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Delusions in schizophrenia as an interdisciplinary phenomenon for the philosophy of mind*

El delirio en la esquizofrenia como objeto de estudio interdisciplinario en la filosofía de la mente

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Abstract

Delusions are a transdiagnostic phenomenon with higher prevalence in schizophrenia. Historically, delusions have been regarded as the hallmark of psychosis. Over the last 20 years, delusions have attracted the attention of philosophers, psychiatrists, and cognitive sciences due to the ways in which they challenge some of the most fundamental claims about the nature of the human mind. However, despite its clinical relevance for the diagnosis of a number of conditions, the study of delusions still leads to a number of conceptual and empirical disagreements. This article clarifies some of the most fundamental problems raised by the observation of delusions in schizophrenia from an interdisciplinary point of view. Our analysis is meant to inform experimental approaches to the phenomenon, and, in turn, advance its treatment. In this sense, conceptual progress in this field is fundamental to map different paths for empirical and clinical research. This because any theory aiming at explaining delusions in schizophrenia should offer answers to the problems that we clarify in this paper.

Keywords

Delusions, psychosis, philosophy of mind, phenomenology, schizophrenia.

Resumen

El delirio es un fenómeno transdiagnóstico más frecuente en la esquizofrenia. Históricamente, el delirio se ha considerado la marca de la psicosis. Dada las formas en que desafía algunas de las premisas más fundamentales acerca de la naturaleza de la mente humana, durante los últimos 20 años el delirio ha atraído la atención de filósofos, psiquiatras e investigadores en ciencias cognitivas. Sin embargo, a pesar de su relevancia clínica en el diagnóstico de una serie de condiciones, el estudio del delirio aún produce diversas discusiones conceptuales y empíricas. Este artículo intenta clarificar algunos de los problemas más fundamentales que surgen del estudio interdisciplinario del delirio en el contexto de la esquizofrenia. Es importante señalar que la resolución de tales discusiones no constituye un simple ejercicio retórico, sino que permitiría, en el mejor de los casos, sentar las bases para el avance en la investigación clínica y experimental conceptualmente bien informada y, por ende, permitiría importantes avances en su tratamiento. En este sentido, el avance conceptual en el área será importante para definir la carta de navegación de la investigación empírica en el tema. Esto, porque cada teoría que intenta contar una historia explicativa completa y contextualizada del fenómeno de los delirios en la esquizofrenia debería ofrecer respuestas a los problemas que identificamos en este trabajo.

Palabras clave

Delirio, psicosis, filosofía de la mente, fenomenología, esquizofrenia.

Introduction

Delusions are one of the most severe disturbances of the human mind (Hooker, 1850; Berrios, 1991; Sass, 1992; APA, 2013; Connors & Halligan, 2020). Individuals who have delusions may indicate being dead (delusions of Cotard et al., 1995), or that some parts of their bodies are controlled by external agents (delusions of external control, Frith, 1992), that they can be in two parts at once (Weinstein & Kahn, 1955), or that different entities can introduce thoughts into their head (López-Silva, 2018), among many other things. Whatever the case, delusion has histo-

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rically been predominantly understood as believing something that is not the case (Porter, 2002; Bentall, 2003). In psychiatry, Karl Jaspers (1965) defined delusion as the hallmark of psychosis, an idea that appeared in contemporary psychopathology. With the popularization of phenomenological and scientific-experimental approaches to the phenomenon of mental illness as a medical issue in the 20th century, delusions have a key role in the context of the diagnosis of psychosis when it is included by Schneider (1959) in his list of *first-rank symptoms* of schizophrenia, becoming one of the main guides for the diagnosis of the condition in the last century, especially in Germany, the United States and the United Kingdom (Peralta & Cuesta, 1999; Murray & Quattrone, 2021). However, considering the elimination of preferential treatment of delusions in the diagnosis of schizophrenia in the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, APA, 2013), the diagnostic role of delusions in psychiatry is an open discussion (Tandon, 2013; Soares-Weiser et al., 2015; López-Silva, 2017a).

