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On Bizarre and Non-Bizarre Delusions

Laura K. Matthews
University of Pittsburgh
lkm55@pitt.edu

Abstract: This essay has two aims. The first is to explore the role that affect plays in delusional experience. I suggest that delusions are not purely doxastic states but rather are shaped, enabled, and sustained by affect, which I construe in terms of Martin Heidegger's notion of *Befindlichkeit* (disposedness). Delusions can then be understood in terms of the reciprocal relations between moods, as modes of disposedness, and the interpretations and assertions that those moods enable. The second aim is to draw a sharper distinction between bizarre and non-bizarre delusions than the one that is currently recognized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR). Non-bizarre delusions consist of moods and interpretations that are consistent with normal consciousness and with delusions that are classified in other diagnostic categories. Bizarre delusions, by contrast, involve more serious disruptions to intersubjective consciousness. They can also consist of a type of bizarre mood that I relate to the noetic quality of mystical experience. I conclude by discussing some consequences of this view on treatment and nosology.

Keywords: Heidegger, Martin; Fuchs, Thomas; bizarre delusions; non-bizarre delusions; affect; cognitive-affective complex; mystical mood; DSM-5-TR.

Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR) categorizes delusions as symptoms of psychotic disorders and describes them as

> fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose)…Delusions are deemed *bizarre* if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence.[1]

There are many problems with this definition, and there are many puzzles that the concept of delusion raises. For example, Tim Bayne and Jordi Fernández focus on whether defining delusions in terms of resistance to counterevidence sufficiently delineates delusions from other ordinary kinds of false beliefs that result from bias and self-deception.[2]

[1] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision*, Washington, DC: American Psychiatric Association 2022, p. 101. [Henceforth cited as *DSM*]

[2] Tim Bayne and Jordi Fernández, "Delusions and Self-Deception: Mapping the Terrain," in *Delusion and Self-Deception: Affective and Motivational Influences on Belief Formation*, New York, NY: Psychology Press 2009, pp. 1-21.

In this essay, I focus on a different question: Why are delusional beliefs held with such certainty? Whence, if not from the relevant evidence, comes their certainty? I will suggest that one source of a delusion's resistance to counterevidence comes from its emotional, rather than its cognitive, content.

Phenomenologically, non-bizarre delusions can be characterized by the reciprocity between interpretation and mood, as, for example, Martin Heidegger argues in his work *Being and Time*.[3] These delusions involve non-bizarre moods, that is, moods that are consistent with normal or healthy conscious experience. Occasionally, the moods involved in non-bizarre delusions can be non-pathological (as in cases when paranoia is justified), or they can be more extreme versions of normal experiences (for example, grandiosity may be an exaggerated version of self-confidence, arrogance, or self-importance). In casting non-bizarre delusions in this fashion, it becomes clear that they are not restricted to psychotic disorders but rather are present in a wide variety of mental disorders, including major depressive disorder (MDD), obsessive-compulsive disorder (OCD), and certain specific phobias (such as agoraphobia). Non-bizarre delusions are delusional experiences that necessarily involve an affective component, and whose resistance to counterevidence may be in part explained by this affective component. If confirmed, this view suggests certain consequences for treatment. When the belief is bolstered in part by the emotional experience that enables it, targeting that emotional experience may be an effective way of opening up the belief to counterevidence and ultimately dissolving the delusion.

I then contrast this with bizarre delusions, which differ in at least two ways. First, bizarre delusions, which are perhaps primarily a feature of schizophrenia rather than mood disorders or other psychotic disorders, involve disruptions to the structure of intersubjective consciousness. There are many ways to construe this disruption. I adopt the approach offered by Thomas Fuchs in identifying this disruption as one of open intersubjectivity.[4] Bizarre delusions then involve more significant disruptions to consciousness than non-bizarre delusions do.

Furthermore, bizarre delusions may appear at first to be held unemotionally. For example, Louis Sass notes that patients sometimes express these beliefs matter-of-factly and are unmotivated to act on the delusions they seem to uphold so firmly.[5] One explanation for this phenomenon is that bizarre delusions do not contain emotional content in the same way as non-bizarre delusions. I will suggest, however, that in at least some cases, bizarre delusions appear to consist of bizarre moods, which I will argue are characterized by a mystical quality. Mystical experience has been described in the psychological literature using the Pahnke-Richards Mystical Experience Questionnaire (MEQ), which identifies seven features of mystical experience. I will present an account of the mystical mood in bizarre delusions by focusing on the noetic quality of these experiences. When cast in this way, bizarre delusions do appear to have an emotional content, yet one that does not motivate this-worldly action, and which can be misinterpreted as involving a lack of emotion. What this means is that, just as with non-bizarre delusions, the certainty experienced in bizarre delusions is explained in part by their emotional content.

I conclude by discussing some of the potential ramifications of this view on treatment and nosology. There are two implications for treatment: (1) if delusions are maintained by affective rather than purely cognitive content, then challenging the cognitive content in isolation will not be an effective way to remove the delusional belief, as both the affective and the cognitive content must be challenged; (2) bizarre delusions involve more in-principle challenges to treatment due to the disruptions to intersubjective consciousness that are involved.

There are also implications for nosology. Instead of viewing bizarre delusions as more severe types of non-bizarre delusions, the distinctions between the two should be drawn more sharply. Non-bizarre delusions can then sit on a continuum with delusions in mood disorders, whereas bizarre delusions may be placed in a separate category.

[3] Martin Heidegger, *Being and Time*, transl. John Macquarrie and Edward Robinson, Oxford, UK: Blackwell 1962, pp. 172-89. [Henceforth cited as *BT*]

[4] Thomas Fuchs, "Delusion, Reality, and Intersubjectivity: A Phenomenological and Enactive Analysis," *Philosophy, Psychiatry, & Psychology* 27/1 (March 2020), 61-79. [Henceforth cited as *DRI*]

[5] Louis A. Sass, "Delusion and Double Book-Keeping," in *Karl Jaspers' Philosophy and Psychopathology*, eds. Thomas Fuchs, Thiemo Breyer, Christoph Mundt, New York, NY: Springer 2014, pp. 125-47. [Henceforth cited as *DDB*]

Non-Bizarre Delusions

To begin, I will present a view of non-bizarre delusions which construes them as cognitive-affective complexes. Viewed in this way, non-bizarre delusions are both more consistent with fixed beliefs in mood disorders, as well as differentiated from bizarre delusions, which involve additional disruptions to the structure of intersubjective consciousness.

