologists who emphasize the qualitative differences between delusions and non-delusional beliefs. Importantly, phenomenological and cognitive perspectives *both* agree that delusions can be understood to some extent. However, the two perspectives differ on how exactly one should approach an understanding of delusions. I propose that, at least in the case of delusions in schizophrenia, CBT offers conceptualizations that fail to appreciate the qualitative differences between delusions and non-delusional beliefs. Qualitative changes associated with the delusional experience, changes which have their source in disturbed experiences of self and world, suggest that certain delusions should not be understood as merely exaggerations of non-psychotic psychological processes. I will first discuss the general CBT model for delusions, including its explanatory terms and its commitment to the claim that delusions are best understood as quantitative variations of normal beliefs. I will then survey the major claims of phenomenological investigators writing about delusion and focus on the views of Jaspers specifically, who is often used as a foil by cognitive theorists in discussing how delusions can be understood. I then discuss the limitations in two lines of evidence that are often taken to support the notion of a continuum between delusions and non-delusional beliefs. One line of evidence comes from the measurement of schizophrenic-like symptoms in the non-clinical population. The second line of

evidence concerns the link that depression and anxiety have with delusions. After identifying the weaknesses in interpreting this evidence as indications of continuity, I offer revisions, related to the role that anomalous experiences play, for the CBT model for delusions in schizophrenia. I also suggest that the current view of CBT regarding delusions may be well-suited for what phenomenologists have called 'empirical delusions,' but it may be necessary to develop somewhat different treatments that are better suited to address the ontological delusions found in schizophrenia.

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TABLE OF CONTENTS

Preface

This paper examines the conceptualization and treatment of delusions in schizophrenia. Cognitive-Behavioral theorists and clinicians have developed cognitive models for explaining delusions and therapies for treating them. Both the models and the therapies have been supported through numerous empirical studies (Garety & Freeman, 1999, 2013; Tarrier & Wykes, 2004; Turner, van der Gaag, Karyotaki, & Cuijpers, 2014; Zimmerman, Favrod, Trieu, & Pomini, 2005). Against this record of empirical support exist two lines of criticism, both aimed at Cognitive-Behavioral Therapy (CBT) and schizophrenia more generally, rather than CBT and delusions specifically. One criticism centers on whether CBT for schizophrenia is more effective than non-specific interventions when methodological quality is taken into account (Lynch, Laws, & McKenna, 2010). The second line of criticism addresses the face validity and theoretical suitability of the cognitive account of delusions and other schizophrenia symptoms, raising concerns about its overall plausibility and philosophical merit (Gipps, 2010; Skodlar, Henriksen, Sass, Nelson, & Parnas, 2012).

This paper, inspired largely by phenomenological philosophy applied to the study of psychopathology, represents an effort to understand how cognitive and phenomenological conceptualization of delusion can arrive at substantially different claims, even while both approaches attempt to honor the experiences of persons who have delusions. Part of this difference reflects the purposes of the perspectives: Applied to the study of delusion, one seeks to find an adequate model that has explanatory power while the other focuses on accurate description of the phenomenological features of delusions and, when appropriate, provides a hermeneutic reading of their nature. Even so,

there remain unaccounted differences between the two perspectives in what is required for understanding a delusion and in even defining what a delusion is. Juxtaposing these two perspectives on delusions is likely to be mutually enlightening for both approaches, given that perspectives utilizing different epistemologies and methodologies can be jointly corrective (Gallagher, 1997). In addition to highlighting the differences between phenomenological and cognitive perspectives on delusions, this paper also draws attention to the consistencies between the two perspectives and suggests ways that the CBT model might be expanded and revised. A perspective that highlights the qualitative differences between delusions and non-delusional beliefs should foster interpersonal understanding, which is an essential component to quality CBT.

Despite the large evidence base generally supporting cognitive models and CBT treatments for delusions, there is work to be done in articulating how the CBT model and phenomenological accounts of delusions can differ so radically, especially with regard to the way that CBT conceptualizes delusions as distressing reactions to anomalous experiences—anomalous experiences that are common in non-schizophrenia populations and therefore not qualitatively unique as experiences. Thus, this criticism of CBT looks beyond the empirical basis of the model to more basic issues of the overall conceptualization and phenomenology of delusion.

As a starting point CBT renders delusion as a primarily cognitive, belief-based phenomenon. In this CBT shares much company, including variants of the doxastic (meaning, believing in a proposition about the world) positions on delusions in contemporary philosophy and strains of this position in the DSM-IV-TR, all of which assume that delusions are beliefs. CBT adds to this basic position in consequential ways.

CBT formulates the nature of delusions as beliefs that, although extreme, can be conceptualized in much the same way as non-delusional beliefs. Delusional beliefs are said to be on a continuum with other (non-delusional) beliefs and are to be distinguished from them primarily by the degree of distress that is produced by the delusion. In treating delusions as very distressing, extreme forms of belief, cognitive-behavioral models certainly earn a claim that delusions can be addressed by CBT (especially cognitive) principles. However, in this cognitive approach to addressing delusion, CBT models have minimized the relevance of experience in defining delusions. From a phenomenological perspective, this means that cognitive models have not dealt with the primary nature of delusion—a failure to deal with the primary challenge of the delusion as a lived phenomenon—as a way of experiencing that is crucial to characterizing the essence of delusion.

To address this inconsistency between phenomenological and cognitive approaches to delusions, the basis for the cognitive model's definition of delusion needs analysis. In Chapter I of this paper, I review the basic cognitive model for delusions as well as the historical conditions that lead to the prominent CBT claim that delusions are understandable. I unpack the theoretical commitments associated with the cognitive definition of delusion, including its 'normalizing' tendency in conceptualizing and modeling delusional experience, delusion formation, and delusional beliefs. Of particular focus is CBT's claim that anomalous experiences themselves are not clinically remarkable and therefore are not a definitive feature in defining the pathological properties of delusions.

In Chapter II of the paper, I review the contrasting perspective on delusions given by phenomenologically-based psychopathologists and provide, to some degree, a defense of the basis for Jaspers' (1963) claim that delusions are un-understandable. Despite recognizing the importance of Jaspers' observations of a distinctive lived world involved in the experience of delusion, I maintain, along with many post-Jaspersian phenomenologists, that delusions are at least partly comprehensible. This paper continues in the explication of points common in the phenomenological study of schizophrenia (Bovet & Parnas, 1993; Fuchs, 2005a, 2005b; Parnas, 2004; Parnas & Sass, 2001; Sass, 1992a, 1992b, 1994, 2014; Sass & Pienkos, 2013) and to some extent, points made in previous phenomenological criticism of CBT for schizophrenia (Škodlar et al., 2012) . This includes the idea that delusions—or at least primary delusions—are not best considered variants of normal beliefs, are not always enacted in behavior, and do not necessarily apply to objective states of affairs. More crucially, primary delusional experience involves subtle but important changes in the structuring of the experience of self and world. These changes place conditions on how persons with delusions should be understood and they provide a basic entry point for understanding how their experience differs from our own. These are experiences that cannot be accounted for by a model of delusion based on a normative, non-delusional, fully embodied model of experiencing. I then claim that the cognitive models rely on a questionable line of evidence for supporting their proposal that delusional experiences involve no qualitative shift in experience and are thus continuous with non-delusional experiences. In contrast to what cognitive theorists are inclined to see in the evidence that depressive and anxiety processes are relevant for understanding delusions, phenomenological analysis suggests

that it is inappropriate to model the delusional experience along the same lines as anxiety and depressive disorders, given 1) that the mood states of depression and anxiety may be relevant to but are hardly characteristic of delusional experience and 2) the challenges involved in expressing delusional experience with everyday psychological language. There is also reason to be skeptical about claims that delusional experiences measured by self-report instruments are sufficient for claiming that the experiences being measured in non-clinical populations are qualitatively identical to those reported in clinical populations.

In Chapter III, I review some of the consequences of assuming that delusions are merely variants of non-delusional beliefs. I conclude that this assumption of continuity is not only unnecessary but untenable within existing cognitive theory. The continuity view weakens the phenomenological validity of the cognitive model by treating all anomalous experiences as basically equal until persons interpret such experiences. In doing so the cognitive account minimizes the nature of self-disturbance in the anomalous experience itself. This minimization is most visibly evident in the claim that such an experience involves no experiential discontinuity with non-delusional experience—that an anomalous experience is on a continuum with unremarkable, non-clinical experiences. I also argue that the cognitive position creates an artificial separation between the anomalous (delusion-like) experience and the interpretation of that experience and then places far too much emphasis on the cognitive reaction when pinpointing the 'psychotic' or 'pathological' nature of delusion (i.e., the claim that the anomalous experience is benign in itself, acquiring its distressing or pathological character by virtue of cognitive reaction to the experience).

I then consider how this phenomenological reading might inform future theory, research, and therapy. This includes suggesting that studies examine the possible diversity within the broad category of anomalous experience as well as offering a way to expand and clarify the theoretical range of types of delusions. I join other phenomenological investigators who have written on the importance of the distinction between empirical and ontological delusions (Bovet & Parnas, 1993; Parnas, 2004; Parnas & Sass, 2001; Sass, 1992a, 1992b, 1994, 2014) and who have suggested that such a distinction be placed within the cognitive and CBT literature (Skodlar et al., 2012). I also try to provide some account for why CBT seems to be so effective in treating delusions when its models are so discrepant from the phenomenological understanding of delusion. Chiefly, I consider the ways in which a wavering of the intersubjective attitude in persons with delusions might influence both the communication of delusional content and the reception of that content by the clinician.

Chapter I

Prominent Models of CBT for Schizophrenia

Cognitive-Behavioral Therapy (CBT) is a class of psychological treatments that address unhelpful thoughts and behaviors that influence or maintain psychological difficulties, as well as the environmental circumstances that influence both. There is considerable variation among treatments on which of these three components are emphasized for explaining and changing symptoms. Originally conceived as an explanation and treatment for depression, CBT is now used for treating schizophrenia, a treatment which has been actively pursued for more than 30 years, with randomized controlled trials beginning in the 1990s (Thase, Kingdon, & Turkington, 2014)[1].

Although the basic approach for CBT for psychosis has been acknowledged as a contribution from Beck (an article written in the 1950s (Beck, 1952)) and has been influenced by Beck's writing on depression (stressing the relationships among thoughts, behaviors, and depressed feelings), CBT for psychosis[2] was developed primarily in the United Kingdom. The principles and techniques used in CBT for psychosis overlap considerably with CBT for other disorders. Most CBT approaches emphasize a collaborative understanding of symptoms, inquiry to grasp the personal meaning often attached to symptoms, structured but flexible sessions, and a set of techniques, including testing beliefs or assumptions, Socratic questioning, and behavioral experiments (Tai & Turkington, 2009).

There are several influential models and therapeutic strategies that have served as a basis for developing CBT for schizophrenia (e.g., Chadwick & Lowe, 1990; Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Kingdon & Turkington, 1994; Morrison,

2001; Tarrier, Harwood, Yusopoff, Beckett, & Baker, 1990; Tarrier et al., 1993). These models differ with respect to what explanatory terms are emphasized and which therapeutic techniques are considered most important (e.g., cognitive-based, behavior-based, distress reduction, coping enhancement Tarrier, 2008, 2014; Tarrier et al., 1993;). More recently, strains of CBT have been evolving towards the third-wave of CBT thinking, increasingly stressing meta-cognitive reactions to symptoms (Tai & Turkington, 2009). These intrinsic variations within CBT for psychosis make any typification of *the* CBT account misleading, but common features can be identified for rhetorical purposes.

Although often designated as 'CBT for psychosis' or 'CBT for schizophrenia,' a broadly dispersed skepticism towards the concept of schizophrenia itself has furnished cognitive models that focus on specific symptoms rather than a larger disorder. Symptoms stand on their own, apart from an underlying disease process putatively responsible for a collection of different symptoms. In cognitive theories, delusions represent a particular way of responding to anomalous experiences. In this sense, delusional beliefs are not wholly different from other maladaptive, non-delusional cognitions that provide functional but unhelpful interpretations of events (Mander & Kingdon, 2015). Representing delusions as another variety of maladaptive cognitions that lead to distress, "Cognitive models outline how hallucinations and delusions can occur when anomalous experiences that are common to the majority of the population are misattributed in a way that has extreme and threatening personal meaning" (Tai & Turkington, 2009, p. 866).

The various cognitive accounts of delusions use comparable (but differentially weighted) explanatory factors. These include negative schemas, self-esteem,

interpersonal history, the importance of trauma, reasoning biases, coping resources, and avoidance[3]. Consistent with cognitive theories for others disorders, schemas and associated reasoning biases play an especially prominent role in CBT's account of delusions. Garety, Bebbington, Fowler, Freeman, and Kuipers (2007) speak of an "enduring cognitive vulnerability, characterized by negative schematic models of the self and the world that facilitate appraisal biases and low self-esteem" (p. 1383). Negative schemas (Fowler et al., 2006)) and negative self-concept (Barrowclough et al., 2003) can affect appraisals by introducing biases that lead individuals to minimize personal power and control, to overemphasize the power and control that others have (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001), and to inflate estimates of perceived threat (Moutoussis, Williams, Dayan, & Bentall, 2007).

In addition to these common explanatory factors, there has been increasing emphasis, in some models, on the explanatory power of emotions (Smith et al., 2006) and anxiety as triggers of cognitive biases (Freeman & Garety, 2003; Garety et al., 2001), particularly jumping-to-conclusions (a cognitive bias in which insufficient data is collected and conclusions are generated prematurely), which is posited as a major factor that leads to incorrect, or at least unhelpful, conclusions about experiences, especially the interpretations of anomalous experiences (Garety & Freeman, 2013)[4]. Emotion may also interact with negative schemas, which may perpetuate anomalous experiences and influence distressing interpretations (Smith et al., 2006).

CBT approaches have long recognized that working therapeutically with individuals who have psychoses is a clinically unique endeavor with its own set of challenges. Building therapeutic alliances and having patience in exploring non-ordinary

experiences are chief among these challenges (Thase et al., 2014; Turkington & Kingdon, 1996). Despite this awareness of how therapy should be modified to treat persons who have psychosis, much of cognitive theory and treatment is modeled on other, non-psychotic and non-schizophrenic disorders. For example, "Persecutory delusions are conceptualised as threat beliefs that share a number of maintenance factors with anxiety disorders" (Freeman & Garety, 2003, p. 931). These threat beliefs or delusions can be viewed "in just the way anxiety disorders are viewed by cognitive psychologists" (p. 934). For instance, rumination or worry processes that are operative in anxiety disorders are hypothesized to function similarly in delusions—e.g., worry as a systematic avoidance of circumstances that would otherwise be fear-correcting. Empirical investigations have supported the appropriateness of this analogy. Greater worry is associated with greater distress in delusions (Freeman & Garety, 1999) and with persistence in persecutory delusions (Startup, Freeman, & Garety, 2007). The significance of these claims can be partly understood to represent the application of a transdiagnostic approach to delusions, but there is more at stake in showing that processes such as rumination and avoidance are relevant to delusion. There is a direct line connecting delusions to normal beliefs, anxiety-producing beliefs, and cognitive-behavioral processes associated with obsessive thinking.

Explaining delusions in CBT, then, can be done by thinking about the delusion in virtually the same terms used for explaining symptoms in non-psychotic disorders. Delusions emerge because of cognitive and emotional responses to anomalous experiences. They partly function to make sense of events and are driven by schemas, processing biases, attributions, and emotions. And although certain cognitive tendencies,

such as jumping-to-conclusions, may be of particular importance for explaining delusions, schemas and cognitive biases (which may partly depend on strong emotion for their activation) that play such a prominent explanatory role in non-psychotic disorders play a similar role in delusions in schizophrenia.

What can be gleaned here is a meta-theoretical commitment to a demystification of psychotic experience. This entails several characterizations of the nature of delusions. First, the cognitive conceptualization of delusion is consistent with a doxastic position (doxastic is a term roughly synonymous with belief, as in believing that something is actually the case) (Bayne, 2010) in which delusions are treated as functional beliefs that apply to a reality accessible to anyone (i.e., objective reality that is taken for granted). Delusions should thus serve as a motivation for objective, real-world action. Second, the emotional character of the delusional state is readily definable and presents no remarkable challenge for understanding and natural empathy. For persecutory delusions, for example, the emotional character of a delusion is like the threatening feeling of anxiety in anxiety disorders. Third, although delusions may be regarded as a psychotic symptom, the cognitive account rejects any categorical separation of psychotic disorders from what have traditionally been deemed neurotic disorders (and from non-clinical experience more generally). In this sense, the concept of psychosis loses its substance in the cognitive account. These characteristics are implicit in defining delusion "as a false belief at one end of the spectrum of consensual agreement" (Brabban & Turkington, 2002, p. 62). That is, delusions are continuous with normal beliefs: Instead of differences in kind, there is a spectrum from normal beliefs to highly distressing delusional beliefs. The validity of delusions can be evaluated in terms of true or false (whether or not they

are empirically true, much like other beliefs are weighed). They have no unique emotional or affective properties, and they do not represent a distinctive class of experience.

Delusions in Cognitive Theory and Therapy: Distress-Inducing Interpretations Applied to Intersubjective Reality

In addition to the above common explanatory terms and the commitment to the demystification of delusion, CBT approaches share two assumptions about the nature of delusion itself, which make the notion that delusions are not so different from non-pathological beliefs more plausible. The first common assumption is that delusion does not involve any major change in how self, world, and reality *are experienced*. That is, there is no reason to think that the content of delusional claims has a special status. To some extent, this might be a byproduct of what might be called a content-driven frame for defining delusion, in which delusions are best understood in terms of the contents of delusional statements. The content typically conforms to identifiable themes (e.g., persecutory, grandiose, religious) and is assumed to map on to states of affairs within the world (e.g., claims about 'external reality,' implying that they describe something potentially true for everyone, carrying objective weight). This use mirrors diagnostic criteria (e.g., DSM-5, DSM-IV-TR, ICD-10) for delusions, though cognitive models place considerably less stress on the intensity of conviction and the imperviousness to counterargument, both of which are included in traditional diagnostic definitions. This use is also consistent with the doxastic model mentioned above, but the implications of how such a view relates to personality and personal history are very detailed in the cognitive model.