During the last 20 years, delusions have attracted the attention of philosophers and researchers in the field of cognitive sciences because it will enable to learn about fundamental aspects about the conceptual and cultural nature of the human mind (Stephens & Graham 1994; Zolotova & Brune, 2006; Bortolotti, 2010; Radden, 2011; López-Silva & Cavieres, 2021a). In this context, the study of delusions in psychopathology has become a source of multiple conceptual and empirical debates on the structure of rationality, the nature of self-consciousness, the phenomenology of agency and voluntariness, among many others. Most of these debates are still open and present diverse ways of research for different (López-Silva, 2020). Based on a critical qualitative analysis of the literature, this article aims to clarify some of the most fundamental debates arising from the interdisciplinary study of delusions in the framework of psychosis focused on the following debates, the typological problem of delusions; the etiological problem; the problem about the adaptability of delusions and, finally, the phenomenological problem of delusions. After this, our conclusion will try to present some of the challenges that remain open in the literature. It is important to note that the relevance of this type of analysis lies in the fact that the solution of several of these discussions does not constitute a simple rhetorical exercise but would allow to lay the groundwork for a conceptually well-informed experimental approach to the phenomenon and, therefore, would allow important advances in its clinical treatment (López-Silva, 2020). Thus, the conceptual advance in the area is important to define the chart of empirical research in the field,

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because every theory that attempts to tell a complete explanatory story of the phenomenon of delusions should offer answers to the problems identified in this paper (Connors & Halligan, 2020).

Delusion and the typological problem

The way of studying delusions is normally through the patients' verbal reports. Accepting the existence of several methodological and epistemic problems derived from the above, our initial gateway to the phenomenon of delusions is what patients say. Now, when Geraldine tells me that her coffee is 'too bitter' and that she should have chosen another with a lower percentage of cocoa, what is Geraldine reporting? It seems no problem to accept that this verbal report makes sense as a report of a *taste sensory experience*. Now, when she tells me that she wishes she had lived during early medieval Scotland, Geraldine's verbal report is the report of an *imaginative cognitive* state. When Geraldine tells me that her new car is yellow, that report implies the report of a *visual sensory experience*. So far, there seems to be no controversy. In each case we can clearly define what the mental state is at the basis of such reports; we can identify the experiential modality (sensory or cognitive) that informs Geraldine's reports.

But what happens when a patient reports that trees have been inserting thoughts in their head? (Payne, 2013) Is it by virtue of 'feeling' or 'seeing' trees inserting thoughts into their head? Does the patient actually feel that? Is it something they are imagining? This is a problem in psychopathology as it involves the challenge of identifying the type of mental state a delusional patient is reporting. In the literature, this issue has been referred to as the *typological problem of delusions*, which involves defining the type of mental state that is instantiated in the reports of patients who are suffering from delusions (López-Silva, 2017b; López-Silva, 2021). For some people, formulating typological problem might seem overly conceptual, a matter more important for philosophers than for psychiatrists. We do not completely agree with this. All experimental research and psychotherapeutic treatment of delusions lie on the idea that this phenomenon is a specific type of mental state (Bayne & Pacherie, 2005). Let us imagine that delusions instantiate a type of mental state M. Experimental research on delusions is only possible as the investigation of how M is produced in the brain and how alterations in the processes of M production would produce delusional states in a subject (McKay et al., 2005; López-Silva, 2022). Without the typological definition M, it would

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be very difficult to advance on empirical research in the field of delusions. On the other hand, progress in the psychotherapy of delusions is only possible if we understand how to deal with a specific type of mental state. If we do not understand what type of mental state a delusion is, and thus do not understand its main characteristics and paradigmatic behavior, how could we generate forms of psychotherapy that are only effective and efficient if we know the type of mental state we are dealing with and its paradigmatic behavior? Much of current psychotherapy involves anticipating and foreseeing potential delusional behaviors in a patient, but this would be very difficult to achieve without having an answer to the typological problem, and therefore, this debate is not a mere theoretical exercise, but a practical problem for current psychopathology as well.

Potential alternatives to the typological problem

There are currently two major alternative solutions to the typological problem in the literature. On the one hand, the doxastic approach indicates that delusional reports instantiate abnormal beliefs (Bayne & Pacherie, 2005; Bortolotti, 2010, 2014; López-Silva, 2017b). For this approach, delusions are beliefs that lack certain paradigmatic features but can nonetheless be considered as beliefs (Bayne, 2010). The initial appeal of this approach stems from the fact that delusions seem to be reported in the same way that some beliefs are reported (Green et al., 2018). There are at least two major formulations in the doxastic model of delusions. On the one hand, the bottom-up formulation will indicate that certain patterns fed over time by delusional ideas begin to set in the way a subject begins to interpret reality. Over time, this delusional pattern could even contaminate the content of a subject's sensible experience, which would imply the origin of delusion (Campbell, 2001). On the other hand, the bottom-up formulation will suggest that anomalies in a subject's sensorimotor apparatus will be the basis for the creation of delusions as beliefs. In this sense, delusions would have their basis in experiential anomalies with highly abnormal content (Bayne & Pacherie, 2005). Although there are other distinctions within the bottom-up formulation of the model, the doxastic approach has become the dominant alternative within the typological discussion because of its conceptual clarity, empirical scope, and heuristic power (Bortolotti, 2010).

