The deluded person as an actor in an aberrant scenario

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- Delusion is classically defined as an abnormal belief in a false idea. Jaspers considered that the true delusion is the **primary delusion,** which takes place through a **psychopathological process**.
- In a manual of descriptive psychopathology[1], it is stated that:

> "For Jaspers, delusions: (a) are false judgements, (b) are held with an extraordinary conviction, with an incomparable subjective certainty, (c) there is imperviousness to other experiences and to compelling counter-argument, (d) their content is impossible".

[1]Oyebode F. (2008). Sims' symptoms in the mind. Elsevier, Edinburg, London.

- Other definitions of delusion are:

Berrios[2]: „Delusions are likely to be empty speech acts, whose informational content refers to neither world nor self. They are not the symbolic expression of anything. Its „content" is but a random fragment of information „trapped" in the very moment the delusion becomes crystallized".

- The reduction of the delusion to "empty speech acts" is debatable. However, it suggests the idea of "speech" and language. And human language is mainly narrative. The persons with autism spectrum disorders rarely develop delusions, because they lack narrative language.

Scharfetter[3]: „A delusion is a man's private, overriding, isolating conviction about himself and his world".

- Being a phenomenologist, Scharfetter does not give great importance to language and narrativity. He believes that the essential characteristic of delusion is the subjective experience of the person.

[2] Berrios G.A. (1996). The history of mental symptoms. Cambridge University Press;
[3] Scharffeter C. (1980). General psychopathology. An introduction, Cambringe University Press;

- Munro[4] considers that any delusion has the characteristic of „centrality”: the subject feels that something particular happens to himself, to his own person.
- The self is the one involved in the delusional belief (narrative theme). This aspect is important for differentiating delusion from:

  - the belief regarding facts and the state of affairs (for example: outside is raining when, in fact, it is not raining);

  - the shared communitarian, scientific and cultural beliefs (political, religious beliefs etc.). These beliefs can become delusional only if the subject personally involves in a scenario related to those beliefs; for example if he thinks that he is the inventor or discoverer of a religion.

[4] Munro A. (2000). Delusional disorder. Paranoia and related illness, Cambridge University Press.

- If we maintain the traditional approach that **the delusion is a pathological belief in an aberrant, unreal idea**, two questions remain unclear:

  - what does **idea** mean in the context of delusion, in comparison to its use in the expression “flight of ideas” in the manic states or in the one of “obsessive ideas”?

  - what are the structures of the human psyche that are dysfunctional in delusion? (structures which are different from the ones impaired in mania or obsessive states).

- There are some difficulties when discussing delusion, for various reasons:

A) Delusion is part of multiple clinical contexts. We consider that, from a psychopathological perspective, the most representative delusion is the one from the clinical category of "Persistent delusional disorder" from ICD 10 (F22). It is more relevant to our purpose than the schizophrenic delusion.

B) Delusion is frequently correlated with disorders of perception and of the situation's significance: illusions, hallucinations, derealization, sensitivity, "centrality", reference.

- These interference draw attention to the fact that the psychic structure disturbed in delusion is a trans-situational one, implying a meta-representational level.

C) There are various terms used to characterize delusion, from different domains. We can mention some of them:

belief

evidence (clear, distinct) **truth**

arguments

doubt **idea** **certainty**

experiences

faith

proofs

conviction

- These terms are also used in philosophy. The ancient sceptics talked about "doubt" and so did Descartes. The concept of "idea" was discussed by Platon, Kant etc. and has various meanings at present.

- The conceptual difficulties did not discourage the psychopathologists. We propose and try to sustain the following theses:

- The delusion is a distinct psychopathological disorder, different from the affective and obsessive disorders. It is an abnormal belief in the identitary role of the subject in a narrative scenario, a more or less **fictional** one. This scenario refers to the person's identity, including: his state, value, his relationships with others, with himself or with a situation. For example, the role of a sick, dismorphophobic, spied, persecuted, cheated, over-capable, guilty or incapable person.

- Unlike delusion, the affective disorders – mania and depression – derive from normal, adaptive states which consist in a global attitude towards the self and the world regarding different future possibilities or events. In these cases, we cannot speak about a role in a scenario. The interest for various events or actions is decreased, in favour of a high preoccupation for one's self , value and capacities.
- The obsessive-compulsive pathology is characterized by a dysfunction in the **self-control** of one's actions and relationships with others and with the physical ambiance. In this case as well, the emphasis is not on an identitary role, but on the self-control concerning decisions, spatial environment, actions and relations.

- Our thesis stresses the aspect that best defines delusional beliefs is the assumption of a certain identitary role in a narrative scenario. This perspective relies on Hermans' narrative psychology. Hermans [5] suggests that the person permanently generates dramatic scenarios under the pressure of events. He assumes a role in a scenario, he plays it and has the ability of solving situational problems. In normality, the subject is continuously involved in multiple scenarios of different durations, which he can give more or less importance, passing from one to another or letting them go. The person is able to have a dialogue with himself because the different roles and scenarios are based on an inner biographical temporal dimension that sustain a dialogical self. But he is permanently maintaining his self-identity and the agency of creativity of the situational problem. After the scenario is over, the subject places it in his biographical memory. Personal narrativity involves the languages and expresses through different imaginary scenarios, self dialogues, biographical reports, potential or real narratives of situations and events.

[5] Hermans H.J. (2011). The dialogical self. A process of positioning in space and time. In: Shaun Gallagher (Ed). The Oxford Handbook of the Self, Oxford University Press, 2011, p.634-650.

- In the case of delusion, a certain scenario becomes dominant. The subject falls in a specific dominant role, which merges with his own identity. The person's receptivity and his creativity decrease. He only lives his aberrant scenario because his psyche is simplified and non-differentiated. And this scenario drags him in a fictional reality. The fictional reality can be dominant and become similar to a novel.

- The deluded person lives an aberrant belief related to his role in a situation that concerns him: the role of a sick person, a cheated or a persecuted one, the role of a person who has special missions etc. In the case of monothematic delusions, real persons can be involved in this fictional scenario, in different manners. E.g.

"A patient shoots a man because he thinks that the man is a murderer enemy and he is the king's bodyguard".

"A patient believes that she is Queen Mary of Scotland. She agrees that the queen has lived centuries ago, but she says that she is her reincarnation".

"A patient explains that other people smile at him when they meet him because they know that he is sent by God to denounce the devil; he has a letter for the Pope for this purpose."

- In the first phase of delusion, the delusional perception of some special meanings is also part of a similar narrative scenario:

"The soup has a particular smell because the dinner made for the patient is part of a sacrificing ritual".

