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ORIGINAL ARTICLE

Phenomenological distinctions between delusions in schizophrenia and the affective psychoses

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The article addresses phenomenological differences between delusions in the three functional psychoses – schizophrenic, depressive and manic psychosis. We show that psychosis in Depression differs fundamentally from that of Schizophrenia in respect of their delusions, whilst, contrary to expectations, in Mania it resembles schizophrenics more than they do depressives. Our deliberations incorporate the insights of most of the major 20th Century psychopathologists who have tackled the topic, are illustrated by actual delusions of subjects we have both encountered, and draw on philosophical apersus of the matter.

Keywords: delusion, phenomenology, schizophrenia, depressive psychosis, mania.

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INTRODUCTION

For more than a century, discussions on delusion have purportedly focused on the nature of delusion in general but taken schizophrenic delusions as the benchmark of this. Jaspers initiated this trend, with his notions of primary or pure delusions restricted to schizophrenia and merely delusion-like ideas prevalent in depression and mania (Jaspers, 1963). This has had a deleterious effect, in our view, both in furthering knowledge as to the nature of delusion, and as to the essence of Schizophrenia itself. For, delusions, even defined by strict Jasperian criteria, undoubtedly occur in non-schizophrenic states, and the nature of any entity whatsoever must surely take into account all extant varieties. Furthermore, the very nature of schizophrenia is illuminated by psychopathological exemplars of what does not belong to it, including the sorts of delusions that occur in other conditions. By denying delusional status to crazy beliefs held by those with Mania or Depression, which is what Jaspers, and, more recently, Spitzer did, then delusion is no longer a problem for general psychopathology, but a specifically Schizophrenic issue, and this leaves the peculiar beliefs in Mania and Depression in limbo (Spitzer, 1990). In this article we treat delusion as a general problematic for psychopathology and survey the sorts of delusion that can occur. If this requires a revision of the definition of delusion to accommodate our considerations, then so be it.

We review the main ways in which delusion has been formulated, almost always with schizophrenia in mind, and show that, far from excluding the varieties occurring in Mania and Depression, each thesis proposed not only accommodates the depressive varieties with a little revision, but is strengthened by having different, and, in most cases, inverse versions of it exemplified by subjects with depression, and to a much lesser extent, Mania.

The delusional profile, as we call it, abstracted from this literature, has several elements, and we focus on six in this article:

1) an anomalous pre-delusional state of mind;
2) a transformation in the 'meaning of meaning';
3) an alteration in the coherence between belief and action;
4) a shift away from a first person perspective on all matters;
5) a change in the nature of referent and reference;
6) individual knowing and consensual factuality at variance.

In each case we aim to show that there is something essentially true about the insight achieved by earlier psychopathologists, yet further demonstrate that it is true for the three varieties of delusion studied, albeit in different ways.

1. CHANGES IN PRE-DELUSIONAL STATE OF MIND

In the premonitory phase of delusion there is often an anomalous state of mind in which hitherto customary ways of experiencing the world are replaced by a new framework. In the psychopathological literature this is referred to variously as perplexity, delusional mood or delusional atmosphere. Jaspers and Conrad are particularly good guides here as to the nature of this experience (Conrad, 2013; Jaspers, 1963). Any phenomenological difference between the three states, however, has never been convincingly formulated, and, in line with our introductory remarks, all three have been consistently linked with schizophrenia. Examples of the Pre-delusional state of mind are portrayed in Table 2 and an analysis of their rapport provides us a different locus for the perplexity. The problematic in Schizophrenia appears to be the external world: what on earth is going on out there – walls moving in and out, day turning into night? Buildings taking on a life of their own, people turning into devils? That of depression and mania, on the other hand, appears to be perplexity about themselves: What's happening to me? Am I a pathetic idiot? What are they telling me?

As the situation hardened into actual delusions we hypothesised that a similar pattern of clear-cut world change coupled with uncertain personal meaning might occur in Schizophrenia, whereas an uncertain world situation coupled with clear-cut personal meaning might characterise the depressive and manic picture. We had the series of psychotic subjects reported by Cutting (unpublished data) to assist us – 250 subjects with Schizophrenia, 100 subjects with Depression and 100 subjects with Mania –in Table 3 and 4. We present an analysis of whether there is an overt signifier or referent without any overt signified or reference (e.g. people signalling to her by switching lights out) and whether there is the converse situation of an overt signified or reference without any clear-cut signifier or referent (e.g. 'Recently I've noticed that they notice I've had a stare'). The results are supportive of our proposition for Schizophrenia vs Depression. The subjects with the former diagnosis have a significantly greater proportion of world-based signifiers with no exact personal significance, whereas those with depression exhibit the converse – a significantly greater proportion of adduced meaning or significance for themselves without any overt basis for this. Patients with Mania almost exactly resembled those with Schizophrenia (except for a greater incidence of numerical or verbal signifiers, see below).