Delusions as Cognitive-Affective Complexes

As described above, non-bizarre delusions can be understood as "fixed beliefs that are not amenable to change in light of conflicting evidence" and whose content is understandable to same-culture peers (*DSM* 101). Examples include persecutory delusions, in which the subject is convinced of being surveilled or harassed by this-worldly entities, such as a police force, or delusions of reference, in which seemingly neutral environmental events are interpreted as directed at oneself. The shortcomings of defining delusions in this way have been widely discussed, for example by Lisa Bortolotti who suggests that delusions cannot be differentiated from other closely related phenomena, such as self-deception or confabulation, based on their epistemic features alone.[6] I here consider an alternative shortcoming of this definition, namely that it fails to delineate the role of affect in the structure and maintenance of delusion. My intention here is to provide a conceptual basis for understanding how affect is implicated in the phenomenological structure of delusion by way of borrowing some concepts from Heidegger, according to whom mood is always implied in interpretation.

Following Evan Thompson's enactive approach as described in his work *Mind in Life*, I understand affectivity as being deeply linked to cognition.[7] On this view, both cognition and affectivity are routed in the embodied mind's experiencing and understanding its lifeform in relation to the world at any given moment, given its needs, goals, and desires. Affectivity is then implicated in the process of generating beliefs about one's self and the world. My belief, for example, that walking alone at night in an unfamiliar place is dangerous involves not only the judgment that such behavior is objectively dangerous, but also the feelings of fear I experience in that circumstance. Rather than understanding such a belief as a dispassionate judgment, I suggest understanding it in terms of a cognitive-affective complex, namely, one in which the affective content enables a certain judgment and in which a particular judgment enables an affective response. Delusions also consist of these cognitive-affective complexes. It is important to note that, while cognition may be said to include emotional processes, I use the term to refer to processes related exclusively to judgment. One might also call these fixed beliefs doxastic-affective complexes.

The connections between affect and judgment can be seen in the example of persecutory delusions. They are described in the DSM-5-TR as a patient's belief in being harassed, surveilled, or harmed by some individual or group. When presented in this way, the belief appears to be a phenomenon exclusively related to judgment, namely, the cognitive faculty that involves taking something to be true or false. However, paranoid delusions also involve an affective component consisting of the pervasive fear of persecution. Evidence for this can be seen in several research studies conducted by Daniel Freeman *et al.*, who demonstrate that persecutory delusions are associated with high levels of anxiety, which in turn usually lead to behavioral attempts to avoid this persecution.[8] I therefore suggest that to understand a delusion, one must do more than merely describe the propositional content of a belief. Instead, one must take the belief as being part of a more complicated structure, which I have coined a "cognitive-affective complex."

The deep connections between the affective and cognitive aspects of delusions or fixed beliefs serve to make sense of their resistance to counterevidence. In both pathological, non-bizarre delusions as well as more ordinary fixed beliefs (such as a belief in God, which is often healthy rather than pathological), the cognitive and affective aspects are deeply linked together. Someone who suffers from persecutory

[6] Lisa Bortolotti, *Delusions and Other Irrational Beliefs*, New York, NY: Oxford University Press 2010, p. 22.

[7] Evan Thompson, *Mind in Life: Biology, Phenomenology, and the Sciences of Mind*, Cambridge, MA: Harvard University Press, 2007.

[8] For example, Daniel Freeman, Philippa A. Garety, Elizabeth Kuipers, "Persecutory Delusions: Developing the Understanding of Belief Maintenance and Emotional Distress," *Psychological Medicine* 31/7 (October 2001), 1293-1306.

delusions does not merely assent to the propositional content that describes the belief but instead feels afraid and feels to be constantly under surveillance. Since the feeling does not change in consideration of competing evidence in the same way that a judgment might, the affective content can serve to explain the belief's resistance to counterevidence. To the extent that the feeling remains and is bolstering the judgment in a cognitive-affective complex, the delusional belief will remain intact despite evidence to the contrary. In non-pathological fixed beliefs, the emotional content of the cognitive-affective complex plays the same role. If one considers, for instance, devout Christians' belief in God, it is apparent that not only do they assent to the proposition that God is real or that Jesus Christ is their Lord and Savior, but they also feel the truth of these statements. This experience is often described by devout Christians in terms of a felt connection between oneself and God or as a feeling that God is in each and every human being. This is one reason that pointing out contradictions in Scripture or demonstrating other incoherencies in their beliefs does nothing to change their views.

When fixed beliefs are understood as cognitive-affective complexes, rather than purely doxastic states, then the connections between the non-bizarre delusions of the psychotic disorders and the affective fixations of the mood disorders are much more evident. For example, in bipolar disorder (BD) and major depressive disorder (MDD), fixed beliefs can take the form of excessive and overwhelming guilt:

> The sense of worthlessness or guilt associated with a major depressive episode may include unrealistic negative evaluations of one's worth or guilty preoccupations or ruminations over minor past failings…Such individuals often misinterpret neutral or trivial day-to-day events as evidence of personal defects and have an exaggerated sense of responsibility for untoward events. The sense of worthlessness or guilt may be of delusional proportions (e.g., an individual who is convinced that he or she is personally responsible for world poverty). [*DSM* 186]

This description applies to major depressive episodes, which may occur in both BD and MDD. Notice that what is being described in this passage is a mental process that has both cognitive and affective elements. The depressed person is plagued by guilt insofar as guilt is the content of the emotional experience, but such guilt is also connected to evaluative judgments about oneself. In fact, it might be more proper to say that the guilt consists partially of negative evaluative appraisals of oneself. These negative appraisals tend to persist despite conflicting evidence, for example, from loved ones who reassure the depressed person to be worthy of love and respect.

