

University of East London Institutional Repository: <http://roar.uel.ac.uk>

This paper is made available online in accordance with publisher policies. Please scroll down to view the document itself. Please refer to the repository record for this item and our policy information available from the repository home page for further information.

To see the final version of this paper please visit the publisher's website. Access to the published version may require a subscription.

Author(s): Harper, David J.

Article title: Delusions and discourse: Moving beyond the constraints of the rationalist paradigm

Year of publication: 2004

Citation: Harper, D.J. (2004) 'Delusions and discourse: Moving beyond the constraints of the rationalist paradigm.' *Philosophy, Psychiatry & Psychology*, 11 (1) 55-64.

Link to published version: <http://dx.doi.org/10.1353/ppp.2004.0041>

DOI: 10.1353/ppp.2004.0041

Harper, D.J. (2004). Delusions and discourse: Moving beyond the constraints of the rationalist paradigm. *Philosophy, Psychiatry & Psychology*, **11**, 55-64.

Running head: Delusions and discourse

**Delusions and discourse: Moving beyond the constraints of the modernist
paradigm**

David J. Harper

School of Psychology
University of East London
Romford Road
London E15 4LZ
United Kingdom

Tel: 020 8223 4021

Fax: 020 8223 4967

e-mail: d.harper@uel.ac.uk

Brief biographical note

David Harper is Senior Lecturer in Clinical Psychology at the University of East London where he is an academic tutor on the Doctoral Degree in Clinical Psychology. He received his Masters degree in Clinical Psychology from the University of Liverpool and his Ph.D in psychology from Manchester Metropolitan University. His research interests are in critical psychology and social constructionist approaches in mental health, particularly in relation to paranoia and delusions. He is also interested in psychological therapies which attempt to avoid pathologising people experiencing severe and enduring mental health problems. He was a co-author of *Deconstructing Psychopathology* (Sage, 1995) and has published widely.

Word count: 5068 words excluding references

Software: Microsoft Word 2000

Abstract

In this commentary, I highlight some of the difficulties encountered by those working within a modernist paradigm (eg Bayne & Pacherie and Klee) and go on to argue that this paradigm is ill-equipped to conceptualise issues which are essentially moral. Georgaca's suggestion that there is a need for researchers to focus more on the contexts which give rise to judgements of delusions and the assumptions which appear to underlie those judgements is a useful one and there is a need for researchers and clinicians alike to learn from the paradigm shift that is taking place in relation to the phenomenon of hearing voices. I suggest that we need to be open to service users' own theories of the meaning of their beliefs and see our goal as helping them find better ways of living with them.

Introduction

This special issue provides a good opportunity to reflect on the range of views about ‘delusions’¹ and it is good to see all the authors taking the issue of how to approach this topic seriously. Here I wish to argue that the traditional psychiatric view of delusions is problematic. In the first half of this article I will group my comments on the issues raised by the papers by Klee and Bayne & Pacherie together as I think that, for their differences, they both share modernist philosophical assumptions. I will argue that the modernist paradigm runs into considerable problems in considering beliefs felt by some to be unusual and I will go on to argue that we need to move beyond this paradigm and embrace different approaches of which the work by Georgaca is an exemplar.

The trouble with (traditional views of) ‘delusions’

The traditional psychiatric view of delusion has come under increasing attack over recent years. As Georgaca has noted, a number of problematic assumptions in the definition of delusion can be identified when they are viewed from a social constructionist perspective (Georgaca, 2000, this volume; Heise, 1988; Harper, 1992, 1996). For convenience I will group these under four main headings.

1. They are based on a naively realist view of the world

The criterion of inaccuracy or falsity implies that deciding on the veracity of a belief is a relatively unproblematic matter. However the reality of claims does not always seem so important in judgments about whether a belief is deluded or not. For

¹ Throughout this article I wish to problematise the notion of delusion. I recognise that some readers may find the use of inverted commas (which might signal this) or alternative terminology irritating and confusing so I will use the term in a pragmatic way. There is, of course, a danger that, in seeking to critique a concept, I end up inadvertently reifying it (cf Danziger, 1997).

example, there is little evidence that mental health professionals systematically investigate the basis for people's beliefs -- rather they decide whether a belief is plausible. Thus Maher has argued that the assessment of the plausibility of beliefs is 'typically made by a clinician on the basis of "common sense," and not on the basis of a systematic evaluation of empirical data' (1992, p.261). He notes that it is not 'customary to present counterevidence to the patient; it is not even common to present vigorous counterargument' (1992, p.261) and there appears to be some empirical evidence of this (McCabe, Heath, Burns & Priebe, 2002). Here then, we begin to see how psychiatry, whilst claiming to have the power to judge the truth of beliefs on the basis of its status as an empirical scientific discipline, can be seen to make judgements on the basis of common-sense and taken-for-granted social and cultural assumptions.