- In all of these examples, the delusional person identifies himself with a certain role in a scenario which could lately be narrated.

- Jaspers considered that the true delusion takes place through a **psychopathological process**, different from the comprehensive development of the prevalent ideas of jealousy. In his article, in 1910, he analyses 8 cases of jealousy. Nowadays, we would say that Othelo's case is an example of a comprehensible prevalent development. In contrast, delusion is something aberrant, absurd and incomprehensible. However, not all delusions start through an obvious psychopathological process. An example would be:

"A 35 years old man gets to the conclusion that his wife is cheating on him with her boss, with all her colleagues and, later, with all the members of the administrative community of the town. For this reason, they move to a different city. There, the process repeats in the same manner. The situation became unbearable, because people were laughing at him on the street. After moving to another place, having the same problems, the man accepts the admission in a psychiatric unit, 4 years after onset."

- In the case of the delusion of jealousy, it is difficult to draw a line between the prevalent suspicion, more or less justified, and the fall to delusion.

- We can give similar examples for other delusional themes. A person can be preoccupied by his health in an anxious, phobic, obsessive, prevalent or delusional manner. A certain border is crossed over in delusion, in the case of jealousy, as well as of hypochondriac, dismorphophobic or persecutory preoccupation.
- Therefore, there is a comprehensible transition from uncertainty to certainty in the case of an identitary preoccupation, different from the psychopathological process, as Jaspers considered 100 years ago.

uncertainty

phobic anxiety

obsessionality

prevalence

delusion

I could be…

I am afraid that I am….

I am obsessively preoccupied of the fact that I could be…

It is very probable that I am….

For no doubt, I am….

Nobody can convince me that I am not…

sick

cheated

dysmorphic

persecuted

certainty

- In the case of the **psychopathological process**, whose prototype is Jaspers' **primary delusion** of schizophrenia, there is a shortcut in the transition we mentioned before. In the primary delusion, the person experiences a particular state of **centrality.** Firstly, chaotic, vague, environmental significations assault the person. In a second phase, a special **significance** of a **perception** or a sudden **intuition** clarifies the narrative scenario of the delusional theme, the patient being the main hero of his scenario.

Symptoms of reference: the things, colours, numbers, events have a special, hidden meaning for the patient (and media, television, radio, newspaper information as well)

↓

Delusional mood (atmosphere):
"something extraordinary will happen to me, everything is strange, unfamiliar"

↓

Centrality

↓

Primary delusion

Derealization, depersonalization:
unreal, uncommon environment
anomalous experience of the body
identity

Sensitive ideas of reference:
"everybody is looking at me, they discuss about me"

Delusions in mania, depression and obsessive-compulsive disorder

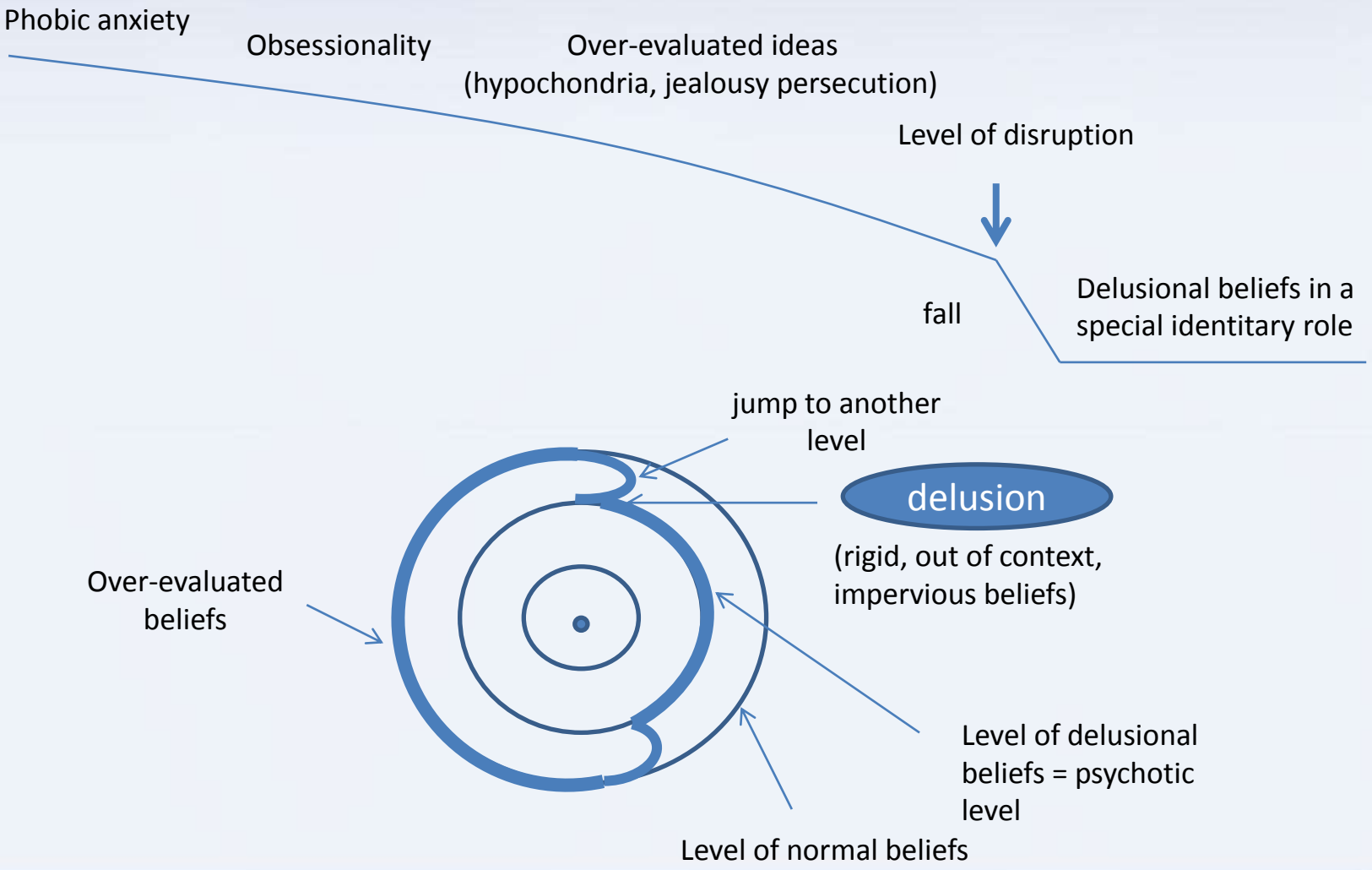
Monothematic systematized delusion

Delusional idea: the subject is part of a special narrative scenario; he has a clear role in this scenario

The primary delusion develops secondary to the disorganization of the **perceptive** process, representing a hierarchical order which organizes the active perception. The whole situation has a special meaning for the subject and the objects appear in a hierarchical and determined correlation. This **hierarchy of significations** collapses in the delusional mood. The primary delusion is significant for schizophrenia.