Once non-bizarre delusions are cast in terms of cognitive-affective complexes, their presence in other diagnostic categories becomes clear. In the DSM's description of specific phobias, for example, subjects are described as experiencing fear or anxiety that is,

> out of proportion to the actual danger that the object or situation poses, or more intense than is deemed necessary...Although individuals with specific phobia often recognize their reactions as disproportionate, they tend to overestimate the danger in their feared situations, and thus the judgment of being out of proportion is made by the clinician. [*DSM* 226]

In specific phobias, fixed beliefs manifest as cognitive-affective complexes in which the affect rather than the judgment appears dominant. Extreme and overwhelming fear in the presence of the trigger situation is the identifying characteristic. Yet the presence of judgments more traditionally conceived also needs to be noted—judgments that are resistant to available counterevidence. The difference in these cases usually consists in insight. Patients suffering from phobias have some sense that their fear is overblown, but they nevertheless continue to overestimate the danger and cannot seem to overcome the accompanying emotional reaction.

Fixed beliefs as I am here construing them can also occur in cases of OCD, a disorder that is generally characterized by two groups of symptoms; the first relating to obsessive thoughts or urges and the second relating to the compulsive behaviors that are often seen as ways of alleviating unpleasant feelings or of avoiding catastrophic events. The DSM details the respective diagnostic criteria as follows:

> Obsessions are defined by (1) and (2):
> 1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
> 2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).
>
> Compulsions are defined by (1) and (2):
> 1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting,

repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive. [*DSM* 265]

Given that OCD is a heterogeneous category, presentations of OCD can vary greatly across patients. But notice that fixed beliefs as cognitive-affective complexes can sometimes be present. OCD can sometimes present with obsessive thoughts that some unwanted event will happen unless some compulsive behavior is performed. This constitutes the judgment of the cognitive-affective complex. Yet OCD is also characterized by oftentimes debilitating and pervasive anxiety as well as fear that the unwanted event will occur. That the cognitive and affective aspects co-occur is a defining feature of the disorder. It is unclear that OCD would be as serious of a disorder if one or the other of these features were absent.

Fixed beliefs can be healthy or pathological depending on whether the cognitive-affective complex facilitates one's autonomous pursuit of one's goals or frustrates it. They differ from more ordinary beliefs or judgments in this sense: ordinary beliefs or judgments can obtain absent the emotional content which makes fixed beliefs so resistant to counterevidence. The belief that the earth is round, for example, is not normally held as part of a cognitive-affective complex as this belief is not something that is deeply informed by and linked to a particular emotional content. This is due to the fact that such a belief does not normally mean anything substantial to me as far as my survival and well-being are concerned. The judgments comprising cognitive-affective complexes are resistant to change partly because of their deep links to highly charged emotional content, which make it difficult for the subject to respond to counterevidence, which often comes in the form of interactions with others. When others attempt to produce evidence that a cognitive-affective complex is unreasonable, one persists nonetheless in judging and feeling in fixed ways. One's fear of flying persists, for example, even when one is aware of statistics that show that flying is much safer than driving. One's overwhelming feeling of guilt persists even when one's loved ones testify to one's lack of blameworthiness. Equally, however, counterevidence might come in the form of insight from the patient. This means that a competing judgment that one's fixed beliefs are untrue might establish itself. Often the patient can be aware that certain judgments and feelings are unreasonable, for example, by having some information about how one's disorder tends to operate. Yet such awareness does nothing to disrupt the pattern of judgment and feeling.

The affective component of fixed beliefs can then serve to explain both the belief's resistance to counterevidence, as well as the sense of certainty often described in delusional experiences. Certainty in persecutory delusions, for example, comes not from a careful weighing of all the evidence as well as from opening one's belief up to critique at every opportunity. Instead, certainty comes from the immediacy and strength of the emotional experience of persecution. As I will argue in the final section, this view suggests that targeting the emotional experience may be just as important (if not more so) than targeting the cognitive content of such a belief.

The Phenomenology of Belief: Mood, Interpretation, and Assertion

In a phenomenological context, non-bizarre delusions may be understood as more continuous with normal conscious experience, in which moods give way to certain interpretations of the world, and in which certain interpretations reinforce moods. Such a reciprocal relationship between moods, understood as atmospheric rather than as discrete emotional events, and interpretations of the world which are enabled by those moods is suggested by Heidegger. By analyzing these concepts phenomenologically, I will advance the thesis that there are deep connections between affect and judgment in both normal and pathological beliefs.

Heidegger's notion of *Befindlichkeit* is usually translated as mood, state-of-mind, or disposedness. Yet when taken more literally, John Macquarrie's translation as "the state in which one may be found" becomes pertinent (*BT* 172n2). Heidegger will also refer to this aspect of being-in-the-world in terms of one's "Being-attuned." By this, he means one's manner of being in touch with oneself and the world or one's manner of resonating with that which is. Mood is that aspect of being-in-the-world that corresponds to Dasein's thrownness, which refers to the fact that it always finds itself as always already in the world. Dasein always

finds itself as being always already in some mood. Heidegger writes:

> in every case Dasein always has some mood…A mood makes manifest "how one is, and how one is fairing." [*BT* 173]

Moods disclose the world with a type of certainty that Heidegger describes as facticity, or the "that it is and has to be" (*BT* 174). The type of certainty involved is not the kind of certainty that Dasein might have about entities present-at-hand within-the-world. It is never "something that we can come across by beholding it" (*BT* 174). Instead, the type of certainty disclosed by moods is the certainty of facticity, which lies in the fact that one can never be the author of one's moods, and moods always disclose the nature of the world to one in ways that, though not rationally deduced, cannot be denied. The mood is thrust upon me, and consequently the world is disclosed to me as having a particular kind of character. Whether it be joyous, burdensome, eerie, irreverent, terrifying, or uncanny, the world is given to me as having this character, and while thrown into such a mood, Dasein is certain that it discloses the world as it really is.

Moods as Heidegger describes them are more primordial and encompassing than what psychologists describe as emotional states. Emotions tend to be short-lived phenomena that can be understood in terms of physiological changes and environmental events. *Befindlichkeit*, by contrast, is more fundamental than this and involves a basic mode of attunement to the world. Heidegger's moods are therefore the condition of possibility for more acute emotional experiences. While it is true that certain moods which Heidegger describes, such as fear, exhibit some features of the traditional intentional structure (for example, Dasein is fearful of a lion), in other ways *Befindlichkeit* challenges this intentional structure, which itself presupposes the standard division between subject and object or world. *Befindlichkeit* is disclosive of being-in-the-world, which is to say it discloses both Dasein and the world equiprimordially. This is true even though some emotions will be more object-directed than others, as fear is more object-directed than anxiety.