Some commentators have suggested that delusions should be identified less by whether they seem to accord with reality but more by whether a person gives evidence for their belief (Gillett, 1995; Spitzer, 1990). However, this seems to be based on an idealised view of how people manage their beliefs in everyday life. For example, I would question how many of us have evidence for many of the beliefs (eg political, ethical, religious etc) we hold dear -- indeed it would be hard to think of what evidence we could have for some of them (eg religious and ethical beliefs). Some recent work has suggested that the diagnosis of delusion is made on the basis of how people with delusions talk and interact, for example some have argued that they do not appear to appreciate the hearer's point of view (Palmer, 2000). However, here and in previous work, Georgaca (current issue, 2000) has shown that people with delusions are able to talk about and negotiate disagreements about their beliefs and that many disputes of 'fact' cannot be settled in conversation.

2. People said to have delusions are seen to vary in the conviction with which those beliefs are held

There is evidence that people considered to be deluded vary in the conviction with which they hold beliefs (Garety, 1985) and can also be persuaded to modify their beliefs if this is conducted in a sensitive and collaborative manner (eg Chadwick, Birchwood & Trower, 1996). This challenges the idea that delusions are held with unwavering conviction. Indeed some recent work exploring the process of cognitive behaviour therapy (CBT) with clients with psychosis suggests that some move between accounts where they see their psychotic experiences as 'real' and where they see them as signs that they are 'ill' (Messari & Hallam, 2003). Clearly simplistic notions of strength of belief or conviction do not do justice to the complexity of belief talk.

3. Delusions are not meaningless and irrational

Rather than being 'empty speech acts' (Berrios, 1991), there is evidence to suggest that beliefs regarded as delusions may relate to a person's purpose and meaning in life (Roberts, 1991). Links may be found between the content themes of delusions and themes in their current or earlier life (Rhodes & Jakes, 2000). 'Delusions' may serve important functions for the individual (Schock, Clay & Cipani, 1998). Moreover, what may seem to some to be a conspiratorial and paranoid way of looking at things may actually make sense to others in similar social contexts. For example, Mirowsky & Ross (1983) have described a link in the general population between social positions characterised by powerlessness, the threat of victimisation and exploitation (eg in terms of gender, ethnic group and socio-economic status) and paranoid beliefs.

The role of experiences of victimisation in the development of paranoid beliefs is an important area for future research (Bentall, 2003; Morrison, 2001).

4. Conventional psychiatric theories see delusions as 'abnormal' in some way

Delusions are seen as abnormal but who decides this? Abnormal compared to whom? Abnormal in what sense? Opinion surveys regularly demonstrate that large sections of the population believe in UFOs, ghosts, telepathy and so on. For example a Gallup survey in the UK revealed that in their sample: 45% believed in telepathy; 45% believed in the ability to predict the future; 42% believed in hypnotism; 39% believed in life after death; 39% believed in faith healing; and 31% believed in ghosts (Social Surveys/Gallup Ltd, 1995). On what ethical and empirical basis are we judging the normality of beliefs?

In large part, the impression of abnormality is maintained by researchers who focus exclusively on groups of psychiatric service users on the assumption that they are somehow categorically different from the rest of the population. However, as with research on hearing voices, when researchers move out of the psychiatric clinic and investigate the 'normal' population with no previous psychiatric history, 'delusions' appear to be more common than might be expected. Thus in Verdoux et al.'s (1998) study of 790 attenders at French primary care clinics, endorsement of individual Peters Delusions Inventory (PDI-21, Peters & Garety, 1996) items by those without a previous psychiatric history varied between 5% and 70% (though those with a psychiatric history had higher frequencies of agreement in general). Van Os, Hanssen, Bijl & Ravelli (2000) reported that 3.3% of their sample of 7,000 Dutch people had 'true' delusions whilst 8.7% had delusions which were not associated with

distress and did not require intervention. By the end of their 15 year longitudinal study of New Zealanders, Poulton, Caspi, Moffitt, Cannon, Murray & Harrington (2000) reported that 20.1% had delusions with 12.6% judged as being paranoid. Ellett, Lopes & Chadwick (2003) found that 153 of their 324 non-clinical population of college students reported an experience of paranoia including a clear statement that they felt there had been a planned intention to harm them.

In a series of studies Emmanuelle Peters and colleagues have attempted to see if it is possible to differentiate between psychiatric and normal populations. Peters, Joseph & Garety (1999) reported that 'psychotic inpatients' had higher scores on the PDI compared to 'normal' controls. However, they also found considerable overlap between the two groups. They argued that the main factors discriminating between the groups were not the beliefs *per se* but the distress, conviction and preoccupation they caused. In a related study, Peters, Day, McKenna & Orbach (1999) compared members of New Religious Movements (NRMs) -- Druids and Hare Krishnas -- non-religious people, Christians and people diagnosed with delusions. They found no differences between the NRMs and those diagnosed with delusions on the number of 'deluded' items they endorsed or with the conviction with which they were held, but there were differences in the distress and preoccupation caused by the beliefs. There were no differences between the non-religious and Christian groups.