- However, in schizophrenia, there is a disorganization of the **significations,** not only in perceptions, but also in language, concerning the semantic meaning of words and concepts.
- In the case of the systematized delusion, the process of perception and the linguistic functions are not altered. The main dysfunction is the one related to an identitary role in a fictional reality, which distorts the person's functioning in real life. The subject is not able to navigate in different realities and to elaborate different scenarios in order to solve various problems.
- In the primary delusion, there is not a gradual passing from uncertainty to certainty, but a **fall** on a deficitary existential orbit: a rigid, out of context, isolating one. The thematic, absurd beliefs in an identitary role, which develop progressively, must also attend this inferior orbit in order to be considered delusional.

The continuum between normality and delusion



- Researchers should study the process that lies behind the psyche's "fall" (jump) on an inferior level from normality. In the state of delusion, the psyche connects the various aspects of everyday reality with the inferior orbit of delusion. We can compare this with a theatre play. The deluded person follows the causal, spatial and temporal rules of a secondary reality of the play and identifies itself with an aberrant role.

- For a better understanding of the delusion, we invite you to compare it with a narrative drama scenario – similarly to a play or novel. The subject is absorbed in an identitary role which restrains his possibilities of adequate responses to certain situations.
- This way of understanding delusional pathology reveals an anthropological perspective. The personal narrativity, with the subject being the main hero in a scenario lived from the **first person perspective** interferes with the cultural narrativity, where the subject can identify himself with legendary, historical or drama heroes.

- Understanding the delusional idea as the placement of the subject in an aberrant identitary-relational role in a narrative scenario is consistent with Gallagher's point of view. He considers delusion from the perspective of **multiple realities** (MR) theory. Gallagher goes further with Shultz's interpretation of James' concept of "sub-universes" and discusses the realities that are different from the everyday life: the reality which exists when going to the theatre, to the cinema or when playing a video game. The subjects can temporarily identify with the role of the characters of these realities and can take part of their adventures. Similarly, in his dreams, he is the hero of some particular events. Still, in normality, the subject permanently stays in contact with everyday events and he always returns to the real life after spending time in fictional or virtual reality.

Gallagher[6] :

"It seems quite possible that one can enter into a delusional reality just as one can enter into a dream reality or a fictional reality, or a virtual reality. Like other multiple realities, some delusional realities are ones that are more or less cut off from one's everyday reality; ones that are incommensurable with the normal rules of reason that govern one's everyday normal life world and ones that offer a different set of affordance... Accordingly, the multiple realities (MR) hypothesis is this: when a subject enters into a delusional state, he or she is entering into an alternative reality".

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[6] Gallagher S. Delusional realities. In: Matthew Broome, Lisa Bortolotti (eds). Psychiatry as Cognitive Neuroscience. Philosophical perspectives (2009), Oxford University Press, p. 254-262.

- Considering delusion from the perspective of the subject's identification with an aberrant role in a narrative scenario helped us answer Jaspers' question regarding the notion of "idea" from the expression "an aberrant belief in a false idea".
- However, the second problem remains, which refers to the psychic structure impaired in the delusional pathology.
- Jaspers approaches delusion in the context of the **psychic faculties' doctrine**. Accordingly, the delusion, defined as an aberrant belief, is placed in the area of cognitive, thought and beliefs disorders. Nowadays, this issue can be seen differently, from an anthropological perspective, referring it to the instances of the self.
- In order to define the structural instance of the self, which is specifically impaired in delusion, it is useful to make a comparison with the mood and obsessive-compulsive disorders, which are also founded in normality and need some trans-situational structures, placed in a meta-representational level.

- If we consider the main ways a person relates to the situations, we can identify the following:

1. – the active solving of problematic situations in a pragmatic way;
2. – the dispositional attitude of the subject towards different events;
3. – the person's preoccupation for the clarification of his identitary role, related to others, himself or the world.

- These possibilities can lead to long-term projects, preoccupations and prolonged moods, if we consider the perspective of **mental time travel (MTT)**[7] and accept Tulving's autonoetic distinction. The possibilities we mention can be considered the normal psychic ground for obsessive pathology, mood disorders and delusions.

