

THE CONCEPT OF PSYCHOSIS: A CLINICAL AND THEORETICAL ANALYSIS

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Abstract

Psychosis is a phenomenological concept and we have no robust biological marker of its presence. Psychosis is an irreducible concept that designates being *afflicted* by a radical irrationality, i.e. a serious displacement out of the social consensus. Psychosis may manifest itself explicitly, through delusional propositional contents, or it is *implicit* non-propositionally in the alterations of other anthropological dimensions: expression, action and affectivity. We ascribe psychosis to a *person*, thus bringing in unique features such as personality, history and rationality. We also try to illuminate a related group of terms such as reality, reality testing, and delusions. Finally, we sketch out possible nosological consequences of our analysis.

Key Words: psychosis, reality, reality testing, delusion

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Introduction

This essay will attempt a phenomenological description (a description of phenomenal features) of *what the concept of psychosis means today for the majority of European clinicians*—and, how this phenomenological content compares with the current official approaches to psychosis in the DSM-IV-TR and the ICD-10, and in the more local, operational definitions, such as those used in the prodromal At Risk Mental States (ARMS)-Ultra High Risk (UHR) research.

Empirical research only rarely asks itself questions about the validity of its own concepts. Many concepts are so much taken for granted that we use them as *technical* expressions: e.g., DUP (duration of untreated psychosis), DUI (duration of untreated illness), “converting” (i.e. becoming psychotic by crossing a psychometrically pre-defined threshold of symptom severity), etc. These unproblematically sounding terms appear to refer to *facts* rather than to *constructs*. Such technical reifications typically happen when studies demonstrate a satisfactory inter-rater reliability: the original, worrying questions concerning validity sink into oblivion. Similar, but vastly more serious reservations apply to the concept of *psychosis* in the contemporary psychiatry. A few recent theoretical

contributions (e.g. Burgy 2008) are mute on the central, but notoriously difficult and elusive question: *What is psychosis?*, *What is the psychological structure of this condition?*

In the common sense understanding, which *precedes* and helps *founding* psychiatric terms, psychosis is a predicate that *we ascribe to a person* who has seriously transgressed the intersubjective bounds of rationality. The nature of these bounds and this transgression will be our topic, but we can already now anticipate the conclusion. The kind and the degree of irrationality required by the label of psychosis cannot be specified in advance, outside and independently of the contextual psychological and existential circumstances, and we have no biological marker to compensate for that. Thus, we cannot provide a reliable, context-immune, list of the symptoms of psychosis. Moreover, *a symptom* cannot be psychotic; only a *person* may be psychotic (Heinimaa 2002a). A person is a “primitive” (non-reducible) term (Strawson 1959), referring to a human being, with personality, abilities, dispositions and biography. A person is always situated—i.e. finds herself in her specific existential context. In using the concepts of *person* and *context* in the definition of psychosis, the latter also becomes resistant to a reduction into simpler elements and hence to the attempts of operationalization¹. To say that

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psychosis involves a “lack of insight” or “reality testing” is merely a tautology than operational description (see below). These terms simply convey that the person suffers from psychosis. This difficulty, as we will see, shines through the eloquent mutism of the DSM and the ICD with respect to the definition.

The questions surrounding psychosis are *both* philosophical *and* empirical-phenomenological. Moreover, a meaningful discussion of these questions requires a solid grounding in clinical experience and knowledge. The notion of psychosis possesses co-constitutive, legal and ethical dimensions. This is to say that legal consequences not only *follow from* the concept of psychosis, but that this relation is reciprocal. The very existence of a category like “psychosis” is partly motivated by ethical, social, and political concerns (e.g. through the notions of personal autonomy, responsibility, and accountability).

