**Delusional Beliefs and Thought Insertion**

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**Abstract**

In this Chapter, we consider thought insertion (TI) in relation to other kinds of delusional beliefs often observed in schizophrenia-spectrum psychoses. We compare TI with the more common delusional beliefs, such as delusions of persecution and reference, and evaluate whether TI is better conceptualised as a delusional belief in its entirety or as a near-sensory experience of passivity and thought interference which is often accompanied by a delusional elaboration. We take into account historical and contemporary literature on the nature of delusions and argue that TI at least on some levels are fundamentally different, both phenomenologically and clinically, from many of the other delusional beliefs found in schizophrenia and other psychoses. We conclude with recommendations for future research and practice and emphasise that not all experiences of TI are of the same psychopathological nature or best understood as delusional beliefs.

1. **Introduction**

Imagine a sudden interruption in your thinking process. Imagine a thought that is present in your mind, yet it is so alien that it cannot possibly be your own, and of which you have no recollection of how it connects to prior thoughts. You are certain that you did not think such thoughts and therefore they cannot be yours. Such thoughts are so real – almost visceral, as if it is felt by your entire being – yet extremely strange at the same time. This uncanny, almost indescribable experience naturally calls for an urgent explanation, for it threatens the very integrity of your mind and of your self. All this may sound like the product of science fiction to the vast majority of individuals; indeed, most people will never wonder, let alone doubt, whether the thoughts in their head and minds are truly theirs. In fact, most people would not even question what makes a thought *theirs* in the first place. This seemingly obvious insight is the Cartesian certainty – thinking leads to existence and thus links to self. Any breach to this certainty directly challenges ideas of selfhood and existence. It is exceedingly hard to imagine what it might be like to ‘find’ thoughts in your head that are not yours because to most, it is simply nonsensical to even begin considering such a possibility.

 However, to some individuals, such a feeling is not only a possibility but a truth held with absolute conviction. This bizarre experience is called thought insertion (henceforth TI). TI is defined as the experience of thoughts that do not have the feeling of familiarity, of being one’s own, but have been put into one’s mind without one’s volition (Mellor, 1970). Not surprisingly, TI is widely regarded as a psychiatric symptom. Even less surprisingly perhaps, it is a psychiatric symptom that characterises a psychotic illness such as schizophrenia (a first-rank symptom), and acts as the one of the most significant and sinister hallmarks of a break from consensual reality. It is impossible to fathom the experience of TI because doing so would require us to relinquish our sense of self-autonomy, the most central and sacred evidence of being an independent and free agent. By merely beginning to imagine the loss of control over one’s thinking processes, or having thinking take place that is not part of the activity of the self, it strikes the deepest forms of fear and anxiety by attacking our notion of having a self and unified consciousness, hence those who report these experiences must be ‘mad’ and cannot be trusted or even treated as ‘one of us normal people’. Nothing seems to signal madness more than the claims of TI; to most clinicians, it simply has to be a delusion that needs to be corrected with pharmacological and psychotherapeutic interventions. Clinicians may not have the capacity (or interest, in some cases) to dig deeper into the experiences of TI, for the fear of reinforcing the patients’ delusions. A potential consequence of this active dismissal of the realness of TI from the patients’ subjective point of view is the loss of nuance and, eventually, rapport.

 Here we offer an examination of the experience of TI from the angle of phenomenological psychopathology and question the meaningfulness and usefulness of always assuming that TI is a delusional belief in research and practice. We will evaluate whether TI qualifies as a belief and further, as a *delusional* belief; our aim is to present an argument for a better understanding and more nuanced conceptualisation of TI, with patients’ subjective experience at centre stage.

1. **Defining delusional beliefs**
	1. Delusional beliefs in schizophrenia-spectrum psychoses

One of the most commonly accepted views of delusions is the doxastic view (i.e. delusions as beliefs). In the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5; American Psychiatric Association, 2013, p.819), delusions are defined as follows: ‘A false *belief* based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person’s culture or subculture (i.e. it is not an article of religious faith).’ This consolidates the belief-based conceptualisation of delusions for most clinicians. Given their pivotal role in the diagnosis of psychotic disorders including schizophrenia, delusions are seen as incorrigible, inconceivable and often incomprehensible. In the DSM-5 definition, delusions are beliefs derived from incorrect *inference* about, and not simply a fundamental break from, external reality. This implies some sort of basis in consensual reality upon which false inferences are constructed, and also alludes to a deliberative process (Baker et al., 2019) – patients with delusions somehow arrived at the delusional belief because they made wrong inferences about events in the outside world. Indeed, cognitive theories of delusion formation focus on the inferential process of anomalous experiences perceived to be arising from the external world and align with principles of cognitive neuropsychiatry. In other words, it follows the ‘normal’ pathways of belief formation, also called ‘belief-positive’ models of delusion (for a very comprehensive overview, see Bell et al., 2006). These models are most useful when evaluating monothematic delusions; however, these are not as common in, say, schizophrenia, compared to organic psychoses where clear causal factors may be identified.

