Dead Certainty in the Cotard Delusion (Conference)

Some people say that they are dead. People who maintain they are dead are considered to have the Cotard delusion which was named after Jules Cotard a French neurologist who first described the condition in 1880. While the condition is fairly rare other cases have been reported since then. The claim 'I am dead' is thought to be a paradigmatic example of a delusional utterance. While we can imagine contexts in which this might not seem so strange, some people are reported to have insisted that they really are dead. One lady was even reported to have persuaded her family to go out and buy her a coffin.

What I am going to do in this seminar is to talk about some of the theories that have been offered about delusions in general and about what might be going on in the Cotard delusion in particular. In the last part of the seminar I will offer an alternative account of what might be going on for most people with the Cotard delusion and then I shall have a brief look at some of the implications of this for treatment.

Before I get properly underway I want draw your attention to the point that while delusions are typically considered to be beliefs I will focus on offering an explanation of the delusional subjects utterance 'I am dead'. It is because people make utterances such as these that they are classified as being delusional and so I shall focus on an explanation of the delusional utterance. Other theorists are not so explicit about this distinction, they grant that delusions are beliefs and go on to offer accounts of how the delusional subject could come to believe such a crazy thing. Although I ultimately accept the view that delusions are beliefs I take issue with the standard interpretation of the content of the delusional belief and do not wish to beg the question as to what in fact the delusional subject believes. Rather I shall attempt to focus on explaining why they say the things that lead to them being considered to be delusional.

Why would someone be led to say such a thing?

While the causes of depression may be hard to pinpoint, it does seem clear that people with clinical depression tend to benefit from psychotropic medications. What people have surmised from this is that in depression something has gone wrong with levels of neurotransmitter in the brain. The medication is thought to assist because it helps rectify the problem. If depression is left untreated, however, then some people can deteriorate over time, becoming more and more depressed. As this happens the persons sympathetic nervous system no longer produces the typical heightened physiological response to various stimuli. Instead, their levels of arousal become progressively dulled, or muted. Subjects begin with making claims that they don't feel real, or that they feel disembodied, and if they continue to deteriorate they may eventually reach the conclusion that they are dead. The Cotard delusion is now even rarer than it once was as modern advances in psychotropic medications now largely prevent people deteriorating to that level.

In other cases people develop the Cotard delusion in response to cerebral trauma. They may have been involved in an accident that has resulted in damage to parts of their brain, or a blood vessel may have burst which may result in a similar kind of damage. People who develop the Cotard delusion in response to cerebral trauma may suffer from other conditions, some even suffer from other kinds of delusion as well. It has been found that these people also exhibit muted levels of physiological arousal.

Sass considers that in response to the lack of usual autonomic response these people may well no longer feel connected to their bodies, to other people, or to the world in which they inhabit. Sass claims that the person 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.'

Although we may not be able to empathise 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'; a period of flattened affect or emotional non-responsivity. He considers that in these cases we do talk of feeling 'dead' or 'deadened' and thus the delusional subjects utterance would seem to be 'well within the extended penumbra of comprehensible meanings of this term'. Sass maintains that the delusional subjects experience is just a severe variation on this and that it is this feeling that prompts the delusional utterance.

The Role of Anomalous Experience in the Explanation of Delusion

The psychological theorist Brendan Maher attempts to offer an account of the role of anomalous experience in the production of delusion. While he is primarily focused on offering an explanation of schizophrenic delusions he also maintains that his account should be able to be modified to apply to other types of delusions as well. Maher considers that delusions are normal, rational, or understandable responses to certain kinds of anomalous experiences. He considers that delusional subjects have a certain kind of neurophysiological deficit. The neurophysiological deficit is responsible for the production of an anomalous experience. He maintains that when the anomalous experience is intense and prolonged the person feels compelled to explain the anomalous experience. He considers that delusions are the inevitable result of such an attempt at explanation.