Continuing problems with theorisation

Unfortunately the papers by Klee and Bayne & Pacherie sidestep many of these difficulties and, in this, they are quite representative of mainstream psychiatric literature. This side-stepping occurs, in my view, because of a number of factors.

Firstly, there is a tendency to describe delusions in abstract and reified terms. Brief versions of idealised delusions are often presented shorn of the kind of important context which might give apparently delusional statements some meaning. One could characterise such abstract entities as examples of the philosopher's and neuroscientist's concept of delusion -- and one is reminded here of Bentall's (1999) description of researchers claiming they have the best description of an elephant when, in fact, they only have a partial view. Moreover, there is often an assumption that by losing context one can develop 'pure' classification categories (based on content for example) and stage or factorial models.

Secondly there is an assumption that 'delusions' are different from 'normal' belief processes but there is usually little or no evidence presented about 'normal' belief processes. Indeed, social psychologists have long shown us that notions of 'belief' and 'attitude' are complex -- discourse analysts suggest that talk about 'attitudes' is highly variable for example (e.g. Potter & Wetherell, 1987). Bayne notes Sass's observation that people with supposedly delusional beliefs rarely seem to act in a way one might predict from their beliefs but on what basis do we assume that this is different from 'normal' beliefs given the longstanding difficulty social psychologists have found in predicting behaviour from attitudes? Why should we assume that 'beliefs' are less problematic? We have already seen, for example that the assumption that supposedly delusional beliefs vary in conviction over time is not consistent with empirical reports suggesting otherwise.

Thirdly, there is little discussion of affect in discussions about beliefs considered to be delusional, with more of an emphasis on neuro-cognitive processes. In a recent project (Harper, 1999; 2003) extending a previous study (Harper, 1992, 1994), I interviewed users of psychiatric services and the professionals working with them (including their psychiatrists and also their general practitioners or their community psychiatric nurses). I was struck by the emphasis that both diagnosers and the diagnosed placed on the experience of fear in accounts of beliefs considered to be paranoid.

From critique to deconstruction

No doubt Klee and Bayne & Pacherie might agree with some of these points. Indeed, there are similarities between many of the criticisms I have made and those of some cognitive theorists especially those critical of neo-Kraepelinian models and, in this respect, it is a pity that some of the recent contributions by cognitive theorists (e.g. Bentall, Corcoran, Howard, Blackwood & Kinderman, 2001; Morrison, 2001) are not represented in this special issue. The last 15 years have seen a number of changes in the way psychotic experiences are viewed by these researchers and clinicians. Firstly, there has been a growing focus on particular experiences, the single symptom approach, given the well-evidenced, but largely ignored, problems with larger diagnostic categories like schizophrenia (Bentall, 2003; Boyle, 2002). Secondly, there has been a willingness to engage with people seen as psychotic and to attempt to understand their experiences. Such an approach has a long history within phenomenological approaches (see, for example, Sass 1987, 1994) but British psychologists have emphasised the importance of theorising psychotic experiences using principles from 'normal' (as opposed to 'abnormal') psychology (British

Psychological Society, 2000). This has also begun to influence policy to the extent that the UK's National Institute for Clinical Excellence has supported both cognitive-behavioural and family interventions for those with a diagnosis of schizophrenia (National Institute of Clinical Excellence, 2002).

However, as I have argued elsewhere (Harper, 1996) such criticisms and changes do not go far enough because, whilst these critics avoid some problematic assumptions, others remain unchallenged because of an adherence to a modernist paradigm. I find it helpful to draw a distinction between critique and deconstruction: critique challenges statements by working within the same world of assumptions; deconstruction, on the other hand, explores those very assumptions (Spivak, 1990). An example of the implications of such an idea can be seen in the exchange disarmingly reported by Richard Bentall between him and Marius Romme. Romme said to Bentall 'I really like your research on hallucinations, Richard. But the trouble is, you want to cure hallucinators, whereas I want to liberate them. I think they are like homosexuals in the 1950s -- in need of liberation, not cure.' (Bentall, 2003, p.511, emphasis in original). Here, we can see one approach to delusions, predicated upon implicit assumptions of normative belief, therapy and cure, contrasted with a socio-political approach predicated upon implicit assumptions about human rights, freedom of thought and so on.

Another example of an unchallenged assumption in the mainstream literature is that delusions lie 'within' the person with a delusion and that it is possible to point to defining features of delusional beliefs. The fact that this is problematic is often acknowledged (see, for example Bentall, 1999; Birchwood, 1999) and some, like

Oltmanns (1988) instead argue that delusions share different numbers of features out of a longer list. I have argued elsewhere (Harper, 1994) that this very flexibility of the diagnostic repertoire serves powerful social functions in professional discourse. Indeed, one might argue from a discursive view that such acknowledgement often serves as a way of inoculating against potential criticisms whilst the current approach to delusions is maintained. As Georgaca argues, a far greater difficulty has, to a large extent, been ignored: that delusions occur in an interactional context – a context obscured by work conducted within a modernist paradigm.