 Delusional beliefs in schizophrenia tend to be more systematised and polythematic and pose their own unique challenges when it comes to theorising. This latter category sometimes calls for ‘belief-negative’ models of delusion formation, where the belief formation process itself is pathological (such as a perceived tendency towards irrationality and impulsivity when forming inferences). A typical example of this may be a hallucination leading to delusion formation. In this case, the trigger or precursor to delusion formation is not based in external reality, yet something faulty about the patient’s inferential process itself compelled the patient to 1) become convinced that the hallucination is real; and 2) become convinced that the hallucination comes from a malicious other, giving rise to a persecutory delusion (see Section 3.1. below). Of course, this is not the only pathway. Persecutory delusions do not by any means have to arise from negative or emotion-laden hallucinations; instead, unlike some of the more bizarre experiences seen in schizophrenia, persecutory delusions are far more transdiagnostic and can sometimes be found in nonclinical populations, albeit in milder forms such as magical thinking and conspiracy theories (Freeman, 2006). It is unlikely that there will ever be a specific subtype of delusion that sufficiently indicates a diagnosis of schizophrenia, at least not any judgement based on delusion content. Rather, it is often the *form* (the how and not the what) of delusional thinking that imbues a schizophrenic psychosis from other psychotic and non-psychotic disorders.

* 1. Delusional beliefs and first-rank symptoms

Schneiderian first-rank symptoms (FRS) remain a contentious topic in psychiatry, perhaps at least partly due to a loss of the nuanced approach first adopted by Schneider in contemporary diagnostic systems (Broome et al., 2012; Heinz et al., 2016; Moscarelli, 2020). FRS are traditionally conceived as characteristic of schizophrenia and may aid differential diagnosis. However, despite recent evidence showing higher prevalence of FRS in the schizophrenia spectrum (e.g. Humpston et al., 2020), others have found practically no clinical utility for FRS (e.g. Peralta & Cuesta, 2020). A moderate approach may be to acknowledge the higher prevalence of FRS in schizophrenia-spectrum disorders whilst refraining from inferring diagnosis specificity (Shinn et al., 2013), as even the most bizarre FRS hardly act as the sole criterion for a diagnosis of schizophrenia in practice.

 Arguments about clinical utility aside, the nature of FRS also stimulates fascinating debates. Most FRS, including TI, involve a profound alteration in one’s ego-boundary. In other words, the boundary between what is self and what is other is not only blurred, but also severely damaged (yet never truly absent). Patients may report feelings of passivity, such as they are under the control of an alien force like an automaton or a replacement of will (Hirjak et al., 2013). Thoughts, emotions and even actions may no longer possess first-person authority, for they are not perceived as willed by the patient themselves (i.e. ‘made’ impulses and ‘made’ volitional acts). Many FRS challenge the tight connection between first-person experience, selfhood and agency – yet the miracle is that, despite this, patients can function in other ways and non-alienated and non-passive experiences still occur, and this sustained ability to function perhaps challenges our default Cartesian assumptions. Nevertheless, there is something that grants the experience of TI a special status, as compared to other thought interference symptoms such as thought withdrawal, broadcast or echo. Perhaps it is because in the latter cases, no matter how distressing the experience, the thoughts in question remain the patients’ own thoughts. There is a striking difference between the statement of ‘these thoughts are *not* mine’ and ‘other people can hear *my* thoughts’, or ‘*my* thoughts are being taken away from me’. Amongst all the FRS, TI in this sense is clearly the closest to ‘qualifying’ as a delusional belief (‘delusion of TI’), perhaps with the exception of aforementioned passivity phenomena (Section 4.2 of this Chapter) which are also referred to as ‘delusions of control’ in many cases. Nevertheless, as we will argue later, TI and other associated FRS are far more than just delusional beliefs and do not necessarily require a delusional aspect *or* belief status to take hold in a patient’s mental space.

