Chapter Four

4. Delusional Content: Anomalous Experience Reconsidered

4.1 Perceptual Versus Affective Anomalous Experience

In the last chapter we considered how Davies et al. (2001) specified the nature of the second factor as the person accepting an anomalous perceptual experience as veridical despite having rational grounds to doubt the veridicality of their percept. They then consider that if this is indeed the nature of the delusional error then we would expect people with delusions to do this same thing in response to other anomalous perceptual experiences such as the experience of visual illusion. Davies et al's account would thus seem to entail that a person with delusions should be routinely fooled by visual illusion despite evidence to the contrary. Davies et al. consider this prediction to be fairly implausible. While it is clearly an empirical matter whether people with delusions would be found to do this or not, I think it would indeed be surprising if this had not been noticed and commented on by family members and clinicians up until now.

Stone and Young (1997, p. 358) consider that

> the particular form of perceptual impairment we propose to account for the Capgras delusion involves a loss of affective reactions; whether one sees this as primarily a perceptual deficit or primarily emotional is in part a question of which label is preferred.

They do not elaborate on what other considerations might come to bear on this issue as to which label should be preferred, however. I would like to suggest that the problem of the unwanted prediction might well be one such consideration in the

sense that the problem seems to arise from taking the relevant anomalous experience to be perceptual rather than affective.

Stone and Young consider that people with prosopagnosia seem to have a perceptual deficit as they are unable to provide a name or biographical details which enable them to identify or recognize the person who is before them. People with the Capgras delusion are able to report that the person in front of them looks just like the person they have allegedly replaced, however. Stone and Young go on to consider that while in prosopagnosia the perceptual pathway is disrupted, in the Capgras delusion the disruption occurs on the affective pathway. Prosopagnosia would thus seem to be better described as the result of a *perceptual* anomaly while the Capgras delusion would seem to be better described as the result of an *affective* anomaly.

Davies et al's account can be modified so that it no longer entails the unwanted prediction. Instead of considering the delusional error to be in the acceptance of an anomalous *perceptual* experience as veridical despite rational grounds to doubt we can consider the relevant anomalous experience to be affective rather than perceptual. I think that it would indeed be surprising if a person with the Capgras delusion were found to exhibit an abnormal SGR to visual illusions. If they exhibit normal SGR to visual illusion and the relevant anomalous experience for delusion is affective rather than perceptual then we would have no reason to expect them to be repeatedly fooled by visual illusion. Perceptual anomaly that is unrelated to an inappropriate SGR may simply be the wrong kind of anomalous experience for the production of delusion.

4.2 A Familiarity Mechanism and the Production of Rich Content Anomalous Experiences

Maher (1999 p. 554) considers the content of the relevant anomalous experience to be a '*vague general feeling'* that something is different. If this is the content of the

anomalous experience for people with the Capgras delusion then there would need to be a step of inference between the content of the experience and the content of the delusional belief. Maher thus considers that delusions are *explanations* for anomalous experiences. In considering the role of attributional bias Stone and Young seem to be similarly thinking along explanationist lines where there is a step of inference between the content of the experience and the content of the delusional belief. Stone and Young consider that people arrive at a delusional explanation for their anomalous experience as a result of attributional bias, a tendency to jump to conclusions, and an acceptance of an explanation that is observationally adequate rather than appropriately conservative. Davies et al. diverge from the explanationist line. Instead they consider that the general content of the delusional belief might be given by the content of the anomalous experience directly. If this is the case then there doesn't need to be a step of inference between the content of the anomalous experience and the content of the delusional belief. What I want to do now is to attempt to cash this out a bit more with respect to offering an account of how a sub-personal cognitive level breakdown might be responsible for generating such a rich content anomalous experience.

Stone and Young did not explicitly consider the function of the affective pathway except to posit that a breakdown in this pathway results in the anomalous experience that is relevant to the production of the Capgras delusion. While this is very speculative I would like to suggest that the affective pathway may function as a low level recognition mechanism. It might be plausible to consider that such a system may operate on a low level so that higher level cognitive resources are available for alternative activities. The evolutionary advantage in having such a system would be that people would be able to quickly and automatically assess situations with respect to whether people, objects, places etc are familiar or unfamiliar. This would allow us to monitor for strangers and situations that might be likely to pose a threat. If this notion is plausible then we may have some reason to posit the existence of a fast, low level, primitive recognition system. It may be plausible to consider that if this mechanism were to malfunction and give a false

negative then the content of the anomalous experience may be 'this [stimulus] is unfamiliar to me' as in cases of Capgras and at least one variety of reduplicative paramnesia. In the case of a false positive the content of the anomalous experience may be 'this [stimulus] is familiar to me' as in the case of the Frégoli delusion, and déjà vu experiences in the case of objects / situations.