Diagnostic systems

In the DSM-IV (American Psychiatric Association 2000) the term *psychotic* refers to the presence of certain symptoms. The specific constellations of these symptoms vary across the diagnostic categories. In Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term *psychotic* refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behaviour (a flamboyant subgroup of catatonic symptoms). In Psychotic Disorder Due to a General Medical Condition and in Substance-Induced Psychotic Disorder, *psychotic* refers to delusions or only those hallucinations that are not accompanied by *insight*. Finally, in Delusional Disorder and Shared Psychotic Disorder, *psychotic* is equivalent to being delusional. There is no term of “psychosis” used as a substantive.

The definition of psychosis in ICD-10 (World Health Organization 1992) uses the same symptomatic indices (hallucinations, delusions, incoherence, gross disorganisation, catatonic features). ICD-10 mentions the general concept of psychosis, but the definition is replaced by a reference to a hypothetical failure of “reality testing” (which is another expression for “insight”). In brief, psychosis is either *undefined* or *under-defined* in the diagnostic manuals.

The architecture of the ARMS – UHR research aims at high transition rates from ARMS passed the psychometric threshold of psychosis. Here the concept of psychosis is epitomized by DSM-IV positive symptoms. The definition of psychosis is operationalized through the presence of “clear-cut threshold level” psychotic symptoms (delusions, hallucinations, and formal thought disorder², all scored above a pre-chosen psychometric threshold), i.e. occurring several times per week for at least 1 week in a help-seeking population (Yung 2003). Such pragmatic definition lays claim to clear treatment implications (symptoms above the threshold warrant antipsychotic medication) and it applies equally well to nosologically heterogeneous symptoms: substance-related, symptoms with a mood component—either depression or mania—and schizophrenia spectrum disorders.

Reality, reality testing and sense of reality

“Reality” is often used as a contrast to psychosis and psychosis is thereby thought of as “standing outside of the real”. The real is usually defined as something that exists independently of our conscious acts, such as fantasy or imagination. The material world serves as a fulcrum of reality, and reality is often attempted to be reduced to the physical realm (physicalism). But that is a mistake: e.g., the thoughts, feelings and intentions going through my mind right now are also real, even if not directly specifiable in material-mechanic terms.

Human reality is a reality of a “lived world”, i.e. a world always imbued with meaning, relevance, and objectivity co-constituted by our (inter)-subjectivity, with symbolic, social and cultural dimensions. For example, our concept of space is not only Newtonian or metric, but also subjective. Sense of proximity or distance is not only based on objectively measurable distance, but also depends on our ability to reach out, and this ability itself is not a purely motor skill, but depends on motivation and technological development. The appearing object manifests itself in a figure-ground relation, with meaningful, mainly pragmatic, references to other objects, to other subjects, and ultimately to the shared lived world. This shared lived world, in turn, is not an assemblage or a container of all individual objects, but is rather a *background dimension*, horizon or a *condition of the objects’ existence*. Phenomenologically speaking, reality does not *first* present itself as a raw, naked, physical reality, which we *subsequently* dress with meaningful layers with the help of reflection, and distinguish the real from the imaginary. Rather, all perception happens *from within* of our familiarity with the lived world, a source of our “perceptual faith” (Merleau-Ponty 1962). This original belonging to the world is a *sense of reality*, a sense of *self-presence* in the midst of a shared world. The basis of this background sense of reality is not of cognitive, but of affective nature. *Felt reality* is not just the outcome of a neutral disclosing world: as Husserl (1913) mentions, our cognitive grasping of the objects relies on a sense of being affected by, and belonging, to the world. The way we are anchored to the world is by inconspicuous background feelings, or ‘existential feelings’ (Ratcliffe 2008), which make up the pre-reflective horizon of experience and constitute the way of finding ourselves in the world. Damasio (1999, 2003), attempting to clarify the neurological basis of such basic feelings, claims that these feelings constitute the very context in which cognition and reflection takes place. Their overall structure is ‘touch-like’ (Ratcliffe 2008). Like in touch, a *self-presence* and experience of *otherness* are inextricable aspects of the same unitary experiential structure. These experiences are *ways* in which the world appears. It is the sense of embodied self-presence that constitutes the “realness” of reality (Varga 2010). Very much in the same spirit, Jaspers (1963) has emphasized that “we must distinguish the *original experience* from the *judgments* based on it.” We must distinguish between reality, created through a reflective reality judgment and primary awareness of reality (sense of reality), which is an immediate certainty of reality. “Conceptual reality carries conviction *only if* a kind of presence is experienced” (Jaspers 1963) (*italics added*).

