

DELUSION AND AFFECTIVE FRAMING

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ABSTRACT – DELUSION AND AFFECTIVE FRAMING

Clinically significant delusion is a symptom of a number of mental illnesses. We rely on what a person says and how she behaves in order to identify if she has this symptom and it is clear from the literature that delusions are heterogeneous and extremely difficult to define. People with active delusions were interviewed to explore *what it is like* to develop and experience delusion. The transcribed interview data was analysed to identify themes and narrative trajectories that help to explain the phenomenon. Results showed that delusions can sometimes provide pragmatic (protective) benefits and that the genesis of some delusions can be characterised in terms of the *enactivist* notion of *affective framing*. Affective framing is a term that captures the background emotions that enable know-how in terms of goal directed action and cognition. If a person's affective frame alters the world is no longer understood and know-how is lost. The way in which a person relates to her environment can be highly anomalous thus requiring her to find an extraordinary explanation. I argue that delusions arise as a result of a breakdown in affective framing and offer a conceptualisation of delusion supported by empirical findings.

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Table of Contents

CHAPTER 1 - INTRODUCTION	1
1.1 Background	1
1.2 Overview	2
CHAPTER 2 - ON THE DIFFICULTY OF DEFINING DELUSION	7
2.1 Introduction	7
2.2 Context	8
2.2.1 Karl Jaspers and DSM 5	10
2.2.2. Assumptions and Terms	13
2.2.3. Approaches and Problems.....	15
2.3. Characteristics	16
2.3.1 Clinical Significance	19
2.3.2 Other Dimensions or Characteristics of Delusion	20
2.3.3 More Problems	23
2.4. Doxasticity, Rationality and Normativity	25
2.4.1 Are Delusions Beliefs?	25
2.5. Impossibility, Plausibility, Un-falsifiability and Amenability to Revision	33
2.5.1 Impossibility	33
2.5.2 Falsity.....	35
2.5.3 Implausible or Incomprehensible?	36
2.5.4. Un-falsifiability	38
2.5.5 Amenable to Revision?	43
2.5.5.1 One factor or Two?.....	44
2.5.6 Interim Summary	48
2.5.7 Impossible to Define	49
2.6. Summary and Conclusion.....	51
CHAPTER 3 - PHENOMENOLOGY AND THE IMPORTANCE OF FIRST PERSON DESCRIPTION.....	54

3.1 Introduction	54
3.2 Folk Psychology and the Intentional Stance	55
3.2.1 The Intentional Stance	56
3.3 What is ‘Mental’ about Mental Illness?.....	58
3.3.1 Subjective Privilege	60
3.3.2 Contradictions	62
3.3.3 Interim summary	64
3.4 The Developing Science of the Mind.....	65
3.4.1 Context, Culture and Environment.....	67
3.5 The Bio-Psycho-Social Model	71
3.6 The Decline of Phenomenological Enquiry	74
3.7 Jaspers’ Phenomenology	81
3.7.1 Features of Experience.....	82
3.7.2 Objective and Subjective Features.....	83
3.7.3 Genetic and Static Features.....	84
3.7.4 Empathy	86
3.7.4.1 Everyday Experience	92
3.7.4.2 Bizarre or Anomalous Experience	93
3.7.5 Philosophical and Psychological Phenomenology	95
3.8. Summary.....	98
CHAPTER 4 - INTERVIEWS	100
4.1 Introduction	100
4.2 Empirical Research.....	101
4.2.1 Methodology	103
4.2.1.1 Approach.....	103
4.2.1.2 Context.....	105
4.2.1.3 Recruitment Strategy.....	105
4.2.2 Participants.....	107
4.2.3 Data Collection	108
4.2.4 Data Analysis.....	109
4.2.5 Reflections, Problems and Limitations.....	114

4.2.5.1 Protocol and Collaborators	114
4.2.5.2 Eliciting Responses	115
4.2.5.3 Lost Data.....	116
4.2.5.4 Credibility	117
4.2.5.5 Other Limitations	117
4.2.5.6 Interviewer Stance.....	118
4.3 Empirical Analysis	120
4.3.1 Participants' Lived Experience	121
4.3.2 Guilt, Justice and Doing the Right Thing.....	123
4.3.2.1 Barbara	123
4.3.2.2 Alison	124
4.3.2.3 Andrew.....	125
4.3.2.4 Caroline.....	127
4.3.2.5 Interim Summary	128
4.3.3 Coping with Change - A Radical Alteration in Lived Experience	129
4.3.3.1 Barbara	129
4.3.3.2 Alison	131
4.3.3.3 Andrew.....	132
4.3.3.4 Caroline.....	133
4.3.3.5 Interim Summary	135
4.3.4 Re-interpreting the world	135
4.3.4.1 Barbara	135
4.3.4.2 Alison	137
4.3.4.3 Andrew.....	139
4.3.4.4 Caroline.....	141
4.3.5 Interim Summary	144
4.4 Implications and Discussion.....	145
4.4.1 Avoiding Epistemic Injustice	145
4.4.1 Understandability	147
4.4.2 Stigma Reduction.....	148
4.4.3 Treatment, Prevention and Early Intervention	154
CHAPTER 5 - AFFECT, PERCEPTION AND EMOTION.....	158
5.1 Introduction	158

5.2 What Sets Clinically Significant Delusion Apart?	159
5.3 Emotions, Affectivity and Perception.....	166
5.3.1 Emotions	166
5.3.2 Affectivity	167
5.3.3 Perception.....	168
5.4 Perceptual, Affective and Emotional Anomalies.....	169
5.4.1 Perceptual Anomalies in Schizophrenia and Delusion	169
5.4.2 Affective Anomalies in the Capgras Delusion.....	171
5.4.3 The Perceptual Affective Anomaly of Alien Control	172
5.4.4 The Perceptual Anomaly of Voice Hearing and Thought Insertion.....	174
5.4.5 Emotional Anomalies in Delusion Formation.....	176
5.5 Affect, Perception and Emotions in the Empirical Analysis	178
5.5.1 Affective Anomalies.....	179
5.5.1.1 Barbara	179
5.5.1.2 Andrew.....	181
5.5.2 Perceptual Anomalies.....	182
5.5.2.1 Voice Hearing and Related Phenomena.....	182
5.5.2.2 Delusions of Control.....	187
5.5.3 Emotional Anomalies.....	189
5.6 Discussion and Implications.....	193
CHAPTER 6 - THE PROTECTIVE NATURE OF DELUSION.....	197
6.1 Introduction	197
6.2 Empirical Evidence	197
6.2.1 Barbara.....	199
6.2.1.1 Antecedents	199
6.2.1.2 Prodromal phase	200
6.2.1.3 Development of the delusion.....	200
6.2.2 Andrew	205
6.2.2.1 Antecedents	205
6.2.2.2 Despair	207
6.2.2.3 Development of the Delusion.....	208
6.2.3 Alison	211

6.2.3.1 Antecedents	211
6.2.3.2 Development of the Delusion	213
6.2.3.3 Despair and suicidal ideation.....	215
6.2.4 Interim Summary	217
6.3 Implications and Discussion.....	218
CHAPTER 7 - THE ENACTIVE APPROACH.....	224
7.1 Introduction	224
7.2 Why Psychiatry is so Hard	225
7.2.1 Case Examples	227
7.2.1.1 Case Example 1	227
7.2.1.2 Case Example 2.....	229
7.3 The Enactive Approach	231
7.3.1 Picking Raspberries, Affordances and the Mereological Fallacy.....	231
7.3.1.1 Picking Raspberries.....	231
7.3.1.2 Affordances	232
7.3.1.3 The Mereological Fallacy	233
7.3.2 Overview of the enactive approach.....	239
7.3.3 Mind as an Embodied Dynamic System	243
7.3.4 Embodied Culturally Embedded Colour Perception.....	247
7.3.5 Interim Summary	250
7.4 Empirical Evidence Relating to the Body and Lived Experience	251
7.4.1 Phantom Limbs and Rubber Hands	251
7.4.2 Eating and Drinking	253
7.4.3 Other Bodily and Environmental Stimuli	254
7.4.4 Interim Summary	256
7.4.5 Lived Environment, the Body and Mental Health.....	257
7.4.6 Talking Therapies, Relationships and Mental Health	260
7.4.7 Interim summary	263
7.5 Implications	265
CHAPTER 8 - AFFECTIVE FRAMING	267
8.1 Introduction	267

8.2 Emotions and Affectivity	268
8.2.1 Emotions, Affectivity and Perception	268
8.2.3 Neuroscience and the Somatic Marker Theory	269
8.2.4 Affordances	270
8.2.5 Interim Summary	271
8.3 An Extended Version of Affective Framing	271
8.3.1 Levels of Responding	274
8.3.2 Sub-personal Affectivity	276
8.3.3 A Preference for Coffee and the Impact of the Environment	278
8.3.4 Interim Summary	280
8.4 Thought Insertion, Voice Hearing and Attenuated Affective Framing	281
8.4.1 Thought Insertion	281
8.4.2 Voice Hearing	282
8.4.3 Schizophrenia	282
8.4.4 Thoughts, Voices and Affective Framing	283
8.5 Delusion Formation as a Breakdown in Affective Framing.....	285
8.5.1 Making Sense of Marriage Breakdown	287
8.5.1.1 “And Then the Music Started Talking to Me”	288
8.5.2 Making Sense of Persecution and Injustice	289
8.5.2.1 “I Could Hear Long Distance Conversations”	289
8.5.3 Making Sense of Bullying at Work	290
8.5.3.1 “The Power Cannot be Described”	290
8.5.4 Making Sense of an Abusive Relationship	291
8.5.4.1 “Not Me Controlling My Arm”	291
8.6 Discussion and Implications.....	292
8.6.1 A Tentative Conceptualisation of Delusion	294
CHAPTER 9 - CONCLUSION.....	297
9.1 Context.....	297
9.2 Implications and Findings.....	298
9.2.1 Towards a Different Conceptualisation of Delusion	298
9.2.2 Wider Implications for Psychiatry	301

9.2.3 Stigma Reduction.....	302
9.2.4 Multiple Routes to Prevention, Early Intervention and Treatment	303
9.3 Quality Assessment	304
9.4 Future Research	309
9.5 Policy Changes.....	310
Appendices	312
Appendix 1 – Protocol and Flowchart.....	313
Appendix 2 – Information for Keyworkers	329
Appendix 3 – Letter of Invitation.....	332
Appendix 4 – Participant Information Sheet.....	335
Appendix 5 – Consent Form.....	342
Appendix 6 – Consultant Letter	343
Appendix 7 – Demographic Questionnaire.....	344
Appendix 8 – Interview Schedule	345
REFERENCES.....	349

Tables and Figures

Table 1: Commonly Reported Themes of Clinical Delusions.....	17
Figure 1: Interview Data Analysis Flowchart.....	113

CHAPTER 1 - INTRODUCTION

1.1 Background

I am a person-centred psychotherapist working in private practice with a particular interest in experience – that is, I am interested in ‘what it is like’ to be another. Individual differences abound and yet human beings are similar enough that we can communicate our differences and they can be understood and even empathised with by another person.

I embarked on a broad study around the philosophy of psychiatry and became interested in delusion as it seemed particularly difficult to pin down. In the first instance I thought that an interrogation of the literature would show me what the significant features of clinically significant delusion are and would tell me something about how delusions are formed and maintained. Whilst this did help me to understand more, I found out that delusions are a heterogeneous group and are notoriously difficult to define. I also became aware that decontextualized quotes from historical phenomenological enquiry were repeatedly used in the philosophical literature to support novel and varied conceptualisations relating to mental activity. These decontextualized quotes did not seem to capture experience and I found myself wondering *what it is really like to experience anomalous mental activity?*

I resolved that my study should include empirical work as I felt that I might better grasp the nature of these experiences if I listened to what people had to say about them. Whilst this is not a thesis about phenomenology I felt that I needed a grasp of how phenomenology might be used in empirical enquiry. I have attempted to integrate some ideas about phenomenology, qualitative empirical study and conceptualisations relating to the enactive approach and affective framing as they relate to delusions within this thesis.

1.2 Overview

In chapter 2 I briefly examine some of the philosophical and psychological literature in relation to the difficulty we have (and have had historically) when trying to define delusion. The way in which we understand delusions and delusion formation has implications for prevention, research, treatment and stigma. I hoped that I would get a clearer idea about what it is I am studying and perhaps identify important features or characteristics of delusion that relate to the definition. However, I soon came to realise that delusions are a heterogeneous group and, whilst I might be able to list features that have been identified as being important, this did not seem to help me understand the phenomenon as it might be experienced. Because the external features of clinically significant delusion, once formed, share many features with other psychiatric symptoms (eg: overvalued ideas) and with ordinary features of experience (eg: religious faith, believing in ghosts etc.) I wondered whether the significant features might be better understood in terms of genesis or

onset. This meant that I needed to undertake a more detailed phenomenological enquiry which included data about context and onset.

In chapter 3 I examine some of the literature on first person description and on phenomenology. It quickly became clear that phenomenological enquiry is on the decline and psychiatric diagnosis has been reduced to ever-shorter checklists of symptoms or features. This means that important features of experience are lost and we might treat people in the same way who would benefit from different treatments. I also use my own examples to help elucidate why first person description is important and how we might use phenomenological methods to expand our understanding of the delusional experience. I conclude that a full phenomenological enquiry is the best way to capture all the relevant factors that make up this experience. We can capture information about the form or structure of the delusional experience and gain an understanding of any meaningful content the delusion might have in relation to a person's history, personality, culture and values. Phenomenological enquiry can also tell us about the genesis of the delusion, that is, the context in which it arises and how this is experienced as well as what factors contribute to the maintenance of the delusion.

In chapter 4 I set out my methodology for my empirical work. I interviewed four NHS patients with clinically significant delusions (as identified by NHS staff) for approximately two hours each. I used a semi-structured interview and in the first one hour interview I asked about history and onset and in the second one hour interview I asked about what the experience was like at the

time of interview. The interviews were recorded and transcribed. I then analysed the data. In this endeavour I was influenced by narrative methods and by Interpretative Phenomenological Analysis (IPA) which aims at understanding the meaning that a particular experience has for a particular person as well as identifying themes that might relate to a number of individuals undergoing a similar experience. Two broad themes stand out in the empirical work: 1) radical alterations in lived experience and 2) guilt, justice and doing the right thing. Understanding how a person might come to terms with injustice and a radical alteration in lived experience gives context that shows how environmental factors make a contribution to psychiatric illness. I conclude that an attempt at grasping *what it is like* for a person to live through this experience has ethical implications in terms of ensuring that epistemic justice is done as well as implications for stigma reduction, prevention, early intervention, treatment and research.

In my analysis of my empirical data stress and intense emotions as well as affective and/or perceptual anomalies characterise the onset of the delusions for all four of my research participants. In chapter 5 I examine some of the literature on percept, affect and emotion in relation to psychiatric illness and delusion formation. I then link the findings from my empirical work to the literature to show how these features are present prior to and/or at the onset of the delusional experience in each case. I speculate that this might be a significant sub-set of delusions characterised by the affective, perceptual or emotional tone at onset.

In chapter 6 I look at some of the literature on the protective nature of delusion and show how some of my data can be analysed in terms of short-term protective or adaptive outcomes. Three of the people that I interviewed could be described as protecting themselves from unbearable psychological distress and perhaps even suicide through the development of their delusions. Again, I suggest that if we understand delusion formation as sometimes being protective or even adaptive this enables us to reduce stigma. How can we think that a person who is responding to radical and distressing alterations in lived experience in an adaptive way has something 'wrong' with them? This might also have implications for treatment. Understanding the ways in which we might help someone who has developed a protective delusion must take her individual experience into consideration.

In chapter 7 I introduce the *enactive approach* which posits that cognition is an emergent property arising from a dynamic embodied system embedded in an environment with which it is constantly interacting. This conceptualisation of cognition can capture all the features that relate to *what it is like* for a person to live through an experience. It recognises a person as an autonomous dynamic system embedded in an environment and recognises that mental experience (and thus mental distress and delusion) is constituted through the brain, the body and the environment. I call this system the *brain/body/world system* (BBWS). I cite research that shows how various factors relating to the body as well as factors in the environment influence what we think and feel and how we respond. I also cite a number of studies that show how certain environments correlate with adverse mental health

outcomes. I conclude that the enactive approach is the only way to fully account for all the factors that might be involved in delusion formation.

In chapter 8 I introduce the notion of *affective framing* and how this might be used to capture how affect, percept and emotion are involved in negotiating the world and in decision-making. I take the notion of affective framing further than its originator and posit that, in line with the enactive approach we must take seriously the idea that affect is also an emergent property of the BBWS. When the affective frame breaks down, which can have its origins in endogenous and/or exogenous processes, a person's ability to negotiate the world is altered and new strategies are required. Know-how is compromised and this might result in delusion formation. I provide a short description of a tentative conceptualisation of a sub-set of clinically significant delusions which is supported by the literature and my empirical evidence.

In chapter 9 I conclude and summarise my thesis in terms of the conceptualisation of cognition within the enactive approach, how a breakdown in affective framing can capture the process of delusion formation in some cases and how my empirical research supports this. I also summarise the implications of these findings in terms of prevention, early intervention, treatment, research and stigma reduction and seeing that epistemic justice is done.

CHAPTER 2 - ON THE DIFFICULTY OF DEFINING DELUSION

2.1 Introduction

In this chapter I examine some of the philosophical, psychological and psychiatric literature on the definition of delusion. I also consider my experience of my own mental activity and experiences from my therapeutic work as a person-centred counsellor. Through examining the literature and reflecting on my experiences it becomes clear that current definitions of delusion are unsatisfactory, they are extensionally inadequate as they do not capture all and only those things which are delusions. I suggest that further research is needed to clarify the phenomenology (or more likely the phenomenologies) of delusion. This chapter will shed some light on the kind of considerations that might be relevant for a more adequate understanding of delusion.

In section 2.2 I look at the context in which the definition of delusion is used. In section 2.3 I briefly look at some of the problems there are when trying to understand delusion as well as different approaches to our understanding and identify some of the features or characteristics of delusion. In section 2.4 I look at doxasticity, rationality and normativity. In section 2.5 I look at impossibility, plausibility, amenability to revision and whether some delusions

are un-falsifiable. Finally I summarise my findings and the implications of these findings (Section 2.6).

2.2 Context

I have chosen to examine clinically significant delusion¹ in the context of the psychiatric literature as, certainly in Britain, a person seeking help who is experiencing clinically significant delusions is likely, at least in the first instance, to seek help (or have help sought on his or behalf) through the National Health System (NHS) which is likely to involve referral to a psychiatric team. Those seeking help are then (usually) given a diagnosis and treated in accordance with their diagnosis, a diagnosis made by psychiatrists, based on psychiatric criteria. Whilst I recognise that there are other approaches to an understanding of the kinds of problems that might lead to delusion (such as those referred to in the British Psychological Society on understanding psychosis and schizophrenia (Cooke, 2017)), in clinical practice and in research they are less influential than the psychiatric approach. I use the term *psychiatric illness* simply to denote those experiences that cause a person to seek psychiatric help (or have help sought on their behalf) that result in intervention or treatment by a psychiatric team. Research into psychiatric illnesses is usually done using psychiatric diagnoses found in diagnostic manuals such as DSM 5 (American Psychiatric Association, 2013) and ICD 10 (World Health Organization, 1993b). Where psychiatric illnesses are concerned diagnosis is made based on identifying

¹ See section 2.2 for a definition.

symptoms which manifest in terms of mental distress and problems with functioning. There is often no discernible aetiology and as such it is theoretically possible to group symptoms that seem to co-occur in any way that we choose to give a syndrome which, once named, takes on a life of its own as a disease entity. Research and treatment currently hangs on these named 'diseases'. As the current version of the American Psychiatrists Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM 5)* puts it:

“... in the absence of clear biological markers or clinically useful measurements of severity for many mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria.” (American Psychiatric Association, 2013, p.21).

The most important features that might cause a person to seek psychiatric help (or have help sought on one's behalf) can be understood in terms of the impact experience has on that person's wellbeing. My own experience (of myself) and some (anecdotal) analysis of client experience tells me that there may be no clear line between the mentally well and the mentally 'ill' (for evidence supporting this see Bentall, 2004). I do not propose to examine the details of this problem in depth here. It is worth noting, however, that there is a growing consensus within psychiatry and psychology that research and interventions may be more productively focused upon understanding specific

symptoms and the interactions between them rather than on ‘illnesses.’² I align my work in this thesis with this view, and consider delusions to be important phenomena in their own right. At the same time I do not propose that delusion should be isolated from other features of experience that might be relevant to our understanding.

Delusions are a significant feature of a number of distressing psychiatric problems and it is widely recognised that delusions are a heterogeneous group (Maher, 2001). To develop and improve approaches to research and to treatment, it is important to have a working definition of delusion which is consistent with the phenomenology of delusional experiences. Given the broad spectrum of such experiences this has proven difficult. If we can gain a more accurate understanding of the delusional experience and why it is problematic we might use this information to identify novel therapeutic intervention and perhaps identify different classes of delusion which warrant different treatments.

2.2.1 Karl Jaspers and DSM 5

The difficulty in describing delusion has a long history in psychiatry. In Karl Jaspers’ *General Psychopathology*, originally published in 1913, he describes delusion as follows:

² For example in 2008 the U.S. National Institute of Mental Health (NIMH) began to develop the Research Domain Criteria (RDoC) in contrast to DSM 5 which aims at identifying individual psychological constructs or concepts relevant to human functioning, behaviour and mental disorders in terms of units of analysis such as genetics, neurobiology, physiology, and self-report (NIMH, 2017).

“The term delusion is *vaguely* applied to all false judgments that share the following external characteristics to a marked, though undefined degree: (1) they are held with an *extraordinary conviction*, with an incomparable, *subjective certainty*; (2) there is an *imperviousness* to other experiences and to compelling counter argument; (3) their content is impossible... We can then distinguish two large groups of delusion according to their *origin*: one group *emerges understandably* from preceding affects... The other group for us is psychologically irreducible...” (Jaspers, 1997, pp.95–96).

For Jaspers the first group (with understandable origins) are *delusion-like ideas* and the second group (where the delusion is psychologically irreducible and therefore not understandable) is known as *delusion proper*. He goes on to say:

“If incorrigible wrong judgements are termed ‘delusion’, who will there be without delusion, since we are all capable of having convictions and it is a universal human characteristic to hold on to our own mistaken judgements. Nor can the prolific illusions of entire peoples and persons be given the title of ‘delusion’, since this would mean treating a basic human characteristic as if it were an illness.” (Jaspers, 1997, p.195).

Whilst Jaspers’ *General Psychopathology* was not published in English until 1968 we can see that, whilst it does not distinguish between delusion proper and delusion-like ideas, the current diagnostic definition (from DSM 5) is close

to Jaspers' original definition. I set out the two definitions together (below) in order to highlight the similarities and differences:

“A false belief [*Jaspers' – “false judgement(s)”*] based on incorrect inference about external reality that is firmly sustained [*Jaspers' – “held with extraordinary conviction”*] despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary [*Jaspers' – “imperviousness to other experiences and compelling counter arguments”*]. The belief is not ordinarily one accepted by other members of the person's culture or subculture (e.g. it is not an article of religious faith) [*Jaspers' – “...nor can the prolific views of entire nations be given the title delusion...”*]. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility.” (American Psychiatric Association, 2013, p.819; Jaspers, 1997, pp.95–95 & 195).

So, the term delusion is 'vaguely' applied to false beliefs held with conviction despite the availability of counter evidence. However, as Jaspers well knew, we do not routinely think that religious, spiritual or certain other supernatural beliefs are necessarily problematic or symptomatic of illness and it is a very ordinary human trait to hold unexamined mistaken beliefs.

A person might seek psychiatric help as a result of distress because she believes that she will go to Hell due to her past actions. If it is known that she is Catholic, even if others think she is mistaken about the existence of Hell

this would not be classed as a clinically significant delusion. It is, rather, a culturally normal belief that is perhaps overvalued or that she has become obsessed with resulting in psychological distress. This kind of problem might mean that a person is described as delusional in one culture but not in another. So what is it that differentiates a delusion that might turn out to be clinically significant from other kinds of mistaken beliefs? Debates around impossibility, falsifiability, plausibility doxasticity, rationality, normativity and un-falsifiability abound and I briefly explore these debates in sections 2.5 and 2.6.

In the next section I lay out some assumptions and terms that I will use in order to explore this further.

2.2.2. Assumptions and Terms

My starting position when engaging with this project is that I take the person's explanation seriously and will not 'explain away' peculiarities in terms of 'the way things normally are'. A person experiencing anomalous mental activity has access to information about that experience that others do not have and it is incumbent on any researcher to take this seriously³. I acknowledge the obvious problems of lack of first person access to the experience of another person – exacerbated by the problems associated with the peculiarities of psychopathology. That is, I accept that perhaps some experiences (perceptual and otherwise) are beyond the scope of ordinary (more typical) human experience. Further, I do not assume that all things classed as

³ I will say more about this in chapter 3.

delusion take the same form or have the same aetiology (this is a matter for empirical research - perhaps cognitive neuroscience coupled with phenomenological research) and I agree with Brendan Maher:

“The principle of parsimony would seem to demand that the implications of accepting the patient’s reports of his experience should be exhausted and found fruitless before turning to interpretive theoretical formulations.”
(Maher, 1974, p.109).

This quote was written over forty years ago and, in some ways, the patient’s experience is undoubtedly taken more seriously now. However, we still have problems with regard to the decline of the use of phenomenology⁴ and we certainly have not exhausted the possibilities of this form of analysis.

Partly because the accepted definitions only vaguely apply to the phenomenon that I am trying to study we find that, within the literature, different writers use the term *delusion* differently. In this thesis, I use the word delusion in the following way(s):

1. Delusion – all idiosyncratic beliefs that are firmly maintained despite being contradicted by what is generally accepted as reality and/or by rational argument, including those beliefs maintained by people in the ‘normal’ population. This would include everyday folk psychological use of the term, such as ‘he’s delusional if he thinks he’s going to pass that exam,’ as well as extreme bizarre clinically significant delusions and everything in between.

⁴ I discuss this further in chapter 3, section 3.6.

2. Clinically significant delusion – I adopt the term ‘clinically significant delusions’ to denote those delusions broadly meeting the DSM 5 criteria that give rise to significant functional, emotional or cognitive problems and lead a person to seek psychiatric help or to be forced to have psychiatric treatment. This term is used in preference to ‘pathological’, which might imply a disease entity and perhaps a biological underpinning or aetiology. As we cannot say for sure that delusions have any such common ‘cause’ I prefer (like Jennifer Radden) to use the term ‘clinically significant.’ (Radden, 2011).

In what follows I look at some of the different approaches that we can take and some of the problems we have when trying to apply the clinical definition of delusion to case examples and how this relates to other mental phenomena.

2.2.3. Approaches and Problems

In the vast majority of cases of clinically significant delusion, there is currently no identifiable biological underpinning. This is also true for most psychiatric illnesses (American Psychiatric Association, 2013, p.21). This means that psychiatrists must rely on symptoms as presented and must endeavour to understand when these represent significant problems.

There are, of course, illnesses with identifiable biological underpinnings that are associated with delusion formation. For example, Alzheimer’s disease, associated with protein build up and plaque formation in the brain which interferes with neuronal connections, is linked with delusion formation (Green,

2017). Capgras syndrome⁵ (or the Capgras delusion) is the delusion that loved ones or relatives have been replaced by imposters. This syndrome can be associated with brain damage as well as dementia and can also be associated with people who have no obvious brain damage but have acquired a diagnosis of schizophrenia (Edelstyn and Oyebode, 1999). This highlights the problem that we have with regard to understanding symptom expression in terms of *form* (a false belief held with conviction) and *content* ('my relatives have been replaced by imposters') alone. Capgras syndrome is unusual. It is rare, monothematic⁶ and has been extensively researched compared with other delusions. The fact that the external characteristics of the syndrome are similar in the case of the person with dementia, the person with brain damage and the person with a diagnosis of schizophrenia suggests that delusion is not only heterogeneous but also multiply realised (perhaps biologically and/or psychologically).

In the next section I take a more fine-grained look at some of the characteristics associated with delusion.

2.3. Characteristics

There are many different delusions and they are normally categorised in relation to the kind of *content* of the belief (see table 1).

⁵ I say more about this in chapter 5, section 5.4.2.

⁶ Monothematic delusions have just one theme (as opposed to, for example, the elaborate polythematic delusions sometimes associated with a diagnosis of schizophrenia).

Table 1. Commonly reported themes of clinical delusions (Bell et al., 2006, p.220)

Defined by DSM	Examples:
Persecutory	“My food is being poisoned by the police”
Grandiose	“I have the power to heal all illnesses”
Jealous (Othello syndrome)	“My partner is cheating on me”
Erotomania (De Clerambault’s syndrome)	“A famous pop star secretly signals her love to me over the radio”
Somatic (e.g. delusional parasitosis/Ekbom’s syndrome)	“I am infected by tiny parasites”
Bizarre	“My mother’s thoughts are being carried on raindrops that fall on the air conditioner”
Misidentification	
Capgras syndrome	“My relatives have been replaced by identical looking impostors”
Fregoli syndrome	“The same person is disguising himself as others”
Reduplicative paramnesia	“My present location exists in two places simultaneously”
Mirrored self-misidentification	“The reflection in the mirror is another person”
Other	
Thought insertion/withdrawal	“Thoughts are being inserted into/withdrawn from my mind”
External control	“My mind/body is being controlled by an external agent”
Guilt	“I am responsible for the AIDS epidemic”
Religious	“I am the reincarnation of Solomon”
Cotard delusion	“I am dead/do not exist,” or “My body is decaying”
Lycanthropy	“I am/have transformed into an animal”

At first glance these seem as if they might take a similar form (although the content is quite different) in that they share some of the external characteristics of delusion as defined by DSM 5.

At first glance one might say these delusions are:

- False and made through inferential error about external reality
- Doxastic (or belief-like)
- Strongly held against counter argument/evidence
- Culturally/sub-culturally abnormal

But our first impression may not hold on closer inspection. Currently there is disagreement about what delusions are which highlights the inadequacy of the definition. They might be thought of as manifesting as a series of measurable dimensions or characteristics (Garety and Hemsley, 2013; Jones and Watson, 1997) and their origins might be described in terms of perceptual anomaly alone (Gerrans, 2002; Maher, 1974) or perceptual anomaly plus cognitive deficit (Davies et al., 2001; Coltheart, 2007). They can also be understood as: doxastic (Bortolotti, 2012; Bayne and Pacherie, 2005); irrational non-doxastic acceptances (Frankish, 2012); imaginings mislabelled as beliefs (Currie and Jureidini, 2001); irrational, un-falsifiable, personally significant emotionally salient beliefs originating from trivial occurrences (Leeser and O'Donohue, 1999); fundamentally incomprehensible (Heinimaa,

2002) or un-understandable (Gorski, 2012).⁷ I briefly explore some of these conceptualisation in what follows.

When the definition (above) is consulted and compared with the literature and with different examples of clinically significant delusions it becomes clear that the definition given may not be sufficient to differentiate between clinically significant delusions and non-clinical delusions or to distinguish between delusions and other psychiatric symptoms.

2.3.1 Clinical Significance

One could argue that Jaspers' wording is not intended to account for the experience of clinically significant delusions as it only 'vaguely' applies⁸. One could also argue that the definition of delusion in DSM 5 is not intended to fully account for clinically significant delusion. In order to identify those delusions that are clinically significant one must also include the criteria for mental disorder. On attempting to qualify 'clinical significance,' the DSM 5 introduction states:

"... a generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." The text following the revised definition of a mental disorder acknowledges that this

⁷ This list represents a small number of the theories deemed relevant to this project, the literature is vast and it is not possible to cover more here.

⁸ I return to this in chapter 5, section 5.2

criterion may be especially helpful in determining a patient's need for treatment.” (American Psychiatric Association, 2013, p.21).

This means that unless there is significant impairment or distress there may be no need to treat (and perhaps those whose ‘delusions’ meet the other DSM 5 criteria but who are *not* distressed or suffering from impaired function would not seek or attract psychiatric help). As Bill Fulford suggests, there is always a value judgment made where clinical significance is concerned (Fulford, 1989).

Here, I suggest that the noteworthy dimensions of clinically significant delusion relate to *impairment in function* and *distress*.

2.3.2 Other Dimensions or Characteristics of Delusion

We might also want to establish other characteristics of delusion that impact directly on these two dimensions (impairment in function and distress) and these might be used to help establish the clinical significance or severity of the delusion and perhaps help to differentiate between delusions and other kinds of beliefs and psychiatric phenomenon. Characteristics of delusion that are deemed subjectively measurable have been identified and scales to measure them have been developed by Edgar Jones and J.P. Watson and by Philippa Garety and David Hemsley amongst others.

Jones and Watson compared the beliefs of those with a diagnosis of schizophrenia who had clinically significant delusion, those with a diagnosis of anorexia and those with strong religious conviction to try and identify

significant differences. The characteristics they measured were: degree of conviction, degree of influence on behaviour, degree of influence on other thinking, degree of objective truthfulness, degree of personal importance, frequency, degree of acceptability to others, degree of imagination required, speed of formation, degree of perceptual evidence involved, degree of focused thought involved and degree of affective content. These characteristics were measured using a self-report on a five-point scale with 1 being correlated to absolute agreement to the characteristic and 5 being a total absence of the characteristic (for example, in the case of conviction, 1 would correspond to 'I absolutely believe' and 5 would correspond to 'I do not believe.'). They found that those with anorexia did not think their beliefs about their body image were actually true from an objective standpoint (yet still acted on them). Whilst those with religious beliefs and those with clinically significant delusions had equally strong convictions that their beliefs were objectively true. They also found that imagination was heavily involved in belief formation for those with religious conviction but not involved in belief formation for those with clinically significant delusion (Jones and Watson, 1997).

Garety and Hemsley have written comprehensively about the various measuring tools used to try to capture important characteristics of the delusional experience as well as undertaking their own study. They used a scale with eleven belief characteristics drawn from the literature that could be assessed by the subject (as opposed to assessed by an observer) and used a visual analogue scale where each patient was asked to mark along a line the

degree to which they experienced the different characteristics. The characteristics they measured were: Intensity of belief, preoccupation with the belief, degree to which the belief interferes with behaviour, desire to resist thinking about it, ability to dismiss the thought, absurdity of the belief, self-evidential nature of the belief, reassurance seeking behaviour with regard to the belief, degree of distress or worry associated with the belief, degree of happiness in relation to the belief and degree of pervasiveness or intrusion of the belief.

They found that conviction was the only characteristic that received a high score from all the participants. Two thirds of the sample showed high resistance and some other factors were variable and surprising, for example, interference and pervasiveness proved the most difficult for subjects to rate and showed little correlation with other variables. Again this serves to highlight how little we really understand about the nature of delusion as it is experienced. They conclude that their findings support previously examined research and literature suggesting that delusions are multidimensional (Garety and Hemsley, 2013).

This method of thinking about what delusions are, combined with undertaking longitudinal studies might be useful for differentiating between delusion and other psychiatric symptoms as well as perhaps identifying appropriate therapeutic interventions and the timing of these interventions. Whilst these methods might capture some of the features of delusion and contribute something to our understanding of the experience I suggest that they do not

go far enough and there are other features that might inform us about the experience. Commensurate with some more recent psychological accounts about delusion formation (such as those explored in Cooke, 2017; Gumley et al., 2013) I suggest that we need more context relating to lived experience of a person prior to the onset of delusion such as history and other mental and emotional experiences as well as changes at onset and what it is like once the delusion is formed. This will enable us to grasp the nature of the experience.

2.3.3 More Problems

Another key issue is that the DSM definition does not adequately distinguish between delusions and other kinds of peculiar beliefs or belief-like states. It may also be the case that some delusions do not meet the (vague) criteria of the definition at all. For example, a delusion that is unstable (not continuously held with conviction) and does not engender the behaviour one might expect of a belief might still seem to have the signature of a problematic or clinically significant delusion. It is also the case that the definition is so general that it allows us to count *different* phenomena *as if they were the same kind of thing* (perhaps this applies to the Capgras delusion described in section 2.2.3) thus leading to potential problems for treatment and research.

There are other significant problems that might, in part, be associated with the inadequacy of our understanding of delusion. For example there are racial disparities in psychiatric diagnosis with black and ethnic minorities as well as immigrants acquiring diagnoses of schizophrenia more frequently than their white counter-parts (Schwartz and Blankenship, 2014). Exactly why this

happens is not fully understood but there is some speculation that misunderstandings in relation to cultural differences might be a significant factor (Balsa and McGuire, 2003). This might mean a clinician will over-treat if, perhaps due to bias or cultural incompetence, she fails to understand the cultural significance of a strongly held belief. It might therefore be useful if we could understand delusion in terms that do not require a clinician to be culturally competent with regard to all cultures that she is likely to come across. This might help to pick out real features of delusion and make the clinician's job easier. Over treatment should be avoided due to the risks attached to treatment. Taking neuroleptic medication (often prescribed for psychotic illnesses) has many side-effects and can create dependency (Moncrieff, 2006) and acquiring a psychiatric diagnosis gives rise to stigma⁹ and is detrimental to social capital and thus to life opportunities (Webber et al., 2014).

I now turn to the philosophical literature about delusion in order to further examine the ways in which the definition can be vague or inadequate. In the following two sections I propose to briefly examine the notions of *doxasticity*, *rationality* and *normativity*, as well as the concepts of *falsifiability*, *plausibility*, *impossibility* and *amenability to revision*. I will examine how these ideas fit with examples as well as looking at what others have to say about these concepts.

⁹ I will say more about this in chapter 4, section 4.4.2

2.4. Doxasticity, Rationality and Normativity

If a person says she believes something then I am inclined to take this at face value. A person usually holds many mundane unexamined or implicit beliefs (e.g.: I believe that when I turn a tap on water will come out) as well as examined or explicit beliefs or opinions (e.g.: I believe that liberal democracy is the best political system). Against this background of other beliefs, it is not appropriate to 'second guess' a person about her own experience or about the belief status of what she says. Not everyone would agree with this and some would argue that delusions do not meet the criteria for beliefs as they are irrational, do not necessarily affect behaviour and often do not cohere with other beliefs.

2.4.1 Are Delusions Beliefs?

According to the clinical definitions cited above delusions are beliefs. However, some argue that they do not meet the standards required to qualify as beliefs. However, this depends, to a large extent on how belief is defined. Lisa Bortolotti argues that beliefs have relations with a person's other beliefs and intentional states, are sensitive to evidence and impact behaviour. They can be occurrent (explicit) or dispositional (implicit), can vary in stability as a result of many factors (environment, mood and affect) and may or may not be attended to in any given situation (Bortolotti, 2012) and this notion of how beliefs operate is consonant with the social psychology literature (see for example Potter and Wetherell, 1987).

The general 'vagueness' of the definition of delusion leaves an expandable term that can be widened to include a myriad of different experiences. There is also a problem of circularity in that examples are used to try to clarify the definition – yet the examples already have the label 'delusion'. If we were to undertake detailed phenomenological examination of experiences described as delusions, we might find that the broad label covers more than one 'kind' of phenomenon. For example, if some delusions are not beliefs, then the fact that the definition includes the word belief leads us to assume that a person with a delusion believes the content of her delusion.

Greg Currie and Jon Jureidini propose that a person with a delusion fails to identify an *imagining* as being self-generated (the person is in some sense not the agent of the imagining). This mental activity is then mislabelled (representationally) as a belief and somehow 'given' as true. So the delusional person has a thought with content *P*. He does not believe *P*. He imagines *P*. And then he believes that he believes *P*. For Currie and Jureidini some delusions are imaginings with a strong feeling of subjective conviction. (Currie and Jureidini, 2001). This is an intriguing way of describing *some* delusions and it helps us explain why some people do not seek to integrate their delusions into their lives or to act on them (we do not routinely act on our imaginings)¹⁰. However, there are problems here – the most

¹⁰ Some argue that imagination can play the same motivational role as belief and belief is distinguished from imagination and other attitudes by the fact that it aims at tracking truth (Shah and Velleman, 2005). Children often act on their imaginings in games of make believe (eg: I am Luke Skywalker and I am fighting my father, Darth Vader, in the ultimate battle of good versus evil. I still

obvious being that there are many examples of people acting on their delusions and integrating them into elaborate belief networks that pervade the rest of their lives - for example, the person who believes he is a millionaire, a general and a senior psychiatrist who regularly phones the bank to check on his millions, attempts to arrange to inspect local military bases and applies for a job as the chief executive of a hospital (Bentall, 2004, pp.295–296).

The other problem arises from establishing how Currie and Jureidini's characterisation of delusion differs from the experience of people who do not have delusions who are 'believers'. It is easy for me to say that I believe something, compartmentalise it and not act on it – does this mean that it is not a belief? Would others say that I do not believe it? I doubt it. They would be more likely to say that I am just not very good at acting on or following through on my beliefs. If this argument is used as a way of showing dis-continuity with ordinary (more typical) mental activity or the typical way in which we sometimes hold beliefs it does not hold up to scrutiny. Our normal propositional attitudes can be manifest as beliefs, which we may not act on, which may not be integrated into the rest of our beliefs and which may also appear to be irrational. For example I might say that I believe *smoking kills people and I do not want to die sooner than necessary*, yet I continue to smoke. This series of un-integrated beliefs might include an unexamined belief (or sub-clinical delusion) that *I am special and the detrimental effect of smoking will somehow not have an impact on me*. If questioned about it I

retain the belief that I am not Luke Skywalker but in the game I behave as if I am).

would probably concede that the (weakly held) belief that *I am special* is not true, yet I am unlikely to change my behaviour. Or I might simply be accessing the belief *smoking relaxes me* and ignoring the belief *smoking kills* at times of stress or craving. Further, one could successfully argue that my behaviour and my thinking in this case is irrational but it is unlikely that one would question the belief status of my statement about smoking.

Tim Bayne and Elisabeth Pacherie defend the doxastic conception of delusion. Their starting position is that belief is multi-dimensional in nature and not defined by rationality constraints. Ideal (normative) rationality is not consistent in human beings and perhaps complete normative rationality is not even possible. Therefore one cannot deny the doxastic nature of delusions simply because they are sometimes irrational (Bayne and Pacherie, 2005). For Keith Frankish, delusions are not beliefs because they are only subject to some of the norms of rationality some of the time. Frankish calls them *non-doxastic acceptances* which might be formed for pragmatic reasons, including sub-personal reasons (that the person is not self-consciously aware of). They are not always integrated with other beliefs so they fail to meet the norms of procedural rationality. They are not always acted upon, so they fail to meet the norms of agential rationality. And they are not formed on the basis of sufficient evidence, so they fail to meet the norms of epistemic rationality (Frankish, 2012). I, like Bayne and Pacherie, would question if it is possible to differentiate this class of non-doxastic acceptances from what we ordinarily understand beliefs to be. Frankish focuses on the normative desirable kind of rationality that we ought to adhere to which is clearly not the kind of rationality

that human beings always follow (see the smoking example above). It is too strict and does not reflect our ordinary understanding of belief, nor does it fit with the concepts of other theorist.¹¹ However, if we agree that non-doxastic acceptances are an ordinary form of mental activity, different from a strict normative definition of beliefs in the way that Frankish describes, then delusion might be a kind of non-doxastic acceptance. This also means that most of the mental activities that we currently describe as *beliefs* are in fact non-doxastic acceptances and we have not said anything significant that helps us differentiate delusions from other forms of mental activity.

It is also completely normal for people to come to believe things that may have started as imaginings. Consider the X-factor¹² hopeful who has rehearsed in front of a mirror with a hair brush as a microphone imagining the roar of the crowd, praise from the judges and her name up in lights. She comes to believe that she is a good singer (even though she is not), tells all her friends and family that she is going to win X-factor and enters the competition. When she fails, others can that see she is mistaken in her belief (and perhaps she cannot see it - preferring to think that the judges have made a mistake rather than accepting that she is not a good singer). We don't question the belief status of her conviction that she is a good singer, she does believe it, she is simply mistaken. It is also possible that this person does not ever enter the competition but continues to 'practice' and tells everyone she is

¹¹ As mentioned in 2.4.1 above

¹² X-Factor is a television program where unknown singers compete against each other and are judged by experts and the television audience to win a record contract.

as good as any of the competition winners. Again, she does not act on her conviction (she does not seek fame or enter the competition) but we would still say she believes that she is a great singer who could win X-factor.

Bortolotti argues that delusion ascription is a species of belief ascription. Therefore delusions, like beliefs, have relations with the subject's other beliefs and intentional states, are sensitive to evidence, impact behaviour and can be explicit or implicit. She recognises that these features do not give us necessary or sufficient conditions for belief and that they do not distinguish beliefs from other kinds of mental activity. She terms her view on delusions as 'modest doxasticism' and holds that whilst delusions share some characteristics with beliefs this does not tell us everything we need to know about delusion and leaves open the possibility that some delusions are not instances of belief (Bortolotti, 2012).

Whilst it *might* be true that *some* delusions are not beliefs this does not alter the fact that our ordinary conceptualisation of beliefs sometimes seem to have the same external characteristics as the phenomenon that Currie and Jureidini describe as *imaginings mistaken as beliefs* and that Frankish describes as *non-doxastic acceptances*. Of course, as we are unable to consistently and accurately define or describe beliefs or imaginings, I cannot say more about it here. However, beliefs that people sincerely state they are committed to can vary depending on all sorts of factors such as mood, audience and pragmatic constraints and we often behave in ways that are at odds with our stated beliefs. Further, the way in which belief and imagination

interact suggests that beliefs and imaginings are complex overlapping forms of mental activity.

If people experiencing delusions describe them as beliefs it is incumbent on psychiatrists and others to take this description seriously. Whether all delusions are beliefs is an empirical question and descriptive phenomenology can help us answer it. As it stands, we cannot say if people with delusions ordinarily think of the thoughts and feelings that are associated with the delusion as a belief or if this experience has the same kind of status as other beliefs that they hold. We do not ask these kinds of questions of them. Perhaps we should. I speculate that the high level of conviction suggests that people who have delusions might (subjectively) experience these thoughts as more akin to *knowledge*¹³ than to belief.

The dimensions highlighted in this sections – *rationality*, *integration with other thinking* and *integration with behaviour* - might be important when trying to understand delusion and perhaps to differentiating between different kinds of delusion. Two of these dimensions have already been highlighted as potentially relevant when characterising delusion (see section 2.3.2). We might also think that *rationality* is an important characteristic too. Perhaps a third party can say how rational a belief seems in terms of plausibility of reason giving. So, for example a delusion that is impossible or incomprehensible might be termed completely irrational and a delusion that

¹³ I am not suggesting that delusional beliefs *are* knowledge just that they are subjectively experienced in the same (unquestioning) way that we usually experience knowledge

was entirely possible and had a strong degree of likelihood (yet was untrue) would be termed relatively rational.

The degree to which a person's delusion is *integrated with other thinking* might also be important. If, for example, a person says that she is being observed by the government through the air conditioning vents at work, yet she has no other thoughts or beliefs connected to this idea then integration might be said to be low. If, however, the person also says that the government has information about her, will use it against her, blackmail her or share it on the internet and also says that a letter that she received from her local MP recently is personally salient in relation to this government surveillance, then one would say that the degree of integration with other thinking is high. If the person continues to go to work and her *behaviour* is unaffected by her delusion, one could say that it has no affect on her behaviour (in this instance perhaps she would not seek psychiatric help). If, however, the person seals up the air conditioning vents or refuses to go to work and reports the intrusion to the police then the delusion could be said to have a large impact on action or behaviour. As interference and pervasiveness proved difficult for people to rate on self reports (see section 2.3.2) the feature of impact on behaviour might be better judged by a combination of self-report and third party observer report.

Whilst both Jaspers and the DSM 5 definition hold that delusions are not amenable to revision by counter argument I suggest that if they are continuous with ordinary (more typical) beliefs then perhaps they are

amenable to revision. It is often (but not always) possible to change one's belief when presented with evidence that contradicts that belief. It is also true that some beliefs (those with a faith-like quality) are un-falsifiable and perhaps some delusions are of this kind and therefore there is simply no available counter argument. I now turn to the literature and some examples to develop this point.

2.5. Impossibility, Plausibility, Un-falsifiability and Amenability to Revision

2.5.1 Impossibility

There are differences between the modern DSM 5 definition of delusion and Jaspers' original 1913 definition. Here, I focus on the idea that content of a delusion is (or might be) impossible. One of Jaspers' three criteria for delusion is stated as follows:

“The term delusion is *vaguely* applied to all false judgments that share the following external characteristics to a marked, though undefined degree:.... (3) their content is impossible...” (Jaspers, 1997, p.195).

It seems obvious that a delusion need not have impossible content since there is often a degree of likelihood so the content of delusions could range from the unlikely to the impossible. However, the use of the term impossible might tell us something about certain kinds of delusion. Maybe some do have impossible content.

The DSM definition does not refer to impossibility of content and instead refers to incorrectness. The DSM definition is stated as follows:

“A false belief based on incorrect inference about external reality...”
(American Psychiatric Association, 2013, p.819)

If I believe that something is *false* then this might be because I am simply *incorrect*. For example, if I believe that my cup of coffee is hot and on picking it up to drink I find out that it is cold I have simply made a mistake. Others would think that it is reasonable to believe that the coffee is hot. It is plausible, and I have judged that, because it was hot when I made it and I only poured it a few minutes ago, it is still hot. The belief is *plausible* – coffee is usually hot – yet the belief was false, I was *mistaken* - my belief was incorrect. In this example the question of *plausibility* arises and a judgment is made.

Contrast this with the belief that my cup of coffee contains a full-sized live elephant. This is a false belief too. However, it is *not plausible*. Further, it is *not* (nomologically/physically) *possible* either (just as a matter of basic physics an elephant will not fit in an ordinary coffee cup)¹⁴. In this example the question of *plausibility* simply does not arise.

In both examples I am mistaken, my belief is false and I am incorrect. In the first example I (and others) can consider the plausibility of my belief and make

¹⁴ I am not interested here in metaphysical or logical possibility as it is not relevant to this project.

a judgment. In the second example, the question of plausibility (for a third party) is simply not relevant because the belief is *impossible*.