Setting this in the context of the psychopathological literature, the received opinion is that perplexity and it's supposed distinctive offshoots – delusional mood and delusional atmosphere – it virtually confined to Schizophrenia. Störring (1987), for example, writes:

> "The perplexity associated with manic-depressive illness does not have the quality of strangeness which is part of the schizophrenic experience. It also occurs much less frequently"

He does go on to say, however, that in Schizophrenia "the changes in his perceptual world perplex him" whereas in Depression it is accompanied by depersonalisation, which is in line with our findings. Tellenbach and, quite recently, Stanghellini and Raballo also pinpoint the situation in depression as focused on the self and not the world (Stanghellini and Raballo, 2015; Tellenbach, 1961). In general, though, we are of the view that perplexity, delusional mood and delusional atmosphere have been unfairly abrogated to schizophrenia, whereas they are merely subsets of a pre-delusional anomalous state of mind shared in Depression and Mania. What sets apart Schizophrenia and Depression in this respect is that in the former it seems a centripetal process – the subjects focus first in what's happening "out there in the world" and changes follow a centripetal direction ultimately changing the subject. In the depressives the changes in the pre-delusional state of mind seem centrifugal: the problematic first attaches to the subject: "who am I? What have I done?" and

only then permeate the world they inhabit.

From a philosophical perspective, Heidegger's notions of the adequacy of world-building can be invoked here (Heidegger, 1938/1995). The depressed subject, within this framework, is world-impoverished (not appreciating what in the world gives rise to his or her distress), whereas the subject with Schizophrenia is world-enriched, albeit a dilapidated or fragmentary world (appreciating quite adequately his or her ruinous world, possibly more so than the sane, but failing to understand how it relates to himself or herself). From a neuropsychiatric viewpoint, the study of saliency in Schizophrenia shows an increased (and aberrant) saliency during psychotic episodes also suggesting an augmented, and yet incoherent world (Kapur, 2014).

2. TRANSFORMATION IN THE 'MEANING OF MEANING'

Delusion itself was formulated by Grühle as a Beziehung ohne Anlass [an unreasonable connection], which he elaborated as follows:

> "It is just those cases, in which the patient knows that there is a meaning but not what that meaning is, which illustrate the primary nature of this morbid happening"
>
> "the patient is not disturbed in the so-called elementary components of his perceptual experience (colour, etc.), nor in their functional meaning (this is a table), nor in his further elaboration (this is a rococo table), but only in the compulsion of his symbolic experience (this table means that the whole world is as twisted as its legs)."
>
> (Berze and Gruhle, 1929).

The thread running through this succinct summary is that something has happened to the 'meaning of meaning' in delusion. Grühle was concerned here with the schizophrenic's 'primary delusions', but an adaptation of his formula whereby it becomes a transformation in the meaning of meaning may be a good starting point for unravelling all the sorts of delusions we are concerned with here. The second entry of Table 1 presents examples of such transformation. In each case what is 'meant' and what is tacitly acknowledged are at variance. This is exactly what Grühle held about delusion: the meaning conveyed by some state of affairs is out of kilter with an otherwise adequate recognition of the sense of the situation. In schizophrenia he recognized his family but they 'meant' nothing; whilst in depression and mania they were quite aware of their surroundings too, but something about those surroundings 'meant' that he or she was different – dangerous (head of a cigarette company). This centrifugal and centripetal tendency, respectively between schizophrenics' delusions on the one hand and depressives' on the other, was analysed in the previous section. Here we are concerned with delusion as a general transformation in the meaning of meaning, and to make progress here we need a different approach.

The phenomenological literature is of little assistance here. The thrust of psychopathology in the 20th Century was only to accord the discovery of new meaning in banal situations in Schizophrenia, and to ignore the capacity of this respect in Depression and Mania. But those with Schizophrenia in our sample experienced a loss of meaning in their discourse with their family, whilst subjects with Depression and Mania found new meanings. In fact we can cite numerous cases of Depression and Mania who found new meanings in hitherto everyday situations. We can also find that subjects with depression, but not those with Mania experience an evisceration of meaning, just as our schizophrenic did. All this challenges the 20th Century psychopathological tradition in which schizophrenics have a monopoly on delusion, and that their delusions are replete with meaning. The meaning of meaning is transformed in delusion, neither consistently highlighted nor debased, certainly in schizophrenics and depressives.

This topic has eluded psychology and neuropsychology researchers in their incursions on psychosis. Psychology seems uninterested in, if not antagonistic to, the diagnostic differences that concern us here. Sass, who has consistently stressed the 'paradoxes of delusion' (Sass, 1994) that the one theme that psychologists are largely united about – an attributional or 'externalisation' bias in delusion – is less obvious than what Sass refers to as a 'subjectivising' bias, manifest, according to Sass, in the celebrated case of Schreber (Sass, 2015). Neuropsychology suggests semantic memory disorder and visual agnosia (which are disturbances in meaning appreciation) but its tools seem too crude to

account for the subtleties we are dealing with here (Gabrovska et al., 1991). There are instances of agnosia where the subordinate exemplars of some basic object are mistaken while the basic object itself is correctly recognized – e.g. models of car with preserved distinction of a car from other general vehicles (Gloning et al., 1966), or members of a farmer's herd of cows, well known to him before a brain insult, with preserved ability to distinguish cows from horses (Bornstein et al., 1969). Also, Grühle's patient not only recognized that the object in front of him was a table, but even knew that it was a rococo table (Berze and Gruhle, 1929). These get closer to the subtle anomalies in meaning we are addressing in this section, but, so far, no neuropsychological deficits have been described where someone can recognize a rococo table as such but then draw the irrational conclusion that the world is as twisted as its legs, or recognize his family but claim to feel no meaning in the experience, or recognize people as people but take their looks to mean that he is a pathetic idiot.