The sense of reality and unreflected presence in the intersubjective world is therefore not based on a hypothetical *reality testing* (defined in cognitive science as an ability to distinguish imagination from perception) or *reality monitoring* (ability to distinguish external and internal stimuli). Testing and monitoring imply that we perform incessant online comparisons of what we are experiencing with some representational model or criteria. We are thus claimed to continuously, on-line, compare our perceptions and fantasies with each other, and with a reality model. But my self-awareness of imagination (my awareness of being now engaged in imagining) is precisely what *constitutes* my experience *as a case* of imagining. I need no reflective scrutiny to know when I am imagining or when I perceive (in fact, even to say that “I know that I perceive or imagine” borders on incoherence, because we do not have here an epistemic *knowledge relation* at all).

It is possible that reality testing- and monitoring do take place on a subpersonal, neural level, but that’s not reflected in the way our experience articulates itself. Phenomenologically speaking, a modular function of “reality testing” *does not exist* and should therefore not be used as a psychiatric *descriptor*.

On the other hand, as Jaspers points out, we do have a possibility of a reflective *judgment about reality* (like when I am looking and assessing how much repair needs the roof of my summerhouse). Such explicit relation to reality is not a feeling or a pre-verbal experience, but a *cognitive, conceptual attitude*. It contains *reflection*, changing perspectives, meta-cognition (thinking about thinking) and judgments about reality. In this attitude, we may mobilize additional cognitive resources (like when we stretch our arms to compensate with movement and touch for lacking visibility upon entering a dark room). Yet, the important point here is that we are not dealing with a restricted, *modular function of “reality testing” or “insight”* but rather with general and complex multifaceted cognitive, reflective abilities, not completely insulated from the psychotic process. The ability to improve on one’s rationality is not independent of one’s preexisting irrational predicament.

Rationality and irrationality

The phenomenological concept of psychosis (madness, insanity, folie) indicates that the person’s rationality (her judgement, grasp, or understanding of reality, of the world) is markedly dislocated in relation to what is contextually and socially acceptable. The patient’s world-understanding appears to us beyond the bounds of rationality. We need therefore to dwell briefly on the issue of rationality. Traditionally, a Cartesian call for “clear and distinct ideas” has favoured the view of rationality as “theoretical rationality”, i.e. a reasoning capacity dependent on serial, discursive-propositional steps, and guided by inferential logic. The result of this process is usually propositionally structured like “I believe that we are heading out of the recession”. Phenomenology has always pointed to yet *another type* of rationality, a “practical rationality”. “It is not a logic of the logicians but the logic of the world” (Tatossian 1979), a “common sense”, a non-reflective, pre-

linguistic and pre-conceptual sense of affective salience, proportion, and relevance, an *attunement* enabling to negotiate one’s way in a world that is not pre-defined and static, but dynamic and constantly changing, and moulded by the subject’s own actions (Parnas and Bovet 1991, Parnas et al 2002)³. Today, it is quite common for cognitive science to distinguish these two types of rationality; it is an open question whether this complexity is even bigger.

The irrationality, which is the hallmark of psychosis, is often “theoretical”, propositionally structured in discursive thought contents, *presented as delusions*, reporting of hallucinations, or as certain delusional explanations of abnormal experiences. Yet, psychosis may also manifest itself as irrationality of a pragmatic-affective kind, i.e. in the patient’s implicit *understanding of the world*, revealed through affectivity, expressivity and action (e.g. catatonia, hebephrenic behavioural style [e.g. a Danish patient in a yoga position on the floor of the hospital’s waiting room, would most likely turn out, upon closer examination, to be psychotic], patterns of peculiar actions—e.g. the so-called “crazy actions” (“Unsinnige Handlung”; “délire en acte”), affective changes with a profound sense of existential transformation (the future’s non-existence; pervasive, enclosing sense of guilt). In most of such cases, the post-hoc explanations obtained from the patients are evasive, vague or strangely illogical—and only with a considerable difficulty translatable into a comprehensible propositional belief-structure.