* 1. From thoughts to beliefs to *delusional* beliefs

Whether the belief formation process itself is intact, explaining delusions under a purely doxastic framework has its own shortcomings. A prominent example against the doxastic account is the observation that many delusions do not lead to action in accordance to the delusional content (‘double-bookkeeping’) and are sometimes so amorphic and indiscrete in nature that they lack the basic qualities of even non-pathological beliefs (Gerrans, 2013). On the other hand, a fully non- or anti-doxastic account also fails to capture for example the level of conviction and in some cases the action-guiding quality of delusions. Delusions are clearly not just some random thoughts. Contemporary theorists have defended a kind of ‘modest doxasticism’, arguing for complexity and nuance (Bortolotti, 2012). However, perhaps a more pertinent question to ask is when does a random thought become a belief and when does this belief become delusional? There is certainly no easy answer; as mentioned previously, by using the word ‘become’ it already implies a (meta-)cognitive and deliberative process. Maybe thoughts do not have to ‘become’ beliefs and certain beliefs do not have to ‘become’ delusional – it is neither a linear nor a ‘filtering’ process where only some of the thoughts in a patient’s mind end up as (delusional) beliefs. Whilst none of these features directly diminishes the explanatory power of the doxastic account, they do encourage us to look at the bigger picture especially in a specialised case such as TI.

1. **TI: Always a delusional belief?**
	1. TI and persecutory delusions

Persecutory delusions are the most severe forms of paranoid ideation and are considered as ‘threat beliefs’ (Freeman, 2016); they are frequently associated with significant distress, preoccupation and affective disturbances such as high levels of anxiety and low mood. The most widely accepted explanation for persecutory delusions used to be one of cognitive bias with regard to attributional style (i.e. externalising bias), yet more recently theories about their aetiology have shifted from the cognitive to the negative affective domain including a strong focus on the role of stress, self-esteem and trauma (Hardy et al., 2016). Persecutory delusions may also arise as a consequence of anomalous sensory and perceptual experiences such as hearing critical voices attacking the individual. The individual may form the belief that the voices come from their neighbours who are gossiping behind their back, which can lead to arguments, litigative claims and, in some extreme cases especially when there is severe distress, violence against the perceived persecutor (Ullrich et al., 2018).

 The relationships between TI and the ‘prototypical’ paranoid delusional belief of persecution are complex and under-studied. To date has been no systematic comparison between the two symptoms. However, one striking similarity is the external agency and sometimes personification of the source of the patient’s strange belief/experience. In TI, the thoughts do not belong to oneself and in persecutory delusions, someone else is causing harm. Still, the alien agency may also be a differentiating factor. Neither persecutory delusion nor TI necessarily *require* a fully personified ‘other’, whether it is the persecutor or the source of one’s alien thoughts. Both may occur as the end result of sensory abnormalities and experiences of passivity in thinking, affect and volition. Just like persecutory delusions sometimes arise following hallucinations (especially those of a negative or abusive nature), TI does not usually manifest ‘out of nowhere’ either; despite some well-cited counterexamples claiming that patients simply ‘discover’ alien thoughts in their mind out of the blue (e.g. Mullins and Spence, 2003), the lack of causal coherence in contrast to the patient’s ‘own’ stream of thoughts does not always automatically lead to them believing the thoughts come from someone else, especially when the thoughts are less emotion-laden than those often associated with persecutory delusions. That said, some inserted thoughts can be extremely unpleasant and can force the individual to act upon such thoughts. Indeed, the formation of persecutory delusions may well be one endpoint of repeated episodes of TI, although this link has yet not been studied empirically.

* 1. TI and other thought interference symptoms

As mentioned previously, TI differs from other thought interference symptoms (thought withdrawal, broadcast, echo – which are all considered FRS) in that TI is an ego-boundary permeation phenomenon (i.e. permeability of the barrier between the individual and their environment; see Sims, 1993) where both the agency and possession (ownership) are perceived as alien, ‘not one’s own’ (see Table 1 in Mullins and Spence, 2003). Again, how well TI ‘sits’ within the range of thought interference symptoms has not been properly profiled; however, it does seem that the alien thought possession (as opposed to thought agency) is the differentiating factor. TI also differs from unsolicited, ‘influenced’ thinking or even the kind of spontaneous thoughts we all have where, although in both cases the direction of ego-boundary permeation is inwards, in influenced or unbidden thinking the thoughts themselves still remain as the patient’s own – it’s just that they are ‘made to think’ (i.e. the problem lies with thought agency only). On the other hand, the direction of ego-boundary permeation in thought withdrawal and broadcast is outwards and the thoughts involved are the patient’s own; the difference between thought withdrawal and broadcast is that in withdrawal, the thought is taken away from the patient from without whereas in broadcast, the thought not only diffuses outwards but is also accessible to other people. In this sense, thought echo would be audible thought broadcast (also a type of hallucination) and thought withdrawal would be reverse TI. We have argued elsewhere that ego-boundary permeation, combined with various ‘levels’ of external accessibility and perceptualisation (e.g. audibility), are best viewed as forming a spectrum or even multiple spectra where experiences can shift and morph between one another especially in schizophrenia (omitted for review).