But there are inputs from philosophers of the phenomenological school, in particular Scheler, who provided an account of meaning that offers a framework within which such anomalies, as we have uncovered here, are possible (Scheler, 1973). The crucial element in his treatise on values is his appreciation that the human being is an evaluator of any situation as well as a cognitive appraiser of what that situation factually is, and, furthermore, that the two – evaluation and cognitive appraisal – are conducted in parallel, not serially. The legacy of Wundtian psychology was that meaning is a final 'add-on' in a stepwise build-up in the cognitive appraisal of something – a scenario that Grühle seems to condone by the way he presents his rococo table case. But this is not at all how things are. Not only are there several levels of distinct evaluation of something, four according to Scheler – in respect of that something's agreeableness, vitality, mental value and spirituality available to a human beholder – but the human being also has the wherewithal to cognitively appraise two versions of any object whatsoever (Scheler, 1973). One is its sense – a non-objectified awareness of something's being around (akin to Heidegger's notion of Zuhandenheit [readiness to hand], but with the added elaboration that this 'object' is zufälliges Sosein [a coincidental agglomeration of something's thisness, whereness, whenness and whoseness]). The second is its 'meaning' as an objectified thing (akin to Heidegger's notion of Vorhandenheit [already present], but with the critical gloss that only something's whatness or essence can be truly meaningful). 'Meaning' in a broad sense is multifarious, and encompasses: 1) Scheler's restricted notion of meaning, which is only available to human beings, who have the capacity to grasp the essence of something (Scheler, 2008); 2) something's sense of being around in a particular place at a particular time and of a unique nature in itself and in relation to a knower (Scheler, 1995); and 3) anything's status as one of a tetrad of potential evaluations on the part of a human evaluator (Scheler, 1973).

The distortion in the 'meaning of meaning' inherent in any delusion would then derive from the fluidity of meaning in any situation, something barely acknowledged by psychologists, psychiatrist, or even philosophers. Scheler's account in his work as a whole at least opens up the delusional problematic. A schizophrenic delusion, Grühle's rococo table exemplar for instance, might emanate from an intact appreciation of the sense and meaning (Scheler's restricted gloss) of some object but an inappropriate evaluation – e.g. treating the object as a spiritual symbol (spiritual value) rather than something enjoyable (agreeableness value) or aesthetically pleasing (mental value) as a normal person would. The depressive, and possibly manic, delusions, on the other hand, seem to emerge from a more inchoate realm of disturbed cognitive appraisal itself, where the subject – certainly the depressive – does not even know what something is, and this loss of the cognitive appraisal of meaning (Scheler's restricted sense) could account for their nihilistic delusions (Cutting and Musalek, 2015).

3. CHANGES IN THE COHERENCE BETWEEN BELIEF AND ACTION

This idea trails back to seminal accounts, as of Eugen Bleuler who was of the view that subjects with Schizophrenia rarely acted in accordance

with their delusions (Bleuler and Brill, 1924):

> "the reaction to the delusion is frequently also inadequate. One can almost say that those actions which would follow on the basis of logic from the delusional premises are the very ones which are met with rather infrequently"
>
> "none of our generals has ever attempted to act in accordance with his imaginary rank and station."

For patients during Manic Episodes and Major Depression, the received opinion by early 20th Century psychiatrists was that they, unlike patients with Schizophrenia, did act on their delusions. Examples of such are provided in Table 1.

Homicide is especially frequent in those with depression who find themselves disproportionately amongst murderers. Krafft-Ebing and Westphal expressed strong views along these lines (Krafft-Ebing, 1900). The forensic evidences are mostly anecdotal. Schipkowensky concluded that those with psychotic depression were over-represented and mania under-represented in such samples (Schipkowensky, 1968). Suicide rates are also indirect support for there being a difference between schizophrenia and bipolar disorders in the impact of delusions on action. The lifetime rates for suicide in Depression, Schizophrenia and Mania are given as around 20%, 10% and 10%, respectively (Sainsbury, 1982). The fact that suicide in neurotic depression (Roth and Kerr, 1994) have a much lower rate than psychotic depression (1% vs 17% in (Helgason, 1964)) and the fact that in Schizophrenia who do commit suicide are generally depressed support the notion that being psychotically depressed and not just being psychotic or depressed is what triggers the act (Roy, 1982).

In a direct study of 'acting on delusions' (Wessely et al., 1993) a sample of deluded subjects of various diagnostic categories were interviewed, along with an informant, and it was found that only three aspects of someone's mental state were associated with acting on delusions. These were: persecutory delusions, delusions of catastrophe, and a depressed, anxious or fearful mood. All are highly linked to a depressive psychotic picture. By contrast, for instance, delusions of control, typical of Schizophrenia, were not positive spurs to action of any sort. Altogether, therefore, there is some clinical and phenomenological support for the proposition that depressive delusions differ from schizophrenic in that they motivate the subject into action. The same could be argued for mania where Grandiose Delusions were not, in this study linked with action.

We are wary of entering the tangled philosophical topic of action and its underpinnings. Yet we feel impelled to point out that Bleuler's notion of 'affectivity', which is trundled out as an explanation for action in these contexts, is highly unsatisfactory (Bleuler and Brill, 1924). Recent psychological commentators on emotion regad emotion as heterogeneous, with different emotions covering different realms of the human condition, and so to lump them all together as 'affectivity' is not crude but wrong (Lambie and Marcel, 2002; Panksepp, 2003). Moreover emotion is rather the registration of a value and not in itself the spur to any action. It is the value of some situation that sets in train the action sequence, not the emotion. Our appraisal of Scheler again sheds light onto this topic by his idea of the tetrad of value that determine all human action – see above – each of which has its own cluster of emotions (Scheler, 1973).

