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1 **Acting on delusion and delusional inconsequentiality: a review.**

2

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1 **Abstract:**

2 *Objectives:* Two of Europe's most influential psychopathologists at the start of the twentieth
3 century (Eugen Bleuler and Karl Jaspers) pointed out the fact that patients rarely act according to
4 their delusions. This study proposes an investigation of how this issue is addressed in
5 psychopathological literature.

6 *Methods:* This article offers a critical review of psychopathological literature which focuses on the
7 influence of delusional ideation on behaviour.

8 *Results:* Phenomenological psychiatry has relied on the paradox pointed out by Bleuler and
9 Jaspers to **emphasize disorders of self-experience** in psychosis **whereas** analytical philosophy of
10 delusion has focused on the psychological status of delusion, regarded as belief, certainty, or
11 imagination. The empirical studies conducted during the past three decades – which were devoted
12 to acting on delusion – focused on violent and safety-seeking behaviours. These studies have
13 shown that these behavioural disorders are motivated by an emotional outburst (anger and/or fear)
14 rather than by delusional content.

15 *Conclusion:* Delusional inconsequentiality **can be clarified by conceptual research in**
16 **phenomenological psychiatry and analytical philosophy**, even though its role in the
17 psychopathological processes has not yet been clearly identified or conceptualised. Empirical
18 psychopathology on acting on delusion confirms the delusional inconsequentiality, but only
19 implicitly, by highlighting the role of affectivity (rather than beliefs) in delusional actions. Given
20 the major implications of better understanding this phenomenon, in terms of psychopathology and
21 clinical practices, we suggest considering delusional inconsequentiality as a promising concept
22 which could guide further research in contemporary psychopathology.

23 **Key words:** Acting on delusion, Delusional belief, Delusional inconsequentiality,
24 Psychopathology, Schizophrenia, Psychosis

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1. Introduction

Fear drawn up around psychiatric delusion arises from the popular conviction that delusional ideas inevitably lead to action, like any other belief. However, clinical work with people suffering from psychotic disorders suggests that the relationship between delusional ideas and behavioral disorders during delusional states is highly uncertain and ambiguous. Classical psychiatric literature even underlines the fact that delusions are rarely acted upon. It suggests that behavioural disorders observed in patients suffering from delusion are most often not related to their delusional concerns. In this literature review, our objective is to investigate how this clinical fact is discussed in contemporary literature.

First, we would like to briefly recall how two influential psychopathologists of the early twentieth century (Eugen Bleuler and Karl Jaspers) reported this clinical fact, in different terms. We will then apply the field of philosophy of psychiatry in order to find relevant conceptual models so as to better define the theoretical issues raised by delusion. Is delusion a belief like any other, logically leading to action? To shed some light on this issue, we suggest setting forth the arguments of two important currents in philosophy of psychiatry: phenomenology and the philosophy of mind. To conclude, we will present how contemporary psychiatric literature addresses this issue. In the discussion, we will consider the rationale for introducing the concept of *delusional inconsequentiality*, its definition, and its potential implications for research in the field of psychopathology and psychotherapy.

2. Methods

We conducted a narrative and critical review of psychiatric literature focused on the relationship between delusion and action. The rationale for proceeding with this methodology rather than a systematic review is that there is no pre-existing conceptual framework to model how subjects suffering from delusion act, think and feel congruently to it. Consequently, we were compelled above all to find conceptual and historical resources in order to define and delimit the concept of delusional inconsequentiality.

We conducted a narrative review of contemporary psychiatric literature, looking at its attempts to render this concept operational, as well as at ways to highlight empirical evidence. We identified three major fields of literature. First, we will present the *Maudsley Assessment of Delusions Schedule*, which is used in most empirical studies regarding behavioural disorders in subjects with delusion. Then we will address the literature on delusion and violence, hallucinatory command, and safety-seeking behaviours.