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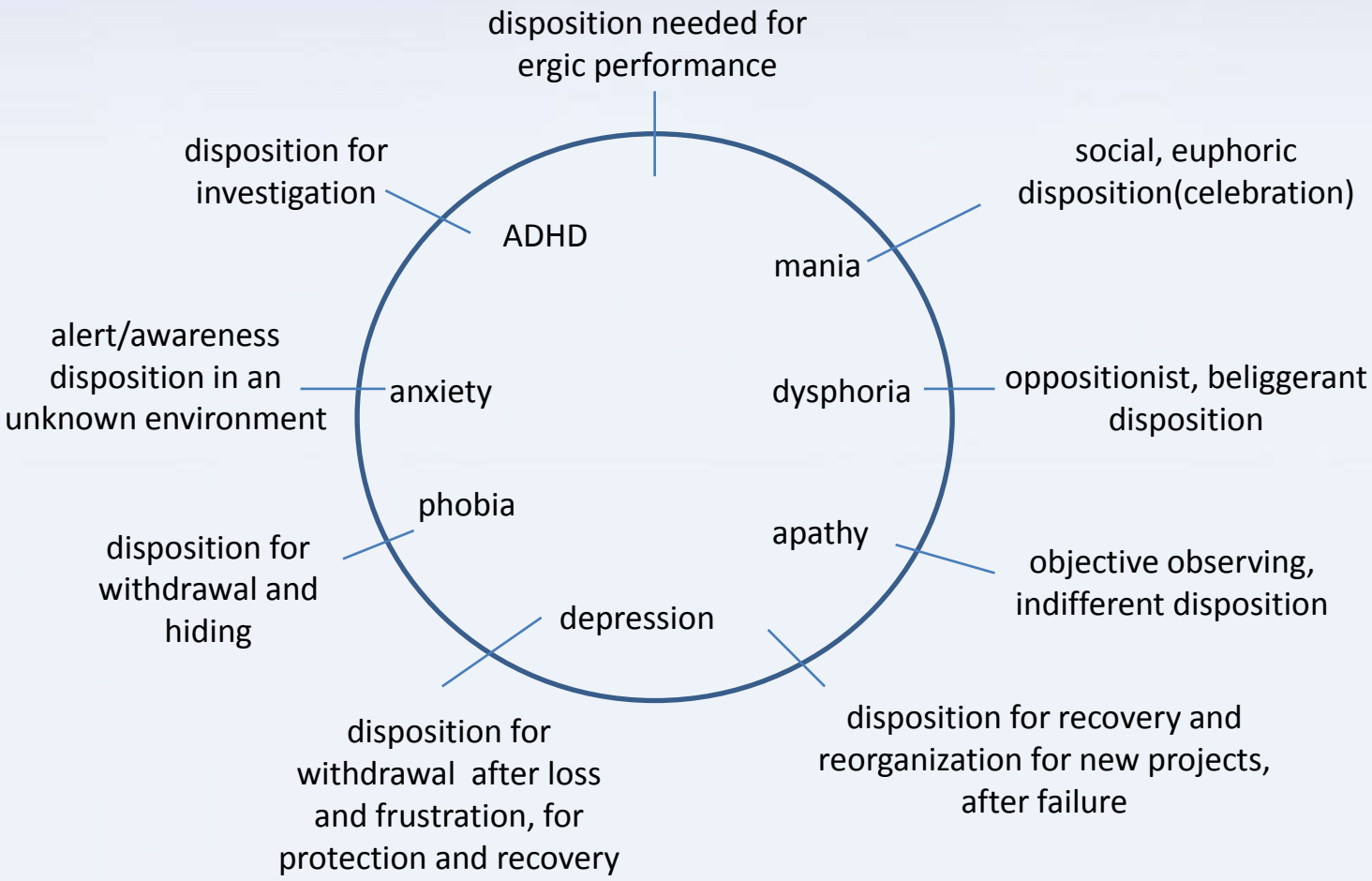
[7] Kennett J., Matthews S. Mental time travel, agency, and responsabilities. In: Matthew Broome, Lisa Bortolotti (eds). Psychiatry as Cognitive Neuroscience. Philosophical perspectives (2009), Oxford University Press.

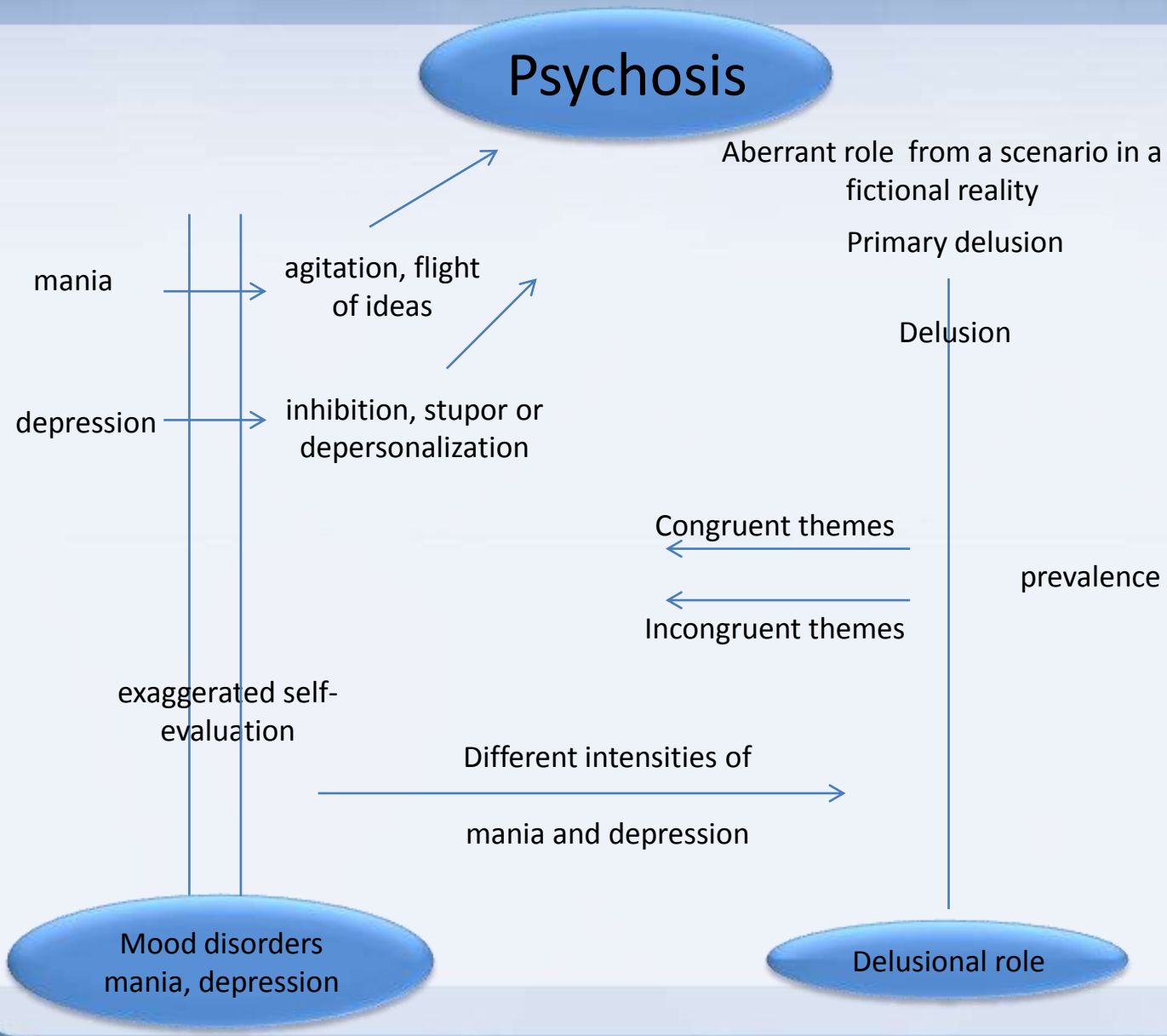
The psychopathology of mood disorders and its correlation with delusion

- Mood disorders can be understood as deriving from normal, adaptive attitudes and dispositions, which help the person be prepared for specific events or actions. When being in a certain disposition and mood, the subject evaluates himself, in order to have at his disposal the resources needed in a particular domain. For example, when being in an unknown territory, the subject experiences a disposition of alert which makes him capable of dealing with possible dangers.