Maher does offer examples of different kinds of neurophysiological deficit that may be responsible for the production of delusion. He also provides examples of different kinds of anomalous experience that the delusional subject may be attempting to explain. He allows that there may be other kinds of neurophysiological deficit, and other kinds of anomalous experience that he has not considered. In light of the findings regarding levels of physiological arousal it would seem natural to add this anomalous experience to Maher's list. There is still more work to be done with respect to finding the precise nature of the neurophysiological deficit or deficits that underlie the production of such an

experience. The experience seems to be multiply realized as it can be produced by either localized cerebral injury or a more global problem with neurotransmission.

So, by piecing together what we know about depression and cerebral trauma with what we know about the physiological responses of such subjects it looks like we are starting to get something of an account of the production of the Cotard delusion. Maher considers that the anomalous experience is both necessary and sufficient for the production of delusion as subjects are compelled to explain their anomalous experience which invariably leads them to the delusional utterance.

The Second Factor in the Explanation of Delusion

In their paper '*Monothematic Delusions: Towards a Two-Factor Account'* Davies et al., consider that while an anomalous experience may be necessary for delusion, it cannot be sufficient. They maintain that some people have comparable anomalous experiences, yet they do not exhibit comparable delusions. While they agree that such an anomalous experience is in need of explanation they do not consider the experience to be sufficient to determine that the person must arrive at a delusional explanation for it.

Davies et al., consider that the account thus far would seem to go some of the way towards explaining why it is that the delusional hypothesis occurs to the subject. They also maintain, however, that the above account is not enough to explain why it is that the delusional subject accepts the delusional hypothesis as a belief 'despite everything they previously knew to be true' and despite other people attempting to persuade them out of their delusion.

One route to belief is the route from perception to belief. While this input clause is not typically considered to be a rationality constraint we can consider whether we would call someone irrational who failed to form beliefs in this way. Suppose I am in a room walking around and I fall over a chair. You ask 'what happened? Didn't you see the chair?' I reply 'Oh, I saw it alright, I just didn't believe it was there'. In this case I might

be described as being irrational for failing to believe what I had perceived. Whether we consider this to be a failure of rationality or not it does seem that something abnormal is going on here.

It would also seem that it is not a normal, rational, or typical response to always believe what we perceive, however. Sometimes what we perceive diverges too radically from what we previously knew to be true. It diverges too much from our prior beliefs and perceptions. When we experience visual illusion it may well be a typical initial response to judge the lines to be of different length when viewing the Muller Lyer illusion. Once we come to understand something of how the illusion is produced, however, or once we see the arrows removed and reinserted then we no longer believe what we perceive. We judge the lines to be of equal length despite the way that they appear to us to be.

Davies et al., consider various suggestions that have been offered as accounts of the nature of the second factor. They settle on the line where the delusional error is to 'accept an anomalous perceptual experience to be veridical when there is rational grounds to doubt its veridicality'. In considering the anomalous experience to be a perceptual experience Davies et al., are led into the problem of the unwanted prediction. They acknowledge that a problem with their account is that it would predict that a person with the Cotard delusion should be routinely fooled by the Muller-Lyer illusion as they come to believe what they perceive. The subject with the Cotard delusion should be unable to inhibit this response despite coming to learn about how the illusion is produced, and despite perceptual information to the contrary such as seeing the arrow heads removed and then reinserted.

One way around this problem for Davies et al's account of the nature of the second factor would be to consider that the anomalous experience need not be perceptual. Indeed, from what we do know about the various kinds of anomalous experiences that seem to feature in the production of various kinds of delusion it seems that in the clear majority of cases the experiences have more to do with the persons affective response system or levels of physiological arousal rather than with perceptual deficit.

So the way that Maher told the story we have a neurophysiological deficit that produces an anomalous experience. Because the experience is intense and prolonged the subject is compelled to attempt to explain it and they thus develop a delusion. The way that Davies et al., tell the story is similar with respect to there being a neurophysiological deficit that produces an anomalous experience for the delusional subject. Davies et al., also note that normally people are able to inhibit the formation of belief from a perception that conflicts with other perceptions or beliefs but that the delusional subject is unable to do this. It would seem that sensory perceptions are not the only things that we form beliefs from, however, and in these cases the delusional subject may be having an affective response that prompts belief which they are unable to inhibit????