The minimisation of the role of the ‘hearer’ in the diagnosis of delusion

Georgaca illustrates how a person's views cannot be simply regarded as delusional in the abstract -- they must be regarded as such by a particular person in a particular historical and cultural context, at a particular time. This issue becomes even more important when we hear of how variable that judgement can be from person to person, and the problems of reliability in diagnosing delusions testify to this. Of course, as she notes, the hearer who diagnoses delusion is not just anybody, they are a mental health professional (eg a psychiatrist) located in a web of power (eg mental health legislation, government policies on mental health and so on). Moreover, the professional hearer of statements uttered in a psychiatric context has the power to infer a belief from such statements and to decide on its plausibility. Professional judgements are transformed into hypothetical constructs (eg symptoms or disease processes) which then obscure the integral role of the judgement process (Fernando, 1997). David Ingleby has drawn out the moral nature of such judgements:

understanding someone is simply not possible without crediting them with a basic degree of plausibility. And the more charitably inclined we are to someone, the more likely we will be to see their actions as 'making sense'; in this way, judgements about intelligibility are inextricably linked to moral attitudes.

Ingleby (1982, p.133)

As well as being moral these judgements are, as David Heise (1988) has argued, also intrinsically social. Rather than beliefs being judged against an assumed objective comparison, Heise foregrounds the fact that judgements are made by people in particular contexts which are rule-governed and argues that 'delusions are a form of cognitive deviance' (p.267). Thus the plausibility of a hypothesised belief is not an essential quality of a belief -- it is a quality of the interaction between speaker and hearer. In other words, to be plausible, stories need to match certain cultural and narrative expectations (Foress Bennett, 1997). As Heise has pointed out beliefs are not compared to an objective norm, rather they are compared with unarticulated assumptions and expectations. Edward E Sampson (1993) has characterised one group of such cultural assumptions as that of the unitary Western rational subject.

My discourse analysis of these interviews suggested that accounts of plausibility and rationality judgements about service users' apparently unwarranted fears (or 'paranoid delusions') imported not only a variety of criteria not found in diagnostic manuals (eg intelligence, social standing etc) but also assumptions about gender, culture and class.

I would agree with Georgaca that the breakdown of plausibility and understanding does not lie 'in' the supposedly deluded person's talk but, rather, *between* the speaker and hearer since the speaker fails to provide what the hearer expects -- there is a breach in expectations and assumptions between speaker and hearer. This is not to say that many people (including myself) may not find some accounts odd or unusual but, rather, that they are not necessarily odd *in and of themselves* because of the structure of talk.

Delusions and discourse

Georgaca's work reminds us that the 'delusional beliefs' measured in experimental studies and clinical trials are inferred constructs on the basis of structured interviews, questionnaires or vignette studies. However, when talk is analysed (and diagnoses are constructed in a discursive context of interviews, case discussions, letters, reports and so on) it seems that far from encountering clear-cut beliefs we see ambiguous and subtle shifts in discursive positions. I think there are two interesting aspects to this. Firstly, that we can learn a lot from focusing on the interviewer or therapist in such interactions -- for example, some studies reveal professionals' discomfort in talking about service users' delusional beliefs (McCabe et al., 2002) and a conflict between therapists' beliefs in collaboration and their wish to persuade clients to modify their beliefs (Messari & Hallam, 2003).

A second aspect of interest is the way that in these conversations, service users often appear caught in what might be called discursive traps. In my own research (Harper, 1999) I found a similar feature in interviews with service users. They seemed faced with a three-fold tension. First they needed to warrant behaviour that others regarded

as problematic. Since one alternative explanation for such behaviour is willfulness which might lead to social disapproval, this could be achieved by being seen as suffering a psychiatric 'illness'. However, given the moral ambivalence about whether those diagnosed with psychiatric problems are seen as wilful and responsible (eg psychiatric patients may be seen both as not responsible for their actions and, on the other hand, as 'resistant' and 'manipulative') there appeared to be a need to provide further evidence against a wilful interpretation and thus the person needed to be seen as motivated (ie as a 'good' patient). Furthermore, since dominant Western cultural views of people with psychiatric problems regard them as completely irrational, unpredictable and potentially violent the person also needed to present themselves as an ordinary person who could act as a rational agent and citizen. It is obvious that these three imperatives pull in different directions and have contradictory effects. That service users are trying to negotiate their identities under these constraints is an important point and should cause us to consider the contradictory assumptions of much mental health practice (Bracken & Thomas, 1997).

The influence of the survivor movement

A final challenge to professional constructions is posed by mental health service users and survivors. There is a danger of service users' experiences being colonised by professional categorisations and classifications rather than allowing users of services to theorise those experiences themselves in their own words. Some of these conceptualisations will, of course, reflect dominant professional conceptualisations but others will be different. Those who use psychiatric services have argued that they have a right to understand their experiences in a way which makes sense to them and have set up self-help groups to support them do just this – the UK Hearing Voices

Network is an excellent example of such an approach (Downs, 2001a,b; James, 2001). Indeed Wallcraft & Michaelson (2001) have argued for the development of a ‘survivor discourse’ in order to reclaim the language used to describe their experience back from professionals.