In the case of schizophrenia there are several studies demonstrating that in Schizophrenia subjects experience a sense of beauty in the same way as do controls, and so a blanket disorder of affectivity, as Bleuler imagined, is not their problem (Burbridge and Barch, 2007). Their problem, according to Stanghellini and Ballerini is that religious and moral values (ontological / abstract in nature) with their concomitant emotions dominate their existence, and, if this is so, their actions may well look strange and at variance with everyday assumptions of how people should behave. Subjects with depression and mania clearly experience emotion (Stanghellini and Ballerini, 2007). The very names of their condition attest to an age-old conviction by professionals and non-professionals alike that their emotions have got the better of them in some way. But these labels have obscured the fact that not all emotions are available to them. In fact, paradoxically in view of the usual way

depressive psychosis is formulated as morbid sadness, Schulte has convincingly demonstrated that psychotic depressives do not experience sadness (Schulte, 1961) – a mental emotion in Scheler's scheme – whereas others have shown that the cluster of emotions that depressives do have in excess of controls are bodily emotions (Otto et al., 1987) vital emotions in Scheler's scheme. Furthermore, what Minkowski, Tellenbach and Kraus (Kraus, 1982 ; Minkowski, 1970; Tellenbach, 1982) appreciated was that the depressive was overly dependent in his or her actions on other people in his or her milieu, so much so, in Minkowski's sample of subjects with depression, that other people were experienced as having a hypnotic influence on them. Action, under these circumstances, has nothing to do with affectivity in Bleuler's sense. It is one-to-one, almost automatically induced behaviour, registered bodily, and likely to lead to action more so than the valuations made by schizophrenics, for the simple reason that it is automatic and not subject to the cogitations that characterise the schizophrenic's preparation for action.

4. CHANGES IN THE AVAILABILITY OF A FIRST PERSON PERSPECTIVE

A prominent theme in the recent psychopathology of schizophrenia is the portrayal of the schizophrenic as he or she who thinks too much, so much so that it interferes with getting anything done. Known as hyperreflexivity, the phenomenon manifests itself as a replacement by introspective ruminations for spontaneous doing and natural engagement in the world (Sass et al., 2011). Our patients also provided examples of hyperreflexivity which are provided on table 1. Some regard the phenomenon as a primary psychopathological event that determines the attenuation of the first person experience of the actual world. Sass is one such person, who even attempts to explain all negative symptoms of the condition in this light (Sass, 2000). Blankenburg rather sees the Verlust der natürlichen Selbstverständlichkeit [loss of the natural self-evidential nature of anything] as itself primary, and any upsurge in rumination as a secondary consequence (Blankenburg, 1971). Certainly, an imbalance of this kind is one of the most constant themes in major psychopathological accounts of schizophrenia, albeit differently formulated depending on the prevailing psychological model of the human being. For example, when psychoanalysis was becoming the normative account one finds Freud's statement: 'there is a predominance of what has to do with words over what has to do with things' (Freud, 1957). In the current era of cognitive psychology it has been pointed that there is "a weakening of […] current perception […] and the intrusion into consciousness of unintended material from memory" (Garety et al., 2001).

How this moulds schizophrenic delusions is not addressed in he various discussions of the matter. But we think that it plays a crucial role in the genesis of many of the characteristic schizophrenic delusions known as first rank symptoms. A core element in hyperreflexivity is a shift from a first person perspective to a third person perspective of experience. Experience is no longer unique to me, but shorn of its Meinhaftigkeit or moiété [myness] and becomes everyman's. Delusions of control – the English term for what Kurt Schneider referred to as made feelings, made imputes, and the like – are precisely a third person perspective on, or degradation of, the myness of experience (Schneider, 1959). Nothing is mine anymore, but theirs. Delusions of thought insertion and extrusion, also first rank symptoms, are of the same ilk and provenance.

In depressive psychosis and mania the situation is quite different. Minkowski is the best guide here and the examples on table 1 come directly from his work (Minkowski, 1970). The psychotic depressive subjects he encountered were exquisitely aware of being devoid of any capacity to think, but were yet motivated to act by outside forces. As the 1st example suggests – she was as if hypnotised as if a person had taken possession of her … an invisible force had impelled her to leave the house […] on one occasion she had walked 20 kilometres in the middle of the night whereas in her normal state she could scarcely walk one kilometre […] she also had the impression that someone was rummaging about in her past life, digging up

everything she had done since childhood […] A force greater than her was dominating her.

Superficially resembling the delusions of control in Schizophrenia, these account by depressives are in fact poles apart. The depressive is enmeshed in an 'I-you' tangle, a second person perspective, quite unlike the third person perspective of the schizophrenic. It is person-to-person, not mechanical like the schizophrenic's sense of control by X-rays or gadgets. It is a living or proximate 'force', 'magnetism' or 'hypnosis' and not distant inanimate rays. Furthermore, it requires another person's actual presence for its effect, and, if that person moves away, the influence subsides, whereas in schizophrenia there is a constant control from afar. In the same way as the schizophrenics' morbid third person perspective explains many of their delusions – made feelings, thought extrusion – so the morbid second person perspective explains some depressive delusions, particularly those of guilt. The depressive, overly 'embroiled' in another's affairs, as Minkowski's patient put it so well, is then exquisitely responsible for the woes of others – actual and imagined.