 Another pertinent question is whether thought interference symptoms are delusional beliefs. If they are indeed all delusional beliefs, then TI as one subtype of these symptoms must also be a delusion. A further question is whether being a delusion *defines* the experience of TI in its entirety, for example through accounts of delusion based on ‘faculty psychology’ or even the DSM which often refer to TI as ‘*delusions of* TI’ or ‘a common delusion in schizophrenia’ (e.g. Gibbs, 2000). Framing TI and related thought interference symptoms as mainly, if not purely, ‘false beliefs’ severely undermines the reality of such experiences and further feeds into the epistemic injustice to which many patients with schizophrenia are subjected (i.e. everything the patient says is situated in a delusional milieu and therefore not to be trusted). We consider such an approach far too simplistic, if not damaging, and does not at all capture the nuance and intricacies involved, especially when taking into account patients’ subjective experiences when these symptoms occur. Yet there are clearly cases where delusional beliefs even by the strictest definitions have taken hold in patients who report TI; next, we offer some suggestions as to how we can potentially reconcile the clinical and phenomenological differences between these cases.

* 1. TI *with* delusions versus TI *as* delusions

One way to differentiate between the various mental states during and after episodes of TI is the detailed investigation of first-personal experiences as reported by the patient; however, an added layer of complexity is that individuals who have such unusual experiences often speak in metaphors, because common language cannot possibly convey their true meaning – let alone what it actually ‘feels like’. The Schedules for Clinical Assessment in Neuropsychiatry (SCAN; Wing et al., 1990) instrument, for example, separates ‘replacement of will’ (i.e. passivity symptoms of thought including TI) from delusions and requires the former to possess a primary generative experience first. It is this kind of deep and intricate investigation that is necessary to truly disentangle the patients’ subjective experiences: instead of grouping all reports of TI as delusional beliefs, it is perhaps more accurate and clinically useful to say there are TI *with* secondary delusions regardless of the belief status. We do not think this is merely a game of lexicon; the label of ‘delusion’ can have powerful consequences for the patients’ self-identity, sometimes leading to persistent doubt about the ‘abnormality’ of one’s own mental state even if it is just an everyday unbidden thought that the patient is having.

 In a sense, the label of delusion may not even be applicable to most cases of TI, even though delusions can often manifest in patients who report TI. Again, this is not just a difference in language use. TI as an experience itself is frightening, confusing and disorientating; a delusional elaboration could just be the desperate measure the patient’s mind calls out for in order to reduce the instability and anxiety caused by losing control over one’s thinking processes. Delusion formation can act as a long-awaited yet erroneous revelation (‘apophany’; see Mishara & Fusar-Poli, 2013; Broome et al., 2012, p.178) so full of meaning and significance that fits perfectly within the structure of consciousness, becoming something so intrinsic to the patient’s being that the mind just cannot let go of it. As long as the original generative experiences persist, the secondary delusion will be ‘called upon’ repeatedly, leading to consolidation and maintenance. Although not all experiences of TI will inevitably result in delusion formation and not all delusions are the consequences of aberrant sensory or motoric perception, reports of TI should never be straightforwardly dismissed as ‘delusional beliefs’ – at least not until there is clear evidence of the latter. The words patients use may sound as if they fully believe in the veracity of their experiences and there can still be delusions involved; TI in this case however is best framed as a duplex phenomenon consisted of the generative/experiential alteration first and foremost, before any foundation for delusional beliefs can be constructed.

* 1. The belief status of TI

Are the experience of having inserted thoughts and the act of ascribing them to another agent beliefs, even though they might not always lead to delusion formation? William James (1889) defined belief as ‘the mental state or function of cognising reality', and that ‘belief will mean every degree of assurance, including the highest possible certainty and conviction’ (p.21). He went on to argue that ‘The true opposites of belief…are doubt and inquiry, not disbelief’ (p.22). In this sense, the experience of TI will almost certainly lead to a very curious state of mind: one of doubt and inquiry *and* one of conviction and certainty. Patients reporting TI do not usually begin with a strong conviction that their thoughts are definitely not generated or possessed by themselves (but by another agent); rather, it is akin to a profound sense of *dis*orientation or uncanniness – ‘are these thoughts mine?’ – which calls for the eventual *re*orientation and in some cases delusional elaboration as an attempt to answer this urgent and debilitating existential question. The delusions that form from TI are qualitatively different from those arising as a consequence of, for example, traumatic brain injury where delusions tend to be monothematic and fit better with the traditional definitions of ‘belief’ (Stone & Young, 1997). To us, TI exemplifies the paradoxical nature of many symptoms of schizophrenia that are distinct from symptoms of organic or even other non-organic (e.g. affective) psychoses. As we mentioned in the Introduction, the mere act of questioning whether the thoughts in one’s mental space (which does not have to be a physical demarcation of inside/outside the head) are one’s own in the literal sense indicates a kind of subtle change in a person’s subjectivity that cannot be easily explained away by whether one believes in it or not. Sometimes a person does not need to actively believe in something for it to bear truth or *feel* real. This in-between state of reality and falsehood, doubt and conviction shapes if not defines the mental state of a person with schizophrenia where language used to convey shared human experiences breaks down; they are at the mercy of an interfering ‘other’ whilst being ‘othered’ by those around them. TI is an extremely isolating symptom associated with a very lonely illness that reaches far beyond common sense or what is humanly possible; as such, what most people would usually consider as beliefs also fall short when trying to examine experiences like TI.

