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Different Realities: Challenging Conventional Ways of Conceptualising Delusions and Hallucinations

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Abstract

Delusions and hallucinations are typically regarded in contemporary Western societies as signs of serious mental illness - that is, as essentially meaningless surface expressions of a biological process, that are almost invariably distressing and harmful to those experiencing them. However, these conventional ways of conceptualising delusions and hallucinations are increasingly being contested (by critical psychologists and by some of those who experience these kinds of phenomena). As part of this trend, this thesis highlights the need to move beyond traditional ways of construing delusions and hallucinations and to open up new ways of thinking about them. In Part One, I present analyses from an international survey of 58 mental health practitioners and researchers, which I conducted to investigate their understandings of delusional and hallucinatory content. I explore their views concerning the importance of attending to the content of delusions and hallucinations, and a possible relation between gender and the content of these phenomena. In Part Two, I present analyses of interviews with 11 women who have experienced delusions and hallucinations. I explore the linguistic resources available to those who experience delusions and hallucinations for talking about these kinds of phenomena, and the ways in which they may attempt to make sense of such experiences. I illustrate some of the challenges to traditional ways of conceptualising delusions and hallucinations by drawing upon the accounts of five of the women I interviewed. I aim, in this thesis, to question and disrupt conventional understandings of delusions and hallucinations and to increase the availability of some alternative (marginalised) ways of construing them. I emphasise the need to consider (and critically examine) the potential practical and moral implications of various ways of conceptualising delusions and hallucinations.
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1: Introduction

Delusions and hallucinations are typically regarded in Western societies as signs of serious mental illness (Thomas & Leudar, 1996; Leudar, Thomas, McNally & Glinski, 1997; Clarke, 1998; Watkins, 1998; Honig et al., 1998; Romme & Escher, 2000a; Leudar, 2001; Leudar & David, 2001). Over the last century, it has been customary to conceptualise delusions and hallucinations as being meaningless, surface expressions of an underlying biological illness (following Kraepelin, 1913/1919; Jaspers, 1946/1963). Accordingly, within certain dominant psychiatric approaches, the content of delusions and hallucinations has been looked upon as incomprehensible and irrelevant (Read & Argyle, 1999; Leudar & David, 2001). The orthodox view within contemporary mainstream Western psychiatry1 is that delusions and hallucinations are almost invariably distressing and harmful to those experiencing them (Watkins, 1998). Clarke (1998), for example, states as fact that “hearing voices is distressing and frightening” (p. 29). From this perspective, delusions and hallucinations are to be eliminated and suppressed, typically through the use of psychotropic medication (Watkins, 1998).

Yet, these conventional ways of conceptualising delusions and hallucinations are increasingly being challenged. Firstly, there is growing recognition that it is not uncommon within the general population for persons to experience delusions and hallucinations and not seek (or require) professional help (e.g., see Posey & Losch, 1983; Tien, 1991; Watkins, 1998; Romme & Escher, 2000a; Johns & van Os, 2001;

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1 In this thesis, I focus specifically on the framework of mainstream Western psychiatry, rather than the broader realm of the psy disciplines (Rose, 1985) – that is, psychiatry, psychology, psychotherapy, psychoanalysis, counselling and so on. I have deliberately decided not to use this overarching concept, as it is debatable the extent to which the psychiatric framework applies to all psy disciplines (e.g., it may be taken up to varying degrees by different psy disciplines).
Verdoux & van Os, 2002). For instance, it has been reported that, in Western countries, the number of people who hear voices and do not seek help is higher than the number of voice-hearers who receive psychiatric diagnoses (Tien, 1991; Romme & Escher, 2000a; Johns & van Os, 2001). It has been claimed that many people who hear voices are not particularly distressed by this, and some even report that the voices enrich their lives (Romme & Escher, 1989, 2000a; Jackson & Fulford, 1997; Watkins, 1998). This challenges the notion that hallucinations, at least, are necessarily pathological or distressing. Even among those who have sought assistance from community mental health (CMH) services, there are people who describe some of their experiences of hearing voices and seeing visions as having been “helpful” and “supportive” (e.g., Brigitte, Sue, Mem & Veronika, 1998, p. 204).

The terms delusions and hallucinations might be regarded as relatively straightforward, particularly within the mental health field, but a number of critical psychologists have argued that they are highly problematic (e.g., Harper, 1992, 1994, 1996; Georgaca, 2000; Boyle, 2002). Such critiques are useful, as they challenge us to question taken-for-granted ways of thinking about delusions and hallucinations. I bring some of these critiques together here to highlight the need for us to rethink the meaning of delusions and hallucinations.

Delusions are defined within contemporary mainstream Western psychiatry as erroneous or highly implausible beliefs not shared by others (American Psychiatric Association [APA], 2000). According to the diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000), they are said to be beliefs that are: bizarre, false or implausible; idiosyncratic; held with absolute certainty; and resistant to change, even in the face of contradictory evidence. Hallucinations are defined as false perceptions or percept-like experiences
that may occur in any sensory modality, in the absence of corresponding external sensory stimuli (APA, 2000).