2.5.2 Falsity

It is possible for the content of a delusional belief (or belief-like state) to be (accidentally) true. So falsity of content in itself cannot define delusion. Consider the oft cited example of the man who believes his wife is having an affair because the fifth lamppost on the left is unlit (Oyebode, 2015). If we were to establish that his wife *was* actually having an affair we might still think that there was something wrong. Even if the content of the delusion is true (his wife is having an affair) there is something wrong with the *grounds* for coming to this conclusion – it seems odd that the fifth lamppost somehow imparts the information about the wife’s affair (assuming that I have established that he literally believes that the lamppost not being lit is the sign, reason, grounds and/or explanation for the belief that his wife is having an affair, i.e.: he is not using this as some kind of metaphor). Whilst the belief (or belief-like) content of the delusion is true, this man’s overall experience might best be described as incomprehensible and the grounds for his belief might be best described as impossible – it is impossible (in this world) that the fifth lamppost somehow imparts the information about the wife’s affair.¹⁵

¹⁵ This does not mean the delusion is meaningless and, if we had more context and explanation from the person experiencing this delusion, we might find that it ceases to be incomprehensible (I will say more about this in chapter 4).

2.5.3 Implausible or Incomprehensible?

Markus Heinimaa analyses the role of the DSM definition of delusion and its fit with notions of mistakes or incorrectness compared with the notion of incomprehensibility. He examines the distinction between the implausible - which requires a degree of likelihood in order to be implausible - and the incomprehensible (or as Jaspers puts it the un-understandable) - for which plausibility is simply not a factor (Heinimaa, 2002). Strangeness alone does not imply impossibility, just unlikeliness (or implausibility). It is entirely conceivable for a strange delusion to be possible, for example: *I am descended from the Russian aristocracy and was shipped to England in a Faberge egg*. This is very unlikely and therefore implausible (it would've had to be a very large Faberge egg even if I was shipped here as a baby) but it is not impossible.

Heinimaa rightly points out that Bizarre delusions, which are defined as implausible and incomprehensible (American Psychiatric Association, 2013, p.87), cannot be both. If something has a degree of plausibility it cannot be incomprehensible. If a person can weigh plausibility then there must be something comprehensible about the delusion (Heinimaa, 2002). Perhaps there is a class of bizarre delusion which are incomprehensible (perhaps with impossible content) and these might be like the example in table 1: 'My mother's thoughts are being carried on raindrops that fall on the air conditioner' which is impossible (in this world) and incomprehensible. In this

case, with regard to bizarre delusions we have no need of the concept of plausibility or implausibility.

For Heinimaa, it is certainly true that some (but not all) delusions are incomprehensible (ibid). I would not, however, conclude (as Heinimaa has done) that psychiatry is better served by a focus on incomprehensibility except in the case of 'bizarre' delusions (see the example above taken from table 1) and perhaps with regard to the *grounds* cited for certain other delusions (such as the lamppost example above). Many delusions are understandable and I would suggest that perhaps only a subset of delusions can be described, in some sense, as incomprehensible.¹⁶

Perhaps Heinimaa is drawing a distinction here between delusion-like beliefs and delusion proper. If so delusion proper might be the true domain of psychiatry and other kinds of 'understandable' delusions are the domain of psychology. In this case an incomprehensible delusion would be compatible with Jaspers' notion that some delusions (delusion proper) are psychologically irreducible.

These days, it is not fashionable to distinguish between Jaspers' delusion proper and delusion-like beliefs (Jones et al., 2003) yet when one examines the literature it is entirely possible that there are different classes of delusion with different characteristics and that Jaspers' distinction is an important one.

¹⁶ Again, I caution against incomprehensibility being conflated with meaninglessness – human experience is complex and context is required to understand what elements of an experience are incomprehensible and what elements hold meaning (I say more about this in chapter 4)

In the next section I examine the notion of falsifiability in relation to delusion to establish if it is an important characteristic of delusion.

2.5.4. Un-falsifiability

As Karl Popper tells us a theory can only be said to be scientifically valid if it is falsifiable. If, for example, I have only ever seen men with red hair I may therefore conclude that all men have red hair. This is an entirely reasonable conclusion based on my experience and the empirical evidence that I am aware of. Whilst it is not logically true for me to say that all men have red hair I would tend to believe (and behave as if I believed) that it were true in the absence of evidence to the contrary. The theory is falsifiable because it would only take one instance of a man with different coloured hair to disprove my theory that all men have red hair. If a theory does not have this kind of quality – the possibility of being disproven – then it is un-falsifiable and it cannot be said to be scientifically valid (Popper, 1998, chap.1).

If a belief is un-falsifiable then it is not responsive to any kind of counter argument. This applies to many of our everyday beliefs, the most obvious being religious beliefs. If I have faith that God exists then, whilst one could reason that there are counter arguments to this, one can never *prove* that God does not exist. One could say the same about ghosts or telepathy – how can one prove that ghosts do not exist or that telepathy is impossible? As William O'Donohue and Jaimie Leeser would say:

“A significant portion of delusional beliefs... are of the sort that lack any clear empirical content. In other words there is no clear way to

determine the truth or falsity of such beliefs.” (Leeser and O’Donohue, 1999, p.687).

In their paper on the epistemic dimensions of delusion they argue that delusions are, by their very nature, un-falsifiable and they list six factors that are significant in regard to clinical examples that give these beliefs a ‘faith-like’ quality. They explore how a sufficiently robust irrationality criteria (which in ordinary (more typical) thinking hangs on understandable justification and reason giving) negates the need for the falsity criterion and reduces the need to weight the cultural (or sub-cultural) element so heavily (Leeser and O’Donohue, 1999). If I were to apply their criteria to the lamppost example it is likely to meet all of them. It is a *non-basic, protected, un-falsifiable, emotionally salient belief originating from trivial occurrences interpreted as highly significant*, it is *not of a particular variety of scientific belief* and it *(may) prompt complex un-testable explanations when challenged* (Leeser and O’Donohue, 1999).

In some sense this kind of belief (if indeed it is a belief) can be said to be neither true nor false. It is simply un-provable either way. No third party can have access to the ‘evidence’ cited by the person experiencing the belief as it is, in some sense, purely experiential and subjective.

In the lamppost example the subject of the belief is unable to give a rational justification that can be understood by others and this would be the case whether the belief (that his wife is having an affair) were true or not. Whilst I can see how this negates the need for a falsity criterion (in Leeser and

O'Donohue's terms) I'm not convinced it would reduce the need to weigh the cultural element. For example, if we lived in a culture where lamp posts were worshiped as deities this might alter our clinical interpretation of the man who says the lamppost being unlit is grounds for the knowledge or belief that his wife is having an affair.

Whilst I have no doubt that *some* delusions are of this kind, not all are. One of my own clients had a history and diagnosis of depression and paranoid delusions although she was relatively well for the period that I was seeing her. She told me how she was brought up in a very strict and unloving family where she had to compete for attention, that she had been in a violent relationship for several years, then lived next to a very anti-social neighbour and that formal complaints about her situation and her housing problem had been written off by the local housing association and council because of her 'mental health issues'. She began to think that everyone she met was going to do her harm and she felt she needed to avoid contact with others and protect herself aggressively from any attention from others. It is no wonder she developed paranoid delusions. If the people around you really are doing you harm and the local authority that is meant to help you refuse to do so it is completely understandable that you would extend this idea to the wider population and behave accordingly. This is certainly understandable and might even be thought of as appropriately adaptive self-protective behaviour given her experience and her immediate environment.

Maybe Leeser and O'Donohue are also talking about differentiating between Jaspers' delusions and delusions 'proper' (above)? I suspect that their definition is only representative of a small sub-class of clinically significant delusions and that other classes of delusion may not fit with their stated phenomenology. I recognise that if this phenomenon is not satisfactorily defined in the first instance then there will inevitably be debate about what we should include or not include. If we are to take up Leeser and O'Donohue's definition then other abnormal beliefs which loosely meet the DSM criteria and are a bit like (but not exactly like) their definition of delusions and in some instances cause people to seek psychiatric help, will need another (separate) definition. Perhaps what they are saying is that there is more than one class of delusions and this class (the one characterised by their criteria) is the one they are interested in. Others, such as Mike Gorski, cite Jaspers' delusion proper as a separate kind of psychiatric phenomenon due to the fact that by (Jaspers') definition the *genesis* of the delusion is psychologically irreducible. This means that the psychic state that a person experiencing delusion has at the onset of her delusion, that is, the subjective feel of this experience is inaccessible to other (non-delusional) people (Gorski, 2012, p.100).

In other words 'delusion proper', which is incomprehensible, un-understandable (or impossible) and psychologically irreducible, should be termed 'delusion'. Everything else would be delusion-like belief and perhaps would need a different, separate definition.

Many delusions are difficult to understand but are not incomprehensible. Some features relating to delusion formation might, in some sense, be incomprehensible. My concern about a focus on incomprehensibility, impossibility and psychological irreducibility is that we might conclude that delusions with these properties are therefore meaningless. I think this is highly unlikely. If something is incomprehensible (in the sense that it takes the form of the lamppost example above and meets the criteria set out by Leeser and O'Donohue) it does not follow that it is meaningless. However, at the same time, I want to resist the temptation to *explain away* strange phenomenology by insisting that it *is* understandable. Perhaps there really are cases where elements of experience are un-understandable or psychologically irreducible.

Un-understandability, impossibility or incomprehensibility (appropriately defined) might be a real feature of some delusions (or as Jaspers would have it delusion-proper). In the lamppost example one could argue that it is not possible (in this world) that the lamppost being unlit is indicative of the man's wife's affair. Yet the content of his new belief might be an expression of the fear that his wife might leave him, and this is an understandable phenomenon. Its attachment to the sign of the unlit lamp is more difficult to understand and this might be psychologically irreducible¹⁷. As stated above, this is probably an example of a delusion that has a faith-like quality and is un-falsifiable. After all, if there is no reason to believe that the man's wife is having an affair

¹⁷ If we knew more about the context of the development of this delusion we might be able to say for certain whether it is psychologically irreducible.

(except his own experience *that it is true*) then there is no argument to be had about the reason – how can one argue with the ‘given’ knowledge received when seeing that the lamppost was unlit?

This may only turn out to be important if the statement made by the person (that his wife is having an affair because the fifth lamppost remains unlit) is granted belief status. We may demand some understandable explanation, reason or grounds for holding the belief. If the statement does not have belief status, understandable grounds or reasons may not be required. If, for example, it is a *feeling* which the subject cannot shake, or a future which the subject has often imagined, then different criteria may come into play. Perhaps a person can feel or imagine anything he chooses, even if that thing is not currently possible in the world in which he lives.

2.5.5 Amenable to Revision?

The current DSM definition is similar to Jaspers 1913 description of delusions regarding amenability to revision through evidence and counter argument.

Delusions are:

- 1) “...firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary...” (American Psychiatric Association, 2013, p.819)
- 2) “...held with extraordinary conviction... there is an imperviousness to other experiences and compelling counter arguments...” (Jaspers, 1997, p.195)

For Jaspers, delusions are impervious to experience and counter argument. The use of the word 'impervious' implies that counter argument is impossible and perhaps this means they are un-falsifiable (see section 2.5.4 above). The DSM 5 definition states that delusions are firmly sustained despite proof to the contrary. There might be differing degrees to which a belief may be 'firmly' sustained. Perhaps one delusion can be less firmly sustained than another.

2.5.5.1 One factor or Two?

In 1974, Brendan Maher challenged the accepted idea of the time that some paranoid delusions result as a consequence of an underlying thought disorder resulting in an inability to make reasonable inferences from information or data. He postulated that sensory input is distorted such that the evidence available to the subject is altered and this evidence is therefore powerful enough to resist counter arguments. He is very specific that, if this theory holds water, it is likely to only apply to a subset of delusional experiences. At the time of writing there was no strong evidence that the thought processes of people with delusions were any different from the ordinary population¹⁸. So, for Maher, the person employs ordinary cognitive processes to explain perceptual anomalies and this results in delusion. The person is no more rational or irrational than would be ordinary in the general population and there is no clinically significant cognitive deficit (Maher, 1974).

If the experience of a person provides or includes the evidence for a delusion and the experience is anomalous (outside more typical experience), then a

¹⁸ I say more about this in chapter 5, section 5.2.

third party cannot hope to fully grasp the person's explanation. These experiences are primary and have the irreducible quality of sensory experiences (Maher, 2003, p.18). Further, there is no point of intervention in any ordinary sense to dispute the subject's delusion. Addressing the apparent irrationality or implausibility of the delusion by, for example, presenting a person with counter evidence will be unlikely to have any impact. If Maher is correct then maybe this is a different class of delusion with perceptual 'grounds' (which are perhaps un-falsifiable) and requiring different treatment from delusions that have been developed over time due to readily understandable cognitive processes.

There is now neuro-scientific evidence that this kind of 'perceptual' explanation applies to the Cotard and the Capgras delusion (see table 1 above) (Ramachandran and Blakeslee, 1999)¹⁹. There is still, however, debate about whether perceptual anomaly alone is where the clinical significance lies in these (and perhaps other) delusions, or whether other cognitive anomalies are required as well. These two different ways of thinking about the 'cause' of delusion are usually described as the 'one factor' model (perceptual anomaly alone) (advocates include Gerrans, 2002; Vosgerau and Newen, 2007) and the two-factor model (perceptual anomaly plus cognitive deficit) (advocates include Coltheart, 2007; Davies et al., 2001).

I cannot say here whether delusions with different characteristics and different aetiologies respond differently to different therapies (although I think this

¹⁹ I say more about this in chapter 5, section 5.4.2

would be an interesting area for research), as we do not fully understand the phenomenology of the myriad of different kinds of delusions let alone their aetiology. However, whether delusions are formed through perceptual anomalies, cognitive anomalies or a combination of these and other factors (biological, psychological, environmental and/or affective), we do know that delusions are sometimes amenable to challenge. The understandable paranoid delusions of my client (as described in section 2.5.4 above) and the behaviour associated with them were improved by (among other things) examining the psychology of the formation of the problem and identifying people who were not trying to do her harm. Further, there is now evidence that some delusions respond to Cognitive Behavioural Therapy (CBT) and research is continuing in this area (see Hutton and Taylor, 2014; Williams et al., 2014).

Some delusions have faith-like qualities and are perhaps un-falsifiable in the sense that it is impossible to prove that they are not true (see section 2.5.4 above) and perhaps the Capgras delusion is of this kind. If the evidence of a person's experience (the absence of the sub-personal perceptual 'feel' of 'familiarity') tells a person that her husband is an imposter in the Capgras delusion then how is it possible to dis-prove this?²⁰ For example, if a woman who has the Capgras delusion and believes her husband is an imposter was shown evidence that he is her husband perhaps this would simply highlight

²⁰ One could argue that her delusion could be proved false through DNA testing but I suspect the person with Capgras delusion would cite DNA results as evidence of how good the replication is. Her evidence is a 'felt sense' that something is wrong, it is subjective and is not accessible to others.

what a good imposter he is. If she looked at photographs and discussed shared memories with him, yet she *knew* he was not her husband, she might simply think that he had prepared incredibly well for the role. Nothing about this kind of intervention directly alters her *direct subjective perceptual experience* in the presence of her husband. It is, of course, possible that she could come to understand that the ‘unfamiliarity’ of her husband was due to this anomalous perceptual response but she would need to employ cognitive effort to override the evidence of her direct subjective experience *every time* she interacted with her husband. The evidence she has (that her husband *does not seem familiar* even though he looks like her husband) is not available to others and a third party must use their imagination to grasp the difficulties that this subjective alteration in experience poses.

It seems that some delusions may be impervious to counter argument perhaps because they are un-falsifiable in the sense described above. Other delusions may be less firmly held and therefore open to revision through counter argument and other evidence. I propose that these characteristics – *intensity of belief* or degree of conviction and *amenability to revision through counter argument and evidence* are significant factors (as discussed in section 2.3.3). Further, a delusion might be described as *un-falsifiable* which may mean that amenability to revision by ordinary cognitive methods is impossible. Perhaps in this case novel alternative therapies might be required.

2.5.6 Interim Summary

I propose that where delusions are concerned we use the term 'impossible' (in preference to incomprehensible or un-understandable) and recognise that this is a feature of *some* delusions. A delusion with some impossible features (content, stated grounds for formation or both) can still retain meaning and it is incumbent on the researcher, clinician or therapist to explore any meaning the delusion might hold for a person. I also suggest that there is a close link between the *un-falsifiable* and the *impossible*. If the grounds for a delusion are impossible they are likely to be un-falsifiable. In the lamppost example, it is because the *grounds are impossible* that we cannot make a counter argument and this renders the delusion un-falsifiable.

Whether delusions are meaningful can only be established if we engage with the content, so a privileging of form over content (advocated in psychiatric texts such as DSM 5) is inappropriate. If the content of the delusion is ignored how will we know if it is meaningful (in the context of the subject's life history, environment, culture and personal psychology)?

Deciding whether someone requires treatment might be independent of the incorrectness/impossibility debate and properly hangs on distress and problems with functioning (as already mentioned above). However, the *kind* of treatment a person ultimately receives might be dependent on such distinctions. It might also depend on other characteristics and on the phenomenology prior to and relating to the onset of the experience. Perhaps *understandable mistaken beliefs* give rise to different kinds of delusions from

impossible beliefs. Maybe these are two separate subsets of what we ordinarily class as delusion. So beliefs where the content of the belief or the grounds for forming the belief are impossible might correspond to Jaspers' delusion-proper and some psychologically understandable mistaken beliefs are delusion-like beliefs and are *different* from delusion proper.

I suggest that we have here two distinct dimensions of delusion – *plausibility* and *impossibility*. The degree of likelihood or plausibility of a delusion might be a significant factor when trying to understand the severity of a delusion or perhaps trying to establish if it warrants attention from psychiatric services at all. A highly likely or plausible belief is unlikely to be classed as a delusion even if it is false. Impossible delusions might be of a different class.

2.5.7 Impossible to Define

In his paper *On the Impossibility of Defining Delusion*, Anthony David considers two vignettes to inform his writing. In these vignettes the two people have a similar onset of a kind of religious conversion. One goes on to have a normal life and the other goes on to attempt suicide as a response to 'voices' and attracts a diagnosis of chronic paranoid schizophrenia. David identifies possible ways of conceptualising delusion in order to attempt an explanation of the difference between the first scenario and the second (David, 1999). If we simply look at the external characteristics as compared with the (DSM 5) definition we cannot really distinguish between the two scenarios. Further, in this kind of scenario, it is possible that neither of the two subjects would seek nor would they attract psychiatric help until they were

experiencing serious problems. On the other hand, if they are both referred to a psychiatrist at the onset of the delusion, how would one decide if treatment were necessary?

David concludes that clinically significant delusion might not be definable:

“...delusions exist in a world of values, assumptions, prejudices, incorrect inferences, superstitions, wishful-thinking and paranoia... this is what makes delusions possible and also what makes them impossible to pin down.” (David, 1999, p.19).

We may need to include something about the history of the subject and the formation of the delusion in order to differentiate between clinically significant delusions and other delusions or strongly held beliefs. The cultural component of a working definition of delusion may be important but may also become less significant if other criteria are better defined and understood. Perhaps an understanding of the context in which a delusion develops and the history of the person experiencing it might give us grounds to recognise a delusion as problematic without the need for evaluating cultural normalcy. Notwithstanding the possibility of a better definition it still may be the case, as Tim Thornton puts it, that *tacit knowledge* is required and the details of what constitutes ‘problematic’ history and ‘problematic’ delusion formation and maintenance are part of the *body of skills* in medicine in general and therefore in psychiatric diagnosis which are *implicit* and *ineliminable* (Thornton, 2006).

2.6. Summary and Conclusion

I suggest that the dimensions discussed here might all be significant and should be considered when trying to understand a person's experience of delusion. When I embarked on this research, I thought that perhaps I would identify characteristics that are measurable in some way. Factors such as *degree of cultural normalcy* as well as the *degree to which a person's affect, history, upbringing, personality and recent environment* contribute to the *formation and maintenance* of the delusion all seem relevant. I now see these factors as intermeshed in ways that are not readily separable or measurable and that the phenomenological enquiry required to grasp what experiences might be significant in relation to delusion formation and maintenance is far from complete.

I suggest that a detailed phenomenology of a person's lived experience might give us a better understanding of delusion. If David and Thornton are correct then we cannot hope to define delusion comprehensively (David, 1999; Thornton, 2006). It is unlikely that we will be able to provide necessary and sufficient conditions for something to count as a delusion. Still, there are some important dimensions we might consider when trying to understand delusion.

Based on my exploration in this chapter I suggest that some noteworthy dimensions of clinically significant delusions could include:

- An attempt to explain or make sense of perceptual anomalies
- Degree of impairment to functioning

- Level of distress
- Degree of preoccupation
- Degree of Pervasiveness
- Plausibility or likelihood
- Impossibility (perhaps impossible delusions are a different class than plausible ones)
- Rationality and understandability (is the delusion understandable to a third party?)
- Degree of integration into other belief systems
- Degree to which the delusional influences behaviour
- Intensity or degree of conviction
- Amenability to revision through counter argument and evidence (if a delusion is described as un-falsifiable this may mean that amenability to revision by ordinary cognitive methods is impossible)
- Degree of cultural normalcy
- An understanding of the way in which a person's affect, history, upbringing, personality and recent environment contribute to the *formation* of the delusion
- An understanding of the way in which affect, history, upbringing, personality and recent environment contribute to the *maintenance* of the delusion

Whilst we can say that delusions share at least some characteristics with normal beliefs it has become increasingly clear that delusions are a

heterogeneous group having different dimensions and perhaps different aetiologies. It is clear that researchers would need to undertake detailed phenomenological enquiry in order to understand how these dimensions impact a person's experience and to perhaps identify similarities and differences between delusions.

I suggest that further phenomenological research is needed which focuses on the lived experience of the person experiencing delusion and thus might capture the dimensions listed (above) as well as other factors. Assessment based on pre-defined dimensions alone might mean we ignore important features of the experience. There may be other dimensions that are involved in delusion formation and maintenance and some might say these can be categorised and measured in order to understand the nature of delusion (see for example Garety and Hemsley, 2013). However, dimensions of delusions, once formed and stripped of context in relation to history and onset in particular might mean that we are missing vital factors about the experience. These factors might point out different 'classes' of delusion and help identify different therapeutic interventions as well as informing us with regard to further research and perhaps early intervention or even prevention.

In the next chapter I look at phenomenology and first person description in order to elucidate the importance of this approach.

CHAPTER 3 - PHENOMENOLOGY AND THE IMPORTANCE OF FIRST PERSON DESCRIPTION

3.1 Introduction

Saying what a delusion is by describing its external characteristics cannot capture the experience. Further, the ever-narrowing lexicon of signs and symptoms used in psychiatric diagnosis give an impoverished understanding of the delusional experience and thwart research and treatment. Philosophical and empirical enquiry might help remedy this. In this chapter I discuss the importance of first person descriptions and the methods we might use to capture data about the human experience in relation to delusion.

I will first look at how we understand ourselves and others through the language of folk psychology (section 3.2). Secondly, I will ask what is 'mental' about 'mental illness' and how this concept relates to expressions of subjective experience (section 3.3). I then consider how folk psychology and our understanding of mental illness relate to the developing science of the mind (section 3.4), the introduction of the bio-psycho-social model (section 3.5) and the decline of phenomenological enquiry (section 3.6). Finally, I suggest that a return to Jaspers' phenomenology can improve our

understanding of the delusional experience (section 3.7) and I summarise the chapter (section 3.8).

3.2 Folk Psychology and the Intentional Stance

In philosophy of mind the concept of folk psychology is used in a number of different ways. Here I use the term *folk psychology* to refer to those cognitive capacities that ordinary people endorse, including the assumption that others have a mental life (that others experience thoughts and feelings) as well as such capacities as the ability to predict and explain behaviour and the ability to infer mental experience (such as thoughts and feelings) from observable behaviour (Ravenscroft, 2016). When we use everyday folk psychological rules, we assume that a person is broadly speaking rational: that is, she acts and speaks with a degree of regularity and predictability. On this basis, a third party can then identify what another person's beliefs and desires might be, based on knowledge about her place in the world and her intentions and thus predict her rational goal-seeking behaviour. This is perhaps the most practically useful way of thinking about the behaviour and mental activity of a person.

Folk psychology does not always deliver accurate predictions of people's behaviour, but it is 'good enough' and makes mutual coordination and cooperation possible from a practical point of view. Things can go wrong, of course: a person may sometimes behave irrationally or unpredictably, we might base our prediction on incomplete knowledge of the other or the environment or some other influential factors may be neglected.

Notwithstanding the potential for error, this method of understanding others has huge predictive power.

In the next section I illustrate the practical utility of folk psychology using Daniel Dennett's notion of the *intentional stance*.

3.2.1 The Intentional Stance

Daniel Dennett illustrates how a Martian lacking in the skills of human folk psychology but with perfect physicalist knowledge of the world would be able to predict the closing balance of the Dow Jones in two days time using this knowledge. Processing physicalist knowledge means identifying every physical cause and effect pertaining to this situation at the level of atoms. This Martian would need to process vast amounts of information in order to make this prediction. The Martian would also inevitably recognise patterns in the world of human beings whereby infinitely complex and differing physicalist states and processes could give us the same behavioural outcome (e.g. a person could buy 500 shares in General Motors in any number of different ways). What Dennett highlights is that the Martian would need vastly more information than a human being uses to make these everyday predictions because he would not be able to use folk-psychological rules. The pattern emerging in people's behaviour can be understood in terms of Dennett's *intentional stance*. The intentional stance is an attitude we adopt when we want to understand and predict people's behaviour which relies on the assumption that people are rational. For instance, a person who wants to make money believes that buying shares in General Motors is desirable for

her purposes and, being rational, acts on her desire to make money by buying the shares. The exact way in which she does this, and all the physical underpinnings of this action, make no difference to the outcome. What is important here is that we see a real pattern in the world, which gives us great predictive power without needing to rely on the knowledge of the physical processes underlying people's behaviour (Dennett, 1989).

We can explain our hopes, desires, beliefs, and actions as well as how we are feeling or what we are thinking using (in most cases) everyday folk psychological language. Dennett's intentional stance shows us how the folk psychological notions of basic assumptions about rationality and knowledge of a person's goals (and perhaps how these might be guided by drives and feelings²¹) enable us to predict a person's behaviour. People usually (although not always) have explanations for their thoughts, feelings, and behaviour and feel they are able to predict their own behaviour. People can also predict the behaviour of others based on knowledge about the beliefs and desires of the other as well as being able to infer beliefs and desires of others from their behaviour. For example, we can predict that a person will buy a slice of carrot cake in a coffee shop if she has told us that her favourite cake is carrot cake. Conversely, we might infer that a person's favourite cake is carrot cake if we have observed the person buying carrot cake on a number of occasions. These predictions and explanations are readily understood and used by people in everyday interactions.

²¹ I will say more about this in chapters 5 and 8

I suggest that it is vital that we understand this kind of goal directed behaviour and sense or meaning-making as a basic attribute of human beings. It is this capacity that is sometimes called into question when people become mentally ill. In the next section I look at what is 'mental' about mental illness.

3.3 What is 'Mental' about Mental Illness?

In mental illness the problem lies with the mental. That is, any of the person-level or sub-personal processes involved in the psychology or cognition of the individual could be described as either not working as they ordinarily would do and/or interacting with the world in a way which is highly anomalous and/or distressing to the person. The mental is private in the sense that only I have direct access to my own mental activity. If I am mentally ill I might experience peculiar thoughts, feelings, or perceptual experiences that have a detrimental effect on my wellbeing (American Psychiatric Association, 2013, p.21).

When a person is psychologically distressed or when she experiences significant changes in her mental activity she might seek medical or psychiatric help or help might be sought on her behalf. Mental illness is something that is experienced at the personal level. A person lets us know (directly or indirectly) if she is mentally ill. That is, some people identify problems with their own mental activity and seek help as a result. Other people may not recognise or acknowledge their mental illness yet people around them (such as friends, family, healthcare workers, and others) recognise changes in their behaviour which can be conceptualised as changes in their mental life. We are only able to do this because we notice

that a person is no longer behaving in a relatively straightforwardly predictable way (as described in section 3.2).

There might be some underlying identifiable physical or biological causal contributions to some mental illnesses. However, discrete identifiable physical or biological causes, in most cases, have yet to be identified. In any case, physical or biological factors must be correlated with the mental experience in order to count as possible causal contributions. This is because it is the mental experience that lets a person know that there is a problem. It is only if the person has anomalous or peculiar underlying thoughts, feelings or perceptual experience that she is a candidate for a diagnosis of some kind of mental illness. There are a vast number of ways of being human and, as such, the things that make us mentally ill are not fixed in symptomatology. In order for an anomalous mental experience (or set of mental experiences) to be problematic clinical criteria must be met. As I have already mentioned in chapter 2, it is not possible to separate normal and pathological symptoms within diagnostic criteria and distress and disability such as impairment in social, occupational, or other important areas of functioning are used to establish whether a problem is clinically significant and, therefore, if a person is in need of treatment (American Psychiatric Association, 2013, p.21).

If we want to understand the way in which mental illness is experienced we must take peoples' descriptions of their own experiences seriously. This is because mental illness is manifest at the level of the *person* and (usually) relates to the perceived violation of epistemic, moral, emotional, or social

norms (Broome and Bortolotti, 2009; Banner, 2013). Brain anomalies alone tell us little about mental illness. If a benign tumour is identified in the brain it is described as benign because it is not growing and it has no effect on brain activity. If a tumour is found which is impeding an important brain activity then we will know that this is the case because the person is unable to perform this activity as they usually do. In order for any useful correlation (or causal contribution or link) to be identified we first need to know what the impediment is.

With regard to self-consciously experienced mental activity a person has subjective privilege to this and I discuss this in the next section.

3.3.1 Subjective Privilege

Whilst there might be observable objective signs and symptom indicating mental illness, person-level (as opposed to sub-personal) mental activity itself can only be directly accessed by the person experiencing it (aspects of it can only be inferred by a third party on the basis of observation and psychological tests)²².

What I mean here is that a person can introspect on her own mental activity and has the potential to identify aspects of that experience that may not be observable in other ways. For example, I might smile and behave kindly towards a person I despise for the sake of appearances or because I am

²² There are, of course, many processes that underpin person-level knowledge that are not accessible through introspection, they arise out of non-conscious process and are best understood through inference in relation to behaviour (for a detailed exploration of this see Wilson, 2002)

pursuing some particular goal that requires me to show kindness. In this case, the other person might not be aware of my feelings of contempt. It is possible that the person notices my micro-expressions (facial changes which might be associated with contempt) and senses that my behaviour is disingenuous. It is also possible that a third party notices this and identifies my real feelings. It is therefore possible for others to correctly infer aspects of my mental life through observation. But the complex thoughts and feelings that I have relating to this experience are only *directly* accessible to me. In this sense I have *privileged* access. I might have reasons (rational or otherwise) for not liking a person; I might have goal directed thoughts about moderating my behaviour; I might be in a particular mood; I might have memories about previous interactions with the person I despise. All of this information is directly available to me and is not available to anyone else unless I decide to share it. Some of this information (about my mental activity) might, of course, be *indirectly* available to others through inference relating to observable behaviour.

There is some sense in which I cannot make a mistake about how I experience myself (in the moment). I can, of course, have false beliefs about the experience as I can have false beliefs about the world, and I can change my mind about things. My moods, thoughts, and feelings have varying degrees of stability. I might, with hindsight or through further introspection, realise that I was mistaken about the person I despised. She then no longer seems despicable to me. I might even be incredulous that I felt that way.

None of this alters that fact that, at the (previous) time of introspection, I had the thoughts and feelings of contempt described above.

We can, of course, behave in ways that appear to contradict our stated beliefs and I discuss this in the next section.

3.3.2 Contradictions

There is some debate about whether a person is always correct about what her beliefs are. Problems arise when a person does not behave in accordance with her stated beliefs. In this case, a common sense folk psychological understanding might lead us to think that the person has made a mistake about her beliefs. This seems to counter my assertion that a person has *privileged direct* access to her mental life. For example, if I say that I believe in animal rights and wear leather shoes an observer might say that I am mistaken about my stated belief.

Another example of a case where we might dispute a person's stated beliefs relates to what is known as *implicit bias*. Implicit bias is a phenomenon where a person's stated belief might contradict her behaviour, perhaps only at the micro-behavioural level. For example a person who says she is not racist, sexist, or homophobic might respond to cues in the lab that demonstrate that she might feel negatively towards certain groups thus contradicting her stated beliefs. This is not an unusual or pathological phenomenon and evidence suggests that this kind of implicit bias is common in many populations (Nosek et al., 2007).

Where mental illness is concerned a paradigmatic example of this kind of observable contradiction relates to the phenomenon known as *double bookkeeping* (Sass, 2014). In some cases, people who appear to have avowed delusional beliefs do not act on them. For example, a person who seems (in some sense) to believe that staff on a psychiatric ward are trying to poison her still eats the food they give her. What is interesting here is not whether she is right or wrong about her beliefs but that they give observers cause to think that there is something unusual about her experience. She appears to sincerely state that she believes people are trying to poison her yet behaves as if she does not believe it (Gallagher, 2009).

The three cases described - the animal lover who wears leather, the implicitly racist, sexist or homophobic person who believes she is none of these things, and the person with delusions who does not act on her delusions lead us to question the nature of some mental activity and perhaps the nature of belief. This suggests that we need *both* third-party observations and first-person descriptions of mental life to understand what is happening in some cases.

In these kinds of cases there is more to say about the phenomenon and an in-depth phenomenological enquiry is required to better understand what is happening. If we undertake a detailed phenomenological enquiry, where we take what a person says seriously, we can discover or uncover what a person's mental life is like. Even if we ultimately conclude, for example, that their avowed beliefs are unstable we cannot reach this conclusion without first accepting their description of their experience and then observing how this

might contradict behaviour. For example, if a person says they are not angry but shouts and complains to her partner about the washing up then both parts of this scenario are interesting and important. She says she is not angry and behaves as if she is. The understanding of what is going on here can only be fully grasped if we take seriously the fact that she says she is not angry. Something about not being angry is important to her in ways that need exploration in order to be understood. If we take the stance that we simply dismiss her assertion (that she is not angry) as mistaken then we fail to understand the complexity of her mental experience.

3.3.3 Interim summary

If we are trying to understand what a person's experience is like it is safe to assume that she has some information that an observer does not have. What a person experiences, particularly if it is peculiar or bizarre is what highlights that there is a problem. There is no sense in which a person could be described as mentally ill if her mental activity was completely ordinary (although there might be marginal cases where it might be desirable to treat relatively ordinary mental activity resulting in mild depression or anxiety with some kind of therapeutic intervention). Provided a person is behaving normally and reports no unusual mental activity, even if we identified anomalies at the neuronal level, that is, if we looked at a person's brain structure and saw that it was highly unusual in some way, this would simply show us that degrees of neuronal 'difference' correlate with ordinary human functioning. What people tell us about what they believe or experience as

well as how they behave tells us when something is wrong. Unusual mental activity (usually) underpins unusual behaviour and a detailed understanding of what this is like can help us with research and therapeutic intervention.

A person's psychological life consists of perceptions, thoughts and emotions, the meaning the person gives to those experiences (more thoughts) and the way the person understands what these things represent at a conceptual level (more thoughts). Some of these experiences are readily translatable into mutually understandable language. Other experiences, such as some of those occurring in mental illness and relating to anomalous perception in particular, are perhaps less readily translatable²³.

In the next section I look at the developing science of the mind and how it relates to research in mental illness.

3.4 The Developing Science of the Mind

It is true that folk psychology has hardly begun to give us explanations or an understanding of many aspects of the human experience. We know little about the nature of sleep, mental illness, creative imagination, differences in intelligence among individuals, memory or our abilities with regard to how we negotiate our environment in all sorts of complex ways. We also make mistakes with regard to our folk psychological explanations. For example, we regularly make mistake about our own drives and desires – I might say I want a cup of coffee because I like the taste but a better explanation might be that I

²³ I will say more about this in this chapter, section 3.7.

am addicted to caffeine. We also make mistakes about our beliefs – I might say that I do not believe in God because I have examined the evidence and come to this conclusion but a better explanation might be that I was told from an early age that people who believe in God are a bit foolish or deluded. Our folk psychological explanations are also culturally dependent. For example an Indian woman might believe that she should (and therefore would) feel shame if she has been raped whereas a white British woman might believe that the person who raped her should feel shame and she should feel anger²⁴.

Paul Churchland would say that these problems (lack of progress, mistakes, and cultural dependency) as well as the seeming incommensurability with physical science show us that folk psychology is false and, although useful at times, it tells us nothing substantial about the human condition. If this is true then ultimately, through a paradigm shift, we will replace folk psychology with scientific explanations (Churchland, 1981). It is clear that if we assume that folk psychology is a valid theory about the human condition, there would be a huge amount of work to do. As the science of the mind develops some might claim that neuroscience is the scientific explanation for our psychological life. This leaves us with (at least) four questions: how might we expand or enrich our understanding of folk psychology; how might we correlate this understanding with neuroscience; is this kind of correlation even possible; and how this might relate to culture, context and environment. In the next section I

²⁴ This is recent change in British culture and it could be argued that women still (inappropriately) feel shame in relation to this experience.

briefly highlight how culture, context and environment might impact a person's experience.

3.4.1 Context, Culture and Environment

Culture can be understood in terms of an historically transmitted system of inherited concepts, meaning and expression used to develop, perpetuate and communicate knowledge in relation to attitudes toward life (Geertz, 1973, p.89). We are born into specific environments and respond to these environments in a context specific culturally patterned way. Because we *just do* have context, culture, and environment (and these are ineliminable from the human experience) folk psychology²⁵ understood in terms of context, culture and environment is the best way to account for the complexities of the human experience.

A person is born into an environment to which she must adapt in order to survive²⁶. For example, such basic capacities as language are learnt depending on the environment. A person born in the UK with Polish parents is likely to learn Polish and English from a young age and to be fluent in both – the basic capacity to communicate with those around her would be vital to her survival. A person born into a hunter-gatherer environment will develop know-how in relation to survival in this environment. Such capacities as identifying which plants in the environment are safe to eat and chasing, killing, gutting, skinning, cooking and eating animals would be part of this person's

²⁵ As research continues and our knowledge expands this may, of course, be an enriched or expanded version of what we currently understand by folk psychology.

²⁶ I will return to this in Chapter 7.

know-how. A person born into a developed Western environment will develop know-how in relation to the environment in which she finds herself. This might include capacities such as how to cross a busy road safely and an understanding of what the local currency is worth. There are many capacities a person must develop in order to survive and flourish in her environment. Environments can be small and diverse and include sub-cultures and families – two people in different families but in the same country might need similar capacities to negotiate some scenarios which relate to the country that they find themselves in. These same people might develop different capacities in order to negotiate other scenarios relating to their family or sub-culture. Thus the environment shapes us from the moment we are born and continues to shape us as we grow and move through our environment and as the environment changes around us. Human beings are incredibly flexible and can adapt and survive in diverse environments as well as actively shape the environment in complex and diverse ways in order to meet their needs (Wexler, 2006). However, as we will see in the next chapter and in chapter 8, radical changes to environment can sometimes present enormous challenges which are incredibly difficult to adapt to.

At the level of individual difference our environment and history have a huge impact on our capacities, mental life and ability to survive and flourish in new and diverse situations. The fact that we do not have folk psychological explanations for some of the complex mental activities that human beings experience and the fact that we sometimes make mistakes about our own motivations and potential behaviour as well as that of others does not mean

we should abandon the whole system. It simply means that we need to do more work to fill the gaps. So we might, over time, and as we find out more, revise some of our notions of what constitutes correct folk psychology.

One's experience of, say, being angry has a *phenomenal character* (Burwood et al., 1998) or 'raw feel' that can only be experienced subjectively. Some raw feel retains no matter how one labels it. If the taxonomy changes one might have something different to say about the 'raw feel' but one would still have a first-person subjective experience. This experience may have some kind of neuronal correlate. However, the neuronal correlate is not the raw feel in the same way that the atoms that make up the glass that I am drinking out of is not the glass. In this case I do not deny that my drinking vessel is made of glass and glass is predominately made from silicon dioxide. I am simply saying that, for the purposes of practical utility (i.e. using the glass to drink out of) the level of explanation required is not the chemical substance from which it is made. When one talks about, for example, anger all the other mental activity connected to this raw feel is also retained i.e. what one is angry about, how angry one is, how it affects one's mood, how this relates to one's other thoughts, feelings, actions etc. One might feel inclined to raise one's voice or punch someone or one might feel inclined to take action in some other way about a perceived injustice. One's mental and behavioural reaction to a situation is, to some extent, culturally and environmentally determined. It relates to a person's history and upbringing as well as to the environment she finds herself in at the time of expression. For example, a person might express her anger differently if she is surrounded by others who agree with

her stance (ie: that she is justified in feeling angry about a given situation) than she would if she was surrounded by people who did not agree. Knowing that one is in, say, 'brain process a' gives one no advantage. Bare decontextualized information about brain processes, neurons firing or adrenalin production increasing would not give us the right kind of information for therapeutic intervention either. In fact, it is impossible for me to write about neurons firing or hormones increasing without saying that they are firing in virtue of something. It would be nonsensical to talk about the physical attributes and responses of the brain without saying what they are responding to. The experiential descriptive component must exist in some form or another. I do not experience my brain processes, I have no direct access to what my brain is doing but I *just do* have subjective access to my experience. The angry person is angry *about something*. This is usually something tangible that is in the environment. Even if she is angry about, say, a *perceived* injustice (and is mistaken) we can still think of this in terms of anger *about* something outside herself. Her concept of what is just and unjust (in the world) is engaged and her expression of her feelings relates to the environment she finds herself in at the time of expression. Her response engages her capacities for know-how within her environment based on patterned responses developed (at least to some extent) in order to survive and flourish. Whilst it is true that we might develop a different taxonomy for our experience (a non-folk-psychological one) we would still need to say something about the experience in readily understandable language in order to continue our research into how these processes work and to develop

therapeutic intervention for those experiencing psychological distress. As Thomas Nagel puts it:

“...it’s a mystery how the true character of experiences could be revealed in the physical operation of that organism.” (Nagel, 1979, p.172).

Understanding, for example, function and behaviour tells us *something* about human beings and a third party can often say *something* about the mental activity of another person by observing her behaviour. However, third party observation *excludes* what is experiential and private or privileged. I suggest we need to consider all the factors that relate to an experience, including context, culture and environment, if we are to fully understand what that experience is like.

In the next section I look at recent history and how we have, theoretically, moved away from the biomedical model for illness towards the bio-psycho-social model.

3.5 The Bio-Psycho-Social Model

In 1977 George Engel proposed how we might use the bio-psycho-social model for medicine, arguing that the biomedical model was insufficient when dealing with people presenting with symptoms, distress or illness. *People* have illnesses and as such we should consider a person’s lived experience as well as any biological problems when managing patient care (Engel, 1977). He elaborates further on appropriate training and education for clinicians in

terms of components that can be considered separately in their own right and which are also components of the larger system and are connected hierarchically. So molecules, cells, tissue, nervous systems, organs, people, families and community can each be understood in their own right. In addition each feeds into the other in the hierarchical order specified and can be studied or understood at different levels (Engel, 1981). We have yet to see a full integration of this kind of model into healthcare (Kontos, 2011). And I further suggest that this model does not go far enough²⁷.

Engels' critics argue that the model is too vague and, until we are able to explain how illness emerges from the complex connectivity between the biological, the psychological and the social, we should stick with what we know (Guze, 1989). Others say that, as medicine is heterogeneous, no one model can account for all of medicine and that includes the biopsychosocial model (Kontos, 2011). Reductionist approaches, such as biological disease models, are compelling because they simplify understanding and enable targeted treatment. So, if we believe that schizophrenia is a disease with a biological cause (notwithstanding that we have yet to find a biological aetiology) then, in theory, we can treat this disease using biomedical means. Yet if the reductionist approach is false – perhaps there is no circumscribed biological aetiology - then we thwart our ability to research, understand and treat people who have this diagnosis. If we fail to acknowledge the possibility

²⁷ Engels suggests a hierarchy that ignores the intermeshed nature of these factors and the possibility of feedback and feedforward loops and I will say more about this in chapter 7.

of other (psycho-social) causal contributions we will only be looking for biomedical causes and identifying biomedical interventions.

If we truly grasp and understand that a person's experience is created through her lived experience, history, meaning and environment we might be better able to grasp both preventative methods as well as truly bio-psycho-social interventions with regard to mental illness. This is not a new idea. People know that they are in process responding to their environment (although I feel sure that they would not use a philosopher's terminology in this regard). This kind of multi-factor approach is illustrated in Peter Chadwick's first person description of recovery from psychosis. He makes meaning from his history and experiences and realises that a number of factors have brought about and are maintaining the cognitive process that we call psychosis (again this is not his terminology, this is mine). For Chadwick personal recovery includes medication, cognitive and psychodynamic insights and a change of environment (Chadwick, 2006). If people experiencing psychosis, and indeed ordinary lay people with no experience of mental illness and no medical expertise understand experience in this way (as relating to their history, experience and personal psychology as well as their physiology) why do we not fully incorporate this kind of investigation into our research and understanding of mental illness?

I suggest that we can begin to understand how these things are inter-related using the enactive approach and by recognising that a person is embodied and embedded in a changing environment to which she must respond²⁸.

I now look at the decline of phenomenological enquiry and the impact that this has had in psychiatry.

3.6 The Decline of Phenomenological Enquiry

Here I define *phenomenological enquiry* as relating to all aspects of a person's lived experience. The version of phenomenology that I am interested in relates to the entirety of the experience. This includes embodied perception, thoughts (including meaning) and affect (and the structure of these) as well as context, culture, history, and environment. These aspects of experience cannot be examined in isolation and we are in danger of missing vital information about the experience as well as the onset and maintenance of mental illness if we ignore any of these aspects. I accept that this makes the enquiry messy and complex – but this is the reality of the person's lived experience. If one isolates aspects of an experience for the purposes of simplicity or clarity one loses important contextual information about the experience. Nevertheless this is what has happened over the last century. This has long been a recognised problem in psychiatry. It is not easy (perhaps not even possible) to reconcile the objective and subjective. It might be useful to have a detailed understanding of the kinds of experiences or symptoms that are problematic and that lead to psychiatric illness, however

²⁸ I expand on this in chapter 7

we should not do this at the expense of recognising the person *as a person*. A person cannot be treated as an object for science or biology, and psychiatric enquiry must relate to the “being of a man as a whole” (Binswanger, 1975, p.211).

I suggest that Jaspers’ phenomenology is the kind of method we require to examine the experience of mental illness as it encompasses all the features that relate to a person’s lived experience. This kind of detailed descriptive account of a person’s experience is no longer sought in the psychiatric interview. Further, research is often focused on diagnostic groups which are heterogeneous in nature and are determined by ever narrower symptom ranges.

In his article on the use of phenomenology in psychopathology Paul Mullen notes that Bleuler’s phenomenology of the schizophrenias had 95 possible symptoms, Kraepelin used 75 and DSM IV has 30 (Ungvari and Tang in Mullen, 2007). The current DSM (DSM 5) lists just five key features, namely: delusion, hallucination, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia) and negative symptoms (American Psychiatric Association, 2013, p.87). If we use restrictive questionnaires to elicit answers to questions about symptoms which meet DSM 5 criteria we have created a limiting tool with no possibility for understanding the full experience of the individual. Further, we cannot capture, describe, or research subtle similarities or differences.

So we have a problem:

“The descriptive psychopathology of Jaspers has gradually been transformed into a caricature which has substituted authority for enquiry and simplification for subtlety.” (Mullen, 2007, p.113).

In 1912 Jaspers commented on the decline of phenomenological enquiry in favour of general symptom categories (Jaspers, 1968). Unfortunately his warning went unheeded. We are (still) in danger of losing our understanding of the lived experience of a person who has sought psychiatric help and thus we are also in danger of losing our ability to help him or her in any meaningful way.

As Nancy Andreasen, a member of the DSM III and IV task force, puts it in her paper on the decline of phenomenology: DSM criteria were intended as the minimum requirement for a diagnosis, they were never intended to be comprehensive. The requirement to use DSM symptom checklists is an integral part of psychiatric training in the US and this takes precedence over other methods of enquiry. Taking a detailed history of an individual patient experience has all but disappeared and psychiatrists are not encouraged to get to know their patients. Validity has been sacrificed for reliability. So, clinicians might all arrive at the same diagnosis based on a limited checklist of symptoms but the meaningfulness of the diagnosis might be lost as we are working with extremely narrow constructs. This might also mean that we can only undertake research based on these constructs thus excluding or denying features of psychological distress that are outside these diagnostic limits (Andreasen, 2007).

Nassir Ghaemi calls for a return to phenomenology highlighting the ‘mixed’ nature of various disorders and citing the use of the DSM checklist as contributing to oversimplification (Ghaemi, 2007). Giovanni Stanghellini has written about how the standard approach of diagnosis by diagnostic schema may be impeding the evolution of psychiatric knowledge. Observation and documentation of signs and symptoms that meet diagnostic criteria might mean that other peculiar or abnormal phenomena may go unnoticed. A structured diagnostic interview might fragment personal experience, assume shared meanings between interviewer and interviewee, suppress the interviewee’s narrative and, falsely, give the impression of a ‘neutral’ interaction (Stanghellini, 2013). There are other consequences to the decline in full phenomenological enquiry with regard to treatment. People often feel that psychiatrists are not listening to them (Chadwick, 1997). This is an *epistemic injustice* (Fricker, 2007) – it is an ethical harm that does an injustice to the person by undervaluing the knowledge that he or she has about their own experience²⁹.

Where the narrative of a person’s experience is replaced by diagnostic categories, medication and what Femi Oyebode calls the ‘rituals’ of psychiatry:

“...wards are still permeated and characterised by a lack of respect for patients; a subtle coercive atmosphere still presides.... unreflective and

²⁹ I will say more about this in 4, section 4.4.1

inhumane indifference to anguish can still be observed.” (Oyebode, 2003, p.268).

Concerns about how a person is treated and the way in which science can objectify are not new, as Ludwig Binswanger puts it:

“For as soon as I objectify my fellow man, as soon as I objectify his subjectivity, he is no longer my fellow man...” (Binswanger, 1975, p.210).

In their paper on the psychiatric interview Julie Nordgaard and colleagues express the worry that:

“...there is an implicit assumption that symptoms exist as ready made, pre-defined mental objects... the structured interview pre-defines what counts as information.” (Nordgaard et al., 2012, p.4).

They conclude:

“We need a methodological approach that is faithful to (mental or experiential) reality rather than an approach that implicitly distorts this reality in order to make it fit to its own prejudice. Faithfully to assess another person’s anomalies of experience, belief, expression, and behavior (the second-person perspective), adds certain specific demands to our clinical skills and analytic-conceptual knowledge, constituting psychiatry also as an academic and scholarly endeavor, while at the same time providing solid foundations for achieving empirical objectivity.” (Nordgaard et al., 2012, p.362).