If there is a mechanism that operates as a low level recognition system then this may also go some way towards explaining why it is that they are not able to just ignore the message that the person / object is familiar / unfamiliar despite others trying to argue them out of their delusion. The pathway may be of use to us primarily because it delivers a fast and compelling verdict that is typically accurate. It might take a bit of time for a new part of the brain to take over the old function, for the person with delusions to learn how to consciously inhibit the 'unfamiliar' or 'familiar' message their experience is giving them, and / or for psychotropic medication to take effect to mute their anomalous experience. While this is rather speculative it would seem to go some of the way towards explaining how it might be that there are rich content experiences. If this is plausible then it would provide some support for Davies et al's line that the content of the anomalous experience may provide the content of the delusional belief directly.

The anomalous experience may be found to occur fairly reliably whenever the delusional subject experiences the object of their delusion. Aside from this anomalous experience the delusional subject may well have normal experiences, however. Positing such an anomalous experience with fairly specific content would thus have prospects for explaining why it is that the object of the delusion has been selected and why they have the general kind of delusion that they do. The 'alarm bells' signal that something is wrong, but more than that, they signal just what is wrong, namely that that stimulus which would have produced the strongest SGR prior to cerebral trauma is unfamiliar to them. We can also consider that the same delusional content may result from the auditory rather than visual modality as we saw in Chapter 2.

The difference between monothematic delusions and polythematic delusions may be that in the first case there is a deficit with respect to processing a specific kind of stimuli, whereas in the second case there may be a deficit in processing more of a range of stimuli. This may be plausible if we consider that monothematic delusions are typically found in association with fairly specific cerebral injury whereas polythematic delusions tend to be associated with people with psychosis and more distributed problems with neuro-transmission / structure that affect multiple areas of the person's brain.

Some theorists (e.g., Frith, 1992; and an earlier paper of Campbell, 1999) have postulated a mechanism to monitor the self initiation of actions and thoughts. If these mechanisms malfunction then that might lead to delusions of alien control and thought insertion respectively. Here the notion is that delusions of alien control may result from a breakdown in a mechanism that leads to the experience 'that is not my action'. Subjects with delusions of thought insertion may have a breakdown in a comparable mechanism so that their thoughts are experienced as being ego alien. Pacherie et al. (in press) have recently suggested that the notion of an external agency might even be implicated in the content of the delusional anomalous experience rather than being arrived at by way of inference or elaboration in their paper 'Phenomenology and Delusions: Who Put the Alien in Alien Control?'. While I shall not consider these delusions or the mechanisms that have been postulated in order to explain them in any more depth, these examples illustrate that different delusions may well result from different kinds of malfunction to different kinds of cognitive mechanisms.

If it is granted that there can be a fairly rich and specific experiential content then it would seem that we are able to bypass the problem of how the delusional hypothesis occurs to the person in the first place. Instead of considering the role of cognitive biases such as an attributional bias and a tendency to jump to conclusions the content of the anomalous experience for people with the Capgras delusion may be 'this person is unfamiliar to me' as the result of a certain kind of break in a

familiarity mechanism. It would seem that there is still a step of inference or elaboration to get the subject from 'this person is unfamiliar to me' to some of the more specific hypotheses that people have come to regarding the identity of the impostor, however. In Chapter Two when we considered the possible role of attributional bias in the production of the delusional hypothesis it was noted that this problem of specific content occurred in the positing of an attributional bias as well. It would seem that the specific hypothesis does arise as an elaboration or inference from the content of the anomalous experience. Once again, it is hard to know what more to say about this, though I shall attempt to say a little more later in the chapter.

People with the Cotard delusion often have depression and this depression has been found to result in the subject having a loss of SGR in general. Sass (2004 p. 73) considers that the subject with the Cotard delusion

> has lost the capacity to experience affect due to a global shutting down of affective processing in which "information derived from perceptual or cognitive channels have no bodily consequences"… such a person is conscious, yet his consciousness lacks a quality that has always accompanied his conscious experience, a quality that is, in fact, intimately allied with his experience as a living subjectivity.