Delusions are generally conceptualised as beliefs that are separate from, or out of touch with, (inter-subjective, consensual) reality (Harper, 1992; Boyle, 2002). However, as Georgaca (2000) argues, it is almost impossible to determine whether a belief is true or false, plausible or implausible. While in some instances, a discrimination concerning truth/falsity may seem quite straightforward, this is not always the case. It has been reported that there often is some evidential basis (or at least a ‘core of truth’) to many so-called delusional beliefs (Kaffman, 1981). Leeser and O’Donohue (1999) dismiss the relevance of the falsity criterion, claiming that delusions are “uniquely unfalsifiable beliefs” (p. 687). It has been said that the question of whether or not an apparently delusional belief is true is either not applicable, applicable but unlikely to be solved, or solved, but insofar as the belief turns out to be true (Spitzer, 1990). Beliefs that appear to be delusional may make more sense (e.g., seem less implausible) when considered in context. For example, Gottschalk (2000) argues that suspicions of being watched and monitored may be viewed as a relatively understandable response in Western societies, in which electronic surveillance and information-gathering are now ubiquitous. Harper (1996) contends that certain versions of events come to be regarded as true, or at least plausible, not according to their inherent truth, but rather according to how well they fit with the sociopolitical context in which they are voiced.

Georgaca (2000) points out that if a particular belief appears to be idiosyncratic, this does not necessarily mean that it is false. If this were the case, then any non-shared knowledge, such as new scientific theories, might be regarded as delusional (Georgaca, 2000). On the other hand, a belief is not necessarily true
simply because a large number of people endorse it (Harper, 1992). Psychiatric diagnoses, in general, rely upon, and reproduce, the notion of a self-contained, unified and stable self, retaining the individual-social dualism (Gottschalk, 2000). In this framework, phenomena such as delusions (and hallucinations) are located within the individual - they signify that there is something wrong with that particular person (Drewery & Winslade, 1997; Gottschalk, 2000). However, as will be discussed in the following chapter, the notion that each person has a coherent, core self that is self-contained has been problematised (e.g., Potter & Wetherell, 1987). Georgaca (2000) argues that the formation of beliefs, delusional or otherwise, tends to be a social, rather than individual, process. She points out that our knowledge about reality is arrived at by drawing upon culturally available ways of making sense of the world and ourselves. “The establishment of truth is an inter-subjective achievement which entails processes of validation, negotiation and persuasion in specific inter-subjective, social and cultural contexts” (Georgaca, 2000, p. 230). In addition, Boyle (2002) claims that the decision to label a belief as a delusion typically occurs in a social context in which there is disagreement between the person expressing the belief and a more powerful person hearing it. She asserts the need to recognise that:

psychotic behaviours and experiences [that is, delusions and hallucinations] are relational, that they arise in social and interpersonal contexts, that their form and content are given meaning by those contexts and that such behaviours are officially transformed to ‘pathology’ only through a relationship of unequal power (Boyle, 2002, p. 316-317, emphasis in original).

The diagnostic criteria of conviction and incorrigibility have also been critiqued on the grounds that they uphold the notion of the normal person as being someone rational, willing to examine, debate and revise her/his views logically, in accordance with available empirical evidence (Georgaca, 2000). Yet, (non-
delusional) scientific theories and political and religious beliefs are often held with considerable conviction, in the face of logical counter-arguments (Maher, 1988). Conversely, it has been pointed out that delusions are not necessarily held with complete certainty (Georgaca, 2000), nor are they always resistant to change (provided that counter-arguments are presented in a particular way) (e.g., see Kingdon & Turkington, 1994; Fowler, Garety & Kuipers, 1995; Chadwick, Birchwood & Trower, 1996).

Critical psychologists (e.g., Boyle, 2002) argue that the conventional way of conceptualising hallucinations shares many of the problematic assumptions underlying the traditional way of construing delusions (e.g., reliance upon a realist stance and the notion of a self-contained, unified and stable self). Watkins (1998) claims that the way in which hallucinations are defined within contemporary mainstream Western psychiatry reflects a materialistic bias. He suggests that although terms such as psychiatry and psychology are derived from the ancient Greek word psyche, which originally referred to the human spirit or soul, there is little place for consideration of non-material matters within mainstream mental health services.