They also maintain that the delusional subject accepts their experience as veridical as normal subjects do. The delusional error, however, is that we would expect them to be able to inhibit this 'believe what you perceive' response when what they believe diverges too radically from everything they previously knew to be true. The delusional subject should be able to take evidence that runs contrary to their delusion and thus come to see that their delusion is false.

The Biological Model of Delusion

At this point I wish to take something of a detour into having a look at the notion of rationality, and into how much we can expect to be able to understand delusion if it is in fact an irrational phenomenon. Delusions have long been taken to be a paradigmatic example of irrationality. If delusions are in fact irrational then it might be the case that they will resist our attempts to explain them. Karl Jaspers was an early psychiatrist / philosopher who considered that primary delusions, or delusions proper are ununderstandable in the sense that they cannot be explained by recourse to the subjects prior perceptions, experiences, and beliefs. Jaspers considers that while such delusions may possibly be given a neurological explanation which appeals to some underlying

brain pathology he thought that primary delusions are ununderstandable from the intentional level.

John Campbell is similarly led to the conclusion that we cannot offer an intentional explanation of delusion. He maintains that 'a finding of irrationality can always be traded for a finding of mis-translation'. Along the lines of Quine, he considers that we are required to make use of the principle of charity in intentional state attributions so we must always radically translate so as to make the subject out to be rational by their use of the term. He concludes that there is no content that we can attribute to delusional utterances that makes the subject out to be rational, and thus delusions don't seem to be contentful states. They thus seem to be beyond the reach of intentional explanation.

It is an important point that while some delusional subjects, typically subjects with schizophrenia seem to have become enmeshed in their own solipsistic world coming up with a new delusion in response to almost every question that is put to them - this is not always the case. Some people have a mono-thematic delusions like the Cotard delusion. Mono-thematic delusions are based on a single theme and aside from that delusion the person seems to exhibit beliefs and behaviors that are comparable to normal subjects. The significance of this is that in the cases of monothematic delusions at least it would clearly be inadequate to posit a complete breakdown or failure of rationality. The delusional subject seems to have comparable rationality to normal subjects in other contexts. It seems that if we do need to add a second factor to anomalous experience in order to explain delusion then we need to specify a more limited breakdown or deficit than a complete breakdown in rationality.

To try and get into the spirit of the problem of irrationality it is worth looking at the American Psychiatric Association's definition of delusion. The APA maintains that delusions are 'radically false beliefs based on incorrect inference about external reality that are firmly sustained despite what everyone else believes and despite incontrovertible and obvious proof or evidence to the contrary'. It would seem to flow rather naturally from this definition to consider that the delusional subject is making a false claim about

their no longer being biologically alive. This has historically been the main interpretation of the claim that the subject is attempting to express with their delusional utterance.

Clinicians attempted to provide evidence against the subject's claim that they were dead by drawing their attention to such facts as the subject being able to walk around, being able to feel their heart beat, and feeling bodily urges such as the need to go to the bathroom. That the subject did not seem to take such biological signs of life as evidence against their delusional belief was itself taken as evidence for the irrationality of the delusional subject. It seems to have been the result of observations such as these that the APA has been led to conclude that delusions are held 'despite incontrovertible and obvious proof or evidence to the contrary'. It was thus thought to be pointless to attempt to argue a delusional subject out of their delusion.

What doesn't seem to have been noted is that beliefs such as 'I can feel my heart beating' and 'I can still walk around' do not seem to straightforwardly contradict the belief 'I am biologically dead'. To extract a contradiction from these beliefs we need to add further beliefs and make them explicit.