3. Results

3.1. Delusion and action according to two classical psychiatrists

Eugen Bleuler and double-bookkeeping

Bleuler introduced the psychopathological concept of schizophrenia in 1911, effecting a conceptual renewal of the Kraepelinian notion of *Dementia Praecox*. He described in this disease a concomitant recording of delusional material and real events, which he called double-

1 bookkeeping (*doppelte Buchführung, doppelte Registrierung*). This duplicity results from a
2 splitting (*Spaltung*) of the mind. Splitting is a basic symptom (*Grundsymptome*) leading to the
3 phenomenon of “schizophrenic autism” — a detachment from reality in conjunction with a
4 relative or absolute predominance of the inner life. Autism generally manifests itself through the
5 coexistence of the real world and the autistic world, which amalgamate each other in the most
6 illogical way and without the patient taking the contradiction into account [1]. Delusional ideation
7 is likely to evolve without influencing – or only minimally or indirectly – the cognitive
8 apprehension of reality. There is also a form of indifference or “discordant affectivity”
9 surrounding delusion: emotions may be unrelated to the delusional content. This indifference is
10 due to the “splitting of the psyche”, which leads to a separation between delusional ideas and the
11 “everyday ego” [2].

12 Bleuler points out that realistic thinking, in which the patient is well-oriented, most often
13 determines his actions. On the other hand, autistic thinking leads to delusions, logical errors, and
14 other symptoms related to the disorder, but has a low impact on patients’ attitudes. Therefore,
15 those two coexisting thoughts are distinct in their very form. Patients act in accordance with a
16 shareable reality, as if they do not draw the consequences of their delusional beliefs [1]. Although
17 patients refuse to admit the truth, Bleuler says, “they behave as if the expression is only to be
18 taken symbolically” [2, p. 140]. Patients complain and protect themselves, but they usually do
19 nothing to achieve their delusional goals: “Kings and Emperors, Popes and redeemers engage, for
20 the most part, in quite banal work”, Bleuler says: “None of our Generals has ever attempted to act
21 in accordance with their imaginary rank and station” [1]. He argues that “the splitting of the
22 psyche into several souls always leads to the greatest inconsistencies” [1, p. 129], further
23 highlighting the lack of a logical relationship between delusion and action.

24

1 *Karl Jaspers and "double orientation to reality"*

2

3 In his famous *General Psychopathology*, Jaspers [3] argues that delusion is not an erroneous
4 belief in the sense of a product of falsified judgement. Delusional ideas are characterised by the
5 fact they are maintained alongside rational and critical thinking. To explain such a delusional
6 conviction, impervious to rational arguments and evidence, Jaspers assumes the existence of a
7 deep alteration of personality. This essential transformation, called “primary delusion” (also
8 known as “delusional atmosphere”) is to be distinguished from “delusion-like ideas”. Primary
9 delusion, phenomenologically speaking, refers to the patient’s uncanny feeling that everything
10 holds new and suspicious meanings. This delusional atmosphere, full of vague and imprecise
11 content, is unbearable for the patients who feel as if they have lost their grip on things and on
12 meaning. For Jaspers, delusional atmosphere is incomprehensible because it entails a basic
13 alteration of experience itself. Delusional idea corresponds to the appearance of a *notion* capable
14 of restoring meaning to the surrounding world as experienced by the patient. Now, if primary
15 delusion is incorrigible, it is because “any correction would mean a collapse of Being itself,
16 insofar [as] it is for [the patient] his actual awareness of existence. Man cannot believe something
17 that negates his existence.” [3, p.105].

18 Jaspers adds, however, that “we cannot say the patient’s whole world has changed, because
19 to a very large extent he can conduct himself like a healthy person in thinking and behaving.” [3,
20 p.105]. Thus, a person persecuted within their delusion will not act in the same way as an actually
21 persecuted person. He thus concludes that true delusion is “peculiarly inconsequent” which is why
22 rational thinking and delusional thinking can coexist without influencing one another: we
23 sometimes observe in patients a "double orientation", which leads them to orient themselves
24 simultaneously to the world of psychosis and that of real life [3]. The process of personality

1 transformation through psychiatric illness also leads to a discrepancy between delusion and
2 emotional experience, for subjects with delusion may be insensitive to terrifying ideas.

3
4 It can be noted that these two major classical authors reported the following characteristic of
5 delusion: it coexists with a maintained contact with reality, and does not directly influence
6 behaviours. **This is a paradox of delusion: it is both *incorrigible* and *inconsequential*.** Before we
7 consider how empirical psychiatric research addresses this issue, we will explore the field of the
8 philosophy of psychiatry in order to find relevant conceptual models so as to better define this
9 theoretical issue.