In summary, as we have seen (above) the reduction of psychiatric assessment to 'signs and symptoms' prevents us from understanding the full experience of the person in distress. It makes it more likely that we will objectify a person and assume that those with the same diagnosis have similar experience. This in turn leads to a 'one size fits all' approach to therapeutic intervention. It also means that we may undertake research on diverse heterogeneous groups (based on diagnosis) that will be less likely to give us meaningful outcomes. If, for example, we give the same drug to a group of people that have the same diagnosis it is possible that different people within that group might have different symptoms (and certain that they have different overall experiences). Even if we were to narrow pharmacological intervention to patient groups with the same symptom we might find that at symptom level our understanding is still not fine grained enough.

If we assume that the experience of those that have delusions is 'the same' in some important way we might try to identify neuronal correlates or anomalies for the delusional experience. This might mean we make mistakes and correlate perceived 'patterns' in neuronal activity that do not really relate to the phenomenon we are trying to understand. If there are delusional experiences that are actually different in significant ways that have not been fully understood then the clinician's attempt at mapping the neural correlates for an experience will be too broad brush and they will fail in identifying anything significant. If we understand the differences between people's

experiences we might find out something more accurate and useful at the neuronal level.

This problem also applies to pharmacological and other therapeutic interventions. If, for example, one's delusion includes a strong sense of alienation from one's body then a bodily/physical therapy might be indicated (e.g. yoga). If one's delusion carries no such sense of bodily alienation then therapeutic yoga would not be indicated. I am, of course, speculating about the kinds of interventions that might be helpful as this is an empirical question. Ultimately, the point that I am making is that unless we attempt a more fine-grained approach to understanding the experience of those with mental illnesses we cannot say what, if any, the important differences and similarities might be. And if we do not have the right kind of information about people's experiences we limit our opportunities of developing novel and appropriate therapeutic interventions. Of course we might find out that broad symptoms and/or diagnoses can provide useful neural correlates or identifiable genetic or other biological markers but as we have so far *failed to find these correlates* I suggest a new approach is required. There is some evidence that we can differentiate between sub-types of depression which respond to different therapeutic intervention (Drysdale et al., 2017). However, this whole area has been neglected *because* of the ways in which diagnosis and treatment has been oversimplified (as described above) in the last several decades.

I now turn to some exploration of phenomenological approaches to the understanding of another person. I do this by returning to Jaspers who was writing at the beginning of the last century before the decline in phenomenological enquiry.

Whilst Jaspers doesn't specifically write about the ineffability of the experience of the other he does recognise the translation problem that we might have when trying to understand the experience of another who has a diagnosable mental illness. This is particularly noticeable when a person's experiences are radically different from the usual (more typical) human experience. People sometimes find these experiences impossible to explain to others particularly where the normal unity of conscious (human) experience is compromised.

3.7 Jaspers' Phenomenology

In some mental illnesses, such as psychosis, there is an assumption that a person's experience cannot be communicated or that any attempt at communication is unreliable. I suspect that this assumption thwarts research. Whilst it is true that some people's experience is very different from the experience of others, this does not mean that it is beyond the realms of understanding.

A full phenomenological enquiry is the best way to capture all the relevant factors that make up experience. It can help us appreciate the form or structure of the delusional experience, that is, the way in which it is manifest

in terms of how it is experienced. This might include anomalous self-experiences which are difficult to articulate. It also gives us an understanding of any meaningful content the delusion might have in relation to a person's history, personality, culture and values. Phenomenological enquiry tells us about the genesis of the delusion, that is, the context in which it arises and how this is experienced. It might also tell us what factors contribute to the maintenance of the delusion. In Jaspers terminology we can gain information about the *Form* and *Content* of the delusion and the *Meaningful* and *Causal* connections relating to that delusion. We also might gain an *Understanding* and/or *Explanation* of the delusion, identify *Objective* and *Subjective* characteristics and identify *Genetic* and *Static* features of the delusion (Jaspers, 1968). In the next three sections I briefly explain these terms.

3.7.1 Features of Experience

In his attempt to document the different kinds of mental disorders Jaspers distinguishes between *Form* and *Content*, *Meaningful* and *Causal* connections, *Understanding* and *Explanation* and between *Objective* and *Subjective* phenomena (Jaspers, 1968). For the purposes of context, I will briefly describe what he means by these terms using examples.

If I insist that I am the Queen of England then (assuming I am not the Queen of England) the *form* of this thought is delusional (because it meets Jaspers' criteria; loosely – it is a false belief, held with conviction, and immune to counter-evidence) and the *content* is that *I am the Queen*. If I am refusing to get out of bed and crying all the time because my husband has died this is

both *meaningful* and *understandable*. In this case there is a reason for my reaction that can be understood by other people. This reason is understood in narrative terms – I have a meaningful history with my husband and his death constitutes a loss that engenders sadness.³⁰ If I am refusing to get out of bed and crying all the time for no reason that I or others can intuit based on recent events, however, subsequent investigations show a tumour on my thyroid which, when treated brings about symptom reduction, then this is both a *cause* and an *explanation*. If I am crying and refuse to get out of bed where no meaningful or understandable reason can be found then Jaspers *assumes* a causal explanation (Jaspers, 1997, p.606). This does not mean, however, that a causal explanation *will* be found. In the above example recent psychiatry might suggest the ‘cause’ is low serotonin and would probably treat with Selective Serotonin Reuptake Inhibitors (SSRIs)³¹. Jaspers’ investigation of subjective phenomena is of particular interest as his empathic method is intended to enable the translation of the subjective into mutually understandable language. This method is used to illuminate the bizarre and unusual aspects of a person’s experience and, as such, might help us to see what constitutes what is clinically significant about these illnesses.

3.7.2 Objective and Subjective Features

For Jaspers, objective symptoms include observable phenomena such as conduct, appearance, reflexes, capacities such as memory and cognitive

³⁰ I will say more about this in chapter 4

³¹This causal explanation is by no means agreed upon although clinicians and the general public behave as if this is a known cause (for a critique see Kirsch, 2009)

ability as well as the rational content of communication including, for example, the content of a patient's delusional thought (e.g. I am the Queen of England). Subjective symptoms relate to the *form* of a disorder and include inner processes such as emotions, which the patient does not articulate straightforwardly as well as other mental processes which are outside the scope of ordinary (more typical) experiencing and relate to the *way in which something is experienced*. Some of these experiences are not therefore easily describable in ordinary language. Furthermore they are (usually) outside the scope of a researcher's experience and perhaps outside the scope of the researcher's imagination. This might mean that this kind of experience is easily dismissed and it is assumed that the patient is an unreliable witness to her own experience. For Jaspers, subjective phenomena can only truly be perceived 'subjectively' through empathy. This might include, for example, the clinician's detailed 'grasping' or 'immersive' experience of a feeling of dread experienced by a patient. It might also include a 'grasping' of the difference between reality, mental imagery and, say, hallucinations experienced by the patient (Jaspers, 1968).

3.7.3 Genetic and Static Features

Jaspers differentiates between the genesis of the patient's experience (the events, thoughts, ideas and feelings leading to what he calls the pathological experience) and the experience itself. He uses the term 'genetic understanding' to describe the clinician's knowledge of the former and 'static understanding' to describe her knowledge of the latter. In this latter category

there are three groups of phenomena: those known to us from our own experience; those that are extremes of everyday experiences (and thus can be grasped relatively straightforwardly through the imagination) and; those that are inaccessible through empathic understanding (because they are not ordinary (more typical) human experiences) and can only be better understood (although never fully grasped) through metaphor and analogy (Jaspers, 1968).

Jaspers is not clear about the distinction between some of the objective phenomena and some of the subjective phenomena. Both involve elements described by the patient. However the difference between the objective *symptoms* described by the patient (including those to do with emotions and other mental process) are those that are readily understood by both the patient and other people and the *subjective symptoms* (which might also be partly understood through information articulated by the patient) are *not readily understood*. They are not 'rational' in the sense that they are not directly understandable by others. They are outside the everyday experience of the investigator and as such require careful, phenomenological exploration. Whilst we can never fully grasp these bizarre experiences, Jaspers suggests that by careful empathic phenomenological enquiry and perhaps by the use of metaphor we can increase our knowledge of the mental phenomena involved in illness (Jaspers, 1968).

For Jaspers, objective investigation leads

“...quite systematically to the elimination of everything that can be said to be called mental or psychic.” (Jaspers, 1968, p.1314).

Whereas his phenomenological method, which employs subjective psychology leads to a different kind of knowledge which:

“...aims at the final realization of the concepts and ideas which form the inner representation of psychic process...”(Jaspers, 1968, p.1314).

I notice that he says that this method *aims at* the realisation of inner mental process. There is a recognition here by Jaspers that whilst this method gives us more information about the patient's particular experience it is not definitive, it does not (and cannot) give us full knowledge of the experience of the other. Any explanation of a person's experience necessarily abandons the subjective. A person's explanation of her own experience is just that – an explanation – it is not the experience itself. A third party can explain the experience of another in mutually understandable language but something is always lost. Descriptions are not experiences. Still, we can attempt to get as close an understanding as possible using Jaspers' phenomenology.

I now turn to the notion of empathy and how it might be used to gain new knowledge about experience.

3.7.4 Empathy

For Jaspers the mental experiences (the psychic life) of the patient cannot be understood purely through objective observation and measurement. He believes that his empathic phenomenological method can be used to identify

the vast array of possible mental experience, expand the taxonomy and make a richer, more diverse, and more accurate source for diagnosis. He recognises the difficulty in this undertaking as it is not usual for a person to consider a mental phenomenon in isolation yet it is this that he is suggesting we can do using his phenomenology. He also acknowledges that any empathic experience an investigator might have is useless from a scientific point of view and must be translated into communicable knowledge (Jaspers, 1968). Phenomenological enquiry involves the bracketing of assumptions or a formal suspension or epoché (Husserl in Moran, 2000). This means that the researcher must not allow her own experience and assumptions to influence the collection of data. Jaspers (like Husserl) believes that this whole process must be undertaken without contamination from the investigator's psyche and must accurately represent the conscious experience of the patient. The investigator improves her skill at the phenomenological approach through repetitious effort and attention to elimination of prejudices. She immerses herself in the world of the patient, through direct apprehension ('grasping' or 'actualizing') of the patient's world and through fine-grained questioning and reading first person descriptions by patients of their mental experiences (Jaspers, 1968).

Of course we have an immediate contradiction here. Jaspers and Husserl are suggesting that one can 'bracket' one's own experience and assumptions to provide an uncontaminated view of the experience of the other. Yet if there is no shared 'humanness' and language any understanding would be impossible. It is impossible for me to abstract myself from my embodied,

embedded, inculturated 'humanness' – in fact one needs one's humanness in order to attempt any kind of phenomenological enquiry into another's experience. At the same time it is incumbent on the researcher to be mindful of personal assumptions that might hinder the enquiry. This bracketing process is an aspiration and is not truly possible (Merleau-Ponty in Moran, 2000), yet an attempt must be made to see the experience of the other as it presents itself and as it is experienced by the other. One can always gain *some* understanding of another's experience through gathering the right kind of information in the right way.

Empathy and the ability to see another's point of view or to put one's self in 'someone else's shoes' can be used to better understand the experience of another. There is something in the notion of empathy which most of us experience to some extent in the context of every day situations that does seem to tell us *something* about the other. For example, if my partner comes home from work, throws his papers down on the kitchen work surface, fills the kettle and slams it down I might surmise that he is angry or annoyed about something. If I ask him about it he might say he has been asked to do more admin. I already know that he hates admin. It's easy for me to understand that a person who hates admin might be angry about being asked to do more of it. I might bring some assumptions to this interaction – for example, I would assume that he is rational and that his experience of the world has something in common with mine. I would probably be very surprised if he was angry with the kettle – this would not make sense to me. However in order to attempt a truly uncontaminated empathy (uncontaminated by my assumptions) I would

need to bracket any such assumptions about whether he may or may not be angry with the kettle (maybe he has a delusion that all kettles are 'out to get him' and this kettle caused him to be late for work). I would also need to recognise that the fact that I love admin is not relevant here. There would be no point me saying '...yes but admin is fun, you are making a mistake, get over it...'. This would lack empathy. I am seeing the 'problem' from my point of view, not his. In short, I have not 'bracketed' off my worldview. Being empathic becomes increasingly more difficult the farther a person's experience is from other similar mental phenomena ordinarily experienced by the empathiser.

To empathise with someone is to 'feel' what it is to be in her shoes. This in turn provides additional information about the experience of the other (information outside the overt observable signs and symptoms and outside what the other has communicated verbally) which increases the researcher's understanding of a person's experience.

If I am successfully able to communicate my empathy in language in a way that is understandable and recognisable as empathic to the other then this might constitute a new 'objective' feature of her experience. I am avoiding the word 'interpretation' here which is problematic to me. I do not want to interpret the experience of the other – I want to *attempt* to capture it – I can only do this if it is recognised as true or real by the other. If I am 'interpreting' perhaps I am translating her experience to something that she no longer recognises. Whilst it will always be the case that something is lost in this

process, the endeavour must be collaborative and the outcome must be understandable to both parties. This kind of researcher engagement with another is difficult and time consuming and is rarely undertaken.

There are a wide variety of ways of being human. We all have different experiences and, as Havi Carel puts it:

“Overall, there is no consensus on what the experience of illness is like, if it is like anything at all.” (Carel, 2012, p.99).

A ‘phenomenological toolkit’ might be required in order to change our approach to understanding mental illness. This would aim at making the phenomenological reduction possible for those experiencing all kinds of illnesses. Instead of looking at behaviour, symptoms, diagnostic categories or notional causes we ask the person *what her experience is like*.

“Phenomenology offers a step back from conventional understandings of illness and offers an opportunity for a genuinely unconstrained examination of illness.” (Carel, 2012, p.100).

Empathy is a kind of fellow feeling in which the empathiser has an affective or emotional response similar to the person she is empathising with, which stems from taking the perspective of that other person³². I endorse a version of empathy much like that favoured by psychologists Tracy Spinrad and

³² Other sub-personal mechanisms that make this possible might include mirror neurons (Gallese, 2005), facial mimicry (Ekman, 2003) and non-verbal vocalisations (Sauter et al., 2010) along with other (familiar, culturally learned) cues like the tone of a person’s voice and her body language (Harré and Parrott, 1996).

Nancy Eisenberg because if it is true and we *can* 'feel in to' the experience of another then this can give us *new knowledge* about the experience of the other. This *adds* to what a person can tell us directly and what we can observe objectively.

"Empathy is defined as an affective response which stems from the apprehension or comprehension of another's emotional state or condition and is very similar or the same as what another person feels or would be expected to feel." (Spinrad and Eisenberg, 2014, p.61).

I do not agree, however, that empathy lets one experience 'the same' emotion that another would feel because the empathiser's experience is always 'at one remove' from the other's experience. As Carl Rogers puts it the empathiser is alongside the other 'feeling in to' her experience as if she were in her shoes yet always retaining the 'as if' quality (Rogers, 1961, p.284). Martha Nussbaum describes this as requiring

"...a participatory enactment of the situation of the sufferer, but is always combined with the awareness that one is not in oneself the sufferer." (Nussbaum, 2001, p.327).

In summary, as we have seen (above) empathy is affective in nature (the empathiser *feels* something) and has enough of the appropriate features of the emotion (or affective response) that the other is experiencing (or would be experiencing) for it to be recognisable to the empathiser. Of course this is not an error free endeavour - we can make mistakes. One might feel sad in the presence of another's sadness without recognising this as their sadness or

one might feel sad coincidentally about something else. In research empathy must be experienced, understood and articulated in a way that is understandable to the person with whom the researcher is empathising. This is one way in which new knowledge can be gained.

3.7.4.1 Everyday Experience

Consider the person living in England who comes from a different culture. Whilst one cannot have immediate uneducated access to this person's world-view it is likely that with enough of the right kind of information this could be easily remedied. Recently a client of mine from South Africa told me about her daily experience of fear of violence before moving to England. Whilst this danger of violence existed for her throughout her formative years and some of her adult years she is no longer in the same kind of danger in this country. Her highly attuned attitude to personal safety and concern about loss of property seems strange to her (English) peers and they sense that she is over-reacting or perhaps 'paranoid' (in the folk psychological sense as opposed to the psychopathological sense). It is straightforward (obvious even) that most people, with this history, background and upbringing, would have developed a degree of hyper-vigilance in relation to personal safety. One need only use one's imagination to understand her position. This applies to human experience in general and it is why we are able to use phenomenology to study the experience of others. The *way in which* this person experiences her fear or hyper-vigilance can be understood subjectively to some extent by 'feeling into' her experience using empathy. If

the empathiser then articulates this feeling this might count as new knowledge.

This might fall into Jaspers 'second' kind of phenomenon (as mentioned above in section 3.7.3), i.e. an extreme version of an ordinarily 'understandable' human trait. It is true to say that one can never experience *exactly* what another experiences due to the complexity and diversity of the individual lived experience. However, this does not mean that the subjective experience is closed to others. In fact, given enough of the right kind of information about the other, it becomes obvious what her experience is like and what it might mean to her. This is a very straightforward example of how one can use empathy to understand another.

3.7.4.2 Bizarre or Anomalous Experience

Although more challenging than this everyday example, one can extend the use of this method to understand much more complex and bizarre experiences. I, like Jaspers, believe that this method can increase our understanding of anomalous mental experiences and the researcher can use this understanding to inform further research and therapeutic intervention. Jaspers denies that we can fully empathise with people who have anomalous experiences and describes them as un-understandable, yet he does think we can gain some knowledge of these experiences by paying careful attention to what people say and by using metaphor and analogy. People often struggle to explain their peculiar experiences and find that they sometimes do not have the language to describe them. They might persist in the struggle or they

might employ metaphor or analogy to try and get the experience across.³³ I disagree with Jaspers and believe that we can, to some extent, 'feel into' bizarre and anomalous experiences. What I mean here is that, whilst we might not be able to fully 'feel into' the anomalous experience of, for example, ideas of reference (where things in the environment stand out and seem personally important or salient), we might be able to imagine what it is like to experience things in the environment taking on an unusual significance or importance that can be overwhelming and that demands explanation. A significance that draws a person in and that cannot be accounted for by recourse to ordinary language or everyday experience. We might be able to use our imagination to get some sense of what it might be like to feel other intense, peculiar or anomalous experiences given the right kind of descriptive or metaphorical information. Further, I suggest that, whether it is truly possible or not the attempt should still be made. We cannot hope to gain knowledge about a person's experience unless we attempt to do so employing the tools available to us. This should include an attempt to empathise.

In uncovering the meaning and nature of a person's experience we transcend the 'subjective' and embrace the phenomenal. The meaning, explanation, and nature of the experience of the other is a public process which involves language. This is not *the same* as the subjective experience (which is not possible using this method). Instead we have the best communicable approximation *about* what it is like to experience what another has

³³ We see examples of this in chapter 4.

experienced. The potential to understand all human experience can be conceptualised in this way. This would even be true in the case of, say, the psychopath. If we take the metaphors seriously that the psychopath uses to describe herself in the world, for example that she is a predator and others are prey or that she is a cat in a world of mice (Hare, 1999) we can understand that she does not empathise with others (that is, does not have fellow-feeling for other human beings and cannot *feel into* the experience of other human beings, they do not even seem to her to be the same species as she is) then her goal seeking behaviour, devoid of consideration of other human beings becomes understandable. Again, whilst it is difficult to understand, we can use our imagination about what it might be like to simply not see other people as being *like us*, and the difference that this might make to our lived experience. The attempt to gain an objective understanding of the other can only be achieved by taking her description of her experience seriously. I suggest that this is essential when trying to understand the human condition in general as well as those in psychological distress and those who have diagnoses of various mental illnesses.

3.7.5 Philosophical and Psychological Phenomenology

Philosophical phenomenology is usually associated with such aspects as agency, ownership, embodiment, temporality, spatiality, intentionality and self-awareness. Psychological phenomenological enquiry usually concerns itself with thoughts, emotions and meaning. I suggest that a full understanding of a person's experience must include both philosophical and psychological

phenomenology. Jaspers would agree with this (although he uses different terminology). Further, in the pursuit of understanding the more anomalous experiences one might employ Jaspers' empathic method (as described above) in an attempt at 'gaspings' a person's metaphorical or analogous explanations in ways that give us a greater understanding of the altered structure of her experience

Phenomenological enquiry relating to the structure of experience (or, in Jaspers' terms the *form* of the experience) can give us information that informs neuroscience. If one wants to understand the ways in which brain processes are altered in relation to anomalous experiences associated with mental illnesses one needs to understand what the anomalous experiences are. The structures of experience exposed by this kind of enquiry might tell us something important about the experience of the components of background reality that we take for granted. As Matthew Ratcliffe notes in his article on the indispensability of phenomenology first person description often tells us something important about the structure of experience. For example features such as a sense of loss of practical possibilities or potential in people with depression might be closely associated with alterations in the experience of time. A pervading feeling of dread or anxiety might be described as an alteration in a background sense of belonging to the world, so too might a sense of fading, ghostliness or even the sense that one might be dead. The sense of alienation from one's body or of intense physical pain throughout one's body might best be described as an alteration in the (ordinarily) 'given' nature of embodiment (Ratcliffe, 2009). In the experience of delusions in

general a transformation of the total awareness of reality is implied (Jaspers, 1997). For example, in the delusion of *thought insertion*³⁴ the experience might be described as an alteration in the experience of agency and ownership of thought (Bortolotti and Broome, 2009; Gunn, 2016b). In the experience of schizophrenia a pervading sense of disconnection from the world might be described as an alteration in one's sense of self (Parnas and Sass, 2001). In the Cotard delusion a person who says he is dead might be described as having an altered sense of relationship to his body (Gerrans, 2002). I do not mean to endorse any of these notions - I am agnostic in this regard. I merely mean to point out that a phenomenological enquiry into the structure of an experience (or what Jaspers' would call the *form of an experience*) might yield important information that can inform neuroscience and therapeutic intervention. I suggest that these kinds of experiences are those that Jaspers would describe as inaccessible through empathic understanding (because they are not ordinary (more typical) human experiences) and can only be better understood (although never fully grasped) through metaphor and analogy (Jaspers, 1968). Whilst I agree with Jaspers that metaphor and analogy are required when exploring these experiences I am not sure that I agree that we cannot empathise as part of a shared understanding of the experience. Identifying changes in the structure of experience is just part of what is required to understand what it is like for a person who has a mental illness and we can use our imaginations to 'grasp'

³⁴ I say more about this in chapter 5, section 5.4.4

what this might be like. Other psychological, social and environmental factors are also needed to obtain a fully filled out picture of the person's experience.

I suggest a change is needed. A broader phenomenological approach is required if we are to truly understand what the experience of another is like. This in turn can lead us to better neuroscience and differentiated therapeutic intervention. To this end I suggest that we employ multiple methods embracing philosophical and psychological phenomenology when we analyse first-person description.

3.8. Summary

Phenomenological enquiry has declined in the last century and this may be thwarting research and the possibilities for therapeutic intervention as well as doing an injustice³⁵ to the patient who has knowledge of her experience that does not readily fit into current signs and symptoms checklist.

I suggest that we can and should attempt to account for all the elements of the delusional experience using Jaspers' phenomenology: its *form* (or structure), *content* and *meaningfulness*, the *causal* connections which include *understanding* and *explanation* and the *objective* and *subjective* features of the experience. We should, like Jaspers, distinguish between the *genetic* understanding (how the delusion formed) and *static* understanding (what the experience is like once formed) and we should use all the tools available to us including empathy.

³⁵ I say more about this in chapter 4, section 4.4.1

Whilst some experiences are outside ordinary (more typical or *given*) human experience we should not *assume* meaninglessness (although it is possible that it might turn out to be the case that some aspects of delusion are, in some sense, meaningless). Human experience is never meaningless and a person's interpretation of anomalous or bizarre events must form part of our understanding of the overall experience.

In the next chapter I explore, among other things, meaningful aspects of the delusion experience using original research where I interview people who have clinically significant delusions.

CHAPTER 4 - INTERVIEWS

4.1 Introduction

I am interested in the phenomenology of lived experience because, as I have argued in chapter 3, a full phenomenology is the best way to capture all the relevant factors that make up experience. My epistemological stance is that I assume that people are meaning-making or sense-making beings and this fits with those assumptions as explicated in Chapter 7 in relation to the Enactive Approach. Further, I assume that one of the ways that people make sense of the world is through stories or narratives. To this end, I have chosen research methodologies that enable a focus on story and on meaning. I am particularly interested in 'what it is like' for people who acquire psychiatric diagnoses to live through this experience and for the purposes of this thesis I am focussing on the experiences of those who have active delusions. Philosophical texts rely on oft repeated de-contextualised quotes from psychiatric texts and articles (e.g.: Jaspers, 1997; Mellor, 1970) and on highly detailed first-person descriptions from philosophically minded writers (e.g.: Schreber, 2000). There are autobiographies written by people who have experienced mental illness (e.g.: Cockburn and Cockburn, 2012; Jamison, 2011) but there is little symptom-specific qualitative data available in the literature. My purpose in embarking on these interviews was to attempt to understand people's experiences in context and add to the literature on what it might be like to live through these experiences.

In section 4.2 I describe my research methodology for this study as well as problems that I encountered and the limitations of this research. In section 4.3 I report, summarise, and interpret my empirical findings and in section 4.4 I comment on some of the implications.

4.2 Empirical Research

People negotiate the world based on their experience of how their world works. A person is born into a family with particular relationships within that family and that family lives within a relatively circumscribed culture. A person might move through different cultures or sub-cultures as she develops and finds her place in the world. Her family environment might change too especially as we have more ‘blended’ families (i.e.: step-parents, step-siblings and others) as a result of increased divorces. We are relatively good at adapting to our environment and it is evolutionarily desirable that we are able to do this in order to survive and to procreate³⁶. Neuroplasticity enables us to learn new skills and thus survive in a changing environment (Costandi, 2016). The difference between the lived experience of a hunter-gatherer in the Amazon Rainforest and an investment banker in the City of London highlights how flexible human beings are.

However, there might be circumstances under which an alteration in a person’s lived experience is so radical or distressing that rapid adjustment is

³⁶ For a survey of ideas relating to human diversity in terms of psychological, behavioural, ecological and evolutionary adaptability see *Philosophical Transactions: Biological Sciences* (Brown et al., 2011 and its companion articles).

not possible. At this point a person might be unable to cope with her lived experience. This might lead to despair, depression or even suicide. A person might require a new explanation of how the world works in order to make sense of her experience.

Karl Jaspers distinguishes delusion proper from delusion-like ideas, the former being psychologically un-understandable and the latter being psychologically understandable. According to Jaspers (and other psychiatrists of his day) the un-understandable delusions (as well as other problems that are grouped within the psychoses) are likely, to have a biological aetiology which has yet to be discovered (Jaspers, 1997, p.607). This is a dualism of sorts. People are biological organisms and mental activity is experienced at person level thus mental activity is *both* biological and psychological. If we confine our attention to biological aetiology we might fail to capture other important factors that help us understand delusion and other psychiatric symptoms. When things go wrong and someone becomes mentally ill there are many factors that might contribute to this as we will see in what follows.

Using original research where people who have clinically significant delusions are interviewed we can see how a radical alteration in lived experience shows a trajectory that leads to the forming of new explanations about the world via intense affective, perceptual and emotional experiences,

4.2.1 Methodology

4.2.1.1 Approach

Whilst, in an ideal world, open-ended interviews engaging in in-depth detailed phenomenological enquiry (as described in Chapter 3 above) would have provided the 'filled out' and detailed kind of information that I am seeking, this was not possible given time constraints and NHS ethical and practical considerations. Ultimately, to facilitate my enquiry, I planned to interview, record and transcribe the experiences of up to ten people with active delusions and analyse the transcriptions using Interpretative Phenomenological Analysis (IPA). IPA has its origins in phenomenology and as such, at least to some extent, fits with an attempt to capture experience as I have described in Chapter 3. Smith and colleagues use Heidegger's notion of *appearing* and liken interpretation to a kind of detective work where the researcher is *mining* the material for possible meanings thus allowing the phenomenon of interest to *shine forth* (Smith et al., 2009, p.35). The double hermeneutic means that the researcher is always trying to make sense of the participant trying to make sense of what is happening to her within the context of her lifeworld as an embodied, situated person. In this way interpretation and understanding involves a synthesis of *both* the research participants' sense-making and the researcher's sense-making. This involves deep engagement and navigation through different layers of interpretation. The double hermeneutic is invoked here - interpretative layers arise out of the dual interpretative engagement of empathy *and* suspicion (Ricoeur, 1970). When

engaging with IPA, these two hermeneutics are employed to encourage a both/and approach on the part of the researcher. On the one hand to assume an empathic stance and imagine *what it is like* to be the participant and, *at the same time*, to be critical and probing in ways in which participants might be unwilling or unable to engage with themselves. IPA thus aims to produce rich experiential understandings of the phenomenon under investigation whilst remaining close to the participant's sense-making. *At the same time* the researcher can put aside what has been accepted at face value in order to develop a narrative of other possible meanings and still retain the primacy or privileging of each participant's material (Eatough and Smith, 2008). This is in contrast to other qualitative methods such as ethnography, thematic analysis and grounded theory which do not specifically employ the double hermeneutic in this way (Howitt, 2016).

IPA aims at understanding the experience of a particular person in a particular context in terms of the meaning that her experience holds for her. It is a qualitative method, where in-depth interviews are undertaken, and is designed to be used for small numbers of participants – typically between 4 and 10 people. Each interview is analysed to identify themes and common themes shared across the group are identified (Smith et al., 2009). IPA has also been shown to be a fruitful way of illuminating a person's situated, embodied meaning-making experience and is thus compatible with the enactive approach to cognition³⁷ (Larkin et al., 2011). IPA is also compatible with a narrative analysis. Narrative is a way in which we can understand life

³⁷ I will say more about this in chapter 7.

experience over time, the meaning it holds for the storyteller and how she sees herself within the narrative (Smith et al., 2009). In addition, people tend to describe experience in terms of narrative, whether we ask them to or not, and this was the case with all my research participants. I had not grasped this when I wrote my research protocol. However, on gathering the data, a need for a degree of narrative analysis became obvious³⁸.

4.2.1.2 Context

I hoped to find appropriate research participants through local National Health Services (NHS) trusts. In order to achieve this I relied on introductions to potential participants from NHS collaborators. A detailed research protocol and protocol summary flow chart (see appendix 1) was written and submitted for National Health Service (NHS) Ethical approval and for NHS Research and Development (R&D) approval via the Integrated Research Application System (IRAS). On completion of the approval process I was issued with a letter of authority enabling me to work on NHS premises.

4.2.1.3 Recruitment Strategy

I was introduced to various healthcare workers (via my named NHS collaborators), I explained the research to them and provided them with the document 'Information for Keyworkers' (see appendix 2). NHS staff were advised of the inclusion and exclusion criteria for potential participants.

The inclusion criteria were as follows, a participant must:

³⁸ I will say more about this in my analysis section (this chapter, section 4.2.4)

- be a service user within local mental health services
- have active delusion(s)
- be able to give informed consent to participate in the study
- be able to talk about their experiences
- be at minimal risk (of distress) when talking about their experiences
- be able to speak English (no translator is provided)
- be willing to travel to a suitable location to participate in the interview

The exclusion criteria were as follows, a participant will be excluded if:

- the lead healthcare professional believes he/she would be at risk (of severe distress or suicide) by participating
- the lead healthcare professional believes that the participant represents a risk to the interviewer
- the lead healthcare professional believes that the participant is unable to give informed consent to participate in the study

NHS staff were given the 'Invitation to Participate' document (see appendix 3) which they were asked to give to potential participants. Once introduced to a potential participant I explained the research to him or her, provided a 'Participant Information Sheet' (see appendix 4) and checked that they understood what I had told them and that they had the capacity to make an informed decision using the 'Mental Capacity Act Tool Kit' (Medical Ethics Department, British Medical Association, 2008). Capacity was subsequently checked on each occasion that I met with each potential participant. If he or she expressed an interest in participating we either went through the

Participant Information Sheet there and then or made an appointment to go through the sheet at a later date.

Once we had discussed the Participant Information Sheet, if the potential participant was still interested in doing the research I checked that they had understood everything and they completed and signed a consent form (see appendix 5) which specified what the research included and how the data would be used. Forty-eight hours later I contacted the potential participant to see if he or she still wanted to participate. If they agreed then an appointment was made to conduct the first interview and a letter was sent (appendix 6) to their consultant psychiatrist confirming that they had agreed to participate in the research.

4.2.2 Participants

Two people discussed the research with me and declined to participate at the initial discussion. Four people discussed the research with me, agreed to participate in principle and then declined to participate for various reasons when I next made contact with them.

Four people (one man and three women) agreed to participate and were interviewed for this research. Two were recruited via a psychiatric outpatient clinic and two were recruited from a psychiatric day hospital. All four identified as white British. Three out of four lived alone and one lived with her husband. Three were unemployed and one was retired. All of them had unstable or changing diagnoses or no diagnosis at all. Their ages ranged between 25 and 65 and all but one had been using NHS mental health services for a few

years. One had been using NHS mental health services for just 3 months. All of them described experiencing psychological distress before the onset of their delusional experiences. None of them sought help at the initial 'distress' phase. All of them said that they had told me things they had not told their psychiatrist or support worker (if they had one). As I have said (in chapter 3, section 3.6) I suspect this relates to the way psychiatric assessment is structured which focuses on symptom identification and on risk assessment, as well as time constraints when interviews take place. I also speculate that patients fear the consequences (in terms of increased medication and detention) of 'admitting' to the strangeness or worrying nature of their experience.

4.2.3 Data Collection

This is qualitative research and the emphasis is on what a person's lived experience was like during the lead-up to and onset of the problems experienced in relation to her contact with mental health services. Each participant was interviewed twice for approximately one hour on each occasion using semi-structured interviews (see appendix 8)³⁹. In the first interview the participants were asked about their history and the onset of their problems. In the second interview participants were asked what their experience was like at the time of being interviewed. In practice the interviews were free-flowing with the participant describing their experiences

³⁹ A short demographic questionnaire was also completed from data spontaneously supplied during the interviews. At the end of the final interview gaps were filled by asking the questions that were not covered (see appendix 7).

in whatever way came to them. The focus was on what was important to the participant. The interviews were recorded and transcribed. Transcripts are not included in this thesis in order to retain participant confidentiality. This approach (using open questions, encouraging the participant to talk about what was important or relevant to her and recording and transcribing the whole of a research participant's interview) is designed to enable bracketing of assumptions about what I (the researcher) might understand about the experience of delusion, thus emphasising what is important to the research participant (Smith et al., 2009).

4.2.4 Data Analysis

My data analysis was influenced by IPA as this aims at understanding what experience means to an individual and aims at identifying themes across different people's experience. In the first instance I analysed the findings with a view to establishing chronology and along narrative lines in order to try to grasp context and trajectory (some of the transcripts were difficult to follow as I discuss in section 4.2.5). What I mean here is that, in order to undertake any kind of analysis, I must first take the whole or a person's story seriously, and I do not ignore or dismiss anything as irrelevant. Telling stories is a significant way in which individuals construct and express meaning which develops naturally in children without explicit instruction or training. Narratives enable internally consistent interpretation of how we understand the past, how we experience the present and how we anticipate the future. They are of special importance as a mode through which individuals express

their understanding of events and experiences. If storytelling and story comprehension are natural and pervasive modes of communicating meaning we must take the *whole story* (or narrative) seriously and must not suppress parts of a person's response to a research question as irrelevant. If everything that a respondent says is relevant to and has a place in the story then it is incumbent on the researcher to determine how the story fits together (Mishler, 1986). As Christine Stephens and Mary Breheny put it:

“...narrative is a pervasive structure with which we convey and comprehend the experiences and meanings of events, account for our own and others' behaviour, or reveal ourselves to others in the way in which we would like to be seen. In doing so, we also reveal something of the structure of our social world.” (Stephens and Breheny, 2013, p.14).

Narrative stories shape identity, guide action, and constitute our mode of being. Narrative psychology, takes seriously the view that a person is a storytelling animal and engages with the move toward selves and identities as *active* and *interpretatively constituted* through *embodied* narratives. Narrative enables the researcher to engage with the question of *how* the story and social reality is constructed *and* with the substantive elements and organisation of the narrative: its plot, characters, and content - thus emphasising the *what* questions (Smith and Sparkes, 2006).

Narratives can be described as the organizing principle for all human action and are generally understood as stories that order events across time, enable

us to come to make sense of the storyteller's social world and account for events in ways that give meaning to the experiences of that story teller. Stories might also define or constitute a person's social identity and explain and enable moral decision-making. Thus narrative provides an important basis for the analysis of qualitative data and, whether we ask them to or not, participants in qualitative research interviews often shape their accounts as stories. If we are to interpret these accounts, it is helpful to attend to these narratives: stories are not distractions from important information about experiences. Stories themselves *are* important information (Stephens and Breheny, 2013).

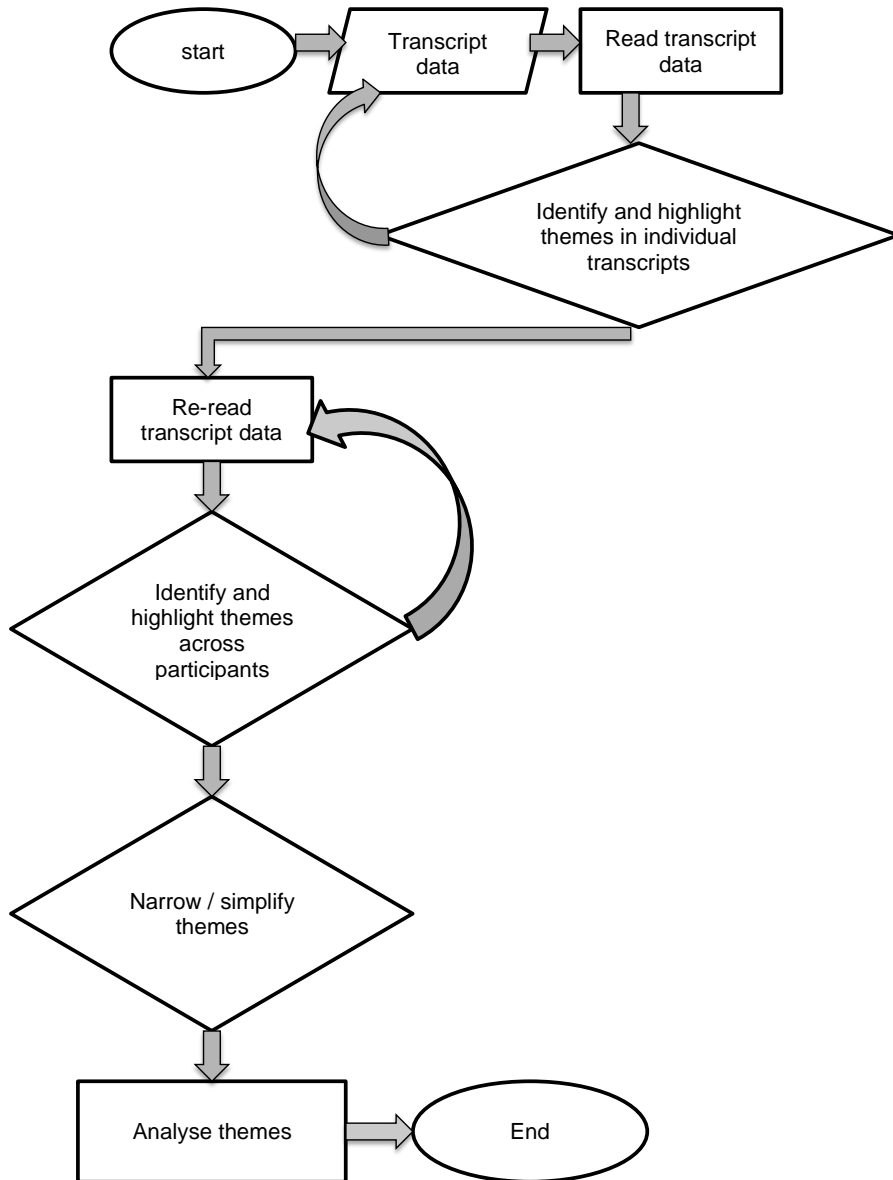
My research relates to lived experience and a person's narrative is vital in this endeavour. I am also interested in what makes a delusion problematic (as compared with everyday mistakes/false beliefs held with conviction) and what differentiates it from other psychiatric symptoms. In order to try and understand what might be problematic about the experience I then analysed the data to identify themes using IPA whilst still taking the *whole story* (narrative) seriously. In this way I made sure that I did not exclude elements of the narrative (such as those that did not directly answer specific questions about delusion). In short, I aim to understand both the experience of the delusion and the meaning it holds as well as the context (in narrative terms) in which the delusion arises. I also analysed the data to try and understand something about the form or structure of anomalous self-experience. I did not ask formal questions about the structure of experience in these interviews

nevertheless I was able to glean some information about what these experiences were like as the interviews unfolded.⁴⁰

Data was analysed recursively for each participant and across the different participants (see figure 1). The process of analysis involved listening to the data a number of times to familiarise myself with the material, transcribing the data and anonymising it where appropriate (eg: changing street names and family names). I then read each transcript a number of times and highlighted themes within the individual transcript. I produced a table of descriptive, linguistic and conceptual themes with references to quotes on the transcript that illustrated the themes and then performed the same task for each of the transcripts. Once I had completed this first level of analysis I identified themes that were common across the different research participants. These themes were highlighted on the tables already produced. I then checked the credibility of these themes by referring back to supporting quotes within the transcripts. credibility was sought from my PhD supervisors through providing them with the full transcript data and my initial (and ongoing) analysis of themes. This process (repeated listening, transcribing, repeated reading of transcripts, annotation and tabling of themes, checking, re-checking and seeking credibility with a third party) is designed to enable bracketing of my (the researcher's) biases and assumptions (Smith et al., 2009).

⁴⁰ Specific anomalies relating to self-experience have been identified by Josef Parnas and colleagues and a detailed questionnaire (Examination of Anomalous Self-Experience - EASE) has been developed to research how these experiences relate to different diagnoses (Parnas et al., 2005)

Figure 1 – Interview Data Analysis



There were only four research participants and they have all had different experiences. As discussed (above) narrative trajectory is vital as it gives context and shows how things develop over time so I have analysed the data in narrative terms as well as using IPA to identify themes.

I was struck by the fact that all the people interviewed were coping with radical changes to their lived experience. These included radical environmental changes and unusual or anomalous intense and persistent perceptual, affective and emotional, experiences. I have identified some themes and come up with two. In section 4.3 I will focus on the broad themes of *coping with radical change* and *guilt, justice and doing the right thing* as these are, to some extent, common across all four narratives.

4.2.5 Reflections, Problems and Limitations

4.2.5.1 Protocol and Collaborators

Writing the research protocol, identifying research collaborators and getting ethical approval and R&D approval took much longer than expected. Two colleagues of one of the collaborators each identified a potential participant. Towards the end of the formal research period one research collaborator left the area and I then identified a new collaborator. The new collaborator enabled access to a psychiatric day hospital and two more research participants were identified. This was only possible because I was able to extend the formal research period (and my honorary NHS letter of access) by 3 months.

Identifying possible methods for analysis was problematic because, at the time of submitting my research proposal (which documents the methodology to be used) I was hoping to get up to ten research participants. I chose a method of analysis (IPA) based on very little knowledge about the various methods available and on an assumption that, with ten research participants, themes would be revealed. In the end I only recruited and interviewed four participants. Despite this difficulty I did manage to identify two broad themes that applied, to some extent, to all participants.

4.2.5.2 Eliciting Responses

Eliciting responses to specific questions was problematic. On the one hand it seemed important to let the interviews unfold and at the same time I wanted to know about the delusional experience.

One research participant (Andrew) did not tell me anything about his delusional experience until the second interview and had to be heavily prompted to do so at all. Andrew also spoke continually and was focussed on describing what he thought was going on in his work place and how he thought the world should be (which was obviously very important to him) and found it difficult to talk directly about his own experience. Another participant (Caroline) found it difficult to describe her experiences at all and there were some long silences where I tried to rephrase things to try to be better understood and to prompt her to continue.

At times I found it very difficult to ask questions and felt that what I was asking for was not relevant to the participant or was something that they were only

thinking about because I was asking about it. This might mean that some of the things that the participants said had little to do with their experience and simply served to fill a gap when prompted to answer.

Some of the interviews were difficult to follow (Alison in particular) and context and narrative trajectory were hard to understand. As context is vital to an understanding of the onset of symptoms this proved quite difficult to untangle and there are gaps in the narrative which only came to light after the full interviews had been listened to a number of times and the full transcripts had been written up and analysed with a view to chronology. As I was unable to go back to research participants to ask questions to fill the gaps (due to the limitations of my research protocol) these gaps remain unfilled.

4.2.5.3 Lost Data

Due to problems with the recording device one interview (Barbara) was cut short and another interview (Andrew) was lost. I explained the situation to Barbara at our next meeting and she agreed to cover some of the missing material again. This meant that, overall, there was less time (approximately 1 hour and 40 minutes) recorded with Barbara than with others. I explained the situation to Andrew and he volunteered to re-do the first interview. As a result, due to shortage of time, I undertook Andrew's second interview a day later and had little time to reflect on the first interview and identify gaps or unanswered questions.

4.2.5.4 Credibility

As stated above (section 4.2.4) credibility checking was sought from my PhD supervisors through providing them with the full transcript data and my initial (and ongoing) analysis of themes. I was somewhat limited with regard to additional verification as my research protocol did not include sharing the full data with a wider audience. I did not specify or recruit other researchers to help me in checking the credibility of my analysis and, in practice, I do not think I would have had time to include these additional steps given the time taken to achieve NHS agreement and the difficulty I had in recruiting participants in the first place. IPA as an approach is supportive of triangulation approaches to credibility checking, but cautious about erasing the analyst's insights through over commitment to multiple forms of such checking, and critical of ascribing value to these checks (Smith et al., 2009). From an IPA perspective, such checks do not *validate* the analytic findings, but they do provide useful feedback on its development.

4.2.5.5 Other Limitations

Different people have different degrees of 'psychological mindedness.' The degree to which each person was able to introspect was variable and it was clear that some of my questions did not really make sense to some participants. This, in itself, is interesting as it shows that some people simply do not have the kind of self-narrative that philosophers, psychologists and others rely on to explain or understand symptoms and psychological distress.

Some of the experiences were highly unusual and therefore very difficult to describe. This was recognised by the research participants who did not expect me to understand what had happened to them because I had not been through what they had been through and they would not have believed it had it not happened to them.

4.2.5.6 Interviewer Stance

I am interested in the history of psychiatry and, as I have argued in Chapter 3, detailed phenomenological analysis of a person's experience (which might include such features as those highlighted by Jaspers phenomenological method) can enrich our understanding of experience. I am trained as a person-centred therapist and, as such, am used to paying close attention to what people are saying. My usual way of engaging with people in therapy relates to trying to 'put myself in the shoes' of the other and includes empathic engagement. I found the research interviews difficult and often felt cold, detached and disingenuous. I was aware that I had to censor myself and move on with the interview. I did not always achieve this and occasionally found myself responding as I might have done in a therapeutic situation.

I am aware that I have a preference for taking things at face value. I tend to assume that what someone tells me is true and I suspect that I would grant that there is much more truth in the narrative relating to a delusional schema than others might. For example, in the case of Alison, who had a number of problems with various neighbours I assumed that what she said to me was true with the exception of those things that seemed implausible (eg: that the

local council had a machine that could read people's fingerprints on the leaves of garden plants and her neighbour was using this machine to prove that Alison had been in her garden). I am aware that her husband disbelieved most things that she said had happened in relation to the neighbours but I am inclined to believe them unless there is a *very* good reason not to. This, of course, affects my interpretation of the situation. If I am right then she was persecuted by her neighbours and this eventually contributed to her becoming ill. If her husband is right, then she had persecutory delusions for a long time with no basis in reality.

There is evidence that mental health professionals are biased in the opposite way assuming that, once a person acquires a psychiatric diagnosis, her thoughts, feelings and behaviour all relate to that illness. In the classic 1970s experiment researchers who told healthcare professionals that they experienced one symptom of a mental illness and were admitted to hospital, were kept in hospital and their behaviours were documented as being part of the illness even though they behaved normally (Rosenhan, 1974). I have witnessed this kind of bias directly when a client of mine was ignored when she tried to alert the local authority to a fraud in relation to building works on her council property. She sued the authority and gained access to records that had been kept about the numerous phonecalls she had made and letters she had sent in which she found that they had assumed she was 'making things up' or 'delusional' because she had a mental health problem. (She exposed the fraudulent building company, their contract with her local authority was terminated and they were prosecuted for fraud). As I have

argued in chapter 3, there is good reason to take a person's experience seriously thereby doing justice to the knowledge that they have about themselves and their experience.

Once I had analysed the data and whilst undertaking further research on the enactive approach I came across the idea (as espoused by Michelle Maiese) that some features of mental illness (and perhaps mental illness as a whole) might be described as resultant from attenuated *affective framing*. This seemed to be a plausible fit with my research findings and I explore this further in Chapter 8.

In the next section I summarise my empirical finding in terms of meaning and sense making in relation to the themes identified 1) guilt, justice and doing the right thing and 2) coping with change – a radical alteration in lived experience.

4.3 Empirical Analysis

What follows represents just one way in which the data can be summarised and interpreted. In section 4.3.1 I describe the lived experience of Barbara, Alison, Andrew and Caroline prior to the onset of their delusion. Quotes are used to illustrate the themes of guilt, justice and doing the right thing (section 4.3.2) and coping with radical changes in lived experience (section 4.3.3) and to illustrate how they each re-interpret their new world (section 4.3.4).

4.3.1 Participants' Lived Experience

This qualitative research relies on the participant to tell his or her story in whatever way they choose. An assumption that a person has said what they deem to be significant is made here. Details about their lives before the onset of their delusions are, in some cases, particularly sparse yet it is possible to glean some information about what was important and meaningful to them and what they expected from life.

One of the research participants, who I have called Barbara, was married to a man who was a serial adulterer. He had already left or threatened to leave her on a number of occasions for other women. She had been desperate for him to stay with her and he had done so each time. Her marriage was extremely important to her and she had made decisions against her better judgement at her husband's behest in order to prevent him from leaving. Barbara's husband had afforded her some form of stability as, despite his liaisons with other women, she had believed that he would always ultimately return to her.