1. **TI and transformations of self-consciousness**
	1. Ego-boundaries and their permeability

The very concept of ‘ego-boundaries’ is complex, contentious or even elusive, and is one that has largely faded out of medical education and symptom-based psychiatric diagnoses. However, ego-boundaries and their disturbances play a pivotal role in the psychopathology of schizophrenia (and perhaps less in other disorders), at least historically. Almost all the forefathers of psychiatric theory and nosology (e.g. Kraepelin, Bleuler, Minkowski, Schneider) have written about the profound alterations in (and in the most severe cases, loss of) unity, coherence and integrity of self-consciousness. Such alterations often arise from a kind of permeation, diffusion or perforation of ego-boundaries: the demarcation between self and other, the ‘innate’ ability to differentiate what is an inner and what is an outer (mental) space. In schizophrenia, this demarcation is damaged to the extent of dissolution or distorted into something unusable and unrecognisable. But this may all sound like a grand metaphor, as there is still no neurobiological ‘hard evidence’ supporting the existence of a fixed ego-boundary, where it is located or how it is constructed. All we know seems to be derived from philosophical investigation and patients’ self-report, which (wrongly, in our view) do not carry much weight in contemporary ‘evidence-based’, biologically centred psychiatry.

 In a recent account, Gipps (2020) rejects both the metaphysical and the epistemological conceptualisations of ego-boundary; the former refers to the ego-boundary as akin to a cellular membrane able to undergo some kind of ontological osmosis, which in turn renders the whole concept unnecessarily obscure and practically impossible to study, whereas the latter focuses too much on one’s explicit self-knowledge and its failings in recognition. Both approaches ‘objectify’ the ego-boundary, as if it was a measurable and quantifiable ‘thing’ like a physical membrane, and at the same time (perhaps paradoxically) makes it too mysterious to be intelligible. Moving away from cognitivist accounts of symptoms such as TI, Gipps instead offers an enactivist approach, where ego and its boundaries are continuously constituted by a transcendental self, amenable to its interactions with the world and other inhabitants in it. This notion is supported by empirical research on disturbances in bodily representation and peripersonal space in schizophrenia (e.g. Costantini et al., 2020).

 We too reject the (purely) epistemological account of self-acquaintance and are sympathetic to Gipps’ enactivist approach; ego-boundary is not unchangeable or concretised *a priori*. Nevertheless, we think there is some value in the analogy with the metaphorical cell membrane – metaphorical being the key word here – the process of ‘ontological osmosis’ does not have to be static either and can indeed be actively modifying itself given the external and internal circumstances. We admit this may appear elusive, yet to us schizophrenia is characterised (if not defined) by ontologically impossible experiences and the distorted metaphysical dimensions of self cannot be fully understood in commonsensical or even interpersonal terms.

* 1. TI, passivity phenomena and auditory-verbal hallucinations

Analogically speaking, TI is to thinking what passivity phenomena are to action and volition; both involve fundamental and substantial transformations in how one’s minimal selfhood is constructed and embedded in the wider environment and not just what one (consciously or unconsciously) acknowledges as self-generated. In fact, some theorists argue that TI is in fact a form of passivity phenomenon but ascribed to thoughts (Henriksen et al., 2019). The authors consider TI ‘a cognitive experience of a thought content that the patient claims is not his own’ (p.4). It breaches almost everything an individual takes for granted about first-personal authority and the privileged nature of what they think and perceive, but is it really only a cognitive experience and does the patient need to ‘claim’ anything for the said experience to be not theirs? Gray (2014) puts forward the argument for a third factor in delusion formation in relation to passivity experiences (including TI), namely one where the subject needs to make a judgement about whether a thought is theirs or not, i.e. the necessity for identification. However, the need for identification (which is normally absent) for a thought that is first-personally accessible does not have to lead to a delusional elaboration either. After all, the subject might just conclude thought is still theirs. If the first-personal authority and awareness of the taken-for-granted presence of ‘for-me-ness’ over one’s thoughts cannot be challenged, then it may follow that the awareness of *absence*, i.e. the thoughts are not willed by self, cannot be disputed either.