Nor should moods be understood as analogous to the contemporary psychological understanding of a mood, which tends to refer to longer-lasting emotional experiences. Contemporary psychologists refer to moods when they aim to discuss a persistent affective state, rather than an acute emotional experience. But such usage is misleading when referring to the phenomenon of moods precisely because it emphasizes the distinction between subject and world and describes affective experience as arising from within the self as a response to worldly events. A mood, by contrast,

> comes neither from "outside" nor from "inside" but arises out of Being-in-the-world, as a way of such Being. [*BT* 176]

In other words, moods are a mode of the holistic phenomenon of Being-in-the-world. They are not subjective appraisals of an objective world but rather are ways of disclosing the holistic Dasein-world structure.

This is important to understanding the phenomenon of delusion. Moods depict the world as being such and such a way with a kind of certainty that cannot be intellectually denied. I argue that this is how the affective dimension of delusion ought to be understood, and that the affective content of the delusion is precisely what makes it most difficult to deny for a delusional patient. Moreover, moods are atmospheric—they disclose the entirety of the world as having a certain character. Moods open up specific opportunities depending on how one is attuned. Moods then enable certain interpretations, and pathological moods can produce pathological interpretations and beliefs. To see these connections, I suggest considering how Heidegger describes what I refer to as the cognitive side of the cognitive-affective complex.

Equiprimordial to moods is the projection of understanding. Heidegger conceives of understanding as a kind of skillful know-how: Dasein understands its possibilities through engagement with the world. In manifesting these possibilities, or what Heidegger calls projecting onto them, Dasein simultaneously constructs and makes sense of itself. Possibilities that the understanding may project onto are disclosed through Dasein's mood. One can see this in the way, for example, that work sometimes feels exciting and at other times burdensome, though the nature of the work may remain unchanged. Heidegger writes:

> A state-of-mind always has its understanding, even if it merely keeps it suppressed. Understanding always has its mood. [*BT* 182]

If mood refers to the way that the world is always already disclosed to Dasein, thereby corresponding to Dasein's thrownness, understanding refers to the futural possibilities that Dasein projects itself onto in

skillfully navigating the world. Dasein understands Being-in-the-world through its own possibilities, which in turn are structured by Dasein's stance on its own being, or its "for-the-sake-of-which." Understanding for Heidegger is then a matter of the significance of worldly possibilities for Dasein, which is only possible through Dasein's stance on itself and, hence, its moods. Understanding is then the implicit grasping of possibilities. In understanding, Dasein presses into these possibilities in a way such that the "in-order-to," that is, the goal which Dasein seeks to accomplish, is the focus of Dasein's awareness. The skill with which Dasein completes its task and the equipment that Dasein uses to this end are never explicitly the focus of Dasein's attention in understanding.

Grounded in these equiprimordial modes of disclosive Being-in-the-world is the more explicit form of knowing which Heidegger calls interpretation. For Heidegger, interpretation is the "development of the understanding" (*BT* 188). It is the understanding of "something as something," by which Heidegger means that what is implicitly grasped in understanding becomes more explicit in interpretation. In understanding, Dasein employs the ready-to-hand with skill in order to accomplish its goals. In interpretation, that which Dasein employs becomes understood as that which it is. In other words, the ready-to-hand is not subordinated to the in-order-to but rather becomes seen as that which facilitates some goal. In the understanding, the door is seen simply in terms of the possibility to exit in order to achieve some goal. When I exit the door, I do not take it as a door but simply exit it in pursuit of my other concerns. In interpretation, the involvement relations, that is, the relations between equipment that allow a piece of equipment to function properly, become more explicit, and I come to see a door as a door, that is, as that specific piece of equipment in the totality of relations in my world in which I am embedded. Hubert Dreyfus explains that for Heidegger Dasein grasps in a circumspective manner its possibilities in understanding, which is to say that it grasps its possibilities in a non-explicit, non-thematic awareness that characterizes Dasein's skillful coping with its existential situation.[9] In interpretation, circumspection becomes explicit, and Dasein comes to see the ready-to-hand equipment as the equipment that it is.

All of this yet occurs without the addition of language. In assertion, that which is interpreted becomes expressed in a linguistic fashion. An assertion involves ascribing a predicate to some subject, such as in the utterance, "the hammer is heavy." Heidegger defines assertion as

> *a pointing-out which gives something a definite character and which communicates*. [*BT* 199]

Assertion is to be understood in terms of its basis in interpretation. The development then occurs in the following way: That which is understood is used for some purpose. In the understanding, the ready-to-hand is subordinated to the in-order-to, such that it becomes transparent. In interpretation, that which is ready-to-hand is dealt with more explicitly, such that it can be treated as the thing that it is, in the context of the involvement relations in which it is embedded, for example, the door is seen as a door, rather than as the to-go-out. In assertion, Dasein can begin to point out features of the door, but only in ways that maintain the door's connection to its involvement relations.

Interpretation occurs through Dasein's engagement with the ready-to-hand. Dasein can interpret without making any assertions. Heidegger explains:

> Interpretation is carried out primordially not in a theoretical statement but in an action of circumspective concern—laying aside the unsuitable tool, or exchanging it "without wasting words." From the fact that words are absent, it may not be concluded that interpretation is absent. On the other hand, the kind of interpretation which is circumspectively *expressed* is not necessarily already an assertion. [*BT* 200]

Interpretation then involves a minimal kind of judgment, one which is implicit in action, but which is not necessarily articulated in speech. Interpretation alone may be sufficient to constitute the "cognitive" aspect of the cognitive-affective complex. For example, the interpretation of the passerby as a threat may be implicit in locking the door. Unless asked to, psychotic patients may never articulate their delusions, and such beliefs would not have anything like the structure of a proposition.

Yet articulation can sometimes occur. Heidegger then proceeds by asking what assertion adds to interpretation. Assertion is that which begins to point

[9] Hubert L. Dreyfus, *Being-in-the-World: A Commentary on Heidegger's Being and Time, Division I*, Cambridge, MA: MIT Press 1991, p. 66.

out what is present-at-hand in what is ready-to-hand. In saying "the hammer is too heavy," Dasein begins to make claims about the ready-to-hand in ways that point towards the present-at-hand, although the reference to the involvement relations is not absent (too heavy for whom or for what purpose?). In assertion, the seeds of a more purely theoretical attitude which directs itself toward the present-at-hand are sown (*BT* 200). However, detailing this is not of interest to my purposes here.