Beyond the modernist paradigm: Towards a social constructionist approach to 'delusions'

To my mind, a broadly social constructionist theoretical framework is best able to accommodate an agnostic approach to ‘delusions’². Such an approach would open up new research questions. For example, if we accept that the diagnosis of delusion is a social judgement made in an interactional context, what can we learn about the process by which such judgements are made? What influences are there on such judgements? Do the ‘hearers’ of belief talk vary in the cultural assumptions they use in judgements of plausibility? Given that diagnosers appear to draw on diagnostic criteria flexibly (Harper, 1994) are there other criteria which they draw on to justify their decisions? What rhetorical strategies are used to demonstrate that beliefs are plausible or implausible? What can we learn about the ways in which psychiatric service users are trapped between competing imperatives? Perhaps most importantly there needs to be more debate about the ethics and politics of psychiatric practice in relation to beliefs.

If researchers become less focused on the reality of beliefs it might be more important to focus on the ‘fit’ between a person's beliefs and the life they wish to lead. What influences are there on that ‘fit’? How do some people manage to live lives as

² There exist a number of ‘straw person’ characterisations of social constructionism in mental health but space does not permit a detailed refutation here and the reader is directed to texts detailing important debates (eg Burr, 2003; Nightingale & Cromby, 1999; Parker et al., 1995; Parker, 1998).

‘mystics’, ‘eccentrics’ or even ‘extremists’ (the subject of investigations by Peters, 2001; Weeks & James, 1997; and Ronson, 2001 respectively) rather than as psychiatric patients? If researchers begin to focus more on ‘normal’ populations what can we find out about the diversity of beliefs people hold and how they manage the ‘fit’ between those beliefs and their everyday lives? However, perhaps more fundamentally, we need to move away from traditional conceptions of belief. If we begin to see ‘delusions’ as positions that people take up and/or are positioned in discourse what influences might there be on this? Fruitful avenues appear to be narrative (de Rivera & Sarbin, 1998) and dialogical models (Hallam O’Connor, 2002).

Such an approach would also hold out the possibility of different practices to help those distressed by their beliefs (and I will continue to use this term pragmatically in discussing alternative forms of help). Research on those who hear voices suggests that people who develop an explanation of their experiences which allows them to make sense of their experiences (and does not unduly distress them), puts them in contact with a community which shares these meanings (eg spiritualist churches, hearing voices group etc), which involves certain helpful practices (eg meditation, political action etc) and which allows them to continue living their lives in a relatively uninterrupted manner means that they may never come into contact with psychiatric services (Romme & Escher, 2000). One could argue that those who do come into contact with psychiatric services do so not just (or even) because of their beliefs *per se* but rather because they: do not have a meaningful explanation for them; are distressed by them; feel isolated with them; have failed to find practices which might

help them; or because of the reactions of others. Thus there are a number of points of intervention with people apart from trying to change their beliefs.

Alternative approaches

The last few years has been an increased awareness that mental health concepts and practices are contested which some have seen as evidence of a 'post-psychiatry' (Bracken & Thomas, 1997). Instead of trying to ignore such debate some innovative approaches have explicitly drawn on it. Thus a training package based on the British Psychological Society's report on psychotic experiences (British Psychological Society, 2000) foregrounds the fact that mental health is a contested area, theoretically speaking, with differences of view between service users and professionals and within those two groups (Bassett et al., 2003). Moreover, Seikkula et al., (2001a,b) have developed an 'Open Dialogue' model where a team of professionals meet with families including a person with a diagnosis of psychosis with the specific aim of generating dialogues amongst and between the professionals and families about their experiences rather than simply offering one explanation (eg a psychiatric diagnosis) and one treatment (eg psychiatric medication).

Perhaps the best example of an alternative approach is to be found in the area of hearing voices, traditionally conceptualised within psychiatry as auditory hallucinations. Romme & Escher's (1993, 2000) pioneering work deliberately took an agnostic position on the nature of the experience and specifically set out to treat it as an example of human diversity – a view backed up by research on normal populations. They investigated how people who had these experiences, but did not come into contact with psychiatric services, coped with them. They also explored the

different theoretical models adopted both by ‘normal’ populations and groups of psychiatric service users and found they drew on a very wide range of approaches ranging from psychiatric to cognitive, parapsychological, spiritual and so on.

In my view the way we conceptualise ‘delusions’ or unshared beliefs would benefit from adopting a similar approach. This would open up new and more fruitful questions for researchers and more helpful practices for those felt to hold such beliefs. Indeed, in the UK, a paranoia self-help group based in Sheffield has begun to set up the Paranoia Network, modelled on the Hearing Voices Network (James, 2003).