 We argue that this awareness of absence is not about the thoughts themselves (it is extremely rare that TI can fully ‘replace’ the patient’s own thinking), but about the first-person givenness of thoughts that exist and are accessible within one’s mind. One’s stream of consciousness does not always need to be accessed through active introspection; rather, it is the ‘becoming sensory’ of some thoughts that drive them towards an absence of wilfulness and being experienced as inserted from an external source or agent (Sterzer et al., 2016). It must be pointed out that this ‘becoming sensory’ does not necessarily lead to auditory-verbal hallucinations (AVH), which are far more transdiagnostic and are by no means specific to the schizophrenia-spectrum. Thoughts ‘becoming sensory’ cannot be simply heard through one’s auditory capacities but are absorbed into the very basis of their self, with an immeasurable level of immediacy and salience. These ‘soundless voices’ (Ratcliffe & Wilkinson, 2015) might actually be more clinically useful than ‘actual’ AVH as indicators of schizophrenia, as they precisely captures the paradoxical, unstable and unsustainable ‘in-between’ states of thought, perception and volition that lie at the core of the experience of a schizophrenic (rather than broadly psychotic) disorder.

* 1. What makes TI so different?

We have already alluded to the observation that TI differs from other thought interference symptoms as well as ‘prototypical’ delusional beliefs in psychosis such as persecutory delusions. As mentioned above, in TI the ‘diffusion’ through a permeable ego-boundary is inwards only, as opposed to outwards (thought broadcast and withdrawal) or in some way bidirectional (thought echo, where the thoughts are ‘reflected’ back at the individual). This means an added layer of invasion and violation of one’s inner psychological space and may possess a higher propensity to ‘require’ an explanation. Sometimes (but not always) TI arises as part of ego-dystonic states situated within an all-encompassing affective disturbance which might be an indication of subconscious rejection of certain intolerable thought contents and the associated distress or anxiety (López-Silva, 2016). In other cases, TI is preceded by depersonalisation and derealisation as well as other subtle perceptual changes, which is consistent with recent empirical findings suggesting detachment and dissociative symptoms ‘travel’ along similar trajectories with FRS over time (Humpston et al., 2020).

 Still, there are widespread debates and disagreements between explanationist and endorsement accounts of TI (Sollberger, 2014; López-Silva, 2018); whilst we tend to be more sympathetic for the explanationist view (i.e. delusions in TI form as an attempt to make sense of the anomalous experiential component rather than framing TI as a delusion in its entirety), we do consider TI to hold a special status in psychopathology that even a delusional elaboration can only serve as a mere *attempt* to explain its influence which can sometimes fail. In this sense, we are very supportive towards the potential meaningfulness of FRS in the differential diagnosis of schizophrenia and view the apparent lack of clinical specificity over ‘other’ delusions and hallucinations likely due to the progressive deviation from their original conceptualisation. A thorough understanding of Schneider’s FRS is supposed to offer a rare glimpse into the subjective worlds of patients with schizophrenia, with all the rawness, richness and immediacy of the psychopathological experience. It should not come as a surprise that a nuanced view of TI as an FRS possesses inherent utility for carrying out highly focused investigation into schizophrenia.

* 1. Ontologically impossible experiences in schizophrenia

TI is one example of the kind of ‘ontologically impossible’ experiences that typify schizophrenia, and in our view is more entrenched and impactful than any (delusional) belief. This extensive breakdown of first-person authority originates from a sense of detachment from commonsensical reality in the most ineffable, enigmatic and literal manner that nothing short of a delusional construct will help to calm the mind undergoing such detachment and transformation. For the patient with schizophrenia, in order to reintegrate with the ‘real’ world and protect the fragile equilibrium between the two ‘worlds’, self-disturbances may seem a petty or even worthwhile price to pay (Ratcliffe and Broome, 2012). However, to articulate their delusional-hallucinatory world also carries the heavy burden of the intrinsic shortfalls of everyday language, which is evolved to convey *humanly possible* experiences (even imaginations are confined by what is *imaginable* in the first place). Of course, gaining ‘access’ to a separate ontological dimension never makes the sufferer of schizophrenia less human; if anything, it makes them *more* aware of a form of reality that has to run parallel to the shared social reality. Any cross-contamination or entanglement between the two would lead to a collision with disastrous consequences including the paralysis of self.