This is what delusions of guilt are, as O'Connor and colleagues also realized – 'the moral system on overdrive' (O'Connor et al., 2007). Unlike the subject with Schizophrenia, who feels no personal responsibility even for his or her own thoughts, sensations or drives, the patient with Depression feels responsible for everyone "failed to help man on park bench or to fed worm to sparrow". Psychopathologists subsequent to Minkowski were on the trail of this. Tellenbach and Kraus, as we mentioned earlier, both appreciated that the depressive was someone whose premorbid personality was marked by an over-reliance on their current social nexus, and that life events disturbing this were the trigger for an actual depressive illness (Kraus, 1982; Tellenbach, 1982).

Two philosophical inputs are of particular relevance. One is from Buber who conceived the human being as vacillating between two relationships the 'I-Thou' and the 'I-It', the former a more fundamental, ethical stance (Buber, 1955). The other is Scheler was also of the view that the most original human relationship was an undifferentiated tribal 'you-ness', and that any individual strove hard to 'lift its head' above the precepts and opinions that dominated his or her upbringing and the herd mentality (Scheler, 1913/1954). A depressive condition, and at least some of its delusions, therefore, seems to represent an atavistic regression into the 'I-Thou' or her mentality, with an immersion into what 'you' want and an annihilation of any first person perspective. Schizophrenic delusions, on the other hand, appear to be the polar opposite of this, in that an anonymous 'they' overtakes the constraints of what 'you' or 'I' see in any situation.

5. A CHANGE IN THE NATURE OF REFERENT AND REFERENCE

The psychopathological entity delusional perception has achieved a pre-eminent position in the literature and its essence has been variously formulated. Schneider, like Grühle (see above) saw it as a two-stage process, whereby a normal perception of some extant object in the world was then hijacked by a rogue, symbolic meaning. This is unsatisfactory as an explanation on four counts: 1) it fails to account for the process itself; 2) it sheds no light on why this but not that referent in the world is selected as a focus for the new meaning; 3) it has nothing to say about why this but not that reference is the new meaning itself; and 4) the way perception is assumed to take place is 19th Century associationism and is almost certainly incorrect.

Matussek and Blankenburg progressed the matter and addressed all four points (Blankenburg, 2013 ; Matussek, 1952/1987). Matussek realized that the Gestalt model was a more plausible account of perception than associationism, that if the ability to form Gestalts were compromised in schizophrenia then the entire world would look different and mean something other than usual, and that new referents would be highlighted and new references accrue according to the laws of a Gestalt breakdown. Blankenburg's suggestion was also a considerable step forward. He invoked a change in the valuation of what surrounds us. He presented a case of a car worker, with no compelling previous interest in art, who chanced to see a painting in an art gallery on his way

to the doctor's (possibly he was already in a delusional mood), and thereupon was captivated by its blue colour and thenceforth preoccupied with the aesthetics of colour. Here again he tackled all four points which were left in limbo by Grühle and Schneider: valuation determines what one perceives (see below); if valuation changes – here is an aesthetic, spiritual direction – then so does perception; and new referents and new references crop up accordingly.

We propose that delusional perception is a problem of a new referent-reference nexus in the world, and, furthermore, that it is not a one-off mysterious concomitant of schizophrenia, but rather an exemplar of other anomalous referent-reference nexi which are exemplified, albeit in different ways, in manic and depressive psychosis.

We have dealt with the difference between delusions in Schizophrenia and Depression in previous section in terms of the focus on world or self. Here we are concerned with the very constitution of referent and reference. What emerges from these samples is that the referent in Schizophrenia appears to be a thing (e.g. handkerchief, sweets, hole in the road, poker); in Depression it appears to be a person's voice or personal encounter or environmental noise; and in Mania we found no clear pattern (e.g. subject's own action, numbers, clock ticking, weather). As for the reference there was no obvious theme our subjects with Schizophrenia (escape, everyone like him, assistance) or Mania (animals would appear, parents didn't like him, different events happening) whereas for Depression there was invariable some "mundane" culpability (real-life matters and not related with planet scale interferences) or action with reference to some specific ontic (again not involving human kind in general but the subject in his life) – see further in section 6. These are analysed in breadth in Table 2, which shows that the signifier in Schizophrenia is predominantly a thing (e.g. handkerchief on scaffolding) or a specific piece of behaviour (e.g. sniffing, coughing, blowing in subject's face) or a word or number (e.g. letter A in GREAT). The signified is un-categorizable in any neat way. By contrast the rare signifiers in depression are heterogeneous whereas the signified is without exception something negative with regard to the moral value of the subject. Subjects diagnosed with Mania resemble those with Schizophrenia in the heterogeneity of what is signified but have a greater tendency to have a numerical or verbal signifier.

Looking to the psychopathological literature for help here the best proposals for how new referents and new references are constituted are the aforementioned of Matussek and Blankenburg. Neither author considered the particular problem of the mania and depression in this respect, but both showed extraordinary insight into the state of affairs in Schizophrenia along the lines we shall be promoting below.

