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The Person with Delusions

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"And the end of our exploring
Will be to arrive where we started
And know the place for the first time."
(Eliot, 1952, p. 145)

In preparing this report I made the mistake of looking back in the literature, the literature not only of delusions, but also including some more general works of the earlier clinical writers, such as Birnbaum (1923), Conrad (1958), Jaspers (1963) and Kretschmer (1927). It was a humbling experience; these were obviously people who knew something about patients and about the realities of symptoms. For these writers, notions such as delusions were not just abstractions, not even just abstractions with operational definitions. These authors described real experiences of people, and their descriptions reflect the importance of studying patients from close clinical contact.

At the same time, in their writings, one is also impressed that the clinical descriptions, opinion, and perhaps the prestige of the person writing are implied to be sufficient to establish truth. There was no discussion of sampling issues, statistical demonstrations of probability, or reliability of measurement.

Somehow, in our field, we have found it difficult to combine the two parts, descriptions of the complex experiences of real patients and demonstrations of statistical likelihood. In this report, I will not attempt such a synthesis. I will, however, suggest that in studying delusions we currently err by emphasising almost exclusively the reliability of measurement and the values of large-sample survey, and that some balance to more detailed clinical inquiry is also essential. I do not claim to "know the place for the first time", nor do I claim definitive truth for the following hypotheses. But I do want to discuss delusions using some clinical examples, hoping to enlarge further the narrow perspective of most current descriptive psychiatry, which limits us excessively and may even be misleading.

If one of our major problems at this time is that we neglect the importance of detailed clinical inquiry, how might such inquiry be conducted? Piaget used what he called the 'Clinical method' in his studies of human development. A common type of functioning, such as a child's understanding of the constancy of matter, was taken as the centre of each of his efforts. Piaget would then explore such issues through studying them in various situations, and through interview and observation. Beyond following the tendency to focus on brief description, epidemiology, biology, and theory (e.g. Sno & Linszen, 1990), we could carry out analogous inquiries in studying symptoms, exploring their longitudinal and cross-sectional vicissitudes and contexts. Goethe wrote, in his novel *Elective Affinities* (Goethe, 1809), about a woman who had suffered a terrible loss of the man she loved: "She even looked ahead to the common but sorry consolation that time would heal even such torments as these. She cursed the time it would take to heal them; she cursed the dead time when they would be healed" (p. 105). Today, in much of descriptive psychiatry, we would focus narrowly on the cross-sectional characteristics of this particular woman, and if we noticed that she was having a kind of "dead time", then we might consider that she demonstrated flat affect. Among other things that Goethe appeared to be trying to tell us in this and other work is that to understand people it is important to think not just about a particular moment, but to consider process, what actually happens over time. In psychiatry, Kraepelin, Bleuler, Freud, and Meyer consistently took such a perspective. Piaget again and again made the statement about understanding any kind of complex human behaviour: if you want to study it, you have to look at its vicissitudes and see how it evolves.

Thinking about processes and about closer observations of real people over time, what can we learn about delusions? First of all, delusions often appear to start out as very normal or normal-appearing ideas. Then sometimes, after an idea evolves into a delusion, the delusion may fade back more or less to normal again. A woman I saw while making clinical rounds about two weeks before writing this report had the delusion that she could control people, especially that she was able to control men. She had been admitted to hospital because these kinds of ideas had become so extreme and so preoccupying that she was not able to manage her everyday life. For this particular patient, we also happened to have a record of an out-patient visit that she had made to the clinic 24 years earlier. She had been in college at that time. The psychiatrist noted the many problems she was having – anxiety, difficulties deciding about her college life, troubles with her

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boyfriend, feeling that to some extent she had too much power over him. There was absolutely no evidence of any kind of psychotic symptoms, and in fact the diagnosis of 'anxiety neurosis' had been made. This woman, seen now, had an extreme form of an idea noted 24 years earlier by a psychiatrist evaluating her, apparently for another problem. That idea appeared to have become more and more powerful until at the present time it had reached delusional intensity. Although one could hypothesise that the idea had been delusional for the entire time, that would be using a particular theory to mould the data, a belief perhaps warranted, perhaps not.

A patient seen in the Washington Center of the International Pilot Study of Schizophrenia (IPSS) (World Health Organization, 1973) portrayed the follow-up side of this longitudinal view. This woman had been psychotic with the delusion that the devil was controlling her; in fact, half way through the assessment interview she stood up, saying that the devil was making her do it. When seen in a follow-up interview two years later, she had married, had a child, was doing well, and appeared to have no particular problems. At that point we were using a brief version of the Rorschach Test along with descriptively orientated interview techniques for assessing patients. In response to one Rorschach card this woman said that it seemed very strange, it was as though the devil was trying to get somebody to do something.

From such examples it appears that delusions may evolve over time from less extreme thoughts and themes and then begin to fade back into those themes again. Possibly even then, the potential for abnormal thought is still present in a covert form that may be brought out in certain circumstances.