Lets look at the logic of this

P1) I can feel my heart beating
P2) I can still walk around
P3) I feel bodily urges such as the need to go to the bathroom

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C1) I exhibit biological signs of life

P4) Anything that exhibits biological signs of life cannot be biologically dead

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I am (biologically) dead

If the delusional subject believes that they exhibit biological signs of life and that anything that exhibits biological signs of life cannot be dead and that they are biologically dead all at the same time then this would seem to result in the subject

endorsing contradictory beliefs. I am not sure that these steps have been brought to the delusional subjects attention to see whether they are prepared to endorse these beliefs or not. Rather, their endorsement of Premises 1-3 has been taken to be sufficient evidence of their irrationality in believing a contradiction.

The Cartesian Model of Delusion

While the Biological model doesn't seem to straightforwardly entail that the delusional subject is endorsing contradictory beliefs there has been another model that has been suggested in which the delusional subject is supposed to be endorsing a more explicit contradiction, or a self-defeating belief. One delusional subject is reported to have said 'I am not and am condemned to going on being nothing forever'. Descartes showed us that so long as one appreciates that doubting is a form of thinking it is impossible to doubt one's existence as a thinking thing. If the delusional subject is attempting to express the belief that they do not exist as a thinking thing then it would seem that not only is the subject professing to believe something that they cannot believe, but we cannot make sense of what the delusional subject is saying or believing as the content of the belief is self-defeating.

What we seem to be running into in these two interpretations are the rationality constraints that govern intentional state attributions. In the biological interpretation we seem to want to attribute beliefs that contradict other beliefs (though perhaps not straightforwardly so). In the Cartesian interpretation we seem to be wanting to attribute a straightforwardly contradictory or self defeating belief to the subject. Both of these interpretations run into difficulties with respect to making sense of the delusional subjects utterance. They reinforce the idea that delusional subjects are irrational and that delusional utterances are not amenable to rational or intentional analysis

There are two things that I wish to note at this point. Firstly I want to reiterate what I said near the start that we do not have direct access to the delusional subject's beliefs. While delusions are typically considered 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 subjects utterance 'I am dead'. To figure out the content of the delusional utterance we need to engage in translation. What we have seen so far is that the term 'death' may be ambiguous. According to Sass the subject may be using it to refer to their state of emotional death, or numbness. In the Biological model the subject is using it to refer to their state of biological death. In the Cartesian model the subject is considered to be attempting to use it to refer to their own inexistence as a thinking, or experiencing thing. So we have three distinct readings of what the content of the delusional utterance might be. What I wish to do now is to turn to considering two different things that the subject may be attempting to do in making their delusional utterance.

From Experience to Belief

Maher, Davies et al., and the APA definition of delusion are similar with respect to what they construe the delusional subject as doing in making their delusional utterance. They concur that in making the claim 'I am dead' the subject draws a false conclusion from their experience to what is the case in the world. They thus similarly consider delusional subjects to be expressing a belief about external reality – or the world beyond the subjects experience. So if this is the case then what are we to make of the subjects claim that they are dead? It might be natural to think that the subject goes from the experience of emotional death that Sass talked about to making a claim about their biological death. Whether the claim that the subject is biologically dead is true or false is mind independent in the sense that the subject can have false beliefs about the way things really are outside of their minds. It is typically granted that the claim 'I am biologically dead' is a false belief.

On this analysis of what the delusional subject is attempting to express in making their utterance there may be a problem with respect to consistency within the subjects belief network. Normal subjects are also not perfectly rational, however. Sometimes we discover that we do have contradictory beliefs in our belief network. While holding contradictory beliefs may not be so very abnormal we do expect people to be able to see

that they are in fact endorsing a contradiction once the logic has been pointed out to them. While I am not so sure that the contradiction has been pointed out explicitly to the delusional subject it would be hard to see what sense we could make of them retaining their beliefs if it was.