Other variants of irrationality, such as severe formal thought disorder (incoherence), amnesia, disorientation, and global disorders of attention, may affect communication to a degree where clinicians are at ease with the label of psychosis.

Delusion

Although a delusion *is a paradigmatic index of psychosis*, it is clinically incorrect to restrict psychosis to “delusionality”, i.e. reserve this concepts for patients with delusions, i.e. to those patients who are *willing* and *capable* to communicate their thoughts and convictions through clear propositional statements (e.g. I believe that CIA contaminates the drinking water to make males sexually impotent) and which we then can classify as *delusions*. As indicated above, we also need to consider the possibility of psychosis in cases where it is expression, behaviour, and affectivity that are disturbed.

Moreover, defining psychosis through the presence of delusion does not solve the issue of operational definition. The problem simply moves into the defining delusion. Here, the problem becomes even amplified: not only delusion defies a simple definition, but, moreover, the existing DSM-IV criteria are empirically wrong. The most common criteria (falsity, conviction, and incorrigibility) are usually ascribed to Jaspers. What is omitted from this reference, however, is the fact that Jaspers explicitly *did not consider this triad as defining what delusion was* (it was a non-reducible personality change). He coined them as “external indicators” that, if present, may *suggest* a presence of delusion, but not

define it. The DSM-IV-TR, however, goes further than Jaspers and defines the delusion as:

“A false personal belief based on incorrect inference about external reality and firmly sustained in spite of what almost everyone else believes and in spite of what constitutes incontrovertible proof or evidence to the contrary”.

In fact, all these criteria have been questioned e.g. (Sass 1995, Spitzer 1990). A delusion needs not to be (and sometimes is not) empirically *false* (e.g. delusions of jealousy may be empirically true); it may not be *personal* but apparently involve other people or impersonal world affairs; it is not always about *external reality* (which itself is left operationally undefined), for it may involve body or mind as themes; it needs not to be (and frequently is not) based on *inferential reasoning*; nor does it need to be believed with full “conviction” to be clinically significant.⁴ The type of reality, which the DSM definition presupposes, oscillates between the objective truth (in-itself) and a construct of social consensus (which need not to go hand in hand: think of Galileo, who, with these joint criteria, would be considered as mad, both *then* and *now*).

Although all delusional patients are psychotic, not all psychotic patients are delusional, in the sense which the operational definition tries to capture.

It almost never happens that we assess (or even have a possibility of assessing) the truth or falsity of a potentially delusional claim, but rather focus on probability, plausibility and its way of presentation. From the revealed thought content and its way of presentation and experience, we realize that it is not merely the falsity-status of single claims that matters decisively. Something more is at stake, something more global, transpiring through the patient’s way of arguing. This whole includes the fabric of other mental contents, and, ultimately, the overall framework of consciousness and experiencing. It is through focussing on these aspects, contextual to the focal content in question that we decide whether a given statement is delusional. This role of context in determining the delusional quality of *the same propositional content* is illustrated below by a modification of an example adapted from Heinimaa (Heinimaa 2002b):

The Helsinki scenario

The example takes place in Helsinki, Finland. A man comes to a psychiatric emergency and complains of anxiety and insomnia, because he knows that Russia is going to invade Finland tomorrow. It all happens at the heydays of Russian-Western relations, and you would be liable from the start to consider the statement as delusional (you would be more cautious in your judgment if all this happened few days after the 2008 invasion of Georgia). However, if the patient turns out to be the chief of Finland’s Intelligence Service, you would suspend your instant hunch and will try to be very careful in performing your assessment. The patient, it turns out, grounds his conviction on his experience from the previous evening. Then he attended a cocktail party at the Russian Embassy and got a very unpleasant

feeling that the party had a kind of arranged, fabricated atmosphere and that all people stared at him. Upon this information, you would suspect a psychotic condition preceded by delusional mood. If the patient tells you that Russia *has* invaded Finland three years ago but no one has yet noticed it, you would be liable (assuming that the patient is not sarcastic or joking etc.) to think that the patient’s “concept of invasion” (and its more encompassing framework) does not match with yours, perhaps pointing to a degree of irrationality justifying the diagnosis of psychosis.