It may be the case that a different mechanism is responsible for the production of an abnormal SGR in delusions of mis-identification (e.g., Capgras, Frégoli, reduplicative paramnesia) than is implicated in the Cotard delusion. If the person with the Cotard delusion has an experience of being dissociated from their body, or of being affectively numb or 'dead' then it may be the case that the content of the anomalous experience is quite different even though there is similarity between Capgras and Cotard with respect to comparable loss of SGR to familiar faces, and similarity between (one variety of) reduplicative paramnesia and Cotard with respect to comparable loss of SGR to familiar objects. If the anomalous experience

of people with the Cotard delusion is different from the anomalous experience of people with the Capgras delusion then we do not need to appeal to attributional bias to explain why it is that one person arrives at one of these delusions while another person arrives at the other. It may be the case that the anomalous experience of people with these different kinds of delusion is quite different. The finding of a genuine case of co-present Cotard and Capgras would provide some support for this notion as the attributional bias hypothesis would seem to rule out people being able to exhibit both biases and hence both delusions at the same time.

4.3 Observational Adequacy Regarding Experiences: Explanations Versus Reports

What I wish to do now is to go back to the two readings of observational adequacy that Davies and Coltheart suggested. As we considered in Chapter Three on the first reading of observational adequacy the data to which one's beliefs are supposed to be observationally adequate concern the external world object of the person's experience under the assumption that ones experiences are veridical. On the second reading of observational adequacy the data to which one's beliefs are supposed to be observationally adequate concerned the one's experiences in themselves rather than as being assumed to be veridical representations of the external world. Davies et al. eventually adopt the first interpretation of observational adequacy with respect to the veridicality of their experiences and are led into the problem of the unwanted prediction. While I have already suggested that their account can be clarified so that the unwanted prediction is no longer implied, I would also like to re-examine the alternative reading of observational adequacy where the data to which ones beliefs are supposed to be observationally adequate concern one's experiences. I would like to see whether there are prospects for furthering the explanation of delusions along these lines, especially in regard to explaining why it is that delusional utterances are retained with such a sense of certainty / conviction.

Davies and Coltheart (2000 p. 24) consider that if the delusional subject's error is in their adopting beliefs that are observationally adequate regarding their experiences rather than adopting beliefs under the assumption that their experiences are veridical then 'the overall account would need to appeal to something like attributional biases to prioritize the delusional hypothesis'. Davies and Coltheart thus consider that on the second reading of Stone and Young's observational adequacy requirement delusions are *explanations* for their anomalous experiences. They consider that there would seem to be delusional and non-delusional explanations for their experiences, however, and thus an attributional bias would need to be appealed to in order to explain how the person arrives at a delusional as opposed to non-delusional explanation for their experience.

Davies and Coltheart, (2000 p. 20) consider that this line seems problematic as 'The patients anomalous experience does demand explanation. But the correct explanation is that, as a result of brain injury, the patient is suffering from an affective deficit'. They maintain that if we attempt to take the subject to be explaining their experience then a problem arises in that the delusional explanation

> is no more observationally adequate to the nature of the Capgras patient's experience (seeing a face that looks just like their relative, but without experiencing the affective response) than any of a host of alternative hypotheses (Davies and Coltheart, 2000 p.21).

We have already considered, however, that there would not seem to be a host of alternative psychological explanations *for the subject's anomalous experience.* Appealing to 'brain injury' changes the level of explanation. If the person is attempting to come to a psychological explanation for their experience then it would seem that appealing to neurological deficit would be inadequate.

In Chapter Two we considered how Maher attempted to offer a psychological explanation of delusion by appealing to the anomalous experience of delusional

subjects. We noted that Maher did not attempt to offer a psychological explanation of the delusional subjects' anomalous experience in turn, however. Instead he considered that anomalous experiences were to be given a neurological explanation by recourse to underlying neurophysiological deficit. If the person is attempting to arrive at a psychological explanation for their anomalous experience and the only non-delusional explanations for their experience are neurological then it may be that there aren't any alternative explanations for their anomalous experiences at the level of explanation that is required. If this is the case then it may be that the delusional subject is behaving in a similar manner to scientists who may cling to an inadequate paradigm despite its obvious implausibility because until a suitable replacement is found it may well be the best explanation they have.