A content-driven frame for defining delusion lends itself to the notion that delusions are beliefs employed in the same way as non-delusional beliefs—that is, they have no special reality status and are ultimately distressing explanations for unusual experiences. Delusional claims are rooted in a (shared) social world because nothing in the delusional experience has changed the individual's experience of their personality or the world. In fact, a continuous chain between the individual's historical personality and the psychotic experience is assumed. Thus, it becomes more sensible to think of delusions as merely extreme forms of belief. For understanding the personality in relation to the delusion, "one should expect there to be clear themes linking personal experience, schema *and* emergent psychotic symptoms (both in form and content)" (Brabban & Turkington, 2002, p. 66, italics original). Though perhaps not initially apparent, key concerns of the personality can be identified through the skillful use of inference chaining in which questions are posed with a focus on why a particular piece of information is personally important. For example, a delusion that one is the "Second Coming of Christ" (Turkington, Kingdon, Weiden, 2006, p. 368) might express a person's hope that "the world will be put to rights," and that people will be held accountable for past transgressions after the person's early experiences of "always being bullied at school." There is, then, an implication that nothing in the individual's personality or sense of self has been altered in the delusional state. The individual's personality and self-schema continue to influence beliefs and explanations. The delusion is a kind of expression of self-concept and its preoccupations, much like how the negative beliefs about self (e.g., I am unworthy) are reflected in the automatic cognitions typical of depressive disorders.

For understanding how the delusion relates to the world, one might note that "earlier adverse experience may cause a person to be anxious and have enduring beliefs about the dangerousness of others and the world, leading to anomalous experiences such as voices…[which are then] interpreted as persecutory" (Freeman & Garety, 2003, p. 931). This interpretation presumably reflects the broader feeling that people in the world are threatening[5]. Again, we find no reason to think that *how* the world is experienced has been changed in the delusional state. Interpreting anomalous experiences is a matter of utilizing world schemas. Illustrative of CBT's conceptualization of how delusion directly relates to a shared world is CBT's (quasi) reality-suspending, non-confrontational stance of curiosity towards delusions that nonetheless assumes that the delusional realities involved pertain to a reality or world that can be shared: Responding to a patient's belief that the Mafia is monitoring their house, a clinician says, "Well, that is possible…But why do you think it is the Mafia? Could it be some other organization? Or is something else happening altogether? How could we find out?" (Turkington et al., 2006, p. 367); or "'Can microchips really be inserted without your knowledge when you are asleep?" (p. 368). Seemingly, there is here an attribution of the 'natural attitude' to persons with delusions, a term used by Husserl (1982) that refers to an implicit framework taken up in the normal state affairs in daily living in which physical objects, persons, and naïve constructs are treated as clearly or self-evidently real and uncomplicatedly present.

In how delusions relate to the self and the world, a normal relationship between personality and the experience of the world is assumed, one in which the objects involved in delusional claims and the ontological status of those claims apply to a lived world in which we all participate (e.g., 'dangerousness of the world,' 'threat beliefs' about the

world). Clinicians can 'enter' that world, helping individuals to gather evidence or suggesting alternative explanations. Thus, in the cognitive account, the experience of delusion involves no major shift. There is no qualitative alteration, either in the way individuals experience themselves or the world. The content of delusional beliefs have a direct relationship to the world (e.g., there has been no substantial alteration in ontology).

The second common assumption is the shared terms used to describe the process of delusion formation. The terms 'anomalous experience,' 'belief' (or reaction, appraisal, interpretation), and 'distress' are indispensable to CBT formulations of delusions in that they form the basis for a common explanatory sequence for delusion formation. By using this sequence, it is possible to specify when exactly beliefs become clinical delusions. This sequence holds that (anomalous) experiences are followed by interpretations that attempt to explain the anomalous experiences. These interpretations are driven by schemas, biases, and possibly emotions, and some interpretations lead to distress. When distress is experienced, the belief becomes a delusion. For example, when interpretations of anomalous experiences involve attributing the source of one's experience to the environment (called an externalizing bias) and then become distressful, the belief is said to be delusional. Thus, the *reaction* or *response* to an anomalous experience, in the form of a belief that frames the experience in a way that is distressful, is what best denotes or specifies the delusion as a clinical phenomenon.

This leads to a claim, to some degree, in which distress is really the characteristic of what is psychopathological, a "main issue" (Steel & Smith, 2013, p. 3) to be considered for deciding whether to therapeutically target an experience or not: "While an individual may be expressing highly unusual beliefs, for example, relating to alien

abduction, this may not be a cause of concern to them" (p. 4)[6]. This sensible and pragmatic criterion of distress offers guidance for the thorny issue of when to target a delusion for treatment, but it also raises a difficult question of how to think of delusions that are not distressing (e.g., would delusions that enhance meaning in life still be considered a delusion?)

In emphasizing distress as a determinant of whether or not a particular psychotic experience should be considered pathological or not, cognitive models share an assumption with at least one version of a psychosis continuum model, in which "experiencing symptoms of psychosis such as delusions and hallucinations is not inevitably associated with the presence of disorder" (van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009, p. 179). The non-disordered and the disordered can have qualitatively similar anomalous experiences which become psychotic or presumably, healthy, by virtue of cognitive reactions, *perhaps* in combination with other factors that contribute to the expression of symptoms, e.g., "intrusiveness, frequency and psychopathological co-morbidities on the one hand, and personal and cultural factors such as coping, illness behavior, social tolerance and the degree of associated developmental impairment on the other."

There are philosophical, practical, and empirical reasons for holding these assumptions about delusions—as being beliefs-about-the-world and as involving experiences that are not qualitatively different from non-delusional experiences. An analysis of the historical context will help to situate the intellectual dynamics that gave rise to these claims in cognitive theory and freshen the lens for identifying the key issues at stake.

The Cognitive Position as Reactionary

Cognitive explanations initially targeted the positive symptoms of schizophrenia. To lay the groundwork for these explanations and the treatments indicated by them, it was necessary to make a claim contrary to the much of the ethos of the time—at least in the United States. The standard treatment for psychotic disorders was thought to largely reduce to a matter of administering the neuroleptic that best suited the patient. During this time innovators such as Tarrier, Chadwick, Kingdon, Turkington and colleagues were suggesting the possibility that positive symptoms could be further decreased with psychological therapy as an adjunct to neuroleptics. Implicit in such a suggestion was the unorthodox proposal that psychotic symptoms could be understood in psychological terms (e.g., understood by using the same concepts and constructs used for explaining non-psychotic symptoms). In the process, cognitive accounts were giving a voice to patients whereby their communications and experiences became meaningful and subject to constructive dialogue.

David (2010) has characterized the renewed interest in a psychological understanding of psychosis as a kind of moral victory. On this line of thought, the application of CBT to psychosis is perhaps best viewed as a moral reaction to claims that delusions are un-understandable (e.g., in Jaspers) and to the view, rightly or wrongly attributed to late 20th century biologically-based psychiatry, that symptoms of schizophrenia have no value as an object of psychological study. Kuipers, Garety, Fowler, Freeman, Dunn, and Bebbington (2006) note that for much of the 20th century, "scientific explanations of schizophrenia emphasized its otherness. The statements and experiences of people with the disorder were regarded as quintessentially

incomprehensible" (p. S24). This doctrine of incomprehensibility, along with a focus on the biology of schizophrenia, were associated with a view in which the "symptoms of psychosis were seen primarily as the building blocks of diagnosis, rather than having an interesting and meaningful content." The notable exceptions notwithstanding, Kuipers et al. (2006) capture something characteristic about the spirit of views on schizophrenia in psychiatry and clinical psychology at the time, especially in light of schizophrenia representing the 'sublime object of psychiatry,' a condition resisting customary description and comprehension (Woods, 2011).

Although the idea that psychotic symptoms can be understood is a humane suggestion, it may also be viewed as minimizing precautions by phenomenologically-oriented psychopathologists. In much of the phenomenological literature, it is held that the attempt to understand psychotic experiences, especially delusions in schizophrenia, may not only stretch the normative assumptions and constructs that usually ground psychological explanation (such as personality, belief in external reality) but also that understanding itself may be an impossible task[78]. The impossibility of understanding delusions is a view notoriously associated with Jaspers, whose absolutism regarding the impossibility of understanding delusions has been questioned by numerous phenomenologically-based investigators (e.g., Sass, 1994). Although Jaspers' view may have been a reaction to an important aspect of experience in schizophrenia, his claim on its incomprehensibility was too strong. When one considers that the cognitive position on the understandability of delusions is a reaction to the extreme position of the their un-understandability, this antithetical position on the understandability, and even normalcy, of delusion might be viewed as an extreme position itself. Considering a synthetic

formulation of complete incomprehensibility and clear comprehensibility[910] might be a more plausible way forward.

Indeed, the cognitive model exists against a backdrop of numerous writers who have stressed the qualitative differences involved in the phenomenology of delusional experience in schizophrenia. Many of these have been phenomenologically-based psychopathologists, but there are other sources as well, such as Chadwick (1997), a psychologist diagnosed with schizo-affective disorder, who writes: "Once delusions are in place and systematised, no two sets of people have a bigger gulf between them. Be they black and white, French and English, male and female, heterosexual and homosexual, the gulf separating them pales literally into insignificance when compared to that between the sane and the floridly insane" (p. 39). The need for being cautious in thinking about the similarities between psychosis and non-psychotic experience can also be heard in commentators such as David (2010), who noted several methodological and conceptual weaknesses in studies of non-clinical psychosis before reminding us that there is room for both continuous and categorical perspectives.

The important work done in CBT for psychosis has led to a reconsideration of the relevance of psychological therapies for persons with psychosis. In being sensitive to the subjective experiences of persons with psychosis, CBT models and therapies have also reintroduced the need to examine the study of subjectivity itself. Very much in this spirit, this paper attempts to provide a rationale for a more balanced view of the comprehensibility of delusion, one that entails both qualitative difference and some degree of comprehensibility. A form of experience that is comprehensible need not be a form of experience that is qualitatively identical. Comprehensibility need not imply

sameness.

Arguing that delusion does entail important qualitative transformations (which are nonetheless partly comprehensible) does not reject the importance of cognitive studies of delusions that do show how delusions can be understood with constructs that are similar or identical to the ones used to explain non-psychotic disorders (e.g., avoidance, reasoning biases). Such an argument does, however, serve to question the assumptions operative in such explanations, assumptions that involve a minimization of the kind of experiential change involved in certain forms of delusion. Certain types of delusion, especially ontological and solipsistic delusions (discussed below), do not map very well to conventional ways of understanding beliefs and experiences, and these delusions require a sense-making theory that is sensitive to the self and world transformations often involved in their experience. These transformations have implications for how we interpret the meaning of delusions, how we empathize with and relate to the experience of persons with delusions, and what we imagine as the kind of lived world given in delusional experience. In insisting that delusions can be fully understood and explained on the model of normal experiences, cognitive models are at risk of losing the qualities thought to be crucial to characterizing certain types of delusions, and they also avoid a more direct confrontation with the nature of anomalous experience in question. This is the case despite the formal characteristic of CBT that clinicians should make a substantial effort to understand many aspects of a delusion, such as why a particular delusional explanation is chosen.

The Importance of Cognition in Defining Delusion

Despite the seemingly unusual nature of anomalous experiences (such as hallucinations and depersonalization), the cognitive position denies that this experience is the critical or defining feature of delusion and would reject the importance of the primal aspects of experience in the process. Rather, it is "the particular interpretation that causes the associated distress and disability" (Garety et al., 2007, p. 1378). Steel and Smith (2013) explain: "an individual who 'hears a voice,' and decides that this perceptual experience is due to a lack of sleep is likely to have a different outcome to an individual who decides that the Devil is speaking to them with bad intent" (p. 5). Similarly, Tai and Turkington (2009) comment that "an individual who experiences physical sensations of tingling and attributes this to job stress is likely to have a markedly different outcome to persons who believe that people at work are persecuting them and have planted microchips under their skin" (p. 866). This is consistent with the cognitive principle that the interpretation, rather than the event itself, is what determines how a person will experience an event: The experience, the event, the sensation, the perception are not decisive. They are not even relevant for defining what a delusion is[11]. Here, anything that is intrinsic to the experience of anomaly is de-emphasized, because what is important is the cognitive framing (and, in some accounts, whatever emotions or interpersonal consequences are invoked in the process). The need to even account for the anomalous experience is thereby reduced. As noted above, the *reaction* or *response* to an anomalous experience, in the form of a belief that frames the experience, is what best denotes the delusion as a clinical phenomenon[12].

The cognitive perspective is surely correct in arguing for the relevance of cognitive factors in delusion. However, by emphasizing only the responses to anomalous experiences, the cognitive position is focusing on *thoughts* about experience (or at least the cognitive framing of experience, of which emotions may play some role) and perhaps overreaches on the extent to which experience is constructed and constituted or captured by thought—as if the cognitive framing of experience is what essentially defines the quality of an experience.

The role that thoughts (or language) play, particularly our customary ways of thinking, in modifying or distorting primary experiences (e.g., of things themselves) has been a prominent theme discussed by major phenomenologists such as Heidegger. The need for caution when examining the interaction between language and experience is perhaps especially true of delusional experiences in schizophrenia. Numerous writers have discussed the ineffable or language-challenging nature of the experience. Schreber (1988, p. 28) says "it is extremely difficult to describe such changes in words because matters are dealt with which lack all analogies in human experience and which I appreciated directly only in part with my mind's eye." Another individual speaks of a similar struggle: "I would reiterate the extreme difficulties [involved in] trying to explain and describe these experiences. When I talk to other people…it becomes incredibly tempting to resort to easier terms and terms that clinicians understand because [the inability to communicate] gets so frustrating" (Jones & Shattell, 2016, pp. 1-2).

Foucault (1965) was acutely sensitive to this issue, recognizing that reason was pitted against unreason, and that attempts to understand madness by way of reason (e.g., naturalization of experience, socially-shared explanatory frameworks, and especially

psychiatry and clinical psychology) is a one-side dialogue in which madness loses its voice. On this line of thought, our conventional ways of thinking about experience fall entirely short as a way of understanding delusional experience. Customary thought and language, then, may tend to suppress the lived reality of delusional experience—an experience always lying beyond our usual schematics for understanding[13].

It is curious, then, to define delusion with no regard to the kind of experience associated with the cognitive framing. It is likewise curious to primarily rely on the cognitive aspects of delusion when the cognitive aspects offer a limited, and perhaps even misleading, representation of the nature of delusions[14]. Phenomenological writers have cautioned that the 'anomalous experiences' associated with delusions constitute altered structures of experiencing, signaling the dissolution of existential a prioris (Kraus, 2010). As a consequence, readily interpreting the meaning and significance of delusional claims is challenging. A grasp of the way that experience has been altered is necessary for understanding delusions. Focusing on the cognitive basis of delusion provides little space for recognizing and working through this challenge. This phenomenological, rather than cognitive, view of delusion suggests that it is the experience itself, rather than its interpretation and elaboration, that determines the character of delusion.

Consistent with a focus on experience as a crucial part in defining delusion, most phenomenologically-inspired investigators draw conclusions that contrast with how the cognitive perspective defines delusions and with how the cognitive perspective claims delusions relate to non-delusional beliefs. Most phenomenological writers agree that the delusional experience (in schizophrenia) involves *foundational* changes in the experience of both self and world, and that these changes are expressed in both anomalous

experiences and delusional beliefs. This implies that it is not sufficient to consider the content of a delusion, i.e., what is claimed in delusional statements, in defining delusion, and that delusion involves changes in lived experience which make them quite distinct from non-delusional beliefs. Delusions are best defined by their experiential features, and to understand them requires a grasp of subjectivity (Henriksen, 2013; Parnas, 2013; Sass, 1992a; 1994; Sass & Pienkos, 2013). This is partly accomplished by investigating the lived space in which the patient finds himself—an explicit consideration of the pre-reflective attunement to self and world. In particular, the pre-reflective attunement to a sense of what is real (i.e., constitutive of reality) has been stressed by multiple phenomenologists, including Jaspers, who noted that conceptual or cognitive framing means very little without the more basic attunement to a kind of presence in experience, a pre-reflective attunement to a world about which one has thoughts. Thus, the *cognitive* reaction to an experience only partly defines the phenomenon of delusion. The phenomenological conception of delusion is substantially broader, targeting the holistic form of experience[15]. It is also worth pointing out here that this holism problematizes the 'distance' between experience (or event) and cognition that would be required in order to place such importance on cognitive reactions in the cognitive account—as if the cognition occurs without reference to the state of the perceptual system. The experience itself shapes the content of the interpretation. Interpretations also shape what we experience—to the extent that it is even sensible phenomenologically to separate these intellectual categories in this manner when talking about delusional experience (see Chapter III for more discussion on this issue).

To summarize, CBT approaches to delusion are underpinned by the assumption that there is a continuum between delusions and non-delusional beliefs and by the proposition that delusions can best be understood as cognitive reactions to an anomalous experience, with ‘cognition’ and ‘experience’ treated as quite distinct. As discussed in Chapter II, studies on the phenomenology of delusions in schizophrenia suggest that these assumptions and proposals are major limitations of cognitive approaches to conceiving of and treating delusions in schizophrenia.

Chapter II

Phenomenology on the Qualitative Differences between Beliefs and Delusions

The notion that delusions are continuous variants of normal beliefs is intertwined with several crucial features of the CBT account. It 1) makes plausible the idea that delusions are understandable, 2) provides a rationale for explaining delusion by using normative constructs such as personality (i.e., undisturbed experience of selfhood), self-esteem, anxiety, depressive mood, schemas, and cognitive biases, and 3) suggests that delusional beliefs are intended to make claims that correspond to something in the external world. As noted above, these features of delusion suggested by the cognitive account are at odds with one of the major proposals of Jaspers (1963), who is perhaps the most influential phenomenological psychiatrist. Jaspers concluded that 'primary' delusions, a kind of delusion thought to be unique to schizophrenia, could not be understood by appealing to the usual terms for understanding experience. It would therefore be a mistake to try to make sense of primary delusions by using the concepts that help us to understand non-psychotic psychopathological phenomena. In contemporary terms, these might be anxiety, common reasoning biases, underlying negative schemas, normally embodied personality, internalizing and externalizing attributions—some of the key concepts used in the cognitive account of delusion. Jaspers suggested that the nature of primary delusions could not be captured by analyzing quantitative variations in normalized constructs such as these. The reason, thought Jaspers, is that primary delusional experiences involve alterations in the basic constituents of experience, making the experiences entirely foreign and ultimately incomprehensible.

As discussed below, alterations in the basic aspects of experience, including a disturbance in the experience of self, has implications for assessing the potential understandability of delusions as well as for understanding of what kinds of 'worlds' may be operative or experienced in the context of delusion[16]. For example, with careful assessment, a skilled cognitive clinician may very well be able to identify a thematic element linking past (non-delusional) experience and what is being expressed during a delusional state, e.g., the "Second Coming of Christ" (Turkington et al., 2006, p. 368) being linked to "always being bullied at school" (p. 368), but it is not clear exactly how we are to empathize with such a perspective or what exactly is being claimed. How easy is it to imagine what it is like to feel compelled to express one's sense of personal injustice in the form of a delusion such as this? Why would someone 'jump to' *this* conclusion? Is it the desire to exercise such a power, a power unique to a Christ-like figure? And are we to understand this as a belief, e.g., as a kind of working hypothesis for understanding a state of affairs in the world?