This example shows clearly that no operational definition, aiming at a single propositional belief, would be immune to changing contexts. It goes without saying that the problematic status of the operational definition of delusion spills over and severely weakens and destabilizes the validity of a group of psychosis-near concepts such as *self-reference*, *overvalued idea*, *paranoid ideation* and *magical thinking*.

Is delusion a belief?

Another problem confronting the view of delusion as a false belief is the question whether delusion *is a belief* at all (a false conviction that “so and so”). Elsewhere, we have proposed a distinction between “empirical delusions” and “autistic- solipsistic delusions” (Cermolacce et al. 2010, Parnas 2004). Empirical delusions display a propositional and epistemic structure, e.g. “I am persecuted by the CIA”, which is a statement of knowledge with the same basic structure as “I know that Berlin is the capital of Germany”. These delusions typically deal with worldly affairs in which the patient is engaged, and where he seeks the evidence supportive of his claims. The “autistic-solipsistic delusions” (comprising Jaspers’ concept of primary delusion and DSM/ICD concept of *bizarre delusions*) are, on the other hand, *not knowledge statements about empirical matters*, but rather metaphorical extensions of a profoundly changed subjective experience. This latter type of delusion is more plausibly understood in terms of primary changes *in the structure of experience*, affecting the existential feelings, including the sense of presence and *self-presence*. The nature of reasoning processes (judgments) is not independent of the changes in the structure of experience. The sense of reality, which is *presupposed in the very entertaining of beliefs*, is changed or lost. “With an altered sense of reality, patients cannot take things to be the case in the usual way, as the sense of ‘is’ and ‘is not’ has changed” (Ratcliffe 2008). The cardinal point here is to realize that in the “autistic-solipsistic” delusions, the reasoning processes do not just *follow* experience but are embedded in it. Delusions are thus rooted in the existential changes (Ratcliffe 2008). They emerge at the chiasm of experience and judgment. For the patient, his delusional evidence stems primarily from the pre-reflectively changed experience, a source of a private, unique conviction which cannot be adequately described and grasped within a “defective reality testing model”. The patient is mainly indifferent to empirical proofs. We may encounter here “a double book-

keeping” (i.e. a peculiar co-existence of rationality and irrationality⁵). First person accounts of these states suggest that the patient feels a unique and superior access to (another) reality, ahead of, and more “sophisticated”, than what is currently accepted as common sense in the prevailing scientific world-view (Saks 2007, Saks 2009).

Reliability

Yet, all these difficulties in defining psychosis and delusions do not preclude high reliability in the groups of clinicians and researchers, who in their work take psychopathology seriously. Through training (experience) we acquire a context-sensitive (and, to a large extent, pre-conceptual) grasp of psychiatric terms, mainly through ostensive demonstrations of paradigmatic or prototypic cases. We become familiar with the limits of our concepts thanks to ongoing, peer-shared, questioning and reflection, and a theoretical study.

Conclusions

Psychosis, in the Continental European perspective, is an irreducible construct, referring to being afflicted by a radical irrationality, i.e. a serious displacement out of the social consensus (intersubjectivity). Psychosis may manifest itself *explicitly*, through propositionally expressible mental contents (delusions) or it is (non-propositionally) *implicit* in the alterations of other anthropological dimensions, e.g., expression, action and affectivity. Psychosis is a phenomenological descriptive term with no biological marker of its presence.

