Embodied delusions in the cultural-ecosocial niche

Rosa Ritunnano and colleagues[1] have advanced the phenomenology of psychosis considerably by framing delusions as embodied emotions articulated through metonymy. Their work powerfully illuminates the embodied and enacted dimensions of shame, such as the experience of the translucent body, and aligns with the 4E cognitive science framework, viewing cognition not as a solitary brain event but as embodied, enacted, embedded, and extended.[2,3]

To fully realise the potential of this framework, I suggest that the field should also attend to the embedded and extended dimensions of cognition. As Gómez-Carrillo and Kirmayer argue,[2,3] a comprehensive 4E perspective requires a cultural-ecosocial systems view, recognising that the lived body is inextricably coupled with the specific cultural affordances of its niche, defined as the possibilities for action and meaning-making provided by the local sociomaterial environment.

Integrating this cultural dimension offers a crucial refinement to the authors' model. Although Ritunnano and Littlemore[4] focus on the use of linguistic metaphors to articulate pre-existing bodily experiences, evidence from transcultural psychiatry suggests culture acts further upstream, functioning as an architect of the embodied experience itself.

In Taiwan, for instance, the metonymic bridge between shame and the body manifests differently. Grounded in the Confucian concept of *lien* (moral face), where the experience of *diu lien* (losing face) signifies a catastrophic loss of moral integrity, shame might be embodied not as the transparency of privacy violation, but as an intense, localised heat described as an unbearable flushing pain crawling over the face.[5] This distinct looping effect between cultural scripts of morality and physiological arousal suggests that the translucent body described in the UK cohort[1] might not be a universal schema, but a distinct product of a specific cultural-ecosocial niche.

Therefore, embracing the complexity of the cultural-ecosocial system strengthens the argument for delusions as embodied meaning. A delusion is not just an event in the body; it is an event in a meaning system that extends beyond the skin. Decoding these embodied idioms requires tracing the specific loops between the local moral world and the lived body.

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Mental health needs and personality disorders in humanitarian settings

Humanitarian mental health and psychosocial support aims to reduce distress and psychological suffering through restoring safety, functioning, dignity, and coping across populations in crisis.[1] Anwar and Talha[2] suggest humanitarian mental health and psychosocial support programmes must better identify and manage people with personality disorders. We agree that people with personality disorders experience substantial distress during emergencies and deserve optimal care. However, we propose alternative approaches to address the needs of people with complex mental health conditions, including personality disturbances, in humanitarian contexts.

It is methodologically complex to distinguish context-specific responses to extreme adversity, possibly traumatic events, and marginalisation, from persistent dysfunctional personality characteristics. Interpersonal functioning, self-perception, emotional dysregulation, and loss of trust can be substantially altered in humanitarian settings without indicating underlying personality disorders. These conditions involve marked disturbance in personality functioning over extended periods of time across a range of personal and social situations.[3] Periods of acute stress or instability do not allow for meaningful assessment of enduring disturbances. Use of the dwindling humanitarian funds to commission prevalence studies of personality disorders should therefore not be a priority.

Similarly, routine clinical screening for personality disorders raises ethical concerns when specialist expertise for in-depth assessment and appropriate long-term psychotherapeutic care are not feasible. This issue is common in low-resource settings where substantial mental health treatment gaps exist due to low numbers of qualified mental health professionals and scarce referral options. Prioritising disorder-specific case-finding for personality disorders would introduce a diagnostic exceptionalism not applied to other chronic mental and physical health conditions in humanitarian care, in which emphasis is placed on functioning and continuity rather than diagnostic enumeration.

Mental health information systems in humanitarian settings are based on broad syndromes that can be identified by trained and supervised non-specialists.[4]

Furthermore, in humanitarian emergencies, many people accessing mental health services attend only a few sessions. This pattern of service use argues strongly for brief interventions that are solution-focused and integrate skills-development for emotion regulation, problem-solving, and interpersonal effectiveness. Such approaches form the backbone of task-shared, stepped-care models and have been widely researched and used in humanitarian settings.[5] These interventions can benefit a range of individuals with common mental health conditions including those experiencing personality disturbances, without requiring formal diagnosis.

Let us not overstate what is feasible in resource-poor settings with extreme needs. Emergencies are entry points to strengthen mental health systems, workforce capacity, referral pathways, and supervision structures. Over time, humanitarian interventions can contribute to stable and context appropriate care systems that address a full range of complex mental health needs, including for people with personality disorders.

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