11 **3.2.Philosophical debates on delusion and its enactment**

13 *Contributions of psychiatric phenomenology*

14
15 The phenomenological method in psychiatry aims at describing the structure of patients'
16 experiences. Eugeniusz Minkowski, a student of Bleuler and one of the pioneers of the
17 phenomenological method in psychiatry, argues that delusional discourse is an attempt to express
18 with language an ineffable transformation of the basic structure of experiencing (lived time, lived
19 space, intersubjectivity) [4]. Delusional ideas are thus an act of language (for want of anything
20 better - "*faute de mieux*") insofar as they do not refer to shared reality but to a pathological mode
21 of experiencing. Delusion does not belong to the same lived world as reality; it is thus impervious
22 to rational arguments, and it is not intended to be performed in reality. Arthur Tatossian, another
23 canonical thinker of French phenomenology, highlighted this "surprising imperviousness of praxis
24 and delusional ideas" ("*l'étonnante étanchéité de la praxis et des idées délirantes*") and "the

1 pragmatic indifference of delusional knowledge" (*"l'indifférence pragmatique de la connaissance*
2 *délirante"*) [5, p. 194-6]. Referring to the French philosopher Jean-Paul Sartre, he argues that
3 delusional consciousness is neither experienced as real (as in perception) nor as unreal (as in
4 imagination), but as a neutralization. Because delusion is an alteration of the basic structure of
5 consciousness ("transcendental Ego"), the delusional consciousness undergoes meaning, but does
6 not act on it. Delusion should therefore not be seen as a substitute to reality: it is outside reality,
7 and does not imply a direct and logical influence on behaviours, thoughts, and affectivity.

8 Bovet and Parnas [6] suggested in the 1990s that it was necessary to renew the
9 phenomenological understanding of delusional conceptions within schizophrenia-spectrum
10 disorders closely linked to the autistic predisposition, considered to be a defective preconceptual
11 (i.e., before language) attunement to the world. Ten years later, this basic vulnerability was more
12 precisely defined by Sass and Parnas as a "self-disorder"—a disturbance of *ipseity* (from *ipse*, Self
13 or identity): the very basic sense of being the continuous subject of one's proper experience, of
14 having a "first person perspective on the world". This definition of Self refers thus to the most
15 foundational, basic strata of the sense of oneself [7, 8] and must be differentiated from higher
16 cognitive and narrative levels of selfhood. These authors have shown that self-disorders are
17 specific markers of schizophrenia-spectrum disorders, allowing an adequate distinction to be made
18 between schizophrenic and non-schizophrenic delusions. The identification of these subtle
19 disorders of self-experience would also allow a better detection of the prodromal forms of the
20 disease [9]. Schizophrenic delusion is thus experientially characterised by the disturbance of the
21 tacit sense of being a subject ("diminished self-affection") coupled with a paradoxically
22 exaggerated and explicit self-consciousness ("hyperreflexivity"). This also involves a disturbance
23 of the embodied field of awareness ("disturbed hold or grip") that is described as an experiential
24 distance from reality that is coupled with an alteration in the predictability of reality (and the trust

1 that the subject may place in it [8, p. 436; 10]) whereby tacit elements of the field of experience
2 may emerge unpredictably to consciousness. This theorisation has resulted in an extensive corpus
3 of empirical and neuroscientific research, with in particular the creation of three semi-structured
4 interview grids to explore the anomalies of subjective experience [11], self-world relatedness [12],
5 and imagination [13].