There are already a number of therapeutic approaches which attempt to avoid a pathologising people with psychotic experiences: Narrative Therapy (eg O'Neill & Stockell, 1991); a social disability model (Perkins & Dilks, 1992); and solution-focused therapy (eg Rhodes & Jakes, 2002). Such work needs to acknowledge that judgements about delusions are social and cultural rather than ‘objective’. The aim of help should not necessarily be to change a belief or focus on its truth status. Instead, there could be a focus on the content and context of the belief, especially its historical and biographical context, especially given that many of these beliefs occur following experiences of victimisation and in late adolescence (Harrop & Trower, 2003). Help could be focused on enabling the person to get a better ‘fit’ between their beliefs and the lives they wish to lead.

One of the main tasks for those with beliefs others might see as unusual is how to live with those beliefs in a world which doesn't share them. Key issues here might include encouraging the person to: carry on living the life they want to lead; be

careful who they talk to about their beliefs; be careful not to attract attention from others (eg neighbours, family members and the police). An important issue is to address the way frightening beliefs can start to exclude other parts of a person's life and so come to dominate them. It is important for people to find other activities and goals which matter to them.

One relatively under-researched factor which may cause distress is the isolation that can be a consequence of some frightening beliefs. The development of paranoia support groups is one example of how this isolation can be alleviated and how people with distressing beliefs can help each other to cope (James, 2003). For those not able or willing to meet with others, the internet can be a useful resource though this can become unhelpful if it begins to dominate the person's life. As with the Hearing Voices Network a great deal can be learnt from those who have had these experiences and there are now a number of first person accounts (eg Chadwick, 1995; Devalda, 1996; Porteous, 1995). Tamasin Knight (May et al., 2003; Knight, forthcoming a,b), for example, has outlined ways of working within a person's world-view rather than trying to change it:

Some years ago I became very distressed as I believed I had a physical illness which would kill me. I later became able to cope with this by thinking if this was the case then I should do the things I felt were important and which I enjoyed right away rather than leave them to the future. By getting involved in activities I felt were important and worthwhile and building up my social network the unusual beliefs I experienced became less central and troublesome in my life.

Thus, for someone who fears that all tap water is contaminated Knight (forthcoming a) advocates encouraging them to drink bottled water. It is only in drawing on such knowledge that we can begin to move towards approaches which pathologise people's experiences less and which help us escape the constraints imposed by the modernist paradigm.

References

Bassett, T., Cooke, A. & Read, J. (2003). *Psychosis Revisited: A Workshop for Mental Health Workers*. Brighton: Pavilion.

Bayne, T. & Pacherie, E. (this volume). Monothematic delusions, empiricism, and framework beliefs: A reply to Campbell. *Philosophy, Psychiatry & Psychology*.

Bentall, R.P. (1999). Commentary on Garety & Freeman III: Three psychological investigators and an elephant. *British Journal of Clinical Psychology*, 38, 323-327.

Bentall, R.P. (2003). *Madness Explained: Psychosis and Human Nature*. London: Allen Lane/Penguin.

Bentall, R.P., Corcoran, R., Howard, R., Blackwood, N. & Kinderman, P. (2001). Persecutory delusions: A review and theoretical integration. *Clinical Psychology Review*, 21, 1143-1192.

Bentall, R. P., Jackson, H. F. & Pilgrim, D. (1988). Abandoning the concept of 'schizophrenia': Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology*, 27, 303-324.

Berrios, G.E. (1991). Delusions as 'wrong beliefs': A conceptual history. *British Journal of Psychiatry*, 159 (suppl. 14), 6-13.

Birchwood, M. (1999). Commentary on Garety & Freeman I: 'Cognitive approaches to delusions -- A critical review of theories and evidence'. *British Journal of Clinical Psychology*, 38, 315-318.

Boyle, M. (2002). *Schizophrenia: A Scientific Delusion?* Second edition. London: Routledge.

Bracken, P. & Thomas, P. (1997). Post-psychiatry: Broken promises, fractured dreams. *OpenMind*, 88, 18.

British Psychological Society (2000). *Recent Advances in Understanding Mental Illness and Psychotic Experiences*. Leicester: British Psychological Society. (www.understandingpsychosis.com)

Burr, V. (2003). *Social Constructionism*. Second edition. London: Routledge.

Chadwick, Paul., Birchwood, M. & Trower, P. (1996). *Cognitive Therapy for Delusions, Voices and Paranoia*. Chichester: Wiley.

Chadwick, Paul D.J. & Lowe, C.F. (1990). Measurement and modification of delusional beliefs. *Journal of Consulting & Clinical Psychology*, **58**, 225-232.

Chadwick, Peter (1995). *Understanding Paranoia: What Causes it, How it Feels and What to do About it*. London: Thorsons.

Danziger, K. (1997). The varieties of social construction. *Theory & Psychology*, **7**, 399-416.

De Rivera, J. & Sarbin, T. (eds) (1998). *Believed-In Imaginings: The Narrative Construction of Reality*. Washington DC: American Psychological Association.