Instead, I would like to focus on the sense in which Heidegger's notions of mood, interpretation, and assertion provide the structure of the phenomenon of belief in its entirety. Mood discloses the world as having a particular quality, and this enables a specific interpretation, which may or may not be expressed as an assertion. Heidegger argues that this structure is what enables the claim, "the hammer is too heavy." In a paranoid mood, to explore a pathological example, the world is disclosed as pervasively threatening. The mood discloses the world with a certainty which the paranoic cannot deny. The paranoid mood enables a certain kind of interpretation. A wire extending from a television set, instead of powering the TV, appears to be powering a listening device. The assertion may then be made, "They are listening to me." Hence, in non-bizarre delusions, the ordinary phenomenological structure of belief is still present, although the mood be pathological. What makes such a belief non-bizarre is the fact that the mood is consistent with normal experience. In certain circumstances, paranoia is justified. A CIA whistleblower, for instance, may be justified in holding the belief of being surveilled. An anxious and paranoid mood is understandable in these circumstances, and the corresponding belief is non-delusional. As I will show in the following section, one way that bizarre delusions are differentiated from non-bizarre delusions is that the mood associated with them is not an ordinary one, such as paranoia, which can be justifiably experienced in normal populations. Rather, the mood linked with bizarre delusions is clearly extraordinary. I will refer to it as the mystical mood.

Bizarre Delusions

There are at least two features of bizarre delusions that differentiate them from non-bizarre delusions. The first is that they involve disruptions to intersubjective consciousness. One way of conceiving of these disruptions is provided by Fuchs when he writes,

> delusions may be regarded as a *failure to co-constitute reality*, that means, they are characterized by a *disturbance of transcendental intersubjectivity* as the condition of possibility of mutual understanding. [*DRI* 62]

This account relies on Edmund Husserl's notion of open intersubjectivity, according to which awareness of the world is always structured by the fact that the objects of my perception are without exception possible objects of perception for others too. In ordinary consciousness, the world never presents itself to me as private or solipsistic. Rather, objects in the world gain their objectivity from the fact that they are in principle perceivable by a generalized other. Since the world presents itself to me not as subjective but rather as objective, consciousness must contain a structure that enables this possibility. Husserl's answer to this puzzle is that consciousness is structured by open intersubjectivity.

Yet, it is not merely the object's objectivity that is thus explained. Open intersubjectivity also implies that my interpretation of the object is always shaped and constrained by the interpretations of others, and especially those with whom I share a cultural background. Fuchs explains that

> both the presence and the meaning of objects is continuously established through social interactions, particularly including situations of joint attention and joint practices of coping with the world. [*DRI* 65]

The consequence of this is that my subjective viewpoint of the world is relativized, in other words, it is implicitly recognized as one perspective among many, and others' perceptions of the world act as constraints on my own. In navigating between my own perspective and that of others, I might be said to reach an excentric perspective, one which integrates "the ego- and allo-centric perspective[s]" (*DRI* 65).

Delusions can then be understood in terms of disruptions to open intersubjectivity, which Fuchs argues leads to the derealization often described by psychotic patients. If the world no longer appears objective, which is to say, it is no longer structured by open intersubjectivity, then objects seem to exist only for me. Parnas *et al.* argue that these phenomena "cannot be further psychologically reduced"; these

anomalous experiences then lead to delusional beliefs as evidenced by the following example:

> At a party everything seemed to him to originate from him or depend on him.[10]

I would supplement Fuchs' position regarding delusional experiences with an understanding of the role that emotional experience plays in the maintenance of bizarre delusions. Fuchs notes that the derealization that occurs in the prodromal phase of psychosis involves the loss of the stability of the shared world, which Fuchs describes as "a shake whose terrifying effect may hardly be overestimated" (*DRI* 68). Hence, terror for Fuchs is here playing a role, yet the role it plays is in the reaction to anomalous experience, which functions in the formation of the delusion, rather than in its maintenance. He describes delusion as having a

> relieving and restabilizing effect…based on the fact that it converts the *transcendental disturbance* of perception into an *inner-worldly happening*. [*DRI* 68]

In other words, delusion formation is a defense mechanism against the terror caused by the disruption to consciousness that consists of derealization and subjectivization. It serves to make sense of the total disruption to the structure of perceptual experience by construing it as a perception of specific kinds of objects.

Fuchs may be right that such delusions involve disruptions to open intersubjectivity, and that delusion formation is a response to this disconcerting experience; yet one could also align with Heidegger and construe disconcerting experiences as a disruption to the structure of Being-with. Be it as it may, Fuchs does not explore the kind of affectivity that structures the delusion proper once formed. Just as in non-bizarre delusions, also in bizarre delusions affect can play a role in enabling certain interpretations, and those interpretations may reinforce the affect. However, unlike in non-bizarre delusions, the affect involved in bizarre delusions is indeed bizarre, that is, not graspable by same-culture peers and not continuous with the structure of normal consciousness. More specifically, I suggest that what enables and sustains bizarre delusions is a type of mood that shares features with mystical experience, and which I will therefore refer to as the mystical mood.

Mystical experience can be measured by the Pahnke-Richards Mystical Experience Questionnaire (MEQ). The MEQ was developed to assess the quality of experiences elicited by the classical hallucinogens in the so-called "Good Friday experiments" that were conducted in a basement sanctuary at Boston University. The MEQ has more recently been used to assess the mystical experience in participants who received a high dose of psylocibin.[11] Features of bizarre delusions appear to have some of the qualities of mystical experience, and in particular the noetic quality of such experiences, which refers to the sense in which these experiences allegedly involve insights into reality that are otherwise inaccessible. The relevant MEQ measures associated with noetic quality are the following:

- Feeling that the consciousness experienced during part of the session was more real than your normal awareness of everyday reality.
- Gain of insightful knowledge experienced at an intuitive level.
- Certainty of encounter with ultimate reality (in the sense of being able to "know" and "see" what is really real) at some time during your session.
- You are convinced now, as you look back on your experience, that in it you encountered ultimate reality (i.e. that you "knew" and "saw" what was really real).[12]

The noetic quality then refers to the sense in which the mystical experience is felt to give access to a deeper reality, one which is not normally accessible to ordinary consciousness, and one which has a special epistemic status. This special epistemic status, however, is based on a feeling of a unique type of certainty, which is not attainable in everyday reality and is claimed to be accessible only in a so-called mystical world.