Another research participant, Alison, had two young children when her husband committed suicide. She worked as a legal secretary and had a keen interest in the law. She subsequently re-married and had two more children with her new husband. She continued to work because she enjoyed her job and she wanted to help support the family financially. She retired after working for over thirty years. She came across as a caring person and,

despite having some problems with her neighbours, she had looked after some of them and was involved with her community.

Another participant, Andrew, joined a 'job for life' workplace at a young age. He was the office junior and was required to respond to the demands of a number of different people. He was perhaps very naïve and had little experience of relationships outside the family. He says a number of times while recounting his experiences 'I didn't know how the world worked.' He bought a flat in his early 20s and moved out from the parental home to live on his own. His father became ill and his mother became his Father's carer. Andrew, who was very close to his parents, says he was 'left alone to my own devices.' He was fixated with work and had a strong desire to do well.

Caroline grew up in a family where she was required to do what her older sister said or she would be threatened, hit or punished. If she cried or showed she was upset her father would threaten her or hit her. When she complained to her mother about her sister's behaviour she said she would not help her and would say 'I didn't see it, what do you want me to do about it?' (her sister was very careful not to get caught). She says she learnt to 'smile and just get on with it' regardless of her situation. Her Nan, who lived on the same street as she grew up on, was kind and they had a good relationship. Her Nan died when Caroline was in her late teens. Caroline started a relationship with a woman when she was in her teens and some time later they moved in to a house together. Caroline says that the relationship was

good to start with. She had a good job that she liked and was also training to qualify for a better job in her chosen field.

In the next section I illustrate experiences relating to the theme of guilt, justice and doing the right thing.

4.3.2 Guilt, Justice and Doing the Right Thing

Each person encountered injustice or guilt and felt that they must do something to redress the balance. They must 'do the right thing' so that justice could be done.

4.3.2.1 Barbara

When Barbara's husband finally left her she became extremely depressed, she says:

"I was really depressed, really down, really miserable. So I prayed as you do and I asked him to bring my husband back and I said no actually... I've asked that time and time again and it's happened and I said I don't want it. I said if it's not good for me I don't want it. I just want this pain to go away. So... um... I'd already been through a bad time, took an overdose, everything and then all of a sudden... I felt better after I'd prayed." (Barbara 1, 1:9-15)

Barbara was desperate for the pain of this separation to go away. She had been through this kind of emotional pain on a number of occasions and while

she was feeling this misery she took an overdose. She did not elaborate on this in the interview and it is unclear whether she had taken overdoses before.

Guilt about a personal decision she had made which she justified in order to keep her husband now comes to the surface. Barbara experienced the injustice of this situation. She had compromised her principles to keep her husband and he had ultimately left her anyway. Later Barbara was overwhelmed by guilt and felt the need to atone. The guilt seemed to be free floating or objectless at times and she connected it to other activities:

“...and guiltiness, when I smoked and ate chocolate as soon as I’d done it I’d feel really really guilty, the guilt would like... eat you up like you’ve done murder or something. It was... it felt really really guilty.” (Barbara 1, 3:35-38)

4.3.2.2 Alison

Alison had problems on her street about four years prior to her interview. A teenage neighbour regularly set fire to the bins near her house and she was obliged to call the fire service on a regular basis. Alison subsequently moved away and went to live near another family member. This relative was falsely accused of sexual assault. Alison attended court every day. She became stressed and started to have difficulty sleeping. He was found guilty of the crime and subsequently jailed. She describes it as follows, and is clearly disdainful of the decision:

“It was split, and the judge, it was a late Friday afternoon and the judge said well I’m locking you up for the weekend, you can go in there, I’m going to turn the key, I’m going home, he said, unless you can come back quickly with a ten two. So they did. And he was found guilty. He did from the May til Christmas and obviously he’s got ten years now because you have ten years put on don’t you, at home. He’s done three years. But he didn’t do it.” (Alison 1, 3:10-16)

She is horrified that, on this occasion, when her family member is relying on the law to prove that he is innocent the system has failed. She finds this injustice difficult to understand.

The injustices accrued for Alison. She was falsely accused of crimes and reported to the police by a neighbour when she moved back to her hometown. The harassment from her neighbour was so distressing that she decided to move house. Around this time she also found out she had a life-threatening heart condition. It is unclear exactly when this happened but at some point Alison started to think that the neighbour, the local council and the police were working together to prove that she was guilty of something.

4.3.2.3 Andrew

Andrew described his workplace as a ‘hellhole’. He found it very difficult to talk about, resorting to analogy and generalisation. He says:

“It’s that awful I don’t even like talking about it but I will. It’s that awful. You’ve seen the original ‘Planet of the Apes’... film, 1964 I think it is with

Charlton Heston... and you know how he's treated during it? ⁴¹
Management treat you the... similar to that. That's how it felt." (Andrew
1, 6:37-44)

His whole idea of what the workplace should be like and how people should
be treated is brought into question. He sounds contemptuous when he says:

"So when... managers have more power than the worker they misuse it.
It's human nature. Absolute power corrupts and absolute power corrupts
absolutely. If you give people too much power they'll misuse it." (Andrew
1, 7:7-10)

"The overall manager of that department was hated, was despised. Now
the example she sets, what she does filter down. The other managers
copy what she does. And they mis... they mistreat people." (Andrew 1,
7:16-19)

"Because all you get is disrespect, indecency and it's not the way that
man... it's not the way to treat people." (Andrew 1, 8:22-24)

I can only assume he has not experienced this kind of injustice before and he
finds what he witnesses and experiences at work intolerable. It is likely that
he and (others) were being bullied at work. Whilst he does not explicitly say
so, it looks like he did not (and perhaps could not) contemplate finding
another job. He says, on a number of occasions 'I'm not a quitter.'

⁴¹ In the film 'Planet of the Apes' human beings are treated like animals, used
for slave labour, kept in cages and experiments are done on them.

After his anomalous (delusional) experience Andrew felt he had become God's messenger and could meter out God's justice. As God's messenger he wrote an email condemning people and saying how he could right certain wrongs and sent this email to a wide variety of people. He became very powerful in this experience and believed that what he had written in the email about certain people actually condemned those people to Hell:

“...that condemns them... at the end of the day. What that shows to me... is that... heaven and hell... they're off to hell.” (Andrew 2, 18:40-45)

If there was no justice or fairness in the workplace there was justice through God. Andrew, as God's messenger, could communicate about the injustice that was being done, could condemn those who perpetrated this injustice to Hell and could commit to participating in making sure that justice was done by 'doing all that is necessary.'⁴²

4.3.2.4 Caroline

Caroline had, perhaps, experienced injustice all her life but because this was normalised she had developed coping strategies. She is re-assaulted by this injustice in her new relationship, which was initially good, when her partner becomes psychologically and physically abusive and finds that her coping strategies no longer work. Caroline lost a lot of weight, had trouble sleeping

⁴² This is a quote from the film 'Batman Returns' (Andrew uses this quote a number of times and uses other 'hero' film analogies throughout the interviews).

and stopped eating properly. She only recognises this with hindsight and was unaware of this as a 'problem' at the time. She just 'got on with it.'

Caroline felt that she was doing the right thing by staying with her abusive partner and 'just getting on with it.' When she started to experience 'voices' commanding her to behave in certain ways and threatening harm to her family if she did not comply she, again, thought she was doing the right thing by responding to the voices thus protecting her family.

“... yeah, cos they threatened to hurt family and things like that, it was like I had to do these things to protect other people and... things like that so...” (Caroline 2, 6:4-6)

4.3.2.5 Interim Summary

Barbara felt the injustice of the breakdown of her marriage through no fault of her own as well as intense guilt over past decisions and a need to atone. Alison observed the injustice done to her family member when he was found guilty of a sexual offence that he had not committed. She also experienced the injustice of being persecuted by various neighbours with no redress. Andrew experienced the injustice of being bullied in the workplace and felt that justice could be done if he became God's messenger. Caroline experienced the injustice of being bullied and abused by her partner and also felt that she was protecting others by doing what her 'voices' commanded.

Each had tried to do the right thing. Barbara compromised her principles to try and keep her marriage and then tried to atone through talking to God and

denying herself food and cigarettes. Alison supported her family member through his court case and tried to remain a good neighbour even when she was being treated badly. Andrew decided to train in HR to try to improve the working environment for others and then sent an email to various people detailing how he would right various global and local wrongs. Caroline stayed with her partner to prove that she could 'just get on with it' and did what her voices commanded to protect her family.

In the next section I describe how these people re-interpret the world in terms of an attempt at meaning making as a response to the radical alteration of their lived experiences.

4.3.3 Coping with Change - A Radical Alteration in Lived Experience

Each person went through radical changes in experience which they found stressful and difficult to cope with.

4.3.3.1 Barbara

Barbara's separation from her husband represents a significant alteration in Barbara's lived experience. Her marriage gave her meaning and, although her husband was unreliable he had always returned to her in the past thus affording a form of stability.

Barbara suffered anguish and despair over the breakdown of her marriage. However, two weeks later she suddenly felt better. Her depression and mental anguish disappeared and she was enjoying life. At the time she was

relieved, pleased and happy but with hindsight she thought this was odd, she says:

“...but I didn’t realise that... the only reason I was feeling... so happy about being single after the... after that massive crash... nobody gets over a breakup in two weeks do they?... not if they really didn’t want it to break up. But... uh... but because God was holding on to me... but I didn’t know that at the time. I just thought... I’m an independent person, I can do this.” (Barbara 2, 19:45-48)

Around this time Barbara started to get the sense that she was being watched and that songs on the radio were presenting important messages to her. These kinds of ‘uncanny’ experiences (Jaspers, 1997, p.97) or anomalous perceptual experiences (Kapur, 2003) are a common feature prior to delusion formation. She did not seem distressed or worried, perhaps because she was feeling really good and really happy. She did not even seem particularly puzzled although she did think it was ‘weird’ and found it difficult to explain. She assumed there was an explanation and that it might have had something to do with a new work colleague.

“... I’d come home and I’d get the feeling I was being watched... and then the music started talking to me... I don’t know... I can’t explain that very well but I would... I would ask a question and it’d talk to me. And I thought this guy had something to do with it. I thought he’d put set cameras up in my house and was watching me and... and using the radio station to talk to me. It was really weird.” (Barbara 1, 1:28-33)

Then Barbara started getting messages in other ways in the environment, for example, through road signs. Her attention was drawn to particular words and the amalgamation of these words gave her these new messages. She says:

“...it’s how they change your mind... its how you see the messages... you look directly at the right one at the right time.” (Barbara 1, 3:2-4)

Again, she found this very difficult to explain. Certain words appeared salient, they stood out in the environment and her attention was drawn to them.

4.3.3.2 Alison

Alison’s experience with the police and the law constitutes a radical alteration in her lived experience. She previously had positive experiences with the law, the police and authority (due to her job as a legal secretary and from personal experience) and she had faith in the police and the judicial system.

After further problems with her neighbours (who falsely accused her of crimes and reported her to the police) Alison went to bed and stayed there for four months only getting up to go to doctor’s appointments and to see family when they called at the house. She was probably depressed but this was undiagnosed. Eventually she decided to go out (there was a family event she wanted to attend and a cardiology appointment she wanted to attend).

Alison said she could hear other people having conversations (when those people were not present). She also said she could hear people who were present but who did not look like they were ‘talking’ (they were not opening

their mouths) and she could communicate with others without 'saying' anything. She has difficulty explaining this and, at times, is adamant that this was happening and at other times she questions the experience and wonders if it was 'all in her head'. She says:

"I got the voices in my head... um... I felt that I could talk to people without moving my mouth, I could hear long distance conversations, but yeah sometimes I still do. And sometimes I walk past people and I feel as though I know what they're thinking." (Alison 1, 3:46-49)

"Well, no, that is **true**. I **could** hear people's thoughts. And I used to go like this as I passed them [puts fingers in ears]. And D said to me one day what on earth are you doing and I said, nothing. They're having a conversation and I don't want to hear it." (Alison 2, 5:4-7)

Alison incorporated this into her experience of the world. She did not believe that people could have these kinds of 'long distance conversations' until it happened to her.

4.3.3.3 Andrew

After prolonged distress through bullying at work Andrew developed obsessional thoughts, checking behaviours and mild paranoia. He was diagnosed with Obsessive Compulsive Disorder (OCD). He says:

"...I've got brain lock over urine, I can't move or function without... thinking that I need to go to the toilet literally 24 hours so I needed to

take sleeping tablets to get to sleep... it was ridiculous. It was very very frightening.” (Andrew 1, 1:14-21)

“...and then it just got worse into total chaos, um... chaos and torture.”
(Andrew 1, 1:38-39)

This represents a radical alteration in Andrew’s lived experience. Prior to this he lived with his parents and enjoyed a relatively stress free life. Although he did not say so specifically it is unlikely that he had any serious problems negotiating relationships with, for example, school friends and others (he certainly does not mention any problems) and he had a good relationship with his parents. He found that he was unable to negotiate the relationships at work and felt huge anxiety in this regard. He became stressed and fearful about his job and had trouble sleeping. He stopped looking after himself and lost a lot of weight. He also became isolated prioritising work and study over friends and family. He did not recognise this as a problem to start with.

4.3.3.4 Caroline

It is not clear how long it lasted but it appears that Caroline had a short period of respite. She moved away from her sister and her father into a new relationship which was good to start with. Some time later her ability to negotiate the world becomes radically altered. Caroline’s relationship, which started off well, starts to break down. Her partner begins to bully her and becomes verbally and physically aggressive. With hindsight Caroline could see that she was unable to acknowledge her own emotions or express herself. She was unaware of this at the time and she just put up with it as it

got worse. She assumed that this abuse was 'normal' as she had experienced it from her sister and her father. She says:

“um... not that I would've realised at the time. Now it's a bit later and I've seen different things and talked to different people um... I never realised at the time I was in an abusive relationship... both mentally and physically. So of course that's not going to help your state of mental health sort of thing. Um... but I guess I just didn't realise it at the time, I didn't... I just thought this is how it was, you just... did what she did to me sort of thing and... Some people do it and some people don't and it was just normal to have people out there that did do them things...”

(Caroline 1, 6:34-42)

She was used to being able to shut off her emotions and put up with anything. She now finds she can no longer do this. Caroline had a couple of incidents where she felt she couldn't breathe. She then had a number of panic attacks that she did not understand and sought help from her GP. She was given beta-blockers. At this stage she had no explanation for her behaviour. She started to take overdoses of prescription medication and ended up in hospital a number of times. She said that it sometimes felt like someone else was taking the tablets. She could not say, at the time, why she was doing this. Her experience of herself as a robust person who could just get on with life is completely shattered.

4.3.3.5 Interim Summary

Each person's environment had altered in a number of ways. Barbara's marriage had broken down and she was experiencing the 'uncanny' sense that she was being watched and that objects in the environment afforded important messages for her. Alison's trust in the police, the law and authority had disappeared and she was experiencing her thoughts and imaginings as un-owned by her. Andrew's safe just world was altered by his experience of being bullied at work, he became fixated with work, experienced intrusive thoughts, developed checking rituals and felt compelled to send an email to redress the balance in this unjust world. Caroline could no longer 'just get on with it,' she became panicky, took overdoses and started behaving oddly at the command of her 'voices.'

Each person needed a new explanation of how the world worked to account for their experiences.

4.3.4 Re-interpreting the world

4.3.4.1 Barbara

For Barbara, over time, what started out as ideas of reference evolved into delusions of reference holding specific meanings relating to her delusional schema⁴³. Later she noticed words on signs and song lyrics that seemed to

⁴³ An idea of reference is "The feeling that causal incidents and external events have a particular and unusual meaning that is specific to the person. An idea of reference is to be distinguished from a **DELUSION OF REFERENCE**, in which there is a belief that is held with delusional conviction." (American Psychiatric Association, 2013, p.823)

afford important messages from God. It is unclear exactly when it started to happen but at some point she experienced God replying to her questions and prayers. She says that God was talking to her directly 'by telepathy.' Barbara received a message from God about a decision she had made to keep her marriage. When she received this message Barbara was overwhelmed by fear and guilt and the need to atone. She began to deny herself food and tried to give up smoking. Eventually she developed an elaborate schema in which she was God's daughter, all other people were devils and were doomed to mortal lives, she could talk to God any time she wanted to and he would talk back to her, God loved her unconditionally and regularly told her positive things about herself⁴⁴ and she would live forever in Heaven.

Barbara was sectioned under the Mental Health Act and detained in hospital against her will. When she arrived at the psychiatric hospital she was asked if she saw devils. She replied that she could see them in the doctor's eyes.

Barbara's new world included anomalous affective and perceptual experiences. Things stood out in the environment in ways that were novel and hard for her to understand. As time went on the environmental anomalies seemed to provide specific self-referential messages. She tried to find an explanation and, at first thought it was something to do with a work colleague. When she realised this was not the case she continued to puzzle over these strange experiences. Barbara also felt intense emotions (fear, love, anger and guilt) that seemed to be free floating and objectless at times. She

⁴⁴ I return to this in chapter 6, section 6.2.1.3

sometimes attached these feelings to things in the environment but at the same time felt that the emotions did not relate to these things appropriately. Eventually she realised that her experiences could only be supernatural in origin. When she first realised God was talking to her it was 'really lovely.' This enabled her to make sense of her experiences and make new meaning in this new world. The new world-view also enabled her to feel that she was loved and lovable, that she was intelligent, beautiful and important and was forgiven for past actions.

4.3.4.2 Alison

After months of persecution from her neighbour Alison moved house to get away from this abuse and found out that the old neighbour was friends with the new one.

"The current neighbour that I've got, yeah my old neighbour, yeah they were best pals. I though *what* have I done? It sounds silly, it sounds far fetched but it's totally, totally true." (Alison 1, 4: 51-53)

After this she takes to her bed and stays there for four months. Alison's worry about the neighbours was dismissed by her husband and he said it was 'all in her head.' When Alison first developed voice hearing (and related) experiences she thought she was going mad:

"That's when I first thought perhaps D's right, perhaps I am ill. And then... I just let things go on and things got worse." (Alison 2, 6:51-52)

When asked about what happened when she could hear other people's thoughts and communicate telepathically she says:

"I think... all around two... three months ago say... it all really started to kick off. And... I don't know why... because um... there is a drug you can have that can make you do that and whether I thought I'd had that drug, I don't know." (Alison 2, 29:34-37)

"Well... well not now, but I mean at one stage I could do it at any time as I thought, yeah." (Alison 2, 29:41-42)

"I'd just have a conversation with er... like... um... a police officer, you know, cos I thought oh he's got the same drug [laughs]. So it's just nonsense in my head." (Alison 2, 29:47-49)

This was a persistent experience and went on for a number of months. If she was mis-identifying her own thoughts, fears, wishes and imaginings as external in some sense (either 'voiced' out loud or 'picked up' through telepathy) she required an explanation. If she thought that these thoughts and voices were not *her* then she looked to the environment for an explanation. Those who were around her, such as neighbours and visiting police, seemed likely candidates. If she could pick up the thoughts of others then it seemed likely to her that they could pick up her thoughts. This seemed to her to be true as what she experienced seemed like a conversation (using telepathy). Alison's new world incorporated these experiences. She did not need to worry about 'going mad' because she was telepathic.

4.3.4.3 Andrew

Andrew was taken over by God, wrote an email where he committed to righting some global wrongs and sent it to a large mailing list, called the police and called an ambulance. He says that God spoke to him saying:

“... ‘you need to take a massive leap of faith. Trust in me. Trust in God and send this e-mail. You are the only person who can do it. You are... a modern day Noah’. And what I did is... I sent it to all the most powerful people I know, my mentors who are older, some of these people are HR directors, they’re doctors, world-renowned doctors one of them. And I literally wrote... everything... that it felt I was commanded to by God.”
(Andrew 2, 6:30-36)

Andrew tried to describe the experience of becoming God’s messenger and found it incredibly difficult:

“...all I know is what happened was is that I was... went on the floor, went on my... this was on my lounge floor, went on the floor and it just felt like evil was trying to turn me into its thing.” (Andrew 2, 5:9-12)

“So it was like a power... it felt like a test from God... that’s what it felt like. Or the devil or whatever you want to call it, but I would say a test from God.” (Andrew 2, 5:38-44)

It was a force that was so powerful I can’t even explain it to you.
(Andrew 2, 11:49-50)

“I wouldn’t even be able to, it’s futile.” (Andrew 2, 12:1)

“The... the power cannot be described. The only person who could be able to... is someone who’s been through it as well.” (Andrew 2, 12: 26-27)

Andrew felt that he now knew how the world worked. God was in charge. This might help to restore his previously held ideas about the world being just. This new world, in which he was God’s messenger, enabled him to make sense of being overwhelmed by an inexplicable power and make sense of the past ‘torture’ that he has endured.

This allowed him to believe that God always had a plan for him and enabled resolution of the tension he felt about not being able to fully explain, understand or negotiate the world. It restored a sense of power or agency that has been missing whilst he was suffering in the workplace and suffering due to his OCD and enabled him to make sense of his new world. He says:

“...even whilst all the suffering I’d been through, like during it, I’d always thought that this was potentially God’s plan. For me. (Andrew 2, 11:19-21)

“I’ve got a huge amount of courage. I’ve always had that even as a child. So if I am... a chosen God’s messenger it’s because of... because of courage predominantly. Cos I do have the courage to do all that is necessary.” (Andrew 2, 13:45-48)

“...at the minute... I do... I think I’m one of God’s messengers, yeah I do” (Andrew 2, 21:6-7)

4.3.4.4 Caroline

Caroline’s world was radically altered. She found she was behaving oddly, doing things she could not explain, having panic attacks and taking overdoses. She says:

“...it was just like it weren’t me... and... I’m there taking these pills and... it was like... I’m sat there and I’m looking at them... but is not me controlling my arm to take them.” (Caroline 1, 12:2-5)

Caroline was asked by a clinician, after an occasion when she was hospitalised as result of taking an overdose, if she heard voices. Although she didn’t really understand the question at the time, she came to the conclusion that she was hearing voices. She had thought this was ‘normal’ and that others could hear what she could hear. She didn’t suddenly notice voices, she just ‘grew into them.’ She described looking around for where the voices were coming from on some occasions, thinking there were speakers behind her somewhere, thinking there was a chip in her arm (put in by the government) and puzzling over how she was hearing what she was hearing. At the same time she also seemed to think it was normal in some sense. She could not remember when it started and perhaps assumed that others also had these kinds of experiences.

“when... I realised other people couldn’t hear them, then went into ‘is it an implant?’ have the government already took me and put something inside me, um... and... yeah... I went through ‘have they got speakers all around me?’ ‘are they broadcasting from different places so when I move I just can’t see where the speaker is and that?’” (Caroline 2, 7:32-36)

“I... I went through speakers... um... sort of... more... I think because I’m an electrician... just more electrical stuff [laughs]... so it’s someone put a speaker behind my head or... were... Broadcasting from somewhere where I couldn’t... get hold of... I don’t know... I never... I knew I had like... these thoughts there must be something there because I can hear it... but I never... I thought a little but not too hard about what it could be.” (Caroline 2, 5:18-24)

Caroline took these experiences in her stride and incorporated them into her world-view. She was not particularly worried about where the voices were coming from to start with and, although she does not explicitly say so, perhaps she did not even contemplate this until she was asked (by a clinician) if she heard voices:

“...though I had the voices I was more focused on what they were saying and having to do these things than I was where they were coming from.”
(Caroline 2, 5:40-42)

With hindsight she said that taking overdoses must have been a way to get out of the relationship she was in because she did not think she could just

leave as she was too scared. So she could not leave and she could not stay. She did not understand this at the time and was unable to express her emotions (she could not acknowledge that she was upset or afraid). When asked about the impact her upbringing had on her she said:

“I think in a way it stopped me from showing any emotion... if you weren't happy and leading what they would class a normal life then that's it you just... you're strange or weird or something, I don't know... but... yeah... you've got to smile and just get on with it.” (Caroline 1, 8:17-25)

Her 'voices' seemed to have a commanding nature which she did not question. She simply incorporated them into her world as real and felt compelled to do what they commanded. Sometimes she would resist but the voice would persist and the threat would increase until she did what she was told. There are obvious parallels between this and her sister's behaviour ('do this or I'll hit you'), her father's behaviour ('don't get upset or I'll give you something to really be upset about') and her partner's threatening and abusive behaviour.

Caroline started behaving oddly. She was doing things that she felt her voices compelled her to do out of fear of reprisal. She lost some friends as a result and attracted the attention of the police and mental health services. Eventually she was able to leave her abusive partner. However, her fears of being hurt were not resolved. She had shared finances with her ex-partner and negotiating resolution about this took over two years. For most of this

time she lived in fear of reprisals. Although she did not say so specifically I suspect that her living arrangements at this time were not ideal as she had moved back in with her father. She did say that there were some basic improvements – for example her father would regularly make meals for them to share (she had not been eating properly for some time prior to this).

Caroline's new world needed to incorporate a new experience of herself. She was no longer a person who 'just got on with it.' She had had a number of panic attacks and taken a number of overdoses and she found this puzzling at the time. On top of this voices were threatening her and commanding her to behave in odd ways. These voices were incorporated into her lived experience and enabled her to make sense of what has been happening to her without the need to acknowledge difficult emotions which she may not have had the language for.

4.3.5 Interim Summary

Periods of stress, difficulties, trauma and injustice were followed by periods of poor self-care and despair or depression in each case. A need to do the right thing, see justice done or atone for past behaviour was evident to some extent in the experience of each research participant. They all experienced a radical alteration in lived experience which demanded a re-interpretation of the world. As the new worlds were interpreted meaning was sought and found in what might be described as delusional explanations. The alteration in lived experience included intense and persistent affective, emotional and

perceptual changes and this might be a significant feature of the formation of clinically significant delusion.

4.4 Implications and Discussion

I suggest that the research analysed here has implications with regard to doing justice to the knowledge that people have about their own experiences (section 4.4.1), our understanding of people's experience of delusion formation in general (section 4.4.2), stigma reduction (section 4.4.3) and therapeutic intervention and prevention of illness (section 4.4.4).

4.4.1 Avoiding Epistemic Injustice

There is evidence that minority groups and those perceived to be less powerful than others can be treated as if their evidence has less value than the evidence of others. Miranda Fricker coined the phrase *epistemic injustice* to capture this phenomenon (Fricker, 2007). Because those with mental health problems are often stereotyped as having cognitive deficits, being emotionally unstable, lacking capacity to make decisions and generally 'not of sound mind' there might be a tendency to deflate the epistemic value of their testimonies and defer to the psychiatric 'expert.' Paul Crichton and colleagues suggest that prejudices against people with mental disorders are entrenched in our society in what Fricker calls the 'collective social imagination' (Fricker, 2007). Psychiatrists, the general public, organisations, politicians and friends and family of a person with mental health problems

might be capable of committing this kind of injustice due to prejudice and stereotyping (Crichton et al., 2017).

In order to ensure that epistemic justice is done with regard to the knowledge that people who seek psychiatric help have about their own experience Crichton and colleagues suggest a number of changes. These include: introduction of 'Schwartz rounds' which are intended to focus on existential, ethical and personal aspects in relation to a particular person seeking psychiatric help; multi-disciplinary team meetings to look at multiple aspects of care; the training of psychiatrists to listen carefully to what their patients say and to engage collaboratively with regard to treatment and decision-making; and changes in the social and political arena - suggesting that the news media should cease to engage in negative stereotypes in relation to people who are mentally ill and that politicians should ensure a fair distribution of healthcare resources (Crichton et al., 2017).

Lack of detailed phenomenological enquiry made available in the public domain combined with media portrayals of the 'dangerous' mentally ill person help to reinforce the stereotype and this in turn feeds the potential for epistemic injustice. At the individual level, this kind of injustice - *testimonial injustice* is an ethical harm to that individual person and might impact treatment and add to self-stigma. At the level of practice – if people's experiences are routinely given less weight than is appropriate – we lose vital information for research and treatment, thwart our understanding of what

these experiences are really like and reinforce the stereotypes and thus the stigma that is already widely held.

4.4.1 Understandability

Instead of thinking of delusion formation in terms of an un-understandable problem with an underlying biological cause which has yet to be found (Jaspers, 1997, p.607), or thinking of psychiatry as the study of disorders of the brain (Bargmann and Lieberman, 2014) or as being synonymous with neuroscience (Tandon et al., 2015), we might think of mental illness in general and delusion formation in particular as a far more complex phenomenon. The phenomenon might be said to be understandable given the context in which it arises. Whilst we might not straightforwardly understand ‘uncanny’ prodromal states (e.g.: Barbara), voice hearing phenomena (e.g.: Alison and Caroline) or being overtaken by an inexplicable power (e.g.: Andrew) that people can experience, we can understand that their attempt to describe them tells us that they have undergone a real subjective experience that is primary. If this kind of experience is intense or persistent enough it is integrated into experience and the normal human desire for sense making means that an explanation is needed. The explanation that a person adopts to explain the experience is then understood as delusional. In the cases presented here, the context enables us to see that the delusion – at least in these cases - is formed following a period of distress, despair, or depression and poor self-care and has not come ‘out of the blue’. The context in which experience breaks down is vital for our understanding of delusional formation. Any

successful account of delusion will thus have to extend beyond the brain, and engage with the complexity of experiential context. If psychiatry is the study of the different factors contributing to delusion formation and other mental phenomenon associated with mental illness it must, therefore, incorporate an understanding of lived bodily environmental experience.

When people are faced with despair, negative emotions, and suicidal thoughts, the adoption of new beliefs that make sense of their experiences is understandable and might protect them from intolerable feelings. This process can be conceived of as an unconscious defence mechanism or as a basic biological response to life-threatening or unbearable distress. This might even be considered pragmatic or beneficial.⁴⁵

4.4.2 Stigma Reduction

Nicholas Rüsçh and David Thornicroft highlight a number of factors that might have an impact on stigma and thus on treatment and prevention. *Poor mental health literacy* or lack of knowledge about risk factors and protective factors might prevent people from seeking help before they become ill thus preventing mental illness in the first place. Poor knowledge about early signs and symptoms might prevent people from getting help at the onset of a mental illness and poor knowledge about treatment and relapse prevention might prevent people from seeking help at relapse. *Public stigma* might engender an unwillingness to participate in preventative practices, avoidance of seeking help at onset, and avoidance of seeking help at relapse. People might also

⁴⁵ I say more about this in chapter 6.

feel pessimistic about the success of potential intervention and might experience discrimination in relation to areas such as work, housing and social life as a barrier to recovery. *Self-stigma* might lead to self-labelling, shame, social isolation and pessimism about recovery. *Structural discrimination*, say at government level, might lead to fewer resources being made available at all levels (prevention, early intervention, treatment and relapse prevention) and structural discrimination, by the media, leads to negative portrayals of people with mental illness (Rüsch and Thornicroft, 2014).

Whilst the authors acknowledge we do not fully understand how these domains might interact (for example, we do not know what the general public actually does, if anything, with regard to prevention of mental health problems) it seems likely that these four domains: poor mental health literacy, public stigma, self-stigma and structural discrimination all influence each other and have a negative impact on prevention, early intervention, treatment and relapse prevention (ibid).

If we take a contextual holistic view of the person experiencing mental health difficulties and make this information available in the wider public domain we might improve mental health literacy and perhaps reduce stigma and increase access to treatment.

Although there is some evidence that there is a genetic link for some conditions such as schizophrenia (e.g., Wicks et al. 2010), no clear genetic markers have been identified thus far (Farrell et al. 2015). The medical model

(that mental illnesses are biological brain disorders) is alleged to reduce stigma in relation to blame as no responsibility is placed on the person for developing psychotic symptoms. The downside, however, is that stigmatising associations can be made between psychosis and (a) dangerousness, (b) lack of autonomy, and (c) chronicity (Corrigan and Watson 2004; Mehta and Farina 1997). If those who have psychotic symptoms are at the mercy of a biological disease, then (a) they might be unable to control their own behaviour and therefore be unpredictable and dangerous; (b) they might be lacking in capacity and autonomy, and therefore lose some of their rights and require a third party's benevolent intervention; and (c) the 'disease' might be seen as chronic and irreversible, making recovery impossible.

A model of psychosis which takes into account not only biological factors, but also social, psychological and environmental ones may offer a more balanced account of the person's capacities and limitations, and may enable us to view and at least partially understand the individual symptom within the context of the person's overall life experience. The more we know about the experiences of other people, the closer we get to understanding their beliefs and behaviour. Even a very implausible belief can make sense in context.

This does not mean that we need to rule out the possibility of distinct identifiable endogenous biological aetiology. This might contribute to the cause of some kinds of mental illness. Further, it might be distressing for some people to have their illness associated with childhood trauma or other trauma or distress where there is none. There is no doubt that the model that

people are given as an explanation for mental illness has an impact on how they respond to treatment and how they feel about themselves and there is some evidence that a combined psychological and biological explanation can be most helpful in terms of compliance with treatment (Lüllmann et al., 2011). The evidence is mixed and there are few studies relating to the impact of patient belief about the cause of their illness on outcomes. There is some evidence that a person who cites a biological cause for her illness is more likely to comply with medication, is more likely to engage with keyworkers but might be more likely to experience self-stigma. More research is required in this area to understand what the impact a patient's beliefs about the causes of her illness might have on outcome (Carter et al., 2017). I suggest a plurality of understanding for this heterogeneous group of illnesses and symptoms where research, grounded in phenomenology, might distinguish between different kinds of psychosis or different kinds of delusions perhaps with different aetiologies.

In each of the cases described above, the new (delusional) meaning that a person makes from a radical alteration in lived experience relates powerfully to significant events in that person's life. At the time when it is first adopted, it enables the person to make sense of her lived experience. If we take this perspective it may be a more effective way to break down the stigma associated with psychosis than to describe people with psychosis as simply having some kind of biological illness. The descriptions of people's lived experience help us to appreciate the context in which delusions are adopted, as it shows us that dire circumstances in the person's social and physical

environment contribute to the onset of mental health problems. This might happen to anybody. Although some individuals may be more vulnerable than others to developing delusional symptoms, I suggest that a continuum approach better describes the person/environment combination that enables delusion formation. Even a person who is considered to be mentally or psychologically robust or resilient might still develop delusions given the 'right' environmental stressors.

If delusion formation is an understandable outcome (which might even be beneficial or pragmatic in the short term) resulting from extreme life stresses leading to intense or anomalous perceptual, affective and emotional experiences, then we cannot 'blame' the person. Life stresses occur in everyone's life and some people are luckier than others and have fewer life stresses. Child development problems and childhood trauma might be considered a highly significant life stressor making a person more vulnerable to developing delusions in later life (Hardy, 2017). Again, we cannot blame the person, she has just been unlucky. Context is vital. If we understand the context in which delusions develop then a person's reaction to the life stresses becomes, at least to some extent, understandable. And if we understand a person, then we are less likely to think in terms of 'them and us.' As survival is evolutionarily desirable, then delusions formed as a pragmatic response to protect a person from life threatening despair is also desirable. How can we blame a person for protecting herself from this and how can we think there is something 'wrong' with her when, even under duress, her survival instincts are still intact?

A person trying to make sense of her lived experience is just doing what we all do, sense-making is an inherently human capacity. We need to make sense of our world in order to negotiate it. How can we think that a person who has become delusional as a result of trying to make sense of her new experience is somehow 'other' or significantly different? Further, a person responding in an understandable way to extreme life stress can recover so we need not think of her as chronically ill. She is not inherently dangerous - she is no more likely to be dangerous than any vulnerable person trying to protect herself. Nor is she in need of an overly paternalistic intervention. She might just be in need of understanding and the right kind of therapeutic (and perhaps social/environmental) intervention. What I am saying here is not new:

“Anti-stigma initiatives should emphasize the well-researched psychological and social contributors to mental illness in addition to biological factors. This framing provides an accurate and less stigmatizing explanation of the causes of mental illness. Recognizing that people can and do recover is perhaps the most important way to end the stigmatizing ‘us vs. them’ attitudes and behaviours too often experienced by people living with mental illnesses.” (Canadian Health Services Research Foundation, 2013)

Yet somehow this attitude has not been taken on within the public understanding of mental illness.

If we want people to seek help earlier, we need to reduce the stigma associated with mental health issues and more data like those analysed in this paper should be gathered and made available in the public domain. If people better understood the nature and the trajectory of mental health issues such as delusions in terms of their context then they might be more able to recognise signs of distress in themselves and others, and less concerned about the perceived negative or stigmatising consequences of seeking help.

4.4.3 Treatment, Prevention and Early Intervention

There is evidence that early intervention in psychosis predicts better outcomes in children and young adults (McGorry, 2015). But what about intervention in other groups, how early can we intervene, what form should the intervention take and what are the ethical issues to be addressed? In the At-Risk Mental State (ARMS) literature in relation to psychosis, Andrew Thompson and colleagues' review a number of research articles with a view to understanding the efficacy of various ARMS assessments, the ethical issues that preventative treatment raises and the treatment options that are available. They conclude that, whilst those assessed as 'at risk' are much more likely to develop a psychotic illness than the general population, the majority do not actually become ill. The potential risks associated with unnecessary treatment are therefore a serious consideration (Thompson et al., 2016).

In the kind of examples above, if these people were to present to psychiatric services prior to the onset of their delusions, early intervention might take the

form of talking therapy helping them to come to terms with change and the circumstances they find themselves in that might otherwise lead to unbearable despair or distress. Whatever form the therapeutic intervention takes it should be tailored to the needs of the individual. This has wider political or socio-economic implications, because the distress might be related to a person's environment and this might have to change in order for the despair or distress to be ameliorated. For example, a client of mine after a long-term hospitalisation, was housed in a block of flats where his neighbours were people who had recently come out of prison (who were engaging in low-level criminal activity), drug addicts and recovering drug addicts. He felt his environment was unsafe and (quite understandably) his persecutory delusions resurfaced very quickly resulting in him being re-hospitalised. This form of housing was clearly inappropriate for this person.

If environment causally contributes to mental illness⁴⁶ this has still wider political and socio-economic impact in terms of prevention. If predictors include poor housing, poor social support, poor sleep, nutrition and self care then there might be more to be done in terms of prevention. We might reduce the risk of development of some mental illnesses by improving education around these environmental risks, providing more support for those at risk and by building appropriate housing within environments that ameliorate these risks.

⁴⁶ I give some examples of how increased incidence of mental illness correlate with environmental factors in chapter 7, section 7.4.5.

The discourse around seeking help and treatment at early intervention might be altered if context is understood and we think of coping with significant life change as a flag for potential problems. Understanding the development of delusion in terms of perceptual, affective and emotional anomalies might change the way we intervene. Specific therapies might be developed that target percept, affect and emotion. This might include psycho-education and perhaps talking therapies designed to improve a person's ability to manage her emotions as well as perhaps poetry, literature and film used as therapeutic tools. If perceptual anomalies are impacted by a sense of self / body ownership then perhaps bodily or bodily/visual therapies might be developed. Body awareness therapy, yoga, music therapy, dance, other forms of movement therapy, occupational therapy and art therapy might be indicated (for a survey of these kinds of therapies see Maiese, 2015a, chap.6). Of course I cannot say exactly which therapies would work for which people in what circumstances this is an empirical question. Little research in this area has been done but there is some evidence that these therapies can be useful for certain groups (ibid).

The kind of help offered is likely to have an impact on stigma – if we offer anti-psychotic medication then we imply a 'downward' trajectory and label 'ordinary' problems as highly problematic. The people interviewed in this study were not looking after themselves - none of them were eating or sleeping properly. If we offer therapies that relate to nutrition, healthy sleep patterns and coping with change, perceptual, affective and emotional

problems not only do we reduce the potential for harmful side-effects⁴⁷ and iatrogenic dependence on anti-psychotic medication (Moncrieff, 2006) we 'normalise' these prodromal (or even pre-prodromal) 'symptoms' and perhaps prevent psychosis from developing in the first place.

As we have seen from the empirical data in this chapter each research participant experienced strong emotional, affective and/or perceptual anomalies prior to and/or during the onset of their delusions. In the next chapter I survey some of the literature on emotion, affect and percept in relation to delusion formation and show how this relates to my interview data.

⁴⁷ Side effects of anti-psychotic medication are numerous and some are potentially life threatening (for a comprehensive guide see Gardner and Teehan, 2011)

CHAPTER 5 - AFFECT, PERCEPTION AND EMOTION

5.1 Introduction

As I have shown in chapter 2 delusion is notoriously difficult to define. Clinical definitions usually relate to false beliefs in the absence of supporting evidence that are held with conviction despite the availability of counter evidence. At first pass this makes it look like the 'problem' lies with processes used to make inferences. But is this really what is going on? In this chapter I look at some literature relating to delusion formation in terms of a phenomenon that arises out of extreme or unusual affective, perceptual or emotional states. I argue that delusions arise as an understandable response to 1) heightened emotional experiences such as trauma, 2) bizarre or anomalous perceptual or affective 'felt' experiences and 3) other 'free-floating' or objectless intense emotions. I suggest that any of these (or a combination of these) if intense and/or persistent enough partly constitute a radical alteration in lived experience and thus *demand* a re-evaluation of a person's understanding of the world resulting in delusion formation.

In section 5.2 I look at some literature about what it might be about clinically significant delusions that differentiates them from other 'ordinary' mistaken beliefs, in section 5.3 I link the literature to my empirical findings, in section

5.4 I discuss the implications and finally I summarise and make my concluding remarks (section 5.5).

5.2 What Sets Clinically Significant Delusion Apart?

As we have seen in chapter 2 most clinical definitions of delusion relate to false beliefs held with conviction. It is worth re-stating the most commonly cited definition from DSM 5 and its similarity to Jaspers' definition (which predates DSM 5 by 100 years) in order to reiterate what some of the problems are and how we can move from this 'vague' definition to a way of better capturing what is problematic about clinically significant delusions. According to DSM 5 and to Jaspers a delusion is:

“A false belief [*Jaspers' – “false judgement(s)”*] based on incorrect inference about external reality that is firmly sustained [*Jaspers' – “held with extraordinary conviction”*] despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary [*Jaspers' – “imperviousness to other experiences and compelling counter arguments”*]. The belief is not ordinarily one accepted by other members of the person's culture or subculture (e.g. it is not an article of religious faith) [*Jaspers' – “...nor can the prolific views of entire nations be given the title delusion...”*]. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility.” (American Psychiatric Association, 2013, p.819; Jaspers, 1997, pp.95–96 & 195)

Brendan Maher concludes that the clinical definition of delusion requires that we hold certain assumptions about belief formation and about delusion formation: that beliefs can be verified from available evidence; that people routinely look at appropriate evidence when forming beliefs; culturally held superstitions and religious beliefs do not arise as a result of the kind of faulty inference process associated with clinically significant delusions; and extreme cases of implausibility should be included as delusions. He posits that these assumptions might cause us to hypothesise that the 'pathology' (or clinical significance) with regard to delusions formation lies in a defect in inferential processes (Maher, 2001, p.309)

Jaspers describes 'external characteristics' that are similar to modern definitions and can only be recognised as possible delusions, in the first instance, from these external characteristics. He says that the term delusion can only 'vaguely' be applied to his definition (above) and that the content of a delusion is more like a rudimentary feeling which has an obscure certainty (Jaspers, 1997, p.95)

Despite his definition (above) and the fact that he says we can only identify a delusion using this definition which 'vaguely' applies he is quick to point out that he does not intend that we understand clinically significant delusion in terms of problems with inferential processes:

“...in any case the mentally ill person has as much right to be illogical as the healthy one. It is wrong to consider the failure in reasoning a morbid symptom in one case but normal in the other.” (Jaspers, 1997, p.97)

On this point Maher agrees and cites evidence demonstrating that if we assume that there are 'ideal' ways in which we use deductive and inferential reasoning (such as the ways in which a scientist would use these processes) we might find that many of us fall short of this ideal. But most of us are not delusional (Maher, 2001).

For Jaspers, understanding delusion cannot rest on reasoning deficits (although some would disagree with my interpretation of Jaspers, see for example Uhlhaas and Mishara, 2007). For Jaspers our understanding of this phenomenon requires a different approach:

“We should rather address ourselves to the problem of what it is that occasions the incorrigibility and causes us to recognise certain modes of wrong judgement as delusional.” (Jaspers, 1997, p.195)

For Jaspers there is something that 'occasions incorrigibility' and this is what is clinically significant.

As I have mentioned in chapter 2 Jaspers differentiates between delusion proper (or primary delusion) and delusion-like ideas. For Jaspers, if delusion can be psychologically understood in context then it is not delusion-proper but simply a delusion-like idea. When the whole meaning of a person's lived experience alters at the onset or genesis of delusion and the subjective feel of this psychic phenomenon cannot be understood in any kind of psychological context then this is delusion-proper (or primary delusion).

Jaspers' detailed phenomenology shows that people with delusion-like beliefs form them in ways which are understandable and emerge from other psychic events such as affects, drives, desires and fears. Primary delusions, on the other hand, are psychologically irreducible and derive from an 'uncanny' feeling that precedes delusion formation and represents a change in lived experience and the meaning that the world holds for the person:

"We find that there arise in the patient certain primary sensations, vital feelings, moods, awarenesses... Patients feel uncanny and that there is something suspicious afoot. Everything gets a *new meaning*... there is some change which envelopes everything with a subtle, pervasive and strangely uncertain light." (Jaspers, 1997, p.98)

Perhaps *because* of the clinical definition of delusion that relates to belief formation and suggests a problem with inferential processing there is considerable research around problems with reasoning in relation to people with delusions.

There is evidence that people with a diagnosis of schizophrenia who have delusions are more likely to jump to conclusions than controls under experimental condition (Dudley et al., 2016). *Belief flexibility* includes the capacity to accept the possibility of being mistaken, the ability to develop alternative explanations and the capacity to take on board evidence that is counter to an established belief. There is some evidence that populations with clinically significant delusions perform less well in these areas than those who do not have clinically significant delusions (Ward and Garety, 2017).

These biases might be thought of in terms of Daniel Kahneman's notion of *thinking fast* (intuitive thinking) and *thinking slow* (reflective thinking) (Kahneman, 2012) and this might have implications for treatment (Ward and Garety, 2017). However, we cannot say whether people become unwell because they have a tendency towards reasoning biases or they *now* have this tendency because they are unwell. The 'jumping to conclusions' (JTC) literature only demonstrates that people with a certain psychiatric diagnosis make decisions more quickly and with less evidence than people who do not have this diagnosis *not* that their actual decision making is impaired (in Huq et al., 1988 correct decision making was no worse for people with delusions than for people without). Whilst it is possible that people with delusions may have problems with reasoning there is no clear evidence that demonstrates that this is clinically significant. I suspect it is unlikely that people with delusions have reasoning problems that are any worse than the rest of the population and, in any case as Jaspers says (above), a failure in reasoning is not considered a morbid symptom in the normal population so why would we consider it to be so in a person who has delusions.

I further suggest that by focussing on this characteristic we miss the nature of delusion formation. If we listen to what people say we find that anomalies in experience are the precursor to delusion formation. These anomalies need to be investigated. As we have seen (in chapter 4) people sometimes find their experiences extremely difficult to describe and the researcher (who is unlikely to have experienced what is described) finds the description difficult to understand. Nevertheless we should attempt to understand. When a degree

of understanding is reached then the delusion formation becomes understandable. We might not understand elements of the anomalous experience when taken out of context but nevertheless, if we take what a person says seriously in the context of her lived experience we can move towards a better understanding.

A person experiencing extreme or unusual perceptual, affective or emotional anomalies must make sense of the world by incorporating these experiences into her world. This is an ordinary process that we all go through. We pick up cues from our environment and from the people around us and incorporate what we experience into our world-view in a meaningful way. A person always has subjective experiences which are not directly available to others. There is always 'something that it is like' to be that person undergoing her unique lived experience. All the elements that contribute to her experience form part of the environment from which the person must derive meaning and make sense.

I am agnostic about whether there is a strict difference between (Jaspers') primary delusions (or delusion-proper) and delusion like ideas. In addition to distress and/or problems with functioning, at least with regard to the experience of my research participants, I suggest that the alterations in the affective, perceptual and emotional nature of lived experience prior to delusion formation (which may come about by a number of different means – psychologically understandable or not) is the characteristic that enables us to differentiate between clinically significant delusions and ordinary unexamined

or mistaken beliefs held with conviction by people who never acquire a psychiatric diagnosis. On this point Jaspers' would agree. Delusion-proper arises from an 'uncanny' change to 'primary sensations, vital feelings, moods, awarenences' and delusion-like ideas arise from (psychologically understandable) affects, drives, desires and fears.

The degree to which a person's experience is altered might give rise to different delusional outcomes. For example, it might be the case that in some circumscribed or monothematic delusions there is a specific or relatively narrow alteration in experience. It might be the case that in florid psychotic delusions with elaborate schemas the alterations in lived experience might be much more broad and all-encompassing.

Subjective states such as the 'uncanny' feeling described by Jaspers and the prodromal states described in more recent literature (see for example Kapur, 2003) as well as the subjective affective and emotional states that might be involved in some (perhaps more readily psychologically understandable) delusion formation are primary. A third party cannot dispute them. If a person feels, for example, fear then this is her experience of herself at the time she felt that fear. Of course she might decide, on reflection, that she had nothing to be afraid of and in this case perhaps the fear would dissipate. This does not, however, alter the fact of her experience at the time that it happened.

Anomalous subjective states are the territory that I am interested in. I suggest that they can take a number of forms relating to altered perception, affect and emotion and it is these alterations that lead to delusion formation.

In the next section I briefly describe what I understand affect, emotion and perception to be in order to explore these notions in relation to psychiatric illnesses in general and delusion in particular.

5.3 Emotions, Affectivity and Perception

5.3.1 Emotions

I take human emotions to be experience that is 'felt' and is at once bodily *and* cognitive.⁴⁸ Bodily or 'felt' arousal alone is not emotion and we need other factors to explain experience.⁴⁹ If my heart rate increases and I start to feel bodily agitation I will look to my environment for an explanation. If there is nothing in the environment that 'explains' this to me I might think I'm having a panic attack or even a heart attack. If I look to the environment and see an attractive man I might think this is the cause of what I now label 'excitement.' If I look to the environment and see a tiger I might think this is the cause of what I now label 'fear.' The environment is thus partly constitutive of the emotion. Without the stimulus or explanation (as well as the 'feel') I would not be experiencing what human beings usually understand as emotion. If I see an attractive man and think to myself 'he's attractive' but I have no 'felt' or bodily response I am not excited. If I see a tiger and think to myself 'there is a dangerous tiger' but have no 'felt' or bodily response then I am not feeling

⁴⁸ There is a huge literature on emotions and what an emotion *is* is by no means settled. Some see emotions as judgments (e.g.: Solomon, 2007) and others see emotions as fundamentally bodily or perhaps perceptual (e.g.: Prinz, 2004) and there are a number of hybrid theories (e.g.: Goldie, 2002).