Devalda, S. (1996). Blackmind. *Voices Magazine*, **17**, 5.

Downs, J. (ed) (2001a). *Coping with Voices and Visions*. Manchester: Hearing Voices Network.

Downs, J. (ed) (2001b). *Starting and Supporting Hearing Voices Groups*. Manchester: Hearing Voices Network.

Ellett, L., Lopes, B. & Chadwick, P. (2003). Paranoia in a nonclinical population of college students. *Journal of Nervous and Mental Disease*, **191**, 425-430.

Fernando, S. (1997). Peeling labels. *OpenMind*, **87**, 16-17.

Foress Bennett, J. (1997). Credibility, plausibility and autobiographical oral narrative: some suggestions from the analysis of a rape survivor's testimony. In A. Levett, A. Kottler, E. Burman & I. Parker (eds) *Culture, Power & Difference: Discourse Analysis in South Africa*. London: Zed Books.

Garety, P. (1985). Delusions: Problems in definition and measurement. *British Journal of Medical Psychology*, **58**, 25-34.

Georgaca, E. (2000). Reality and discourse: A critical analysis of the category of 'delusions'. *British Journal of Medical Psychology*, *73*, 227-242.

Georgaca, E. (this volume). Factualization and plausibility in 'delusional' discourse. *Philosophy, Psychiatry & Psychology*.

Gillett, G. (1995). Insight, delusion and belief. *Philosophy, Psychiatry & Psychology*, **1**, 227-236.

Hallam, R.S. & O'Connor, K.P. (2002). A dialogical approach to obsessions. *Psychology and Psychotherapy: Theory Research and Practice*, **75**, 333-348.

Harper, D.J. (1992). Defining delusion and the serving of professional interests: The case of 'paranoia'. *British Journal of Medical Psychology*, *65*, 357-369.

Harper, D.J. (1994). The professional construction of 'paranoia' and the discursive use of diagnostic criteria. *British Journal of Medical Psychology*, 67, 131-143.

Harper, D.J. (1996). Deconstructing 'paranoia': Towards a discursive understanding of apparently unwarranted suspicion. *Theory & Psychology*, 6, 423-448.

Harper, D.J. (1999). Deconstructing Paranoia: An Analysis of the Discourses Associated with the Concept of Paranoid Delusion. Unpublished PhD thesis, Department of Psychology & Speech Pathology, Manchester Metropolitan University. (www.criticalmethods.org/thesis0.htm)

Harper, D. (2003). Developing a critically reflexive position using discourse analysis. In L. Finlay & B. Gough (eds) *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Oxford: Blackwell Science.

Harrop, C. & Trower, P. (2003). *Why Does Schizophrenia Develop at Late Adolescence? A Cognitive-Developmental Approach to Psychosis*. Chichester: Wiley.

Heise, D. R. (1988). Delusions and the construction of reality. In T. F. Oltmanns & B.A. Maher (eds). *Delusional Beliefs*. New York. Wiley.

Ingelby, D. (1982). The social construction of mental illness. In P. Wright & A. Treacher (eds) *The Problem of Medical Knowledge: Examining the Social Construction of Medicine*. Edinburgh: Edinburgh University Press.

James, A. (2001). *Raising our Voices: An Account of the Hearing Voices Movement*. Gloucester: Handsell publishing.

James, A. (2003). Voices of reason. *The Guardian*, 10 December.
<http://society.guardian.co.uk/societyguardian/story/0,7843,1103141,00.html>

Klee, R. (this volume). Why some delusions are necessarily inexplicable beliefs. *Philosophy, Psychiatry & Psychology*.

Knight, T. (forthcoming a). *Alternative approaches to delusions, obsessions and unusual experiences*. Stockport: Asylum.

Knight, T. (forthcoming b). You'd better believe it. *Open Mind*.

Maher, B.A. (1992). Delusions: Contemporary etiological hypotheses. *Psychiatric Annals*, **22**, 260-268.

May, R., Knight, J. & Knight, T. (2003). Making the personal political. *The Psychologist: The Bulletin of the British Psychological Society*, **16**, 182-183.

McCabe, R., Heath, C., Burns, T. & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal*, **325**, 1148-1151.

Messari, S. & Hallam, R. (2003). CBT for psychosis: A qualitative analysis of clients' experiences. *British Journal of Clinical Psychology*, **42**, 171-188.

Mirowsky, J. & Ross, C.E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, **48**, 228-239.

Morrison, A.P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural & Cognitive Psychotherapy*, **29**, 257-276.

National Institute for Clinical Excellence (2002). *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care*. London: Department of Health. (www.nice.org.uk).

Nightingale, D.J. & Cromby, J. (eds) (1999). *Social Constructionist Psychology: A Critical Analysis of Theory and Practice*. Buckingham: Open University Press.

Oltmanns, T.F. (1988). Approaches to the definition and study of delusions. In T. F. Oltmanns & B.A. Maher (eds). *Delusional Beliefs*. New York. Wiley.