Another suggestion that has come up is that the delusional subject could simply preface their utterances with 'it seems to me as if…' or 'it is like…'. If they were to do this then they would not be considered to be delusional. If this is an alternative hypothesis then it would seem that there are non-delusional explanations available to the delusional subject and thus the second reading of observational adequacy may be insufficient to determine that the subject arrive at a delusional explanation for their anomalous experiences. It is an important point that 'it seems to me as though my wife has been replaced by an impostor' is not an *explanation* for their anomalous experience so much as a way of *reporting* their anomalous experience. Davies and Coltheart considered a direct content line as opposed to an explanationist line on the first interpretation of observational adequacy and it may be that there is a similar direct content / explanationist distinction to be made on the second reading of observational adequacy as well. I have already considered that if they are attempting to offer a psychological explanation for their anomalous experience then it may well be the case that there are no non-delusional alternatives to the delusional hypothesis. From this point I shall consider that they may simply be reporting on their anomalous experience to see whether this line can similarly lead the subject to endorse a delusional belief. We shall return to the 'as if' objection for the reports of experience model later in the chapter.

While delusions are typically considered to be beliefs, and irrational and radically false beliefs at that, it is worth laboring the point that all we have direct access to is the delusional subject's utterances that we considered in *Table 1*. To figure out the content of the delusional belief, or to figure out what the delusional subject is trying to say in making their utterance we are required to engage in translation. What we saw in Chapter One was that in the case of the Cotard delusion the term 'death' may be ambiguous. In the Cartesian model the subject was interpreted as attempting to express the belief that they do not exist as a thinking thing. In the biological model the subject was interpreted as attempting to express the belief that they are biologically dead. Here we have two quite different content attributions of the utterance 'I am dead' that would both seem to be licensed by standard usage of the term 'dead'. A third interpretation has been suggested by Sass (2004). He considers that although we may not be able to empathize with the delusional experience completely we may be able to grasp something of it by recalling times where we have felt a strange neutrality of mood, or as Sass puts it 'a diminution in the normal tonality of life'. He considers that in these cases we do talk of feeling 'dead' or 'deadened' and thus if the person was attempting to report on their state of affective non-responsivity with the term 'dead' then this would seem to be 'well within the extended penumbra of comprehensible meanings of this term'.

Maher, Davies and Coltheart, Davies et al., Stone and Young, and the APA definition of delusion are similar in that they consider the delusional subject to be making a false claim about the way things are in the world. They consider that the delusional subject realizes that their delusional belief is likely to be considered implausible by others, and thus they do not seem to have completely lost touch with normal rationality constraints. They also do not seem to have lost their grasp on standard meanings of the terms as they are able to use the words with which they express their delusional utterance appropriately in other contexts. If Sass is correct in considering 'emotional death' to be licensed by standard meanings of the terms then this may be a more plausible interpretation of the content of their belief. The

person may well realize how other people are likely to interpret their utterance, however, and this might be an alternative explanation for why it is that they seem to appreciate that others will find their utterance implausible.

4.4 Prospects for Delusions as Reports of Experiences

It is often thought to be a fairly significant problem for models of delusions that consider delusions to be false beliefs about external reality that in most cases people with delusions do not follow inferences we would expect and they do not act in ways in which we would expect were they to believe what they are saying to be literally true of the world. In the Capgras delusion, for instance, the person maintains that someone who is close to them has been replaced by an impostor. We might expect that they would attempt to talk to the alleged impostor to see whether they have access to the memories of the original. We might expect them to show some concern as to where the original has got to or concern as to what might have happened to them. Subjects with the Capgras delusion do not attempt to locate the original. They do not contact the relevant authorities to inform them of the disappearance of the original.

While we could attempt to attribute all sorts of other beliefs and desires to the delusional subject in order to make these behaviors rational given their delusion and their other beliefs and desires this is not a line that anybody seems to have pursued. Rather, these facts about delusional subjects most often not acting in ways we would expect has been taken to be evidence for their irrationality. It has also led some theorists to consider that delusions may not be appropriately classified as beliefs. I think that viewing delusions as reports of anomalous experience is able to solve the problem of inferential relations and the problem of inaction quite naturally. There wouldn't seem to be any obvious behavioral consequences for beliefs that the delusional subject has regarding their anomalous experiences as opposed to being left having to explain their circumscription if we take them to be making false claims about the external world.

In the last chapter we considered the rich content that Davies et al. assigned to the content of the anomalous experience. In this chapter I attempted to cash that out a bit more by considering how a certain kind of breakdown in a certain kind of cognitive mechanism could result in a rich content anomalous experience. If it is plausible that there is such a mechanism and that it could provide such a rich content anomalous experience then it may also seem plausible to interpret the delusional utterance as the person reporting on their anomalous experience, rather than arriving at the delusional content as a result of attempting to explain them. Davies and Coltheart (2000 p. 17) consider 'Experience itself may become the object of enquiry because it has been classified as illusory rather than accepted as veridical'. We considered this in the last chapter where Davies and Coltheart maintained that in the case of the pink elephant one's other beliefs would normally lead to the experience being classified as illusory, and thus the appropriate explanandum is not why there is a pink elephant in the room, rather it is why it *seems to me* that there is a pink elephant in the room. Davies and Coltheart continue, however

> this is not the only way in which our explanatory interest can come to be fixed on the nature of our experience rather than on events in the external world. In the case of some experiences, there is no question of a correct or incorrect presentation of how things are in the external world. Itches and tickles, for example, are not classified as either veridical or illusory, but they can certainly claim the attention of the person undergoing them (Davies and Coltheart, 2000 p. 17-18).