This epistemic status possibly also pertains to the psychotic world. A brief selection of case studies taken from Helene Stephenson *et al.* demonstrates

[10] Josef Parnas, Paul Møller, Tilo Kircher, Jørgen Thalbitzer, Lennart Jansson, Peter Handest, Dan Zahavi, "EASE: Examination of Anomalous Self-Experience," *Psychopathology* 38/5 (September 2005), 236-258, here p. 255.

[11] Roland R. Griffiths, William A. Richards, Una D. McCann, Robert Jesse, "Psilocybin can Occasion Mystical-Type Experiences Having Substantial and Sustained Personal Meaning and Spiritual Significance," *Psychopharmacology* 187 (7 July 2006), 268–283.

[12] https://www.ocf.berkeley.edu/~jfkihlstrom/ConsciousnessWeb/Psychedelics/Pahnke-Richards_Mystical_Experiences_Questionnaire.pdf

how this type of affect may be playing a role in the maintenance of bizarre delusions:

> Case 28: I feel profoundly emotionally distanced from other people because I feel that I have access to a different level of consciousness than others.
> Case 15: The patient described that even when she felt that her psychotic experience was not true, the sense or significance of these experiences was nevertheless preserved: "It was a strong feeling. I think it can maybe be defined as a delusion, maybe you can call it that... Now, I can see that it makes no sense that my frontal lopes are made of starlight, but I still have a feeling deep inside, believing that this is the case."
> Case 26: when you are in the situation, it is extremely difficult to think logically because you see it, hear it, or feel it, and it is very difficult to contradict something that you can see.
> Case 21: I think [the daydream world] has an emotional reality—not an objective [reality]. It can feel true.
> Case 10: There are the psychotic symptoms, and what is that? To see things that are seemingly not there, which other people do not see or experience. Well, I have done that for 17 years now ...The mystical and the supernatural. It just exists...I actually think that both the voices and the visions originate from the astral dimension. It just makes sense to think about it in that way because I can't explain it in any other possible sense.[13]

It appears that in these cases, psychotic patients experience their delusional reality as a mystical one. Just as in non-bizarre delusions, an emotional reality and a cognitive reality are mutually informing and sustaining each other. The difference is that in non-bizarre delusions, the emotional reality is ordinary even if pathological. In other words, both paranoia and grandiosity are understandable for humans living in everyday reality. Each of these moods may be non-pathological in certain circumstances, or else are exaggerated versions of normal experience, and hence they are in this sense continuous with normal consciousness. However, in bizarre delusions, the emotional reality is quite extraordinary and perhaps only understandable to those who have experienced the noetic quality of the mystical experience.

Consequently, bizarre delusions are more stable and resistant to counterevidence. They resist counterevidence for the reasons Fuchs discusses, namely, that they result from disruptions to the very capacities of intersubjective consciousness necessary to entertaining the perspective of the other (*DRI* 66-72). They also resist counterevidence for they consist of cognitive-affective complexes, and even when a patient may be intellectually aware of the possibility of being deluded, nevertheless the patient's interpretation persists since the atmospheric mood that enables this interpretation remains vivid. Such beliefs are felt to be true. Additionally, the mystical mood consists of a feeling of insight into a deeper reality that is closed off to others. The mystical mood is therefore even more compelling than a paranoid or grandiose atmosphere. Bizarre delusions are then that much more persistent than non-bizarre delusions.

One might object to this view by pointing to the phenomenon of flat affect. Psychotic patients oftentimes appear disengaged and unemotional. Instead of consisting of a kind of mystical mood, their affect is flat, absent, or muted. But it is not necessarily clear how to interpret flat affect, since it can be seen as a muted emotional response or as a muted emotional expression or report thereof. One suggestion is that flat affect be interpreted as an artifact of double bookkeeping, in which case it would not indicate a lack of emotional responsivity. For example, Sass describes double bookkeeping as the phenomenon whereby persons with psychosis may experience two realities simultaneously, the shared world and one's own psychotic world (*DDB* 5-6). Evidence for this phenomenon comes from reports from patients who sometimes recognize that others do not perceive their psychotic reality. This is evidenced by Stephensen *et al.* as follows:

> Case 8: I've always lived in two parallel worlds...Meaning that I live in the world everybody else does, where we know that the table is a table, and then in my own world, where I have visions and hear voices. But my sense of reality is intact. I know that you can't see and hear what I can see. I can easily keep them apart. [*SSD* 3]

In order to interact with the non-psychotic world, psychotic patients may need to create some distance from their psychotic reality, which may sometimes appear as emotional distance. Moreover, a mystical mood need not necessarily be a mood of high emotional valence. Instead, it consists of a sense of certainty and insight, especially insight into other-worldly realities, which may not clearly bear on this-

[13] Helene Stephensen, Annick Urfer-Parnas, Josef Parnas, "Double Bookkeeping in Schizophrenia Spectrum Disorder: an Empirical-Phenomenological Study," *European Archives of Psychiatry and Clinical Neuroscience* (hybrid 21 April 2023) 1-11. [Henceforth cited as *SSD*]

worldly reality. Support for this interpretation comes from Sass' comments on the case of Paul Schreber, a lawyer and later judge who suffered a series of hardships that led to his mental breakdown at the age of forty-two. Sass' commentary focuses on Schreber's memoirs, which were written in a successful attempt to be released from the public asylum to which he was confined. It is important to note that many there are many ways of interpreting Schreber's memoirs. For example, in her introduction to his memoirs, Rosemary Dinnage notes that Schreber's case can be interpreted as a misuse of power by psychiatrists who deprived him of his humanity and turned him into a case study. Such abuse undoubtedly continues today. However, Sass focuses on the apparent otherworldliness of the content of Schreber's delusions, which may indicate support for my view that bizarre delusions consist in part of a mystical mood. For example, Schreber writes

> I could even say with Jesus Christ: "My Kingdom is not of this world"; my so-called delusions are concerned solely with God and the beyond; they *can* therefore *never in any way influence my behavior* in any worldly matter.[14]

On this reading, bizarre delusions are not necessarily unemotional. Instead, their emotional content is best captured in terms of a mystical mood directed toward an otherworldly realm.