Matussek envisaged the process as progressing through the following stages:

1) as a result of a Gestalt breakdown there is a loosening of the 'natural perceptual context' and single or fragmented details stand out in the view of the world;

2) these details are then the subject of 'rigidity of perception' whereby the details take on significance by the very fact that they are focused on;

3) elements so focused on these undergo what he calls 'perceptual framing' whereby the very framing facilitates ruminations about new meanings;

4) there is then an elaboration of a 'new context' whereby something framed, e.g. a dog, links up with other frames items, e.g. a foal, to be taken together as exemplars of some higher order symbol such as the manifestations of nature.

Blankenburg also arrives at a similar conclusion regarding delusional perception, whereby the subject of such an experience fixes on some partial aspect of an object, in his example the blue of a painting, and not only becomes preoccupied with its blueness, and is not only transported by this into ruminations about the nature of aesthetics (which he had never considered before), but is convinced that he has been given privileged access to eternity and essences.

Such psychopathological formulations are crying out for a philosophical explanation, which neither Matussek nor Blankenburg proffer. What needs explaining above all else

is how someone can shift their allegiance from the everyday humdrum world that they have been used to into the higher realms of symbolism and aesthetics, essences and eternity. Again, Scheler had insights into the normative situation, which illuminates the pathological state of affairs elucidated here. What occupy the foreground of any normal person's attention are the objects that reflect and potentially satisfy their drives (Scheler, 1926). So, a hungry man walking down the High Street will 'see' food outlets but not shoe shops. A burglar might see jewellery shops. The value correlated to the drive determines current experience. Someone who is captivated by the blue of a painting in a gallery on the High Street and who is propelled into a reverie about aesthetics might be an artist (and Blankenburg in the same article discusses the difference between a schizophrenic and an artist in their captivations), but the Mercedes-Benz car worker was not an artist by inclination and therefore we can only assume that his valuative scheme had been the subject of some 'morbid' process that had altered what value was not determining his experience, his 'foreground'. Scheler's tiers of values – agreeableness, vitality, mentality, spirituality – were referred to earlier, and it is clear that the car worker had evaluated mentally and spiritually something that would have formerly passed him by because it did not hold the values of agreeableness and vitality that he previously lived by. But why did he talk about essences? According to Scheler the mental evaluation of anything, restricted to human beings, is concerned with the essence of anything (Scheler, 1961). Moreover, the perception of anything by a human being is a coming together of that thing's whatness or essence and its co-incidental properties (Scheler, 2008). What Blankenburg's patient experienced was therefore not just a breakdown in Gestalt and its consequences, as Matussek claimed, nor just an inexplicable entry into the realm of symbols, as Blankenburg described it, but a window into the very nature of perception itself, one-sided certainly because essence and co-incidental qualities are inextricably experienced together in a normal state, but he was not in a normal state and was experiencing things in a way that only the schizophrenic has at his or her disposal. In our Table 2 it has to be admitted that a mental or spiritual dimension is not overly represented, but Matussek's and Blankenburg's patients and numerous other reports on delusions Schizophrenia conform to them (Naudin et al., 1999 ; Parnas and Handest, 2003).

What of the subject with Depression? (The situation in Mania, as we have said several times, is not particularly illuminated by our endeavours in this article). Table 2 points to there being something quite similar about all the depressive psychotics and one is reminded of Binswanger's comment: "everyone becomes schizophrenic in his own way, whereas he becomes manic or depressed in the way anyone does" (Binswanger, 1960). Minkowski's case studies of psychotic depressives are, in our view, the key to what is happening here (Minkowski, 1958). As well as feeling beholden to whoever is around them, as we described in section 4, his patients experienced a descent into, and stasis in, the vital realm of values. Mental values were unavailable: "You see these roses. My wife would say that they are beautiful, but, as far as I can see, they are just a bunch of leaves and petals, stems and thorns."

Thus, unlike Blankenburg's schizophrenic patient who was so preoccupied with the beauty of something he's seen that he took up the study of aesthetics, Minkowski's depressive could not even sense beauty in a simple object. Moreover, other patients would describe themselves in the most animalistic terms, as if they were nothing but something vital:

> "he is oppressed by a feeling that he is nothing other than rampant materiality, and, although he complains of being nothing himself, he is actually mounds of food and what defecates, and is only a living thing with guts, a lumpen mass, a sort of animal functioning"

Stanghellini and Raballo also highlight the depressive's slide into banality, but Minkowski's patients tell us more than this (Stanghellini and Raballo, 2015). The depressive, in Minkowski's view, is he or she who illustrates in vivo the materialist philosophical position, the position of those philosophers who regard the human being as a mere animal. Obviously their references will be, as we demonstrated in Table 2, to an immoral

being, because that is what humans regards the animal as – nature raw in tooth and claw. In fact, the animal is amoral, not immoral, but, as always in psychopathology, there is a double bookkeeping going on, as Bleuler first noted in Schizophrenia, a sense of what was normative before the psychotic break continuing to inform the new experimental framework (Bleuler, 1950).