6 Sass also suggests overcoming the “paradox of delusion” underlined by Jaspers (delusion is
7 lived with absolute and incorrigible conviction, and yet it is not acted upon), assuming that
8 delusional thought is “quasi-solipsistic”: patients consider their experience as the only possible
9 perspective on reality. To them, delusional conviction appears in an “apodictic” way: delusion has
10 the evidence of absolute truth, a definitive proposal there is no reason to doubt. Therefore,
11 delusional belief does not have to be demonstrated or confronted with rational proofs and
12 arguments [14 – 17]. This applies to the “true-delusion” of schizophrenia, but may not be relevant
13 for other delusional experiences. In the conceptualization of true-delusion, a term specific to the
14 post-Jaspers phenomenological tradition, there is a clear distinction between the experiential and
15 psychopathological nature of schizophrenic delusion and the other persistent delusional disorders
16 (paranoid delusion, delusions of jealousy, paraphrenia, etc.). Whereas non-schizophrenic
17 delusions are of an "ontic" nature—they concern objects of experience (a belief, a person,
18 relationships, a social position, etc.)—schizophrenic delusions are in fact characterized by their
19 "ontological" status: they involve a mutation of the ontological framework of experience itself
20 [17]. As we continue our review of the empirical evidence, this hypothesis will need to be further
21 evaluated, as we examine in particular whether enactment is a relevant discriminating factor.

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24 *A debate in the philosophy of mind: doxasticism and anti-doxasticism about delusion*

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Philosophy of mind, as well as phenomenology, attempt to account for the paradox of delusion: it is both incorrigible and inconsequential. In philosophy of mind, this issue has been addressed through the debate on the status of delusion, and whether it should be considered as a belief (*doxasticism*) or something else (*anti-doxasticism*).

Doxasticism maintains that delusion is a belief, and within this definition we can distinguish several models of doxastic theory. According to the empirical approach, a delusional belief is based on an abnormal experience (e.g., a hallucination), which is then explained by the delusions [18]. According to the rationalist model, on the contrary, abnormal certainty (referring to Ludwig Wittgenstein’s concept of “certainty”) is primary, and it affects experience, which explains the incorrigible nature of the delusional idea: it cannot be defeated by experience, as it directly affects it [19]. Other authors have put forward an endorsement model, which integrates the two previous models: delusional content is constitutive of experience, meaning that living the experience is equivalent to endorsing its content [20].

This doxastic conception is opposed by anti-doxastic accounts, which consider that delusion is not a belief. For some authors, delusion is only an act of empty speech, a meaningless result of neurobiological events [21]. For others, delusion is a cognitive hallucination: delusions are imaginative states that are wrongly considered as beliefs by patients. According to this model, patients believe that they believe in the delusional content [22]. The psychological status of delusions thus lies between belief and imagination: it would have hybrid status of "bimagination" [23].

3.3. Contemporary psychopathology: the contribution of quantitative methods

1 We will now investigate how contemporary psychiatric literature discusses the influence of
2 delusion on behaviours. Most studies pertaining to acting on delusion use the *Maudsley*
3 *Assessment of Delusions Schedule*, built in the early 1990's. The literature focuses on violence,
4 hallucinatory commands, and safety-seeking behaviours.

5

6 *The Maudsley Assessment of Delusions Schedule (MADS)*

7

8 One of the first systematic observations of acting on delusion was made in 1993 by a team
9 from the London Institute of Psychiatry [24 – 26]. For this purpose, researchers developed the
10 *Maudsley Assessment of Delusions Schedule (MADS)*, the aim of which is to measure several
11 dimensions of delusions – conviction/insight, negative affect, action, inaction, preoccupation,
12 pervasiveness, and fluidity – based on a semi-structured interview [27]. A rotated component
13 factor analysis of the dimensions of delusions using the MADS with 328 delusional subjects
14 revealed two factors, regardless of the diagnosis or the type of delusion: “intensity and scope”
15 (consisting of conviction, pervasiveness, and preoccupation) and “action and affect” (consisting of
16 action, inaction and negative affect) [28]. These findings show that the influence of delusions on
17 behaviour (the “action” and “inaction” dimensions of the MADS) is more strongly correlated to
18 affect than to delusion's others aspects.

19 In order to objectivise the frequency of delusional acts, researchers from the London
20 Institute of Psychiatry interviewed both delusional patients and informants, in order to identify the
21 main delusional theme and the link between delusional content and abnormal behaviours. The
22 patients' testimonies revealed that 60% of them had reported at least one delusional action (20%
23 claimed three or more). The information collected from the informants indicated that about half

1 the patients probably had or definitely had acted out on their main delusion in the month prior to
2 the interview [25].

3 The authors of this study concluded that, regardless of the method used (self- or hetero-
4 evaluation), acting on delusion appears to be much more common than suggested by conventional
5 literature. However, they stressed that one of their main findings is the lack of congruence
6 between subject and informant reports [25].