The rich content experiences of people with delusions might well be such experiences. Instead of considering the subject to be attempting to make a false claim about reality on the basis of their experiences, perhaps they are simply trying to report or express their experience as it appears to them. If this is indeed what they are doing then this would make sense of why it is that they are so very certain

about what they are saying. If they are reporting on their experience then they are entitled to be certain that things are in fact the way they seem to them to be.

One of the problems with interpreting the person to be making a false claim about reality was the point that people with the Cotard delusion did not consider it to be relevant to what they were saying that they were still able to walk around. Perhaps they did not find it relevant because they did not draw the implicit steps. It would seem that an alternative explanation for this might be because facts such as their being able to walk around are indeed irrelevant to their utterance. If they are reporting on their experience then those facts would be irrelevant as facts about the external world are irrelevant with respect to providing supporting or disconfirming evidence for one's experiences. This could similarly be the case for people with the Capgras delusion as on one level they may know that the person is their wife and so they do not search for her or mourn her disappearance. Yet on another level they no longer feel attached to her and thus things will not be as they were before though in some cases people with the Capgras delusion do go on to form amicable relationships with the 'replacement'.

Campbell writes that delusional beliefs seem to have been elevated to the status of Wittgensteinean framework propositions by which he seemed to mean that they are immune to supporting or falsifying evidence. Delusional beliefs seem to have taken on this quality where they seem to be beyond the reach of supporting or disconfirming evidence. If delusions are reports of experience then their framework status would be understandable as their claims would indeed be immune to supporting or falsifying evidence from external reality. If they are simply reporting on their experiences then they cannot be wrong, which may be why the delusion is held with such conviction. Their utterances would also not be in conflict with what they previously held to be true.

While Davies et al. enumerated the second factor as them holding on to their delusional belief 'despite rational grounds to doubt'; we would not seem to need a second factor if we interpret them as reporting on their anomalous experiences. This is for the simple reason that reports of experiences are comparable to reports of pains and tickles and other first person states. These reports are entitled to be held with conviction and there is no external world evidence that could either lend support to or falsify the subject's report of the experience that they are having.

4.5 Intensity of Experience and Delusional Certainty

Maher considered that the difference between delusional and non-delusional anomalous experiences was that delusional experiences are more intense and prolonged than the experience of non-delusional subjects. Maher was also particularly careful to emphasise that delusional anomalous experience is a severe variation on normal experience rather than being different in kind. Sometimes we do fail to recognise someone as being familiar to us. These mis-identifications often occur in bad light, or when we see a person in the distance, or when we see the person briefly from behind rather than when the person is standing in front of us pleading for recognition, however. One might consider that a big enough difference in degree may plausibly lead to a difference in kind. The specification of the content of the anomalous experiences that we have considered might be construed as being different in kind from the experience of non-delusional subjects, while not being so very radically different that we are unable to grasp and empathise with the delusional anomalous experience. While the everyday experience of the familiarity mechanism being briefly fooled is different from a reliable deficit in the mechanism, such an everyday experience may provide us the leverage we need in order to be able to empathise with the delusional anomalous experience. The same may be the case with the relatively normal experience of affective flattening and the Cotard subject's more intense and compelling experience of affective non-responsivity.

We have already considered that instead of saying 'I am dead' or 'my wife / cufflink / canary has been replaced by an impostor' the person could say '*it seems to me as though* I am dead' or '*it is like* my wife / cufflink / canary has been replaced by an impostor'. It was noted that these are not alternative *explanations* for their experience, but they would seem to be alternative *reports* of their experience. If the delusional subject is intending to report on their experience then we need an explanation as to why they insist on their delusional utterance instead of accepting one of these non-delusional alternatives.