⁴⁹ There is evidence that primitive brain responses which are probably consistent across mammalian species and perhaps other animals too underpin the human emotions (see Panksepp, 2012).

fear. I can, of course, feel fear by *imagining* a dangerous situation so the 'environment' might be in my imagination. These principles apply to other emotions too. An emotion *can* be (but may not be) recognised and labelled by the person experiencing it. A person's capacity to name an emotion is linguistically and culturally determined. The (bodily) feeling relating to certain kinds of experience is similar enough to other experiences for this to be recognisable. For example my fear of tigers feels a bit like my fear of snakes.

5.3.2 Affectivity

I take *affectivity*⁵⁰ to be a term that captures all the subtle responses that a person might have relating to pleasure, pain and desire as well as more obvious (recognisable and easy to articulate) emotions and moods. It is not synonymous with emotions but includes emotions. It also includes the bodily and the non-self-consciously cognitive and might include unmediated (direct) responses to perception. Affectivity includes sub-personal drives that bring about goal directed action. Affect might draw a person towards a pleasurable object or situation or toward an activity that meets a person's wants or desires. Affect might also repel a person from objects or situations that cause pain or suffering or that prevent a person from meeting her wants or desires. As such, affect can alter (increase or decrease) a person's capacity to act.

⁵⁰ The literature in this area is vast and affectivity is cognitive for some (e.g.: Lazarus, 1982), bodily and sometimes directly 'perceptual' for some (e.g.: Prinz, 2004) and automatic and not synonymous with emotion for others (e.g.: Massumi, 1995). Antonio Damasio has written extensively on the different 'states' of this kind of experience: bodily (or somatic) emotion, feeling and feeling made conscious (Damasio, 2000, 1996). Whether affect is cognitive or bodily also rests on definitions of cognition that are enormously varied (for a brief critique see Zajonc, 1984; or Loewenstein, 2007).

5.3.3 Perception

I take perception to be the ability to see, hear, smell, taste, touch or become aware of something through the senses. Perception and affect are overlapping capacities that can be intermeshed⁵¹. For example, perception is influenced by attention so I might perceive (see, hear, smell, taste or feel) something because my attention is drawn to it. I might, for example, have my attention drawn to (or 'notice') the smell of coffee in the environment because it is lunchtime and I did not have my usual cup of coffee this morning. I might also hear my name called against a noisy background in which I cannot distinguish other words and phrases (Driver, 2001). The environment is partly constitutive of perception (no coffee, no smell⁵²). This 'noticing' of something salient in the environment is affective and relates to goal seeking behaviour. 'Noticing' (or perceiving through smell) that coffee is available in the environment enables me to seek out the coffee and to satisfy my craving. Noticing my name against a background of other noise enables me to turn my attention to listening to speech that is aimed at me. Conversely, if I am paying close deliberately focussed attention to something then other things in the environment can become invisible. This is known as inattentional blindness (Simons and Chabris, 1999). So a person's capacity to perceive things in the environment is, to some extent, intermeshed with her affective goal seeking behaviour.

⁵¹ The extent to which affect and perception are intermeshed or overlap is hotly debated in the literature (for a review of some of the arguments see Firestone and Scholl, 2016 and the companion articles in this edition of Behavioural and Brain Sciences).

⁵² Unless I am having an olfactory hallucination.

In the next section I give some examples of perceptual, affective and emotional anomalies from the philosophical literature on psychiatric illness

5.4 Perceptual, Affective and Emotional Anomalies

5.4.1 Perceptual Anomalies in Schizophrenia and Delusion

In their article on perceptual anomalies in schizophrenia Peter Uhlhaas and Aaron Mishara review the territory with a view to integrating phenomenology and cognitive neuroscience. As we have already seen in chapters 3 and 4 whilst the practice of phenomenology is atheoretical the findings from phenomenological analysis might provide important insights about how subjective experience relates to psychiatric disorders which might lead to testable hypotheses about underlying mechanisms. They cite a number of examples from the literature suggesting that people who go on to acquire the diagnosis of schizophrenia experience perceptual anomalies prior to diagnosis. These anomalies relate to 1) an inability to see a scene as a whole (the scene is fragmented and only individual details are available), 2) movements of people and objects in the environment cause the scene to 'disappear' requiring effort to reconstitute it 3) an inability to make sense of other people's conversations (their words do not 'fit together') 4) certain objects standing out in the environment (experienced as personally salient) and 5) an inability to distinguish between the relevant and the irrelevant (Uhlhaas and Mishara, 2007). Perception provides the background through which we experience the world and enables the world to show up as an

organized meaningful whole. In human beings meaningful sense-making occurs as a direct result of perceptual input.

“Perception is, by definition, a meaningful awareness of one’s environment and one’s perspective on it. Lacking access to cognition, pure perception would be devoid of meaning and consist instead of an absolute associative agnosia in which the conceptual recognition of environmental objects and events is entirely absent.” (Clare and Proffitt, 2016)

If perception is impaired, lived experience becomes odd or peculiar. The environment is not readily recognisable and objects and sounds in the environment do not ‘cohere’ into a meaningful whole. People experiencing these kinds of alterations find it increasingly difficult to make sense of the world in which they find themselves. If a person’s perceptual experience is altered she must somehow make sense of this new world.

Klaus Conrad describes three phases in the development of delusional perception. In the first phase the environment takes on a new significance but this is not understood (similar to Jaspers’ ‘uncanny’ experience), in the second phase certain objects have immediate personal significance and in the third phase certain objects have specific personal meaning (Conrad in Mishara, 2009).

Uhlhaas and Mishara review the experimental data and phenomenological data and conclude that perceptual anomalies might be present in some people who acquire a diagnosis of schizophrenia, the degree of perceptual

impairment might be linked to the severity of the illness and perceptual impairment might be primary leading to reduced processing capacity in relation to other mental activity (Uhlhaas and Mishara, 2007).

5.4.2 Affective Anomalies in the Capgras Delusion

In the case of some monothematic delusions there is some evidence that there is a breakdown in certain affective capacities. People with the Capgras delusion (or Capgras syndrome) think that loved ones or close family members are imposters of some kind. They might think that they are aliens or robots or that they are another person in a very good disguise. They do not deny that the 'imposter' looks like the loved one or family member but they routinely describe a sense of 'unfamiliarity.' Capgras is a heterogenous syndrome and there are a number of different explanations for the formation of the delusion (for a review of research in this area see Sautter et al., 1991). There is, however, some evidence that a person's capacity for facial recognition has a number of components relating to the look of the person as well as to an affective or emotional feeling of 'warmth' or 'familiarity' toward a known person. When impairments in the capacities that contribute to the affective 'feel' of familiarity occur then the Capgras delusion develops. Face processing impairments relating to identification of familiar faces, recognition of emotional facial expressions and matching of unfamiliar faces have been shown to be present in people who have developed this delusion (Young et al., 1993). The galvanic skin responses (used to measure heightened emotions or affect) of people with the Capgras delusion were the same when

looking at familiar people as when they were looking at unfamiliar people. This is in contrast to populations who do not have the Capgras delusion where the galvanic skin response is higher for familiar faces (Ellis and Young, 1990). This lack of affective response to the 'imposter' is not readily understood by the person experiencing it. 'What it is like' to interact with the loved one is altered in a way that is hard to articulate. This suggests that the normal affective response is absent when the Capgras patient looks at the family member. An explanation for this difference in subjective experience is required and the delusion arises as the result of a person's accounting for this change (Stone and Young, 1997). On this account 'imposter' status is 'given' in the experience (at a sub-personal level) and the delusion that develops might have differing (personally salient) content (eg: my wife has been replaced by the government).

5.4.3 The Perceptual Affective Anomaly of Alien Control

People with the delusion of alien control think that their body parts and/or their thoughts are controlled by a third party. Thought insertion is often described as a delusion of control and seems to share some phenomenology with the delusion of (bodily) alien control as well as with voice hearing experiences. The phenomenology variously includes the sense that one's body parts are not one's own, an inability to distinguish between one's body or mind and those of other people, the sense that someone or something else is controlling one's body or one's mind and an inability to prevent involuntary movements or to make deliberative movements. This might be described as

1) a perceptual anomaly or 2) an affective problem relating to salience or 3) an affective/perceptual problem where sense data and affect (valenced subjective feel) are both attenuated. In 'alien control' experiences a person's ordinary perception of ownership of her own body and agential movement of her body parts is altered or her own body movements lose their 'given' sense of personal ownership and agency in some way and seem to gain the salience of the external action of others. Chris Frith's influential model posits that a breakdown in our (sub-personal) ability to predict our own thoughts and movements leads to the experience that those very same thoughts and movements are not our own (Frith, 1987). The ability to 'predict' exists just so that we can tell the difference between our own movements and that of others. Others' actions are highly salient and our attention is drawn to them because they are not predicted. If our (internal) ability to predict our own movements or thoughts is compromised we cannot tell that they 'belong' to us and we lose the ordinary 'given' sense of agency and mine-ness (Blakemore et al., 2003; Hohwy and Rosenberg, 2005).

We know that perception of ownership and agency over our own body parts is complex. For example, we can trick people into incorporating rubber hands and mirror reflections of a hand and arm into their own body schema⁵³. So we know that our perception of our own bodies is partly constituted by visual feedback. As it is not settled or fully understood how these delusions are formed and they are heterogeneous there might be different aetiologies. It is

⁵³ I say more about this in chapter 7, section 7.4.1.

possible, then, the delusion of alien control arises in part due to some kind of perceptual and/or affective anomaly.

5.4.4 The Perceptual Anomaly of Voice Hearing and Thought Insertion

Voice hearing or Auditory Vocal Hallucination (AVH) is a phenomenon where a person might experience her own thoughts (imaginings, hopes, fears or desires) as if they are externally voiced from somewhere outside herself. Thought Insertion is a phenomenon where it is thought that a person experiences her own thoughts as if they belong to other people. In psychiatry these are thought of as distinct symptoms but many agree that there might be some overlap. For Irwin Feinberg:

“...auditory hallucinations are perhaps the most common symptom in schizophrenia. They often seem *more cognitive than sensory* and frequently have strong affective tone.” (my emphasis Feinberg in Feinberg, 1978, p.638).

It is likely, then, that people describing ‘voices’ and people describing ‘thought insertion’ may, in fact be experiencing a similar phenomenon (see also Frith, 1992; Langland-Hassan, 2008; Stephens, 2000; Gunn, 2016b).

These phenomena might be described as altered perceptions. A person ordinarily experiences her thoughts as self-generated with a sense of ownership or ‘mine-ness’. Thoughts show up in a person’s stream of consciousness and ownership and agency is ‘given.’ It would not occur to most of us to wonder who owns or who generated the thoughts to which we

have first-personal access. There is also evidence that people who have voice hearing experiences have what is termed as an 'externalising bias'. In experimental conditions it has been shown that when played 'white noise' those who experience voice hearing are more likely to say that what they heard contained a person talking than others who do not experience voice hearing. In recall tasks this group are also more likely to think that they said a word out loud (when they were only asked to think about that word - not say it) and more likely to incorrectly recall the experimenter saying a word (when it was actually the research participant who had said it). There is also some evidence that when asked to respond to positively or negatively valenced words those who heard voices felt that they were less in control of their responses than they were with regard to responses to neutral words. This was in contrast to controls where there was no significant difference in their perception of control over neutral words and valenced words (Morrison and Haddock, 1997). The results of these kinds of experiments are mixed and might be thwarted by the fact that research groups have different diagnoses and other symptoms (as well as voice hearing). Further, there is a consensus that voice hearers are a heterogeneous group with different experiences and that 'voice hearing' experiences might have differing aetiologies (for a review of research in this area see Brookwell et al., 2013).

In summary, further research is needed in this area but there is some evidence to suggest that the environment is more readily misinterpreted by some people who hear voices and that emotionally positive and negative words might increase the propensity to misattribute thoughts and words to a

third party and this anomalous experience might be described as both perceptual and affective.

5.4.5 Emotional Anomalies in Delusion Formation

Delusion is a common symptom of psychotic illnesses and it is well established that emotional stress is linked to psychosis (for a review of research in this area see Myin-Germeys and van Os, 2007). The British Psychological Society also posits a distress model for the development of psychosis citing such factors as childhood trauma and bullying as well as everyday life stresses such as bereavement, divorce and redundancy as contributing to the development of psychosis (Cooke, 2017). They cite evidence to support this and go as far as to say that:

“Some psychologists are reaching the conclusion that psychosis is often no more and no less than a natural reaction to traumatic events.” (ibid, p.43)

Others have written extensively on the impact of emotional distress on the development of psychosis as well as the influence emotions might have on the experience of psychosis itself and the effect emotions might have on recovery citing literature from psychoanalysis, cognitive science, developmental psychology, evolutionary psychology and neurobiology (see, for example Gumley et al., 2013).

There is increasing evidence in the literature that emotions have an impact on delusion formation specifically. In a recent study by Daniel Freeman and

colleagues people with persecutory delusions were randomised to three groups. In one group short term worry was induced by asking each person to think about a particular area that he or she was prone to worry about. In another group worry was reduced using meditative techniques. In the third group participants were given magazines to read. Each group was assessed prior to the interventions and after the trial using established measures. The investigators hypothesised that working memory would be reduced, propensity for jumping to conclusions (JTC) would increase and that aberrant or anomalous perceptual experiences associated with delusion formation would increase in the worry induction group. Whilst there were no reductions in working memory or increases in propensity for JTC there were significant increases in aberrant or anomalous perceptual experiences in the worry induction group. The researchers conclude that excessive or increased worry increases aberrant or anomalous perceptual experiences associated with delusion formation and that therapies that target worry reduction might reduce propensity to delusion formation (Freeman et al., 2013). Their finding is supported by a pilot study that evidenced that a specific focus on diffusion of the emotional components of persecutory delusion reduces distressing symptoms (Hepworth et al., 2013).

Other research, reviewing a number of studies on grandiose delusions, proposes a model for delusion formation by at least two different routes. One route involves a highly positive affective (or euphoric) internal mental state, perhaps after a positive triggering event or after substance abuse, which leads to judgements about the internal state and thoughts about specialness

or special abilities. Another route might be as a defensive reaction to negative life events threatening self-esteem or social rank thus protecting the person from an intolerable reality. These two routes are not mutually exclusive and might interact with each other (Knowles et al., 2011). In either case a radical affective alteration in lived experience is involved. In the former case a person experiences a kind of 'high' or euphoria that, if sufficiently persistent, demands a re-evaluation of the world and leads to delusion formation. In the latter case a person experiences psychologically intolerable negative life events which might demand a response that protects her from fully acknowledging this experience⁵⁴.

I suggest that when affective, perceptual or emotional anomalies occur which are *intense and persistent enough* then a person will form what others might call a delusional explanation. In the next section I illustrate this using data from my empirical research.

5.5 Affect, Perception and Emotions in the Empirical Analysis

It is difficult to separate affect, perception and emotion. They are overlapping phenomena. Things might be said to stand out in the environment or be salient if a person is drawn towards them or repelled by them. This might be described as both perceptual and affective. Objects have a different perceptual impact because they have a different affective impact. Ordinarily a person notices an object in the environment because it helps her to make

⁵⁴ I discuss the protective nature of delusion formation in more detail in chapter 6.

sense of her environment. For example, a dangerous object in the environment might stand out and be repellent affording the possibility of avoidant behaviour. An edible object in the environment might stand out and be attractive affording the possibility of feeding oneself. Mood might also have an impact on what a person notices in her environment and a euphoric person might 'see' her environment differently from a depressed person (for a brief review of some evidence showing the interaction between mood, affect, emotion and perception see Zadra and Clore, 2011).

In this section, I show how the experiences described by the research participants prior to delusion formation all contain these kinds of anomalies. These anomalies, which are persistent and/or intense, come to form part of a person's lived experience and are incorporated into the meaning or sense-making of that person's experience. The new (delusional) meaning is an ordinary response to extraordinary experience.

5.5.1 Affective Anomalies

5.5.1.1 Barbara

Barbara's ordinary affective engagement with the world was radically altered. She experienced being drawn towards things in the environment such as music on the radio, road signs and things that people were saying. Prior to this experience Barbara had no special response to road signs, songs on the radio or to what people were saying. She experienced them in the way that most of us do. Road signs simply gave information about the roads, music on the radio was just background noise and other people's conversations were

not especially important to her. As we have seen in chapter 4 Barbara finds this very difficult to explain.

As the experience intensified Barbara finds she is drawn to the conversations of others and that these conversations become personally salient:

“Then... it started happening everywhere, everywhere I went people were talking about me, talking about things in my house. Even in... their own conversations. I was like [whispers] what’s going on here?”
(Barbara 1, 1:37-40)

Certain things and people in the environment were no longer ‘neutral’. Certain people and places, repelled her. They were experienced as ‘evil’ and this meant they had something to do with the Devil:

“I really wanted to smoke and I got signs saying no smoking, stuff like that. It weren’t nice signs it was... like evil signs.” (Barbara 1, 2:23-25)

“...this doctor said to me do you see Devils? I said yes I see them right in your eyes right now. Cos it was really frightening, you *could* see them, you could see the Demons around you.” (Barbara 1, 5:43-46)

“...when the devil wants me to, he can just make me see something really ugly and really scare me.” (Barbara 2, 20:51-52)

“I went into this club, and everyone... was just staring at me. And I was like L [her friend] I have to get out of here, I said I’m sorry I just have to get out of here. I was only drinking water. I said I have to get out of

here everyone's staring at me. It was like okay, she took me home. But... it was all redeye and... stuff like that. It was all a Devil's den."
(Barbara 2, 20: 39-45)

Certain experiences became polarised. Some related to the Devil and some related to God:

"...cos back then I used to take messages from the tears as well. One would be the left side which was the Devil and one was the right side which was God. It was all weird..." (Barbara 1, 6:24-26)

"A police car signalled the Devil and an ambulance signalled God. And I still see the ambulances now. God still talks to me through them."
(Barbara 1, 6:34-36)

All of these experiences were unusual for Barbara, she had not experienced them before and she found it hard to articulate what was happening to her. Nevertheless, this was a real subjective primary sensory experience which is not directly accessible to others. The experience is intense and persistent and affectively charged.

5.5.1.2 Andrew

As we have seen in chapter 4 after years of distress, OCD, intrusive thoughts and lack of sleep Andrew experienced an overwhelming 'power' come over him. The way he describes it makes it sound like it was both bodily and perhaps (self-consciously) cognitive as well as affective. He 'feels' the power and seems to immediately know it is something to do with a battle between

good and evil. He has the sense that God is controlling him and he finds it very difficult to explain. He 'feels' this and it is thus affective in nature but does not have the signature of a recognisable emotion. As we saw in chapter 4 he realises that it is unusual and intense and that others would not be likely to understand it.

It was a force that was so powerful I can't even explain it to you.
(Andrew 2, 11:49-50)

"I wouldn't even be able to, it's futile." (Andrew 2, 12:1)

"The... the power cannot be described. The only person who could be able to... is someone who's been through it as well." (Andrew 2, 12: 26-27)

Again, for Andrew, this was a real and intense subjective primary sensory intensely affective experience. He felt a power come over him and he had a sense that good and evil (or perhaps God and the Devil) were doing battle over him.

5.5.2 Perceptual Anomalies

5.5.2.1 Voice Hearing and Related Phenomena

Alison, Barbara and Caroline all had 'voice hearing' or related experiences. As I have mentioned above (in section 5.4.4) voice hearing (or Auditory Vocal Hallucinations – AVHs) and similar related phenomena are common symptoms in some diagnosable mental illnesses (American Psychiatric

Association, 2013, p.87). The experience itself is usually described as hallucinatory and the explanation that a person might give for having this experience is described as delusional. 'Voices' and related phenomena are also experienced by people who do not seek or require psychiatric help (Romme and Escher, 1993).

Alison's delusional explanation for her 'voices' related to hearing other people's thoughts and conversation, Barbara felt that God was talking to her and Caroline thought her 'voices' had something to do with the government. Their ordinary experiences of their own thoughts, imaginings, hopes, desires and fears seemed to somehow be outside themselves. They did not seem to be self-produced and they had no sense that these thoughts were owned by them. Alison, Barbara and Caroline experienced their own mental activity (perhaps combined with other sounds or prompts in the environment) as coming from outside themselves in some sense. This is a direct subjective primary sensory experience to which others have no access. All three of them experienced this over months or years.

Alison found that she was experiencing 'voices' in the environment when there was no one else there or when she could see that those who were present were not actually speaking. She at first found this peculiar and thought she might be ill.

"I'd got an appointment with him and I woke up and I said to D today I'm going to take control of my life, I'm going to see Dr T [laughs] I said and this time I'm going firstly I'm going to apologise for the time before

because I did scream the surgery down literally. And I said I'm going to tell him that I need help and can he please help me. And D said why and I said because I've got voices in my head..." (Alison 1, 5:45-52)

As this experience persisted she came to accept that something was happening to her that required explanation. As we saw in chapter 4 she incorporated this anomalous perceptual experience into her world view in a way that made sense of what was happening and came to accept that she could talk to people without moving her mouth, hear other people's thoughts and hear long distance conversations.

At the time of being interviewed Alison had sought help and recognised that the 'voices' were a stress response relating to her 'breakdown.' However, as we saw in chapter 4, she was still adamant that she *had* been able to hear other people's thoughts:

"Well, no, that is *true*. I *could* hear people's thoughts." (Alison 2, 5:4)

This demonstrates the vividness and intensity of this subjective primary sensory experience. While it was happening she concluded that she could 'hear' long distance conversations (when no one else was there), read the minds of others (when people were there but did not appear to be speaking) and converse with people 'telepathically' (with people who were present and people who were not). This subjective experience is not readily dismissed. On the one hand Alison knows she was ill and on the other hand she is convinced she could 'hear people's thoughts.'

Barbara felt she could talk to God through telepathy and God would talk to her. This realisation came about after she had experienced intense emotions and after anomalous perceptual experiences where objects and sounds in the environment stood out to her and became personally salient. It is not clear exactly when or how the intense emotional experiences and perceptual anomalies gave way to direct communication with God. She does, however, say that when she realised that she was talking to God and God was talking back she was really happy.

“And I was like... Oh my god... and it was really lovely at first I was just talking to... I was just talking to god. And I was like really really happy.”

(Barbara 1, 2:7-9)

She had been searching for an explanation for the anomalous experiences and this appeared to give her some relief from her confusion. This feeling of relief or resolution is a common feature at this stage of delusion formation.⁵⁵ Once she realised that God was talking to her and that his love was unconditional she needed an explanation for the mental pain and negative thoughts she was also experiencing. At some point the negative thoughts become ‘detached’ and she experiences them as coming from outside herself in some sense. Again, she struggles to make sense of this.

“Well... god was picking me up and talking to me all the time and so the messages were coming into my mind as well... but.... Then I realised there was a devil. I did realise there was a devil. And... he was

⁵⁵ I discuss this more in Chapter 6.

threatening me but I was begging God to clear my mind and tell me which one was God and which one was the devil, because I didn't know." (Barbara 1, 3:28-32)

Barbara's experiences were intense, persistent primary and subjective and others did not have access to them. She incorporated these experiences into her world view and concluded that she and God were conversing using 'telepathy.'

Caroline said she 'grew into' her voices and does not remember when they started. She realised with hindsight that her odd behaviours, that she did not understand, where she felt compelled to act were driven by voiced commands that she was unable to resist. She recounts an incident where a voice is commanding her to behave in a way that she would not normally:

"...it started off like a command. So I felt impelled to do the actions, so... yeah, I lost one friend because I tipped a drink over their head sort of thing. Um... some of them afterwards understood... I didn't want to do it, I kind of... had to be compelled to do it" (Caroline 1, 5:19-22)

Caroline was often afraid that the government or some third party was going to do her or her family harm. The 'voices' threatened her and told her she had to behave in certain ways to prevent this harm. The experience was primary, intense and persistent. She did not question whether these voices were real and she was less worried about where they were coming from than what they were actually saying. She assumed that the harm that they threatened would come to pass if she did not act in the way that they commanded. No one else

has access to Caroline's experience. The way she described it and her behaviour as a result of it points to the compelling nature of this anomalous subjective experience.

Alison, Barbara and Caroline all had 'voice hearing' type experiences. They experienced their own thoughts as being somehow 'outside' themselves. These experiences might be thought of as perceptual anomalies.

5.5.2.2 Delusions of Control

Caroline also had some experiences where she felt it was not her that was acting. When I asked her if she could tell me more about what it was like when she was taking overdoses she replies:

"I can't really, cos... it did just... it was just like it weren't me... and... I'm there taking these pills and... it was like... I'm sat there and I'm looking at them... but it's not me controlling my arm to take them". (Caroline 1, 12:2-5)

As I have mentioned above (in this chapter, section 5.4.2) this is known as a delusion of control and is a common symptom in some psychiatric diagnoses.

Andrew also experienced delusions of control. He fell to the ground when he was overtaken by an inexplicable power. When he started writing he had the sense that he was not in control of this process and that someone else (God) was 'making' him write. Andrew's ordinary sense of ownership and agency with regard to his body and with regard to action was altered in a way that he found extremely difficult to explain:

“but I was compelled... not compelled... commanded to write. There’s only one way that I can explain it. Imagine someone put your hands on a piano, and... they play it for you. That’s exactly what it felt like. And it felt like God was... on my shoulder or over my shoulder, however you want to coin it, or... inside me. (Andrew 2, 6:49-53)

Despite what he has been told about his mental illness Andrew’s direct subjective experience of this overwhelming perceptual anomaly was so compelling he could not dismiss it:

“...was that my brain that’s... did that? Or... or was it a religious experience? At the moment I do not know.” (Andrew 2, 13:4-5)

“...you know... because I don’t know enough about the medical c... I don’t know enough about either. I don’t know enough about the medical and I don’t know enough about the religious experiences that people have. I can only go by what I felt, and it did *not* feel medical.” (Andrew 2, 13:9-13).

Andrew was struggling to make sense of what had happened to him. He knew he had been ill and he understood that his OCD, intrusive thoughts and addiction to sleeping tablets were all problematic. With regard to his delusional experience he found the subjective experience so compelling that he could not see how it could be ‘medical.’

5.5.3 Emotional Anomalies

Barbara felt despair about her husband leaving and became suicidal. She was overwhelmed by feelings of guilt about past decisions. She also experienced intense joy, fear and anger. At times these emotions were free-floating and objectless. Her guilt too felt objectless at times and became attached to other experiences like eating and smoking. To start with she did not understand this and felt that the degree or intensity of her feelings did not make sense. These free floating intense emotions were unusual and demanded an explanation:

“...I’d already been through a bad time, took an overdose, everything and then all of a sudden... I felt better after I’d prayed.” (Barbara 1, 1:14-15)

“...and this absolute fear then came among me.” (Barbara 1, 2:15-16)

“...I felt like a robot. And I was like, this is not living, this is existing and I was really in a bad temper. And I got my plates and I smashed them all and then I went... I went up to bed. I was sleeping in bed and I woke up with this... absolutely agonising pain. And I was like oh my god I’m sorry, I’m sorry, I’m sorry. And the pain went away.” (Barbara 1, 2:32-37)

Barbara has experienced extremes of emotional pain. She was desperate and took an overdose, she then felt terror in relation to guilt and the fear of retribution and felt the need to atone. Her atonement behaviours (starving

herself, staying in and giving up smoking) made her feel like a 'robot' and then she became extremely angry. After smashing her plates she went to bed and woke up in agony (she does not elaborate on this so I am unclear if this was mental pain or physical pain). Begging God's forgiveness released her from the pain (and perhaps re-enforces her delusion).

She describes her 'messages' (from God and the Devil) as being emotional in nature:

"I was getting all these messages some from God, some from the devil, but mostly... it was love and fear, like anger, fear." (Barbara 1, 3:33-34)

Barbara describes extremes of emotion – from agony to ecstasy – including severe physical pain with no readily available explanation:

"I was in absolute agony. Really really pure agony. Boredom, pains in my arms, it felt like my arms were broken, pains in my neck, I couldn't lie down, every pain you imagine. And I was scared." (Barbara 2, 6:12-15)

"...when I sit and talk to god I still get high and happy and I'll smile or I'll cry because I'm quite tear struck when I'm talking... when I'm sitting talking to God. But... then I get pain, and I cry cos of the pain. Or I get bored and I'm fed up and I cry cos of that." (Barbara 2, 13:32-35)

"I mean mental pain... it's worse than a headache. Because you can't... it's... that... that's... that's what the devil does to me. It's like a cloud in your brain and you can't do anything through it." (Barbara 2, 14:3-6)

Barbara was high and happy when she talked to God and was in pain (physical and mental) when the Devil was involved. These emotions were extreme, intense and unusual. Although the different emotions come and go the persistence of intense emotions of one kind or another is evident. Barbara has felt intense sadness (or depression), intense joy, intense fear, intense guilt and intense anger. Over time she comes to associate feeling good with interacting with God and feeling bad is associated with interacting with the Devil.

Caroline was traumatised from an early age. She was bullied by her sister, physically abused by her father and grew up in an emotionally cold environment. Emotions were not acknowledged in her family and she grew up with an inability to express her emotions through language. Later, her relationship with her partner deteriorated and, whilst she did not recognise it at the time she says, with hindsight, that she was trapped and desperate to get away from this distressing situation. Caroline experienced intense distress but was unable to acknowledge or articulate this at the time. She had previously felt 'numb' or 'ok' and, whilst she had been in stressful situations in the past, she had been able to negotiate them and, in some sense, manage her emotions. As the distress intensified she was no longer able to do this. She started to take overdoses and felt compelled to behave in odd ways for which she had no explanation at the time. She did not or could not allow herself to articulate her intense emotional distress. When talking about being in an abusive relationship she says:

“I don’t think it was so much that I weren’t feeling it, I was... it’s just the fact that you’ve got to bottle it.” (Caroline 1, 9:35-36)

“...you can’t show it, it doesn’t mean you don’t feel it but you just can’t show it. And... yeah I... think for the start of... it made me upset but by the end I was just numb because it just happened so many times.” (Caroline 1, 9:40-43)

“Yeah... you just trap so many emotions inside that you don’t know which one to show or which one you’re feeling at the time, that it just becomes all numb... that... I’m not sure... if it’s numb you’re not feeling anything or if it’s a numbness you’re feeling everything at once and you just can’t process that quickly...” (Caroline 1, 10:8-12)

When Caroline talks about acknowledging her voice hearing experiences she says:

“I still felt emotions as such. So I was scared because I didn’t know what was going on, fearful of them... um... confused a lot of the time, but again it was just one of those... you got to bottle it, you can’t show... that it’s a problem, which just added to the fact it become numb on a lot of occasions.” (Caroline 2, 12:17-20)

Caroline experienced intense, distressing emotions for which she had no language. She was unable to articulate what she felt at the time and could make no sense of her own behaviour. Later, when she experienced ‘voices,’ this added to her distress and confusion and, at the time when it first

happened and for some time afterwards, she was still unable to articulate any of this.

Andrew was bullied at work. He became fearful and hyper vigilant in relation to work colleagues, fellow students and his tutor. He developed OCD and intrusive thoughts. These problems prevented him from sleeping. He describes the level of distress he was feeling at this time as 'torture.' This intense emotional response became unbearable. The 'torture' was persistent and terrifying. He did not understand what was happening to start with. These intense and distressing feelings went on for months before he sought help.

When he had his delusional experience intense affective states were involved here too:

"Um... now all I know is what happened was is that I was... went on the floor, went on my... this was on my lounge floor, went on the floor and it just felt like evil was trying to turn me into its thing." (Andrew 2, 5:9-12)

Andrew felt he was fighting for his life in a battle of good versus evil. He had to take certain actions to do what he felt was required and this whole experience was very frightening.

5.6 Discussion and Implications

It is well established that stress is involved in psychosis. When endogenous and/or exogenous stressors exceed a level that is tolerable for a person then

psychosis occurs. The exact nature of the stressors and the levels of intensity required for psychosis to develop will be different for different people (Zubin et al., 1983). The literature suggests that some people have a vulnerability to stressors and are more likely to become mentally ill than others. Whilst this might be true I suspect that *enough* stress can make even the most robust person ill. Stress and anxiety can have a number of different effects on eating behaviour including reduction in appetite (Macht, 2008). Stress also has different effects on sleep and can prevent a person getting enough sleep. This is bi-directional and lack of sleep can, in turn, affect a person's mood and emotional life (Kahn et al., 2013). Everyday stress is experienced through lived experience and is persistent and on-going. Being human is a process. People do not have fixed states. If a person lives in a stressful environment she will respond to this through the *process* of living through it. A person's emotional response to an incident might have an affect on what she thinks about herself and the world, this might have an impact on how she responds to others in her immediate environment and their response to her might have a further impact on her emotional life, what she thinks about the world and what she thinks and feels about other people – and so it goes on. In this way environmental stress, affect and cognition are intermeshed and therefore multi-directional.

If my understanding of what my research participants have told me and their recollection and descriptions are accurate it would seem that, in the cases of Alison, Barbara, Andrew and Caroline persistent intense affective, perceptual and emotional anomalies are present prior to the formation of their delusions.

If delusions form as a result of some kind of affective, perceptual or emotional overload related to lived experience then this means that any of us might become delusional. It is of course possible that there are people who are more prone to delusions, perhaps due to problems with emotional regulation or specific emotion related personality styles as a result of developmental and biological or physiological factors. Two people need not respond in the same way to the same lived experience. However, I want to suggest that *whoever you are* a significantly intense and persistent affective, perceptual or emotionally anomalous environment would result in a demand to re-evaluate your understanding of the world and this would result in delusion formation.

If we understand delusion formation in this way then we can no longer think in terms of 'them and us' when it comes to mental illness. As I have said in chapter 4 gaining this kind of understanding about mental illness and making this publically available opens discourse, reduces stigma and might mean that people seek help sooner.

If delusions are understood as arising as a result of persistent and/or intense perceptual, affective or emotional anomalies then this has implications for research both in cognitive science and in neuroscience. We might also think that a move away from the cognitivist definition of delusion is called for. Understanding delusion in terms of affective, perceptual and emotional anomalies might also have implications for treatment and novel interventions that target perceptual, affective or emotional domains might be developed as a result.

In the next chapter I look at how delusion formation might perform a short term protective role enabling a person to avoid unbearable distress and how this is supported by my empirical research.

CHAPTER 6 - THE PROTECTIVE NATURE OF DELUSION

6.1 Introduction

Whilst I was not specifically looking for evidence that delusions might be protective in some way it became clear to me from the descriptions given by my research participants that three out of the four people interviewed had delusions that could be described as having a short-term beneficial impact on wellbeing. Taken in context, within the narrative of the individual, the delusion provides meaning, protection from despair and perhaps even protection from suicide.

Three of my research participants each gain some of these short-term protective benefits through their delusion formation. In section 6.2 I take each person in turn and, using quotes to illustrate the experience, I describe the antecedents to the onset of their illness, the way the illness develops and the possible protective or beneficial nature of delusion formation. In section 6.3 I explore the implications of this.

6.2 Empirical Evidence

There is evidence that sub-clinical delusional optimism about personal attributes and abilities as well as future outcomes and relationships is both

normal and good for a person's mental health (Sharot, 2012). We routinely see the world through 'rose tinted spectacles' and assume things will turn out well for us. Provided we do not experience too many distressing incidents that give us evidence to the contrary we are able to maintain this outlook and this gives us a sense of hope for the future (even if the present is difficult) and enables us to retain a sense of agency and to retain vital and meaningful connection with our environment.

In cases where a person's environment threatens this sense of agency, meaning and connection life might become unbearable. Despair ensues and a person seeks any means available to them to regain agency, meaning and connection. It is thought that delusions can form to protect a person from these (potentially unbearable) losses. If the environment becomes perplexing then forming new ideas or beliefs about the meaning of this environment and how a person can relate to it provides relief (Jaspers, 1997; Mishara, 2009). Delusion formation then represents a complete reorganisation of the person's experience enabling the person to retain vital connection with that new environment (Mishara, 2009) and has been described as an adaptive breaking of 'the doxastic shear pin'⁵⁶ to preserve 'more expensive parts of the system' (Mishara and Corlett, 2009). Delusion might prevent a person from acknowledging facts about their circumstances that are unbearable (McKay et

⁵⁶ A shear pin is a mechanical safeguard or safety device designed to shear or break in the case of a mechanical overload. Typically if a piece of equipment is used incorrectly or forces are applied that should not be applied the shear pin breaks and prevents this incorrect use or force from damaging the equipment (only the shear pin is broken) thus saving the rest of the equipment.

al., 2005) and help to preserve agency in the short term after a crisis (Bortolotti, 2016). There is evidence that persecutory delusions can mask low self-esteem (Lyon et al., 1994) and there is some evidence that people with delusions find life more meaningful than other (non-delusional) groups tested in the same way (Roberts, 1991). Occasionally delusion formation can be positive and can contribute to a person's flourishing (Fulford and Jackson, 1997).

I now examine the ways in which delusion formation might be thought of as beneficial for three of my research participants. Caroline is not included here as her delusion(s) did not have any obvious benefits.

6.2.1 Barbara

6.2.1.1 Antecedents

As described in chapter 4 one of the research participants, Barbara, was married to a man who was a serial adulterer who had already left or threatened to leave her on a number of occasions for other women. When they finally split up Barbara became extremely depressed.

Barbara was desperate for the pain of this separation to go away and she had been through this kind of emotional pain on a number of occasions. While she was feeling this misery she took an overdose. She did not seek psychiatric help at this time. Although there might have been some ambivalence about whether she wanted to get back together with her husband or not she seemed to be saying that she did not want to go through

this distressing and depressing cycle again. She prayed for resolution and for the pain to go away.

6.2.1.2 Prodromal phase

Barbara suddenly felt better. Her depression and mental anguish disappeared and she was enjoying life. She was engaged with the world, seeing friends, going out and enjoying herself. At the time she was relieved, pleased and happy but with hindsight she thought this is odd. As we saw in chapter 4 around this time Barbara started to get the sense that she was being watched and that songs on the radio were presenting important messages to her.

6.2.1.3 Development of the delusion

This general feeling that she was being watched and that she was getting messages from the radio persisted. One day she got messages in such a way that made her certain her experience was supernatural in some way:

“...you don't imagine that it's going to be something out of this world. You believe it's something in this world and you try and explain everything.” (Barbara 1, 1:34-36)

She suddenly realised it must be God. At first she was really happy and she described this realisation (that God was sending her messages) as ‘really lovely.’ This feeling of relief from puzzlement or resolution is a common feature at the onset of the formation of a delusional schema (Mishara, 2009; Jaspers, 1997). The world, which Barbara experienced as ‘weird’ and finds

difficult to describe suddenly made more sense. An explanation had been found for the sense that she was being watched and for the messages that she had been getting.

A few days later Barbara suddenly got messages about a personal decision that she had made a number of years earlier. She made this decision against her better judgement in order to keep her marriage together. Her husband had insisted on it and threatened to leave if she did not do what he asked. When she received this message Barbara was overwhelmed by fear and guilt and the need to atone.

As we saw in chapter 4 Barbara also experienced other intense emotion: love and anger (as well as fear and guilt). On the one hand it seemed to her that the intense emotions had something to do with God and the Devil and at the same time she appeared to recognise that the emotions did not 'match' her initial attempt at reason giving. She described her guilt as more akin to the kind of guilt a person might feel if they had murdered someone. This guilt is intense⁵⁷ and perhaps experienced as free floating with no obvious object. She attached the guilt to her smoking but this still did not quite make sense to her.

Barbara was sectioned under the Mental Health Act and detained in hospital against her will. While she was in hospital she drew a paper shield, she says:

⁵⁷ A psychodynamic therapist, or perhaps any psychologically minded person might think this guilt relates to the past decisions she made against her better judgment in order to stay with her husband and that this is unexamined or unresolved.

“Now, I didn’t make that shield God made it through me and it said all nice things about me, that I was beautiful, I was intelligent, I was important. And it felt really good. I said look what I’ve done look what I’ve done, I was really happy. I was really happy, and... then... as I was writing one verse, I seen ‘I am beauty in his sight’, I went to write I am beauty in his sight. And I thought aw no... and God cried, my eye came with tears and everything. God said no that is right you can write that down. So I wrote it down and put God... I am beauty in his sight.”
(Barbara 1, 6:16-24)

As I mentioned in chapter 4 at times Barbara’s direct communication from God related to positive thoughts about her, she says:

“...as God was talking to me he was making sure that I knew there was *nothing* wrong with me. And he’s always there, whether I’m right, whether I’m wr... well, he, he says I’m never wrong, God says I’m never wrong.” (Barbara 2, 7:15:18)

“Right, if I say something bad about myself and God will cry and say ‘no that’s not right.’” (Barbara 2, 15:1-2)

“And it doesn’t matter how much bad you do, well, it doesn’t matter what I do, he’ll never stop loving me ever.” (Barbara 2, 15:44-45)

“He wouldn’t let me do... he wouldn’t let me do anything that would damage me... something that I wouldn’t be able to live with (Barbara 2, 16:1-6)

Barbara's delusion enabled her to feel that she was loved and lovable, that she was intelligent, beautiful, important and was forgiven for past actions. Her previous depression, guilt and fear were erased when she realised that God's love was unconditional. In addition, her tendency to negative self-talk was responded to by God, directly, through telepathy. God told her that the bad things she thought about herself were mistaken.

The content of this delusion might be described as protective. Barbara was protected from feelings of being unloved which relate to her husband leaving, she was protected from feelings of guilt relating to decisions she had made in the past and she was protected from other negative things she might think about herself. This might prevent a downward spiral of negativity and guilt leading to depression and perhaps suicide.

Eventually God told her she was his child. She now had an explanation about why God did not want her to eat or smoke - she did not need mortal or human comforts - God gave her everything she needed:

"...eventually he told me I was his child, I was his real child just like Jesus. I'm God's first girl. God's firstborn girl, he's never ha... created a girl before. God created Jesus and he created me. And... I was... and it was the food... and then I realised the food and drink weren't because he was punishing me. It's because I didn't need them. Because if God creates someone he'll create them with everything they need to survive. Because he loves me that much he would not leave me without

something I need to survive. So I actually didn't need the food and drink." (Barbara 1 9:14-22)

After a later relapse Barbara described a time of utter bliss. Songs on the radio were all positive and joyful. God told her that all the songs were for her. When God spoke to her she felt euphoric, like a child and full of energy.

After a period in hospital Barbara's euphoria had gone. She hung on to the notion that God was with her in order to put up with the anguish and mental pain that she was now in which she described as unbearable. It is completely understandable that Barbara preferred being euphoric and talking to God than suffering mental anguish. She tried to retain her connection with God, hoping that she could, again, reach the state of bliss that she was in before she was hospitalised.

Barbara said that God had written poems through her which help explain his plan and the way the world is. Barbara said that others would be unable to cope with the knowledge of their own mortality:

"... if everyone knew what I knew... then there'd be mass hysteria, everyone would be crying, upset because they know they can't live, there's no heaven for them. There's no... its only... that's why... I'm the o... because I am going to heaven definitely. It's set in stone." (Barbara 2, 12:14-19)

It seems that the certainty that she is God's child and that she is immortal was protecting her from the mental anguish associated with the inevitability of

death. Barbara used her delusional schema to help her negotiate all mental distress. On the one hand this might be described as protective or adaptive as it prevented her from going into a negative downward spiral. One could argue that the doxastic shear pin *designed* to break when Barbara's knowledge of the real world threatened to overwhelm her (Mishara and Corlett, 2009) enabled her to experience the world differently and thus protected her, at least in the short term, from unbearable mental distress – mental distress that was so bad she wanted to die. This might be described as adaptive. However, Barbara did not get help for several months and her new way of seeing the world became so entrenched that it might be the cause of some of her mental distress.

6.2.2 Andrew

6.2.2.1 Antecedents

As we saw in chapter 4 Andrew joined a 'job for life' workplace at a young age. He was probably been being bullied at work and he found this almost too distressing to talk about describing his workplace as a 'hellhole'. Family circumstances meant that he was very much left 'to his own devices.' He became fixated on work, concerned about doing well in his job and worried about the consequences of getting this wrong.

It seems that he felt utterly powerless in this situation. He realised that he had no choice about what work he was asked to do, who he worked with, how management treated him and how the hierarchy worked.

He described an incident where he was intimidated by three managers who were trying to make him take on more work (work that he did not think he would be able to do). He said, at this stage, he was so distressed that he wanted to 'go nuts' or smash a chair and it took a great deal of effort to stay calm.

He was fixated on work and fixated on doing a good job from the very beginning and the need to do well seemed to become more intense as time went on. Andrew resolved to make things better at work by training in Human Resources (HR) so that he could get out of his immediate environment and improve the workplace environment for himself and others.

Andrew's ability to look after himself deteriorated as he became more fixated on work and on his training course. He realised, with hindsight, that he was not getting enough sleep, he was not eating properly and he was becoming isolated (prioritising his work and his course over his social life). At some point Andrew became addicted to sleeping tablets because he could not sleep as a result of stress, overwork and obsessive or intrusive thoughts. He eventually dealt with his addiction but he still was not sleeping properly or looking after himself.

Andrew started behaving oddly. He started becoming obsessed with what others thought and he describes this as being paranoid. Andrew's description implies that the workplace was a distressing and unpleasant place and that it might be necessary to be concerned about what others thought in order to survive. It is also possible that the 'dangers' in the workplace were highly

unpredictable requiring extra vigilance to be able to navigate the hostile environment.

Andrew became obsessed with a need to go to the toilet, repeatedly thinking about it and finding that this made it increasingly difficult to concentrate on other things. He also developed checking behaviours. After he had finished and passed his training course this problem escalated. He received a diagnosis of OCD about five months later when he eventually sought help. I estimate, based on his description of the build up to this, that his intrusive or obsessional thoughts as well as a degree of paranoia were causing problems for about six months before his full-blown OCD set in.

He got to a stage where he felt utter despair and obsession and was finding it increasingly difficult to function.

6.2.2.2 Despair

For months Andrew was in utter despair. Work was a hellhole, he was obsessed with doing well on his training course, he was obsessed with doing well at work, he was frightened of the people in the workplace environment and the consequences of doing badly or not doing what was asked of him and he was plagued by intrusive thoughts, obsession and paranoid thoughts. As we saw in chapter 4:

“...and then it just got worse into total chaos, um... chaos and torture.”
(Andrew 1, 1:38-39)

Andrew became socially isolated, he left work and he stayed at home watching 'hero' films. Eventually he had what appears to be a psychotic episode. He sent an email, called the police, called an ambulance and ended up as a psychiatric in-patient.

6.2.2.3 Development of the Delusion

With regard to delusion when Andrew recounts his story, in the first instance he denied experiencing anything that others would call delusional and, at the same time, he knew he had experienced strange things and behaved in ways that he previously would not have.

As we saw in chapter 4 Andrew wrote an email about power and injustice saying that he was willing to stand up and challenge various global problems. He sent this to a lot of people. He said that, at the time of writing the email, a sense of being directly in touch with God and being his messenger was overwhelming but has now passed. However, as he talked about the experience he asserted that he was God's messenger and at the same time he wondered if he was mentally ill. He said the notion that he behaved in this way as a result of mental illness seems implausible to him because it did not feel 'medical.' The feeling of the power that came over him was utterly inexplicable and therefore must be supernatural in some way. As we saw in chapter 4 he fell onto the floor, was overwhelmed by a powerful and indescribable force and felt that God and the Devil were doing battle over him. Ultimately he felt compelled or commanded to write and send an email:

“...but I was compelled... not compelled... commanded to write. There’s only one way that I can explain it. Imagine someone put your hands on a piano, and... they play it for you. That’s exactly what it felt like. And it felt like God was... on my shoulder or over my shoulder, however you want to coin it, or... inside me.” (Andrew 2, 6:49-53)

“I’m a... I’m a full believer because I know what it felt like. He was with me, over my shoulder or... or yeah, he was with me. It was a force that was so powerful I can’t even explain it to you. (Andrew 2, 11:47-50)

“I wouldn’t even be able to, it’s futile.” (Andrew 2, 12:1)

“And I know how powerful OCD is. What I experienced then uh... was like [sighs] ... I don’t know... at least 20 times more powerful than that, at least 10 times more powerful than OCD.” (Andrew 2, 12:11-14)

“The... the power cannot be described. The only person who could be able to... is someone who’s been through it as well.” (Andrew 2, 12: 26-27)

One could argue that the powerful feelings saved Andrew from the despair of obsession. He had previously felt utter despair, his life had lost all meaning as it used to revolve around work and he no longer had a job. His ideas about the way the world should be (just, fair, kind) had been shattered. At this point he might feel utterly powerless. He recognised that he found uncertainty difficult and sought constant reassurance from other people. If God had a plan for him then this would resolve the tension he felt about not being able to

fully explain, understand or negotiate the world. It also might restore a sense of 'power' or agency that has been missing whilst he was suffering in the workplace and suffering due to his OCD.

As we saw in chapter 4, he believed that what he had written in the email about certain people actually condemned those people to Hell. This sense of power and agency might help him get relief from the despair that he previously felt.

The sense that his life had meaning and he had suffered for a reason provided relief from perplexity (Jaspers, 1997, p.98), he now understood why he had suffered and why he was overwhelmed by this unusual and inexplicable 'power.' His delusion gave him a preferred reality (Roberts, 1991) as he could now experience the world as just (as opposed to unjust). The notion that he was God's messenger and could help to meter out justice enabled contact to be maintained with the world whilst incorporating this overwhelming and otherwise inexplicable experience (Mishara, 2009) as well as, temporarily, restoring power and agency (Bortolotti, 2016).

After Andrew's inexplicable and powerful experience he recounted his subsequent contact with mental health services in the following way:

"And then I rang the ambulance. They came round and I showed them what I'd sent." (Andrew 2, 7:35-37)

“So the third test was: are you prepared to... check into a mental institute and you might not come back out again, put your faith in me. And that one was frightening.” (Andrew 2, 8:6-8)

“...take a leap of... leap of faith with me you’ve got to do it properly. No... there’s no turning back. It is... you have a big possibility... of never coming out again. That’s how it felt.” (Andrew 2, 8:16-18)

“I’m the one who’s got the courage to do what is necessary. If someone was to say ‘why were you chos...?’ if it is that you’re chosen? I’d only use one word and it’s courage.”(Andrew 2, 13:39-41)

It is not clear whether he went to hospital voluntarily or not, although it does appear that he phoned for the ambulance himself. He has now incorporated being in the psychiatric ward into his delusional schema and described it as a test from God. He chose to undertake this test because he had courage, he was fearless and he was prepared to do ‘all that is necessary’. If nothing else, this helps to preserve his sense of agency (Bortolotti, 2016) and perhaps saves him from a worse alternative - despair and powerlessness.