Dispositions and moods



- In the case of dispositions and moods (anxious, depressive, euphoric, disphoric, apathetic), self-evaluation is the most important aspect.
- Moods are not specifically characterized by narrativity or by the playing of an identitary role, but they can accompany and sustain the involvement of the subject in different scenarios.


Psychosis
Aberrant role from a scenario in a fictional reality
Primary delusion
mania
agitation, flight of ideas
Delusion
depression
inhibition, stupor or depersonalization
Congruent themes
prevalence
Incongruent themes
exaggerated self-evaluation
Different intensities of
mania and depression
Mood disorders
mania, depression
Delusional role

- The psychotic characteristic of mania and depression does not necessarily involve delusion. The interference between mood disorders and prevalent delusional pathology can be present at different levels of intensity of the depressive or bipolar pathology.
- Depressive and manic moods can favour the development of (congruent) delusional themes; but they can also accompany any type of delusion.

Obsessive pathology and its relation to delusion

- Obsessive pathology (Obsessive-compulsive disorder - OCT and Obsessive-compulsive personality disorder – OCPT) develops around an **ego-dystonic hyper-control of the pragmatic actions and of the subject's relations.**
- In the OCPT, the more apparent dysfunction is the one of the pragmatic action, displayed through: a strong adherence to work, the hypercontrol of decisions, an exaggerated preoccupation for plans and organization, endless checking, difficulties in ending an activity etc.
- The exaggerated control regarding relations manifests mostly in OCT, through ego dystonic aggressive impulses, followed by continuous checking.
- In both forms of the obsessive psychopathology, the main aspects are not related to the involvement of the subject in an aberrant identitary role, in a narrative scenario.

- According to DSM V, OCT can become delusional in some severe forms, when there is a lack of insight. E.g.

  The subject is obsessed by the fact that his child could have an accident while away from home; he comes to believe that his obsessive preoccupation raises the chances of the accident (=thought-action fusion); then, he is convinced that the child really had an accident and it was his fault; as a consequence, he does endless checking.

- Same as the case of mania and depression, we can consider that delusion is not specific for OCD; it can only interfere with this pathology.

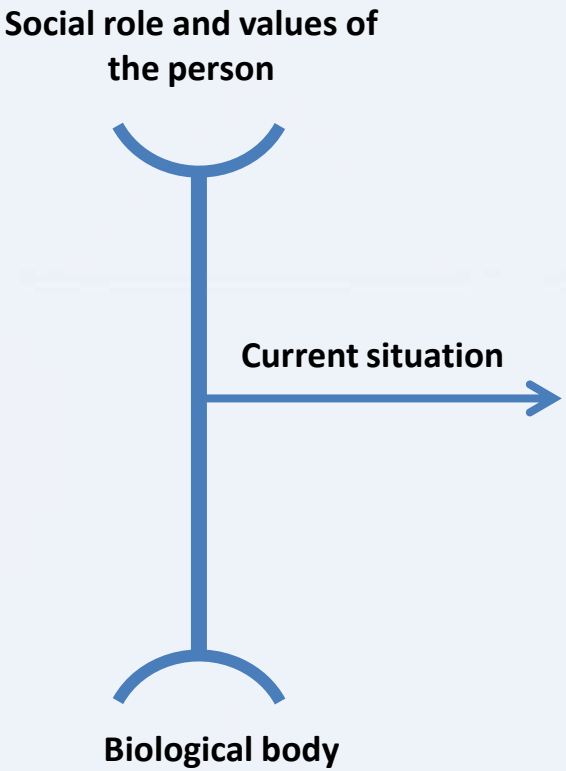
- From DSM's point of view, delusion can only characterize the severe forms of obsessive ideas, which, in this way, become psychotic.
- Similarly to the mood disorders, there can be psychotic forms of OCD without delusions. For example, the severe cases of the "magic rituals" and ceremonies with arithmomania; or "maladie de doute et delire de toucher" (Legrande du Saulle.)
- It would be very useful if the problem of psychosis was considered apart from the stereotyped perspective of hallucinatory delusion.

- The differences we mentioned between delusions, mood and obsessive pathology suggest that distinct disorders derive from different structures of the normal psyche. Accordingly, the need to search for these structures imposes. Understanding psychopathology from the perspective of the dysfunction of normal psychic structures requests the elaboration of comprehensive models regarding human psyche.
- The self can be considered the nucleus of the person's psyche. It has its roots in the biological body (embodied self) and it is framed by the socio-cultural identitary self (name, social role, identity documents, achievements, social biography).

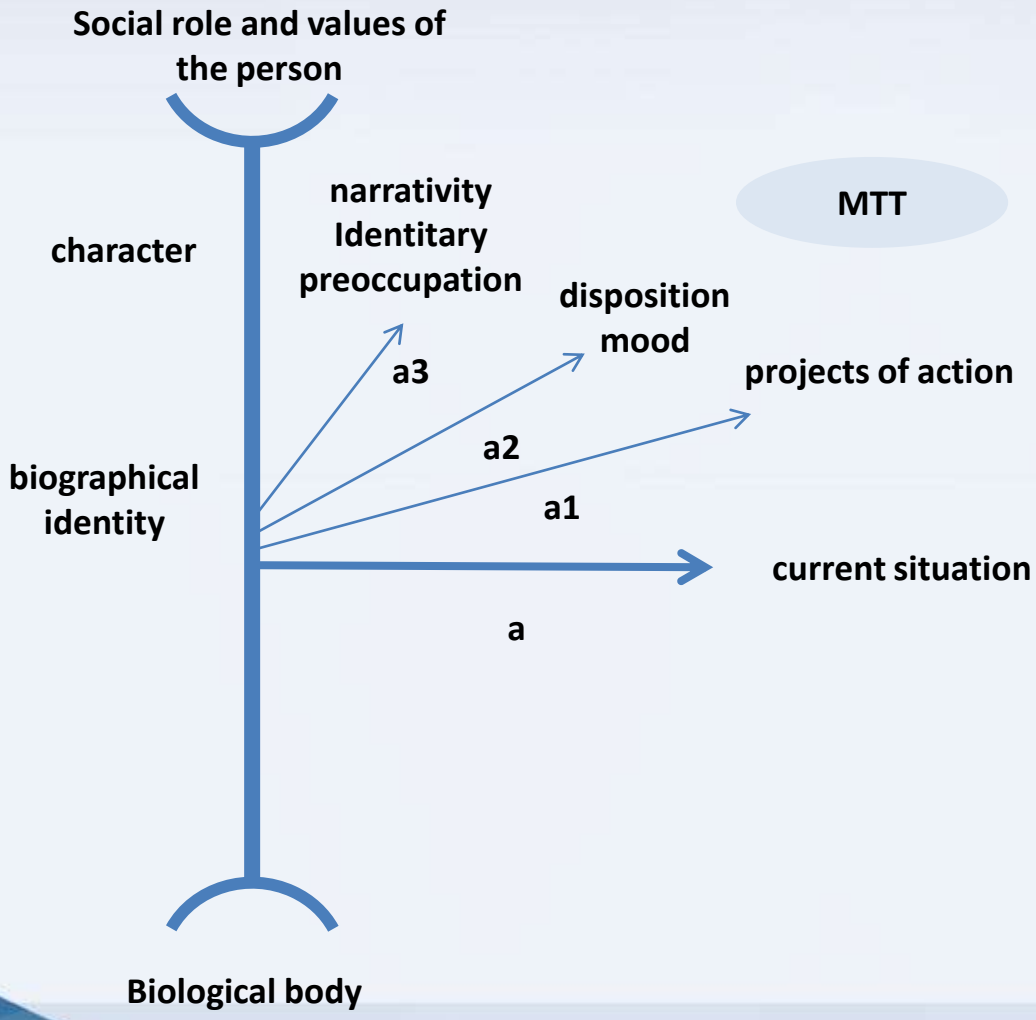
- Firstly, we need to make a distinction between two aspects of the self:

a) The subject's attitude towards the current problematic situations;

b) The trans-actual background of the biographical-characterial identity.



- Between the two axes, we can identify different possibilities of involvement of the self in longer, trans-actual situations, sustained by mental time travel (MTT), beyond the current events and based on the biographical-characterial identity.



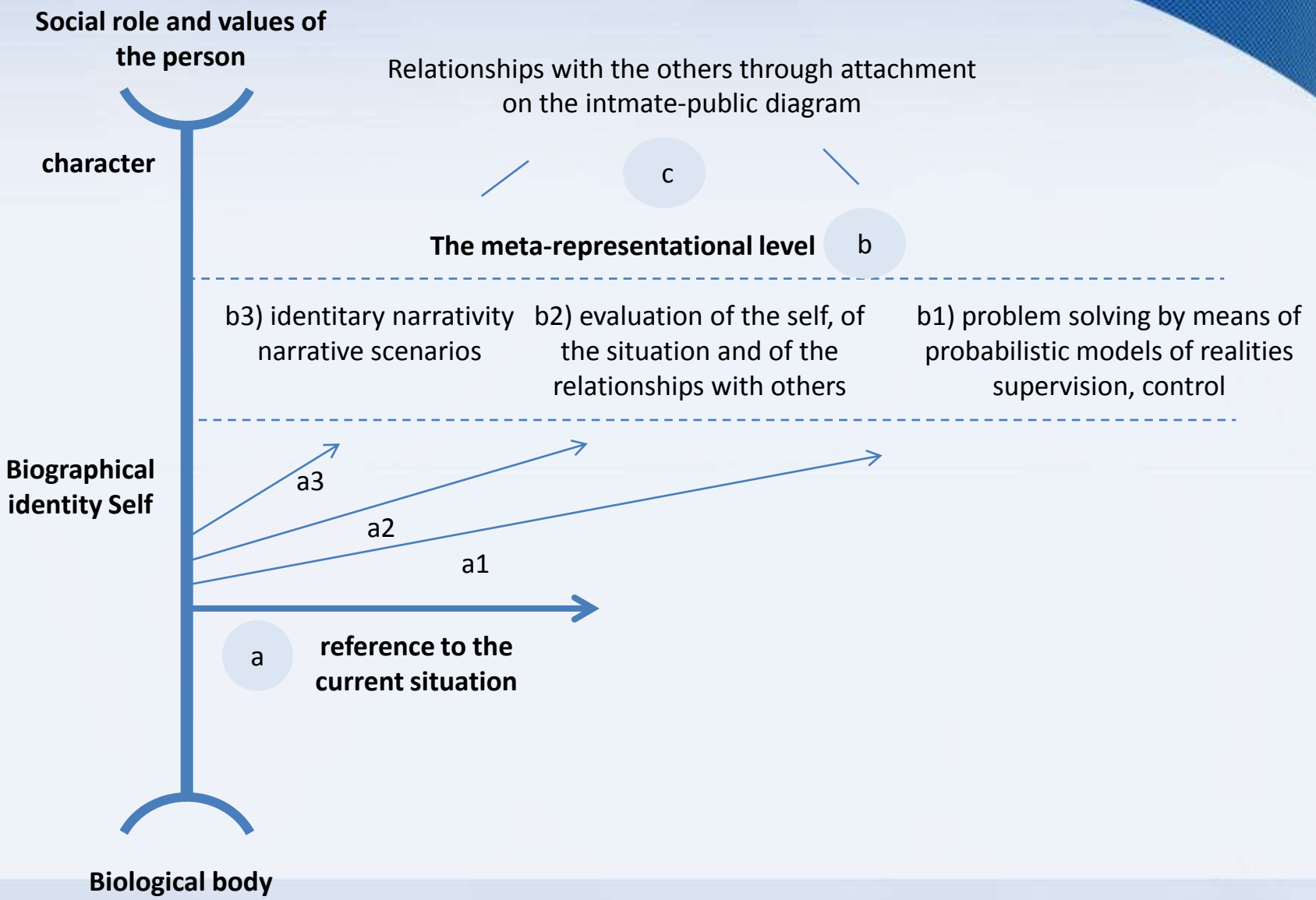
a1) long-term projects, with various objectives and durations; they can run in parallel and can be connected to each other; they imply the elaboration of probabilities of realities and supervision;

a2) long-term dispositions and moods, which orient the subject's resources towards specific expected events; evaluation and especially self-evaluation plays an important role in this situation;

a3) self preoccupations, regarding the subject's identitary state of being, value and relationships, in different scenarios in which he plays a certain role; this fact involves narrativity and biography.

These three aspects, placed between the biographical-characterial identity and the attitude towards the current situation imply the functioning of a metarepresentational level (b).