This might be motivation enough for concluding that delusions are intractable from the intentional level and so one would be better off abandoning intentional explanation in favor of a neurophysiological account of the various kinds of brain damage that might result in delusion. In another more recent paper Davies et al., modify their two-factor account of delusions so that the first factor is no longer the anomalous experience that was talked about by Maher. Instead, they maintain that the first factor is neurophysiological deficit and that further research is needed to determine whether the anomalous experience features early, late, or not at all in the production of delusion. As such, they too seem to have abandoned the attempt to offer an intentional explanation of delusion. Instead they maintain that delusion should be explained by the presence of neurophysiological anomaly despite the point that the precise nature of the neurophysiological anomaly seems to be fairly idiosyncratic to particular subjects. Before we are tempted to give up on intentional explanation altogether, however, it might be worth considering what the delusional subject might be attempting to do in making the claim 'I am dead'.

Reports of Experience

What seems to be in common to the accounts considered thus far is the notion that the delusional subject is taking their autonomic response to be informing them of the further fact that they have died. What I want to consider, however, is that this may not be the case for most subjects who maintain that they are dead. 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 seems to them to be where the anomalous experience of loss of autonomic response. If this is indeed what some subjects 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 indeed entitled to be certain that things are in fact the way they seem to the subject to be.

One of the problems with construing the subject as making a false claim about reality was the point that they did not seem to 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 a more likely explanation for this, however, is that it might be because facts such as their being able to walk around is indeed irrelevant to their utterance. If they are reporting on their experience then those facts would indeed be irrelevant as facts about the external world are irrelevant with respect to providing supporting or disconfirming evidence for the subjects experiences.

Campbell writes that delusional beliefs seem to have been elevated to the status of Wittgenstinean framework propositions by which he seemed to mean that they were immune to supporting or falsifying evidence. It could be taken that our belief in an external world is something that is a framework proposition in the sense that whether the belief is true or false is something that we are unable to verify. Some delusional beliefs seem to have taken on this quality as well where they seem to be beyond the reach of supporting or disconfirming evidence. I would like to maintain that this is because reports of experience and that these are indeed immune to supporting or falsifying evidence from external reality.

If this is the case then it would seem that the delusional subject is simply playing a language game in which the external world falls out as irrelevant. If they are simply expressing 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 though there may be a superficial appearance of contradiction were we to insist on taking them literally to express false and implausible claims about the way things are in the world.

The most obvious objection to this line would be that the delusional subject does not preface their utterances with 'it seem to me as though' or 'it is like…'. Why doesn't the delusional subject simply say 'I have the experience of emotional death' or 'I feel dead' or something a little more like that? This is indeed a tricky problem for the line that they are reporting on their experience. One response might be that these expressions do not convey the sense of conviction that the delusional subject feels. Indeed the subject with depression might start out making claims like this, but if their depression continues untreated they may progress to claiming they are dead. Typically we don't take pains to distinguish between a claim about reality and a claim about our experience. We don't say 'it seems to me as though I am in pain' because the first half of that just seems redundant. To make it clearer that the subject is attempting to report on their experience rather than a state of the world would also require them to acknowledge the external world. I think the problem is more that their experiences have taken on such an intensity and captured their attentional processes to the point that the world really has fallen out as irrelevant.

If one had lost interest in the nature of reality and instead was only focused on ones anomalous experience then this might conceivably lead to the kinds of delusional utterance that subjects actually make. The problem might not be that they have taken their experience to be veridical when they have rational grounds to doubt. Rather, the problem might be construed as their being fixated on expressing their experience to the extent that they are playing a different language game, one in which the external world has been disregarded as irrelevant.

The Problem of Inaction

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 delusional subjects do not act in ways in which we would expect them to act were they to literally believe what they are saying. In the Capgras delusion, for instance the delusional subject comes to maintain that someone who is close to them has been replaced by an impostor. We might expect that the delusional subject 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.

Gregory Currie takes the later line and he attempts to maintain that delusions are not really beliefs rather they are 'imaginings misidentified as beliefs by the delusional subject'. I am not sure whether this line will help solve the problem of inaction, however, as Tim Bayne has queried 'what is the difference between believing something to be the case and believing that one believes something to be the case?' This does seem a little odd and perhaps Curries line is not really enough to solve the problem of inaction. I think that viewing delusions as reports of anomalous experience is able to solve the problem of inaction quite naturally. There wouldn't seem to be any obvious behavioral consequences for believing that one has a lack of physiological response.