In theory, it is possible to view the formation of such a belief in terms of limited data-gathering (i.e., jumping-to-conclusion) combined with a failure to consider alternative explanations (i.e., belief inflexibility). The descriptive merit of these terms, and the evidence for their presence in delusions, is not problematic. There is, however, no hint that being limited in one's explanation for an unusual experience and collecting insufficient evidence are reflections of a more basic change in experience—that they are cognitive biases that correlate with how individuals find themselves in a lived world. These biases are fostered by a particular way of experiencing the world, which makes their use sensible.

Claiming, in some sense, that one's customary identity (e.g., comprised of social, personal, familial sources) has changed seems to require explanations that extend beyond reasoning biases and consideration of developmental history. The biases and the history provide only some indication of how the person has latched on to such a striking conclusion about their identity This change in identity is issued from a place beyond the organized narratives that are normally enacted and thematized, i.e., self-concept. The breadth of self-redefinition involved in such a case requires an analysis of self-experience itself, one that allows us to recognize that the experience of oneself has changed dramatically. A change in identity such as this reaches to the very foundations in the experience of self and the structuring of first-person perspective. This includes but transcends personality, emotional vulnerability, and biographical development (implicating events such as trauma, abuse, formative experiences, and schemas).

The focus on this far more basic aspect of selfhood is motivated by the attempt to really capture what is chiefly operant in the lived world of schizophrenia and schizophrenic delusions. Most commonly, this involves a struggle with self-definition in a pervasive sense (e.g., feeling of not being fully present with oneself, a diminishment in how pronounced the sense of self is, feelings of self-transformation, identity void) (Parnas et al., 2005). This may be discernable as a pattern of numerous fluctuations in one's sense of personal identity and how the world is experienced, which reflect instability in the *ground* for experiencing self and world.

These aspects of delusional experience in schizophrenia have been less emphasized, partly because Jaspers' views on delusion have been treated with suspicion. Considerations of Jaspers'(1963) claims regarding the un-understandability of primary

delusions seldom wrestle with how he thought self-experience related to un-understandability. Instead, Jaspers' position on un-understandability is usually rejected by a consideration of evidence related to the presence of psychotic symptoms in the non-clinical population, the ability for certain conditions, such as sleep deprivation, to induce psychotic symptoms, and the usefulness of psychological mechanisms in explaining psychotic symptoms (see, e.g., Freeman & Garety, 2003). This line of reasoning is impressive and sensible, and some of it will be discussed in detail in Chapter II. It does, however, lose sight of the most essential reasons why primary delusions are not understandable, according to Jaspers (1963), and to this we will shortly turn. Bentall, Corcoran, Howard, Blackwood, and Kinderman (2001) are surely correct when they opine that the concept of primary delusion suffered the dreaded problem of inadequate operationalization. In this light, perhaps the primary delusion was one of the casualties of the race towards reliability that was characteristic of the psychiatry and clinical psychology of the 1980s.

It is worth stating that no amount of weighing the evidence for and against the existence of primary delusion can be a fair test of the validity of the idea if the nature of primary delusions is unarticulated. Rejecting the concept of primary delusion also fails to consider other investigators who have written on the non-ordinary and non-doxastic nature of delusions (e.g., Bovet & Parnas, 1993; Gallagher, 2009; Parnas, 2004; Ratcliffe, 2004, 2013; Sass, 1994, 2014), most of whom accept the concept of primary delusion while rejecting Jaspers' claim that these 'true delusions' are completely incomprehensible. This might be read as a kind of skipping-over, perhaps reflecting a zeal to correct outdated philosophical insights with the strength of evidence afforded by

empirical investigation. Gipps (2010) has observed that Jaspers is often presented as a Procrustean boogeyman who has shackled our potential to understand delusions and whose influence can now be overcome by using normative concepts. But in an era in which a focus on experience and selfhood is not at the forefront of psychological thought, it may just be that the lens for identifying the importance of such issues lacks focus. We will now turn to an alternative reading of Jaspers' (1963) place in our understanding of the significance and nature of delusions, a reading suggested by Sass and Byrom (2015b), which is less of a 'return to the past' than a restating of basic insights lost in translating phenomenological ideas in clinical and research contexts.

Jaspers: The Basis for Un-understandability of Delusion and His Place within Contemporary Phenomenological Study of Schizophrenia

There is a tension within Jaspers'(1963/1997) account of primary delusion. What readers will see in Jaspers, juxtaposed with rich descriptions of various phenomenal features of delusions (such as a sense of overwhelming, perhaps ineffable, significance), is repeated statements that very little can be said about the delusional lived worlds of patients with schizophrenia—lived worlds that represent an "unsurpassable gulf which defies description" (p. 447). Nonetheless, he did provide some phenomenological description that served as the rationale for his claim that primary delusions are not understandable. He did so by discussing these delusions primarily in terms of what they lack in relation to normal experience (Sass & Byrom, 2015b).

In a way that is broadly consistent with the cognitive account, Jaspers clearly considered the idea that delusions might be understood in psychological terms such as character-history or known affects and emotions – all of which are conducive to empathy.

And, in fact, he contended that some delusions could be understood as variants of normal belief and could thus be understood by using these normative psychological concepts. These delusions he termed "delusion-like ideas" (Jaspers, 1963/1997, p. 106) (This distinction is absent in contemporary thought about delusion: What Jaspers would call delusion-like ideas are called delusions). They were kinds of quasi-delusions that involved no profound shift in experience. They were only quantitatively different from non-pathological erroneous beliefs (captured in his phrase "exaggeration or diminution of known phenomena" (p. 577)). In contrast, delusions that could not ultimately be understood (i.e., the primary delusions in schizophrenia) were so because the kind of experience involved was qualitatively different from non-delusional experience. Therefore, these delusions could not be seen as exaggerations (or diminutions) in normal psychological phenomena. Indeed, primary delusions seemed to involve a mode of experiencing self and world that was barely fathomable. As presented here, the cognitive view on delusion represents an eclipse of primary delusions. All delusions are delusion-like ideas. Hence, in cognitive accounts, we find the view that all delusions involve merely quantitative variations in normal belief and emotional processes and occur with no qualitative shifts in experience. There is no kind, only degree.

Reflective of this eclipse, there has been little focus on the reasons why a distinction between primary delusion and delusion-like ideas is fruitful as clinical knowledge. Although one could discuss several elements that form the basis of un-understandability (see Sass & Byrom, 2015b for self-reification and self-deification secondary to hyperreflexive processes in self-disturbance, and partial discussion of these phenomenological features below), one major reason why, according to Jaspers, the

abnormal experiences of primary delusion are not understandable, and why they are qualitatively different, is due to the delusional mood. The delusional mood is a kind of atmospheric feeling encompassing perceptual processes and involves a globally altered mode of experiencing. This mode of experiencing is fundamentally different from normal ways of experiencing – a "*transformation in our total awareness of reality*" (Jaspers, 1963/1997, p. 95, emphasis original).

Particularly relevant for any theory that claims that delusions are understandable in the same way as other false (or unhelpful) beliefs, this global alteration in the mode of experiencing in delusion closes off normal ways of accessing experiential links normally used in process of understanding others. For example, primary delusion tends to involve an immediate realization of significance (a kind of basic, non-conceptual intuition of meaning) rather than significance attained via an inferential process, a process in which a clinician might emulate a series of psychological processing steps in order to understand how conclusions were reached via a rational thought process (Parnas, 2013).

As second major reason why primary delusions are un-understandable is the collapse of normal 'personality' in primary delusions (By 'personality,' Jaspers meant something that more likely would be termed self or personhood in contemporary terms). This collapse, arguably, is constituted by a change in the fundamental coordinates that provide a normal and implicitly organized experience of the self. Later phenomenological investigators have further articulated and formalized this as the ipseity (or disturbance in basic sense of self or self-presence) hypothesis of schizophrenia (Sass & Parnas, 2003).

Jaspers' (1963/1997) position of un-understandability, then, is not a matter of delusional speech being utterly incomprehensible--representing little more than

meaningless speech that should ultimately be ignored. Nor is Jaspers' view inconsistent with cognitive proposals such as "the content of delusions reflects concerns the individual has about himself and how others perceive him" (Brabban & Turkington, 2002, p, 61). The relevance of biographical history and the search for a meaning for self and world is clearly consistent with Jaspers' (1963/1997) account of delusion-like ideas, as it is in the cognitive account. The same might be true up to a point for primary delusions, at least from the perspective of post-Jaspersian phenomenology. One should expect to see some thematic elements of personal history emerge in the content of delusions: This would be the case by virtue of temporality in self-experience. However, biographical history is insufficient for grasping the primary delusion as a phenomenon, owing to the transformation of self and world. Focusing on secondary qualities such as the content of the delusional belief—contents that may or may not be directly linked to biographical history—falls short of accounting for delusion as an experiential phenomenon.

So we may ask ourselves again: How are we to understand this delusion exactly? Are we to connect with the experience and belief by being armed with an understanding of the biases (e.g., drawing conclusions prematurely, in the absence of sufficient evidence), the core beliefs being brought to the interpretation of experience (e.g. one is unworthy, one is weak), and emotional influences (e.g., anxiety)—all of which lends itself to establishing empathy? Or is there something additional in such delusional claims, something that does not exclude the normative considerations but adds to them -- something at a more basic level? And is this something incredibly hard to specify but perhaps easy to recognize non-verbally? Is it not, in fact, quite convenient to pass them over and to focus, instead, on the parts that we can comprehend or empathize with? So

much so that these subtle qualities can be overlooked and even trivialized, their status of realities of experience reduced, especially when compared to the power of the cognitive model, in its normative account, to explain the delusion and provide a road to empathy? Understanding this statement about one's identity as the Second Coming of Christ in terms of personal history and self-concept, although relevant, seems to lack the room needed for grasping how one could claim a new identity as totalizing and pervasive as this one, where there has been a kind of reformatting, a re-establishing identity—where the link between the personal (historical) identity and the new identity shows no sign of itself in even the name. Here, we may not have an entire discontinuity between prior experience and the new 'world' of delusion imagined by Jaspers, but we do have an experiential shift profound enough for a new experience of identity to emerge. Thus, in order for primary delusional experiences to be made comprehensible, there must be an attempt to grasp the transformation in the sense of reality as well as the fragile sense of self that undergirds the experience. Both of these occur outside the set of psychological factors utilized in cognitive models.

A second reason Jaspers emphasized the un-understandability of delusions, and one that may require the principle of charity in reading his work, involves the influence of phenomenology on his thinking. Jaspers' insistence on incomprehensibility may be less of a factual claim and a more of a cautionary statement to students of delusion, a statement motivated particularly by the enigmatic nature of the disturbances in self-presence. An appreciation for the complexity of understanding in phenomenology may have been fostered by his commitment to phenomenological principles which more generally caution against understanding consciousness and experience with metaphors

and models that misrepresent or close off a fuller view of the phenomenon itself (Scheler, 1973)[17]. Hence, we see statements such as "we find changes of the most general kind for which we have no empathy but which in some way we try to make comprehensible from an *external* point of view" (Jaspers, 1963/1997, p. 577, emphasis added). His master work, *General Psychopathology*, was in part driven by his desire to call attention to the tendency to treat signs and symptoms as objective properties (like those characterizing attributes of objects), rather than as subjective realities, and to encourage a critical attitude towards commonly deployed assumptions and concepts (Parnas, 2013).

In sum, Jaspers' stress on un-understandability can be linked to two points. One concerns the change in personality (primal or basic sense of self that grounds experience, rather than the particular attributes that define one's personhood) and associated phenomena such as the delusional mood and the change in the sense of reality. These changes self-experience, mood, and sense of reality affect how we should understand the primary experience of delusion (in terms of what mode of experience gives rise to delusion and the sense of reality associated with the delusional insight). The second concerns the phenomenological principle of exercising extreme caution when describing and interpreting mental states, which, for Jaspers, would have been one step in an uneasy dance balancing human and natural sciences. Subsequent phenomenologically-oriented psychopathologists, especially Sass (1992a, 1994, 2014), have been sensitive to the issue of remaining faithful to the phenomenon of delusion while also suggesting ways in which primary delusions can be understood. This can be accomplished by clarifying the nature of altered self-experience and how it induces a way of experiencing that is not subject to the normal constraints and ways of organizing one's experience of self and world.

A major task in phenomenological psychopathology subsequent to Jaspers' work has been interpreting delusions without construing them in terms of beliefs about empirical realities and without imposing, as much as possible, a model of normal modes of experience on the attempt to understand the delusional experience itself. Such investigations have led to a distinction between what some have called 'empirical' delusions and ontological or solipsistic or autistic delusions (e.g., Bovet & Parnas, 1993; Parnas, 2004; Sass, 1992a, 1994, 2014). The latter involve the change in personality or transformations in experience noted by Jaspers (1963/1997) and are more likely to instance solipsistic, metaphysical, grandiose, and religious themes compared to their empirical counterparts. The themes can reflect a subjectivizing yet alienating stance towards one's own experiences. This stance challenges the commonsensical approach to experiencing self and world. The objective world may transform into something far more subjective and perspectival; causal relationships may not be defined by Newtonian laws; consciousness itself might become a priority 'object' for inspection rather than the world; and self and world may cease to be clearly demarcated (Parnas & Sass, 2001). In contrast, empirical delusions pertain to objects and events within the world, given the lack of change in self and world experience. Empirical delusions have more in common with Jaspers' delusion-like ideas.

It is the ontological delusions that seem to challenge the definitions, characterizations, explanations, and treatments of delusions offered by cognitive models. Ontological delusions poorly fit in a model of delusion formation that segregates the 'anomalous' experience and the delusional belief, as is done in cognitive accounts. Ontological delusions involve claims that express the lived world directly, signifying a

dynamic intimacy between a mode of experiencing and the use of language, independent of the objective (or intersubjective) constraints normally placed on the use of language. 'Insight' in ontological delusions does not come by way of inferences but intuitions that reflect a radical way of being rather than biographical dispositions. They typically are not characterized as experiences occurring from within the normal mode of experiencing self and world (they are in fact thought to often be associated with diminished attunement with common ways of relating to the world, sometimes called schizophrenic autism and loss of common sense) and as a byproduct, they do not necessarily make claims about objective states of affairs in the world. They may be associated with a reduced likelihood of acting in accordance with the 'belief' content (see Buchanan et al., 1993; Wessely et al., 1993). In these respects, they expose the limitations of assuming a continuous relationship between normal beliefs and delusions, and they serve as a basis for questioning the presumption that anomalous experiences themselves are not a defining feature of delusion (indeed, the anomalous experience carries the qualities that suggest the character of delusion and our ability to recognize them as such). If these are the weakest points in the cognitive model of delusion, then it is fitting to ask about the evidence given by cognitive theorists that the concept of primary delusion is invalid, a concept which does make a qualitative distinction between delusional and non-delusional experiences and does assign a priority to the 'anomalous experiences' in defining delusion.

When the character of ontological delusions is considered alongside of the inconclusive evidence for the continuity between beliefs and delusions (considered below), it is reasonable to suggest a need to modify existing CBT theory and treatment in

order to better reflect the phenomenal nature of primary delusions and the qualitative differences they show from normal beliefs.

The Assumption of Continuity between Non-delusional and Delusional beliefs in Cognitive Models

There are multiple ways to understand claims that there is a continuous relationship between non-delusional and delusional beliefs. These might include a consideration at the level of etiology, whereby the claim for continuity between normalcy and psychosis means only that there are no extraordinary etiological mechanisms in psychosis that would not also be found in neurosis. There is, in other words, no unique etiological mechanism. However, the claim regarding continuity in the cognitive literature is stronger than this, extending beyond etiology. Alternatively, claims about continuity might simply reflect an attempt to destabilize the absolutely categorical nature of disease concepts in order to soften the already blurry line between neurosis and psychosis. For example, Freeman and Garety (2003) state, "As neurotic and psychotic disorders can both be understood from a psychological perspective, the rationale for such a sharp distinction between the categories is weakened" (p. 925). But a reduction in the sharpness of the distinction is not the extent of the claim of continuity. Various writers caution us about the tendency to think that psychotic experiences are so different from non-psychotic and even ordinary kinds of experience. The issue of continuity could also be understood within a model linking normal personality variation and psychopathology, in which all forms of psychosis represent extreme (and qualitatively different) ends of normally distributed traits. Such a framing, however, is not stressed in any of the cognitive models of delusions. Instead, the claim is that there are no qualitative

differences between normal beliefs and delusions—everything is a matter of degree, of exaggeration or diminution of normal processes and experiences, in Jaspers' terms[18].

Freeman and Garety (2003), for instance, state that "the empirical evidence is not consistent with the view that psychosis is qualitatively different from normal *experiences*" (pp. 924-925, italics added). One might say, then, that delusions are not that extraordinary—as a phenomenological phenomenon, a psychopathological one, or as a symptom to be treated. Mander and Kingdon (2015) state, "Rather than a distinction between 'normal' and 'abnormal' experiences and beliefs, CBT emphasizes the continuation of experiences within the whole population" (p. 65). Conviction, degree of systematization, and insight may "form crucial points along a continuum between normal worry, overinvested ideas, and delusions" (O'Connor, 2009, p. 155) (though distress, and sometimes preoccupation, is the typical variable evoked in talking about variations along the continuum). Claiming that there is a continuity between delusions and non-delusional states has deep implications in the cognitive account: Assuming continuity means that clinicians and researchers can study delusions as if they are false beliefs voiced by a normally immersed, intersubjectively anchored person. Because of the common experience of the intersubjective world, no extraordinary theory is required for interpreting the meaning of delusions. They are, in other words, just beliefs, separated from other beliefs by variations in distress and preoccupation. There is no need to consider 'background orientations' to reality or any change in the experience of self. There is no reason to be sensitive to the possibility that delusions and over-valued ideas are distinct *kinds* of psychological phenomena despite having some common properties.

This begs the question of what evidence is so compelling to warrant the view of experiential continuity. To be sure, the issue of continuity between non-psychotic and psychotic experience is something to be researched in its own right, independent of cognitive theory, and it is a literature with its own challenges. Decoding data to support either a dimensional or categorical view for the nature of a disorder may be not only a methodological challenge (e.g., even a categorical disease can be obscured within a continuous distribution of symptoms) but a fool's errand, as we primarily observe only properties of diseases, some of which may be best viewed dimensionally and others categorically (Pickles & Angold, 2003), the choice of which may reflect the biases of investigators (David, 2010).