Although the doxastic approach has prevailed in the current literature on the typological problem, there is another group of theories that originated as a critique of it. This approach can be called anti-dox-

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astic and refers to a group of theories that indicate that delusions do not seem to meet the requirements to be considered beliefs (see, for example, Schwitzgebel, 2012). Within the anti-doxastic argumentation, the Imagistic approach to delusions groups several authors who associate delusions with alterations of the imagination. For example, Currie (2000) indicates that delusions are 'cognitive hallucinations', namely imaginative states misidentified as beliefs by a subject. McGinn (2004) suggests that delusions are imaginative states created by the uncontrolled and unmonitored imaginative activity of a subject. While for Currie, delusions arise due to problems in the identification process of different mental states, McGinn says it occurs due to hyper-production and alterations in the monitoring mechanisms of the production of imaginative states. Likewise, Egan (2009) indicates that since delusions have characteristics of imaginations and beliefs, delusions should be catalogued as *bimaginations*. However, these proposals have been criticized by their lack of conceptual clarity and lack of phenomenological and empirical appeal (Bortolotti, 2010; López-Silva, 2017b). For example, it is not clear how alterations in imagination would produce states that are reported as if they were beliefs; neither could one characterize the phenomenology of delusion as a *bimagination* because the very phenomenology of this mental state does not seem to be clear. Finally, there is no clear experimental evidence about how alterations in the production of imaginative states could produce the kind of mental state we call delusion. Whatever the case, the typological problem of delusions is an open discussion and although the doxastic approach has a dominant argumentative appeal in current neuropsychiatric psychopathology, advocates of anti-doxastic approaches continue to propose new options. Clearly this is not something we can solve in this section.

How are delusions formed? The etiological problem

Each alternative to the typological problem may be the basis for telling a story about how that specific type of mental state is formed in the human mind - a belief, an imagination or a bimagination. The above is referred to as the *etiological problem* of delusions (Coltheart et al., 2011). In this context, the doxastic approach has become dominant because most proponents of imagistic approaches have failed to present a consistent etiological story with plausible empirical and/or experimental support (Bortolotti, 2010; 2015; López-Silva, 2022). For example, in the case of

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Currie's approach, it is not clear that people with schizophrenia have a generalized impairment in identifying the typology of their own mental states, and if this could perhaps be explained as the product of delusional atmospheres prior to the emergence of psychotic delusion; the model fails to explain why this type of specific misidentification would generate delusion. For its part, there is no evidence of uncontrolled imagistic activity in psychotic patients as proposed by McGinn. Finally, no one is sure what bimagination is and how it would be produced. For this reason, the three most popular proposals on the etiological problem have adopted the doxastic approach, meaning that they are proposals of delusion formation as beliefs. Alternatives are presented in the following section.

Alternatives to the etiological problem of delusions.

Maher's (1974, 1992, 2001) one-factor model indicates that the type of experiential anomalies present in psychotic patients is sufficient to produce beliefs with the type of content present in delusional reports. The content of the delusions as beliefs would basically be acquired from the content of the first-order abnormal experience that produces them. For Maher (2001), delusions would not be created in ways so different from the way normal beliefs with direct experiential content are generated. Delusions emerge as a theory that attempts to make sense of the aberrant experiential content of psychotic patients. Thus, if delusions are understood as beliefs, the main problem lies in the experiences that underlie them, not in the reasoning processes (Maher, 2001).