Flat affect can therefore be interpreted as a closing off to the non-psychotic world. This view serves to explain why flat affect is associated with poorer outcomes in cases of psychotic disorders. On this view, bizarre delusions involve more severe disruptions to cognition and consciousness than non-bizarre delusions do. Moreover, these disruptions affect intersubjectivity in ways that may frustrate the therapeutic process, which may require the patient's capacity to entertain the therapist's perspective. This suggests that psychotherapeutic treatment approaches may be less effective for patients presenting with flat affect.

Consequences for Treatment and Nosology

In this final section, there are two consequences for treatment and nosology that I would like to consider. I will first address two consequences concerning treatment.

[14] Daniel Paul Schreber, *Memoirs Of My Nervous Illness*, transl. Ida MacAlpine and Richard A. Hunter, New York, NY: New York Review of Books 2000, p. 371.

Consequences for Treatment

First, as I have been arguing throughout the essay, the certainty of delusional beliefs may stem from their affective components, rather than from their cognitive elements. In non-bizarre delusions, the mood is more continuous with normal consciousness, such as paranoia. Psychiatrists and other mental health professionals may find limited success in directly challenging delusional beliefs by providing counterevidence. Indeed, this is to be expected given the traditional definition of delusion and its emphasis on resistance to counterevidence. My suggestion is that this resistance to counterevidence stems from the fact that a delusion is a cognitive-affective complex. The cognitive and affective elements of the belief mutually bolster each other. This means that each of them is stronger together than either would be in isolation.

There are two other possible routes rather than presenting counterevidence for targeting this cognitive-affective complex and thereby correcting the delusion. The first would be to address the affective content of the belief. This could occur through the teaching of emotional regulation techniques, such as those used in exposure therapy or mindfulness-based cognitive therapy. Some of these approaches have been developed for schizophrenia. However, these approaches either do not specifically target delusions or else they tend to target delusions as traditionally conceived, namely as false beliefs. The approach I defend here suggests that emotion regulation techniques for schizophrenia should also be employed to tackle the affective content of the delusion.

The second route would involve a more holistic approach to the cognitive-affective complex as a whole. This might involve combining emotional regulation techniques with more traditional cognitive-behavioral therapy. For example, Neil Rector *et al.* discuss how these cognitive-behavioral therapy techniques for schizophrenia focus primarily on encouraging a patient to challenge delusions with competing evidence.[15] However, as Sameer Jahuar *et al.* argue, these approaches have demonstrated only

[15] Neil A. Rector, Mary V. Seeman, Zindel V. Segal, "Cognitive Therapy for Schizophrenia: A Preliminary Randomized Controlled Trial," *Schizophrenia Research* 63/1 (September 2003), 1-11.

limited success.[16] If my argument presented here is correct, limited success with such approaches is to be expected. Alternative approaches that target not only a patient's belief but also simultaneously the affect that helps to sustain the belief may be needed. This could mean simply supplementing cognitive-behavioral therapy for schizophrenia with emotion regulation techniques. Alternatively, it might involve a type of therapy, such as acceptance and commitment therapy, which incorporates emotional regulation techniques such as mindfulness and acceptance of negative emotions. There is limited available evidence on the efficacy of these treatments on delusions. Ultimately, given the unique nature of psychotic disorders, a more nuanced approach to this type of intervention may be needed, one which recognizes the nature of belief as being cognitive and affective simultaneously and therefore incorporates the precise elements of various treatment approaches.

However, such approaches may be limited when it comes to the treatment of bizarre delusions due to the disruptions to intersubjective consciousness involved. This is an in-principle barrier to psychotherapy for schizophrenia, given that establishing an empathic therapeutic relationship is often thought to be required for effective psychotherapy. Yet again, one might ask whether targeting the mystical mood might be an appropriate way forward. Research on the mystical experience is still in the developing stages since the resurgence of research into psychedelics in recent years. Understanding the nature of the mystical mood as well as its neurological underpinnings may bring some understanding as to how to target effectively this mood in psychotic disorders. For example, Carhart-Harris *et al.* argue that there is some evidence to show that a mystical experience is associated with decreases in activation in the default mode network.[17] A possible hypothesis is that mystical moods may be deactivated through the increased activation of the default mode network.

More radically, however, one might question to what extent such beliefs ought to be challenged whenever double bookkeeping is present and hence whenever the patient appears to have some awareness of non-psychotic reality. In cases where patients do not appear distressed by their delusional beliefs (and in fact may have some affinity for them), it may not prove necessary to eliminate the delusions if there are ways of ensuring that patients can still function effectively. In these circumstances, psychological and social interventions that work with rather than against delusions might be appropriate. From a psychological perspective, therapists may work with patients to develop accepting attitudes toward their delusions, rather than attempting to fix or change them. Such an approach would be consistent with the techniques developed in mindfulness-based cognitive therapy or acceptance and commitment therapy.

Social interventions based on the social model of disability may also be necessary and effective if this latter route is taken. For example, Mohammed Rashed argues that according to these approaches, individual differences in cognitive or physiological functioning are not necessarily disabling.[18] Individual differences become disabling only when positioned in a social environment which does not accommodate said differences. On this view, for example, not being able to walk is not necessarily disabling, however, it will be when living in a society that does not make it a priority to install ramps and elevators. Providing alternative methods of accessing opportunity is required to prevent individual differences from having a disabling effect, thus leading to a lack of access to opportunity. Rashed extends the social model to address differences regarding functioning associated with mental disorders (*DM* 159-63). He suggests that a symptom like auditory hallucinations (most commonly, hearing voices) is not necessarily disabling but ultimately will be in a society that stigmatizes persons with this experience and especially their behavioral responses to those experiences (for example, responding to voices). Consequently, stigma then becomes the largest barrier to effective functioning in such circumstances.