6.2.3 Alison

6.2.3.1 Antecedents

A few years prior to the interview Alison had problems with a neighbour in her home town in the Midlands (a teenage neighbour regularly set fire to the bins on the street where she lived). Alison later moved to the North-West of England near where her other family members lived. At this time a family

member was falsely accused of sexual assault. Alison attended court every day, became stressed and started to have difficulty sleeping. The family member was found guilty of the crime and subsequently jailed. Alison moved back to the Midlands and started to have problems with her new neighbour who accused her of criminal damage and theft as well as accusing her of the same crime her relative was found guilty of. Her neighbour also expressed her fears that Alison's relative would come to visit her and sexually assault her children. Alison previously had a job in the cash office of a supermarket but when there was a problem with her pay she left the job. The neighbour told the other people who lived on her street that Alison was sacked from the supermarket job because she had been stealing from them.

Alison's husband was dismissive of her concerns saying that it was 'all in her head.' Alison had no one else to talk to. The persecution from her neighbour became unbearable so Alison moved house within the local area to get away from these difficulties (organising the move and the finances alone with no help from her husband). She found that the new neighbour was friends with the previous neighbour. On finding this out she took to her bed and stayed there for months only getting up when she had to (e.g, for hospital appointments or when her children came to visit). She was probably depressed (but this was undiagnosed), she did not seek help and her husband looked after her over this time.

Alison said she had not slept properly for a few years (since her relative was first accused of sexual assault). She also had atrial fibrillation which she found

distressing and stressful. This appeared to have both a physical impact on her and a psychological one. She felt panicky when her heart ‘fluttered’ and used breathing techniques to try to ameliorate the ‘flutter’. She was also worried about what the heart condition might mean for her long term health. She had plaques in a major artery, experienced a severe headache for two weeks and lost her sight for a few hours – she did not explain this and I suspect she did not fully understand how these things might be related.⁵⁸ When she told her cardiologist that she lost her sight for a few hours he admitted her to hospital for observation and tests. She was told that she was likely to require some kind of surgical intervention but she did not know what this would be.

At this time her husband was also ill and she was worried about him and found this stressful. Other stressors included moving house, having to manage all the household finances herself and not having anyone to talk to about her concerns and worries.

6.2.3.2 Development of the Delusion

Alison eventually decided that she should go out (she had a hospital appointment and a family event that she wanted to attend). As we saw in chapter 4 she then had a number of experiences related to hearing the thoughts and conversations of others.

⁵⁸ This is life threatening. Plaques can break off and cause stroke or heart attack. Alison’s temporary blindness is almost certainly due to a blockage in the retinal vein.

The first time Alison had this experience she recalled thinking there must be something wrong with her – perhaps she was ill, perhaps it all was in her head. She said she just let things go on and they got worse. On the one hand, at the onset, she recognised the bizarre nature of the experience but, as the experience persisted, it became incorporated into her experience enabling her to keep in touch with a (new) form of reality which included her ability to read minds and have telepathic conversations (Mishara, 2009). As we saw in chapter 4 when I asked her about what happened when she could hear other people's thoughts and communicate telepathically she vacillates between thinking it was a symptom of her 'breakdown' and thinking that she actually could hear the thoughts of others and communicate telepathically.

As the 'voice' experiences diminished Alison was confused about what might have been happening. As she was no longer having these intense and persistent experiences she could see that her explanation about her experience was quite odd. But at the same time, on recalling the experience she was adamant that she had had telepathic conversations with others.

Perhaps this special ability enabled her to temporarily regain a sense of agency in a situation where she felt powerless (Bortolotti, 2016). The policeman, visiting her neighbour next door, was not getting Alison's side of the story, but if she could communicate directly with him telepathically then she felt heard and it became more likely that justice would be done. In this way she might be spared the feelings of powerlessness, the anger over the injustice of the situation and the fear of the consequences of being falsely

accused. This might enable a preferred contact with a just world as opposed to despairing and frightening contact with an unjust world.

It is unclear exactly when it started but at some point Alison developed persecutory delusions (she thought her neighbours were doing things that seem implausible) and voices and abilities enabled her to 'hear' things from her neighbour and social services that were persecutory. On the other hand, her voices and delusional schema about her abilities enabled her to redress the balance by conversing (telepathically) with the police to tell her side of the story.

6.2.3.3 Despair and suicidal ideation

Alison was frustrated that her husband was overly worried about her. As she recounted this she told me that she had felt suicidal because of the stress relating to the problems with her neighbour. She said:

“... whether he thinks I'm going to commit suicide or whether... he thinks I'm going to walk off or... that's the last thing in my head cos I don't feel like that any more... I certainly don't feel suicidal. I did before, I truly did. In fact I popped 400 pills on the table” (Alison 2, 3:25-33)

Alison 'heard' a conversation through the wall between her neighbour and a policeman. She told me about this near the beginning of her first interview.

She said:

“...in the end the night I was... the night I was considering to commit suicide she had a phone call from a police officer his name was sergeant J.’ (Alison 1, 1:19-21)

“...he said, I can see something happening here, there’s a picture forming, I think you’re trying to frame this lady for something she’s not done. Um... I was laying there listening to this, I’d already popped all these pills.” (Alison 1, 1:25-29)

“Um... and I heard him say to her that um... that they were going to watch it and watch the pattern and see how it formed. She went hysterical at him, she was screaming at him ‘arrest her, arrest her, arrest her’. They had a big row and he ended up telling her to f off. He slammed the phone down on her and I ended up thinking well perhaps there is someone who believes me. And that stopped me taking the pills and *that* is the truth.” (Alison 1, 1: 33-39)

She reiterates and repeats this point later on in the second interview:

“If that man hadn’t phoned at the police station, had that row with her next door, which he did...” (Alison 2, 3:44-46)

“Because I heard that conversation, him saying um... I think you’re trying to set this lady up T, um... I can see a pattern forming here. They had a big row, she was screaming ‘I want her arrested, I want her arrested’ and I told you he told her to f off then he slammed the phone down and I

thought oh... somebody is on my side, somebody does believe me. That's how I felt..." (Alison 2 3:54-55 & 4:1-4)

"I scooped all those pills up and put them in the bin, and then I got them out the next morning and flushed them down the toilet cos I didn't want anybody to get hold of them". (Alison 2, 4:8-10)

It is, of course, possible that she could *actually* hear her neighbour shouting down the phone but she would not have been able to hear the police sergeant's side of the conversation. There is a real and pragmatic benefit to this 'voice hearing' experience. Alison was enormously relieved that someone believed her and this prevented her from taking an overdose of prescription medication.

6.2.4 Interim Summary

"humankind cannot bear too much reality" (Eliot, 2001).

Poets and other writers have known for a long time that real life experiences can be unbearable. Barbara, Andrew and Alison all develop delusions that have protective elements. They were all protected from despair in some way and Alison cites what appears to be a delusional or hallucinatory 'voice hearing' type experience as being directly responsible for preventing her from taking an overdose of prescription medication. Andrew regains a sense of agency and meaning from his delusional experience and Barbara staves off unbearable feelings relating to abandonment and guilt and has a counterpoint

to her own negative and highly critical self-talk through her delusional schema.

6.3 Implications and Discussion

There are different ways in which we might understand how delusions arise. There is a tendency for those who do not have mental health problems to view those who do as 'different' or 'other'. People with a mental health problems might be viewed as 'bad' because the problem is part of who they are or part of their personality and this means they are at fault or morally blameworthy. Alternatively, they might be viewed as 'mad' because they are diminished and transformed by the illness, they are not to be blamed because their brain is 'broken' or 'damaged' in some way. As I have said in chapter 4, the medical model is alleged to reduce stigma yet stigmatising associations are still made between psychosis and dangerousness, lack of autonomy and chronicity.

Some strange beliefs with no apparent evidential basis can have grains of truth in them and tell a story when understood within the context of a person's lived experience. In the cases described in this chapter the delusion is not just an abstract or nonsensical aberration it is highly significant for the person who experiences it and relates to other aspects of his or her life. At the time, when it is first adopted, it relieves the person of some heavy psychological burden.

In these cases delusion formation can be seen as a short-term adaptive or protective response to disruptive and traumatising life events. If we understand delusion in this way it may be a more effective way to break down the stigma associated with psychosis than to describe these people as being 'bad' (at fault morally) or 'mad' (having broken or damaged brains). The descriptions of the circumstances in each person's social and physical environment that contribute to the onset of mental health problems helps us to understand the experience. As I have said in chapter 4 this might happen to anybody who experiences distressing intense or persistent life changes (notwithstanding the fact that some individuals may be more vulnerable than others to developing psychotic symptoms).

In the three cases presented here, the context also enables us to see that the delusion is formed following a long period of distress, despair, or depression. If psychiatry is the study of the different factors contributing to mental health problems this might give us more scope for effective care and treatment options. When people are faced with despair, negative emotions, and suicidal thoughts, the adoption of beliefs that make sense of their experiences can, at least temporarily, reduce or control the threats they encounter. This process might be described as adaptive and can be conceived of in various ways. Delusion formation under these circumstances might be thought of as an unconscious defence mechanism or as a basic biological response to life threatening or unbearable distress.

In this context, it makes sense to advocate early intervention (prior to the formation of a delusion). This might take the form of talking therapy helping a person come to terms with her despair or distress in a way that is bearable for that person. As I have mentioned in chapter 4 this has wider political or socio-economic implications, because the distress might be related to a physical or relational environment and this might have to change in order for the despair or distress to be ameliorated.

This view has implications for treatment once a delusion has developed. If a person's delusional schema helps her stave off unbearable feelings, and perhaps suicidality, then simply disabusing her of her delusional belief, especially at critical times, might bring about a worse outcome than the presence of the delusion. A challenge to a delusion that is performing a protective function might be inappropriate and counter-productive. An alternative means to 'protect' the person from what might be unbearable alternatives must be considered within the therapeutic intervention before any attempt at challenging delusions can be made. An ineffective challenge might serve to raise a person's defences and strengthen the delusion and an effective challenge might shatter the delusion but raise other problems that are more psychologically distressing and perhaps even life threatening. When a delusional belief is challenged, something else would need to be put in its place. Perhaps a response to the person's crisis that plays the same protective function but is less psychologically costly than the delusion would be required.

Alternatively, in the short term, as a response to a person's crisis, we might think that therapeutic intervention should take the form of acceptance of the subjective experience and acceptance of the delusional belief (as opposed to challenge) with a view to focus on other areas like relationships and the potential to engage with meaningful flourishing despite illness as well as exploration of the subjective experience (as opposed to denial or challenge) and alternative sense-making. This approach would have to be person-specific and tailored to the individual. Clinically significant delusion is often thought to be paradigmatic of mental illness and, given the short term protective nature of some delusions, we might think of therapeutic intervention in terms of enabling or facilitating continuing to function *within* this illness. Perhaps we just accept that the delusional belief is important and it is thus retained until it is no longer needed. Havi Carel developed the notion of *health within illness* as a response to chronic illness and disability. She suggests that the individual's capacity for *adaptability* and *creativity* should be nurtured and a focus on *care* rather than *cure* should be adopted (Carel, 2007). These aspects might apply equally well in the short term to those experiencing protective delusions.

If healthcare professionals understand that delusions can be adaptive this will alter the way we intervene. If we alter the way we intervene this might also change the way people engage with mental health services. A focus on acceptance and care (rather than challenge and pharmacology) in the short term might make seeking help a more appealing option.

In summary some psychotic symptoms, commonly regarded as marks of madness, such as delusions can be construed as adaptive responses to a psychological crisis, viewed in the context of a person's life experiences. For Barbara, Andrew, and Alison the development of delusions and hallucinations seems to be a response to a sustained experience of despair and powerlessness. Barbara overcomes unbearable feelings relating to abandonment and guilt and counteracts negative self-talk through her delusional schema. Alison cites what appears to be a delusional or hallucinatory 'voice hearing' or 'telepathic' experience as being directly responsible for preventing her from taking an overdose of prescription medication at a time when she felt nobody believed her. Andrew regains a sense of agency and meaning from his delusional experience feeling empowered to restore justice in the world. In the short term such experiences can be considered adaptive.

However, this experience can be mixed. In the case of Alison the content of the voice hearing experiences were at times persecutory. If a delusion persists and an elaborate schema is developed (as in the case of Barbara in particular) then the delusion might add to a person's psychological distress as it becomes increasingly difficult to incorporate experience into the entrenched schema. Andrew's delusion restored a sense of agency and gave him meaning within a preferred reality yet he has also alienated friends, colleagues and others by expressing his delusion in an email.

An in-depth analysis of first-person accounts of the context in which delusions are formed can help us better understand the nature of psychotic symptoms, undermine some of the bases for the common stigmatisation of people with psychosis, encourage people to seek treatment sooner and also inform treatment options.

In the next chapter I look at the enactive approach and how this relates to an understanding of cognition as well as an understanding of mental illness. I also look at empirical evidence that provides some support for the enactive approach to cognition.

CHAPTER 7 - THE ENACTIVE APPROACH

7.1 Introduction

Psychiatric practice is concerned with a vast array of human experiences. If a person is mentally ill she might experience peculiar thoughts, feelings or perceptual experiences that cause distress and have a detrimental effect on her functioning and wellbeing (American Psychiatric Association, 2013, p.20). These experiences can be understood in terms of psychological distress (Payton, 2009), problems with living (Szasz, 1960), problems with one's experience of oneself as a self (Sass and Parnas, 2003) or violations of epistemic, moral, emotional or social norms (Broome and Bortolotti, 2009). However one chooses to conceptualise mental illness it is always identified at the *person* level. As I have said in chapter 3 *people* become mentally ill and the illness is manifest in behaviours, thoughts and feelings that are identified as problematic by the person experiencing them or by others observing them.

In this chapter firstly I look at the difficulties that psychiatrists have in establishing how mental illness has been brought about and how it might be treated in any particular individual (section 7.2). I then look at the enactive approach and how symptoms of mental illness might be framed using the enactive approach (section 7.3). Next I look at some of the empirical evidence for bodily and environmental influence on experience in general and

on mental health in particular (section 7.4), and consider its implications (section 7.5).

7.2 Why Psychiatry is so Hard

“Being a psychiatrist means dealing with ambiguity all the time.” (Dew, 2009, p.16)

When meeting a person who describes a vague and distressing uneasiness psychiatrist Rachel Dew recognises that she could, by asking the right questions, identify a past trauma or a current stress. She finds herself developing a sense of whether the problem is more biological or psychological, simultaneously questioning her own ‘dualist’ attitude – as if the psychological (ie: thoughts and feeling) weren’t also biological.⁵⁹ In her example she goes on to say of the patient that “...she needs her serotonin levels tweaked, that’s why she feels this way.” (ibid) And yet she acknowledges the truth – that she does not really know why the patient feels the way she does. If she thinks the problem is more psychological she will refer her for talking therapy, if she thinks it is more biological she will prescribe selective serotonin re-uptake inhibitors (SSRIs) which make more serotonin available to the brain. She could use either approach or both simultaneously. Further, Dew recognises that what she says to the patient about what she thinks is wrong will (probably) come to form part of the patient’s self-narrative (Dew, 2009).

⁵⁹ I take this to mean that as people are biological organisms and thoughts and feelings are properties or experiences that people have they must also be biological in nature.

Most psychiatrists recognise that physiological processes affect psychological processes and vice versa. They recognise that talking therapy influences psychological processes which in turn affect physiological processes and medication influences physiological processes which in turn have an impact on psychological processes. Psychiatrists also recognise that a person's past experience and current lived experience have an impact on her mental wellbeing. All of these potential influences are non-linear and there is a complex intermeshing which includes feedback loops between the biological, the psychological and the environmental. This looping intermeshed feedback comes about through lived experience at person level. When a person seeks psychiatric help it is unlikely that one can identify a single 'cause' of that person's problems.⁶⁰

There are competing views with regard to what psychiatry is or what it should be. The medical model was challenged by George Engel in the 1970s when he introduced the idea of the bio-psycho-social model into physical medicine (Engel, 1977) and this is (supposedly) the standard way in which psychiatry is now taught and understood and Thomas Szasz described mental health problems as 'problems with living' (Szasz, 1960). Psychiatry remains a branch of medicine and, as such, this means that the tools available to the psychiatrist are predominantly pharmacological. In a small qualitative study on healthcare workers who were given a vignette of a man displaying symptoms that would attract a diagnosis of schizophrenia and then asked to

⁶⁰ See Richard Bentall's open letter on the 'causes' of mental illness (Bentall, 2016)

respond to a questionnaire it was shown that 47.5% of social workers showed support for the social model whereas 91.3% of the psychiatrists and 60.8% of the CPNs (community psychiatric nurses) favoured the medical model (Colombo et al., 2003). Some regard psychiatry as neuroscience (e.g.: Tandon et al., 2015) some say it is simply the study of disorders of the brain (e.g.: Bargmann and Lieberman, 2014) and some regard psychiatry as a much more complex discipline going beyond the biology of the brain and involving social, cultural and psychological dimensions (e.g.: Bracken et al., 2012).

In the next section, I illustrate the complexity relating to the onset and maintenance of mental health problems using some recent case examples.

7.2.1 Case Examples

7.2.1.1 Case Example 1

In psychiatry a clinician's perspective can change as she acquires knowledge about a person. At a psychiatric outpatient clinic (whilst shadowing a psychiatrist) I encountered a person who sought help through psychiatric services as a result of significant low mood, constant crying and thoughts of suicide. A history was taken and it was discovered that she had recently been bereaved. It was understood that she had an on-going thyroid problem and, in the first instance her levels of thyroxin were checked and were deemed to be as they should be. The patient herself felt that the bereavement did not explain the way she was feeling as it was 'too extreme'. She was prescribed anti-depressants and referred to a bereavement charity for talking therapy.

No change was seen in her condition. Her psychiatrist changed her medication twice but she seemed to be getting worse. Finally she was offered ECT (electro convulsive therapy) which she agreed to. At this stage she was desperate and felt that anything was better than continuing to feel the way she did. After several sessions of ECT she attended a routine thyroid check and the levels of thyroxin were found to be incorrect. The thyroxin was adjusted accordingly and within a few weeks she was back to her 'old self'.

Again, the ambiguity involved in psychiatric practice arises – the psychiatrist is forced to make an educated 'guess' about what is wrong and this decision dictates how she will treat the patient. A psychiatrist might say that it looked like the problem was psychological in the first instance. The person was upset by the death of a loved one. This in turn might affect a person's physiology. Talking therapy might help her come to terms with bereavement and anti-depressants might alter her physiology. With hindsight a psychiatrist might say that the thyroxin level was the problem all along and she made a mistake by identifying other factors as significant. However, as the patient recovered after a number of months and after receiving talking therapy, anti-depressants, ECT and an adjustment in her thyroxin we cannot be sure which of these factors (if any) were significant in her recovery. This example illustrates the complexity of problems that a psychiatrist might face when trying to understand what is happening to a person seeking help.

7.2.1.2 Case Example 2

A client recently came to see me after becoming depressed and being prescribed anti-depressants by her General Practitioner (GP).⁶¹ The client had been evicted from her house and was living with her parents. She did not get on well with her parents as they continued to treat her as if she was a teenager (she was in her 30s) and she had to conform to 'house rules'. The consequences of not conforming meant that she was constantly rowing with her parents. She thought that being evicted from her house was evidence that she had not 'grown up'. Her best friend from school had just bought a flat and was moving in with her boyfriend. She complained of feeling stressed and was not sleeping well. The lack of sleep was affecting her mood. She said she was more irritable than normal and recently had a row with a work colleague. She was ruminating on how her life might have been different if she had finished university. She also regretted splitting up with her boyfriend two years ago and wondered whether it was her fault. Her perceived 'failures' seemed to be highlighted when her friend got her new flat.

Whilst one could argue that this client is not, strictly speaking, severely or clinically depressed⁶² because she is still functioning relatively well (going to work/spending time with friends etc.) it is clear that both she and her GP would describe her as depressed. She uses this language when talking about herself and her GP has prescribed antidepressants. Yet the 'treatment'

⁶¹ This case example is taken from one examined in the proceedings of the AISB 2016 conference (Gunn, 2016a).

⁶² For clinical criteria see F32/33 Depressive Episodes/Recurrent Depressive Disorder (World Health Organization, 1993a).

does not seem to address the problems. Given her narrative it is hard to see how the cause of her depression can simply be a problem with her brain chemistry. It is therefore difficult to understand how a pill that increases the serotonin available to her brain can be an appropriate treatment.⁶³

These examples illustrate the difficulties one might have when conceptualising a person's experience in terms of illness as well as the difficulties one might have in deciding on appropriate treatment. This kind of ambiguity is often evident in psychiatry and is further exacerbated because, as I have said in chapter 3, gaining a full understanding of a person's experience is unlikely so the psychiatrist might have too little information to make a decision about what is 'wrong.' There is plenty of evidence to suggest that our lived environments influence our experience, our development and our mental health in ways that are not fully understood and I will return to this in section 7.4.

In the next section I give an overview of the Enactive Approach to cognition in which Varela and colleagues convincingly argue that cognition is *constituted* by the person-environment system. If we take the Enactive Approach seriously we will see the environment as *constitutive* of mental illness.

⁶³ In some circles (although not in GP surgeries) it is controversial whether SSRIs have a significant effect on people with depression. Meta-analysis of drug trials shows that improvements in wellbeing are sometimes no better than placebo (Kirsch, 2009).

7.3 The Enactive Approach

In this section I briefly look at 'affordances' and what is known as the 'mereological fallacy', I then briefly outline the enactive approach as set out by Varela and colleagues in their 1991 book 'The embodied mind: cognitive science and human experience' and elaborate on some of those ideas using recent events in relation to colour perception and from artificial intelligence. I suggest that the enactive approach enables us to adopt a more accurate framework within which to understand cognition in general and mental illness in particular.

7.3.1 Picking Raspberries, Affordances and the Mereological Fallacy

7.3.1.1 Picking Raspberries

As I pick raspberries from a bush in my garden my gaze moves around the bush, I duck under the canopy of leaves and move the spindly branches out of the way with my hand to try to spot the red fruit. I cannot undertake this task without moving and focussing. Each new perspective reveals new fruit ready to pick. Once located my initial assessment of the ripeness of the fruit is based on the colour. White fruit and green fruit is totally unripe and (probably) inedible. Red fruit is what I'm looking for. If it is sufficiently dark red in colour I reach out to pick it. As my thumb and first two fingers close around the fruit I put a small amount of pressure on it and pull it towards me. The pressure has to be just enough to pull a ripe raspberry away from the hull. Too much pressure and I will squash the ripe raspberry leaving it inedible or I will pull an unripe raspberry off the bush, hull intact, snapped off at the stalk. If the

pressure is just right I pull the ripe raspberry off the bush, leaving the hull and stalk behind. I do this without self-conscious thought. My body knows how to look for ripe raspberries, my perceptual system can spot the likely ripe candidates and in some sense my body (my thumb and first two fingers) seems to *know* when a raspberry is ripe enough to pick as I (non-self-consciously) recognise the feel of the ripe fruit. All of this happens seamlessly. I use my body and my perceptual system in a number of different ways as I respond to my environment. All of these systems are employed in order to achieve my goal.

7.3.1.2 Affordances

A raspberry bush affords me the possibility of feeding myself. Object/environment/people combinations enable affordances. The term 'affordance' is used to capture all the possible actions relating to a given object/environment/person combination (Gibson, 1977). Affordances are dependent on the physical properties of the environment and the capacities of a person in any given situation. It is possible for a person to have the physical capacity to realise an affordance but to simply not know that it is a possibility. For example a person presented with a square piece of paper might fold it in a particular way to make a sailor's hat. The possibility of folding the paper to make an origami frog also exists (it is physically possible, the paper is the right shape and size and the person has the manual dexterity to do it). If a particular person simply does not know how to make an origami frog this might be described as a *hidden affordance*. A person might also be mistaken

about affordances. For example, a person might take homeopathic medicine believing it has an active ingredient that has an impact on her wellbeing. This might be described as a *mistaken affordance*.

A person moves through her environment responding to that environment and the possibilities it affords. Her goal directed decision-making arises from her history, her capacities and the environment in which she finds herself. Any given person-environment combination affords an enormous number of possibilities so how does a person decide which one to pursue? I return to this in chapter 8.

7.3.1.3 The Mereological Fallacy

Mereology is the study of the relationship between the whole and the parts that make up that whole as well as the relationship between the parts within the whole. The term 'mereological fallacy' is used to capture the tendency (in science, medicine, philosophy and elsewhere) of taking a part (for example the brain) to stand for the whole (for example the person) (Bennett and Hacker, 2003, chap.3). Advances in neuroscience might even be responsible for increasing this tendency.

The brain has a function within the organism and is an essential part of the organism. So for example, we need a properly functioning motor cortex to walk but we do not walk with our brains. We also need the normal functioning of the brain and of our senses in order to acquire empirical knowledge. We know if someone has knowledge about, say, delusion by her ability to respond to questions, solve problems and correct errors about delusion. Knowledge is

manifest in this way. A brain does not have knowledge, a person has knowledge. A person cannot see if her visual cortex is not functioning properly. Still, we do not see with out visual cortex alone we see with our eyes. We also need light as well as the capacity to make sense of what we see. This capacity is learned as demonstrated by Manoj Kumar Yadav who was born blind and had his sight restored at the age of 22. He was initially overwhelmed by what he saw and could make no sense of it and it took him about 18 months to 'learn' to see (Chatterjee, 2015). A person also needs a fully functioning hippocampus to remember something but it is the person that remembers not the hippocampus. A hippocampus in a vat can have no memory. If we look at fMRI studies which show blood oxygen level increases in certain areas of the brain under certain conditions we can perhaps identify areas of the brain that are necessary for us to be able to think in certain ways but we cannot look inside the brain in this way and identify thoughts. We can observe increased blood flow in a person's legs under certain circumstances but increased blood flow is not running, just a necessary condition for running to take place (Smit and Hacker, 2014). Brains don't have desires, thoughts and feelings - people do, or as Smit and Hacker put it:

“Nothing a brain can do, no matter whether a human or a non-human brain, can satisfy the constitutive grounds (the criteria) for saying of it, that it sees or is blind, feels pain, or wants to go for a walk.” (Smit and Hacker, 2014, p.1081)

I suggest that we can go further still with regard to the way in which the parts and the whole are related. I suggest that mental activity is partly *constituted* by the environment in which a person finds herself.

When I say that the environment is partly 'constitutive' of cognition what I mean is that the environment is a part of the process from which cognition emerges. Or, to put it another way, cognition is an emergent property of people-environment systems. I am only interested here in human beings and I define (human) cognition or mental activity as all the person level and sub-personal processes involved in human consciousness. I understand consciousness in terms of subjective experience. A creature that has subjective experience where there is 'something that it is like' to be that creature can be said to be conscious (Nagel, 1979, chap.12).

'Constitution' in the sense that I am using it does not require that we think of environments 'doing thinking' or 'doing mental activity.' Environments are not in themselves conscious or thinking in any way, they are not 'mental' in themselves they are simply involved in the production of mental activity. In this way *constitution* incorporates the idea that environments, substances or objects in the environment can be said to 'cause' mental activity in some cases. For example, it seems right (pragmatic/relevant/useful) to say that LSD causes hallucinations in human beings. It is also the case that LSD is *constitutive* (in the technical sense described above) of the hallucination experience in the sense that it is the person-LSD system that experiences hallucinations. LSD is a constitutive part of the process from which

hallucinations emerge. Of course individual differences abound and each person will have a different hallucinogenic experience which might be reflective of her individual patterned history as well as her mood and the physical environment in which she finds herself. Although we might describe the hallucination as being caused by LSD I suspect that 'causal' relations that imply a one-to-one linear (or perhaps single) cause leading to a particular mental outcome (or process) are few and far between. Even in the LSD example other factors (such as personal history, current mood and physical environment) will make a difference to the experience. In general, lived experience is far more complex. The complex mereological looping of the person-environment system is always at play. Cognition in the person-environment system is never static, it is always 'in process.'

In this way the debates about whether mind (cognition or mental activity) is extended (see for example Clark and Chalmers, 1998) and whether there is a kind of causal/constitution fallacy (see for example Adams and Aizawa, 2001) cease to be relevant. There is nothing to be gained from these debates. The complex interplay of environment and person 'creates' mental activity. We might still have something interesting to say about the *degree* to which environments are intermeshed with mental activity in different cases. I suggest that a continuum approach works best and enables us to make sense of the person/environment interplay. Transparent use of objects in the environment might be an example of a high degree of intermeshing between person and environment. For example, the cochlear implant is used by a person to enable hearing. She does not self-consciously 'use' the cochlear

implant she is intermeshed with the implant in such a way that it enables hearing and ultimately speech recognition (Gunn, 2014). The cochlear implant is *constitutive* of the mental activity associated with hearing. The experience emerges from the person-cochlear implant system. Perhaps at the other end of the continuum we might say that simply standing still in a given environment, say, on a beach, has a less obvious impact on mental activity but has an impact nonetheless (simple bodily and mental responses to the undulations of the sand and pebbles under foot as well as perhaps affective or emotional responses). The beach is *constitutive* of the experience. The experience emerges from the person-beach system.

Supporters of the extended mind thesis (e.g.: Clark and Chalmers, 1998), the embedded mind thesis (e.g.: Rupert, 2011) and the scaffolded mind thesis (e.g.: Colombetti and Krueger, 2015; Sterelny, 2010) would all agree that the environment must be included in an explanation of mind. My use of the term 'constitute' embraces the notion that the environment must be included in our understanding of mind and that cognitive processes or mental activity emerge from the person environment system. What I mean here is that whether an aspect of the environment can be said to *cause*, *scaffold* or *extend* mental activity these can all be captured by the notion of *constitution*. As I have defined it (above) the notion that environment is partly *constitutive* of cognition simply means that the environment is a part of the process from which cognition emerges then *cause*, *scaffold* and *extension* are simply ways in which the environment constitutes mental activity. We *always* interact with the environment, we cannot do otherwise, the impact this might have on

mental activity is dependent on *both* the environmental factors and on the individual person's patterned history.

A person interacts with her environment through the *process of lived experience*. We are never static and neither is our environment as we move through it. A person responds to the world in which she finds herself, she cannot do otherwise. To put it simply, whilst I can *imagine* picking raspberries this involves different mental and bodily activity than actually picking raspberries. The presence of the raspberry bush is a constitutive part of the mental activity involved in this process.

The world, the evolution of a species and the emergence of cognition through embodied action in the world are in constant flux and this means that cognition cannot be fixed in terms of brain science alone. This might be seen as problematic. If one cannot fix on identifiable defining characteristics of cognition⁶⁴ then what hope is there for the science of the mind? I suggest that the enactive approach offers hope as a framework for a better (more accurate) albeit more complex understanding of cognition.

I now give a brief overview of the enactive approach according to Varela and colleagues.

⁶⁴ Currently the favoured candidate for scientific understanding of the mind is neuroscience (as promulgated by the Journal of Psychiatry & Neuroscience) and for some psychiatry *is* neuroscience (see for example Tandon et al., 2015). The kind of evidence that neuroscience gives includes 'snapshots' of brain processes (usually described as brain states). Brain processes are clearly necessary for (human) cognition but certainly not sufficient.

7.3.2 Overview of the enactive approach

The mereology of the cognising system is critical to the enactive approach. The parts are arranged in a particular way. The relationship of the parts to each other is vital for the function of the whole. The function of the whole is a property of the parts arranged in this particular way. Or, to put it another way: The whole *entails* the arrangements of *these* parts in *this* way. According to the enactive approach a mind does not exist in isolation from a person or the world that the person inhabits. Cognition is a property of the embodied embedded person and as such is subject to the complex mereology entailed in such a system.

In 1991 Varela, Thompson and Rosch provided a pragmatic guide designed to link or synthesise cognitive science with the phenomenology of human experience. For Varela and colleagues a mind does not exist in isolation from a person or the world that the person inhabits. The notion that a person is both embodied and embedded in the world is central to their conceptualisation of mind. Varela and colleagues use Merleau-Ponty to inform the enactive approach:

“The world is inseparable from the subject, but from a subject which is nothing but a project of the world, and the subject is inseparable from the world, but from a world which the subject itself projects.” (Merleau-Ponty, 1962, p.430).

A person both shapes and is shaped by her environment. The enactive approach posits that we exercise skillful know-how through action which is

both embodied and situated and that the person and the world co-emerge through these recurrent sensorimotor patterns (Varela et al., 1991).

A person is born into a world that exists before she does. This world is understood through lived experience. A person is a subject within the world, the world in turn is projected by the person. A person is thus, in some sense, inseparable from the world into which she is born. Varela and colleagues propose the term *enactive approach* to capture the notion that:

“...cognition is not the representation of a pregiven world by a pregiven mind but is rather the enactment of a world and a mind on the basis of a history of the variety of action that a being in the world performs (ibid, p.9).

In order to study mind or cognition it is clear that the subject matter of this study is the person or the self. This cannot be studied without taking seriously the person's experience. Without the person level experience the endeavour has no subject matter. At any time we might shift perspective and look at different systems within other systems (for example the nervous system might be studied separately from the human being as a whole). When we shift perspective we are no longer looking at the same system. In this chapter I am interested in two different systems: 1) the person as an autonomous system and 2) the person-environment system (that is, the way in which a person might be said to be interacting with her environment).

In the enactive approach a biological stance is taken. Cognition is seen as sense-making in terms of basic biological drivers such as survival and

reproduction. As a person is dependent on her environment for survival she must be able to make sense of that environment. Cognition is thus understood in terms of making sense of one's environment. The enactivist understands cognition in the following way:

- Cognition is an activity relating to a person-environment system. Cognition is not something that brains do. It is not something that embodied brains (people) do. Cognition is something that encompasses and engages with the whole person and her environment. I will refer to this as the brain/body/world system (BBWS)⁶⁵. Cognition arises as a result of this BBWS.
- The properties of the BBWS depend on the parts of the system as they relate to each other. Cognition is thus considered to be an emergent property of the BBWS. The properties of the whole depend on the parts as well as their organisational structure.
- Cognition is biologically grounded in terms of survival and propagation of the species. Cognition is thus understood in terms of sense-making in order to maximise outcomes in these (biological) terms. It *entails* all the elements of the BBWS (such as organisational structure, perception, bodily capacities, environment, culture, goals and values).

⁶⁵ The notion of the BBWS was presented at the Artificial Intelligence and Simulation of Behaviour (AISB) conference 2016 in a symposium on depression (Gunn, 2016a)

In order to incorporate this systemic attitude regarding mind and cognition we cannot hang on to any strong sense of representationalism.⁶⁶ There are some cognitive capacities that might be representational in nature and that can be replicated using computer models. An example of this kind of activity was recently demonstrated by AlphaGo.

AlphaGo is a computer model that follows rules, can learn within the paradigm of the Chinese game of Go and can, in theory⁶⁷, represent every possible outcome in the game of Go. AlphaGo recently beat the Go world champion (Borowiec, 2016). This system performs extremely well in one field of activity, namely the game of Go. This is clearly a vastly more simplistic task than living a full human life. In the vast majority of human activities things are much more complex. When, for example, we think about driving a car we can see that this is much harder to systematise. We have a background of knowledge about the driving experience and as we learn to drive the 'know-how' process becomes automatic and therefore invisible. In short, a person driving does not self-consciously think about the process of driving, to do so would make it impossible. It is unlikely that a person who is driving has a fully filled out representation of all possible outcomes in the 'driving' situation yet we manage to respond to novel situations creatively in the moment. For example, if a zebra stepped in front of the car a driver would (probably) make an emergency stop or swerve to avoid the zebra. The action would be

⁶⁶ Strong representationalism holds that the phenomenal character of a mental state is identical to its representational content as instantiated in the brain (see for example Dretske, 2003)

⁶⁷ The number of combinations in Go are so vast that, given current computer processing power, this cannot be done in practice.

context dependent (for example, a person would be unlikely to swerve if this meant she would hit oncoming traffic). In this scenario a person's culturally embedded history also informs her. If swerving to avoid the zebra means that she will hit a child standing on the pavement she had better not swerve⁶⁸. The fact that she has never been in exactly that situation before does not prevent her from responding appropriately. If we need this kind of know-how to respond to the world and this constitutes cognition then an understanding of brain mechanisms alone cannot be sufficient to explain cognition. This kind of know-how is the result of on-going interpretation from our capacities of understanding - capacities rooted in embodiment and lived (culturally bound) experience. A person needs an embodied, culturally embedded background to know anything and these elements are *constitutive* of a filled out science of the mind.

Next I briefly describe *mind* in terms of an embodied dynamic system embedded in an environment which is in constant flux (as opposed to a neural network in the head). This system (which is constituted through what I have called the BBWS) is unique as it has its own history which is made up of the patterned response to previous environments.

7.3.3 Mind as an Embodied Dynamic System

Varela and colleagues argue that mind emerges from the coupling of an autonomous system with a given environment. They illustrate how this kind of autonomous system might work using their (extremely simple) Bittorio model.

⁶⁸ The fact that this does not seem to require explanation is a property of the shared culture of the author and the reader.

Bittorio is simply a ring sequence of 0s and 1s dropped into an environment of free-floating 0s and 1s. The 0s and 1s in Bittorio can change state but the only possible states are 0 and 1. Bittorio is *organisationally closed* as it *only has the capacity to respond in the way that it does* (by changing state from a 1 to a 0 or vice versa as it encounters the free floating 1s and 0s) and its structure *just is* a ring of 0s and 1s. It is *autonomous* in the sense that it is *self-defined* (ie: retains its ring structure). Bittorio conforms to the rule that each 0 and each 1 will change state when it comes into contact with a 0 or a 1. This means that odd numbers of encounters with free floating 0s and 1s will show a change in Bittorio whereas even numbers of encounters will appear invisible as Bittorio will appear unchanged. Bittorio could thus be described as an 'odd number recogniser'. Notice that the action of Bittorio looks like a regular recognisable pattern, yet it doesn't know anything - it just responds in a particular way. It is not programmed to recognise odd numbers of encounters it simply follows a rule of patterned response in relation to its environment. Regularities constitute Bittorio's world – it is not designed to perform any kind of representation – Bittorio's 'behaviour' is simply enacted through a history of structured coupling. Bittorio responds (or changes) *because of the environment that it finds itself in*. Patterned responses to the environment constitute Bittorio's world. The Bittorio model shows us how the human mind, although vastly more complex, might work in this way and might be described as an emergent autonomous dynamic system *constituted* of the embodied person and the lived environment (Varela et al., 1991).

Organisms in general and people in particular display patterns of behaviour that require us to see them as autonomous. The enactive approach posits a person is an autonomous agent. That is, agency and selfhood emerge from the autonomous (self-defining or self-determining) system. Like Bittorio a person has a finite range of capacities and is thus operationally limited but not operationally closed (it interacts with its environment). In a complex autonomous system like a human being the activity of any process within the system brings about (at least) the activity of another process within the system. A person is organised as a self-producing and self-maintaining network that actively regulates its background or boundary conditions so as to remain viable in its environment. In this way a human being is an autonomous system and, in contrast, an automatic cash dispenser is not because it cannot function without input from a third party. Autonomous systems are self-governed (as opposed to other governed). This is not to be confused with the use of autonomy in terms of self-conscious agency or free will. An autonomous system need not be self-aware in this sense. In the case of human beings sub-personal internal processes maintain the organism even if the organism does not 'know' what it is doing.

The autonomous animal meets the environment on its own sensorimotor terms. It's nervous system establishes and maintains a sensorimotor cycle so that what an animal senses depends directly on how it moves, and how it moves depends directly on what it senses.⁶⁹ The system has semi-permeable

⁶⁹ As illustrated in my (very simple) description of picking raspberries in section 3.1.1 of this chapter.

boundaries and is constantly seeking and exchanging matter and energy with the environment so can never be energetically and materially closed to the environment (which, in any case, would be impossible) (Thompson, 2005).

Our understanding of a living person which allow that the system is autonomous *and* constantly interacting with the environment is best served by the notion of organisational closedness and operational openness. A person remains the 'same' *organisationally* – the parts that make up the human being are arranged in the way that they are in human beings, they have finite capacities and operate in circumscribed ways in relation to the other parts of the human being. A composite unity (like a human being) *is* the relations which realise that unity. The *operation* of the (organisationally closed) system is open to the environment and can be influenced by its interaction with the environment. Internal states can change but structure and therefore unity remains intact (Maturana, 1999). Maintenance of such a system requires input from the environment (such as food and drink) so internal states are affected by inputs from outside and internal states are also influenced by a myriad of other interactions with the environment (the system is operationally open). In order to retain unity the inter-relations of the parts of a person remain structurally intact (the system is organisationally closed)⁷⁰.

That a human being is an autonomous system allows that its organisational closedness and its operational openness (coupling with the environment) as well as its patterned history of responses to its environment determine what

⁷⁰ We can of course replace like with like, so a person who has an artificial mechanical heart is still a person.

counts as information. In this way meaningful information as processed by the system is completely independent of an observer's interpretation. The autonomous system is informed because its endogenous dynamics specify what *makes a difference* to the system (Thompson, 2007, chap.3). A difference is made in Bittorio when the 0s and 1s that it is made up of come into contact with odd numbers of free floating 0s or 1s. In some sense then, odd numbers of free floating 1s and 0s that interact with Bittorio's 1s and 0s represent *information*⁷¹ for Bittorio. So a person's endogenous capacities enable meaning to be made through dynamic interaction with her environment and this interaction determines what counts as information. The complex history of patterned responses is unique to each person and helps explain why we do not all respond in the same way to the same stimulus.

In the next section I illustrate how cognition is culturally embedded and embodied using the example of colour perception and how this is realised within different cultures. I also show how colour perception can differ between individuals using a recent 'viral'⁷² internet phenomenon.

7.3.4 Embodied Culturally Embedded Colour Perception

Varela and colleagues use the example of colour perception to demonstrate how the experience is perceptual (recruiting the eye/brain system), cognitive (we name colours) and cultural (for example one culture only names two colours – approximately corresponding to white-warm and black-cool; another

⁷¹ *Information* only in the technical sense – Bittorio has no capacity to interpret or make meaning from the free floating 1s and 0s, it just reacts.

⁷² An internet phenomenon is described as 'viral' when it spreads quickly and is seen by many millions of internet users over a short period of time.

culture has only one word for what we call green and blue). Colour naming or differentiating between colours in any given culture is understood as relating to the visual environment as well as the purposes, meaning or importance that that particular culture might associate with this differentiation. Further, one always sees a coloured 'something' and the coloured object has surfaces and possibilities for use (or affordances) that form part of the perceptual experience (Varela et al., 1991).

The different ways in which colour perception is experienced can be altered by environment or context is well illustrated by a viral internet phenomenon. In 2015 a photograph of a blue and black dress went viral on the internet and was seen by millions of people. The reason it was so interesting was because some people saw it as blue and black and others saw it as white and gold.

The eye-brain combination is not good at judging the absolute colour of anything. However it is very good at comparing colours. For example one can tell whether something is, say, more green (provided one has the language to distinguish green) than another colour. The eye-brain combination functions through maintenance of what visual neuroscientists call 'colour constancy'. A white sheet of paper simply reflects whatever the ambient light colour is. So it should appear white in bright sunlight and red under the red lights of a nightclub. This change of colour is confusing and the brain has evolved colour constancy. It 'adjusts' or compensates for the ambient light so that it still appears to be white. Colour constancy is a survival

advantage. A red apple always looks the same colour, whether it is in the shade, or in sunlight. What one sees relies on basic human brain-percept capacities and a combination of three factors — what the true colour of an object is, plus any colours right next to it, plus the overall ambient lighting. The particular photo of the ‘viral’ blue/black dress includes no bare skin or other dresses so no obvious contrast to help one decide what colour it is. In addition to this the top of the dress has a panel of reflective fabric. These mirror-like reflections on the shiny part of the dress are known as *specularities*. Specularities on this photo give one the impression that the dress is well-illuminated from the front. If the brain-percept system ‘assumes’⁷³ that the front of the dress is in shadow (thanks to the bright blurry background light), colour constancy is applied and the blueish hue of the shadow is removed - the dress appears to be white and gold. However if the brain-percept system ‘assumes’ that the front of the dress is well lit (thanks to the shiny reflections on the top panel of the dress) – the dress appears to be blue and black.⁷⁴ We do not know, however, why different people ‘default’ to either blue/black or white/gold. The colour that one sees is affected by the material one is looking at, the ambient light bouncing off the material and some subtle personal differences (Meese, 2015).

⁷³ The system ‘assumes’ at a sub-personal level – we do not (and indeed cannot) choose how we see the dress.

⁷⁴ See also the classic chess board example where shades of grey of different squares on a chess board appear to be different when they are in fact the same because the chessboard is set up to make it appear that a shadow is cast on one of the squares (Brusspup, 2011)

Varela and colleagues use the colour example to demonstrate how a person's cognition is embodied (bodily capacities are evoked in cognition), embedded (culture and environment influence cognition) and enacted (action influences cognition). They summarise thus:

“...cognition depends upon the kinds of experience that come from having a body with various sensorimotor capacities... embedded in a more encompassing biological, psychological and cultural context... sensory and motor processes, perception and action, are fundamentally inseparable in lived cognition. Indeed the two are not merely contingently linked in individuals; they have also evolved together.”
(Varela et al., 1991, p.173).

7.3.5 Interim Summary

The mind is a culturally embedded embodied emergent property. It emerges from the BBWS through the complex intermeshed mereology of all the parts that constitute a person's lived experience. Brain science alone cannot capture the lived experience so we must look outside the brain towards the body and the world (or environment) to understand what constitutes mind and cognition.

In the next section I briefly review some of the empirical evidence that suggests that there are feedback loops between brains, bodies and environments out of which cognition emerges. I also look at some of the empirical evidence that demonstrates correlations between lived experience and poor mental health outcomes.

7.4 Empirical Evidence Relating to the Body and Lived Experience

In this section I briefly review some evidence that shows how our bodies and our environments impact experience and cognition. I look at evidence from neuroscience relating to visual perception and embodiment, evidence relating to the experience of eating and drinking and evidence from psychology relating to embodiment and emotion. I also look at the impact of talking therapies and anthropological, psychological, epigenetic and psychiatric research showing environmental correlations with increased incidence of mental health problems.

7.4.1 Phantom Limbs and Rubber Hands

The neuroscientists V.S. Ramachandran treated patients with phantom limb pain (specifically arm pain resulting from brachial plexus avulsion⁷⁵ and from amputation of the arm) using a 'mirror box'.⁷⁶ Each patient placed his or her normally functioning arm in a box with a mirror on one side such that the reflection (of the good arm) was in the position of the damaged arm. Whilst looking at the reflection the patients were asked to move their good arm. The reflection showed a mirror image of their good arm in the place that their damaged or missing arm would be. All the participants had the sensation that their 'phantom' (damaged or missing) arm was moving. Out of the dozen patients that Ramachandran saw half of them experienced a reduction in pain (Ramachandran and Blakeslee, 1999). Ramachandran goes on to

⁷⁵ Brachial plexus avulsion is the severing or detaching of the nerves of the arm and hand at or near the spine.

⁷⁶ I have referred to the 'mirror box' experiment elsewhere as an example of extended mind (Gunn, 2014)

challenge the notion (popularised by some exponents of artificial intelligence) that the brain behaves like a computer with distinct modules performing specialised roles. He argues that his experiments involving phantom limbs show that the connections in the brain are...

“...extraordinarily labile and dynamic. Perceptions emerge as a result of reverberations of signals between different levels of sensory hierarchy, indeed even across different senses. The fact that visual input can eliminate the spasm of a non-existent arm and then erase the associated memory of pain vividly illustrates how extensive and profound these interactions can be.” (ibid p.56).

He goes on to say that his findings (here and elsewhere) show

“... that your body image... is an entirely transitory internal construct that can be profoundly modified with just a few simple tricks.” (ibid p.62).

Ramachandran's on-going research in this area includes experiments using a rubber hand. A person's hand is hidden behind a screen and a rubber hand is placed in front of her where her arm might be. The rubber hand is stroked and her real hidden hand is stroked in a synchronous way. This tricks the individual into feeling that the rubber hand is being stroked. Once the person had identified with the rubber hand (that is, she felt that the rubber hand was being stroked) if the rubber hand was subsequently hyperextended or viciously poked the person had a measurable skin conductance response from autonomic arousal. So, seeing your virtual hand being poked causes a bodily (physiological) change (Armel and Ramachandran, 2003).

The experiments of Ramachandran and his colleagues have interesting applications. Not only do they suggest possible treatments for stroke, phantom pain and recovery from painful hand surgery, but they also show us that our responses to what we see in the environment can change our experience (our felt sense) of pain, change our autonomic (bodily) arousal and even change what body parts (real, reflected or rubber) seem to belong to us (Ramachandran and Altschuler, 2009). The way in which a person interacts with or responds to visual input relating to her own body is highlighted through the use of perceptual tricks. This suggests that these processes of looping feedback between a person and her visual environment help to create the person's experience. A person's experience of herself and her ability to act and respond to the world is thus partly *constituted of the visual input* she receives.

I now briefly examine some of the literature on eating and drinking which demonstrates that multiple senses are intermeshed in these experience and our experience can be altered by altering the eating environment.

7.4.2 Eating and Drinking

Research into the multi-sensory experience of eating and drinking shows us that our experience of taste, flavour and texture can be affected in the lab by alterations in colour and sound. For example, research participants when played an amplified or attenuated 'crunch' sound while they were eating crisps perceived that the crisps were fresher and crunchier than when the sound was not altered (Zampini and Spence, 2004); similar findings were reported

when attenuated crunch sounds were played when eating apples (Demattè et al., 2014). White wine dyed red with an odourless dye invoked red wine descriptors in expert wine tasters (Morrot et al., 2001); cinder toffee tasted sweeter when eaten while listening to high pitched piano music and more bitter while listening to lower pitched trombone music (Crisinel et al., 2012). Diners using heavy cutlery said that food was of better quality and they were prepared to pay more for it than those using lighter cutlery (Michel et al., 2015).

If our experience of eating and drinking can be changed by alterations to the environment (such as adding synchronised ‘crunch’ sounds, playing music, altering the colour of a food or giving us heavier cutlery) this again suggest that this seemingly subjective or ‘internal’ experience of smell and taste is partly *constituted* by the environment.