Several criticisms of the one-factor model led to the development of the two-factor approach (Davies & Coltheart, 2000; Coltheart, 2007; Coltheart et al., 2011). For the advocates of this approach, Maher's model would fail to discriminate between people who possess experiential abnormalities but never develop psychotic symptoms such as delusions from those who end up generating this type of mental state. For example, according to the one-factor approach, anyone who suffers brain damage that reduces their affective response to faces should develop Capgras delusion or something close to it. At the basis of this delusion, there is an abnormal experience that is explained by a specific type of brain damage in the area responsible for the emotional response to faces (Hirstein & Ramachandran, 1997). However, people with this type of anomalous experience do not necessarily produce the specific delusion (Davies et al., 2001). In addition to this, it has been suggested that the one-factor model would not be able to explain why delusions persist, even if their

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emergence arises as a way of making sense of the underlying abnormal experience. In this sense, the model is not able to explain why patients do not reject the doxastic hypothesis with bizarre content in the face of evidence against it (Coltheart, 2007), and, therefore, it is normal to think that another type of element (besides the sensory one) could be playing an important role in the psychogenesis of the phenomenon. Therefore, it has been suggested that a second factor could explain these open issues.

For Davies et al. (2001), the second factor in an etiological theory of delusions should account for a subject's inability to reject a potential belief on the basis of its implausibility and inconsistency with the rest of the patient's knowledge. Several proposals have emerged as candidates for the second factor within the model; however, all of them tend to emphasize the role of cognitive type disturbances as a complement to the experiential type disturbances captured by factor 1.

For some (Bentall, 1995; Bentall et al., 2001), factor 2 is an attributional bias, i.e., alterations in the way subjects tend to explain events that occur in their daily lives. Whether externalizing or internalizing, exacerbation of either of these explanatory patterns could cause alterations in the way experiential evidence in a patient's life is examined. For others, factor 2 is best described by the observation of various reasoning biases, indeed, the most popular versions of the two-factor model tend to rely on this idea (Coltheart et al., 2011). According to (Garety et al., 1991; Garety & Hemsley, 1997; Garety & Freeman, 1999), patients at risk of psychosis would tend to jump on conclusions without sufficient evidence for them (*jumping to conclusions bias*). However, this proposal has been criticized for its low explanatory-statistical power, i.e., the differences between the psychotic population and the controls do not seem to be significant enough to support the whole proposal (López-Silva & Cavieres, 2021b). For this reason, Coltheart et al. suggest that the second factor should be understood as a deficit in the general system of generation, evaluation, adoption, and maintenance of beliefs due to a plethora of reasoning problems that may have specific characteristics that may vary from one subject to another. However, this being an experimental subject.

During the last few years, the error-predictive theory has developed which is alternative to the etiological problem and which seems to be complementary to the aforementioned approaches, (see Sterzer et al., 2018; Miyazano & McKay, 2019). This approach is based on the *predictive-coding* paradigm of Corlett et al. (2006, 2015, 2016). According to this approach, the brain attempts to predict potential sensory inputs based on its existing representations of reality. In this sense, the brain would be a predic-

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tion-making machine. When interacting with the environment, the brain compares projected inputs with actual inputs. When there is a *mismatch* in this comparison, the brain will try to minimize the disturbance generated by this mismatch by revising the internal representations from which such predictions are derived. For Corlett et al. (2016), this minimization of prediction error is done by Bayesian logic to the extent that internal representations in the brain are updated as a function of previously predicted inputs and new inputs. Within this context, delusions would emerge as a way in which the brain would attempt to decrease the incongruence arising from various prediction errors in psychotic patients.

This approach has been studied in the last years. However, it has also been pointed out that it fails to distinguish the etiology of various symptoms explained in the same way (*indiscriminability problem*). For example, Sterzer et al. (2016) indicate that prediction errors in the human cognitive system would produce symptoms such as hallucinations and delusions. However, suggesting that these types of phenomena might have a common etiology do not explain how these general system abnormalities manifest in different ways in the subject's consciousness. Another problem associated with this approach is that it seems to apply successfully to the first psychotic episode but fails to explain how the delusion persists over time if the prediction errors have already been neutralized. Whatever the case may be, the etiological problem is an open issue in the current literature and, due to the strengths and weaknesses of the various proposals, there seems to be a tendency to explore hybrid theories that manage to integrate different aspects of the alternatives available in the literature.