Such sequences of the ebb and flow of these ideas/delusions may sometimes be understandable. At least one might be able to explain without making any convoluted interpretations why this waxing and waning is occurring. One woman I saw in some pilot research conducted several years ago had a severe depression with psychotic features. Among these features was the delusion that her actions were being controlled by an outside force. When I asked her more about that, she said it was really quite simple. She had become very depressed and was able to do very little. She noticed that somehow things were happening around her anyway, and felt that some other sources for change must have been operating. These feelings became increasingly strong as time wore on, and that other source became increasingly real and concrete for her.

Beyond this kind of ebb and flow, it appears that delusions are associated with many different causes. From the biological sphere, delusions can be caused, for example, by amphetamines. From the social sphere, one sees other associations. The distress of feeling one's life having lost its meaning may be one. A woman seen on rounds described how her delusions had begun after she lost her job at the post office. She had worked there all her life, and was now in her mid 50s. The post office had reorganised, and her old job was no longer available, although a very different alternative was offered to her. Her job had been the centre of her existence, and this loss appeared to have had a major impact on her.

Another social phenomenon appears to be associated with changes in delusional intensity. In treatment or counselling sessions with patients who are delusional, one can sometimes almost titrate the intensity of delusions the person is having with the amount of interpersonal closeness. If the clinician gets too close, the delusions increase. If the clinician becomes too distant, the delusions increase. There appears to be an optimal level of interpersonal closeness/distance in relation to delusional intensity in such patients.

In the psychological domain many factors appear relevant to the presence of delusions and to their changes. One commonly reported phenomenon is association with self-esteem. A patient in our study, in which we interview people repeatedly over time, is a young woman who has been severely delusional. She has not been particularly well educated or had much psychological treatment. She was telling me in one interview how her feelings that people were controlling her were much better now than they had been before. I asked her why, and she said that was easy, that she did not have to be paranoid any more, since she felt so much better about herself.

More complex kinds of psychological factors, such as developmental issues, seem also to relate to delusions and their vicissitudes. Tyson and I (unpublished) reviewed in detail the series of research interviews of a subject in our study. A man in his 40s stated that when he was about to become more involved in his academic position, delusional thoughts about numbers would appear and become increasingly intense. As the period covered by the re-interviews progressed, he decided he no longer wanted the life of an academic and took another job which used his skills, but was in the public sector. He felt for the first time that he had found a position that he really wanted, and he was not quite sure why he had ever gone into the academic world in the first place. Perhaps, he thought, to please his parents. Although the public sector work was more stressful in terms of administrative demands and public visibility, he became more relaxed, enjoyed his work more, and the delusional ideas diminished. It seemed as though

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the developmental evolution of this man's work life and finding a position that represented his own view of himself was associated with the waning of delusional ideation.

These kinds of examples suggest that many factors seem to drive delusions, perhaps in various combinations, almost like a hydraulic pump, and that a range of variables, biological, social, psychological, or developmental, may have considerable impact on whether delusions appear, increase, or diminish.

Delusions can apparently change qualitatively to another phenomenon. Renee, in Sechehaye's *Autobiography of a Schizophrenic Girl* (1951), describes her delusions becoming voices in certain kinds of situations. These situations often appeared to be connected to how available her therapist, Sechehaye, was to Renee. In a possibly related phenomenon of hallucination–decision linkage, patients will often say they cannot tell if their experience is a thought or a voice. It seems to be in their head, like an idea, but they can almost hear it. The notion of a discrete phenomenon 'delusion' totally different from all other experience may not be upheld by a careful descriptive examination (Strauss, 1969). What may be involved is not a discrete phenomenon 'delusion', but a process that in different situations moves to qualitatively different, but somehow related, experiences (Strauss & Carpenter, 1981).

Beyond the ebb and flow of ideas/delusions, the multiple apparent causes, and the relationships of delusions to other symptoms such as hallucinations, observing patients in depth suggests a fourth factor relevant to the nature of delusions. Many patients appear to have some control over these symptoms. In studies where we have asked patients if there is anything they can do to help their psychotic symptoms, many say there is. Some get busy; others check with people around them and begin to notice if they seem to have the same beliefs; some withdraw. Such actions seem to help certain people return to more normal thinking (Breier & Strauss, 1983). It appears that even when delusions are at their worst, there is often part of the person that does not believe them. Lionel Aldrich, the former American football player who developed schizophrenia and then improved, is an outstanding speaker who now gives talks about his experiences with mental illness. He mentions that even when he was at his most psychotic, there was a part of him that knew there was more than these strange beliefs. But that part had no control over the delusional beliefs and had, as it seemed, to sit by helplessly and watch the part of him that was convinced of their truth.

These reports suggest that delusions are sometimes associated with a self that is separate from them in various ways. At some times that self, the 'sane person', observes but is helpless; at other times that self appears to be able to act in a way to exert significant impact on the delusional experiences.

Finally, I would like to suggest that clinical experiences and reports of patients suggest that delusions, although usually defined by professionals in terms of cognition, are actually far more connected with emotions than is commonly accepted. The cognitive emphasis may be partly our problem. Many professionals who interview patients will, when they learn that the person has a delusion, say something like, "oh yes, the KGB is after you; what do you think they want?" Or the clinician may even say, "Well how does that feel, that the KGB is after you?" But there is usually no reflection from the clinician that this might be a frightening experience, no emotional response. Rather, we tend to the "oh-tell-me-more-about-it" emphasis. Often this is in keeping with our training and how we have learned to deal with the difficult experiences of patients. Although patients sometimes report this 'neutral' attitude as leaving them feeling strange and isolated, we have often been taught to consider it helpful.