O'Neill, M. & Stockell, G. (1991). Worthy of discussion: Collaborative group therapy. *Australian and New Zealand Journal of Family Therapy*, **12**, 201-206.

Palmer, D. (2000). Identifying delusional discourse: Issues of rationality, reality and power. *Sociology of Health & Illness*, **22**, 661-678.

Parker, I. (ed) (1998). *Social Constructionism, Discourse and Realism*. London: Sage.

Parker, I., Georgaca, E., Harper, D., McLaughlin, T. & Stowell-Smith, M. (1995). *Deconstructing Psychopathology*. London: Sage.

Perkins, R. & Dilks, S. (1992). Worlds apart: working with severely socially disabled people. *Journal of Mental Health*, **1**, 3-17.

Peters, E. (2001). Are delusions on a continuum? The case of religious and delusional beliefs. In I. Clarke (ed), *Psychosis and Spirituality: Exploring the New Frontier*. London: Whurr.

Peters, E.R. & Garety, P.A. (1996). The Peters *et al.* Delusions Inventory (PDI): New forms for the 21-item version. *Schizophrenia Research*, **18**, 119.

Peters, E., Day, S., McKenna, J. & Orbach, G. (1999). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology*, **38**, 83-96.

Peters, E.R., Joseph, S.A. & Garety, P. (1999). Measurement of delusional ideation in the normal population: Introducing the PDI (Peters et al. Delusions Inventory). *Schizophrenia Bulletin*, **25**, 553-576.

Porteous, W. (1995). Paranoia and the paratrooper. *Openmind*, **76**, 11-13.

Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. London, Sage.

Poulton, R., Caspi, A., Moffitt, T.E., Cannon, M., Murray, R. & Harrington, H. (2000). Children's self-reported psychotic symptoms and adult schizophreniform disorder: A 15 year longitudinal study. *Archives of General Psychiatry*, **57**, 1053-1058.

Rhodes, J.E. & Jakes, S. (2000). Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical Psychology*, **73**, 211-225.

Rhodes J. & Jakes, S. (2002). Using solution-focused therapy during a psychotic crisis: A case study. *Clinical Psychology & Psychotherapy*, **9**, 139-148.

Roberts, G. (1991). Delusional belief systems and meaning in life: A preferred reality? *British Journal of Psychiatry*, **159** (suppl. 14), 19-28.

Romme, M. & Escher, S. (eds) (1993). *Accepting Voices*. London: Mind publications.

Romme M. & Escher, S. (eds) (2000). *Making Sense of Voices*. London: Mind publications.

Ronson, J. (2001). *Them: Adventures with Extremists*. London: Picador.

Sampson, E.E. (1993). Identity politics: Challenges to psychology's understanding. *American Psychologist*, **48**, 1219-1230.

Sass, L.A. (1987). Schreber's panopticism: Psychosis and the modern soul. *Social Research*, **54**, 101-147.

Sass, L.A. (1994). *The Paradoxes of Delusion: Wittgenstein, Schreber and the Schizophrenic Mind*. London: Cornell University Press.

Schock, K., Clay, C. & Cipani, E. (1998). Making sense of schizophrenic symptoms: Delusional statements and behaviour may be functional in purpose. *Journal of Behavior Therapy & Experimental Psychiatry*, **29**, 131-141.

Seikkula, J., Alakare, B. & Aaltonen, J. (2001a). Open Dialogue in psychosis I: An introduction and case illustration. *Journal of Constructivist Psychology*, **14**, 247-265.

Seikkula, J., Alakare, B. & Aaltonen, J. (2001b). Open Dialogue in psychosis II: A comparison of good and poor outcome cases. *Journal of Constructivist Psychology*, **14**, 267-284.

Social Surveys/Gallup Poll Ltd. (1995). Paranormal behaviour. *Gallup Political Index*, **415**, 24.

Spitzer, M. (1990). On defining delusions. *Comprehensive Psychiatry*, **31**, 377-397.

Spivak, G.C. (1990). Gayatri Chakravorty Spivak: An interview. *Radical Philosophy*, **54**, 32-34.

Van Os, J., Hanssen, M., Bijl, R.V. & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the normal population? *Social Psychiatry & Psychiatric Epidemiology*, **26**, 287-292.

Verdoux, H., Maurice-Tison, S., Gay, B., Van Os, J., Salamon, R. & Bourgeois, M.L. (1998). A survey of delusional ideation in primary-care patients. *Psychological Medicine*, **28**, 127-134.

Wallcraft, J. & Michaelson, J. (2001). Developing a survivor discourse to replace the 'psychopathology' of breakdown and crisis. In C. Newnes, G. Holmes & C. Dunn (eds), *This is Madness Too: Critical Perspectives on Mental Health Services*. Ross-on-Wye: PCCS Books.

Weeks, D. & James, J. (1997). *Eccentrics*. London: Phoenix.