6. INDIVIDUAL KNOWING AND CONSENSUAL FACTUALITY AT VARIANCE

Finally, delusion represents a mismatch between what is individually known and what is consensually factual. So many definitions and formulations of delusion miss this whole point. Jaspers, for example, opined that a delusion is held with extraordinary conviction, is impervious to other experiences and compelling counter-argument, and has an impossible content (Jaspers, 1963). But, as pointed by Munro none of this is essential (Munro, 1999). The first two prongs are intrinsic to any strong belief – think of arguments between theists and atheists – and many delusions are superficially plausible. And the impossible content says more about the world as seen by the interviewer than the patient itself. But Jaspers delineated primary delusion from delusion-like idea on the grounds that the former was an 'immediate, intrusive knowledge of meaning which demands for its exploration a change in the personality', is also suspect, because many delusions creep up slowly and may, further, be encapsulated without any overt impingement on the subject's personality. The further definitions of Kraepelin and Lange that delusions are pathologically derived errors not amenable to correction by logical proof to the contrary, and Hoche's and Bumke's that they are pathologically distorted and incorrigible errors, are no better, as the very nature of their 'pathology' is not addressed, and to call them errors is both true and trivial (Bumke, 1936; Hoche, 1934 ; Kraepelin and Lange, 1927).

Several psychopathologists in recent years, however, were onto a richer vein of thought. The generic similarity of their hypotheses is that delusion is the application of some system of knowledge, not in itself morbid, but inappropriate for the circumstances, i.e. not fit for purpose. So, for example, Kuhn, Sattes and Leaser and O 'Donohue viewed delusions as an inapt scientific analysis of some matter, out of order for its actual everyday setting (Kuhn, 1952; Leeser and O'Donohue, 1999; Sattes, 1953). Spitzer saw delusion as an over-extension of the rules of knowledge as they apply to how we grasp the workings of our own internal psyche – indubitable according to him and of course Descartes – to events in the outside world, which are actually dubious and only validated by recourse to inter-subjective consensus (Spitzer, 2012). Yet other have seen in delusion the marks of immediate sensory knowledge or religious faith masquerading as everyday reasoning (Hedenberg, 1927).

This approach to delusion, treating it as an epistemological illusion, is, in our view, the most innovative since the topic was subjected to phenomenological analysis in the first half of the 20th Century. It still falls lamentably short of the enigma that is delusion, but, nevertheless, deserves wider recognition and investigation (ahead of print). We decided to tackle one such epistemological illusional hypothesis, the allegedly, overly scientific analysis of everyday matters as intrinsic to delusion. For, in addition to the theoretical formulations of schizophrenia as an inappropriate scientific take on all matters, referred to above, there are case reports of subjects with Schizophrenia whose experience or way of explaining their experiences are pseudo-scientific or science fictional (de Haan and Fuchs, 2010; Hirjak and Fuchs, 2010). Our impression was that neither subjects with Depression and Mania described their situation in this way. Stanghellini also holds this view, considering the delusions of psychotic depression to "deal with worldly affairs moral, physical and financial integrity" (Stanghellini and Raballo, 2015).

Table 3 presents the results of an analysis of our same samples of schizophrenic, psychotic depressive and manic subjects as were used earlier, but this time as to whether there was any pseudo-scientific or science fictional explanation for the experiences that the subject was undergoing or whether there was some malign

personal influence going on. It is clear that those diagnosed with Schizophrenia are significantly more likely to nominate ray, electronic implants or other technical explanations, and even non-mechanical processes such as hypnosis, for their situation, whereas subjects with Depression and Mania tend to sense a human involvement in their predicament.

Altogether, therefore, there is support for the notion of delusion in schizophrenia as an intrusion of scientific theses of varying outlandishness into the subject's everyday life – individual knowing and consensual factuality completely out of kilter. The depressive and manic subjects are also in odd state vis-à-vis normals in this respect, as they are overly in thrall to other people, exactly as Minkowski said – see above. Their delusions are person-to-person orientated and are rather examples of an over-involvement, relative to any normal person, in the lives of other people: yet still an example of individual knowing and consensual factuality out of order.

Scheler and Cassirer, independently concluded that the early human being was in thrall to the uniqueness and human face of their surroundings. Scheler proposes that 'If we inquire into the origin of the idea of causality, a characteristic of the primitive causal question is indicated by the form his question takes: 'who is responsible?' The causal concept became objective in the history of the spirit only very slowly. In place of 'who is responsible?' the question increasingly became 'what is responsible?' (Scheler, 1995). Cassirer Physics creates a different kind of world of things (Cassirer, 1996). That is usually interpreted so that physics is taken to replace the reality, of things as they merely 'appear' to us with their 'true' reality. It teaches us to recognize the 'objective' features of things. The sensory qualities recede for physics into a realm of mere 'illusory appearances'. This conflict can also be interpreted in the opposite way: physic diverts us from genuine reality, mechanizes this reality, separates us from "*durée réelee*", from the view of 'true being' which is found in the I, prior to all objectification.

The schizophrenic is, from all this, looking at things like a physicist, when such things do not merit this view. The depressive, and the manic to some extent, are distinguished from the schizophrenic in this very way, and may, as we pointed out above, be more stuck in an atavistic mode of knowledge than the normal.

CONCLUSION

A century of phenomenological research into psychosis has still not lain to rest the unitary psychosis theory, which is implicitly or explicitly held to by many clinical psychologists and not a few psychiatrists. It cannot be coincidence that not one of the major psychopathologists of the last century nor those of the current century are adherents of this. Our article demonstrates yet again the differences in the delusional profile of two of the major functional psychoses, schizophrenia and depressive psychosis. It further illustrates the problematic profile of mania, whose phenomenological pattern is not clarified here.