In cognitive accounts the prominent reasons commonly given for rejecting qualitative differences between psychosis and normal experience are the evidence for psychotic experiences occurring in the non-clinical population and the relationship of anxiety and depression with psychosis. Below I argue that this evidence base falls short for a number of reasons. Despite this, the view that there is a continuity between psychotic and non-psychotic experiences is sensible because there are inherently blurry lines separating disorders. Those lines perhaps become even blurrier when concepts of psychopathology are restricted to symptoms rather than viewing symptoms as external characteristics of the phenomenological properties given in the experience of these symptoms.

Emotions, Neurosis, and Delusions

The arguments made by cognitive theorists for the continuity between beliefs and delusions (and between neurosis and psychosis) partly depend on evidence for the role of anxiety and depression in delusion formation (Garety & Freeman, 2013). To the extent that the symptoms of anxiety and depressive disorders are relevant for explaining the formation of delusions, there is a meaningful link between emotional disorders and psychosis. For example, persecutory themes are considered to be "an extension of anxious and depressive concerns about the person's own vulnerability and lack of worth" (p. 330).

To this end, there are large studies, including one general population study spanning three years, that have found that depression, anxiety and worry processes, and 'emotional disturbance' are risk factors for the development of (distressing) psychotic symptoms (Krabbendam et al., 2002; Krabbendam et al., 2005; Krabbendam & van Os, 2005). These studies suggest that emotional disturbance can help predict future psychosis, especially when there is a proneness to hallucinatory experience[1920].

One problem with this interpretation is that evidence for the presence (and contribution) of anxiety and depression in delusion formation is not sufficient for claiming that the difference between delusional beliefs and non-delusional beliefs is only quantitative in nature. There are a number of considerations that restrict such an interpretation. 1) The studies are not designed to show experiential continuity 2) Atomization overrides the contextualization of experience, which minimizes the distinctiveness of anxiety and depression in schizophrenia (as opposed to anxiety and depression in anxiety disorders and depression) 3) The interpretation overlooks the

difficulty of characterizing emotional and affective life in schizophrenia and delusion, and focuses on how emotional life is most like 'neurotic' problems while not seeing how much they may differ. Each of these will be examined below. Considered together, they constitute a warrant for caution in treating studies on the relevance of depression and anxiety for delusion as evidence for the continuity between delusional and non-delusional states. Furthermore, these three considerations introduce a reason to be skeptical about how apt depression and anxiety are as emotional states representative of emotional life in delusion.

The Relevance of Prediction in Demonstrating a Continuum of States

At first glance, finding that depressed mood can function as a predictor of future psychosis (e.g., Krabbendam et al., 2002) does seem to contradict Jaspers' assertion that delusion cannot be understood as increases or decreases in normal psychological phenomena. However, showing that depressed mood is operative in psychosis does not suggest the relative importance of depression to delusion. That is, predictive power does not inform us about the fit of depression as an intrinsic characteristic of delusional experience.

It would be surprising to learn that emotional disturbances such as depression did not figure in the developmental process of psychosis. Results from the ABC study, for example, suggest that the most common symptom during the onset of symptoms is depressed mood (Hafner et al., 2005). Non-specific complaints, many of which may overlap with symptoms found in depression, typically exist well before psychosis onset. Hafner et al. (1998), for example, remark on a lengthy phase of negative and non-specific symptoms before the onset of schizophrenia. Mood disturbances, as well as anxiety, were

also stressed by some psychodynamic theorists in conceptualizing psychic processing in schizophrenia (e.g., Arieti, 1974). Numerous investigators have pointed out the difficulty in drawing a clear line between depressive and schizophrenic disorders (e.g., Hafner, 2014; Kendell & Brockington, 1980), thereby casting doubt on the idea that the two disorders are actually distinct.

Given that the overlap between depressive symptoms and schizophrenia has been noted so widely, it not surprising that they would be relevant to the prediction of psychosis or play some role in explaining delusion. Granting a role to problems with mood and anxiety in the development of schizophrenia is not unique. It is curious, however, to see this overlap as clear evidence of a continuum.

Showing that depression is a predictor of future psychosis seems to be a long way from demonstrating that depression captures the feeling state of delusion and that the experience of depression is continuous with the experience of delusion. Such an interpretation seems to suggest that the emotional state of patients with delusions can be adequately modeled by using depressive symptoms, an emotional constellation that poorly characterizes emotional and affective properties of delusions. Depressive symptoms may be common in delusions, but they are best seen as one element playing a subsidiary role in a larger feeling state. Hence, the *predictive* value of depression is not a convincing line of evidence for the experiential and formal continuity between psychotic and non-psychotic experiences (even if depression and anxiety share mechanisms with delusion formation).

Modularity/Atomization and Contextualization

To stress the importance of depression and anxiety in the development and maintenance of delusions, without further qualification, could suggest that the depression or anxiety in delusion is something that happens to the delusional patient, afflicting them in much the same manner as someone experiencing only depression or anxiety in the context of anxiety or depressive disorder. Such a view may be fostered by a modular or atomistic approach to psychopathology (Skodlar et al., 2012), where psychological problems are abstracted away from their lived context. Although perhaps very useful for determining the adequacy of our conceptions and measures of disorders in populations, very little is said about the phenomenology of persons living with depression (e.g., depressed being-in-the-world)[21].

A key question, if one is trying to argue for a continuous model of neurosis and psychosis, is whether the feelings of depression and anxiety manifest in the same way for persons prone to delusions and those who are not. For persons prone to (primary) delusions, the feelings of depression and anxiety may occur under fairly unique background conditions of experience: These feelings exists within a larger process of psychopathological development and experience for the patient, both of which are partly characterized by a gradual erosion in the patient's ability to pre-reflectively relate to the world and the crushing awareness of this loss. Skodlar, Tomori, and Parnas (2008) describe this as a "primary and profound incapacity to deal and interact with fellow human beings at a very basic level" (p. 486).

Considering some of the evidence garnered in cognitive research, there does seem to be explanatory power in finding that different types of delusions involve different

emotional qualities. For example, persecutory delusions may primarily associate with low self-esteem and depression, while grandiose delusions may associate with lower levels of depression and high self-esteem (Smith et al., 2006). These correlates are potentially very helpful for priming clinicians to look for such a profile during therapy, and linking emotional states with different types of delusional content provides an interesting basis for future investigation into the mechanisms responsible for such a different psychological composition in two types of delusion. It is certainly reasonable to suggest, as do Smith et al. (2006), that there "is some evidence here that one clue to the development and maintenance of psychotic symptoms is that normal and understandable negative emotional processes are at work" (p. 187). However, there are limits on such interpretations. These findings do not provide evidence that delusions are explicable and understandable entirely in terms of non-psychotic, or even normal, emotional processes (i.e., claiming that the same emotional processes are operative in delusional and non-delusional states). Nor do these findings compel readers to consider that such emotional processes, while relevant to delusion, must be situated within the larger emotional experiencing of someone with a delusion. How exactly is depressed mood experienced when it occurs alongside of the delusional mood, altered self-presence, and compromised immersion in intersubjective relatedness?

Depressed mood and cognition in depression may relate to profound fatigue and diminishment in vitality whereas in schizophrenia, depressed mood may reflect a deeper disturbance in self-consciousness, e.g., operational hyperreflexivity and diminished self-presence (Sass & Pienkos, 2013). In their analysis of delusions in both depression and schizophrenia, Stanghellini and Raballo (2015) concluded that depressed and

schizophrenia patients become delusional and experience their delusions from different lived contexts. In schizophrenia, there is an erosion in the habitual familiarity with others and things in the world, a perplexity as a background feeling that drives individuals to peer into the mystery of the uncanny in search of the significance of what is happening; while in depression, the focus is on one's significance as a moral being, a kind of depersonalization involving the melancholic loss of the capacity to feel. The delusions associated with depression seem to occur without the drive for understanding the significance of what is happening (realizing that any meaning involves a confirmation of their moral ineptitude)[22].

The same need for contextualizing emotional and affective experience may be true of the anxiety and social withdrawal that has been found to be helpful in predicting development of schizophrenia (Johnstone, Ebmeier, Miller, Owens, & Lawrie, 2005; Jones, Murray, Rodgers & Marmot, 1994). The major emotion of anxiety may be best captured as an anticipation of danger or as a threat signal, expressed as a 'threat belief' cognitively. The feeling of anxiety, understood cognitively as a signal of threat or danger, is usually directed towards concrete objects. Whatever is threatening is seen as a threatening object in the world.

However, the kind of social anxiety experienced by those prone to schizophrenia is often a different kind of anxiety than what is experienced by those with a social phobia. Ontological anxiety (discussed as ontological insecurity by Laing (1959), as a loss of basic assurances) does not pertain to objects within the world, but to a feeling that the very foundations of self-existence are tenuous or threatened. The world may not feel like an invariant given, but instead feel threatening, enigmatic, or unreliable (Parnas et al.,

2005). Moutousis et al. (2007) are right to say that the "perception of threat is a central feature of paranoia almost by definition" (p. 497), but the perception of threat merely refers to the anxiety component present in delusional experience. This experience of anxiety, considered as a variation of the kind of anxiety in anxiety disorders, captures nothing of how it manifests as part of a self-disturbance, which would involve more than feeling threatened or overwhelmed. The very sense of self as a stable perspective for experiencing would be under attack—an anxiety rippling through a loss of foundations—and an appearance of a world that reflects the tenuousness of the threads that compel its feeling of being real. This kind of ontological anxiety seems quite different from very focused anxious concerns about how one is being evaluated by others and from even the more diffuse anxiety of Generalized Anxiety Disorder, where the world that is threatening is a stable world. The stable world is, after all, one ruled by natural relationships, and it affords the opportunity for forming tangible, albeit catastrophic, expectations about future events.

How Should Affective Life Be Characterized in Delusions and Schizophrenia?

The relevance of depressed mood and anxiety to delusions makes understanding the delusional state easier. But characterizing the overall feeling state of delusional experience in schizophrenia may be a more difficult task than at first appears (Sass, 2004a)—and the focus on depression and anxiety may be more misleading than clarifying. Characterizing the emotional qualities of the delusional state—let alone claiming that the report of similar emotions in psychosis and non-psychosis implies no essential differences—requires a greater survey of their lived qualities.

At least some investigations of emotional life in schizophrenia suggest that basic or normal forms of emotion are not clearly revealed or manifested in some patients (Kring, 1999). As captured in descriptive labels such as poverty of affect, typical emotions may be absent, diminished, or felt but unexpressed. In this sense, basic emotions are, in a way, uncharacteristic of schizophrenia and by extension, of delusions in schizophrenia.

However, affective life in schizophrenia may be of a more paradoxical nature. Sass (2004a) suggests there may be a diminishment of normal, basic, *inhabited emotions*, but an exaggeration of other feeling states[23]. Basic emotions recede in importance to more subtle, ontological feelings about reality, the world, and one's relationship to it, which usually co-occur with a diminishment in the natural affordances of a commonly experienced pre-given, objective world. The changes usually manifest along with self-reflective psychological processes that involve an inward focus on primarily self-relevant, self-contained, even solipsistic matters, and changes in the lived body, perhaps experienced as fragmented or alien. These global changes in the normal relating to self and world induce feelings of a special variety. These feelings may be more akin to highly-charged intellectual feelings of awe, amazement, or ontological insecurity (Sass, 2004a; Sass & Pienkos, 2013).

This cautionary point—even if it is based primarily on phenomenological investigation rather than replicated empirical results—about the less-than-primary role of basic emotions may be particularly relevant for delusions in schizophrenia because emotions are typically conceived in terms of action-readiness or dispositions to act in relation to objects, with some implication for a behavioral state (Frijda, 1986). Delusions

in schizophrenia often lack these qualities of emotions (e.g., delusions may not refer to matters that are objective; they may not serve as a basis for action; and they may not have the objective call-to-action as something serious—something needing an immediate response (Bovet & Parnas, 1993; Sass, 1994, 2004a, 2014)).

Such complexity in characterizing emotional and affective life in schizophrenia, and the delusions associated with it, problematizes claims that they can be best modeled with an analogy based on paradigmatic emotional disorders such as major depression. This is not to say that the study of emotional disturbance in psychosis should be neglected or dismissed. The radical changes in the experience of selfhood identified by phenomenologically-oriented psychopathologists *should*, in theory, entail dramatic changes in moods, feelings, and emotions, and these changes should affect psychotic experience itself. It is, however, not clear that anxiety or depression capture the affective state of delusional experience—there is nothing particularly apt about depressed mood or anxiety that captures feelings specific to or characteristic of delusional experience. Thus, it may be misleading to place emotions such as depressed mood and anxiety at a prominent place in understanding delusions in schizophrenia, even though they may have some explanatory role, especially as an index of risk for mental health problems. This analysis also indicates that showing the relevance (however powerful that relevance is) of depression and anxiety to delusions is not sufficient for claiming that there is no qualitative difference between psychotic and non-psychotic experiences. Furthermore, any claim that uses the experience of depression as if it were a excessive and disruptive variation of normal human mood risks minimizing the pervasive phenomenological

changes associated with depressed states, which can involve qualitative transformations in normal ways of relating to self and world (Ratcliffe, 2014).

Schizotypy: Interpretations, Measurement, Continuity, Health, and Spirituality

The claim that there is a continuous relationship between delusions and non-clinical beliefs also rests on evidence, commonly cited by CBT theorists, that psychosis and psychotic-like symptoms can be detected in the non-clinical population. This line of evidence challenges more directly (than does research on neurosis and delusion) theories about the qualitative differences between non-psychotic and psychotic experiences and beliefs. There are numerous accounts and studies of evidence of that purport to find psychotic symptoms in the non-clinical population (e.g., Freeman, Pugh, Vorontsova, Antley, & Slater, 2010; Johns & van Os, 2001; Peters, 2001; Peters, Day, McKenna, & Orbach, 1999; Strauss, 1969; van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009). Proposals for the notion of the non-pathological (or non-clinical) nature of would-be psychotic experiences were spearheaded by estimates of psychotic experiences occurring in the general population. For example, as much as 71% of college students endorsed the experience of hallucinations (Posey & Losch, 1983).

More recent studies examining the extent to which schizotypal traits are present in the non-clinical population provide different estimates, perhaps reflecting the use of different measures among studies (that may, for example, assess for different ranges of experiences). For example, Johns et al. (2004) found 5.5% of respondents from the general population reported psychotic or psychotic-like experiences. van Os, Hanssen, Bijl, and Vollebergh (2001) found a prevalence rate of 17.5% for psychotic or psychotic-like experiences (broadly defined)in the general population. Linscott and van Os (2013)

found the prevalence of psychotic experience at 7.2% via meta-analysis. van Os et al. (2009) conducted a systematic study of prevalence studies and found that the median prevalence rate for subclinical 'psychotic' experiences is around 5%.

A difficulty with this evidence, however, is that it is not clear what exactly is being measured in studies of psychotic experience in the non-clinical population, nor is it clear how the results of such studies should be interpreted. As will be discussed below, there is no clear measure of 'schizotypal experience'—one that unambiguously identifies the at-risk, disorder-related forms of traits—and there is no measure, in studies that identify schizotypal traits in the general population, of subjective experience (as opposed to symptoms or *forme fruste* symptoms). A clear measure of subjective experience (i.e., the phenomenal experience of symptoms) is what would permit a claim about pathological schizotypal experiences being qualitatively similar to the experiences occurring in the general population. Nor is there a theoretical model of schizotypy that clearly advocates for interpreting such schizotypal experiences as merely a quantitatively exaggerated form of psychotic experience, i.e., schizotypal experiences as less exaggerated psychotic experiences, differing only in intensity of expression or only in terms of level of distress.

History of Schizotypy and Its Influence on Continuity Research

The evidence for psychotic or quasi-psychotic experiences in the non-clinical population is at least partly born from the concepts and measures used in early identification paradigms of psychosis-proneness research. Central to psychosis-proneness research is the concept of schizotypy. Theories of schizotypy have long involved considerable debate about whether psychotic-like experiences and traits always reflect

psychopathological processes or whether they instead should be regarded as pronounced forms of non-pathological personality traits. This literature gave rise to counterintuitive notions such as the 'happy schizotype' (McCreery & Claridge, 1995), which describes a subset of persons who show many features bearing a likeness to the symptoms of schizophrenia without the distress associated with these experiences, and whose schizotypal traits might actually confer psychological advantages. How to interpret the clinical status of these non-clinical, but schizophrenic-like individuals is still very much an open question that, at times, sounds closed[24].

This debate centers on the question of whether such individuals are merely adjusting relatively well given unfavorable heritability or whether they constitute a healthy minority—a healthy (not merely pathology-absent) schizotypal personality. In neither case, however, is there a license for claiming that the experiences of schizophrenia-prone individuals (or those prone to delusional experiences) and those with schizophrenia are the same as what is seen in 'healthy' forms of schizotypy or from individuals who endorse phenomena that show a resemblance to schizotypal traits.

Even self-ascribed 'fully dimensional' models of personality and psychosis incorporate a quasi-dimensional model on the issue of psychosis (Claridge, 1997, pp. 13-15). This incorporation ostensibly includes a preservation of qualitative difference between the kinds of experiences involved in healthy and psychotic forms; that is, the differences involved in healthy and psychotic 'schizotypal' experiences are not exhausted by a quantitative estimation of distress, preoccupation, or disability. In this sense, fully dimensional models can claim that full dimensionality incorporates a medical, taxonomic, or categorical model within it (though the traits associated with illness are distributed

more continuously than as suggested by a categorical/medical/taxonomic model). This preserves the claim that there are discontinuities between healthy and psychotic variations. One might say that when clinical disorders occur, there is a qualitative difference between the non-clinical and clinical forms of schizotypy[25].

Thus, even if schizotypal experiences (e.g., delusional ideation) are identified in the non-clinical population, a major theory of the *continuous* distribution of schizotypy makes no strong claim for that continuity; if anything, it recognizes categorical differences within the continuous distribution of traits. The lack of 'perfect' continuity would seem to apply especially to the lived experiences of persons with non-clinical and clinical forms of schizotypy [26].

What Do Schizotypy Scales Actually Measure?