I now turn my attention to some research on how other bodily and environmental factors can alter our subjective experience.

7.4.3 Other Bodily and Environmental Stimuli

There is plenty of research that demonstrates that changing our facial expressions changes how we feel. Research has shown that if a person holds a pen between her teeth in such a way that makes her mimic the facial expression of smiling she is more likely to find cartoons funnier than someone who holds a pen in her lips (thus not mimicking the facial expression of smiling) (Strack et al., 1988). Further, in controlled conditions a person pulling her eyebrows together, thus partially mimicking the facial expression

associated with sadness, is more likely to feel more sad than a person who does not mimic this expression (Larsen et al., 1992). Functional Magnetic Resonance Imaging (fMRI) studies show that mirror neuron networks respond to both facial mimicry of pain and to facial expression of perceived pain and are involved in our understanding of the pain expression of the other (Budell et al., 2015, 2010; Vachon-Preseu et al., 2012). Altering our facial muscles actually alters our mental experience which suggests that a person's emotional life is partly *constituted* by facial expression.

Other interesting studies show that our emotions and attitudes are affected by environmental circumstances. Experiments where men were approached by an attractive woman for a survey showed that those on a scary suspension bridge found the woman more attractive than those on a more stable bridge. The arousal caused by fear was misinterpreted as attraction for the woman.⁷⁷ This supports the notion that bodily arousal can be misinterpreted based on the availability of objects or people in the environment that might account for that bodily arousal and our (sub-personal) interpretation of the bodily arousal (Dutton and Aron, 1974).

Everyday experience tells us that recalling a happy memory can make us feel happy and likewise recalling a sad memory or a shameful memory can make us feel sad or shameful. Thinking about the possibility of something dangerous can make us feel afraid and thinking about the possibility of something wonderful happening can make us feel happy. It is this fact - that

⁷⁷ This 'interpretation' is at a non-self conscious level, the bodily arousal is subtle and a person would not be self-consciously aware of it.

thinking can change a person's mood and/or emotional response and hence impact behaviour - which has its origins in Stoicism and is the cornerstone of Cognitive Behavioural Therapy (Beck, 1989). When we see a cute video clip (such as a kitten or a baby playing) or a beautiful scene (flowers, a rainbow, a hillside), we can feel happy (notwithstanding the possibility that a bad mood can prevent us from responding in this way). In sum, thinking about certain things, looking at certain objects or environments and imagining certain scenarios can change the way we feel. Thus, how a person feels might be partly *constituted* by the environment or by self-conscious thinking, imagining or remembering.

7.4.4 Interim Summary

Psychology and neuroscience are beginning to investigate the way in which environment and body impact mental experience and they have only begun to scratch the surface. If visual tricks can change our experience of pain; if what we see and hear changes our experience of what we taste; if facial expressions change how we feel; if bodily arousal alters how attractive we think someone is; if thinking about, talking about or imagining scenarios changes our mood, all this points towards the complex mereology that the enactive approach posits. I suspect that there are many subtle ways in which our environment impacts on our experience and this kind of empirical research might, in time, give us more evidence to support the notion that experience, and therefore mind, is *created by* or *emerges from* the BBWS.

I now look at evidence from psychiatric, psychological, epigenetic and anthropological research that suggests our environment has an impact on mental health outcomes.

7.4.5 Lived Environment, the Body and Mental Health

Psychology identifies new correlations between lived experience and mental health outcome all the time. Marius Romme and his colleagues found that seventy percent of those who participated in their research on hearing voices had suffered trauma and in many cases the content of their 'voices' related to this trauma (Romme and Escher, 1993; Romme et al., 2009). Links have been made between childhood adversity and psychosis and there is some evidence (which requires further investigation) that different kinds of adversity lead to different symptoms (Bentall et al., 2014). Increased urbanicity (measured in terms of population density or in population size of place of residence) is correlated with increased incidents of diagnosis of schizophrenia (Vassos et al., 2012). There is a correlation between those with a lower socio-economic advantage and an increased risk of diagnosis of schizophrenia. Factors used to identify disadvantage include parental unemployment, single parent families and size of housing. The same study identified what is called an 'interaction effect' where there seems to be an increased chance of diagnosis of schizophrenia if there is a possible genetic

risk (ie: other family members have a diagnosis of schizophrenia)⁷⁸ *and* socio-economic disadvantage compared to genetic risk alone (Wicks et al., 2010).

These environmental factors, some relating to upbringing and history and some relating to lived experience at the time of onset of illness may have an impact on the development of illness in ways that are currently poorly understood. Exactly what these studies are telling us is by no means settled. However it is plausible that a person's environment is a *constitutive* part of her mental wellbeing. A person experiences her environment on an on-going basis through her lived experience and what appears to be her subjective or 'internal' experience is a process which might be partly *constituted* by the environment in which she finds herself.

Epigenetics informs us that environmental factors can affect whether genes are switched on or not and can even alter the biology of an unborn child. For example, female Holocaust survivors with post traumatic stress disorder (PTSD) are much more likely to have children with low levels of the stress hormone cortisol making them more likely to suffer from anxiety. Whilst it has been argued in the past that this is due to upbringing alone, further studies of pregnant women who were present at '9/11' (the destruction of the twin towers of the World Trade Centre in New York's Manhattan) suggest that it is more complex. Women in their second or third trimester at the time of the incident were also much more likely to have babies with low levels of cortisol.

⁷⁸ Although there is a familial link (ie people in families where other family members have a diagnosis of schizophrenia are at increased risk of acquiring this diagnosis) clear genetic markers have not been identified (Farrell et al., 2015).

This was tested when the children were just a few months old so is unlikely to relate to upbringing. The hyper-vigilance associated with low cortisol and anxiety is considered to be an adaptive survival mechanism for those born into a hostile, dangerous or traumatic environment (Yehuda et al., 2014; Brand et al., 2006; McFarlane et al., 2011). Other physical illnesses are also associated with adverse in-utero environments and might persist over more than one generation (Harris and Seckl, 2011). We also know, from the tragedy of the Romanian orphans who were not nurtured and were left to cry in their cots, that this kind of neglect means that a number of brain regions do not develop properly resulting in dysfunction in the operation of those brain regions (Chugani et al., 2001). This leaves these children with a diminished ability to be sensitive to others or to manage their own emotions resulting in problems with behaviour and with attachment (Chisholm et al., 1995).

Above I have outlined just a tiny number of studies that provide evidence showing that environment and upbringing have an impact on mental health. If taken seriously these data point to the way in which we interact with our environment on an on-going basis and that in turn highlights the complexity of these processes. Biology, psychology and environment are not separate factors that 'cause' mental health problems. Environment influences physiology (eg: stress when pregnant changes base cortisol levels in unborn babies), physiology influences psychology (eg: low cortisol is linked to hyper-vigilance), psychology influences thinking (e.g., hyper-vigilance might mean we see more danger in the environment), environment influences thinking and behaviour (eg: perceived danger increases vigilance and 'safety' behaviours),

thinking and behaviour influences physiology (thinking about dangerous scenarios raises arousal in terms of increased adrenalin). It is clear that there are looping and feedback effects involved in lived experience. This points to the way in which mental health outcomes are dependent on the complex mereology of a person's lived experience.

I now give a brief overview of some research on relational factors highlighting how our interaction with others might also impact a person's lived experience and thus her mental health.

7.4.6 Talking Therapies, Relationships and Mental Health

Connections and relationships with others might also affect one's mental health. Forms of isolation (including isolation tanks) have been shown to induce hallucinations (Levin, 1974) and have more recently also been used therapeutically to improve mental health (Suedfeld and Bow, 1999). *Prolonged* isolation is used as torture and is linked to suicide (Heiss, 2015). Thus relational factors might impact mental health. Being around (the right kind of) people might be good for a person's mental health and being isolated from others for prolonged periods of time might be bad for a person's mental health.

The way one relates to others and the way in which one understands oneself can also have an impact on one's wellbeing. There is evidence that people with a diagnosis of schizophrenia, mood disorders and anorexia are more likely to relapse if family members display what is known as *high expressed emotion* (HEE) which is measured in terms of criticism, hostility and emotional

over involvement (Butzlaff and Hooley, 1998). There is also evidence that family intervention for people with a diagnosis of schizophrenia whose family members have high EE scores can reduce incidents of relapse. In one study, interventions which are intended to reduce EE and/or time spent with the relative with the psychiatric diagnosis included: 1) education of the family; 2) attendance at therapist facilitated relatives meetings where the group was made up of a mixture of high EE and low EE families; and 3) facilitated family meeting (attended by the high EE family member(s) and the person with the psychiatric diagnosis). The aim of the study (reducing EE and/or time spent) was met in 8 out of 11 cases. None of the 8 relapsed within the 9 month follow-up and this was in sharp contrast to a 50% relapse rate in the control group (Leff et al., 1982).

Whilst mindfulness meditation is thought to improve one's wellbeing, outcomes are mixed (Lomas et al., 2015). Some kinds of intense meditation have been linked with mental illness. The intense act of observing the self and one's mental processes (particularly in isolation from other activity where a person engages in meditation for hours at a time over several days) can bring on psychotic experiences and intense anxiety and panic attacks (Wikholm and Farias, 2015). Talking therapy helps to improve people's mental health yet we find it difficult to articulate *how* this works. For example, people with depression are less likely to relapse if they undergo Cognitive Behavioural Therapy (CBT) (Paykel, 2007). People talk about 'coming to terms with' their problems and about feeling relieved that they have been able to express their feelings. In CBT emphasis is placed on changing unhelpful

patterns of thinking (Beck, 1989) and, whilst normally reserved for milder mental health problems, it has been shown to be helpful for those with delusions (Alford and Beck, 1994).

In psychodynamic therapy (a version of psychoanalysis) emphasis is placed on understanding unconscious processes (Howard, 2005). In Person-Centred (Rogerian) therapy a person develops her self-conscious autonomy and her actualizing tendency. The therapist facilitates a person's exploration of her own internal world and her goals and desires by creating a therapeutic relationship where the person experiences empathy, acceptance and congruence (or genuineness) from the therapist (Rogers, 1951). In focussing therapy the therapist seeks to activate a bodily shift in the felt sense associated with a psychologically distressing experience (Gendlin, 2003) and in Eye Movement Desensitisation and Reprocessing (EMDR) a trauma is re-experienced in a new way to break the pattern of hallucination and dissociation associated with Post Traumatic Stress Disorder (PTSD) (Leer et al., 2014; Schubert et al., 2011).

If we can improve our mental health through relationship and through dialogue by experiencing (or re-experiencing) emotions, creating new narratives, altering patterns of thinking and 'reprogramming' physiological (somatic or bodily responses) this gives us more evidence toward the notion that the environment partly *constitutes* our experience. In therapy we deliberately set out to alter our emotional life and our patterns of thinking. However, we interact with others through dialogue and through physical contact from the

day we are born. If talking therapy can alter a person's subjective or 'internal' experience (perhaps by reducing distress, reducing depression or enabling flourishing) then it is plausible that ordinary daily dialogical and physical interactions with others can also be partly *constitutive* of mental health outcomes.

7.4.7 Interim summary

Child development, trauma, current environment, relationships with others, learning about ourselves (thinking about thinking) and levels of adrenalin and cortisol in utero can all have an impact on a person's cognition in general and on her mental wellbeing in particular. There are many more examples in the literature and the examples above simply serve to illustrate that research shows correlations between such factors as lived environment and personal wellbeing. The complexity of these processes is overwhelming and poorly understood. Yet it seems clear that if we want a full understanding of what cognition is we cannot ignore the myriad of loops of connectivity between the person and all aspects of her environment and her lived experience.

The brain is plastic and there is no fixed brain state, brains are in constant flux. Psychiatry often emphasises the medical model and treats mental illness as 'brain bound'. Some believe that:

“Mental disorders are, fundamentally, disorders of the brain in action, and only by observing the brain in action will we find their signatures and unravel their secrets.” (Bargmann and Lieberman, 2014, p.1039).

Others see the problems of those with mental illnesses as more complex:

“Psychiatry is not neurology; it is not a medicine of the brain. Although mental health problems undoubtedly have a biological dimension, in their very nature they reach beyond the brain to involve social, cultural and psychological dimensions. These cannot always be grasped through the epistemology of biomedicine.” (Bracken et al., 2012, p.430)

If we take too narrow a view of mental illness it then becomes a problem with the brain that can be fixed by medical intervention. In many cases this means by pharmacological means. It is too simplistic to say that people with mental health problems *either* have a physiological (biomedical) problem *or* a psychological problem *or* an environmental problem. This implies a dualism of sorts. A person is subject to the mereological affect of all the significant factors relating to her embodied embedded existence in her environment. This includes her personal psychology, her history and her values; her relationships with others, her lived environment and her biological, physiological and genetic make up. Imagine a person who has an extremely isolated life where there are no friends or family and no other relationships of any kind. If we have established that extended isolation contributes to mental illness then how can a pill help such a person? Talking therapy won't help either unless it helps the person to behave differently (and engage in more social relationships). The complexity, mereology and non-linear nature of the genesis and maintenance of mental illness, as illustrated in this section make

our attempt at a scientific understanding all the more difficult. However, this should not prevent us from the challenge of this endeavour.

7.5 Implications

It is well understood in clinical practice that psychiatry is difficult, complex and full of ambiguity. Understanding a person's mental distress might involve the psychological, the environmental and the physiological. How the psychiatrist understands a person's mental distress will impact the treatment she offers and what she tells that person who is seeking help will impact that person's perception of herself. In section 7.2 I provided some case examples that illustrate this. However, psychiatry is thought of as a branch of medicine and the usual or most readily available therapeutic tools are pharmacological. Empirical research offers evidence that a person's personal psychology, history and values, her relationships with others, her lived environment and her biological, physiological and genetic make-up all impact her mental wellbeing. These influences are complex and are enacted through mereological looping within lived experience. For these reasons it seems that the enactive approach better captures the reality of the process of cognition and therefore gives us clues about the ways in which cognition can go awry. Appeal to the medical model or to mental illness in terms of brain disorders hardly captures the complexity of the possible influencing factors involved in the onset and development of those psychiatric illnesses.

If we understand our functioning and our cognition in terms of the BBWS then we will be able to fully engage with the possibility that any part of the system

might have a profound impact on the functioning of a person and on such factors as her mental distress. This opens up possibilities for other (novel, perhaps bodily or environmental) therapeutic interventions as well as broader preventative strategies with regard to psychiatric illnesses. If lived experience and therefore cognition is understood through the enactive approach then this helps to explain how psychiatric illness comes about and might also have an impact on stigma. Any person might undergo any number of experiences that have an impact on her wellbeing. As I have said in chapter 4 difficult, distressing, traumatic or isolating environments might be constitutive of mental illness and of delusion formation and maintenance and to a large extent whether or not a person undergoes these experiences is just a matter of luck.

In the next chapter I look at the notion of *affective framing* and how this can breakdown through endogenous and/or exogenous means. I argue that a breakdown in affective framing can be used to capture the persistent perceptual, affective and emotional anomalies that typify the onset of some delusional experiences and propose a characterisation of delusion using this concept.

CHAPTER 8 - AFFECTIVE FRAMING

8.1 Introduction

As I have shown in chapter 5, delusion formation can be conceptualised as an understandable response to affective, perceptual and emotional changes which are highly anomalous, extreme and/or unusual and persistent. I have also shown, using empirical evidence from my own research, some further evidence to support this idea. In chapter 7, following the enactive approach, I have shown how cognition might be understood as an emergent property of the brain/body/world system (BBWS). Any part of this system might go awry in such a way as to bring about a radical alteration in lived experience. In this chapter I suggest that the radical alteration in lived experience leading to delusion formation might be understood as a breakdown in *affective framing*.

In section 8.2 I briefly revisit what is meant by *emotions*, *affectivity* and *perception*. In section 8.3 I discuss the notion of affective framing as proposed by Michelle Maiese and add my own emphasis in terms of environment as a constituent part of affective framing. In section 8.4 I outline how Maiese uses the notion of attenuated affective framing to account for 'thought insertion' experiences. In section 8.5 I extend this notion still further and show how a breakdown in affective framing might be used to conceptualise the experiences of my research participants and in section 8.6 I discuss the implications of this conceptualisation.

8.2 Emotions and Affectivity

As we have seen in chapter 5, emotions, perceptions and affective states are difficult to distinguish and include sub-personal bodily or cognitive states that are linked to behaviour but cannot be readily articulated from a first-person perspective. In this section I briefly summarise my understanding of emotion and affect in order to explain how *affective framing* is constituted.

8.2.1 Emotions, Affectivity and Perception

As I have already said (in chapter 5) I take human *emotions* to be experience that is 'felt' and is at once bodily *and* cognitive and is partly constituted by the environment. An emotion *can* be (but may not be) recognised and labelled by the person experiencing it, a person's capacity to name an emotion is linguistically and culturally determined and the 'feel' relating to certain kinds of experience is similar enough to other experiences for this to be recognisable (eg: fear of tigers feels a bit like fear of snakes).

I take *affectivity* to be a term that captures person-level responses to pleasure, pain and desire as well as more obvious (recognisable and easy to articulate) emotions and moods. It is not synonymous with emotions but includes emotions and involves the bodily and the non-self-consciously cognitive. Affect is partly constituted by environment and might draw a person towards a pleasurable object or situation and might also repel a person from objects or situations that cause pain or suffering or that prevent a person from meeting her wants or desires.

I take *perception* to be the ability to see, hear, smell, taste, feel or become aware of something through the senses. A person's capacity to perceive things in the environment is, to some extent, intermeshed with affective goal-seeking behaviour (a person 'notices' things that are salient). It is partly constituted through the environment (if there is nothing in the environment there is nothing to perceive).

In the next section I look at how affective responses might impact on decision-making.

8.2.3 Neuroscience and the Somatic Marker Theory

There is evidence that brain-body systems involved in cognition overlap with systems that are involved with affect. Antonio Damasio found that decision-making is impaired when systems relating to affect are impaired. His somatic marker hypothesis holds that a person's affective capacities originate as somatic feelings (pre-reflective bodily responses) and/or certain kinds of (emotion related) brain responses at a sub personal level. These somatic markers facilitate reasoning by enabling relevant salient options to become available. Without these somatic markers decision-making is impaired (Damasio, 1996).

In a more recent article on bridging emotion theory and neurobiology Marc D. Lewis shows that the neuroscience demonstrates that appraisal processes mediate emotional processes simultaneously or at least rapidly interact and become integrated with activities that mediate emotional processes. Synchronised nonlinear neural interactions give rise to global emotional states

which are fundamental to the emergence of whole appraisals and these processes evolve simultaneously (Lewis, 2005). He concludes that:

“... coherent appraisals are not antecedents of emotions, but emerging outcomes of interactions among constituent systems underlying appraisal *and* emotion... emotional and cognitive processes influence each other continuously during an emotional episode...” (ibid, p.193).

Other research in this area also demonstrates that affective and cognitive mechanisms are intermeshed. Luis Pessoa suggests a network perspective fits what we know about the brain and, whilst we might use the terms cognition and emotion to denote certain behaviours, processes underpinning these behaviours cannot be delineated at the neuronal level (Pessoa, 2015).

In the next section I consider the myriad of possibilities an environment affords.

8.2.4 Affordances

People-environment combinations enable affordances. As we saw in chapter 7 this term is used to capture all the possible actions relating to a given person-environment combination (Gibson, 1977). Affordances are dependent on the physical properties of the environment and the capacities of a person in any given situation. A raspberry bush affords the possibility of feeding oneself – but only if one knows that raspberries are edible and one has the capacity to distinguish ripe ones from unripe ones as well as the right kind of manual dexterity to pick them. Picking apples requires some similar skills but

might require tool use if the apples are too high to reach. A person has to negotiate the world, all the while, exercising her capacities in relation to affordances in the environment. The scope of possible affordances is vast so, how do we do this?.

8.2.5 Interim Summary

Affectivity captures all sub-personal and personal level valenced responses within a given environment and might include bodily feelings and unmediated perceptual responses as well as nameable emotions and moods. If affordances as presented are all the physical possibilities of a given situation how does a person ever decide what action to take? The possibilities are extremely wide ranging. It is clear that some kind of frame is needed to enable goal-orientated decision-making. This is where affective framing fits in.

In the next section I explain *affective framing* and extend the notion to explicitly encompass all the elements of the BBWS.

8.3 An Extended Version of Affective Framing

A person experiences her world as 'showing up' in such a way that enables effective goal-seeking and decision-making. Somehow personally 'important' aspects of a given environment appear in such a way as to enable a person to negotiate her way through this environment, make sense of the world in which she finds herself, survive, procreate and even flourish. It is not at all clear, however, how this comes about.

Maiese's notion of affective framing is used to understand how a person makes sense of her world.

"...'affective framing' is the process whereby we interpret persons, objects, facts, states of affairs, and situations in terms of *embodied desiderative feelings*. Just as a conceptual frame is a cognitive shortcut that people rely on in order to categorize features of their surroundings, an affective frame operates as a feeling-driven shortcut whose interpretive focus is targeted and contoured by an individual's embodied desires and cares. Detection of which aspects of our surroundings are relevant typically occurs outside of reflective self-awareness, is non-algorithmic, and involves bodily attunement and feelings of subjective import." (Maiese, 2015b, p.920)

Her ideas rely on the claim that emotions and affectivity can be both cognitive-evaluative and bodily, and are the means by which personally salient environmental information is filtered and made available to the individual. Evan Thompson and Giovanna Colombetti's example of a person catching sight of another person's angry face illustrate, at least at the phenomenological level, that we have reason to think that there are a number of different intermeshed or concurrent processes. These processes include a triggering event that can be perceptual, imaginary or both, emotion/appraisal processes leading to an affective salience (or a sense of the significance of the event), a hedonic tone (which might be understood as a positive or negative valence), facial or postural changes and visceral (autonomic-physiological) changes

(Colombetti and Thompson, 2005). On this account it is clear that a number of different elements make up a person's response to this stimulus and that there is an affective quality to the experience.

For Maiese a person has desires and needs in relation to survival and procreation and these all have affective components. A person *cares* about herself and how her needs are met. She makes decisions about action in the world based on her response understood in terms of *bodily desiderative feelings* to positively valenced preferences and negatively valenced objects or situations to be avoided. This enables a person to execute know-how in her negotiation of the environment. For Maiese:

“...the very way in which the world is disclosed to the subject, including what she attends to in perception and thought, and what she strives for in action, are shaped and contoured by these feelings of caring.”
(Maiese, 2014, p.524).

According to Maiese the person's affective response to the world is both bodily and cognitive and is best described as being distributed through the body engaging the brain, cardiovascular, endocrine and musculoskeletal systems. As we are sophisticated animals living in a complex world, sense-making in terms of affective responses goes beyond survival and procreation. A person might want to do well, be creative or negotiate social situations (Maiese, 2015).

I prefer to remain agnostic about the mechanisms underlying affect which, as I have said above (in section 8.2.2 this chapter), might include self-conscious

cognition, sub-personal cognition or brain processes, bodily (endocrine/musculoskeletal) systems and direct (unmediated) perceptual responses. Because we are living organisms in process these systems all interact with each other and there is no straightforward linear or hierarchical order for these systems to interact. They are intermeshed. There are feedback and feedforward loops as well as *levels* of responding. Environment, perceptual stimulus and basic or primary emotional brain processes can influence cognition and self-conscious cognition can mediate basic (primary) brain processes.

In the next two sections I first discuss the kind of person level responses that we are usually self-consciously aware of and then discuss those that are sub-personal.

8.3.1 Levels of Responding

Because human beings are sophisticated organisms we have 'levels' of thinking and we can alter our emotional state through imagination and memory. Affect and therefore decisions and action might be cognitive first and then bodily. So, I might first self-consciously think about my long-term goals in a given situation or deliberately imagine an outcome and thus be (perhaps emotionally but at least affectively) *drawn towards* one goal (and therefore the associated action) in preference to another.

A human being is (perhaps uniquely) able to respond to her situation at a number of different 'levels'. These 'levels' might be described as 'felt' somatic (or bodily) (Damasio, 2000), cognitive and meta-cognitive (Flavell, 1980). The

somatic or bodily might include direct perceptual responses as well as other sub-personal processes.

For example, if a person sees a bear running towards her she might start to run away as a direct result of a somatic fear response (with no self-conscious thought about it at all). She might have a similar fear response and recognise it as such (through self-conscious cognition), weigh up the options and decide to hide or 'play dead' instead of run. Or, when faced with, for example a spider, she might have a bodily fear response, recognise that she has a 'fear' of spiders, realise that this response is irrational (at a meta-cognitive level through thinking about her thinking) and decide to do nothing.

In these examples the underlying fear response is at least partially bodily. One knows what it is to feel this kind of 'rush' which relates to fear – the heart rate increases (as a result of increased adrenalin in the body), one might experience pounding in one's ears (probably relating to an increase in blood pressure), one might feel a bodily compulsion to move away from the source of the fear and other objects in the environment might seem to 'disappear' as a result of one's focus being on the object of the fear and/or the need to get away/take evasive or defensive action of some sort (Cannon, 1953). A person then might become self-consciously aware of this bodily reaction and make a judgment about it. Being self-consciously aware of being afraid and having specific thoughts about what it means to be afraid in that particular environment might constitute part of the response to a fearful situation. However it is entirely possible to be *acting* (for example running away) before

an articulable recognition of the fear 'shows up' as a thought. In this way, some responses to our environment are *very obviously affective and bodily*.⁷⁹

8.3.2 Sub-personal Affectivity

It is difficult to give descriptions of sub-personal level affectivity as to do so seems to necessitate language that implies self-conscious thought. For example, I might reach out for a biscuit when presented with a plate with a variety of biscuits on it and 'choose' a chocolate one. It is easy to say that I had a preference for the chocolate one, this implies self-conscious cognition and we routinely infer preference from behaviour. With hindsight I might say I chose it because I preferred it to the others on offer. On reflection I might say I chose it out of habit, to be polite or because it was the nearest one to me when the plate was offered. Perhaps, on reflection, I realise I was not even hungry. Whilst it is, of course, possible to deliberate over this kind of choice I suspect that most of us, most of the time, undertake no such deliberation. Perhaps it would be better or more accurate to say that the person/environment system *acts* as a result of a sub-personal level process which might be best described (in folk psychological terms) as a habit. This kind of process might apply to all sorts of decisions that enable us to negotiate the world in a seamless (non-self-consciously deliberative) way.

⁷⁹ We need certain organs or bodily components to experience fear. Jordy Cernik found that he no longer experienced the feeling of fear in dangerous situations after having his adrenal glands removed as treatment for Cushing's Syndrome. He knows that he 'should be afraid' but the bodily response he used to have simply is not there and he no longer feels fear (McPhee, 2013).

This kind of subtle affective response to the world is at play all the time. If I am in a familiar environment most of what is around me fades into the background. Something new in the environment might stand out to me if it is personally relevant in terms of my sense making, goal seeking, decision-making behaviour. I can, of course, deliberately turn my attention toward things in the environment that enable me to meet my goals. For example, if I am thirsty, I might scan the environment for a drinks machine and 'notice' if there is one. Still, I suggest that most of our affective responses to the environment are much more subtle and we are not self-consciously aware of them. Irrelevant things become 'invisible;' dangerous things stand out to me and I am repelled by them and so avoid them; positive things that enable my goal seeking behaviour draw me towards them and I interact with them. A person does not routinely think about these things, to do so would make the world impossible to negotiate. Nevertheless affectivity is our constant companion and underpins our interactions with our environment (Damasio, 2000; Maiese, 2014).

Without this affectivity towards the world decision-making would become impossible. If a person felt no preference towards anything and was not repelled by anything then total passivity would set in. There would be no goal-directed activity of any kind. The 'restlessness' that directs us to act in the world comes about as a result of the (often sub-personal level) affectivity that emerges from a person-environment combination.

Of course, over time this restlessness, which directs action, might relate to acting in ways that we have become habituated to. Nevertheless, I suggest it is the (non-self-conscious) affectivity of these habits that directs our action. So, for example, if I eat the same thing for breakfast every day I might say, if pushed, that I am comforted by this, it feels 'right'. There might be a point at which I am bored with this breakfast or I just fancy something different or that my body is deficient in some mineral or nutrient that the breakfast does not contain and thus seek a novel alternative. Obviously, as I have mentioned above, I can make self-conscious reasoned decisions too. I might decide, even though I enjoy my breakfast, that there is not enough protein in it and switch to an alternative because I believe it is better for my health. All of these decisions are made because I *care* (at both the sub-personal and self-conscious person level) about my experience and about my wellbeing.

8.3.3 A Preference for Coffee and the Impact of the Environment

The notion of affective framing can capture the components that constitute emotional, affective and perceptual experience. Maiese emphasises the body in her account, however, in keeping with the enactive approach (chapter 7) and the empirical evidence (chapters 4 and 6) I propose that we include the environment as a constituent part of the affective frame. Thus the *affective frame* is constituted through the BBWS and hence *affective framing* (the ordinary human capacity to respond to the world in terms of likes and dislikes as they relate to goal-orientated decision making) is constituted through the BBWS.

For example, a person when presented with a cup of coffee will undergo bodily arousal: if her sense of smell is intact, if she is familiar with coffee and likes it and is, perhaps, addicted to the caffeine-fuelled experience associated with coffee her bodily arousal will be different from that of a person who has never seen the dark brown odd smelling liquid before. A person has a personal history which makes her unique and explains why we do not all respond in the same way in a given environment. The environment, bodily arousal, as well as other sub-personal processes and personal level appraisal will determine the action a person undertakes. The appraisal is also dependent on environmental and relational factors (as well as those of preference for taste or craving).

For example, if there is only one cup of coffee left in the pot I might let my friend have it. This is also a (social or pro-social) affective response where my desire to care for my friend overrides my desire for coffee. If I am in a teashop I might be more inclined to drink tea because I am surrounded by the paraphernalia of tea making, because everyone else is drinking tea and because I like the china teacups that it is served in. I might even feel socially embarrassed by asking for a cup of coffee in a teashop. There are many factors that might affect the choice of action, eg: whether a person is thirsty or not, what other drinks are available, what time of day it is (perhaps one would not want coffee after 4pm if one believed it would prevent one from sleeping), previous coffee experiences etc. This affective bodily arousal, other sub-personal processes and appraisal combination determine one's action. These occur in the way that they do because I, with my *unique personal history*, am

presented with a cup of coffee in a particular environment with particular relationships to others in that environment. The brain/body/environment/coffee system determines the outcome. On this account it is hard to see how one could act at all without an affective component.

If we think about the consequences of an absence of affectivity they might be quite dire. The absence of a capacity for affectivity would lead to neutral indifference to myself and my environment. I would cease to *care* about anything. To give an extreme example: if only tea and coffee were available and I did not 'know' (either self-consciously or sub-personally) that I preferred coffee to tea I might not be able to decide what to drink. I might not drink anything and thus die of dehydration.

8.3.4 Interim Summary

A person cares about herself and might be described as having a concerned point of view. She is interested in what things in the environment mean for her and how action in relation to the environment might meet her needs. A person's interaction with her environment need not be self-conscious, explicit or deliberative. Rather, she is an embodied agent who interacts with and responds to her environment in a flexible and adaptive way. The feedback and feedforward loops between the embodied agent and the environment are mediated through an affective response which conveys meaning to the individual. Elements in the environment 'stand out' and become relevant based on affective significance conveyed in part through the body. People

might have some shared goals, such as survival and procreation, yet each has a unique history and therefore the potential for her own unique response within her lived environment. Thus affective framing enables us to negotiate the world, survive and thrive. It is constituted through the on-going process of the person/environment interaction.

In the next section I illustrate how some common (overlapping) symptoms of schizophrenia and other psychotic disorders, namely, voice hearing and thought insertion can be conceptualised in terms of attenuated affective framing.

8.4 Thought Insertion, Voice Hearing and Attenuated Affective Framing

Maiese describes thought insertion experiences (Maiese, 2015b) as well as other symptoms associated with a diagnosis of schizophrenia (Maiese, 2015a) as the result of attenuated affective framing. In this section I briefly review her position.

8.4.1 Thought Insertion

As I have already mentioned (in chapter 5, section 5.4.4), when someone experiences thought insertion (TI) her sense of subjectivity and her sense of ownership come apart. A person experiencing this phenomenon retains her subjectivity. She knows it is she who is having the experience and she retains a point of view on the experience. Yet, at the same time, she denies that she owns or generated the thought all the while retaining and acknowledging her first-personal (subjective) access to the content of this thought. Maiese

accounts for this phenomenon in terms of attenuated affective framing. That is, a person's ordinary bodily affective responses to certain features of her own mental activity have broken down in some way.

8.4.2 Voice Hearing

Another symptom, that of voice hearing (known as *Auditory Verbal Hallucination* and often abbreviated to *AVH* in the clinical literature) is the perceptual anomaly that gives a person the experience that her own thoughts are being 'heard' – as if being spoken to her by a third party outside herself and perhaps attenuated by background noise. She experiences this as a third party speaking to her or about her and does not recognise the 'voice' as being generated or owned by her. Whilst AVH and TI symptoms are differentiated in the clinical literature there is considerable evidence that they are overlapping symptoms and that a person experiencing anomalies within her own internal (private) mental experience might describe overlapping symptoms in various ways including: 'voices inside my head', 'voices outside my head', 'voices that I hear with my ears' and 'voices that I hear with my mind' (Gunn, 2016b). So, as I mentioned (in chapter 5, section 5.4.4) it is likely that some of those describing 'voices' and some of those describing 'thought insertion' may be experiencing similar phenomenon.

8.4.3 Schizophrenia

Thought insertion and voice hearing are both symptoms of schizophrenia. For those who have a diagnosis of schizophrenia:

“...there is a notable discrepancy between the amount of attention something deserves and the amount that it receives.” (Maiese, 2015b, p.921).

This might apply to a number of different symptoms associated with a diagnosis of schizophrenia such as problems with salience, perception, and alienation. These symptoms are sometimes described as part of a Gestalt that relates to a loss of the ordinary sense of self (Sass and Parnas, 2003; Stanghellini, 2015). As affective bodily states breakdown there is a breakdown in self-experience, objects in the environment seem to lose practical significance and a person might lose her perceptual grip on the world (Maiese, 2015b).

8.4.4 Thoughts, Voices and Affective Framing

When it comes to thinking we do not routinely ask ourselves whose thoughts we have first-personal access to because the process of recognising our thoughts as our own is transparent. The bodily or felt sense of ownership of our own thoughts is given. In the thought insertion experience a person experiences her thoughts as alien, foreign or free floating (even if the content of the thought is mundane) and this is because bodily attunement is diminished and affective framing is attenuated resulting in a diminished sense of ownership (Maiese, 2015b).

In the enactive approach cognition is seen as sense-making in terms of basic biological drivers. It is an activity relating to a person-environment system which I describe in chapter 7 as the Brain/Body/World System (or BBWS).

The properties of the system depend on the parts of the system as they relate to each other (in terms of organisational structure) and cognition is an emergent property of the system. Cognition is biologically grounded and *entails* all the elements of the BBWS (organisational structure, perception, bodily capacities, affordances, environment, culture, goals and values). According to Maiese, affective framing is a human capacity that is both bodily and cognitive. I maintain that affective framing is constituted by the BBWS and thus, if any of the constituent parts are significantly altered then the capacity of the person to respond appropriately might be compromised. In chapter 7 I argued that cognition is constituted through the BBWS and, according to the enactive approach, cognition encapsulates all the sub-personal and person-level processes related to consciousness. Therefore affective framing is a sub-set of all these process – namely those associated with affect. These processes are constituted through the interaction between person and environment. In other words the affective frame emerges from a person-environment system.

With regard to thought insertion and voice hearing one or more parts of the BBWS has failed. According to Maiese, there is an alteration in affective capacities. The ordinary perceptual or bodily experience of thought as belonging to oneself is altered. A person then attributes this experience to some kind of outside force. This can compromise engagement with the rest of the system such as other people and one's environment in general. For example, thoughts that do not have the ordinary quality of belonging to oneself might be experienced as extremely distressing or distracting thus

interfering with or preventing one's capacity to engage in work, hobbies and social relationships. As we have seen in chapter 4, this might have an effect in other areas. For example, if one were to become increasingly socially isolated this might lead to further problems such as depression or deeper psychosis.

Thought insertion and voice hearing might both be described as arising as a result of a breakdown in affective framing. Affective framing captures the capacities that enable a person's concerns and interests to underpin her experience. Without this frame the person loses meaningful contact with perception, bodily capacities, environment, culture, goals and values. The blurring of ownership of one's own thoughts means that a person experiencing this phenomenon can no longer recognise that the contents of her thoughts belong to her – the thoughts have lost their *usual* affective salience and can no longer be understood in terms of personal relevance or 'for-me-ness'. The content of these thoughts might take on a different kind of salience but the relevant kind of salience, that of belonging to the person who has first-personal access to the content, is lost.

8.5 Delusion Formation as a Breakdown in Affective Framing

As already described in chapter 5 and revisited here (section 8.2.1) affectivity is a capacity that enables us to interact with our environment in terms of being drawn towards those things that are positively valenced and repelled by those things that are negatively valenced. These processes can be sub-personal or personal and include emotions and moods. The affective frame relates to all

the components that constitute this capacity and the way in which they are interrelated. So, any part of the process, should it breakdown, can result in a breakdown in affective framing. This means that the breakdown might be complex and might have its origins in the endogenous or the exogenous. In the case of endogenous factors a person might have the kind of experiences described above which are associated with schizophrenia as a result of antibodies associated with encephalitis (Lennox et al., 2017) or she might experience, for example, the Capgras delusion as a result of brain injury (Edelstyn and Oyebode, 1999). Alternatively an endogenous factor might simply be understood in terms of something that is experienced as 'internal' to the person (eg: perceptual anomalies associated with a prodromal state). In the case of exogenous processes a person might find herself immersed in an environment that she is unable to negotiate. Any of these factors might result in attenuated affective framing, and, as we shall see in the empirical research, these factors might be multiple and intermeshed. When the affective frame is compromised this could lead to a person losing her perceptual and/or affective grip on the world.

Each research participant experienced a breakdown in affective framing. The way in which they ordinarily negotiated the world, through goal-directed decision making based on know-how relating to their self/environment interaction, no longer 'worked' for them. The affective capacity that enabled each of them to interact appropriately with their environment was compromised. They each experienced the distress of a radical alteration in

environment leaving them unable to exercise their know-how in this new setting. In short, they no longer knew 'how.'

In each case, immersion in this environment lead to a further breakdown in affective framing. We might speculate that, given the intensity and persistence of the problems, this is an inevitable cascade. This resulted in altered salience experiences, voice hearing, telepathy experiences and alien control experiences. In altered salience experiences the breakdown in affective framing gives importance to previously irrelevant or background objects or experiences. In voice hearing and telepathy experiences the breakdown in affective framing results in a person's own mental activity (thoughts or imaginings) losing their sense of for-me-ness. And in alien control experiences a person loses her ordinary sense of ownership of her actions and perhaps even her body.

In this section I briefly revisit each research participant's experience as it emerges from the interview to show how the breakdown in affective framing captures what leads to the formation of the delusion. I speculate that, if we can identify a breakdown in affective framing in a person's experience resulting in delusion formation, then this might be an important characteristic of the phenomenology of the formation of clinically significant delusions.

8.5.1 Making Sense of Marriage Breakdown

Barbara found herself in a new environment. She was no longer in a loving relationship and had no one to share the burden of guilt associated with the difficult decisions she had made in order to try and maintain her marriage.

She was very young when she met her husband and as an adult the know-how she had developed in relation to negotiating the world had always included the presence of her husband. She found herself in a world where she had compromised her principles for *no good reason* and this was not a world she was able to seamlessly negotiate. Her world had altered so her capacity for know-how experienced through affective goal-orientated decision making in that new world was compromised. Her learned affective capacities were no longer fit for purpose in her new world – she was alone, she was plagued by guilt and she could not understand her past behaviour in the absence of a ‘partner in crime.’

8.5.1.1 “And Then the Music Started Talking to Me”

Barbara started to experience unusual environmental anomalies known as delusions of reference (she sees or hears things in the environment and feels that they are important to her or intended for her in some way). This too is a breakdown in affective framing. Things in the environment that were previously neutral and had no affect or specialness attached to them become important and seem to gain a ‘for-me-ness’ that they did not previously have. Prior to the onset of this problem the ordinary affective experience of these environmental cues was neutral, they had no special meaning and were not seen as significant. When a person experiences delusions of reference the affective frame that enables her to negotiate the world is altered. The ‘background’ takes on a whole new meaning: certain things become salient or positively valenced and the person is drawn towards them. When things first

start to 'stand out' for Barbara as ideas of reference (as opposed to delusions of reference) she has no explanation for this. She does not know why they are important to her. Yet they still *are* important to her. This is puzzling and requires an explanation. She concludes that someone or something is sending her messages in the songs on the radio.

8.5.2 Making Sense of Persecution and Injustice

Alison's new world is full of persecution and injustice. Her family member is falsely accused and found guilty of a sexual assault. The police and judicial system are no longer reliable. Despite the fact that she is community minded and is a good neighbour she has a number of different problems with different neighbours. She is persecuted by one neighbour in particular and it seems that the police support the neighbour's version of events. The know-how Alison had developed was based on a world where people were kind to their neighbours and justice was done. Her new world was dangerous and she no longer knew how to negotiate it. Her affective capacity was no longer fit for purpose, thus her capacity for know-how experienced through affective goal-orientated decision making in that new world was compromised.

8.5.2.1 "I Could Hear Long Distance Conversations"

Alison suddenly found that her own thoughts had lost their 'given' sense of ownership and she experienced them as alien or coming from outside herself. As I have described above (in section 8.4, this chapter) bodily attunement is diminished and affective framing is attenuated resulting in this perceptual anomaly. Her own thoughts had lost their usual sense of for-me-ness. This

was a puzzle to Alison to start with but eventually she concluded that she could hear the thoughts of other people and have long distance conversations with others.

8.5.3 Making Sense of Bullying at Work

Andrew's new world was dangerous. He might be bullied, humiliated or even lose his job and then be unable to pay his mortgage and bills. The know-how that Andrew had developed related to a happy home, good social life and a just and pleasant environment where he was treated well did not apply in this new environment. Andrew's affective frame was compromised, as his previously learned affective capacities were no longer fit for purpose in the new environment thus his capacity for know-how experienced through affective goal-orientated decision making in his new world was compromised - he no longer knew how.

8.5.3.1 "The Power Cannot be Described"

Andrew experienced a loss of sense of ownership of his actions. He wrote an email expressing views about injustice and how he might help to redress the balance but did not experience this as straightforwardly executed by him. He felt he was taken over by an indescribable power and that he was compelled by this power to act. His actions had lost their usual (given or transparent) sense of ownership. Bodily attunement is compromised and affective framing is attenuated. This perceptual anomaly is indescribable. Andrew concludes that the power was so overwhelming that it must have been supernatural.

8.5.4 Making Sense of an Abusive Relationship

Caroline's new world was one in which she could no longer cope. Her know-how included her ability to ignore her emotions and just get on with life. In her new abusive world she became panicky and distressed and could make no sense of this. Her affective frame was altered and her capacity for know-how experienced through affective goal-orientated decision making in that new world was compromised. In her everyday life she had become adept at ignoring her emotions and this is how she had engaged with the world and negotiated difficult or potentially distressing situations in the past. She had no language for psychological distress⁸⁰ and she did not need one as she was not 'aware' of any distress, she 'just got on with it.' As the abuse continued she could no longer ignore her emotional life, she was unable to 'switch off' her affective response to the world and was also unable to articulate her distress. In the new environment, one of fear of bullying and violence and a sense that she was trapped (she could not leave and she could not stay) her old strategy no longer worked. The affective frame is compromised, as her previously learned affective capacities are no longer fit for purpose in the new environment.

8.5.4.1 "Not Me Controlling My Arm"

Caroline started to behave oddly. At first she had no explanation at all for her behaviour (perhaps all the changes that lead to her behaviour change were

⁸⁰ Feeling as well as symbolisation (usually, although not necessarily) in language are all required for self-conscious recognition of and acceptance or understanding of emotional states (Rogers, 1961).

sub-personal). She took overdoses of prescription medication and had the sense that it was not her that was taking the pills. Her usual sense of ownership of her own actions was lost. She experienced her own thoughts as coming from outside herself and her own actions as not being made by her in some sense. She, nevertheless felt compelled to act and felt compelled to do what her voices commanded. These disownership symptoms demonstrate a breakdown in affective framing. Again, bodily attunement is compromised and affective framing is attenuated resulting in a loss in the usual 'given' sense of the ownership of her thoughts and actions. She came to the conclusion that her voices had something to do with the government and they must have done something to her (for example put an electronic chip in her).

8.6 Discussion and Implications

Any part of the system that constitutes the affective frame might be altered in such a way as to precipitate a breakdown in affective framing. This might be endogenous⁸¹ or exogenous, that is, it might be experienced as coming from the inside or the outside. For example, in the case of Caroline the abusive relationship is an exogenous (external) factor which impacts the affective frame and hearing voices might be described as an endogenous (internal) factor. Both of these factors are involved in Caroline's experience. This breakdown in affective framing then demands an explanation in order for a person to continue to negotiate the world in a meaningful way. Persistent

⁸¹ In some cases (but probably not in Caroline's case) endogenous factors may have an identifiable biological aetiology (as already mentioned in section 8.5).

distressing environmental experience and anomalous and persistent affective, perceptual and/or emotional experience are incorporated into the affective frame. Negotiating the world becomes much more difficult and new explanations are required.

Personal experience as a psychotherapist tells me that the degree to which one understands oneself in terms of narrative and through self-conscious cognition is enormously variable. Further, those that present themselves for therapy, being self-selecting, might be more psychologically minded and introspective than many people. That is, they are interested in their own mental activity and pay attention to what things mean to them and to what they are thinking and feeling. In addition, the kind of analysis done by philosophers and psychologists usually involves people who are articulate, psychologically minded and have, at least to some extent, a narrative about what they were like before they experienced mental health problems as well as a narrative about how that has changed. We can experience ourselves as selves without recourse to detailed narrative. There is 'something it is like' to be a person (Nagel, 1979) even if there is nothing to say about the experience. Pre-verbal people (babies) and other animals have a 'minimal self' (Gallagher, 2000), small children can act and respond appropriately to their environment and to others without necessarily being able to verbalise how or why this is so (Bruner, 1986) and it is only through the process of *talking to ourselves about ourselves and what we are doing* that we begin to think, develop a narrative and are able to introspect (Vygotsky, 1986). Young children have a pre-narrative, embodied first-person-perspective and I

suspect that many adults do not have ‘fully filled out’ narratives about themselves. The lived experience of many people might be better described as a cluster of habits where a detailed narrative plays little or no part in how they experience themselves. If we understand that affective framing involves sub-personal processes as well as person-level processes then this might explain the huge difficulty people sometimes have in explaining their experience. A person might be *aware* of a person-level experience that is extremely difficult to explain (as in the cases of Barbara, Alison and Andrew). Alternatively a person might *not be aware* of any person-level experience other than behavioural outcome (as in the case of Caroline). Those who ‘act out’ and are themselves flummoxed by their own behaviour may be experiencing sub-personal level changes in affective framing.⁸²

This way of thinking about delusion formation might have implication for what we understand a clinically significant delusion to be.

8.6.1 A Tentative Conceptualisation of Delusion

As we have seen from the literature on affect, percept and emotion (chapter 5) and from my empirical research (chapters 4, 5 and 6), clinically significant delusion might best be understood in terms that relate to emotions, affect and

⁸² A psychodynamic therapist might say that people always have unconscious ‘knowledge’ relating to such things as trauma and emotional repression that can be brought into conscious awareness and this is what causes unexplained behaviour. Theories relating to defense mechanisms are unfalsifiable and those who attend therapy are already psychologically minded and more likely to ‘go along with’ or make use of these theories. I speculate that these theories might be untrue and the sub-personal mechanisms that relate to certain behaviours are simply cognitively impenetrable.

percept and therefore *affective framing* as described in this chapter. I suggest the following conceptualisation:

A delusion is an emergent property of the person-environment system that shares some of the external characteristics of belief, is held with extraordinary conviction and is grounded in personal (subjective) experience which arise as a result of attenuated affective framing understood in terms of persistent and/or anomalous alterations in affect, perception, and/or emotions.

Contra current conceptualisations of delusion (such as the one in DSM 5) perhaps we need not insist that a delusion is a belief (we only need to say that it shares some external characteristics with belief). We need not insist that it is false: an accidentally true judgement can be incorporated. What others believe ceases to be relevant: a person might still be delusional in relation to a cultural norm. Further, the availability of proof that contradicts the delusion also ceases to be relevant (the grounds for forming the belief are subjective and personal and others do not have access to this information) and we need not worry about rationality or compromised inference processing (this is no longer a distinguishing feature of delusion formation).

As we have already seen (in chapter 2), delusions are a heterogeneous group and therefore my conceptualisation might only relate to a subset of them. I have used my empirical research to support my claim but, of course, it does not follow that all delusions are of this kind. I have used idiographic data relating to just four people with clinically significant delusions and their

account of their experiences cannot be extrapolated to account for all delusions. I have attempted to contextualise each of these accounts, and my analysis has drawn out their commonalities of meaning, with the aim of allowing the reader to appraise their *transferability* (rather than making any claims regarding their *generalisability*). If some delusions are of this kind and these can be identified this might have implications for further research, prevention, therapeutic intervention and stigma. Whether this conceptualisation turns out to be useful is an empirical question and we need more fine grained phenomenology with regard to the delusional experience in order to establish if this is so. As I have already said (in chapter 5), if we understand that some delusions arise through problems relating to affect, percept and emotion, we might find novel therapeutic interventions. We might also find that not all delusions are ‘the same’ and a more fine-grained approach where we differentiate still further might improve strategies for prevention, research and therapeutic intervention. Improving mental health literacy by increasing our understanding of this heterogeneous phenomenon might also help to reduce stigma.

CHAPTER 9 - CONCLUSION

9.1 Context

When I embarked on this study I wanted to gain an understanding of the nature of clinically significant delusion. In the first instance I thought this might be possible by learning about the external features of delusion. I soon realised that these external features could, as Jaspers points out, only *vaguely* capture this phenomenon. This is because these external features share so much in common with other psychiatric symptoms (eg: overvalued ideas) and ordinary beliefs (eg: religious belief or believing in ghosts). Again, as Jaspers points out, the clinical significance lies outside these external features and can only be fully grasped through gaining an understanding of how a clinically significant delusion is formed (the genesis of the delusion). I am interested in lived experience and I felt that I could only truly attempt to comprehend *what it is like* for people to develop delusions and live through that experience if I listened to what they had to say about it. This form of enquiry (detailed phenomenology) is on the decline yet the knowledge to be gained is certainly not exhausted.