 Nevertheless, the effort to navigate between the two worlds and the attempt to keep them parallel often mean that the sufferer is stuck between the two. Unable to fully detach from or participate in either reality, the mind inflicted with schizophrenia sinks deeper into the void as the delusional-hallucinatory world begins to encroach upon the commonsensical one. This is where ‘double-bookkeeping’ fails to protect either reality. Thoughts and percepts may be merging with one another like molecules diffusing and reacting in a suspension in thin air; volition *feels* alien and painful. There is no need to judge or identify their source because there is simply no tangible source to be found in *this* world. Yet such disintegration does not need to arise from a florid state of psychosis – perhaps it is more accurate to describe it as an existential ailment *in addition to* psychotic symptoms – but is something that has been there at the centre of the patient’s self for a very long time, eating its way outwards rather than being invaded from without (Parnas et al., 2020). The patient is plagued by an unspeakable solitude that is paradoxically imbued with significance and meaning from the non-existent ‘other’; a deep sense of being fundamentally different in the very essence of what it means to be human (‘*Anderssein*’). The patient is isolated by consciousness itself. Perhaps this is why schizophrenia is such an ‘othering’ disorder: ontologically impossible experiences are quite physically beyond what the intersubjective world can accommodate.

* 1. Heterogeneity in the experience of TI

Despite being treated as a unitary concept (a delusion) in many cases, TI can possess significant heterogeneity especially in the way it is described by patients with schizophrenia or psychosis. Perhaps some of the controversies in the theory and research of TI come from this apparent lack of first-person accounts; only a handful of perhaps outdated vignettes are quoted again and again (such as the infamous Eamonn Andrews example; Mellor, 1970). In a survey by Gunn (2016), users from multiple mental health online forums shared their experiences of TI openly under pseudonyms. Some even opted to use the term TI in a very clinical sense and stated that they had insight to realise the bizarreness of their experiences. However, their insight was not about the truth or falseness of TI – the user went on to describe in some detail how the government, aliens, chips in their head and psychic powers were the sources of the inserted thoughts in spite of their ‘insight’ telling them these were bizarre ideas.

 Another user asked the question ‘Is it still regarded as thought insertion if you don’t know who is doing the inserting?’ (p.563) which supports our argument of TI being a duplex phenomenon: there is clearly a strong sensory-perceptual component followed by a delusional elaboration or the rejection of another agent being the source (‘doing the inserting’). However, this does not render their experience of TI less real, perplexing or frightening. Just as a patient reported on these forums, ‘I’m aware the thoughts that come to mind are NOT from external people, but I do believe my thoughts are not from me — but from something else in my mind, like the voice that speaks to me, for example.’ (p.564). To us, this quote illustrates both the difficulty in differentiating thought from perception and the strange ‘in-between’ state characteristic of schizophrenia that is almost impossible to be captured by common language use.

1. **Theoretical and clinical implications**
	1. Reviving phenomenological psychopathology in research and practice

Current diagnostic systems and intervention strategies largely focus on the identification and treatment of mental illness at a symptoms level; even in psychological therapy, the aim is mostly to reduce distress and ‘correct’ anomalous thinking patterns. This is particularly true for psychotic disorders, where the breakdown in the shared perception of reality means that ‘re-integrating’ patients into consensual reality carries the most weight when devising treatment plans. In terms of research, there has been a tremendous amount of investment into the neurobiological underpinnings and cognitive mechanisms of psychosis without a deeper analysis of the experiential aspect. As we have outlined in this Chapter, patients with schizophrenia are very unlikely to be totally oblivious of commo nsensical reality or fully ‘believe’ in their delusional-hallucinatory worlds; rather, they are plagued by the awareness of more than one world or reality. Phenomenological psychopathology has taught us that the deficit in schizophrenia does not lie entirely within impairments in ‘reality testing’, but in choosing which reality is more inhabitable. In many cases, it is chosen *for* the patient even before any deliberative or willed action – the delusion simply ‘fits perfectly’ within the structure of one’s self-consciousness or calls for a radical restructuring of one’s existing perceptions of the world (Sips et al., 2020).

 To be able to grasp the complexity, impact and meaning of experiences such as TI, researchers and clinicians ought to familiarise themselves with the richness of experiential data and cannot just focus on images of the brain. Neuroscience and phenomenology should never antagonise each other and should form the kind of ‘inseparable unity’ between the soma and the psyche of which Jaspers spoke (Humpston & Broome, 2020). Even self-disturbances may have developmental roots (Poletti & Raballo, 2019) which complement neurobiological frameworks.