Even if there were a theory of schizotypy that clearly suggested that (healthy) schizotypal and schizophrenic experiences were continuous with one another, a form of measurement error complicates the interpretation of results. A methodological feature of research measuring subclinical psychosis is that it uses psychometric instruments that can measure psychological phenomena that are not necessarily even schizotypal in nature—that is, phenomena that are not necessarily the developmentally significant phenomena of schizophrenia-spectrum disorders. Disappointment regarding the extent of false-positives identified in high-risk research, for example, led to new instruments to address this very issue (e.g., SIPS). The 'problem' of false-positives is, of course, partly a function of the quality and specificity of measures of psychosis-proneness and our ability to target phenomena that are unambiguously distinctive of schizophrenia-spectrum disorders. Lenzenweger (2015) comments, "There could be many reasons for people to report PLEs

[psychotic-like experiences] in the general population—ranging from liability to schizophrenia, liability for bipolar disorder, through anxiety states, borderline personality disorder, drug-related experiences, alcohol-related experiences, religious experiences, sleep paralysis, and so on" (Lenzenweger, 2015, p. S485). In other words, the identification of experiences is non-specific. To some extent, then, measures of schizotypy are so in name only.

Aside from hypothetical reasons respondents might endorse subclinical psychosis in the absence of 'true' subclinical psychosis, it is particularly well documented that measures of subclinical positive dimension phenomena (positive schizotypy) and measures of the positive symptoms of schizophrenia can register both psychopathological and spiritual experiences. There is considerable empirical evidence that the phenomenal properties of schizotypal and religious, spiritual, paranormal, and mystical experiences overlap (Byrom, 2009; Jackson, 1997; Thalbourne, & Delin, 1994). Measures of schizotypy (or at least those measuring positive dimension traits such as delusional ideation) may, then, unintentionally function as measures of these marginal psychological phenomena[27]. This would mean that it is possible to identify spiritual experiences under the guise of 'schizotypal' phenomena in the non-clinical and non-schizotypal population.

Even so, the spiritual experiences possibly identified would not be 'qualitatively similar' to normal modes of experience; they would instead be non-normative, exceptional experiences, for there is nothing ordinary about profound transformative experiences that are religious or spiritual in nature. To rephrase Lenzenweger's (2015) comment in terms of a known empirical occurrence: There is no way to know whether psychosis, subclinical psychosis, religious, spiritual, or paranormal experience are being

measured (unless, of course, one assumes that these diverse phenomena are really expressions of a single phenomenon. See below for additional discussion of this possibility). Whatever is the case, none of these types of experiences involve merely a quantitative metric separating them from normal states of consciousness.

Rather than discovering that schizotypal traits such as delusion-like ideas are present in the non-clinical population and are not qualitatively different from normal beliefs, researchers studying responses to measures of positive dimension schizotypy may instead be rediscovering James' (1902) insight that 'seraph and snake reside there side-by-side.' This eloquent characterization implies that psychosis and spirituality are two classes of exceptional states—i.e., non-normative forms of human experience—involving altered consciousness, that seem to share many features, including deviation from traditional truth claims, changes in the normal salience contextualizing objects of self and world, and an ineffable, or at least language-challenging, quality. Interpreted in more contemporary terms, this insight from James would predict that religious and spiritual experiences overlap considerably with the positive symptoms of schizophrenia, and this may signify more about the intricate relationship between spirituality and psychosis as *exceptional* states of consciousness rather than (to serve as an illustration of) the relationship between normal variation and psychosis[28].

This issue of spiritual and religious experiences overlapping with psychotic-like symptoms is squarely present in an often-cited study (Peters et al., 1999) within the CBT literature as representing evidence for the continuity of delusions with non-clinical beliefs. Peters et al. (1999) found that, in terms of their measure of delusional ideation, a psychiatric sample could be distinguished from a sample of persons affiliated with new

religious movements only on the dimensions of controllability and distress associated with the delusional ideation. Both groups had similar levels of delusional ideation. The interpretive temptation in these results is to assume that there is no essential difference between non-normative religious beliefs and delusions—that they differ only in terms of how distressing they are. Hence, the claim is sometimes, 'it is not what one believes but how one believes it.' This study is certainly interesting, but both persons prone to delusions and persons employing non-traditional religious beliefs share premises that are not consistent with conventional and naturalistic interpretations of events—a principle formal characteristic of the content of delusional and quasi-delusional beliefs—and using such premises may indicate a loosening or a broadening in standard interpretive frames for experiences[29]. This creates a basis for their beliefs to overlap on measures of non-traditional interpretation, but the overlap is suggested without an invested measure of how their experiences differ. Nor is there an investigation of the basis for their non-standard interpretations. In this sense, the two groups might score similarly on a measure of delusion-like ideation simply because both groups reject, in some way, a scientific interpretation of events, conditions which would affect their report of non-traditional beliefs and *experiences*[30]. It is not clear why we should conclude from this study that there are schizotypal experiences present in the non-clinical population when the basis for the overlap in scores on the measure of delusional ideation is uncertain; the lived reality of these experiences is an open question.

Given that delusions and spiritual experiences, often involving altered states of consciousness, are "slippery subjective states," (Prince, 1992, pp. 281-282), it is just as plausible to suggest that studies like these show the limitations of our tools of

measurement, a point which applies not only to broad identification of likely independent kinds of experiences but also to the correct identification of the kind of psychopathology targeted for measurement. Schultze-Lutter et al. (2014) recently commented that measures of self-reported psychotic-like experiences, such as the Peters Delusion Inventory, are "highly sensitive but far too unspecific, as they would have detected nearly everyone with mental problems presenting at the early detection center, including those without any mental disorder" (pp. 199-200). Even in the absence of empirical studies documenting such a correlation between spiritual experience and psychosis-proneness, one would think that an instrument that is not specific enough to target latent or gradients of schizophrenia-spectrum symptoms would be especially likely to conflate other, *non-ordinary* experiences of consciousness[31].

Interpreting the meaning of responses to measures of psychotic-like experiences is not straightforward. A careful interpretation is that what is being measured in studies is the *report* or endorsement of certain experiences or beliefs. What those experiences and beliefs are, and what their report actually means is a far more difficult issue to determine. Since it is not clear what is actually being measured, it is questionable to use research on the report of schizotypal experiences in the non-clinical population to suggest that we discard any non-quantitative distinction between normal beliefs and delusions[32].

Phenomenological Insensitivity of Measures

Measures are also insensitive to aspects of experience that are difficult to operationalize, which can lead to a confusion between the measurement and report of behaviors and the actual lived experiences—lived experiences not only of symptoms but of the broader context of experiencing self and world as well. Questionnaires and

structured interviews have been criticized by phenomenologically-based psychopathologists as insufficient for revealing how experiences and symptoms manifest and what they mean for the purpose of psychopathological interpretation (Norgaard, Sass, & Parnas, 2013). In this sense, psychiatric measures of schizophrenia and schizotypy are not true measures of phenomenology but instead target the report of phenotypic representations of symptoms. This represents something of a misapplication of clinical attention: Our study of disorders uses minimal descriptive characteristics for defining the disorder and our study of their liabilities uses less expressive forms of these characteristics (e.g., schizotypy as a less pronounced form of schizophrenia). On both accounts, one is forced to accept the limiting descriptions of symptoms (a state that some clinicians and researchers acknowledge about the DSM, e.g., Andreasen 2007; Strauss, 2011) rather than the rich experiences that are the subject matter of schizophrenic phenomenology (see also Parnas & Jansson, 2015). The rich experiences may be the phenomena that most likely provide the distinctions between clear-cut symptoms and their liabilities, as well as for psychopathology and non-clinical experiences, while the minimal description of the phenomena of interest may contribute to the appearance of sameness in experience across the spectrum. Recent work has even diminished the distinctiveness of more definitive forms of psychotic experience, with the finding that first-rank symptoms are not necessarily indicative of psychosis but psychopathology more generally (Mitchell, 2015; Morcillo et al., 2015). It is worth reminding ourselves that Bleuler did not even consider delusions and hallucinations to be the primary or essential characteristics of schizophrenia, favoring something far more subtle and difficult to measure, commonly referenced as a splitting of affective and intellectual

psychic functions, and perhaps involving a disturbance in self-experience at its core (Parnas, 2011)[3334].

Conflation of Categories: Psychosis, Normalcy, and Spirituality

As noted above, the fact that certain schizotypal and psychotic experiences appear to overlap with certain non-psychotic experiences and beliefs may suggest more about our measures and our concepts of psychosis than it does our need to deflate the concept of psychosis. Jackson and Fulford (1997) explored this issue after they found that spiritual persons, who were not psychotic, gave responses that were consistent psychotic symptoms. They suggest: Either we need to treat both spiritual and psychotic experiences as a single phenomenon (in which both kinds of experiences share a common factor such as schizotypy), or we should improve our ability to measure and/or define them so as to avoid category conflation. The cognitive approach seems to have, perhaps inadvertently, constructed a theory of delusion formation that clearly falls on one side of this dichotomy and in doing so, has normalized psychotic experience—or, seen from a different perspective, invited the category of psychosis as an important guest to the house of spiritual experiences.

The cognitive account seems implicitly committed to coming down on one side of the dichotomy noted above. In assuming that all anomalous experiences (or their report) are alike because they do not take a definite and distinguishable form until persons react to them, the cognitive position seems to reduce all anomalous experiences to a category of a single kind—a tension to be alleviated only by how an individual reacts to the anomalous experience. This may not be an explicit claim in cognitive theory, but it is built-in as an assumption in the model itself[35].

A plausible alternative characterization of this range of so-called psychotic-like phenomena is one that would identify the ostensibly various and phenomenologically distinct experiences that exist within this broad spectrum of anomalous experiences. This would include a positing of substantial variations within the category of anomalous experience and would require an examination of ways to identify the chief characteristics of religious, spiritual, schizotypal, paranormal, and psychotic experiences as different forms of anomalous experience. Such an attempt would need to be sensitive to the holism unique to these different forms of experience as well as the associated phenomenal features they share. In other words, the position favored here does not deny that the different experiences share certain features (e.g., espousing unconventional or non-scientific claims and beliefs; experiences that reveal new aspects of the world and one's place within it). Instead, it is a strong assertion that the overall feel of each of these experiences—the holistic quality that constitutes their character as lived phenomena—is distinctive, well beyond what can be captured by a consideration of subjective distress. Thus, at least in terms of phenomenology, these varieties of experience are not reducible to a single category (e.g., spiritual experiences are not psychotic or psychotic-like). The disturbed self-experience intrinsic to many of the delusions found in schizophrenia provides a partial justification for this claim. Justification is also to be found in the institutional, cultural, and intellectual bodies that provide the narratives for conceptualizing 'psychotic experiences' and 'spiritual experiences' as distinct and totalizing forms of life[36].

In this part of the paper, I have examined the views of Jaspers on the un-understandability of delusions and broadened, to some extent, the motivating reasons at

stake in his claim of un-understandability by connecting his thought to more recent phenomenological analysis, especially the ipseity-disturbance model of schizophrenia. I have also critically examined the evidence commonly provided by cognitive theorists that supposedly supports the notion that delusions are on a continuum with non-psychotic beliefs and that the anomalous experiences associated with delusions are likewise common in the non-clinical population and therefore are not qualitatively different from non-psychotic anomalous experiences. In both cases, I found reasons for being cautious about the notion of a continuum being applied to the beliefs and experiences associated with (primary) delusions. For Jaspers, I offered a more detailed reading of his insistence that primary delusions involve a qualitatively distinct form of experience that challenges natural comprehension. For the evidence that delusions and psychotic experiences are continuous with beliefs and non-psychotic experiences, I found numerous methodological deficiencies that limit the appropriateness of such an interpretation of the evidence as well as phenomenological considerations that suggest that our understanding of delusions and psychotic experience can be somewhat obscured by our customary measures and ways of thinking about such phenomena. I will now turn towards an analysis of the cognitive theory itself on the issue of anomalous experience, delusion, and continuity/ quantitative variation and also sketch some pathways to create the theoretical space required for cognitive theory to align itself with phenomenological insights on delusions, should cognitive theory be so inclined.

Chapter III

Scope of Revisions for Cognitive Models and CBT for Delusions

This analysis suggests that the cognitive account of delusions would show more consistency with phenomenological accounts of delusions by 1) revising how anomalous experiences are conceptualized, and 2) building on the strength and power of existing cognitive models by enhancing sensitivity to the phenomenological dimensions of delusions. This would include reducing the emphasis on conventional, content-based ways of categorizing delusions (e.g., paranoid vs. religious), taking into account the alterations in self-presence, and considering the ontological basis of delusion by attending to the lived world. These are all important aspects of some delusions that a belief-based model of delusion fails to consider – e.g., there are no experiential transformations recognized. All of these suggest additional avenues related to treatment, such as the identification of *kinds* of delusions as moderator variables—not only paranoid versus grandiose but empirical versus ontological. These suggestions at least provide a rationale for targeting experience, rather than belief, as a primary intervention for the treatment of delusion. Addressing these issues would also involve some degree of re-acceptance of Jaspers' (1963) concept of primary delusion which, as noted by Delespaul and van Os (2003), in their defense of a quantitative view of delusion, "has all but disappeared from the diagnostic process and assessment instruments" (p. 286).

The basis for all of these revisions is, to some extent, traceable back to the assumption of a psychosis continuum, which minimizes the need to investigate psychotic anomalous experiences. The assumption that an underspecified and broad category of anomalous experiences -- thought to be relevant to delusional formation -- are normal (or

at least non-pathological) and commonly occur in non-clinical populations might be seen simply as a clinical tool: It provides a justification for using a normalizing rationale in therapy to help patients with delusions feel less marginalized or strange about the fact that they have such experiences. However, as illustrated in chapters I and II of this paper, the assumption of continuity has multifaceted consequences for the cognitive model. We can now distill them more clearly.

Theorists are seemingly forced, via the assumption of continuity, into the view that the anomalous experiences associated with the formation of stable delusional beliefs cannot be the locus of delusion – since they are in fact relatively common occurrences outside of the clinical population. Likewise, given that all anomalous experiences have the same potential for being healthy or distressful/delusional until persons interpret the experiences, the locus of delusion cannot lie in the anomalous experience. The assumption of a psychosis continuum also extends to the way that delusions are defined as beliefs. It provides a rationale in which it is sensible to treat delusional beliefs as an extension of normal forms of belief rooted in an intersubjective and shared experience of the felt sense of reality present to all. They are beliefs like any other, capable of being entertained and accepted or rejected by other people. Being another variety of beliefs, there is thus no need for a special interpretive theory for understanding these anomalous experiences and their distressing delusional explanations—an interpretation based on what is distinctive to persons with schizophrenia-spectrum disorders and with the liabilities for such disorders. Both of these consequences (that anomalous experiences have no intrinsic ‘psychotic’ value and that delusions require no special interpretive theory situated to the unnatural lived dynamics of delusional experience) reflect the

minimization of the nature of the delusional experience. It is, however, the very delusional experience that contains the essence of delusion (at least for primary delusions), according to phenomenology. The CBT framework of parceling out anomalous experiences and distressing interpretations also leaves the cognitive account with a fragmented vision of delusional experience itself, one in which it is sensible to separate feeling, experience, and cognition and also to focus on 'delusional' or at least 'distressing' post-experiential elements that are less central to the *experience* of delusion.

As I will argue below, CBT and cognitive models for delusions do not even need to claim that delusions are continuous with normal beliefs, nor do they need to defend the questionable evidence on which claims of qualitative sameness are made. One need not assume the continuum theory of schizotypy in order to argue that delusions are understandable and comprehensible. Delusions only need be comprehensible while still doing justice to the phenomenology of them; continuity is not a requirement. In addition, considering that some models grant an explanatory set of variables (e.g., schemas, information processing biases, perceptual dysfunctions) which serve as major contributing factors to the occurrence of anomalous experiences as well as to the formation of delusional explanations, it may be that the claim on the normalcy of delusional experiences is not only unnecessary but also untenable.

The point is not, of course, that 'normal' and 'neurotic' psychological processes are irrelevant to the modeling and treatment of delusions in schizophrenia. Numerous empirical studies show that there is a place for more basic emotions in explaining delusions—to say nothing of the success of well-trained clinicians using CBT as a means for exploring and understanding experiences associated with schizophrenia and delusion.

It is to say that there are aspects of experience that are more crucial to the lived experience of (primary) delusions that need to be considered in cognitive models (or at the very least, experiences of anxiety and depression need to be highly contextualized within a schizophrenic lifeworld, especially as these symptoms may reflect the unfolding of the disease process itself). Phenomenological studies suggest other phenomena are far more effective in describing the lived experience of primary delusion. These include awe, the feeling of being profoundly different, feeling that one's experience of oneself as a person has changed, existential terror, a deep foreboding, fragmentation of objects in perceptual experience, derealization, profound insight, quasi-deification, ontological euphoria, nihilism, and self-reification (Jaspers, 1963; Sass & Byrom, 2015b). Of course, one is reminded here of the limitations of current research, as well as the difficulty operationalizing subtle psychological states. But this is not a reason to fail to acknowledge the *circumscribed relevance* of emotions like anxiety and depressed mood. They should be treated as such rather than heralded that their relevance means affective life in primary delusions is different only in degree from non-delusional, non-schizophrenic states.

Reconsidering the Nature and Role of Anomalous Experiences: Increasing Specificity and Deepening Cognitive-Experiential Dynamics

In placing emphasis on the cognitive reactions to anomalous experiences, the cognitive model does put a fine point on the issue of how to define delusions (i.e., as cognitive reactions to anomalous experiences which lead to distress). However, the concept of anomalous experience is relatively underspecified, and it is inconsequential for defining delusion. In the cognitive conceptualization, anomalous experiences function

as a catch-all concept, encompassing a variety of states. For example, Steel and Smith (2013) state that unusual experiences "may include hearing voices, strong déjà vu, dissociative experiences such as derealization and intrusive thoughts or images" (p. 5). Smith et al. (2006) give heightened perceptions and "thoughts experienced as voices" (p. 182) as examples of anomalous experiences. For Freeman, Garety, Kuipers, Fowler, & Bebbington (2002), the concept of anomalous experience seems more specific, and they use examples far more relevant to phenomenological investigation (e.g., an uncertainty in inner and outer boundaries), but even here, these anomalous experiences only serve a role in the model in bringing forth the search for meaning, a process that leads to delusional explanation. There is nothing intrinsically useful in the experiences for defining delusion[37].

The logic of the cognitive model implies that the only way to distinguish these merely anomalous phenomena from phenomena of clinical interest, i.e., delusions, is by analyzing the experiencer's reaction to the anomalous experience, i.e., when it is distressful, an outcome determined by cognitive factors (e.g., biases, schemas, attributions) and perhaps emotional mediators, it becomes pathological, and thus delusional (but of course, not qualitatively different). If attention is redirected back towards the *experience* in defining the character *and* (pathological) outcome of anomalous experiences, it is sensible to suggest that there are actual differences among these diverse sets of experiences. It thus becomes reasonable, and perhaps necessary, to examine the processes involved in anomalous experiences to determine if there are characteristics and mechanisms that vary for non-delusional anomalous experiences and delusional experiences. When Garety et al. (2007), for example, say that in the vulnerable

person, "stress triggers particular emotional and cognitive changes, resulting in anomalies of conscious experience" (p. 1378), the crucial issue is *who* is the vulnerable person and *what* about their vulnerabilities contribute to the particular quality of their anomalous experiences. And *how* do these factors influence the particular character of the anomalous experience?