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Table 1: Examples of Subjects with Schizophrenia, Depression and Mania

	Schizophrenia	*Depression*	*Mania*
Predelusional State of mind	In the kitchen all the walls were pulsating. I felt boxed in. Then it started in the living room – walls moving in on me. When I got frightened they moved away again. It was all like a story. Middle of day seemed like night.	There was something about me that people saw but I couldn't figure out what it was.	People doing things in order to tell him something. Car registration numbers had special meaning.
	Obstacles, chairs, buildings took on a life of their own; seemed to be making threatening gestures, animistic outlook. People took on a devilish look. Noises irritating, loud and rasping. It was as if everyone were moving slowly and I was moving normally. [As for space] I felt very unreal in it. I felt I was dissolving.	People are saying things with hidden meanings or people are looking at me to say what a pathetic idiot wasting our time.	Everyone behaving strangely. World a soap opera. Numbers looked strange. Everyone talking in code. Could read several meanings into what people said. What people said or did seemed coincidences.
Change of 'meaning of meaning'	My family – I knew who they were – but they didn't mean anything to me, I couldn't relate to them. Sometimes I feel they're all dead. I don't feel they're my family though I can recognize them.	I think I look peculiar because of the way people look at me. I imagined that people thought I was dangerous.	Piece of red plastic in matchbox meant that he was head of Marlborough cigarette company.
Loss of the meaning of meaning'	"Sister had becomed more like her, more left-handed"	Everything in history and in books is as if they never were. I feel as if there was a period when there was nobody on the streets. According to the television it's May, but it's not May. This isn't 1973.	Saw baby in pram and thought it was hers.
	"someone stood in middle of street as if to indicate that she would be run over. He knew it immediately"	Everyone on this planet is the same. We're dead already. We can't have feelings – you, me, or the Duke of Edinburgh. Nothing's going to happen. No-one earns any money.	Episode of East Enders [soap opera] was made with her in mind.
Changes in Coherence between belief and action	"I'm the duke of Spain and I shouldn't be here. Hospitals are no place for royalty" (he had been living near the Zoo where he was a beggar for two years)	"food appeared rotten. I had to throw it out. Nothing tasted right. I had my son vomiting all he had eaten in college"	"I was caught walking my way from Lisbon to London near the French border - no one believes me but I have been summoned by the Queen of England"
	"tobaco is poisoned and it controls our minds" (the patient is very stressed whenever he discusses the topic and yet he continues on smoking 2 packs a day)	see my nails, surely I have a cancer, I already made my testimony and I'm leaving everything to her. I will die tomorrow	"I'm bus driver but I don't stick to the plans anymore. They're useless. I chose my bus path everyday when driving as I know Lisbon well including "shortcuts" and the traffic situation"
Change in the Availability of the First Person Perspective	"I cannot feel myself anymore. It is if I'm always thinking and rethinking what I see. I used to have experiences but now I can't call them that (...) I no longer see television. I know what it was to see television but now when I'm doing it I just feel like I'm thinking about it."	She was as if hypnotised as if a person had taken possession of her (...) An invisible force had impelled her to leave the house (...) On one occasion she had walked 20 kilometres in the middle of the night whereas in her normal state she could scarcely walk one kilometre (...) A force greater than her was dominating her. (Minkowski, 1958)	"I feel exactly how you feel. I couldn't be more attuned to you. You needn't speak anymore as I see what you're saying. I could even tell you in advance." (a Farmer who's son had just told him he finished the PhD)
	I was lying on my bed and reality somehow passed inwards as if my brain turned round. I then became more interested in memory than perceiving reality around me. Reality itself became rather threatening, separate, boring.	I feel as if when you insist on something I must submit to your will. It annoys me intensely, but in truth all I am is a dumb animal incapable of resisting anything someone else demands of me. I dare not do anything without your say-so. Yet it is all automatic. (Minkowski, 1958)	"she was moving her hand and I felt that she understood me. She looked and deeply felt her looking at me. And it that room with here everything seemed saturated of me"

Table 2: Analysis of delusion of reference in Schizophrenia, Depression and Mania – nature of referent and reference				
		Schizophrenia n = 250	**Depression n = 100**	**Mania n = 100**
Total no. with delusions of reference		125	43	35
Total no. with clear-cut signifier		53	6	13
No. of these as:	things	20	3	5
	others' behaviour	21	2	0*
	words / numbers	12	1	8*
Total no. with clear-cut signified		34	23	10
No. of these as:	spiritual	4	0	0
	change in self pos.	5	0	2
	change in self neg.	11	22**	5
	change in self neutral	4	1	2
	fact about someone else	4	0	0
	call to action	6	1	1
* p <0.01 Chi square Schizophrenia vs Mania ** p <0.01 Chi square Schizophrenia vs depressive subjects				

Table 3: Analysis of delusions in Schizophrenia, Depression and Mania– nature of influence			
	Schizophrenia n = 250	**Depression n = 100**	**Mania n = 100**
Any outside influence	222 (89)	52	60
General 'people' Including police, nurses, patients	40 (16)	42**	27
Specific people e.g. husband, boyfriend	52 (21)	8	22
Religious person e.g. God, devil	8 (3)	1	7
Non-mechanical process e.g. hypnosis, magic, spirits	48 (19)*	1	1
Mechanical process e.g. device in body, beams	47 (23)*	0	3
Bizarre process e.g. police in body, caterpillar in body	17 (7)	0	0
N.B. % for schizophrenics in brackets. * p <0.01 Chi square, schizophrenics v depressives; schizophrenics v manics ** p <0.01 Chi square, depressives v manic.			