From both clinical and research perspectives, psychosis forms a characteristic Gestalt in the each of our provisional nosological groupings (e.g. schizophrenia spectrum, bipolar disorders). Following a recently formulated philosophical perspective on psychiatric classification (Kendler and Zachar 2010), we may suggest that although psychosis is *not* a natural kind term, i.e. a lawfully determined, causally individuated, objectively existing *essence* (such as elephant, planet Earth or General Paresis), it can neither be considered as a purely nominalist, social construct. Its ontological status is perhaps best compatible with the Property Cluster Kind (Boyd 1991), an entity that is not a naturally carved essence, yet possesses a certain degree of stable individuality and objectivity⁶. Each prototype of psychosis is perhaps constituted by its distinct and specific phenomenological structure (“generative disorder”) (Parnas et al. 2002, Parnas and Sass 2008), e.g. altered structure of self-awareness in the schizophrenia spectrum disorders (Sass and Parnas 2003) and altered structure of time-consciousness in the bipolar illness. Such clinical prototypes may, in turn, be correlated with relatively specific biological factors.

Because of the ‘epidemiological rarity’ of incident schizophrenia (Warner 2005), the focus of the UHR research — guided from its start by the aim of instigating early treatment—gradually shifted from its original schizophrenia target, to more easily attainable

outcomes: ‘schizophrenia-like’ conditions, then ‘non-affective psychosis’ and finally ‘psychosis’ as such. It is not clear how these conditions and schizophrenia are interrelated. “Psychosis” in the UHR research is linked to a specific psychometric score, and such entity is not directly phenomenologically accessible. Yet, the fundamental clinical issues in the notion of psychosis described above do not go away despite the noblest pragmatic intentions.

If the *science of psychiatry* is seen as being fundamentally dependent on the behaviouristic methodology, i.e. reified, mechanic and context-free view of symptoms and signs, structured psychometric interviews, non-psychiatric interviewers and an overall absence (and even active avoidance) of theoretical-conceptual dimension of psychopathology, then the *concept of psychosis* will never attain a degree of empirical faithfulness and conceptual clarity as to function as a *useful* generic descriptive term (uniting nosologically disparate groups).

Empirical study of mental illness crucially depends on the validity of concepts and on the faithfulness of clinical descriptions. Yet as we see it, and others have noted as well (Andreasen 2007, Ghaemi 2007, Mullen 2007), there is a rapid decline in practical competence and theoretical knowledge of psychopathology. There is a growing hiatus between, on the one hand, the practices of contemporary research and clinical assessments, performed with structured, “operational” checklists, and, on the other hand, a need for a comprehensive phenomenological exploration that is necessary in the evaluation of a person suspected to suffer from a psychotic condition (e.g. history, context, relation to the fabric of other experiential contents and *ways* of experiencing).

References

- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*. American Psychiatric Association.
- Andreasen NC (2007). DSM and the death of phenomenology in america: an example of unintended consequences. *Schizophr Bull* 33, 108-12.
- Boyd R (1991). Realism, Antifoundationalism and the Enthusiasm for Natural Kinds. *Philosophical Studies* 127-48.
- Burgy M (2008). The concept of psychosis: historical and phenomenological aspects. *Schizophr Bull* 34, 1200-1210.
- Cermolacce M, Sass L, and Parnas J (2010). What is bizarre in “bizarre delusions”? *Schizophrenia Bulletin*. In press
- Damasio A (2003). Feelings of emotion and the self. *Ann N Y Acad Sci* 1001, 253-61.
- Damasio A (1999). How the brain creates the mind. *Sci Am* 281, 112-17.
- Ghaemi S (2007). Feeling and Time: The phenomenology of mood disorders, depressive realism, and existential psychotherapy. *Schizophrenia Bulletin* 113-21.
- Heinimaa M (2002). Incomprehensibility: the role of the concept in DSM-IV definition of schizophrenic delusions. *Med Health Care Philos* 5, 291-95.
- Heinimaa M (2000). On the grammar of psychosis. *Med Health Care Philos* 3, 39-46.
- Husserl E (1913/1982). *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy: First book*. Translation F. Kersten. Martinus Nijhoff, The Hague.