The schizotypal individual exhibiting forms of ipseity-disturbance constitutes a distinct kind of vulnerable person, which makes the anomalous experience qualitatively different from someone not prone to disturbances in self-presence. We might imagine, for example, someone who has anomalous experiences without disturbances in self-presence. The two individuals would both have anomalous experiences, though the two experiences would differ due to the presence of self-disturbance.

The characteristics of delusional anomalous experiences in schizophrenia might involve gradients of disturbed self-presence, hyperreflexive shifts in consciousness (especially awareness of normally tacit structuring of experience), the delusional mood, a diminishment of natural affordances, and changes in the felt sense of reality. These are facets of experience that are less clearly tied to cognitive reactions to experience. They are the constitutive elements structuring experience itself, perhaps along with cognition at some level. Future study that examines the possibility that there are such differences in experiences may improve the ability of cognitive models to account for the full phenomenon of delusion and to enhance interpersonal understanding in treatment settings. It may also lead to additional research questions, such as whether the nature of experiences does, after all, play an important role in defining the character of the clinical

delusion *and* a role in determining the properties of the cognitive reaction to the experience.

Opening up the nature of experience as a major determinant in defining the character of delusion also frees the cognitive model from having to make assumptions regarding the normalcy of anomalous experience. In doing so the cognitive model would be saved from certain quandaries inherent to it, as discussed below.

Previous cognitive models of positive symptoms at least seem to have the theoretical architecture necessary for incorporating the notion that there are distinctive forms of anomalous experience—some of which would be distinctive of delusional states in schizophrenia, while others might be distinctive of paranoid delusions, jealousy delusions, and non-delusional, non-pathological forms of experience. Garety et al. (2001), and Kuipers et al. (2006) include in their models basic cognitive dysfunctions (such as information processing deficits) as a contributing mechanism to the *occurrence* of anomalous experiences. The same is true of Freeman et al.'s (2002) model of persecutory delusions. The significance of the mechanisms or psychological factors that would contribute to the occurrence of an anomalous experience has implications that are little considered for a position that emphasizes the *ordinary* (and non-distinctive) nature of anomalous experiences. Namely, if the mechanisms that help explain the occurrence of *delusional belief* formation also help to explain the occurrence of the *anomalous experience*, then the relationship between the anomalous experience and the (pathological) delusional belief must be more causally connected than would be supposed by a theory that attributes no remarkable phenomenological or causal properties to the anomalous experience (beyond a search for meaning).

It would be important to specify the mechanism(s) that lead to the occurrence of anomalous experiences. Taking a cue from the mechanisms hypothesized to underlie delusional belief formation in cognitive models, these dysfunctions might be constituted by the cumulative effects of biases such as jumping-to-conclusions, but this seems more relevant to post-experiential cognitive processes (e.g., as reactions to anomalous experiences; e.g., jumping to conclusions may contribute to increased conviction in delusional beliefs (Garety et al., 2005). The dysfunctions might be more basic, involving sensory or perceptual processes. These dysfunctions might be linked to disturbances in information-processing, whether of the kinds of disturbances discussed by Hemsley (1992, 1998, 2005) or Frith (1992), or the mechanisms might include any number of considerations, such as reasoning biases, negative schemas, and negative affect, whereby much if not all of the common cognitive mechanisms or explanatory terms are included (Garety et al., 2007).

Alternatively, and more simply, negative self-schemas, such as 'I am weak' may predispose individuals to information-processing biases that lead to a sense of threat in an anomalous experience (Garety et al., 2001). This is certainly consistent with much of CBT theory more generally. Such an account would at least provide some basis for linking schemas with the threatening feeling found in some anomalous experiences (e.g., a belief in one's weakness or ineptitude may prime for feelings that one might the fall prey to the influence of exterior forces), but it is not clear why negative self-schemas would produce an anomalous experience. Nor is it clear how one would explain the 'excess' of persons who are prone to anomalous experiences by virtue of having a negative schema yet never seem to experience them. In other words, and at a more

general level, why should emotional and cognitive factors, if just like the processes operative in anxiety disorder, induce the kind of anomalies in conscious experience when they do not in anxiety disorders?

What can be discerned here is an overlap between the factors that are *brought to* and partly determine the occurrence of the anomalous experience and the factors that contribute to a cognitive reaction being delusional or being benign. This would seem to imply that the very factors that cause an experience to be distressing and hence delusional also affect the experience itself by exerting an influence in the generation of the anomalous experience. If those factors (e.g., particular information processing biases) are unique to delusion in that they specify when a belief is a delusion rather than a non-clinical belief, then those factors that are unique to defining delusions are also responsible for the anomalous experience, thereby lending a unique, and one would think, delusion-specific character to the anomalous experience. Obviously, if the anomalous experience is generated by delusion-specific factors, then the anomalous experience can't be 'normal' or 'non-psychotic' or 'non-pathological' in the sense claimed by the cognitive model, because the anomalous experience already admits to delusion-specific conditions in its generation[38].

The causal network whereby delusion-specific factors apply to interpretive cognitions and to experience itself is evident at the broader level of cognitive theory. Schemas, which are operative in all cognitive accounts of delusions—indeed, schemas are a defining mechanism in cognitive-behavioral theory—do not produce their effects only after experiences occur, at least in theory. Schemas affect the very nature of experience itself, by imposing themselves on the contents of experience and structuring

stimuli in various ways (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979; Padesky, 1994). Thus, invoking schemas as an explanatory construct entails the claim that all experiences are cognitively mediated, which would imply that there must be something distinctive about the character of (anomalous) experience. Thus, even the theoretical possibility of non-pathological anomalous experiences seems to be missing if we assume that schemas are what contribute to the occurrence of anomalous experiences.

If there are problems with the use of schemas and, and if reasoning biases do not pertain to anomalous experiences, then what seems most plausible is to use neurocognitive/neuropsychological theories based on the works of Hemsley (1998) and perhaps Frith (1992). Although such an incorporation is not typically explicit in the presentation of cognitive theories, Freeman et al. (2002) do attempt to integrate the work of Frith and Hemsley into the model. The same is true of Garety et al. (2007). The difficulty for the psychosis continuum assumption, however, is that the same relationship between causal origins, experience, and delusional belief noted above apply here as well. In fact, the implications play out even more clearly here.

Incorporating Hemsley and Frith complicates the cognitive model and its commitment to the psychosis continuum theory because the accounts of these respective thinkers include concepts and implications that are not easily incorporated into CBT models of schizophrenia[39]. The anomalies discussed by Hemsley and Frith both give rise to the anomalous experience and are expressed by it, which would suggest that the kind of anomalous experiences caused by these deficits are unique to the schizophrenia-spectrum (see Sass, 1992b, appendix, for a discussion of these theories in relation to schizophrenic phenomenology). Thus, accepting the relevance of such neurocognitive

mechanisms in explaining the occurrence of anomalous experience entails recognizing that the kinds of anomalous experiences of interest for studying (primary) delusion are different from other forms of anomalous experience unrelated to primary delusions. That is to say, there is a qualitative difference in the nature of the experience of anomaly.

Hence, not only does the assumption of the normalcy of anomalous phenomena rest on questionable evidence and appear to be unnecessary; the assumption seems to actually be an untenable position in the theories for *existing* cognitive models. The same is true for the muted role anomalous experiences play in defining delusion in the cognitive model.

The Distinction between Experience and Interpretation

The influence of cognition (i.e., how we make sense of events) on what we experience is undeniable, which is to restate the cognitive premise that, in some sense, experiences and moods can be changed by modifying cognitive framing. However, cognition and affect are intimately intertwined and admit to synthetic constructs, such as syncretic cognition (Buck, 1999). Such notions challenge the rigidity between affect and cognition prominent in cognitive models and serve as a basis for questioning the wisdom in empirically weighting the contributions of each. The same is true of the division between experience and interpretation (which CBT theorists might understand as 'facts' vs. the story about those facts). A nearness of cognitive and feeling states – a nearness implicated in the holism of phenomenal experience -- makes attempts to unpack the relative contribution of emotion and interpretations as elements in the causal chain seem unnecessary. Particularly, it is worth questioning the sensibleness of teasing apart experiences and interpretations as well as emotions and cognition in phenomena as

complex as delusions[40]. A tension in where exactly to place the explanatory stress is already present in the cognitive literature. Some cognitive models increasingly stress emotions in accounting for delusion formation, so much so that it is not clear whether cognitions are more primary than emotions in explaining delusions (Freeman et al., 2002; Garety & Freeman, 2003).

Indeed, the theoretical negotiation between emotion and cognition in accounting for delusions in cognitive models pollutes the clarity of their models. It is already very unclear just how emotions and schemas contribute to delusions in cognitive theory—they apparently work conjointly, but negative schematic self-models also are hypothesized to contribute to delusion independently of mood—at least in persecutory delusions (Smith et al., 2006).

Cognitive theorists are surely correct to stress the contribution of emotion to delusion formation, perhaps especially in the 'search for meaning' and in the disruption of cognitive processes. There are hypotheses, supported by empirical data, that emotions are actually the primary driver of cognitive dysfunctions (e.g., Mujica-Parodi, Malaspina, & Sackeim, 2000). However, the prospect of weighing the relative contribution of emotional versus cognitive factors in delusion formation leads to quandaries within the cognitive account. If emotions are equally prominent in explaining delusions, then why should the cognitive reaction to the delusion be the key determinant separating normal anomalous experiences and anomalous experiences with distressing interpretations (i.e., clinical delusions)? And although the growing emphasis on emotion in delusion formation helps to address shortcomings in the overly cognitive nature of accounts of delusions, to say that emotions play an important role in triggering certain cognitive

biases, which then give rise to particular attributions and explanations, is to move much closer to the experiential properties of the delusional state itself. Where exactly do the 'emotions' of the anomalous experience and the 'emotions' of the reactions to the anomalous experience admit to a separation? This explanatory move towards emotion seems to implicate the lived experience of the delusion itself rather than the cognitive framing of it, which would seem to directly challenge the cognitive definition of delusion as cognitive reaction, explanation, attribution, or belief[41].

It is important to note, however, that focusing on emotion itself should not exhaust the theoretical foray into the nature of delusional experience if the goal of the model is to achieve greater phenomenological validity. There is an importance to experience (what is encountered in immediate experience, e.g., perceptual processing, ontological quality of the lived world) in determining cognition. As argued by Skodlar et al. (2012), interpretations, attributions, and cognitive biases reflect the underlying experience.

For example, Garety et al. (2007) reference the importance of the externalizing bias in the formation of persecutory delusion (for a troubling finding for this theory, see Daalman et al. (2011), a study which found that persons with psychotic disorders were more likely to attribute their auditory hallucinations to an internal source whereas persons who hear voices but are otherwise healthy were more likely to attribute their voices to an external source, often paranormal in nature). Here, the basic idea is that persons encounter an experience that they cannot explain, e.g., an auditory hallucination. Via a failure to engage in an effective form of considering alternative explanation and, perhaps, because a failure to review available evidence sufficiently (i.e., jumping-to-conclusions

bias), in conjunction with other information processing biases related to the schemas employed, the patient makes the attribution that the source or cause of the unusual experience has come from without—from an external source such as a government-created device capable of generating thoughts in persons remotely.

Such a belief, when seen as an attribution about the source of one's experience, suggests that it is something imposed on top of the experience—almost as if the unusual experience had no inherent property inducing this attribution or, at most, the attribution is a reflection of the schemas that provide the cognitive contours to the experience. Attending to the anomalous experience, however, along with a consideration of the background conditions of the experience, suggests that the belief expressed is not a reflected conclusion but a direct expression – even a verbal mirroring—of the existential foundations of the experience—its pre-conditions. If we observe this externalizing bias shown in the delusion of a government-created device that can generate thoughts in persons remotely, several clues can be identified which indicate the transformation in ontology central to many schizophrenia-spectrum experiences. Notably, there is a belief in the ability to produce thoughts at a distance, a belief that thoughts can be physicalized or mechanized in a transmitting device (and the corollary belief that it is possible to have thoughts without a thinker), a belief that one can experience thoughts that are not one's own, and a belief that the government has some interest in controlling one's thoughts. When taken together, these look less like beliefs than like a whole network of altered experiencing in which the perspective assumed finds it sensible that the nature of thought and thinking can work this way. This is not a web of beliefs 'arrived at' but a mode of experiencing that gives this web of beliefs a pre-reflective intelligibility[42]. It expresses

the characteristics of the anomalous experience itself rather than exemplifying a set of rational conclusions all designed to explain an unusual experience.

All of these features certainly suggest that there is more to the phenomenon of an externalizing bias than attributing the source of one's misfortunes (or unusual experiences) to external factors rather than internal factors (or attributing one's successes to external factors rather than internal factors, as might be the case in depressive and some anxiety disorders such as GAD). The very basis on which such attributions take place seems quite different—not a firmly experienced self whose dysphoric mood insures a heavy stagnancy of self-experience and whose attributions are governed by the rule that the origins of success cannot possibly be based in one's actions or abilities. The basis is distinctive: Given the presumably impersonal feel of the thoughts and an associated loss of thought ipseity, there would be a *lack* of the sense that one is hearing one's *own* thoughts being spoken by an impersonal other. They are distanced from ownership, origin, and agency and are located in a kind of transformed cognitive machine with new and special properties. Such a delusion seems to constitute a very complex *non-conscious* form of spatialization in the experience of self. One's actual thoughts are said to occur outside one's mind, and they are said to be located in a device. Though there is a connection between the thoughts one has and the thoughts contained in and generated by the device, these 'device-thoughts' are not experienced as one's own, hence non-conscious spatialization. In other words, the patient reporting this delusion is not simply identifying a part of herself, such as her mind, in an external object, as might be the case with some primary delusions. Rather, the patient is not even aware that she is experiencing her thoughts in this manner: It is not her mind; it is not her thoughts. When

the layers of such an experience are peeled back in this manner, calling this an attribution, a misidentification in the appraisal of the source of 'one's thought' seems to miss the most salient features of how experience has been altered in cases such as these. All of the features above arguably are implicit in the cognitive/Frithian concept of aberrant source monitoring, but it is easy to lose sight of them when they are conceived of as an attribution bias. The cognitive processes involved in such an attribution for the source of unusual experiences do not speak to the profound alteration in the way thought is normally experienced as one's own. It is such an alteration that provides the logic and intelligibility for the externalizing attribution regarding the source of experience—the conditions of this experience 'call for' the attribution, if it is even correct to say that there is an attribution. Furthermore, these features of thought and self-experience might be accompanied by a passivity in the mood, which, far from being marked by threat, anxiety, obsessiveness, or dysphoria, pertains to a diffuse feeling of ontological oppression from the world, whereby one's sense of autonomy diminishes, fluctuates, or collapses according to how the world seems to manifest a feeling *against* the patient (Parnas et al., 2005). All of the above elements are implicit in the broader structural feature of a lack of demarcation between inner and outer. Also, externalizing biases may be relevant to some forms of persecutory delusions, but such a bias does not seem consistent with phenomenological descriptions of psychotic states that involve seeing oneself as the cause of everything (Stanghellini & Monti, 1993), nor with solipsistic delusions, which seem to involve a kind of internalizing hyper-salience that 'misattributes' the origins of the world to one's perception of it (Sass & Byrom, 2015a).

Freeman et al. (2002) are surely right in saying that only a "multifactorial understanding of symptom development and maintenance adequately reflects the phenomenon" (p. 332), but it is not clear that parsing out the relative contribution of various biases, schemas, and emotions will produce the most valid results for accounting for 'the full phenomenon' of delusion, especially when a) the emotions of interest are not the defining features of affective life in delusional experience, b) the schemas (of self and world) are underwritten by unstable first-person perspective and hyper-reflexive attention towards the basic conditions of experience, and c) the biases and attributions reflect the ontological transformations and modes of experiencing. It is worth suggesting that the conceptual grip/perceptual hold feature in the ipseity-disturbance model of schizophrenia perhaps gives theories of 'cognitive reaction' the necessary breadth for including the role played by emotion and affect, as well as pre-reflective attunement (which is partly conceptual and perceptual) to intersubjective reality and other lived realities, in conceptualizing delusion.

Enhancing Sensitivity to Delusional States: Delusions as Beliefs and the Wavering of Intersubjective Attitude

The analysis given in this paper suggests that the cognitive model of delusion varies considerably in its ability to explain the phenomenon of delusion. The cognitive model seems to hold quite well in certain cases. It is reasonable to suggest that the model holds well for what Jaspers' (1963) termed 'delusion-like ideas,' some of which would include paranoid delusions in schizophrenia. The patient who, in a state of paranoia, experiences intense anxiety while talking to a psychologist for the first time might jump to the conclusion that the psychologist is really a detective seeking to collect an

admission of guilt for crimes the patient wrongly believes he committed. Here, treating the delusion like a variation in a normal but mistaken belief holds well. Certain *kinds* of paranoid delusions seem to fall within this delusion-like model: Freeman et al. (2002) openly admit to a focus on persecutory delusions because they seem, at first blush, to share many of the maintaining factors associated with anxiety disorders. Persecutory delusions tend to be distressing, are common, and they are the type of delusion that most likely functions for a basis in acting. All of these characteristics conform to the features of empirical delusions or delusion-like ideas[43]. In addition, regardless of whether a delusion is delusion-like or is primary or ontological in nature, cognitive theory seems very helpful for linking personal, biographical elements in lived history to the contents and themes in delusional utterances.

Yet, there are other cases (e.g., Jaspers' primary delusion) in which treating the delusion like a normal belief becomes less plausible. Schreber (1988) cautioned that his persecutory delusions lacked any kind of analogy in normal experience. Experts recognize an "enigmatic character" (Liddle, 2014, p. 526) in many delusions found in schizophrenia.

Knowing when exactly delusions are empirical (and thus the cognitive model holding) and when they are ontological is a key question—and indeed there may well be mixed or intermediate states. The delusion of the patient who claimed that she was the 'Second Coming of Christ' might easily be classified as empirical or, just as easily, ontological, because such a determination is difficult or perhaps impossible to make by a consideration of belief-content alone. For evaluating whether a delusion is ontological or empirical, the plausibility of its content is far less important than what kind of experience

is associated with the delusion and what kind of attitude is associated with holding the delusion.