People who develop the Cotard delusion tend to start out by making claims that they don't feel real or that they feel disembodied. As their depression progresses they end up concluding that they are dead. It might be that, as the depression progresses and their SGR progressively diverges from the normal SGR; their anomalous experience becomes correspondingly more intense. It may be that the force or intensity of the experience is what the delusional subject is attempting to capture with their delusional utterance. People with cerebral trauma wouldn't seem to have a progressive SGR discrepancy, rather the SGR discrepancy would be pre as opposed to post cerebral injury. In this case the onset of the delusion might be quite sudden. It may still be plausible to consider that they also have a similar force or intensity of experience, however, and it is this that they are attempting to capture with their delusional utterance.

The recurrence and intensity of their anomalous experience may lead to them repeatedly commenting on it, in a similar manner to how some people tend to repeatedly express that they are in pain. If another person attempted to question or deny our reports of experience then while philosophers would recognise this as an illegitimate move I'm sure we have observed people (and children especially) escalating in such situations. If people perceive another person to be doubting their authority on the matter then they tend to report their experience with all the more certainty and conviction than ever before. It is also a point that when normal subjects report that something is painful, they do not take pains to distinguish

between their first person experiences and what may or may not be the case in the world. They do not express their state of pain by saying 'it is *as if* I am in pain'. If someone were to question whether they were in pain or not then they may emphasise that they *really are* in pain, however.

Maher's appeal to intensity and duration has come under fire by other theorists. With respect to duration, in particular, it may be hard to see why this would make much of a difference. Surely it would be possible for a person to come to a delusion on the basis of a single anomalous experience. Delusions seem to be present tense rather than past tense, however. People do not present for neurological or psychiatric attention because they maintain 'my wife used to be an impostor but now she is herself again'. Instead, they present for medical attention because they maintain *that* woman *is* [*presently*] unfamiliar. We may thus consider that the delusional utterance would need to be repeated (with conviction) a fair few times before the subject is brought to the attention of a diagnostician. It would seem possible in principle for a subject to form a delusion on the basis of a once off anomalous experience, though it might well be the case that in practice the delusional experience recurs so as to lead to them repeatedly commenting on it, which has them ultimately considered to be delusional.

With respect to the intensity of the experience there is a concern that intensity of experience should be measurable. We might consider that the *difference* between the SGR that should have occurred and the SGR that did occur might be one measure of intensity of the delusional subject's experience. More work needs to be done with respect to compiling data on SGR to various stimuli in both delusional and non-delusional subjects. More work also needs to be done on the physical instantiation of the cognitive mechanisms that have been postulated in order to obtain the delusional content.

We have been considering that there are two very different things that the delusional subject could be doing in making their delusional utterance. They could

be intending to explain, or more plausibly report on the state of the external world on the basis of accepting their anomalous experience to be veridical (which is comparable to the first reading of Stone and Young's observational adequacy requirement). Alternatively, they may be intending to explain / report the nature of their anomalous experience (which is comparable to the second reading of Stone and Young's observational adequacy requirement). The APA defined delusions as being 'false beliefs about external reality' but it seems to beg the question to say that people who express the kinds of utterances that we considered in *Table 1.* should be interpreted as intending to describe reality.

It may be that many people who say things that are characteristic of certain kinds of delusions are classified as being delusional, and yet they intend their utterance to be an explanation / report of experience. It may be that only when they are making a false claim about the world that they are appropriately classified as delusional. In this case people with circumscribed delusions may well be inappropriately considered to be delusional because they do not meet the APA definition of delusion even though their utterances are taken to be fairly paradigmatic examples of delusional utterance. We could consider that people who are reporting their experience are not in fact delusional because delusions proper involve making a false claim about the world. But the other way we could go is to say that these people clearly are delusional and this shows the inadequacy of the APA definition of delusion. It seems that not a lot of philosophical import rests on this linguistic decision. Either way it seems that more people do not act on their 'delusional' utterances than people who do and thus a larger class of the utterances that we considered in *Table 1.* would seem to be better explained by the reports / explanations of experience model.

4.6 The Problem of Action and Elaboration

For any model that is able to solve the problem of inaction, there is a related problem that arises. How do we account for the relatively few cases where people

actually do act on their delusions? In an often cited case of this one man became convinced that his step-father was a robot and he decapitated him in order to look for the batteries and microfilm in his head. This seems a very strange thing to do if one is merely attempting to report one's anomalous experience. In another case one woman with the Cotard delusion cut herself in order to show other people that she did not bleed (Stone and Young, 1997). Where people do act as though they intend their claims to be true of the external world then it would seem that the report of experience model is inadequate and we are left having to conclude that the utterances that led to these people being classified as delusional really were intended as claims about external reality.