The meta-representational (autonoetic) level of the Self



- The meta-representational level of the self has three functions:

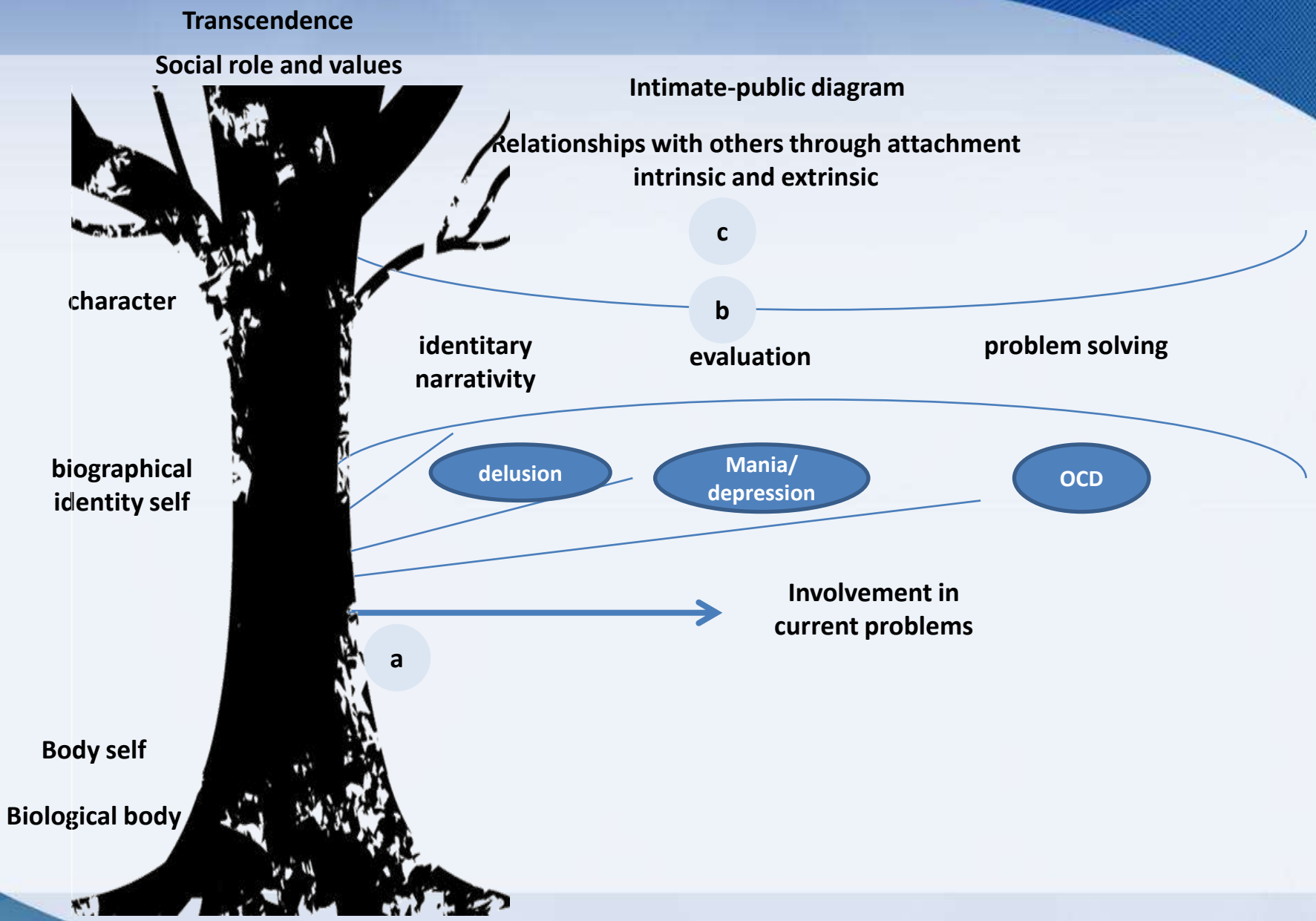
  b1) The rational processes involved in problem solving using probabilistic models of reality, accompanied by supervision and control; this function is involved in the efficiency of the actions and their control. The dysfunction of this structure is mostly expressed in OCD;

  b2) The evaluative processes, particularly the self-evaluation ones, correlated with dispositions and moods. In psychopathology, the impairment of the self-evaluation process is met in mood disorders, in mania and depression.

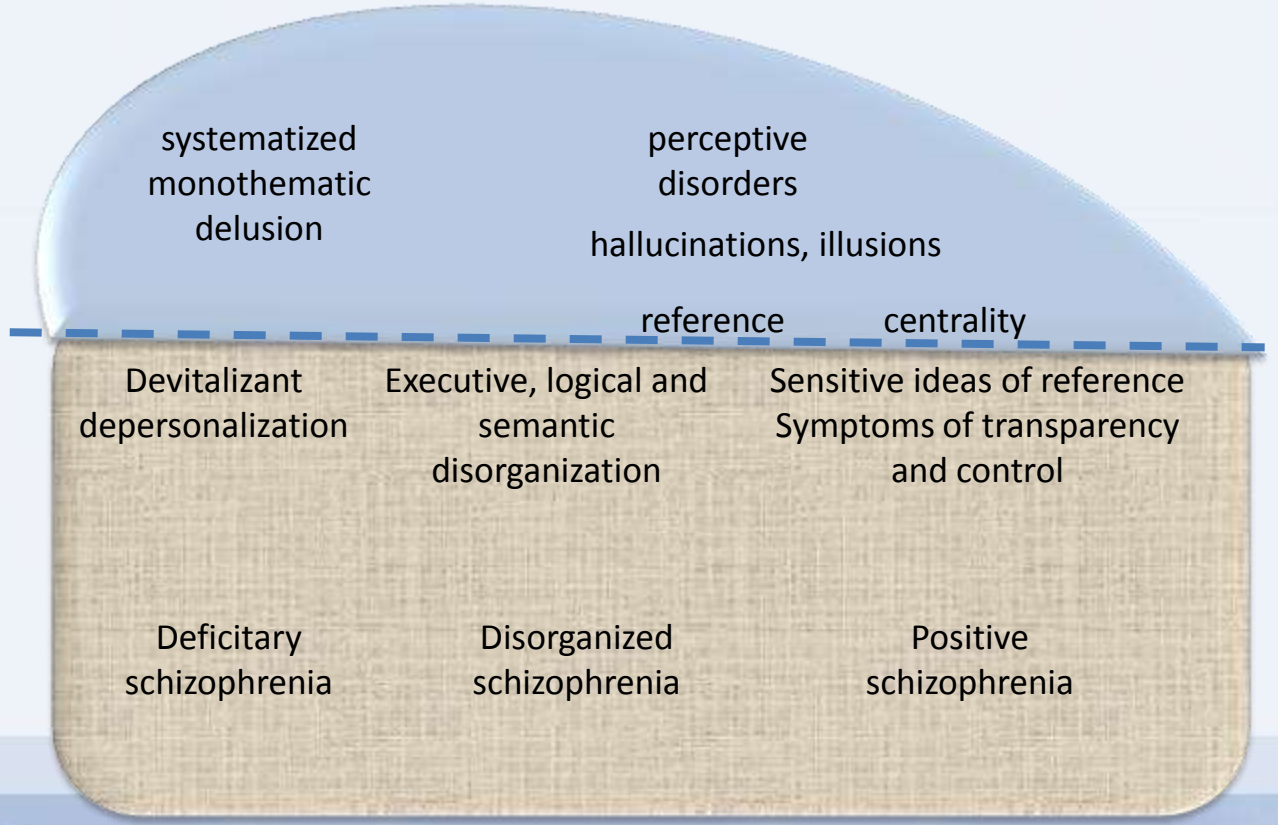
  b3) Identitary preoccupations, regarding the subject's state of being, value, relations and identity; this function involves narrativity and the lived scenarios that can be later related by the person. This function's impairment is more obvious in delusion.