[16] Sameer Jauhar, Keith R. Laws, Peter J. McKenna, "CBT for Schizophrenia: a Critical Viewpoint," *Psychological Medicine* 49/8 (June 2019), 1233–1236.

[17] Robin L. Carhart-Harris, David, Erritzoe, Tim Williams, James M. Stone, Laurence J. Reed, Alessandro Colasanti, Robin J. Tyacke, Robert Leech, Andrea L. Malizia, Kevin Murphy, Peter Hobden, John Evans, Amanda Feilding, Richard G. Wise, David J. Nutt, "Neural Correlates of the Psychedelic State as Determined by fMRI Studies with Psilocybin," *Proceedings of the National Academy of Sciences of the United States of America* 109/6 (7 February 2012), 2138–2143.

[18] Mohammed Abouelleil Rashed, "In Defense of Madness: The Problem of Disability," *The Journal of Medicine & Philosophy* 44/2 (April 2019), 150-174. [Henceforth cited as *DM*]

Rashed recognizes that certain symptoms of psychotic disorders, such as disorganized thought and speech, are likely to involve without exception some universally disabling component (*DM* 164-5). In other words, it may not be possible for society to restructure itself in such a way that these kinds of symptoms are never disabling. He does not address the question of delusions, but I would suggest that a similar type of analysis to auditory hallucinations could be provided for delusions. At least some of the disabling aspects of delusions are caused by judgmental social responses to the expression of such symptoms. This could explain some patients' reluctance to express to mental health professionals that they are experiencing delusions, as well as why persons with psychosis tend to self-isolate. Sass makes the argument that differential levels of stigma may also explain the relatively better outcomes for persons with psychosis in non-Western countries, who are often more accepting of delusional experiences.[19] So long as patients are not acting based on delusional experiences, which the phenomenon of double bookkeeping does seem to support, then stigmatization of delusional experiences might amount to a more disabling aspect of the delusion. Combining the types of emotional regulation tactics discussed in this section with social interventions aimed at reducing stigma may be an effective intervention.

Implications for Nosology

There is an ongoing discussion as to whether a symptom-based approach to classification in the DSM is preferable, which would replace the current approach of reifying disease categories as though they represent distinct etiological processes. For example, Hanna Pickard argues that current disease categories are likely not natural kinds due to issues such as the heterogeneity of disease categories, the complexity and multicausality of disease processes, high levels of comorbidity across current diagnostic categories, and the influence of social and cultural values on diagnostic categories.[20] This last concern is supported by Allan Horwitz and Jerome Wakefield who provide a history of the changes in the diagnostic category of MDD over several iterations of the DSM.[21]

One alternative is to search for natural kind correlates for symptoms rather than entire categories of disorders. Richard Bentall's suggestion is that, while the label "schizophrenia" may not be correlated with any neurobiological or genetic structures, or even with some combination of the two, it may be the case that, for example, delusions or hallucinations are.[22] At the very least, such an assumption can serve as the basis of an alternative path of research and nosology. On this view, the DSM would no longer consist of a list of disorders but, instead, consist of a list of symptoms, with some indication (based on factor analysis) of how these symptoms tend to clump together. This approach may also be consistent with the recent network approach, which is a theory suggesting that disorders are causal interactions among symptoms and not the result of some underlying neurobiological disease process. In this view, symptoms are discrete (biological or psychosocial) realities that are causally related and mutually sustaining.

A consequence of my argument on these debates is that bizarre delusions and non-bizarre delusions should be considered distinct symptoms. The former involve more serious disruptions to intersubjective consciousness, while the latter appear more continuous with the type of delusional thinking found in everyday experience, mood disorders, and specific phobias. Should symptoms be considered in a dimensional way, that is, as being on a continuum from normal to severely pathological, then non-bizarre delusions should be placed on a continuum separate from bizarre delusions. In my reading, bizarre delusions are not simply more severe versions of non-bizarre delusions but rather they are a distinct form of pathology, involving more significant disruptions to consciousness.

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[19] Louis A. Sass, *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought*, Oxford, UK: Oxford University Press 2017, p. 298.

[20] Hanna Pickard, "Mental Illness is Indeed a Myth," in *Psychiatry as Cognitive Neuroscience: Philosophical Perspectives*, eds. Matthew R. Broome, and Lisa Bortolotti, New York, NY: Oxford University Press 2009, pp. 82-102.

[21] Allan V. Horwitz and Jerome C. Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*, New York, NY: Oxford University Press, 2007.

[22] Richard P. Bentall, *Madness Explained: Psychosis and Human Nature*, London, UK: Allen Lane 2003, pp. 495-6.

Such a view seems to have been recognized by Karl Jaspers who distinguishes

> two large groups of delusion according to their *origin*: one group *emerges understandably* from preceding affects, from shattering, mortifying, guilt-provoking or other such experiences...The other group is for us *psychologically irreducible*; phenomenologically it is something final. We give the term "*delusion-like ideas*" to the first group; the latter we term "*delusions proper*."[23]

When Jaspers' distinction is applied to my categorization, this first group of delusions corresponds to what I have been referring to as non-bizarre delusions, and the second group of delusions—of which Jaspers suggests that "all doubt has ceased" (*GP* 96)—I have described as bizarre delusions. The latter's certainty arguably comes from two sources: (1) the loss of the capacity to constrain one's perspective on the world on the basis of another's perspective, and (2) the deeply felt certainty of the mystical mood.

[23] Karl Jaspers, *General Psychopathology*, transl. J. Hoenig and Marian W. Hamilton, Chicago, IL: University of Chicago Press 1963, p. 96. [Henceforth cited as *GP*]

Conclusion

I argue that delusions cannot be understood based on their cognitive content alone but rather must always be understood as a more holistic cognitive-affective complex. Phenomenologically, the structure of belief can be cast in terms of Heidegger's notions of mood, interpretation, and assertion. Understood in this way, non-bizarre delusions consist of non-bizarre moods, which are more continuous with normal experience and with delusional beliefs in other diagnostic categories, such as major depressive disorder, bipolar disorder, or specific phobias. Bizarre delusions, by contrast, involve more significant disruptions to intersubjective consciousness. They can also involve a type of affect, which I have called the mystical mood. This distinction between bizarre and non-bizarre delusions should be taken into account when considering how best to study, treat, and categorize delusional experiences.