There are three complications here. They pertain both to the ways others understand the meaning of delusional utterances and to how persons with delusions may apply their delusions to realities, some of which are intersubjective. 1) It is entirely conceivable that the same patient would experience both delusion-like ideas and ontological delusions at various times, thus requiring clinicians and researchers to be aware that a patient may report delusional beliefs that are ontological at times and empirical at times. 2) It is likely that what sometimes appear, by way of content, as delusion-like ideas are actually ontological delusions. 3) Ontological delusions may be applied, in the patient's mode of experiencing, to the world, much like empirical delusions or delusion-like ideas, but without the lived context that would make such a claim more embodied and intersubjective in nature. This third complication will be discussed further below.

It is possible that more localized *enframing effects* are operative in second case. 'Enframing' is a term used by Heidegger (1977) to capture the way that a technological worldview encapsulates our experience of what is objectively 'there' in the world. More liberally, one might think of enframing as the process by which phenomena manifest by virtue of the worldview that makes them sensible and real. Such a concept alerts us to the possibility that delusions could be ontological in nature, but the power of the cognitive model is such that the phenomena and particular qualities associated with ontological delusions are hidden in the theoretical gaze. Further, the particular qualities of ontological delusions can be molded by the cognitive model so that they appear to conform to its

explanatory terms and sequences (consider, for example, how easy it was to understand how a delusion of being Christ reflected a personal wish for justice in the world—a cognitive and empirical point of view. Being sensitive to possible alterations in self and world, however, suggested the possibility that this delusion expressed how this patient was experiencing herself. The privatized nature of her concern makes it unclear if the delusion is intended to apply to the world, as an objective state of affairs—a phenomenological point of view).

Such an enframing effect might also contribute to the sense that the content of a delusion has been understood: Even while it is possible to a) identify links between the delusion and biographical history (which would be the primary avenue for making delusional beliefs and reasoning for those beliefs understandable, e.g., by way of inference chaining), b) identify distortions in thinking that seem to fit in mapping how a person came to believe a particular delusion, and c) locate a recognizable (impressionistically clear) emotion (e.g., anxiety) amid the creeping, looming, tortuous, and liberating atmosphere of the delusional state, there is still a remoteness in understanding *how* exactly a person can actually believe something so contrary to the beliefs and perspectives typically shared by others (and, presumably, by themselves until the emergence of the delusion)[44]. For example, even though 'I am the second coming of Christ' may express the wish for justice for past bullying, it is not clear *how* the patient can believe that her delusion is true and that this is the best way for her desire for justice to be expressed. In a sense, viewing delusion in this manner is a kind of wish fulfillment: The delusion of believing that one is Christ is an expression of a wish to be powerful and punitive in the interest of making the world just. But if we treat this claim like a normal

(even if dynamically misplaced) utterance from within an intersubjective attitude, viewing the person expressing this claim much as a religious person expressing their felt closeness to a divine being, are we missing something critical about the nature of their experience—something that would be different and unexpected if we assumed a normal experience of self and world? And are these delusions really understood, much like I understand, as a point of view I can actively take up and imagine, what my colleague means when he says that love is the universe's ultimate principle (which is surely a non-physical, quasi-spiritual belief recognized as a subjective claim about what is ultimately true of the world or the nature of existence)? Or are these delusions connected by explanatory terms that allow us to see certain connections while obscuring our attention to the fact that the claims expressed carry with them their own communication of falsehood -- or at least their intended non-intersubjective nature? Such qualities are perhaps discernable via the praecox-feeling applied to delusions. They seem to carry a very subtle, almost indefinable quality in their expression, a quality that nonetheless has the effective impact of signifying their special expression. It is perhaps such expression that drives the observation that delusions are easy to identify when they are operative but exceedingly difficult to define (Gipps & Fulford, 2004). All of this suggests the need to be sensitive to how variations in intersubjective attitude can give clues as to how exactly a delusion should be understood.

One is reminded here of the arresting smile of irony—perhaps a schizophrenia-laden irony—that sometimes accompanies verbalizations related to delusions (Sass, 1994). It is unclear what exactly these para-verbal and non-verbal signs signify, if there is any generalizable pattern at all in expressing a particular meaning. It is perhaps best

treated as a mark of ontological difference. The smile, for example, could be understood as a gesture of pity mixed with a solipsistic and metaphysical grandiosity implicitly communicating that one's interlocutor can never, owing to the nature of the delusional experience, enter into the perspective required to 'see' the truth of the delusion, because the perspective is the privilege afforded by one's own subjectivity, e.g., as if to say 'I have the answers or the truth about things, but I also know that it has nothing to do with the world that you call real—the one that you are duped into believing' (Sass, 2009; see also Stanghellini & Ballerini, 2007). 'Furthermore, it is only me who can know such things—the truth about things—because I know these things by the privilege afforded by my perspective, which provides a way of relating to the beyond. At most, I can *try* to tell you, but I know that it will blow your mind because of your inability to move beyond your own sense of the real. Telling you the truth will fall short because I know that you do not have access to the truth.' Similar sentiments are to be found in the expressions of mystics when they try to communicate their insight (Hood, 2003), though the experiences lack the solipsistic, perspective-dependent quality of delusion, thus permitting the possibility for objectivity -- a knowledge claim rooted in an experience that does not close off the possibility of intersubjective realization, i.e., it is intersubjectively present, objectively afforded to others, e.g., 'you will see it when and only when you know it.'

To clarify how clinicians might reach a path towards empathic understanding and to examine the possibility that delusional beliefs may not be held within an intersubjective experiential orientation, some of the revision here of the cognitive model should involve the reconsideration of attributing an intersubjective orientation (natural attitude or normal sense of reality) to persons with delusions as well as assuming that the

sense of self is largely unchanged. Both are part of the construct armament of the 'normalizing trajectory' utilized in CBT. This would require a sensitivity to the traces of disruptions in self-structure, which may very well be communicated in delusions related to body parts that are said to be missing, or to foreign objects that are present in the body, or in claims that one's identity has been totally transformed from the historical identity, or to the experience that one is somehow floating beyond one's embodiment, manifesting a partial identity in objects or the whole of nature. In particularly severe forms of self-disturbance, the possibility of taking a perspective may be closed off because the stability of perspective that would be required to assume a point of view wavers far too much. Jaspers' position on utter incomprehensibility may not be apt in such cases, but his position on empathy may very well be: The possibility of empathy is fleeting because the conditions (embodied perspectival constancy) required for taking an empathic stance have been too strained.

CBT for Ontological Delusions in Schizophrenia: A Rationale for Modifying Experience as a Therapeutic Goal

The heterogeneity of delusions (e.g., empirical delusions versus ontological delusions) suggests that all delusions should not be treated alike—both in terms of theory and therapy. To the extent that this holds, it would seem appropriate to develop distinct models and treatments for specific kinds of delusions. CBT for psychosis itself seems to be moving towards greater sensitivity to clinical presentation and towards identifying which interventions are most likely to produce beneficial effects for certain kinds of problems. Peters (2014) comments that CBT for psychosis "has now progressed such that it is no longer appropriate to simply lump together psychosis patients assuming that

clinical presentations are the same, that therapy is for the same problem, and that the type of CBT is the same" (p.160).

As discussed above, double bookkeeping, a well-known clinical phenomenon (Sass, 1994, 2014), is an excellent example of where an intervention focused on cognitive framing or on developing an 'evidential attitude' might be inappropriate. In solipsistic delusions, there is no need to validate one's perspective by way of evidence from the world, because whatever belief is espoused, it is done so through the horizon of the delusional mood.

Given how central the delusional mood is to defining delusion in phenomenological perspectives, a plausible therapeutic goal might involve changing the delusional state itself—as a primary experience of immediate meaning—rather than the beliefs or cognitive biases that reflect it. This might involve, among other things, greater attention to the power of socialization during therapy to disrupt a self-referential thought processes and a non-pragmatic stance towards one's experiences. Focusing particularly on successful communication and understanding of the delusional experience may foster in the patient the feeling of being understood, which in itself, may problematize the quasi-solipsistic state often involved in the delusional experience[45].

ACT, which can be considered as a variant of CBT, might be especially apt to address disordered experience as opposed targeting a modification in the contents of what one believes about one's experiences. Tai and Turkington (2009) have discussed the importance of developing more intricate models of the relationships between sensations, thoughts, feelings, behaviors, and environmental contexts to overcome some of the 'faulty thinking' conceptualization in some CBT approaches and to advance cognitive

therapy in a way that is more consistent with ACT's stress on the way thoughts are held or on how persons relate to them.

And more simply, an extensive analysis of the contents of one's experience—a deep exploration—may serve an especially important function in therapy. Extensive exploration of experience is already encouraged by CBT for psychosis. Exploration can be enhanced by using phenomenological considerations. Engaged, collaborative, and phenomenologically-informed exploration may seem like a modest form of help, but actually, when ontological delusional experiences can strain one's ability to understand what is happening or, even more basic, to even describe the experiences, the value in having a trusted partner to help patients find ways of expressing the unclear, the non-conforming, and the perplexing aspects of delusional experience into the language of consciousness and into the arena of intersubjective status may be particularly high.

In some ways, the inability of the language used by clinicians (in their efforts to develop a shared understanding of symptom formation) to resonate with what patients have experienced may leave patients feeling even less at ease. When the maps themselves do not seem to correspond to experience, the result can be even greater disorientation. Patients who are interviewed with the EASE instrument, for example, sometimes feel profoundly understood for the first time (Parnas et al., 2005).

Chapter IV

I have attempted to document the differences between cognitive and certain phenomenological approaches to delusions and, less focally, to note their points of agreement. Importantly, both approaches, as they are represented here, commit to recognizing the role of cognition and emotion (if loosely defined) in explaining delusions. Both commit to the proposition that delusions can be understood and that some degree of empathy is possible for delusional experiences. They differ on the terms that are required for explanation, understanding, and empathy. Most notably, cognitive positions deemphasize the importance of the anomalous forms of experience in defining and constituting delusion itself as well as any qualitative differences between delusions and normal beliefs. I have argued that such a view regarding the continuity of delusions and delusional ideation with non-delusional beliefs, a view central to the cognitive account, rests on interesting but problematic evidence. The fact that there are similarities in content and mechanisms between delusions and non-delusional beliefs should not draw attention away from their important differences. Furthermore, I have argued that the view of continuity is actually an untenable position within the existing cognitive theory. In the process, I have tried to show how the phenomenological reading of delusion can be integrated within and expand the cognitive account, given certain revisions in cognitive theory. Hopefully I have made clear that in considering ontological delusions against non-delusional experiences, we should be attentive to the fact that both kinds of experience involve a distinctive type of experience of being in the world and of the world itself. The major problem with the cognitive model is that it lays its understanding of

delusion on top of a schematic of normal experience, where there is no self-world alteration and, consequently, no change in the ontological status of claims.

Part of the appeal of normalizing anomalous experiences, e.g., of communicating the message that it is not uncommon to hear voices, is that normalizing these distressing and frightening experiences (and what they might mean) can be therapeutic. It may instill a sense of hope for recovery and de-stigmatize unusual experiences. Though this is a plausible rationale, it is not clear that it is in fact the best approach for modeling delusions in empirical work. In addition, for a patient who is more cognizant of the fact how their experiences differ from those of others, normalizing might be heard as a less than genuine acknowledgement of the reality of the experience and thereby close off deeper processes of clinical engagement. Sensitivity to what kinds of reality are in operation in delusional worlds has relevance to therapeutic alliance and case formulation as well. Ratcliffe (2008) puts the issue well, stating, "Changing in the sense of reality cannot be understood if one takes the sense of reality for granted when interpreting them" (p. 278).

The point is not that cognitive models and CBT for delusions have no value—nor is it to argue *against* the cognitive position in any straightforward way. The evidence that is consistent with the empirical predictions of the model and for the efficacy of the treatment speaks for itself. This paper has attempted to come to grips with how it is possible for cognitive models to be as apparently successful as they are when they are so dissonant with much of the phenomenological literature on delusions, especially with regard to the assumption of a natural attitude being present in delusions, the lack of change in how the self is experienced, and the unremarkable, or at least relatively

ordinary, nature of anomalous experience. The point is also not intended to be a debate on the nature of evidence, i.e., phenomenological versus cognitive-empirical. Phenomenology can, however, offer a type of perspective on subjective experience that is difficult to obtain with other methods. The phenomenological study of delusion is distinctive and, one might say, a supplementary perspective in the attempt to render what is actually there, given in the experience of delusion itself. Although the goal is not to infer mechanisms (Bentall, 2015), phenomenology has applications beyond its foremost goal of presenting as clearly, as accurately, and as concisely as possible the complexities of phenomena as lived experiences. It is capable of, at times, offering a hermeneutic account based on the conclusion of phenomenological insight.

The arguments developed in this paper represent an alternative perspective to the cognitive theory. Just as importantly, I have tried to identify what is necessary for cognitive theory to do in order to integrate the points from the phenomenological investigation of delusion. This paper also seeks to expand, wherever it makes sense to do so, on an already-powerful cognitive model and therapy for delusions, and to identify the clearest avenues for which such expansions might take. Such an attempt is actually consistent with the theoretical openness of cognitive perspectives, which tends to accept multiple levels of investigation. How exactly one can remain within a naturalized and mechanized approach to human experience while also being able to utilize phenomenological critique is an exciting interdisciplinary challenge, and is one that will likely become increasingly common, especially in the neurosciences (Gallagher, 1997; Northoff et al., 2006; Robinson Wagner & Northoff, 2016) and perhaps the cognitive sciences (Drayson, 2009).

It is worth emphasizing that the proposal here is not to re-assert a doctrine of incomprehensibility or to see in normal experience and delusional experiences "incommensurable linguistic universes" (Sass, 2004b, p. 73; Campbell, 2001). The position encouraged in this paper is not one of incomprehensibility but one of careful assessment and conceptualization in order to achieve relatively accurate degrees of comprehensibility, which is, in principle, entirely consistent with a cognitive approach. As Gipps (2010) notes, phenomenology has been a chief discipline in promoting the idea that delusions are understandable and in providing a way for how to understand them. Hence, the phenomenological claim is that delusions are at least partly comprehensible but do involve primary transformations in the structure of experience. There is no logical reason to conclude that if delusions are comprehensible, they must be qualitatively similar to non-delusional experiences.

A delusion cannot be properly evaluated by considering the relative presence or absence of certain kinds of aberrant or unconventional beliefs. One is not delusional by virtue of the beliefs one holds but by holding those beliefs in a delusional state. One does not have delusions but instead, one is delusional. CBT models offer impressive advances in our understanding of delusions and the treatment of them, but they run the risk of moving too far away from the phenomenon of delusion itself—what it is that defines the nature of delusion and what it is like to experience one.

There must always be a consideration of the lived experience of the delusion. Ontological delusions are defined less by their content (a delusion is not bizarre because of the impossible reality claims uttered) but by their mode of experiencing. Appealing to the presence of distress as a criterion for delusion is an incomplete representation and

perhaps even misleading. The lived experience must be broadened to include an assessment of how self and world are experienced, including an assessment of the delusional mood, for it is in the whole of the experience that the nature of delusion is contained. Otherwise, CBT for delusions and the cognitive models upon which they are based, will remain incomplete in treating and accounting for delusion as a phenomenon. A more adequate account by cognitive theory and CBT would seem to require some degree of non-ordinary description and modeling of experiencing.

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[1] There have been several studies questioning the efficacy of CBT for psychosis. These studies have been primarily aimed at making the case that the degree of efficacy has been overstated, especially in relation to other psychological and psychiatric interventions (Lynch, Laws, & McKenna, 2010). Such a view is certainly a minority view, at least in the published literature, though the commitment to empiricism among CBT researchers requires a skeptical attitude towards results, especially on the issue of methodology (see Tarrier and Wykes, 2004 for a good example of this). Recent accounts frame the implementation of CBT for psychosis as a matter of urgency (Thase et al, 2014), which reflects attitudes about how effective CBT is generally regarded to be.

[2] CBT for psychosis and CBT for schizophrenia should be treated synonymously for the purpose of this paper.

[3] Many of these factors function as potential resources rather than as essential or definitive elements in explanation, perhaps reflective of CBT's ultimate reliance on empirical studies rather than formulation of theory. See, for example, Tai and Turkington's (2009) discussion of how CBT is moving away from more purely cognitive explanations and towards a more dynamic conception of the relationships between thoughts, sensations, feelings, and environmental contexts.

[4] Garety and Freeman (1999) do not see these biases necessarily as information processing deficits, presumably because the capacities for probabilistic reasoning and hypothesis testing are actually intact but are underutilized due to the tendency to accept conclusion more quickly than justified.

[5] Note that this explanation bypasses the fact that the sense of persecution was present in the experience before an interpretation was ever given a more definitive form.

[6] There is perhaps a good deal of practical wisdom in this approach, but it goes entirely contrary to the notion of insight, which allows for individuals to be symptomatic and treated without having an appreciation that they need to be treated (e.g., they make no causal claim regarding distress and their symptoms). It also, perhaps implicitly, defines the pathology in the distress rather than the symptom; if an experience is not distressful, then it cannot be a symptom, one is inclined to observe by following the logic. More will be said on these issues and the quandaries they create within the cognitive account in Chapters II and III.

[7] Here, the issue is not centered on whether or not delusions and other symptoms of schizophrenia have meaning—i.e., whether they have psychological significance —but how exactly that meaning should be interpreted.

[8] The contrast between delusions as meaningless versus meaningful is a common refrain in CBT accounts, e.g., "Rather than being un-understandable, beliefs in psychosis often reflect personal histories and so are meaningful in the context of anomalous/life experiences" (Mander & Kingdon, 2015, p. 65). Statements such as these perhaps reflect some uncertainty as to the role of biographical history in explaining delusions and the actual basis for un-understandability in Jaspers' thought.

[9] The presence of such extremes may be endemic to work on delusions more generally. Consider Klee's (2004) dichotomy of delusional types, an example from the philosophy of mind: Either delusions are 'stark,' in which the content of delusional beliefs are not sensible in any explanatory framework (categorically inexplicable) or they are 'pedestrian,' in which delusional beliefs are mistaken beliefs that are nonetheless clearly

understandable, requiring no special effort for understanding (Sass, 2004b). Another example is the tone taken against the idea that delusions are qualitatively different experiences from non-delusional experiences: "The biased and selective focus on the extremes of the psychosis distribution continues to portray schizophrenia as a chronic, incurable condition, drawing away hope from patients and carers alike. Neither science nor clinical practice seems to be served by these qualitative distinctions" (Delespaul & van Os, 2003, p. 286).