What is the role of delusions? Adaptability and the functional problem of delusions

The etiological and typological debate are related to a third discussion that arises from the clinical observation of delusion; this debate has to do with the discussion about whether delusion could have some benefit to the functioning of the individual (Freud, 1924, 1986; McKay & Dennett, 2009; Lancellotta & Bortolotti, 2021). The idea is to analyze whether delusion (i) could happen to attenuate certain negative consequences in the psychic apparatus, or (ii) whether the emergence of delusion could have some benefit, even if its emergence is due to dysfunctional mechanisms. On this basis, there are several alternatives in the literature. We will review them below:

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Types of adaptability and alternatives to the functional problem of delusions

The first alternative to the problem suggests that delusions could play a beneficial role in the mental life of patients by the way they manage to attenuate psychological suffering. This type of adaptability is referred to as *psychological adaptability* (Mckay et al., 2005; Lancellotta, 2021). In the history of psychiatry, the psychoanalytic tradition is one of the first to indicate that delusions are produced by the psychological benefit provided to the mental life of patients. In this paradigm, delusions arise because of their palliative role in the way the mind deals with intrapsychic suffering (Bell, 2003). For Freud (1924), a delusion arises as a patch that is placed where there was originally a crack in the relationship between the subject and the external world. For psychoanalysis, delusions are ways of the mind generated to maintain its integrity and reduce the suffering provoked by a traumatic unconscious event -following the classical formulation of the model.

Regardless the various criticisms to the psychoanalytic model of psychopathology, the idea that delusions can play a psychologically beneficial role in the mind of the patient is an *insight* that has been developed by other traditions. For example, the so-called *motivational approaches* - which could be considered as a version of the two-factor approach - suggest that this phenomenon is caused by the psychological benefits they give to the subject (Bentall & Kaney, 1996; Bortolotti, 2014). Here, delusion is an active psychological response that arises in the face of internal or external threats to the integrity of the self by using certain interpretation patterns of the reality (see previous section). For Bentall et al. (2001), delusions arise as a way for the mind to deal with conflicts that are overwhelming for the individuals as they would allow the management, processing, and incorporation of highly negative experiences in their lives.

Similarly, but without appealing to an etiology based on unconscious conflicts, the phenomenological tradition of Jaspers (1965) and Conrad (1958) indicates that the emergence of a delusion in psychosis comes with generalized changes in the way of experiencing reality and the self. This period, commonly referred to as 'delusional atmospheres', can last from months to years and represents the prodromal stage of psychosis. As Conrad indicates, delusions arise in this context as an experience of revelation in relation to what has been causing strangeness and perplexity throughout this period (Fusar-Poli et al., 2022). Conrad says that this experience is usually accompanied by feelings of relief as it would imply regaining functional levels of reflexivity. The idea, we may

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hypothesize, is that in this context, delusion plays a beneficial role insofar as it manages to pathologize only one dimension of reality, contrasting with the generalized patients' experience of reality that precedes delusion (see Mishara & Corlett; 2009; Mishara, 2010). While this proposal needs further elaboration, it is clearly a more plausible alternative than the psychoanalytic one by the experimental evidence available in the literature on the etiology of delusions.

In contrast to this tradition, most proponents of two-factor models for the etiology of delusions have indicated that the phenomenon originates from the existence of distinct *deficits* in the process of belief formation (Coltheart, 2007). Because of this, it seems difficult to defend the idea that delusions can have any intrinsic benefit for the mental life of patients. This conclusion seems to be based on the idea that paradigmatic beliefs play a fundamental adaptive role in the psychological life of living organisms to the extent that their content is true (McKay & Dennett, 2009). However, there are proposals that indicate, although it is true that delusions are produced by multilevel deficits, the mind is designed to reduce the damage of such failures, making it possible to outline the idea of a deficit-based approach that preserves the palliative idea of delusions. Considering the phenomenological evidence described above, this hybrid idea seems to apply to both the one- and two-factor approaches, as well as to the emerging prediction error approach. Undoubtedly, this is a research project that needs to be deepened because of the importance it could have for generating more focused and contextualized psychotherapeutic tools.

Psychotic experience and the phenomenological problem

As indicated in the initial sections, the main way in which delusion is approached is through patients' reports. Moreover, psychosis is a phenomenon of philosophical and medical interest based on the alterations in conscious experience reported by individuals (Jaspers, 1965; Sass, 1992; Fusar-Poli et al., 2022). For this reason, the in-depth description of psychotic experiences from the point of view of the first person becomes an essential issue when defining the elements explain by a theory of the phenomenon (Parnas & Zahavi, 2000; López-Silva, 2018). In this context, phenomenology is essential for understanding the delusional phenomenon (Mayer-Gross, 1932; Jaspers, 1965; Fuchs, 2005; Van Duppen; & Fayaerts, 2020). Phenomenological practice (as developed by Husserl) uses methods to reduce the observer's biases and commitment to certain abs-

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tract conceptions regarding a phenomenon by attempting to 'suspend' them in the description process (Gallagher, 2013). In this context, researchers in psychopathology and philosophy of mind will use the phenomenological method to suspend the naive realism of our own experience of the world (Mishara & Fusar-Poli 2013). However, even the most disciplined phenomenologists are not able to suspend all their preconceptions about reality, and therefore the phenomenological method seems necessarily to include a hermeneutic approach. This will generate several problems in attempting to elucidate the phenomenology of psychosis, which proposes fundamental disagreements in analyzing the elements to which explanatory theories of the phenomenon should make sense.