* 1. The open-minded and inquisitive clinician

It needs to be borne in mind that most patients with schizophrenia find it almost impossible to describe the actual feelings associated with TI – or even psychosis in general. Patients risk not being believed by their clinicians (by using phrases like ‘as if’), yet if they show too much conviction they will be labelled as delusional. It is therefore the clinician’s role to elicit and explore the finer experiential nuances beyond face value, even when the patient articulates their symptoms in a very literal sense. For example, someone experiencing prodromal psychosis might report an overwhelming sense of dread, uncanniness and unease (delusional atmosphere) accompanied with sensitivities to environmental stimuli (e.g. lights becoming brighter, sounds louder), but it is not often likely that they will use any of these terms. Instead, the patient might just say ‘things don’t feel right’ or ‘I can’t think straight’, showing behavioural aversion to the lighting in the room or asking the clinician to speak more quietly. All these signs should be picked up before establishing firm symptomatology. In the case of TI, again patients are unlikely to say in the first instance ‘I believe have inserted thoughts’ or ‘someone is inserting thoughts into my mind’; rather, they might seem perplexed and report thoughts that do not ‘feel’ like theirs (yet they may or may not recognise cognitively that said thoughts are still their own).

 To us, we are not so interested in the judgements of agency or ownership when it comes to TI – in a way, judging TI as one’s own or attributing to an external agent makes little difference to the underlying *experience* – the vital aspect is the raw feeling and basic sense of a breach in one’s first-person authority, which is often indescribable. An attempt to articulate such an experience can by itself give the appearance that it holds some sort of belief status, and the further the patient ‘formulates’ their experience in commonsensical terms, the more deluded the patient will sound to the one doing the clinical assessment. We do not at all suggest that concepts such as delusions and hallucinations should be abolished; we urge clinicians to stay open-minded in their own judgements, as words like ‘delusion’ or ‘hallucination’ carry strong epistemic weights to the patient.

* 1. Delusional beliefs, truth and reality

We are strong advocates of the view that although the patients’ thoughts and perceptions about the external world can be utterly false, they cannot make mistakes about what is *real*. Reality is constructed and experienced through first-personal terms, whereas truth is built upon a shared and intersubjective foundation. Something that is true (e.g. colour) in the world might not be real to the individual (e.g. colour-blindness) and something that is real to the individual (e.g. inserted thoughts and hallucinated voices) might not be true in the physical world. However, physicality is only one such building block of the world. If everyone suddenly became colour-blind, would colour still exist as truth? Similarly, if everyone hallucinated simultaneously, would that hallucination be considered a real percept? We are cautious to not paint ourselves in a naïvely idealistic light; these are merely thought experiments. Still, to the patients with schizophrenia these are more than just curious experiments or uninvited imaginations. They represent a reality that is ontologically impossible, paradoxically inescapable, yet never pathologically incomprehensible. One would think that the world would still exist even if humans became extinct, but no one can hold this view with absolute certainty. Delusional beliefs on the other hand are usually held with more certainty than what ‘normal people’ might all take for granted – do they still carry less truth by definition? We encourage clinicians and researchers to reflect on their own truth and reality before ‘jumping to the conclusion’ that patients with schizophrenia are epistemically inferior.

1. **Conclusion**

In this Chapter, we have presented an account of TI from the perspective of phenomenological psychopathology that is largely non-doxastic; however, this is not to say that (components of) TI cannot *become* doxastic. Instead, we have argued for the conceptualisation of TI as a duplex phenomenon with elements of both frameworks. We have resisted a purely cognitivist account of TI and focused on the paradoxical and ontologically impossible qualities of schizophrenia, as opposed to other disorders in the wider psychosis spectrum. We consider TI and related passivity symptoms (i.e. most FRS) as fundamental violations in an individual’s ego-boundary and such transformations in self-consciousness may indeed have higher clinical utility in the diagnosis of schizophrenia. Further, these symptoms raise fascinating (and in many ways, disturbing) questions against principles that are frequently taken for granted in Western philosophy and in daily life: what if the unity of selfhood and its perceived links to first-personal givenness are nothing more thana historical, social trend, , and the so-called ontologically impossible experiences are actually true? What if the seemingly causal relationship between thinking and the existence of self is merely an illusion? We have no doubt that debates around the nature of TI will continue; our hope is that we have geared the arguments towards a more patient-centred approach. Without patient experience on the centre stage, no amount of philosophical investigations or empirical studies will possess real benefit – not even to the theorists or researchers. In sum, we view TI not purely as a delusional belief nor a sensory experience in its entirety, but as a prime example of the paradoxicality and perplexity that are at the core of the schizophrenia syndrome.

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