Through gaining an understanding of the lived experience of people who have clinically significant delusions both prior to and during onset I realised that factors that might causally contribute to the development of delusion were extremely varied and complex. Understanding a person's lived experience

through delusion formation highlights the heterogeneity of the experience and helps to explain why delusions are so difficult to define.

In the next section (9.2) I look at the implications and findings of my research. I then analyse my research methodology using a quality assessment tool developed for use in qualitative research (section 9.3). I then look at implications for future research (section 9.4) and finally I look at the potential for policy changes (section 9.5).

9.2 Implications and Findings

The implications and findings for this research include: 1) a contribution to the theoretical understanding of what delusions might be in terms of the possibility of a move towards a different conceptualisation of delusion; 2) the wider implication of understanding psychiatry using the enactive approach; 3) the possibility of stigma reduction; and 4) an increased understanding that there are multiple routes to prevention and intervention.

9.2.1 Towards a Different Conceptualisation of Delusion

Whilst investigating delusion I came across the *enactive approach* as a framework for understanding cognition and this seemed to fit with and capture the complexity of human experience. Understanding cognition as an emergent property of the person-environment system enables incorporation of both endogenous (internal) and exogenous (external/environmental) factors in relation to mental distress and psychiatric illness. A person can be understood as an autonomous system with semi-permeable boundaries who

is in constant interaction with her environment. The person responds to her environment as a result of endogenous processes which have developed and continue to develop through her patterned history and her lived experience. There exists in these processes a complex mereology where the parts of the person-environment system (or BBWS) are intermeshed and interact with reciprocal feedback and feedforward loops. This means that 1) it does not make sense to look for a single cause of delusion formation and 2) the complexity allows for multiple routes for prevention, early intervention and treatment.

My empirical research shows that persistent anomalous and/or intense affective, perceptual and/or emotional experiences were present at or prior to onset of the delusion. After I had completed my empirical research I came across the notion of *affective framing* (Maiese, 2015a) and this seemed to afford a plausible fit with my empirical findings relating to percept, affect and emotion. If problems with percept, affect and emotion are important features of some clinically significant delusions then these problems can be captured in terms of the notion of *attenuated affective framing*. Affective framing captures the way in which a person responds to her environment in terms of *embodied desiderative feelings* which have *subjective import* relating to the *desires and cares* of that individual. In line with the enactive approach I have argued that the affective frame is partly constituted through the environment. In this way a breakdown in affective framing is understood in terms of having both endogenous and exogenous components which are intermeshed in the

complex mereology that encapsulates lived experience. In an attempt to capture this sub-set of delusions I offer this conceptualisation:

A delusion is an emergent property of the person-environment system that shares some of the external characteristics of belief, is held with extraordinary conviction and is grounded in personal (subjective) experience which arises as a result of attenuated affective framing understood in terms of persistent and/or anomalous alterations in affect, perception, and/or emotions.

Despite the heterogeneity of the delusional experience, these features were common across all participants in my empirical research. These features can capture what characterises a sub-set of clinically significant delusion without recourse to contentious features that lead to a definition that overlaps with ordinary beliefs and with other psychiatric symptoms. These features also enable an understanding of delusion that does not require or imply a cognitive deficit or problem with inferential processing. As I have already said (in Chapter 8) even if my empirical findings are correct, they only tell us about the experience of the four people I interviewed. Nevertheless, they suggest that, within this heterogeneous group there might be *some* delusions that can be conceptualised in this way.

As Lucy Yardley puts it:

“Some analyses are important not because they present a complete and accurate explanation of a particular body of empirical data, but because they draw on empirical material to present a novel, challenging

perspective, which opens up new ways of understanding a topic.”
(Yardley, 2000, p.223)

9.2.2 Wider Implications for Psychiatry

Psychiatry might be better served by embracing the enactive approach thus enabling the understanding that there is a plurality of factors that causally contribute to psychiatric illnesses and therefore a plurality of possible approaches to prevention and treatment. The bio-psycho-social model is supposed to be the preferred model for understanding psychiatric illnesses, however, in reality psychiatrists tend to practice medicine. Assuming that all psychiatric illnesses can be treated by medical means carries the implicit assumption they are biological in origin and there is little evidence to support this. Assuming a biological aetiology is problematic as it shuts down the possibility of truly embracing the psychological and the social or environmental as significant factors when it comes to prevention and cure. Even if we evoke the bio-psycho-social model this still falls short of a fully filled out way of accounting for psychiatric illnesses. It does not fully account for the complex mereology involved in the emergence of cognition whereas the enactive approach does. The enactive approach also enables us to link cognitive science to everyday experience. A person is a biological entity who is first and foremost a sense-making being. She engages in know-how enabling her to negotiate the world through action and cognition. In this sense we are all ‘doing the best we can’ to make sense of our environment and respond in ways that enable survival, procreation and maybe even flourishing.

Psychiatry might be better served by looking at the mereological relations between people and environments rather than just looking at brain states (or processes) that have emerged from these mereological interactions. A brain state that correlates with an experience is just that, a correlation. If a delusion forms and is maintained through a process of lived experience then a brain state that correlates with the realisation of that (delusional) experience cannot be said to cause that experience. Of course this does not mean that there are no brain-based causal contributions to the delusional experience, just that we need to be really careful about how we understand what a snapshot of a brain state can actually tell us about this.

9.2.3 Stigma Reduction

In my empirical research each person had been dealing with a radical alteration in lived experience, had suffered a significant period of distress or despair and had experienced problems with basic self-care in relation to sleep, eating and/or social interactions. If these features of lived experience are understood as potential 'flags' prior to the onset of delusional experience and this can be communicated to the public at large we might influence people to seek help sooner, perhaps before delusion develops. This might be best done through telling people's stories in ways that are readily understood and that people can identify with.

A better understanding about how delusion might develop can also help to reduce stigma. Life stresses happen to all of us and it might just be a matter of luck what stresses come our way. The nature, degree and persistence

(over time) of these life stresses might turn out to be too much to bear for a given individual at a given moment. Prevention might be dependent, to some extent, on help-seeking behaviour and if we can reduce stigma perhaps people will seek help sooner. Factors such as mental health literacy play a part in help-seeking behaviour so more data like those from my empirical research should be made available in the public domain. Societal stigma, self-stigma and structural discrimination all impede help-seeking behaviour and this in turn might lead to worse outcomes for individuals. If a person does not seek help until she has developed a florid delusional schema not only has she (probably) been through significant (perhaps avoidable) distress, she is much less likely to make a full recovery. Of course, we must have the resources to attend to those seeking help which in times of austerity are not necessarily readily available. However it seems a false economy (if economy is what the NHS is concerned with) to leave someone untreated until a crisis is reached which might result in (costly) hospitalisation and/or prolonged outpatient and/or pharmacological treatment (which carries it's own risks) when this might have been prevented.

9.2.4 Multiple Routes to Prevention, Early Intervention and Treatment

An understanding of the complex mereology of the factors involved in delusion formation also provides us with a number of different routes to treatment and prevention. These might include physical environmental factors such as housing and availability of green spaces, relational factors like family, childcare and social networks, talking therapy in relation to managing emotions or coming to terms with change, bodily therapies (eg: dance, music,

yoga) and other creative interventions including art therapy and using poetry, film or literature.

Novel and creative treatments might be developed and these should be individually tailored and collaborative where the therapist and/or psychiatrist has a detailed understanding of the nature of a person's delusional experience and a good understanding of what is important to that person. For example, in the case of a person who has developed a delusion that is understood to be protective, a *care* strategy might be indicated involving acceptance of the delusion and a focus on (individually) *relevant* occupational therapy and/or creative or bodily therapy and perhaps talking therapy that focuses on exploration of the subjective experience with a view to alternative meaning or sense-making. The exact nature of the kinds of therapies indicated for any given individual is, of course, an empirical question.

9.3 Quality Assessment

Analysis of qualitative data is important because it draws on empirical material in such a way as to present a challenging or novel perspective which might open up new ways of understanding a particular research area. We adopt qualitative methods because we recognise that our knowledge and experience of the world is shaped by our subjective and cultural perspective as well as by our (culturally shaped) actions. In this way *reality*, *truth* and *knowledge* are created by the communal construction of meaning.

Qualitative researchers recognise the need to establish tentative agreement as to the credibility and utility of a piece of research for a certain purpose, whilst accepting that there cannot be a universal code of practice for all qualitative methods. How we evaluate qualitative studies is important not just for academia; it has practical importance for qualitative researchers, quantitative researchers, clinicians and policy makers who may be required to evaluate the worth of studies which employ qualitative methods. Agreement on open-ended and flexible ways of assessing quality, which might be applied to different qualitative methods, using criteria that are themselves open to flexible interpretation, can only help to improve credibility and rigour in the field (Yardley, 2000)

Lucy Yardley's characteristics for good qualitative research emphasise four domains under which a researcher should assess the quality of her work, these are: 1) Sensitivity to context; 2) Commitment and rigour; 3) Transparency and coherence; and 4) Impact and importance (ibid, p.219).

Below, I take each of Yardley's quality criteria in turn and examine how my research fairs with regard to those criteria.

1. *Sensitivity to context* - I have used IPA and narrative methods to understand experience in terms of story and meaning (as explicated in chapter 4, section 4.2) and I believe this methodology is well suited to the subject I am investigating. I have surveyed various theories and literature in relation to the subject I am studying (as explicated in chapters 2 and 5), however, as far as I am aware there is no recent empirical qualitative data

relating to delusion specifically (although I am aware of and have briefly surveyed some data relating more broadly to psychosis and schizophrenia). As a result I have relied, at least to some extent, on the classic psychopathology text of Jaspers (1998) to inform my endeavour as well as more recent research on the characteristics of delusion (Eg: Garety and Hemsley, 2013; Jones and Watson, 1997) and philosophical conceptualisation (see chapter 2). I have recruited and interviewed my research participants following ethical guidelines agreed in my research protocol (see appendix 1). All the research participant had active delusions and were considered well enough to give informed consent to participate in the study. The tension between an ethical consideration and the validity of the data is present here. Each participant was relatively stable, yet retained residual delusions and had vivid memories of what it had been like in the past. It could be argued that those in the throws of a florid delusional state might make better research participants in some sense as they might have more to say about *what it is like* to be in that state. However, ethical considerations meant that I could not interview anyone who was not able to give informed consent. So, in the end, those that I interviewed were still concerned with their delusional beliefs but not as distressed or consumed by them as they had been in the past. They were interviewed on NHS premises and this might have influenced the way they talked about themselves. As an independent researcher (non NHS / non-psychiatric staff) and with no other involvement with the research participants outside the research itself I believe I may have had privileged access to information – for example, all the research

participants said they had told me things they had not told their psychiatrist. I speculate that the research participants might therefore disclose information to me that others (clinicians) do not believe or do not want to hear or collude with. This might, in part, be because I have no medical or institutional power – I cannot prescribe medication or have a person sectioned under the Mental Health Act. This kind of privileged access is vital if we are to expand our knowledge about the experience of those who have the kind of anomalous experiences (such as delusion) associated with psychiatric illness. It is also vital that this kind of research is undertaken with rigour and with quality control in mind. Most importantly, I hope that I have demonstrated sensitivity to context in what I have taken to be ‘relevant data’. In interviewing my participants, I was careful to explore their histories and wider concerns, alongside their unusual beliefs. I approached the interviews mindful of the risk of focusing too narrowly on the *content* and *form* of my research participants’ unusual beliefs and I hope that the merits of *contextualising* the participants’ beliefs (as explored in chapters 4, 6 and 8) have been made clear.

2. *Commitment and rigour* - Prior to embarking on this thesis I have worked (and continue to work) as a self-employed psychotherapist and have engaged in therapeutic relationships with members of the charity Rethink (previously the Schizophrenia Society) for a number of years. I gained an MSc at the Medical School at the University of Warwick in the Philosophy of Ethics and Mental Health and wrote a dissertation on Thought Insertion, part of which was published in a peer reviewed journal (Gunn, 2016b) and I have

undertaken in-depth engagement with the topic (see chapters 2 and 5) with regard to literature and other research in this area.

Whilst I have undertaken some research and training in IPA and narrative methods this is my first piece of research of this kind and as such I cannot claim to feel fully confident in methodological competence or skill. I attempted to ameliorate this shortcoming through sharing my data and my analysis with my academic supervisors, one of whom is an expert in IPA. I lost some data (as explained in chapter 4) however the data I did collect was closely analysed using the rigorous recursive methods described in chapter 4.

3. *Transparency and coherence* - The full research protocol is included in this thesis as is a detailed description of how I analysed the data (see chapter 4). The transcripts are not included in order to preserve the anonymity of the participants and, whilst this might indicate a lack of complete transparency, this is an ethical requirement for this kind of research. Substantial (anonymised) quotes from the transcripts were used to support my analysis and the analysis itself is linked to pre-existing theory that has been used to conceptualise other aspects of psychiatric illness. The sample size was small (only four participants) but IPA, which focuses on depth and meaning, is designed to be undertaken with relatively small samples. Narrative analysis, which focuses on the whole story surrounding a given experience, can be integrated with IPA (Smith et al., 2009). As meaning and narrative are important aspects of the delusional experience IPA and narrative analysis are a good fit for this research. Depth might have been increased if I had spent

longer interviewing each participants. This was particularly noticeable in the case of Alison whose story was difficult to follow. It was only after I had listened to her interviews a number of times and transcribed and re-read the data that I realised there were gaps in the story and in my understanding. Because my research protocol specified two interviews of one hour each it was not possible to fill those gaps.

4. *Impact and importance* - I have outlined in detail the impact that this research might have in terms of theoretical understanding of the important features of (some) delusions. I have also highlighted the practical implications for further research, prevention and treatment as well as the socio-cultural impact in relation to the potential for stigma reduction (see chapters 4 and 5) and have summarised that impact in this chapter (above). In addition my research indicates what future research might be useful (see section 9.4) as well as the potential for policy change (see section 9.5)

9.4 Future Research

I suggest that more fine-grained phenomenological research is required. Data from this kind of research can be used to 1) inform further research – if we identify different kinds of delusional experiences with different kinds of aetiologies we might study them separately to identify patterns and responses to treatment; 2) inform prevention – a detailed understanding of the different ways that delusions might form can help us develop preventative strategies; 3) document and promulgate information about the experience - improving the mental health literacy of the general public and of organisations can reduce

stigma and structural discrimination; 4) increase help-seeking behaviour – a better understanding of these experiences enables a person to identify ‘flags’ that might indicate the potential for developing a serious psychiatric illness and thus seek help sooner.

9.5 Policy Changes

A ‘joined up’ mental health strategy that takes the ideas of the enactive approach seriously and understands that cognition, and therefore mental health problems, emerge from people-environment systems can only improve our understanding and enhance research and intervention. Large-scale anthropological studies might also help us to understand more about the environmental and relational factors that contribute to poor mental health outcomes. This information at policy level might enable us to *do something* to change and improve environments that we know give rise to poor mental health outcomes.

Understanding the experience of people with mental health problems is the starting position to move any of this forward. In this endeavour, we must see that epistemic justice is done, by taking a person’s testimony of her experience of mental illness seriously. If we *understand* we cannot think a person is somehow ‘other,’ ‘different’ or ‘damaged’ in some way. Perhaps this will then mean that attitudes will change and thus public stigma, self-stigma, organisational discrimination and public policy will all improve enabling better preventative strategies and better outcomes for people with psychiatric illnesses.

Appendices

Appendix 1 – Protocol and Flowchart

Appendix 2 – Information for Keyworkers

Appendix 3 – Letter of Invitation

Appendix 4 – Participant Information Sheet

Appendix 5 – Consent Form

Appendix 6 – Consultant Letter

Appendix 7 – Demographic Questionnaire

Appendix 8 – Interview Schedule

Appendix 1 – Protocol and Flowchart



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BIRMINGHAM

Research Protocol

Delusion – a qualitative enquiry

Chief investigator: Rachel Gunn

Research Supervisor: Dr Michael Larkin

Sponsor: The University of
Birmingham

Collaborators: Dr Neel Tambimuttu
Coventry & Warwickshire
Mental Health Partnership
NHS Trust
Dr Andrew Fox
Birmingham & Solihull Mental
Health Foundation Trust

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 1 of 15

Contents:

1	Brief Summary	.....	3
2	Scientific background and justification	.....	3
3	Objective	.....	5
4	Study design	.....	5
5	Inclusion / exclusion criteria	.....	8
6	Methodology	.....	9
7	Data storage and confidentiality	.....	10
8	Ethical issues	.....	11
9	Potential benefits	.....	13
10	Tasks and timelines	.....	14
11	Dissemination	.....	14
	References	.....	15

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 2 of 15

1. Brief Summary

The research aims to examine the experience of those with clinically significant delusions. The study will explore the characteristics of the symptom (delusion) and compare these with current literature, historical accounts (such as Jaspers, 1963) and clinical definitions, such as the Diagnostic and Statistical Manual (DSM5, 2013).

Participants will be recruited from local mental health services and approached by the lead professional involved in their care. The participants may have varying diagnoses, but must be experiencing active delusions to qualify to participate (see inclusion/exclusion criteria and information sheet for full details). Up to 10 service users, who are able to talk about their experiences, will be recruited for the study. Two separate semi-structured interviews will focus on history, onset and characteristics of the symptom. At an initial meeting steps will be taken to gain informed consent, provide the right to withdraw and protect participants' identities (see information sheet and consent form). Interviews will be recorded, transcribed and then analysed using IPA (interpretive phenomenological analysis) (see Smith, Larkin & Flowers, 2009).

The aim of the study is to add to existing literature and increase our understanding of the characteristics of the phenomenon (looking at aspects such as belief status, conviction, emotional components, falsifiability etc.). It is hoped that the findings will inform the philosophical literature and thus therapeutic intervention and future research.

2. Scientific Background and Justification

Delusion is defined in historical accounts (such as Jaspers) and the Diagnostic and Statistical Manual 5 (DSM5) as follows:

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 3 of 15

“A false belief [Jaspers’ – “false judgement(s)"] based on incorrect inference about external reality that is firmly sustained [Jaspers’ – “held with extraordinary conviction”] despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary [Jaspers’ – “imperviousness to other experiences and compelling counter arguments”]. The belief is not ordinarily one accepted by other members of the person’s culture or subculture (e.g. it is not an article of religious faith) [Jaspers’ – “...nor can the prolific views of entire nations be given the title delusion...”]. When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility.”

(American Psychiatric Association. DSM-5 Task Force, 2013, p.819).

The symptom approach to mental health problems is adopted here as opposed to the diagnostic approach (see Bentall, 2009). Diagnoses, such as schizophrenia, which group together various symptoms give us a heterogeneous patient group where it is possible for two people with the same diagnosis to have different symptoms. By taking the participants from the patient group who have some form of psychosis (with varying diagnoses - see DSM 5) and analysing their symptoms in a more fine-grained way it is hoped that the research will illuminate significant features of delusion and perhaps differentiate different kinds of delusion.

In recent years there have been a number of qualitative studies where participants have been interviewed about their experience of psychosis (see McCarthy-Jones et al, 2013; Boydell et al, 2010), so there is precedent for interviewing this patient population. However, these interviews have not been about the characteristics of the experience but rather about psychological impact and recovery.

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 4 of 15

Detailed qualitative descriptions of first-person experience of delusions are hard to come by in the literature. This makes philosophical questions about the nature of delusion difficult to answer and there is on-going debate in the literature about the characteristics as defined. The apparent characteristics (such as the belief status of the experience, falseness (and falsifiability), imperviousness to counter arguments and cultural normalcy) are by no means settled, despite the definition above (for some of the debates see: Bayne and Pacherie, 2005; Bortolotti, 2012; Currie and Jureidini, 2001; Frankish, 2012; Leiser and O'Donohue, 1999; Maher, 1974).

I hope to shed some light on these problems through detailed recording, transcription and analysis of these experiences. The study hopes to add to existing literature and increase our understanding of the phenomenon, thus informing therapeutic intervention and future research.

3.Objective

The aim of this research is to examine the subjective experience of delusion by interviewing participants with clinically significant delusion about their lived experience. This is done in order to better understand the characteristics of the phenomenon.

4. Study Design

Participants:

A minimum of 4 and a maximum of 10 participants will be recruited from local mental health services. These participants may have varying diagnoses but will all have active delusion(s).

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 5 of 15

The sample will be non-random as participants will be approached by their lead healthcare professional/keyworker.

The sample size is small to enable detailed phenomenological analysis of the participants' lived experiences taking into consideration the embodied, situated (cultural and environmental) and relational nature of human experience (Smith, Flowers & Larkin, 2009)

Recruitment process:

The lead healthcare professional (keyworker) for each potential participant will determine whether he/she is suitable for the study. The healthcare professional will be given information about the study (via the information for keyworkers sheet) and will be asked to recommend only those potential participants who meet the criteria for the study, are able to give informed consent to participate, are interested in talking about their experiences and for whom perceived risk of distress is minimal.

The healthcare professional will approach the potential participant and provide information about the study (via the letter of invitation to participate) as well as the contact details for getting in touch with the researcher (also via the letter of invitation). The potential participant can contact the researcher by post or email in the first instance and the researcher will phone/email him/her back to discuss the next steps. When initial contact is made the research will be explained to the potential participant, any questions the participant has will be addressed and formal consent will be sought (via the participant consent form). This will be done at a face to face meeting in advance of the first research interview. If the participant agrees he/she will be contacted after 2 days and an appointment will be arranged for the first interview.

What happens next:

In most cases there will be 2 interviews per participant (the possibility for shorter interviews for those who find a one hour too onerous is also available).

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 6 of 15

The interviews will take place at various local healthcare locations as appropriate (to be agreed with the participant and with the lead healthcare professional/NHS Trust as appropriate).

The first interview will include history taking and onset of the delusion and will take 60 minutes. At the end of the first interview a date will be set for the second interview. The second interview will be a detailed examination of what it is like to experience a delusion and will take 60 minutes. Questions will take a semi-structured form (ie: some specific questions will be asked with the opportunity for the researcher to follow these up as the interview develops - see the interview schedule for more information). All interviews will be audio recorded.

The researcher is a qualified counsellor and has experience of interviewing people experiencing psychological distress and additional guidance will be sought through supervision. All participants will be given the opportunity to talk to a clinical psychologist at the University of Birmingham or their lead healthcare professional (keyworker) should they become distressed and feel the need to talk to a third party.

The data:

Personal computerised data (data identifying participants, such as consent forms, contact details and audio recordings of interviews) will only be seen/heard by the researcher. Paper data (forms with identifying information) will be stored in a sealed envelope in a locked cabinet in the office of the research supervisor at the University of Birmingham.

The interviews will be recorded and then transcribed by the interviewer. The transcribed interviews will be altered to remove/replace any personal data that would identify the participant. The results will be analysed using IPA (interpretive phenomenological analysis) which aims to analyse how

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 7 of 15

individuals make sense of their subjective experiences. Some of the transcript may also be analysed by the investigator's supervisor.

Anonymised transcript data may be seen by the research supervisor and other members of the research team. Anonymised data will be used in the final thesis and at other academic forums (eg: conferences, workshops, blogs etc.). Anonymised excerpts may be used for teaching or training purposes.

All data will be kept in accordance with confidentiality procedures. Personal data (data identifying participants) will be destroyed/deleted 3 months after the end of the research. Anonymised transcripts of the interviews will be archived at the University of Birmingham for 10 years.

5. Inclusion and Exclusion Criteria

Participants must:

- be a service user within local mental health services
- have active delusion(s)
- be able to give informed consent to participate in the study
- be able to talk about their experiences
- be at minimal risk (of distress) when talking about their experiences
- be able to speak English (no translator is provided)
- be willing to travel to a suitable location to participate in the interview

A participant will be excluded if:

- the lead healthcare professional believes he/she would be at risk (of severe distress or suicide) by participating
- the lead healthcare professional believes that the participant represents a risk to the interviewer
- the lead healthcare professional believes that the participant is unable to give informed consent to participate in the study

Refs: 167001
ERN_13_1132
RG_14-251

6. Methodology

Interview questions:

The interview schedule takes the form of a semi-structured questionnaire and is adapted from the Appraisals of Anomalous Experiences Interview, known as AANEX (Brett et al 2007). It has been adapted for relevance and is designed to leave scope for freedom of novel participant descriptions of their experience.

Recruitment:

Local mental health services have agreed to recruit participants for this study. Lead healthcare professionals/keyworkers at various locations within the Trust will be given information about the study as well as inclusion/exclusion criteria (via the information for keyworkers sheet). Healthcare professionals will provide the information sheet and contact details of the researcher to potential participants. Potential participants can contact the researcher directly by phone or post (the researcher will then call them back to discuss participation). Alternatively the potential participant can ask the lead healthcare professional to pass his/her contact details on to the researcher. Potential participants will then have the opportunity to discuss the study and ask questions without committing themselves to participation (the study is voluntary). Information about the voluntary nature of the study is contained in the letter of invitation to participate. More details about the ability to withdraw some or all of the interview material at any time up to 2 weeks after the final interview will be provided on the detailed participant information sheet (given to participants at the first meeting with the researcher, as part of the discussion about the research and consent, prior to the first interview).

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 9 of 15

Consent:

Once a participant has expressed a desire to participate in the study they will be contacted by the researcher to arrange a convenient time and location to meet. Any questions the participant has about the research can be addressed at this meeting and, provided the potential participant is happy to continue, written informed consent will be obtained at this meeting.

Interviews: (see interview schedule for details of questions)

- Initial meeting lasting approximately 30 minutes - to explain the research, answer questions and obtain consent from the participant.
- Interview 1 lasting approximately 60 minutes – to take history and participant's experience at the onset of the delusion.
- Interview 2 lasting approximately 60 minutes – to gain detailed information about the participant's experience of delusion.

(the possibility for shorter interviews is also available, to be agreed with individual participants).

7. Data Storage and Confidentiality

All data stored on computer will be password protected. Any confidential paper data will be stored in a locked filing cabinet at the University of Birmingham.

Anonymised data:

A code name or pseudonym will be applied to the transcript (interview) data for a given participant. This will be stored on the researcher's personal laptop and on the server at the University of Birmingham. The data will be password protected. Only the researcher, the supervisor and other appropriate members of the research team (including peer researchers) at the University of Birmingham will have access to this anonymised data. Changes will be made to the transcribed (interview) data so that participants cannot be identified by their location, work or other identifying characteristics. This

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 10 of 15

anonymised data will be stored at the University of Birmingham for 10 years (in line with university research procedures). The custodian of this data will be the research supervisor.

Personal data:

Personal data, which identifies the participant, will be stored separately from anonymised transcript (interview) data. Only the researcher will have access to this data. Computerised data will be stored on the researcher's personal laptop and will be password protected. Paper data will be stored in a sealed envelope in a locked cabinet in the research supervisor's office at the University of Birmingham. This data will be destroyed (shredded/deleted) three months after the end of the research study.

8. Ethical Issues

Giving informed consent:

Each potential participant will be provided with an information sheet and a consent form. The details will be discussed with the participant, there will be an opportunity for the participant to ask questions and it will be made clear to him/her that the study is voluntary, anonymous (no personal details will be published in the research) and that he/she can withdraw up to 2 weeks after the final interview (for full details see the participant consent form and the participant information sheet).

In accordance with the BMA (2008) the researcher will check that each participant is able:

- to understand the information relevant to the decision
- to retain the information relevant to the decision
- to use or weigh the information and
- to communicate the decision

If the researcher has concerns about the participant's capacity to give informed consent after the commencement of the interviews (perhaps due to

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 11 of 15

deterioration in the participant's mental health) the participant will be withdrawn from the study.

If a participant discloses intent to seriously harm themselves, harm others or undertake a serious criminal activity a third party will be informed (as documented in the participant information sheet and discussed at the initial meeting with the potential participant).

Potential distress:

A small possibility of psychological distress exists. This risk will be mitigated to some extent as the possibility of potential distress will be highlighted on the information sheet, suitability is assessed by the lead healthcare worker and each participant is self-selecting (he/she will decide whether or not to participate based on the information given and the initial discussion). The informed participant is opting-in to the study.

In the unlikely event that the interview proves to be unexpectedly distressing, the interview can be stopped by the participant or the researcher at any time. The researcher will then ensure that appropriate support is sought if necessary (via the lead healthcare professional (keyworker), GP or clinical psychologist - as documented on the participant information sheet). If distress occurs outside the interview the participant will be able to talk to any of these named individuals (details of available contacts will be provided to the participant on the participant information sheet).

Recruitment and Retention:

Recruitment and retention may be difficult. Some participants will be in-patients, some out-patients and some may be in-patients at the information giving session and/or the first interview and perhaps have been discharged by the time subsequent interview(s) take place.

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 12 of 15

Participants will be seen at different local NHS locations. The participant will be required to attend interviews totalling 2-3 hours. Out-patients may also be required to travel to an appropriate local NHS location on 3 (or perhaps more) occasions. Where possible, participants will be seen at a time that is convenient for them. In the case of in-patients it would be at a suitable location and time within the hospital setting. In the case of out-patients this could be done when they are visiting the location in any case (for another appointment). If this is not possible, this may mean that the participant is visiting a location for the sole purpose of participating in the research, in which case travel expenses of up to £20 per person will be offered (provided by the University of Birmingham).

Right to Withdraw:

As well as being given the opportunity to withdraw at any time from any of the interviews the participant will be able to withdraw entirely from the study up to 2 weeks after completion of the interviews. A participant may also choose to withdraw individual statements that they have made during the interview up to 2 weeks after the completion of the interviews without withdrawing entirely from the study. The ability to withdraw is documented in the information sheet and on the consent form. In addition the participant will be reminded of this at each interview.

9. Potential Benefits

There is no direct benefit to participants. However, participants may find discussing the history, onset and experience of their delusion illuminating and perhaps therapeutic.

The data will be used to inform a philosophical thesis about the nature of delusion. It is hoped that this thesis will improve understanding of this phenomenon and inform on-going research and treatment.

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 13 of 15

10. Tasks and Timelines

Total duration for research: 03/11/14 – 01/02/17

Details: (see also flowchart)

- October-December 2014 - IRAS completed and submitted
- January-March 2015 - necessary changes made
- April 2015-March 2017 - recruitment, data collection, transcription and analysis of data
- October 2015-December 2017 - use of analysis to inform philosophical work and write up of final PhD.
- March 2018- destroy/delete all personal data

11. Dissemination

A summary sheet will be made available to participants, keyworkers and other interested parties.

The PhD write up will be available electronically to all those who have appropriate university library access.

Articles may be published in peer reviewed academic journals.

Items may also be published online on academic websites and blogs.

Data and findings may be presented at conferences and workshops or in a book.

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 14 of 15

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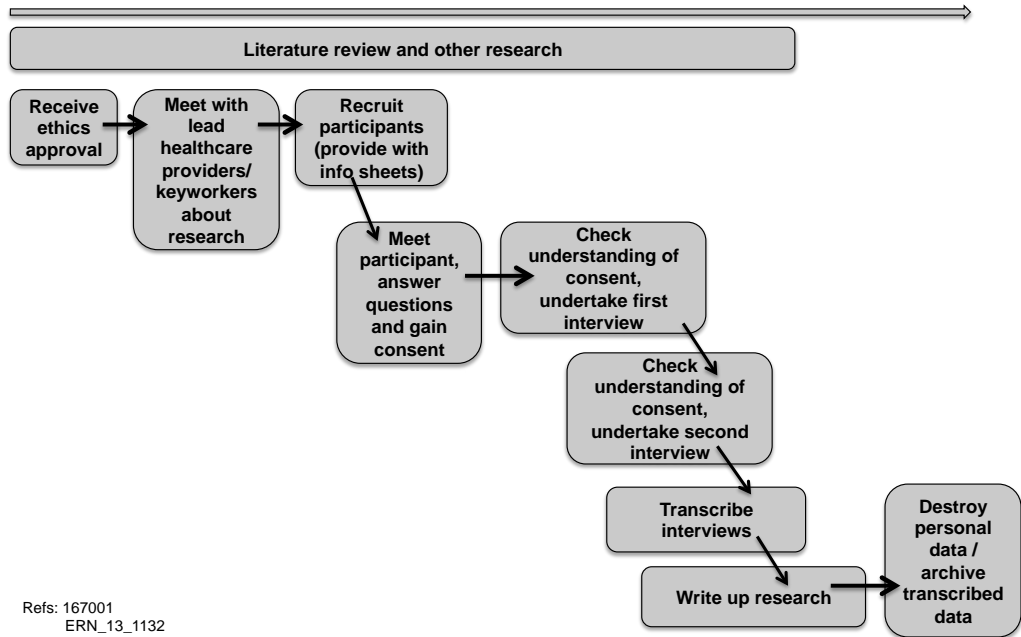
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Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 15/12/16

Page 15 of 15



Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Appendix 2 – Information for Keyworkers



02/11/15

To: Keyworkers and lead mental health healthcare professionals

Research Opportunity

I am a PhD student conducting a research study to look at the experience of **individuals who have thoughts and feelings that others do not understand and that might be described as delusional** by healthcare providers and others. This is symptom-based research and the **diagnosis (or lack of diagnosis) is not significant for this research.**

I would like you to help me find participants for this study. The inclusion/exclusion criteria are as follows:

Inclusion criteria

Participants must:

- be a service user within local mental health services
- have active delusion(s)
- be able to give informed consent to participate in the study
- be able to talk about their experiences
- be at minimal risk (of distress) when talking about their experiences
- be able to speak English (no translator is provided)
- be willing to travel to a suitable NHS location to participate in the interview

Refs: 167001
ERN_13_1132
RG_14-251

Version 2: 15/06/15

Page 1 of 3

A participant will be excluded if:

- the lead healthcare professional believes he/she would be at risk (of severe distress or suicide) by participating
- the lead healthcare professional believes that the participant represents a risk to the interviewer
- the lead healthcare professional believes that the participant is unable to give informed consent to participate in the study

There will be an initial meeting with each potential participant to answer questions and gain consent and then there will be two further interviews lasting about one hour each. The interviews will take place in a suitable NHS location (local and convenient to the participant).

The interviews will take the form of a conversation between me (the researcher) and the participant, where the participant talks about his/her experiences. The participant will also be asked to fill in a very short questionnaire (taking 1 or 2 minutes only).

I will ask questions about:

- How the difficulties started
- Aspects of personal history that might have precipitated or had an effect on the experience
- What the experience is like (how it feels and what meaning it may have)

What to do if you identify a possible candidate:

- In the first instance ask him/her if he/she is interested in participating in the research.
- If he/she is interested give him/her the **letter of invitation** provided.
- At this stage the potential participant may contact me direct via email or post.

Refs: 167001
ERN_13_1132
RG_14-251

Version 2: 15/06/15

Page 2 of 3

- An additional contact option is to ask a member of staff to contact me on his/her behalf. If a potential participant asks you to do this please ask him/her to complete the form on the information sheet and provide this information to me (via phone or email – see contact details below). (Please retain the form and I will collect it from you in due course).

Thank you for your assistance in this research project.

My contact details (chief investigator for this research project) are:

Rachel Gunn Tel:
 Email:

Refs: 167001
 ERN_13_1132
 RG_14-251

Version 2: 15/06/15

Page 3 of 3

Appendix 3 – Letter of Invitation

NHS Trust logo header here.....

Title of Project: What is it like to experience thoughts and feelings that others might describe as delusional?

To: Service users
Birmingham and Solihull Mental Health NHS Foundation Trust

Research Opportunity – letter of invitation

This research is being conducted as part of a program of study at the University of Birmingham. The purpose of the research is to look at the experience of **individuals who have thoughts and feelings that others do not understand and that might be described as delusional** by healthcare providers and others. This is symptom-based research and the **diagnosis (or lack of diagnosis) is not significant for this research.**

Your keyworker has given you this invitation/information sheet because he/she believes you may be able to contribute to the research.

If you would like to talk about your experiences and can commit to giving about two and a half hours of your time to meet with me and answer questions please contact me using one of the methods detailed below. I will then get in touch with you to discuss how we proceed.

If you are interested you will have an initial meeting with me, of about half an hour, where I will answer any questions you may have and provide you with a detailed information sheet about the research. The research is entirely voluntary and if you choose to proceed, I will then ask you to give written consent for your involvement. There will be two further interviews lasting about one hour each. The interviews will take place in a suitable NHS location (local and convenient to you).

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 29/05/15

Page 1 of 3

The interviews will take the form of a conversation between you and me, where you tell me about your experiences.

I will ask questions about:

- How your difficulties started
- Aspects of personal history that might have had an effect on the experience
- What the experience is like (how it feels and what meaning it may have)

You will also be asked to complete a very short questionnaire (eight questions) about yourself. This questionnaire will take no more than one or two minutes to complete.

If you are interested in participating in this research there are 3 options for contact:

1. Fill in the 'agreement to be contacted' form and hand it to your keyworker

2. Fill in the form and send it (in the envelope provided) **to:**

3. Email me direct at _____ with your request to be contacted, your name, your contact number and any additional information that you feel is relevant.

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 29/05/15

Page 2 of 3

Agreement to be contacted

Title of Project: What is it like to experience thoughts and feelings that others might describe as delusional?

Name of Researcher: Rachel Gunn

I agree to be contacted by the researcher regarding this project (please tick)

Name: _____

Contact phone number: _____

Special requirements for contact/meeting, please specify:

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 29/05/15

Page 3 of 3

Appendix 4 – Participant Information Sheet

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Title of Project: What is it like to experience thoughts and feelings that others might describe as delusional?

PARTICIPANT INFORMATION SHEET

(given to potential participants at the initial meeting with the researcher)

What is the purpose of the study?

This research is being conducted as part of a program of study at the University of Birmingham. The purpose of the research is to look at the experience of individuals who have thoughts and feelings that others do not understand and that might be described as delusional by healthcare providers and others.

The interviews will take the form of a conversation between you and me, where you tell me about your experiences. You will also be asked to complete a very short questionnaire (eight questions) about yourself. This questionnaire will take no more than one or two minutes to complete.

I will ask you questions about:

- How your difficulties started
- Aspects of your personal history that might have had an affect on you
- What your experience is like (how it feels and what meaning it may have for you)

Why have you been chosen?

I am interested in talking to you as currently there is only a limited amount known about what these experiences are like. It is hoped that the information provided by participants will help to identify important aspects of the experience. This in turn may

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 1 of 7

lead to a better understanding of the difficulties associated with these experiences and therefore have implications for better support.

Do I have to take part?

No, you do not have to take part. It is up to you to decide whether or not you wish to take part. The decision to participate is completely voluntary.

If, 48 hours after our initial discussion, you are still interested in participating in this study, I will contact you to make an appointment, at a time of your convenience, to come and interview you about your experiences. The interviews will take place on NHS premises.

Remember, if you decide to take part, you will still be free to withdraw at any time. Withdrawing will not affect any current or future NHS treatment.

What will happen to you if you take part?

If, after consideration, you agree to take part an appointment will be arranged at an appropriate NHS location at a time of your convenience.

During the first research session, you will take part in an interview and I will ask you about your personal history and your experiences at the onset of your difficulties. I will also ask you to describe what it is like to have thoughts and feelings that others find difficult to understand. This will take about one hour to complete. At the second session I will ask you about your experience in detail as well as how this compares with other (ordinary) experiences and past experiences. The second session will take about one hour. If necessary we can agree to make the interviews shorter (if an hour seems to long).

The research will be carried out wherever is most suitable for you. It can be either organised at your nearest NHS support centre or at some other NHS location if this is more convenient.

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 2 of 7

Your total involvement in the research will be about two and a half hours (the first half hour meeting will be to discuss participation, ask questions and give consent).

Expenses

Expenses for travel to the research interview location can be claimed in cash from the researcher by presenting relevant travel documents (such as a bus ticket or taxi receipt) or by a mileage calculation (if traveling by car) at 45p per mile travelled.

The maximum that can be claimed by each participant will be £20 for attending each meeting.

What do I have to do?

You will need to be able to talk about your experiences. The total interview time would be two hours. This could be done at two separate one hour interviews or at several shorter interviews if preferred (details to be agreed on an individual basis).

This study will **NOT** involve drugs or any other medical procedures.

What are the possible disadvantages and risks of taking part?

There are no risks involved. However, if you become distressed as a result of your participation, please let me know, either at the time or using the contact details below. In the first instance I will discuss any difficulties that have arisen. If you require professional help, I will discuss this with you first and perhaps suggest that you contact your keyworker, GP, or other appropriate professional. If necessary, there is also the possibility of contacting a clinical psychologist at the University of Birmingham. This can be done by asking the researcher (Rachel Gunn) to make contact on your behalf in the first instance.

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 3 of 7

If the answers that you give to the questionnaires cause me concern about your own well-being, I will discuss this with you and may suggest that you contact your keyworker, GP or other appropriate professional for further advice.

In addition if you disclose any serious illegal activities or intent of harm to yourself or others this will be reported to an appropriate third party.

What are the possible benefits of taking part?

There are no direct benefits in taking part in the study, although you may find talking about your experiences therapeutic. It is hoped that the information provided by participants will increase the knowledge of health professionals and have direct implications for better support.

What if something goes wrong?

Once again, if participating in this research project distresses you, you should let me know. In the first instance, I will discuss your difficulties with you. If you need professional help, I will speak to you about this and you may then want to contact your keyworker, GP or other appropriate professional.

There are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

What if I have special needs?

I will make every effort to ensure that there are no barriers for you if you wish to take part. If you have communication problems such as difficulties with reading, I may be able to offer you more time to complete the study and will assist you in reading the

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 4 of 7

information and consent forms. If you envisage any other problems, please let me know and every effort will be made to make things easier for you.

Will my taking part in this study be kept confidential?

Your participation in the study will be kept confidential. Consent will be sought for audiotaping and for anonymised quotes to be used in the final output of the research.

Personal data – your name and other personal details

The signed consent form and personal data that identifies you will only be seen by the researcher (Rachel Gunn). The research supervisor will keep paper data in a sealed envelope in a locked cabinet in his office at the University of Birmingham. He will not look at the personal data. This paper data will be kept in a locked cabinet until the end of the research project. It will be destroyed by the researcher 3 months after the end of the project. No personal information (information that identifies you specifically) will be kept on any computers.

Your contribution – recordings of the research interviews

The recordings of the interviews will be saved on the researcher's personal computer and will be password protected. This data will be deleted 3 months after the end of the research.

Your contribution – transcription of the research interviews

The interviews will be transcribed by the researcher (Rachel Gunn). This means that everything you say and everything the researcher says will be typed up and saved on the researcher's personal computer. These computerised documents will be password protected and anonymised (no personal information will be on these files). At the end of the research these computerised files will be given to the designated University of Birmingham custodian. These anonymised files will be kept for 10 years and may be used for teaching and training within the department.

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 5 of 7

Please be aware that, although your information will be confidential if anything illegal is disclosed it will be reported to the appropriate authorities.

What will happen to the results of the research study?

On completion, the results of this study may be sent for publication in a scientific journal. Parts of the research may also appear in a book (or books), on academic blogs or websites and be presented at academic conferences. You will not be personally identifiable in any of these publications. Each participant will be informed about the results of the study. If you are interested in the outcome of the research, I can send you a short report of the findings.

Who is organising and funding the research?

The research is being undertaken as part of a PhD in philosophy and psychology and is therefore organised and funded by the School of Psychology and the School of Philosophy and Theology at the University of Birmingham.

Who has reviewed the study?

This study has been reviewed and approved by the local NHS ethics committee according to local regulations.

Contact for Further Information:

If you have any matters that concern you or further questions, you may contact the researcher in charge of this project or the supervisor for this research:

- Rachel Gunn, researcher: email:
- Dr. Michael Larkin, research supervisor, School of Psychology:

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 6 of 7

You could also contact:

Telephone:

Email:

or

Research Support Office, 65 Davies Street, London, W1K 5DA,
Telephone: 020 7514 6262 who can provide independent advice.

or

Consumers for Ethics in Research (CERES) who publish a leaflet with advice for people considering taking part in research, and looks at some questions you may want to ask. A copy may be obtained from CERES, PO Box 1365, London, N16 0BW.

**THANK YOU FOR TAKING THE TIME TO READ THIS
INFORMATION.**

Refs: 167001
ERN_13_1132
RG_14-251

Version 4: 15/06/15

Page 7 of 7

Appendix 5 – Consent Form

NHS Trust logo here.....

PARTICIPANT CONSENT FORM

(2 x signed copies required: 1 for participant; 1 for researcher site file)

Title of Project: What is it like to experience thoughts and feelings that others might describe as delusional?

Name of Researcher: Rachel Gunn

Please initial box

- | | |
|---|----------------------|
| I confirm that I have read and understand the information sheet. | <input type="text"/> |
| I have had the opportunity to ask questions and had them answered. | <input type="text"/> |
| I understand that my participation is voluntary. | <input type="text"/> |
| I understand I am free to withdraw some or all of my interview material at any time during the research process and up to 2 weeks after my final interview with the researcher without giving a reason. | <input type="text"/> |
| I give consent for the interview to be audio taped. | <input type="text"/> |
| I give consent for anonymised quotations to be used. | <input type="text"/> |
| I understand that my consultant and my keyworker will be informed that I am taking part in the research but they will not be told anything about what I talk about. | <input type="text"/> |
| I understand if I tell the researcher something that means I am at risk of suicide, harm to others or serious criminal activity that the researcher may inform a third party. | <input type="text"/> |
| I agree to participate in this research. | <input type="text"/> |

Name of Patient: _____ Signature: _____ date: _____

Person taking consent: **Rachel Gunn** Signature _____ date: _____

Pseudonym / code number for this research: _____

Refs: 167001
ERN_13_1132
RG_14-251

Version 3: 29/05/15

Page 1 of 1

Appendix 6 – Consultant Letter



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.....address.....

.....date.....

Dear Dr.

Your patient insert name..... will be taking part in a qualitative research project in the next few weeks. He/she will be asked about his/her recent thoughts and feelings in relation to experiences that others might describe as delusional.

If you have any queries about this research please feel free to contact me by phone or email.

Yours sincerely

Rachel Gunn
Postgraduate Researcher
School of Philosophy
University of Birmingham

Tel:
Email:

Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Page 1 of 1

Appendix 7 – Demographic Questionnaire



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Questionnaire

(basic demographic description – questions will only be asked if they are not spontaneously offered over the course of the interviews)

Code/pseudonym _____

Date of interview _____

Age range 18-25 25-35 35-45 45-55 55-65 65-75

Sex M / F

Diagnosis _____

How long in mental health services? _____

How long experiencing symptoms? _____

Ethnic group (self describe) _____

In Work / in education / unemployed?

Who do you live with/who's in the household? _____

Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Page 1 of 1

Appendix 8 – Interview Schedule



Interview Schedule

Project title: Delusion – a qualitative enquiry

(This interview schedule is adapted and developed from AANEX - Brett et al., 2007)

Interview 1 – 60 minutes

Context of onset:

1. Thinking back to the first time you came to mental health services for help, can you tell me what things were like for you at the time?

Additional questions to be asked if not spontaneously included in descriptive answer to question 1:

1.1 Can you tell me what your life was like when you this happened?

1.2 What kind of living situation were you in?

1.3 Were there any particularly difficult or exciting events happening to you at the time?

1.4 How were you feeling emotionally at the time?

History:

2. Can you tell me about any significant events in your history that you feel might have contributed to this experience?

Describing the delusional experience:

3. Can you tell me what is it that you experience that other people, such as healthcare providers or your friends and family, would describe as a delusion?

Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Page 1 of 4

Interview 2 – 60 minutes

Thoughts and feelings about the experience:

4. Last time we met you talked about [the experience described at the end of the previous interview]. When you have [that experience], what do you think has happened/is going on?

Additional questions to be asked if not spontaneously included in descriptive answer to question 4:

4.1 Are you still experiencing (use participants previous descriptors, eg: thinking/feeling/believing) that? If yes - Can you tell me more about that?

4.2 If no – Can you tell me about what has changed?

(If delusion is no longer there, continue to ask participant about what it was like, ie: following questions in past tense)

4.3

If EXPERIENCE described:

What sense do/did you make of it?

Do you think there is an explanation for it?

If BELIEF described:

What do you experience that leads you to think that?

Similar questions to be asked if the experience is described differently (eg: as KNOWLEDGE or FEEL or INTUITION or other descriptors) – care to be taken to use the participant's language.

4.4 Can you tell me if you are convinced that what you [experience / feel / know / believe / intuit etc...] is true?

4.5 If yes - Do you always think that? Can you tell me about how that conviction varies?

4.6 If always true - Can you tell me if you can think of anything that would remove / reduce the certainty?

4.7 Before you first experienced this what would you have thought if someone told you this was going to happen?

4.8 Is [describe experience as explained by participant] always the same? If no – In what way(s) does it change?

Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Page 2 of 4

Emotional Response:

5. How do you feel when [this] happens?

Additional questions to be asked if not spontaneously included in descriptive answer to question 5:

5.1 Do you feel very surprised, puzzled or curious?

5.2 Do you have any bad feelings, worries, or fears?

5.3 Do you have any good feelings at all?

Other possible questions – if not already given in previous descriptions

Cognitive Response:

6. So, you've told me [reflect participant's description of actual occurrence of experience, e.g. most recent]. I'm interested in what you think about that experience. Can you tell me about it?

Behavioural Response:

7. Does [the experience] cause you to behave differently than how you would normally or how you've behaved in the past? Can you tell me about it?

Effect of self / relationships with others:

8. What effect has this experience had on how you see yourself?

Control:

9 Can you stop the experience when you want, or do you deliberately elicit it / bring it on? Can you tell me about that?

Understanding / awareness:

10. Were you aware that these experiences could occur before it happened to you? Can you tell me about it?

Alternative Interpretations:

Refs: 167001
ERN_13_1132
RG_14-251

Version 1: 15/12/14

Page 3 of 4

11. Do you think there are other ways of explaining what you experience? Can you tell me about them?

Open section:

12 Are there any other aspects of your experience, which you feel are important, which you'd like to tell me about?

Reference:

Supplementary material from Brett, C.M.C., Peters, E.P., Johns, L.C., et al. (2007) Appraisals of Anomalous Experiences Interview (AANEX): a multidimensional measure of psychological responses to anomalies associated with psychosis. **The British Journal of Psychiatry**, 191 (51): 23–30,

Refs: 167001
ERN_13_1132
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Version 1: 15/12/14

Page 4 of 4

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