For example, thought insertion delusions show patient reports, indicating that different animate or inanimate entities introduce certain ideas or thoughts into their head (Schneider, 1957; Mullins & Spence, 2003; López-Silva, 2018). Generally, this type of delusions - although transdiagnostic, is predominant in schizophrenia - emerges in multiple alterations in intersubjective experience, corporeality, and the self (Mayer-Gross, 1932; Jaspers, 1968; Mishara, 2009; Fusar-Poli et al., 2022). Some authors have attempted to explain the emergence of this delusion as alterations in the sense of mental agency (Zahavi, 2005; Gallagher, 2015). The idea is that the absence of the sense of being the creator of certain thoughts would produce their externalization. There are several problems with this interpretation. However, one of the most important has to do with the way in which the phenomenology of thought in psychosis is analyzed, and the role that the concept of a sense of mental agency occupies in explanatory theories of the phenomenon by noting that:

> Certain people see their thoughts as something they act upon [thoughts as a kind of mental action], and others see them as something that occurs mostly outside their control [...] Thoughts are sometimes simply presented [in consciousness] and seem to determine our behavior without any voluntary control over them, leaving aside any possibility of a sense of agency (Proust, 2009, p. 253).

As can be seen in this case, there are fundamental disagreements regarding the phenomenological elements associated with certain mental states, which, in turn, will generate disagreements in the interpretation that some theories make to explain the origin of delusions. However, it is important to point out that the deepening of phenomenological research in the study of delusions is an open task at present. On the other hand, current progress seems to complement not only the contributions of classi-

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cal authors (Mayer-Gross, Jaspers, Conrad, Kraepelin, among others), but has also begun to explore important connections with some of the current theories being worked to elucidate the neurophysiology of psychotic delusions (Mishara & Fusar-Poli, 2013; Corlett & Fletcher, 2015). Undoubtedly, this is a connection that should continue to be studied to inform theoretical models of delusion and to be informed by such conceptual reflections in their process of mutual feedback and complementary progress.

Conclusions

The study of delusions is full of methodological, theoretical, and empirical difficulties. In this article we have attempted to clarify four of the most fundamental problems that arise when trying to elaborate an interdisciplinary understanding of psychotic delusion. Moreover, it is important to note that each of these debates remains open, arising several challenges for an interdisciplinary and contextualized understanding of the delusional phenomenon. One of these challenges has to do with the current confusion that exists in elaborating theories of delusions without including the diagnosis of which they are a part. For example, in many parts of the literature, psychotic delusion in schizophrenia is treated interchangeably with other delusions that do not appear to be specifically associated with this condition. We believe that failure to include the diagnostic category of delusion might lead to overlooking phenomenological and ecological- and even etiological-features that would fail to plausibly support such comparisons. For example, it does not seem to be the same to elaborate a theory on Cotard's delusions as one focused on delusions arising in schizophrenic psychosis, exactly because they are accompanied by different phenomenological, ecological, and etiological conditions. As seen, psychotic delusion emerges in a rarefied atmosphere where the general experience of the self, intersubjectivity and external reality is altered. In turn, this kind of general alteration of reality seems to be constitutive on the way in which delusion manifests in schizophrenia. Now, this type of context does not seem to be typical of all delusions, and, therefore, it is not clear that we can make direct comparisons if we do not consider these constitutive differences, which does not imply that comparisons cannot otherwise be made. In this sense, we are not indicating that different types of delusions could be different types of mental states -although we do not rule out the option- but rather that the integration of the diagnosis in which a specific delusion is framed would specify some fundamental

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elements to understand different types of delusions to establish informed comparisons. Any approach to the general phenomenon of delusion and its expression in schizophrenic psychosis should consider this complexity when exploring interdisciplinary and contextualized forms of research for this phenomenon.

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