7

8 *Delusion and violence*

9

10 Many studies have used the MADS to clarify the factors that determine acting on delusions
11 or hallucinations, focusing on violent, self-injurious or hetero-aggressive behaviours. They
12 highlighted the key role of emotions associated with productive symptomatology in violent
13 actions. A retrospective study has shown that a negative emotional reaction (anger, anxiety or
14 sadness) to hallucinations or persecutory delusions was typical of violent psychotic groups as
15 opposed to non-violent psychotic groups. These negative emotions, especially anger, had an
16 independent and greater effect on the violent act than the symptomatic intensity [29].

17 A more recent study showed that an intra-hospital assault by a psychotic subject suffering
18 from delusions of persecution was explained by the level of distress associated with the patient's
19 psychotic experience. Thus, transitioning to a violent action underpinned by a productive
20 symptom could be considered as the only way to discharge the emotional tension related to the
21 delusion, in an individual whose self-control capacities are exceeded [30]. Furthermore, anger
22 underpinned by persecutory delusions mediates the relationship between delusion and delusional
23 behaviour [31]. Similarly, two recent studies have suggested that violent acting-out in the context

1 of persecutory delusions is more associated with the intensity of anger than with the delusional
2 content [32, 33].

3

4 *The influence of hallucinatory commands on behavioural disorders*

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6 In recent years, research on acting on delusion has focused on the influence of
7 hallucinatory commands on behaviour. Several factors have been identified as promoting acting
8 on hallucinatory commands: familiarity with the voice, lack of criticism of the hallucination (i.e.,
9 experiencing hallucinations as a reality, especially if the voice is perceived as an external source),
10 and negative emotional involvement which accompanies the delusional command (fear, despair,
11 anger) [34]. A critical review of the literature on acting on injunctive hallucinations highlighted
12 the major role played by the subjective interpretation of the psychotic experience when it comes to
13 triggering behaviour: perceived benevolence of the voice, threatening content of the command,
14 congruence of delusion with hallucination, etc. [35]. The social rank theory suggests that the
15 patient's actions are defensive reactions (submissiveness or escape) to a voice, experienced as
16 omnipotent and hierarchically superior. Impulsivity and the perceived omnipotence of voices (i.e.
17 their power to threaten and to harm the subject who fears the consequences of his disobedience)
18 are the two independent predictive factors which are consistent with command hallucinations [36].

19

20 *Safety-seeking behaviours*

21

22 Acting to protect oneself against a perceived threat has been grouped in the literature under
23 the category of safety-seeking behaviours (SSB). This notion was initially designed for anxiety
24 disorders [37]. SSBs may be an avoidance of feared situations, a means to escape when it occurs,

1 or a strategy to act on the threatening experience. Studying SSBs led to the development of a
2 specific scale: the *Safety Behaviours Questionnaire* [38].

3 In psychotic disorders, a significant association has been measured between SSBs and the
4 assessment of acting on delusion with MADS [39]. A meta-analysis of SSBs revealed a
5 prevalence of these behaviours ranging from 82 to 100% in delusional patients [40]. These
6 delusional SSBs are mostly avoidance behaviours, but they may be strategies of resistance (e.g.
7 arguing with voices), distraction, hypervigilance or control through thought. This meta-analysis
8 also demonstrated the lack of association between positive psychotic symptoms and SSBs. These
9 results are in line with the cognitive model of psychosis, according to which the occurrence of
10 SSBs is related to the subjective evaluation of the psychotic experience. SSBs may also sustain the
11 feeling of anxiety, perceived threat, and by extension, of long-term positive symptoms, since they
12 prevent the delusional belief from being denied by reality [41].

14 **4. Discussion and Conclusion**

15
16 This literature review demonstrates, above all, that there exist few studies which explicitly
17 address [how delusional content is acted upon](#), even though it was raised very early on by two of
18 the foundational thinkers of modern psychiatry. We will now discuss the results of this review,
19 and the relevance of considering delusional inconsequentiality as a promising concept which
20 could guide further research in contemporary psychopathology.