On Davies et al.'s account of the nature of the second factor the nature of the delusional error was considered to be the retaining of this the content of the anomalous experience as being veridical despite evidence to the contrary. At this point one may well wonder whether the delusional belief comes into conflict with what they previously knew to be true, however. In the case of the Capgras delusion the delusional hypothesis may be arrived at on the basis of an internally generated 'feeling of unfamiliarity' in response to the person. I am not sure to what extent this belief conflicts with what the subject previously knew to be true. Hohwy & Rosenberg (forthcoming) suggest that delusions may be a function of the recurrence of the anomalous experience where there are no alternative ways to reality test. The notion here is that typically we can reality test the information provided by one sensory modality with information provided by another sensory modality. We can check things we hear with what we can see, and what we can see with what we can touch. They consider that the nature of the anomalous experience of delusional subjects is one that is not able to be tested by any alternative sense modality. In the case of the Capgras delusion I would like to consider that the experience of unfamiliarity may provide information that is not duplicated by any other mechanism. One might want to maintain that the remaining perceptual pathway and the beliefs that result from that would be enough for reality testing; however, this does not seem to be the case. I would like to suggest that the reason for this is

that the affective response system delivers a more basic and compelling verdict that may take priority because of the evolutionary advantage of monitoring for strangers and possible threat potential. It might also be plausible that the content is not amenable to reason in the same way that some affective experiences have been found not to be.

There is evidence that basic emotional responses (when measured as SGR) can come apart from cognitive evaluation (beliefs) as when a person exhibits a heightened SGR to a stimulus that is presented subliminally and is thus inaccessible to consciousness. Here the perceptual pathway does not get the opportunity to process the stimuli to the point where the person can report on what stimulus was shown to them. Subjects with a phobia of snakes were found to display heightened SGR to pictures of snakes but not spiders or mushrooms, however. People with a phobia of spiders were found to display a heightened SGR to spiders but not snakes or mushrooms. Neither of these groups were able to report the stimulus that was shown to them but they did display a heightened SGR which shows that affective evaluation can be prior to cognitive evaluation. Griffiths (2003) notes that 'this had led to Ekman's thesis that there is an "automatic appraisal mechanism" which is a cognitive subsystem dedicated to determining whether a stimulus will elicit a basic emotion and that this is able to operate independently of the cognitive systems that lead to conscious, verbally reportable appraisals of the same stimulus'.

In another case showing how affect and belief can come apart we can consider how a person can have a phobia for spiders and be afraid of a particular spider despite being well aware that that [particular] spider cannot hurt them. It might be interesting to consider that if the person with the phobia were encouraged to provide a rational explanation for their fear then they may appeal to a belief that the spider can harm them – despite their knowing that it can't. This seems to lead to something akin to delusional 'double awareness' where they insist upon the belief yet also seem to be aware that others will find their belief to be implausible to others. They do not seem to be able to relinquish it in the face of their anomalous

experience. The process of questioning the persons affective experience or requiring / encouraging them to rationalize it may lead the subject to endorse contradiction.

Stone and Young (1997 p. 340) considers a case of unilateral neglect where the person has the delusional belief that his left hand is not his hand.

> The examiner, placing the patient's left hand in the patient's right visual field, asks: 'Whose hand is this?':
>
> Patient: Your hand.
>
> The examiner then places the patient's left hand between his own hands, and asks: 'Whose hands are these?':
>
> Patient Your hands.
> Examiner: How many of them?
> Patient Three.
> Examiner: Ever see a man with *three* hands?
> Patient A hand is the extremity of an arm. Since you have three arms it follows that you must have three hands.

In this case the person seems to be aware of appropriate inferential relations however the delusional belief does not seem to be negotiable. There is nothing wrong with his logic it is just that he comes to endorse two further delusional beliefs that the examiner has three arms and that the examiner has three hands via this process of questioning.

4.7 Reports of Experience, Delusional Conviction and Implications for Therapy

Traditionally it was thought that delusions were not amenable to reason and thus it was pointless to attempt to argue delusional subjects out of their delusion. Fairly recently, however, there has been a move towards offering cognitive therapy as treatment for them. Part of the cognitive therapy approach is to confront the person with evidence and to draw out contradictions and make them explicit in order to weaken their sense of conviction or certainty that the delusion is true. In looking at cases of delusions and case reports of interviews with delusional subjects as therapists attempt to persuade them that their delusions are false I can't help but wonder whether this strategy results in an unhelpful dialectic. One of the main problems they have found with attempting this kind of treatment is that it is hard to build a good rapport between the therapist and the delusional subject and that there are high drop out rates as the delusional subject simply stops going to therapy.