One patient I interviewed in the IPSS described her experience of walking down the street one evening noticing a kind of haze around the lights. She began to wonder what that was about, what was going on. As she described this experience with her vague apprehensiveness becoming more and more powerful and more and more ominous, the hair stood up on the back of my neck. She was living a story that could have been written by Edgar Allen Poe. It was almost with relief – for me as well as her – when she said that the evening ended with her realising that the FBI was plotting against her. That we define such experiences primarily in cognitive terms and that we often talk with patients about them primarily in cognitive terms is striking indeed. As this woman described her experiences, there certainly was a cognitive component, but there was a perceptual and an affective component as well. Even the label 'delusional perception', capturing the perceptual aspect associated with some delusional experiences, omits the affective component and seems not to do justice to the interactions between affect, perception, and cognition that often exist.

The nature of delusions

What could these five possible characteristics of delusions – emerging from normal thoughts and fading again, with multiple causes, evolving into other phenomena, having connections to a separate self,

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having affective and perceptual as well as cognitive aspects – be trying to tell us about the nature of delusions? One aspect is that delusions are far more complex processes than we often realise. A strange characteristic about positive symptoms such as delusions is that one can rate them so reliably that they seem relatively discrete and simple. To some extent that is illusory; it generates in us the illusion that somehow they are easily comprehensible when something very elusive is actually involved. Delusions appear to be linked to people's lives in very intricate ways. They may be temporary exaggerations of prized normal ideas or themes that continue over time; they can be linked with developmental issues and evolutions; they can be linked with very person-specific types of stress, something like losing a job that one had all one's working life. In this regard, just relegating these connections to a generalised notion of 'stress' or 'stimulus window' may provide only the roughest approximation of an explanation, an illusion of understanding that does little justice to the processes involved. Why did the man who changed to a 'stressful' public service job improve? These kinds of situations are not just 'stress'; this is not like depriving a rat of food or shocking a cat. These are experiences that are woven into people, apparently in quite specific ways. We need a working hypothesis about the nature of delusions that does justice to this kind of interweaving with people's lives.

The working hypothesis I suggest is still a primitive one. It is this. People's mental functioning is often viewed as involving a kind of computer function, a central processing unit. That conception may be a start. It helps provide a model to deal with the complexity of mental activity and of mental phenomena. We can think in terms of input, information processing, output, and even feedback loops (e.g. Melges & Freeman, 1975), but that kind of conceptualisation is only a start. It is really not adequate, not anything more than a very rough beginning. One of the major reasons it is inadequate is that, as many such as Piaget have suggested, we are not just an input-throughput-output device; we actively construct our mental world. We have characteristics like intentionality and feelings and meaning so that we are constantly building a mental world and leading and guiding that building process. We have discussed elsewhere in more detail this construction process in relation to mental disorders and the processes of intentionality, self-regulation, and meaning (Strauss, unpublished; Davidson & Strauss, unpublished). In one of these reports (Davidson & Strauss, unpublished), for example, we describe in detail how a woman reconstructed her sense of being an efficacious person following a psychotic episode. The woman who wondered about the lights and began believing the FBI was persecuting her and the woman who was depressed and could not understand how things were happening, may well be examples of people attempting to construct their lives, but for whom something has gone wrong with that construction process.

If we are to deal with people as constructors of their worlds, including intentionality, feelings, meaning, and even development and self-regulation, then we have to have a model of delusions that would be relevant to these processes. My working hypothesis continues, at a primitive level, that in this effort at constructing our worlds, people may be a bit like crystals, in that we have fault lines. And if there is going to be a pressure, those lines influence the way we break. In psychiatry we often call that fault line a diathesis, a vulnerability to developing certain kinds of problems if severe enough and specific enough kinds of things go wrong for us. The development of delusions is one relatively common type of fault line, and under certain kinds of stress, that breaks. Clearly this primitive hypothesis does not go far enough, but for now it is as far as the data of which I am aware lead, except perhaps to suggest how we could learn more.

Certainly we need to continue to pursue the current trends in epidemiological and biological research, but I think these directions are not really enough. In epidemiological studies it is possible to investigate risk factors, but this kind of large-sample study with all its values also has severe limitations. If, in fact, with delusions we are dealing with complex phenomena and diverse patterns of cause and evolution, in order to delineate those patterns we also need more detailed studies of individual patients. We need the kind of study that Birnbaum and others have carried out, but we need them to be performed systematically and over time. One of the important characteristics about the positive symptoms like delusions is that they have vicissitudes, and the reliability of rating that one can carry out permits a measure of these changes. It is thus possible to carry out intensive longitudinal studies to investigate factors associated with change, processes involving biological, psychological, and social variables. We need to attend in greater depth to individual patients. It is in this way that we may be able to "arrive where we started and know the place for the first time".

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