22 **4.1. [Acting on delusion](#) in the psychopathological literature**

1 Bleuler and Jaspers described, each in their own way, what has been called the "paradox of
2 delusion" [14], that is, delusional ideas are both incorrigible and inconsequential. These
3 distinguished psychopathologists assume that subjects suffering from delusion maintain a normal
4 relationship with reality, in parallel with their delusion. Autistic thought and realistic thought
5 coexist without influencing one other (double-bookkeeping, splitting, double orientation to
6 reality). Furthermore, people with delusion mostly act accordingly to their realistic thought, rather
7 than complying to their delusional thought.

8 Based on these conceptions, phenomenological psychiatry has relied on this delusional
9 paradox to highlight self-disorders in schizophrenia. Delusion shall not be taken literally, but as an
10 attempt to express with words an unspeakable transformation occurring within consciousness. [In
11 this sense, delusion is not a belief, but a massive deconstruction of the field of experience, leading
12 to a loss of grip on the world and precarization of common sense \[42, 43\]. Delusional ideas are
13 thus not constructed for practical action, but rather serve as acts of language that reduce the
14 strangeness and puzzling nature of the experience \[44\] by the explicit construction of a narrative
15 or imaginative framework \[45\]. The latter aims to restore meaning to the experience, but in turn it
16 traps the person within their delusion: it forces them to perceive only the avatars of delusion,
17 leaving them, so to speak, inaccessible to any surprise or event that could lead to otherness.](#)

18
19 Analytical philosophy has addressed the issue of delusion by focusing on the psychological
20 status of delusion when it is a belief, a certainty, or an operation of the imagination. A belief is
21 expected to be enacted upon, unlike the imagination which can be inconsequential, but is
22 rectifiable. Therefore, delusion may be a hybrid psychological object, a "bimagination" which has
23 some properties derived from beliefs (incorrigibility) and some properties of the imagination
24 (inconsequentiality).

1 Anti-doxastics (who assume that delusion is not a belief) mainly base their argument on the
2 fact that "delusions lack the kind of holistic character that beliefs are supposed to have: they do
3 not interact with perceptual input, other cognitive states or behaviour in the way beliefs should"
4 [46]. For the defenders of doxasticism, this causal role argument, which is opposed to the
5 theoretical approach of delusion as a belief, is not sufficient to invalidate the doxastic theory.
6 First, they argue that the behavioural inertness invoked by anti-doxastics is not systematically
7 observed in subjects with delusion, who often have safety-seeking or violent behaviours.
8 Furthermore, the same authors consider that behavioural inertness is due to the negative symptoms
9 of schizophrenia: delusion is not enacted due to cognitive disorders (in particular the deficit of
10 working memory), avolition, apragmatism, affective indifference, motivational deficit, or
11 emotional disturbances [46 – 48].

12 These doxastic arguments seem to us insufficient on several levels. Firstly, most studies on
13 delusion in the philosophy of mind are based on the paradigmatic example of the Capgras
14 Syndrome (people who think their loved ones have been replaced by impostors) which is chosen
15 for its monothematic and highly systematised qualities. It is thus far removed from the paranoid
16 delusion of schizophrenia.

17 Furthermore, we argue that the negative symptomatology of schizophrenia does not explain
18 why, within double-bookkeeping, delusion is not acted upon whereas realistic thinking usually is:
19 patients who claim that their loved ones have been replaced by doubles continue to act and react
20 in accordance with realistic thinking. Clinicians know from experience that patients who claim to
21 be billionaires rarely take steps to obtain their fortune, but frequently seek social support to get the
22 allowance to which they are entitled. We have seen that this clinical fact has been highlighted by
23 influential authors in the early 20th century, but this requires empirical evidence as well as a

1 heuristic model. If it were to be confirmed by systematic observation, it would provide a strong
2 additional argument against a strictly doxastic understanding of delusion.

3 More broadly, this philosophical debate on the psychological status of delusion, whether it
4 is regarded as a belief, a certainty, or an imaginative construction, suggests that delusion is
5 reduced to a pathological idea described in the context of healthy psychological functioning. This
6 is why some authors call for moving past this debate, which is based on a popular conception
7 (common sense and “folk psychology”) of delusion and belief, and which fails to both
8 characterise and explain delusion [49].