  c) The meta-representational level is characterized by the functions of the relations with other persons, by means of the attachment process, based on the intimate-public diagram.

- This brief display places delusion, mood disorders and obsessionality in close, but still distinct areas.


Transcendence
Social role and values
Intimate-public diagram
Relationships with others through attachment
intrinsic and extrinsic
c
character
b
identitary
narrativity
evaluation
problem solving
biographical
identity self
delusion
Mania/
depression
OCD
Involvement in
current problems
a
Body self
Biological body

- **The type of delusion presented so far is the monothematic systematized one.**
- Traditionally, delusions were associated with disorders of perception, especially with hallucinations. ICD 10 also accepts this association in the F22.8 category, the one we used as a model.
- American psychiatry considers the presence of delusion and hallucinations equivalent to psychosis and even schizophrenia. The European tradition describes a more complex concept of schizophrenia.



- From the perspective of schizophrenia disorders, we need to take in consideration the following aspects:

  - special perceptual disorders;

  - Schneider’s first rank symptoms;

  - special depersonalization with devitalization and loss of identitary boundaries;

  - disorganization of the language, especially logical-semantic disorganization.

- The **disorders of perception** concerning the current information are common for the delusional psychopathology.
- In the area of the traditional problem of illusions, we can mention two aspects connected to delusion and correlated with the impairment of global functions:

  a) the “anomalous experience”, which implies a feeling of unfamiliarity and strangeness, suggest dysfunctions of the identitary function (based on the body scheme) that are similar to those in depersonalization/derealization.

  b) the exaggerated significance given to salient details suggest the impairment of the “central coherence” function (in Uta Frith’s view).

- As for hallucinations, the commentative auditory hallucinations denotes a dysfunction in the structure responsible for the intimate-public relations, which are specific for Schneider's first rank symptoms.
- The disorders of perception correlated with delusion could express the impairment of the general function**depersonalization, central coherence, intimate-public structure**s () which imply the level of the psyche responsible for the information regarding current situations.

- Shneider’s first rank symptoms derive from the structure that organizes the intimate-public relations.
- It is a commonly accepted fact that an attachment person or a person close to the subject can naturally know and intervene in his attitudes, decisions and intimate thoughts. In psychopathology, the knowledge and control of one’s thoughts or volition is experienced as unnatural, because strange persons are involved in the process. Thus, we can speak about the distortion of the structure governing the intimate/public relationships.
- The symptoms of transparency and control are correlated, in paranoid schizophrenia, with delusion of persecution, through the interpretation and the elaboration of a scenario. This correlation is connected to the phenomena of monitoring and control, such as: symptoms of reference, the feeling of being followed, the monitoring of intimacy through different instruments. These phenomena also express the dysfunction of the structure that governs the intimate/public relations.
- European psychopathology does not consider Schneider’s first rank symptoms as being delusional by themselves, but they can be integrated in the delusional beliefs through interpretations.

Schneider's first rank symptoms in correlation with other symptomatic groups defining "paranoid schizophrenia"

Schneider's first rank symptoms

Commentary auditory hallucinations
- of the person
- of one's behavior/thoughts

- thought echo
- thought diffusion
- thought reading
- thought surveillance
- thought insertion
- thought withdrawal
- thought control
- imposed actions/made acts
- somatic passivity

Sensitive ideas of reference

Supervision/control of intimacy, with instruments

centrality

centrality

centrality

Primary delusion

Exaggerated significations of salient, out of context details

Delusional mood

Symptoms of reference
(special significance regarding the subject)

- **The depersonalization in schizophrenia** refer to the devitalization of the lived body and the loss of the personal boundaries of the self; it is clearly distinct from playing a role in a narrative scenario. But this experience can be secondary comprehended in a narrative scenario about the self. Because the loss of identity is a type of experience.
- On the other side, disorganization is a formal disorder and not one of content, which refers to language. The loss of direction and deviation of communication are not delusional. The other aspect of disorganization, implying the logical and semantic structure, is somehow connected with delusional pathology, through the particular experience of significations in the delusional mood. This process is related to the primary delusion, in which the problem of meanings does not remain in the area of language, but in the one of perceptions. Still, the linguistic disorganization drifts apart from delusion, through the abstract, philosophical, bizarre and out of context preoccupations. Yet, the conceptual abstractions can combine with depersonalization in some aspects of schizophrenic delusions.

- A comprehensive understanding of schizophrenia cannot reduce this disorder to any type of hallucinatory delusion (in the way DSM V does). It is necessary to include here the special type of perceptual disorders, the impairment of the intimate-public relation module, the depersonalization with devitalization and logical-semantic disorganization.
- From this perspective, the schizophrenic delusion is the less appropriate example for the study of the specificity of delusion.

In conclusion I

- Delusion, as a psychopathological syndrome, could be most appropriately discussed through the pathological identification of the subject with a role in a fictional narrative scenario. This identification does not last for a moment, but for a period of time, an idea sustained by the mental time travel perspective (MTT).
- The deluded person thinks and acts according to the logics of the fictional realities and not to the everyday life pragmatic events. From this point of view only, delusion can, sometimes (for example, in the case of dominant bizarre narratives) be considered as an “empty speech act”.

In conclusion II

- The psychopathological problem is: why can't the deluded person get out of the fictional reality, like a novel, in order to be capable of living in different simultaneous realities, as in the everyday life realities?
- The identification with a role from a dramatic scenario implies the meta-representational level of the self, the level where the episodic and identitary memory and narrativity connects not only with the autobiographical identitary memory and narrativity, but also with the cultural narrativity (myths, legends, history, biography, novels, theatre plays)
- This approach could ,eventually, suggest some useful models for research in the problematic area of delusion.

Thank you!