The Problem of Action

For any model that is able to solve the problem of inaction, there is a related problem that arises. Namely, how to account for the relatively few cases where subjects 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 express ones anomalous experience.

Rather than considering there to be a significant problem with all of the accounts offered thus far I would like to consider whether different models might be better placed to account for the different kinds of cases. It would seem that making a delusional utterance yet not behaving as though one literally believed the world was that way would be best explained by subjects attempting to report on their experiences. Where subjects do act on their delusions, however, then I think that a modified version of Davies et al's two factor account where we have an anomalous experience rather than a perceptual experience explains the phenomenon quite well.

I would also like to suggest that subjects come to act on their delusions after progressing from reporting on their experiences to mistaking their experiences to be veridical. What this buys us is the notion that the sense of conviction has become similarly misplaced.

Treatment Implications

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 behavior therapy as treatment for them. Cognitive behavior therapy attempts to make the contradictions explicit and to confront the delusional subject with counter-evidence 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 the therapist and delusional subject aren't continually talking past each other. 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 we grant that delusions are reports of certain kinds of experiences then we may be able to explain why it is that the delusional subject will not back down on delusional utterances. When people attempt to offer evidence to the contrary they miss the point

that the evidence is not relevant as the subject is instead attempting to express the nature of their experiences. If we can instead attempt to think our way into the kinds of experiences that may lead to them expressing them in the way in which they do then we may be 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 explain how they can believe what they are saying we can engage in radical empathy to understand why they 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).

If the delusional subject is indeed reporting on their experience then they are entitled to a hold onto their experience with certainty. I wonder whether attempts to challenge delusional utterances by trapping subjects in contradiction is what ultimately leads them to endorse contradiction in order for them to retain the certainty about their experience. What might be happening here is an unfortunate state of affairs for the delusional subject who might be hard pressed to find an appropriate alternative expression of their experience. Rather than focusing on the logic of their utterance I wonder whether we might have more luck with attempting to empathize with the subjects anomalous experience. Not with the view to arguing subjects out of their delusions, but with a view to attempting to understand what they might be trying to say. And with the ultimate view of assisting them in finding more appropriate ways of expressing themselves. Rather than attempting to argue them out of their delusion by presenting evidence that is not even

relevant to what they are saying one might have more luck with trying to express some empathy for the anomalous experience that they are having.

What I would like to suggest is that regardless of whether the subject actually has made the move from expression of experience to false belief about reality one may be better off establishing rapport by validating the sense of conviction or certainty which is appropriately associated with the subjects anomalous experience. Perhaps the trouble with subjects who have come to false beliefs about external realty on the basis of experience is that they have lost sight of the distinction between appearances and reality. Davies et al., talk about this as a failure to inhibit believing what they perceive, and it sounds to me a lot like the notion that delusional subjects have lost their ability to reality test in the sense that external reality is irrelevant to the reality of ones experiences, and ones experiential reality is certain. One way to lose the appearance / reality distinction is to focus on appearances and disregard the external world. Perhaps what has happened here is that the delusional subject has become lost in appearances being reality where their experiences are sufficiently anomalous.

It may be that there are two different things that we can construe the delusional subject as doing in making their utterance. We could consider that they are making a false claim about the world or we could consider that they are attempting to express their anomalous experience. The DSM considers that delusions are 'false beliefs about external reality' but this seems to beg the question in saying that delusional subjects should be construed as intending to do this. It may be that many subjects who utter claims characteristic of certain kinds of delusions and their claims lead them to be classified as having that kind of delusion and yet they intend their utterance to be an expression of their experience. It may be that only when the subject is making a false claim about the world that they are appropriately classified as delusional, we could consider that subjects who are expressing 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 subjects

clearly are delusional and this shows the inadequacy of the DSM definition of delusion. It seems that not a lot rests on this linguistic decision.

Either way it is interesting that more people do not act on their delusion than people who do so either a large class of the phenomena is explained, or the class of phenomena requiring explanation has been significantly reduced.