9
10 Finally, contemporary psychiatric research has focused on violent acts and safety seeking
11 behaviours, and has shown that they are motivated more by affectivity (anger or anxiety) than by
12 delusional ideation. This focus could be due, in part, to the construction of the MADS scale,
13 which is used by most studies on acting on delusion: as we have pointed out, this scale mostly
14 assesses these two categories of delusional behaviours. Therefore, studies have not focused
15 specifically on acting on delusion understood in the strictest sense, i.e. not only as a consequence
16 of delusion, but as a *consequent attitude* towards it. Thus, even if delusional behaviours do not
17 appear to be closely related to the delusional content, the existing empirical data is insufficient to
18 draw a definitive conclusion. [The authors of the MADS emphasize the difficulty of judging the
19 relationship between a delusional belief and an action \[25\]. Behavioral disorders arising within a
20 delusional state may not be a logical consequence of the delusional content: behaviors may be the
21 consequence of an affective state involved by the delusion, without being logically articulated to
22 the ideational content of said delusion. More broadly, these issues implicitly address what it
23 means to act in accordance with a belief. Non-delusional individuals do not always act in a strictly
24 consequential way in relation to their beliefs. But their “vital contact with reality”, in the words of](#)

1 the French phenomenologist Eugène Minkowski [50], involves a “wonderful harmony” with
2 reality which ensures a close relationship between thought, affectivity, and action. Moreover, a
3 delusional patient may act in accordance with their delusional ideas without fully believing in
4 them, insofar as she can experience them as a dream [17]. Therefore the notion of delusional
5 inconsequentiality should involve an exploration of the articulation between ideas and actions in
6 both normal and pathological contexts.

7

8 **4.2. Delusional inconsequentiality: perspectives for further research**

9

10 We suggest taking into consideration *delusional inconsequentiality* as a promising concept
11 which could guide further psychopathology research. It may be defined as a total or partial lack of
12 effect of the delusional ideation on behaviours, thoughts, and affectivity, irreducible to negative
13 symptomatology (avolition, apathy, emotional blunting, etc.). This phenomenon may have several
14 dimensions. *Behavioural inconsequentiality* is a lack of delusion-based actions : delusional beliefs
15 do not logically translate into action (delusional inertness). *Cognitive inconsequentiality* refers to
16 the coexistence of delusional beliefs and a correct apprehension of reality (*double-bookkeeping*, in
17 Bleuler’s terminology), as if delusional beliefs had no influence on other thoughts. Finally,
18 *emotional inconsequentiality* refers to the gap between delusional content and affectivity.

19 Delusional inconsequentiality is not a well-established fact, but an assumption which calls
20 for systematic examination. It raises several questions: is it an essential feature of delusions, or
21 does it make possible to discriminate between different forms of psychotic disorders? Research
22 has suggested that patients with schizophrenia are less prone to act upon their delusions than
23 patients with delusional disorder. In particular, the degree of systematisation of delusional beliefs
24 was found to be correlated to violent behaviour [24]. This could be due to the distinction between

1 ontological delusions which involve major transformations of the background of experience
2 (schizophrenia) and “empirical” delusions which do not involve such transformations [17].
3

4 Which distortions are actually observed between delusional ideation and its consequences
5 on behaviour, cognition, and affectivity? What can it teach us about the psychopathological
6 processes that underlie psychosis? How could this notion contribute to understanding psychotic
7 self-disturbance? Could it help better anticipate and prevent violent delusional actions, which are a
8 major forensic issue?

9 Further studies are required to validate this hypothetical model and its empirical qualities. In
10 particular, the relationship between these three dimensions should be investigated. Do they
11 overlap? Are they components of a monofactorial structure? Classical literature suggests that they
12 are three aspects of the same phenomenon. If confirmed by empirical studies, this phenomenon
13 may have major implications in the spheres of psychopathology and clinical practices.
14

15 **4.3.Diagnosis of delusion** 16

17 The latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5)
18 defines delusions as "fixed beliefs that are not amenable to change in light of conflicting
19 evidence" [51]: the DSM is definitively based on a doxastic understanding of delusion. The
20 authors add that it can be difficult to make a distinction between delusions and strongly-held
21 beliefs: the distinction lies on their "degree of conviction". However, delusional beliefs and
22 overvalued ideas are differentiated neither by their degree of conviction nor by their degree of
23 insight [52]. Therefore, this quantitative indicator may be insufficient: the distinction between
24 delusion and ideology may rely neither on the degree of conviction, nor of incorrigibility, and it