[10] Bentall (1990, p. 284) rightly states that there is no simple distinction between psychosis and normal human experience. However, there is likewise so simple connection between them, and, as will be discussed in Chapter II, a connection based on a series of continuous points along a spectrum is insufficient so long as such a continuum does not admit to qualitative shifts at certain points.

[11] Others also place stress the interpersonal consequences of holding delusions. Brabban and Turkington (2002), for example, suggest that strongly held normal beliefs can be distinguished from delusions by the confrontational reactions others may have toward the often bizarre content of the delusion.

[12] In cognitive models, "anomalous experiences alone may not be transformed into frank positive symptoms of psychosis" (Garety et al., 2007, p. 1381). The anomalous experience is *never* sufficient. The locus of psychosis lies in interpretations given to anomalous experiences, and it is the distress, which is a consequence of the appraisal or interpretation, that distinguishes clinical from non-clinical psychotic experiences (Peters et al., 1999).

[13] A steep interpretive precaution based on these concerns is obviated, along with the need to consider non-cognitive aspects of experience (e.g., pre-reflective attunement) if, as assumed by the cognitive perspective, there is no basic rupture in experience that would require us to suspend our normal ways of treating claims as intersubjective. Note that this is not just a matter of treating delusional claims as imaginary, applying only to objects entertained by the mind. In this case, it would only be too easy to say that cognitive theory already recognizes such states, as in recognizing the reality of imaginary objects to induce anxious states. Normally, imaginary states are treated intersubjectively as just that: Objects of experience in which both parties recognize the constraints placed on what the one says is an imaginary object. Both parties know how to treat such objects for there is a shared understanding of the ontological status of the imaginary object.

[14] This applies to consciousness and experience more generally as well. One is reminded here of Merleau-Ponty's emphasis on the non-conceptual ways of knowing the world—bodily activation revealing predispositions to act according to certain perceptual and body schematics—as well as the new generation of cognitive science that views cognition as being more fully distributed in interactions with one's environment (e.g., via the concept of affordances) and bodily ways of knowing that situate one's experience in time and space.

[15] This is to say that primary experiences (in the phenomenological sense of the word) and beliefs likely do not function independently. Both likely play roles in rounding out a

fuller representation of phenomenal experience. The same is true of affect, a construct more widely acknowledged in psychology, which is perhaps best described as having a reciprocal causal relationship with thought and perhaps best modeled with nonlinear equations to better capture the interactions and bidirectional relations (Nowak & Vallacher, 1998).

[16] Some cognitively-inclined theorists have argued very reasonably on the problem of empathy, offering nuanced considerations such as, e.g., "behaviors and experiences may vary in degree according to how amenable they are to empathy. By not empathizing hard enough, we may fail to recognize the intelligible aspects of the other person's experiences" (Bentall, 2004, p. 29)). Although there is much here to agree with both in practice and in theory, there seems to be a loss of otherness: The limits of a non-delusional model of experience are bypassed.

[17] See Jaspers (1963/1997) for his own discussion of the issue of separating descriptions of experience from theory-driven description.

[18] It may very well be that 'true' schizotypal traits can be identified in the non-clinical population—and show a prevalence far beyond what would be predicted by 'categorically-based' models of schizotypy. It is potentially misleading, however, to suggest that such schizotypal traits would be normal, as in easy to interpret and understand, e.g., understandable in much the same way as some reporting on their feeling of anxiety and associated thoughts. The issue here is how easily what is said can be understood or comprehended without using some kind of rotation in how the statements are interpreted—a rotation in order to better match the sensibility of what is being said.

[19] These findings are integrated into the cognitive model in a fairly straightforward way. When negative affect is combined with propensity for hallucinatory experience or delusion, the risk for future delusions greatly increases. One can imagine how excesses in negative affect might overtax cognitive processing and coping. When delusion-like experiences are generated, negative affect would combine with cognitive variables such as reasoning biases to produce a level of distress which, if it is of sufficient intensity, would make the resulting belief delusional or symptomatic.

[20] Note that this would seem to bypass the issue that the emotional reactions to anomalous experiences are partly determined by the initial emotional conditions of the anomalous experience itself.

[21] Even more, to use the relationship between anxiety and depression and delusion as a line of evidence for supporting the claim that delusions are instances of extreme normal beliefs underemphasizes the qualitative difference between depression and normal mood states. This is a difference that can be expressed, in part, as a blankness, perhaps imperceptible to others, that gets in the way of a more intimate and uncomplicated way of relating to others (quoted from Ratcliffe, 2008, p. 288), and which can involve significant changes in the lived body (Fuchs, 2005).

[22] Also included in the comparison are the sense of time (a "collection of disarticulated snapshots" (Stanghellini and Raballo, 2015, p. 175) versus "Present and future are merely a repetition of the past" (p. 176), space (a breaking up of the fabric of the visual field versus the feeling of objects being too small or space too confining), bodily experience

(objectification of the body and fluid boundaries between the body and the environment versus devitalization of the body, including deadening presence, heaviness, oppressiveness), self-experience (hyper-reflexivity and diminished self-presence versus disturbances in reflective or narrative self, involving a consistent but highly inflexible personal identity), and social attitudes involving a preference on how to relate to dominant culture (a gravitation towards taking an eccentric stand against norms and an emphasis on uniqueness versus high identification with social norms and relation to common sense).

[23] This is not to say that basic emotions do not occur in schizophrenia--only that attempting to grasp the overall emotional life in schizophrenia reveals a kind of distortion in what we would expect to find in other persons and in other forms of psychopathology.

[24] Sommer (2010) remarks, "Few colleagues will currently doubt the existence of psychotic experiences in non-clinical populations" (p. 1959), and David (2010) characterizes this view as accepted dogma; meanwhile, Beauchaine, Lenzenweger, and Waller (2008) remind us that one of the most replicated findings is that there is a *discrete class* of persons who show a vulnerability to schizophrenia-spectrum disorders —a point apparently conceded, in some sense, even by those arguing for a dimensional model of schizotypy (see Rawlings et al., 2008).

[25] Recent work has, however, argued against this line of reasoning. van Os et al. (2009) state that it "may be argued that it would still be possible that multiple interacting factors contribute to an underlying continuous biological abnormality that, when a certain threshold is reached, gives rise to a dichotomous behavioural phenotype. Although this may be possible, it is unlikely given the fact that the biological and cognitive abnormalities associated with (the genetics of) schizophrenia have all been demonstrated to behave as linear risk indicators without evidence of threshold effects" (van Os et al., 2009, p. 180).

[26] Indeed, the *lived experience* of schizotypy and psychosis is at best a minor concern relative to the identification of empirically measured psychological constructs. Schizotypy research and projects committed to improving the early detection of psychotic illnesses are typically most concerned with the functional or pragmatic value of predictors, such that a particular type of symptom is potentially as interesting as demographic factor (e.g., male, low SES, immigrant status) if they both provide equal predictive power. The focus in these research frameworks is, then, principally obtaining powerful prediction models rather than clearly documenting the symptoms and 'the phenomenology' of early psychosis.

[27] Indeed, Daalman et al. (2011) even argue against the diagnosis of schizotypal personality disorder for their sample of 'healthy' voice-hearers because the magical ideation the research participants showed--via measures of schizotypy--were spiritual beliefs that, along with other possible 'symptoms,' had no clear ties to distress or social dysfunction, and the subjects showed no evidence of constrained affect. Of course this raises the questions: Are the subjects healthy schizotypes or are they non-schizotypal persons who resemble truly schizotypal subjects on certain psychometric measures?

[28] Jamesian scholars will perhaps take issue with my presentation of James, which fails to consider what, in James' thought, might be the origin of or the explanation for the overlap. That is, James' position is stronger than one focused on the overlap in

phenomenology between psychopathological and mystical states. My presentation of James here is primarily rhetorical. Considering James' full account of the shared origins of psychopathological and mystical states in the 'transmarginal region' of consciousness, whereby the emergence of anomalous phenomena is defined by threshold breaches between waking and transmarginal or subconscious forms of consciousness, would require considerable treatment of concepts and terms used in Jamesian psychology and phenomenological psychopathology, and this treatment is beyond the scope of this paper. However, one can't help but see something of a phenomenologist in James, especially in his treatment of spiritual experience in The Varieties of Religious Experience, the subtitle for which is 'A study in *human nature*' (the importance of this subtitle has been stressed by Hood, 2005).

[29] In addition, the finding that the contents of beliefs overlap is less meaningful when one considers that the content of the delusion is not even the defining feature of the true delusion, according to Jaspers.

[30] It is worth pointing out that variables that did distinguish patients from new religious movement adherents in the Peters et al. study are also problematic. Persons undergoing changes in religious outlook or a personal transformation in relating to the world are likely to be attuned to concerns that are totalistic in nature and may feel that they are on the 'receiving end' of a metaphysical metamorphosis. In addition, a change in worldview must involve some degree of distress, even if such distress resists measurement.

[31] The lack of clarity on whether 'true' schizotypal experiences are being measured by virtue of the inclusiveness in the concept of schizotypy and measures of it parallels, to some extent, the inclusiveness in the concept and measurement of spiritual experiences as well. Here, there are considerably broad classes of types of experiences and even within these classes, there are types. For example, religious conversion may involve sudden or gradual conversion experiences (James, 1902; Silverstein, 1988), and mystical experiences tend to be grouped in introvertive and extrovertive forms, each involving a distinctive phenomenology of loss of ego (Hood, 1975, 1976; Stace, 1960).

[32] As others have noted, e.g., Sommer (2010), regarding measures of psychotic and psychotic-like in the general population, "it remains illusive if the 13% scoring affirmative on one item…is phenotypically similar to the .35 scoring on three or more items" (Sommer, 2010, p. 1959). To address such issues, it would seem to require extensive clinical interviews and more information about the phenomenology of the experiences.

[33] Given the insufficiency of operationalized and structured instruments for capturing subtle aspects of phenomenology, interpretive caution is warranted when evaluating what exactly a theory of psychotic continuity means for the presence or absence of symptoms and the experience of symptoms. In denoting what the assumption of continuity means, van Os et al. (2009) state that it "implies that the same symptoms that are seen in patients with psychotic disorders can be measured in non-clinical populations" (van Os et al., 2009, p. 179). Although symptoms may be the primary ways we think about the nature of disorders as psychopathologists, the subjective experience of symptoms, along with non-diagnostic, non-symptomatic aspects of experience, form as essential aspect of

understanding the nature of a disorder. This is necessarily true given that all symptoms exist in and reflect subjective experience. Thus, it is not clear that the 'same symptoms' are being measured in clinical and non-clinical populations, because the experiential basis of these symptoms is not a focus of measurement. In addition, subclinical or schizotypal measures, by definition, are less pronounced forms of clinical symptoms, thereby demanding some sensitivity to the distinction between, for example, magical ideation in schizotypy and delusions of alien control in schizophrenia.

[34] There is a similar issue noted in the literature on auditory hallucinations in relation to the psychosis continuum. There are studies that suggest that the differences between the auditory hallucinations found in a percentage of the non-clinical population and those found in persons with disorders such as schizophrenia are less striking than expected. For example, Daalman et al. (2011) found that, based on their measure of the phenomena, the most powerful distinctions between clinical from non-clinical groups were the negative affect associated with the content of the voices and the controllability of the voices (other significant differences included age of onset of hallucinations and frequency of hallucination). These differentiating variables are strikingly similar to ones identified in studies on 'psychotic' delusional experiences in the non-clinical population (e.g., Jackson 1997; Peters et al., 1999). These studies certainly provide a valuable source of information, and it is easy to understand how variation in controllability and the degree of negative vs. positive affect can be viewed as evidence for a quantitative view. They validate the wisdom of the cognitive perspective in defining delusions in terms of distress and negative affect. There is still, however, the difficulty that these studies beg for the interpretation that, because these given variables were primarily the ones showing significant variability, these are the only ways to distinguish psychotic from non-psychotic experiences—and it is, conveniently enough, it is a quantitative measure of (e.g.) intensity of emotional distress that provides the way. Moreover, Daalman et al. (2011) acknowledge that they are not clear on whether their results suggest clinical and non-clinical 'hearing voices' is the same phenomenon. Other investigators (Stanghellini et al., 2012) have recognized the limitations of studies on hallucination-proneness, and have provided evidence that when patients and non-patients are interviewed regarding their responses to measures of hallucination-proneness, there are definable differences (though most of the items discussed pertained to differences in beliefs rather than differences in hallucinatory qualities).

[35] It is here recognized that some, if not most, readers will find a single factor reduction of anomalous experiences non-problematic. Suggesting that it is problematic to interpret the 'psychotic symptoms' reported in the non-clinical population likely runs against the dominant assumptions in the field. For example, to recall Sommer (2010) once again: "Few colleagues will currently doubt the existence of psychotic experiences in non-clinical populations" (p. 1959). But as argued above, describing what is measured in the non-clinical population using non-specific (and non-phenomenological) instruments as quantitative variants of or even the *same* symptoms seen in the clinical population is at best an over-reaching interpretation. A cataloguing of the empirical possibilities of experiences registered in the measurement of 'psychotic experiences' includes a number of psychological phenomena such as (true) sub-clinical psychosis, spiritual experiences,

dissociative experiences, paranormal beliefs etc., all of which are not best considered as merely instances of anomalous experience. This is a category or type of experience too broad to serve as an effective grounding term for the psychological study of their variety.

[36] The argument that it is necessary to carefully attend to the phenomenal aspects of these anomalous experiences implies, of course, that there are important differences to be in the qualities of spiritual and schizotypal experiences, especially with regard to the constituting structures of experience. There are, in other words, not only functional (distress associated with holding a delusion or a failure to have one's beliefs meaningfully embedded in a rational dialogue with others) but also, and especially, phenomenological differences. And those phenomenological differences can likely be spelled out by those features catalogued in the ipseity-disturbance model of schizophrenia. Arguably, these are the features which drive the classical claim that a primary difference between psychotic and mystical states is that in the former, there is a lack of re-integration with the social world (Wapnick, 1969). The breadth of such a distinction demands that this difference must be partly defined by the functional outcomes of the experience (distress, maladaptiveness, or the far earlier proposal by James (1902), the 'fruits produced by the experience'), but it is easy to overlook the phenomenological bases behind these functional outcomes. The lack of 'recovery' from intense experiences of meaning in the case of delusions in schizophrenia—what, in other words is the lack of re-integrating—reflects the strained self-experience in which a) even that *fact of experiencing* is scrutinized and investigated, b) the sense of personal embodiment is disrupted, a de-locating of experiencing *in* one's body, c) a slowing down of the automaticity of thinking when engaging one's environment and interpersonal world, d) a diminishing grasp on the usefulness and meaningfulness of everyday concepts), e) a feeling that the foundations of experiencing both one's self as something reliably and indisputably always there – and that the world – might be taken away. All of this is suggestive of a kind of severe injury in which the customary intelligibility of always knowing oneself and effortlessly connecting to things and people within the world fades, leaving the terror of the unknown, annihilation, or the mystery of existence -- forming in its wake the tears and empty spaces of the previously presupposed, visible wrinkles that remind of the missing and the painful and thrilling transforming of something new.

[37] That being said, Freeman et al.'s (2002) model of persecutory delusions may be the cognitive model that is most consistent with the phenomenological viewpoint of delusion developed in this paper –at least in certain respects. This model gives more attention to anomalous experience even if it is deflated, responding to internal and external stimuli, and a possible equalizing of the relevance of cognitive and emotion factors via their feedback-qualities. (See also footnote below regarding Smith et al. (2006) and Garety et al. (2001)). However, there are also easily identifiable differences between Freeman et al.'s (2002) model for persecutory delusions and the perspective developed in this paper, e.g., if the nature of the anomalous experience is not clarified and, further, has no intrinsic value in defining the psychotic nature of delusion in the cognitive model, then the cognitive and phenomenological perspective are ultimately incompatible.

[38] A very careful assessment of this critique might note that because delusional beliefs are not really abnormal in the sense that they are merely extreme versions of normal beliefs, the processes that give rise to these delusional beliefs are also not exceptional. Thus, there is nothing unique to the conditions giving rise to either the anomalous experience or the delusional belief/cognitive reaction/interpretation because there is nothing unique or typologically substantial about either of these. This seems to be a coherent line of argument that could be used by cognitive theorists in order to theoretically justify the preservation of the quantitative view of delusions. However, at this level of argument, it is not clear just what delusion means other than a belief that is more distressing than other beliefs and which may impact and negatively affect multiple life domains (e.g., social, occupational, educational). This would seem to be a vote for the idea that the term 'delusion' has outgrown is usefulness as a clinical concept and symptom of illness.

[39] What are arguably kin views have been expanded to include a number of perceptual anomalies (e.g., Micoulaud-Franchi et al., 2011; Uhlhaas & Mishara, 2007; Uhlhaas & Silverstein, 2005), all of which are presumably specific to schizophrenia.

[40] The issue here, between cognitivistic and phenomenological perspectives, is perhaps less about the tendency to carve nature at its joints and more about where that carving takes place.

[41] Smith et al. (2006) come close to a focus on the emotional nature of the anomalous experience, rather than simply cognitive reactions to it, when they speak of "emotional changes" (p. 182) that "feed back into the moment-by-moment processing of anomalous experiences." The emotional changes then "influence their content, and perpetuate their occurrence." If such emotional changes blend with or directly influence the anomalous experience itself (i.e., if the emotional changes are not said to constitute post-experiential reactions to the anomalous experience), this would imply that the experience itself is somehow distinctive.

[42] This is a point that could *potentially* be massaged into the Freeman and Garety (2002) use of multi-attributional networks, a concept presumably designed to serve as linking points for following a sequence of thoughts in more systematic and complex delusions.

[43] The empirical delusion might well involve an anomalous experience too, as in the Freeman et al. (2002) model, but it would be a different kind of anomalous experience than the one implicated in primary delusion.

[44] This concept may recall the usefulness of Jaspers' distinction between explaining symptoms and understanding them. On the account presented here, it is the cognitive model that is actually in the position of explaining rather than understanding delusion in that it fails to account or explain delusion as a full phenomenon—delusions fully understood. Ironically, one could remark here that while Jaspers was clear in his contention that primary delusions were un-understandable owing to the nature of the phenomenon, the cognitive model unintentionally makes delusions un-understandable owing to the limitations imposed by the explanation and model of experience underpinning the explanation.

[45] One need not even use the phenomenological categories of ontological versus empirical delusions to see the relevance in targeting experience rather than beliefs as a therapeutic goal. Walkup's (1995) proposal for a special class of delusions that are un-

falsifiable presents a perspective on delusions broadly consistent with what is suggested here.