- Jaspers K (1963). *General Psychopathology*, translation J. Hoenig and M.W. Hamilton. Chicago University Press, Chicago.
- Kendler K and Zahar P (2010). What kinds of things are psychiatric disorders? *Am J Psychiatry*. In Press
- Mullen P (2007). A modest proposal for another phenomenological approach to psychopathology. *Schizophr Bull* 33, 113-21.
- Parnas J (2004). Belief and pathology of self-awareness: A phenomenological contribution to the classification of delusions. *J Consciousness Studies* 11, 148-161.
- Parnas J, Bovet P (1991). Autism in schizophrenia revisited. *Compr Psychiatry* 32, 7-21.
- Parnas J, Bovet P, Zahavi D (2002). Schizophrenic autism: clinical phenomenology and pathogenetic implications. *World Psychiatry* 1, 131-36.
- Parnas J and Sass L (2008). Varieties on “phenomenology”: On description, understanding and explanation in psychiatry. In KS Kendler & J Parnas (eds) *Philosophical Issues in Psychiatry: Explanation, Nosology and Phenomenology*. Johns Hopkins University Press, Baltimore, MD, 239-286.
- Ratcliffe M (2008). *Feelings of being: Phenomenology, psychiatry and the sense of reality*. Oxford University Press, Oxford.
- Saks E (2007). *The Center cannot hold. A memoir of my schizophrenia*. Virago, London.
- Saks E (2009). Some thoughts on denial of mental illness. *Am J Psychiatry* 166, 972-73.
- Sass LA, Parnas J (2003). Schizophrenia, consciousness, and the self. *Schizophr Bull* 29, 427-44.
- Sass L (1995). *The paradoxes of delusion*. Cornell University Press, Ithaca, NY.
- Spitzer M (1990). On defining delusions. *Compr Psychiatry* 31, 377-97.
- Strawson P (1959). *Individuals*. Methuen, London.
- Tatossian A (1979). *Phénoménologie des Psychoses*. Masson, Paris.
- Varga S (in press). Depersonalization and the sense of reality. *Psychiatry, Psychology and Philosophy*.
- Warner R (2005). Problems with early and very early intervention in psychosis. *Br J Psychiatry suppl* 48, 104-107.
- World Health Organization (1992). *The ICD-10 Classification of Mental and Behavioural Disorders. Clinical descriptions and diagnostic guidelines*. World Health Organization, Geneva.
- Yung AR (2003). The schizophrenia prodrome: A High-Risk concept. *Schizophr Bull* 29, 859-865.

Note

¹ “Operationalized” in the sense of Hempel, i.e. providing action rules that connect the concept to its referent in reality.

² It refers to maximal formal thought disorder: incoherence, neologisms, incomprehensibility.

³ The terms overlapping “common sense” are “Background Capacities” in the analytic philosophy of mind (Searle) and “habitus” in social anthropology (Bourdieu). The varieties of rationality are today aggressively investigated in cognitive sciences.

⁴ Clinically, this is a very difficult feature to assess, because patients often do not reveal their innermost convictions and often conceal their delusional ideation.

⁵ An example, given by Bleuler (1950) is of a university professor, who after his discharge as “cured”, dedicated a treatise to his mistress, signed “Lord of the Universe”.

⁶ “Property cluster kinds are defined in part by the mechanisms that underlie and sustain them, which should accommodate the intuitions of reductionist psychiatrists. However, we suspect that in most cases, the stability of these kinds is maintained by mechanisms at multiple levels, including the symptoms themselves as well as mechanisms investigated by the molecular, physiological, computational, psychological, and social sciences. No one level is likely to capture the full complexity of the causal mechanisms sustaining or underlying the imperfect cluster of symptoms that characterize our best-codified diagnostic categories” (Kendler and Zahar 2010).