1 may be necessary to take into account a further criterion in order to distinguish between delusional
2 belief and other forms of erroneous ideas. Inconsequentiality may be said criterion: we assume
3 that inconsequentiality is typical of delusions, whereas ideological beliefs are consequential. For
4 instance, one may assume that the behaviour of American amateur astronaut Michael Hughes –
5 who accidentally died in February 2020 in the crash of his home-made rocket while trying to
6 prove that the Earth is flat [53] – is typically ideological rather than delusional. His belief is
7 impervious to rational arguments and scientific evidence, but his act, as "crazy" as it may be,
8 remains consistent with and consequential to his beliefs.

9

10 **4.4. The insight issue**

11

12 Further studies on delusional inconsequentiality may help us to better understand the
13 composite and complex notion of insight, i.e., the patient's recognition of his or her pathology,
14 symptoms, cognitive disorders, and need for care. Contemporary psychopathology has paid
15 increasing attention to insight. It has long been considered in a dichotomous manner, an “all-or-
16 none” phenomenon, until studies highlighted the inadequacy of such a conception [54].
17 Subsequent studies have gradually fragmented the concept of insight [55]. Clinical insight now
18 usually refers to a dynamic awareness of psychiatric symptoms and their attribution to mental
19 illness, of one’s need for care and of the potential consequences of mental illness [56]. Beck et al.
20 [57] defined cognitive insight as the ability to evaluate and correct distorted beliefs and
21 misinterpretations. They distinguished intellectual insight (i.e. the understanding and acceptance
22 of a corrected explanation) from emotional insight (i.e. the actual affective and behavioural
23 changes due to this corrected explanation). These two registers of insight offer a range of clinical

1 interpretations with patients being aware, or not, of their delusional beliefs and acting, or not,
2 accordingly.

3 Thus, one may assume that this gradual fragmentation of insight has been necessary in order
4 to account for the various aspects of delusional inconsequentiality. If one considers a delusional
5 component in a context of lack of insight (denial of disorders seen as a delusional belief),
6 delusional inconsequentiality may account for some paradoxical features of insight: insight is
7 neither sufficient nor required for treatment compliance [58]; delusional discourse can coexist
8 with a proper awareness of the disease (a meta-analysis of Mintz et al. found a small relationship
9 between insight and the severity of productive symptomatology [59]); finally, diagnosis can be
10 recognized intellectually without being experienced subjectively [57]. Thereby, the concept of
11 delusional inconsequentiality may contribute to refining and better understanding the
12 multidimensionality of insight, with regard to self-disturbances. The challenge is also to better
13 understand the difficulties and pitfalls of psycho-pedagogical and cognitivist methods in the
14 treatment of delusional ideas [60, 61]. More broadly, this concept might contribute to renewing
15 how clinical, psychoeducational and psychosocial approaches are articulated in the recovery of
16 psychotic patients.

17

18

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19 Given the major implications of better understanding this phenomenon, in terms of
20 psychopathology and clinical practices, we suggest considering delusional inconsequentiality as a
21 promising concept which could guide further research in contemporary psychopathology. It could
22 contribute to a renewal of a classic psychopathological issue which has been neglected in
23 mainstream psychiatry [62].

1 One of the limitations to our work is the lack of consideration of forensic issues entailed by
2 delusional inconsequentiality, which shall be investigated in further studies. Furthermore, it will
3 be necessary to confirm and refine our theoretical work with systematic observations.

4
5
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11
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10

11

12 **Highlights**

13

- 14 ● Psychotic delusion coexists with realistic thought and is both incorrigible and
15 inconsequential
- 16 ● Bleulerian double-bookkeeping and Jaspers' double orientation account for this paradox
- 17 ● Psychiatric phenomenology relates this paradox to [the disorders of self-experience](#) in
18 schizophrenia
- 19 ● Acting on delusion appears mainly mediated by affectivity associated with symptoms
- 20 ● Delusional inconsequentiality updates psychopathological and diagnostic issues