If the delusional subject's sense of conviction or certainty comes from the nature of their anomalous experiences, however, then we may be able to understand something of why it is that they are so reluctant to back down on their delusional utterances. When people attempt to offer evidence to the contrary they may be missing the point that the evidence is not relevant to what the subject is saying. Attempting to draw out the logic of their utterances may result in them coming to endorse greater and greater contradictions in their effort to justify their sense of certainty in the face of their experience. While this might not be fully rational, if we can instead attempt to empathize with the kinds of experience that the delusional subject might be having then we may be better able to arrive at an understanding of why they insist on their delusional utterance despite everyone attempting to argue them out of their delusion. Rather than by engaging in radical translation to attempt to understand the logic of how they can believe a literal interpretation of what they are saying to be true of the world we may be able to engage in radical empathy to understand why they might be led to say the things they do.

Perhaps it is as Walkup notes:

> The distinction between a description of the experience (sometimes called a phenomenological description) and the description of the factual state of affairs is scientifically and clinically important. Scientifically, a subject who consistently failed to describe the perception of certain illusions would be suspected of some visual or neurological abnormality. Clinically, the therapist who challenges a patient's description of his or her experience may sound absurd, just as would a vision researcher who insisted to an experimental subject that the two lines in the Muller-Lyer illusion actually *look* the same length (Walkup, 1995 p. 326).

Rather than focusing on the logic (or illogic) of their utterance I wonder whether it might be more profitable to attempt to empathize with the subject's anomalous experience, not with the view to attempting to argue subjects out of their delusions, but with a view to validating their experience *as an experience.* If one is able to validate the person's anomalous experiences as experiences that are indeed entitled to be held with a sense of conviction then they may be more willing to acknowledge (or come to acknowledge) the distinction between their experiences which are in fact certain, and an external reality that might well be otherwise. If they were to perceive other people as attempting to doubt their authority regarding the experience they know they are having then that might have the counter-productive result of them elaborating and perhaps even acting out on their delusion in an attempt to justify and express their sense of conviction to others. One may be better off establishing rapport by validating the sense of conviction or certainty which is appropriately associated with the subject's anomalous experience and in this manner they may be more open to acknowledging a distinction between the certainty of their experiences and the fact that the state of affairs in the external world is different from the content of their experience in certain specifiable contexts.

4.8 Concluding Remarks

Near the end of Chapter One I considered Sass' recommendation that

> In my opinion the work of many analytic philosophers interested in psychopathology would be enriched if they spent more time trying to discover and imagine what it might be like to experience certain kinds of abnormal psychiatric conditions, and also speculating about what implications such experiential modalities might have for action and verbal expression (Sass, 2004 p. 72)

In this chapter (in particular) I have attempted to do just that. With respect to a psychological explanation of delusions I considered how appealing to a person level anomalous experience would give us a prior psychological state to appeal to. If delusions are reports of / explanations for certain kinds of anomalous experiences then we may be able to explain them insofar as they are reports of / explanations for a person level state. If delusions are false beliefs about external reality then we may still be able to appeal to a prior psychological state if the belief is formed on the basis of a preceding anomalous experience, though we have also considered that they might not be able to rationally doubt their experience if delusional anomalous experiences may be isolated from the persons network of belief comparably to how some emotional experiences seem to be.

While Maher considered the first factor to be anomalous experience and the other theorists we have considered similarly consider the first factor to be an anomalous experience in a later article Davies et al. (2005) consider that the first factor might be neurophysiological deficit rather than anomalous experience and that further research is needed to determine whether an anomalous experience features early, late, or not at all in the production of delusion. This would indeed seem to be an empirical matter and thus it may turn out to be the case that we cannot offer a psychological explanation of delusional belief. In the line I have considered here,

there would only seem to be prospects for person level psychological explanation because of the interaction between physiological, cognitive, and psychological explanation by way of anomalous experience. I think that interaction between these levels of explanation is important with respect to the prospects for a psychological explanation of delusion and with respect to the prospects of therapy for delusions. It might be possible that the kind of explanation offered thus far would be more palatable to delusional subjects than accounts that appeal to strictly underlying neurological abnormalities.

There is still much work to be done on the explanation of delusion. I have only really considered Capgras and Frégoli (as they arise in response to cerebral trauma), one variety of reduplicative paramnesia (for objects), and the Cotard delusion. A fuller explanation of each of these delusions is required, and it still remains to be seen whether the other varieties of delusions that we considered in *Table 1.* can also be explained along these lines.