It could be argued that, like the term delusion, the term hallucination is generally regarded as pejorative (Sarbin, 1967; Sarbin & Juhasz, 1967; Watkins, 1998). Boyle (2002) claims that the use of negative evaluative language depicts persons experiencing hallucinations as having something wrong with(in) them (such as a chemical imbalance in the brain, a neuropsychological deficit or an information-processing bias). It is argued that conventional understandings of hallucinations as pathological not only ignore how common these sorts of experiences are among the general population in Western societies (e.g., see Posey & Losch, 1983; Tien, 1991; Watkins, 1998; Romme & Escher, 2000a; Johns & van Os, 2001; Verdoux & van Os,
but also in some non-Western cultures (e.g., the Xhosa culture of the Northern Transvaal of South Africa) and in some Western subcultures (e.g., certain New Age groups), these sorts of phenomena are viewed in positive terms, and may even be deliberately sought (e.g., by using various forms of deprivation or by ingesting hallucinogenic substances) (Bourguignon, 1970; Leudar & Thomas, 2000). For instance, Cherrington (1994) claims that hearing voices or seeing visions is generally acceptable and often positively-valued within Maori culture, as such phenomena may be regarded as signs as that the person experiencing them has a special gift and spiritual connections with her/his ancestors.

Watkins (1998) lists a range of circumstances in which hearing voices (i.e., phenomena that might be regarded as hallucinations due to the absence of corresponding physical stimuli) are more likely to occur. These include: sleep deprivation; sensory deprivation; severe stress and trauma; ingestion of hallucinogenic substances; a wide range of medical conditions (including migraine, viral encephalitis, and temporal lobe epilepsy); recent bereavement; and hypnagogic or hypnopompic states (i.e., during the period when someone is falling asleep or waking up).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, APA, 2000) stipulates that voice-hearing experiences “must occur in the context of a clear sensorium” (p. 300) in order to be classified as genuine hallucinations (that is, they must occur when the senses are not clouded by psychoactive substances or altered states of consciousness). So, unusual perceptual experiences that occur during

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2 It is difficult to establish with any accuracy how common the experiences that might be characterised as hallucinations are in the general population, as people may be reluctant to state that they have experienced them, as these kinds of phenomena tend to be negatively-valued in Western cultures (Watkins, 1998). To report percentages of persons in the general population experiencing hallucinations may be misleading (by conveying an erroneous impression of certainty and stability). Nonetheless, Johns and van Os (2001) conclude that “studies have yielded consistent findings, showing that a considerable proportion of individuals experience hallucinations at some time in their lives” (p. 1129).
a hypnagogic or hypnopompic state, under the influence of alcohol or drugs, or in the context of sensory deprivation, for example, are regarded as pseudo-hallucinations (APA, 2000). This means of determining 'when a hallucination is not a hallucination' relies upon the absence of plausible explanations for the experience (that appeal to extraneous factors) (Blackman, 2001). A psychiatrist determines whether or not an unusual perceptual experience ought to be regarded as an hallucination according to her/his assessment of the likely context in which the experience occurred. If there appears to have been no plausible explanation (such as intoxication) to account for the experience at the time it occurred, then the phenomenon is more likely to be characterised as an hallucination. Blackman (2001) argues that, as such, the phenomena do not "speak for themselves"... the psychiatric gaze concerns itself with what is 'absent' to the immediate gaze of the psychiatrist" (p. 28). In other words, the judgement relies upon the psychiatrist's ability to surmise the characteristics of a context of which s/he was typically not part.

The DSM-IV-TR (APA, 2000) guidelines about how to distinguish between unusual perceptual experiences that are deemed to be pathological (i.e., hallucinations) and those that are not (i.e., pseudo-hallucinations) convey a sense of certainty, clarity and clinical precision. In practice, however, such discriminations may not be straightforward. As noted above, often psychiatrists are not present at the time hallucinations occur, and they must rely on their own judgement about the existence of plausible explanations to account for these phenomena.

Sarbin and Juhasz (1967) argue that although the term hallucination is meant to refer to a certain type of experience, they believe it is a term used to refer to an experience in a particular kind of person. They suggest that a person exhibiting inappropriate behaviour may be brought to the attention of mental health practitioners,
and the term hallucination is then applied, only after it has been decided that the person warrants a psychiatric diagnosis. "Those people who have already been judged to be mentally ill and who report seeing ghosts hallucinate, those who are not judged to be mentally ill [but report experiencing the same kinds of perceptual phenomena], have an illusion" (Sarbin & Juhasz, 1967, p. 353, emphasis in original).

What these critiques illustrate is that despite the existence of supposedly clear and precise definitions of delusions and hallucinations - such as those set out in the DSM-IV-TR (APA, 2000) - there are indeed numerous ways of conceptualising them. The same phenomenon might be regarded variously as a message from the spirit realm, a simple illusion, or as an hallucination, depending upon how it is construed by the person experiencing it (and/or by others). Recognition of this diversity is important given claims that the ways in which people make sense of delusions and hallucinations markedly affects how they experience and respond to them (Blackman, 2000, 2001; Barker, Lavender & Morant, 2001). For example, Blackman (2000) argues that "there are many different ways of hearing voices and associated feelings of joy, shame, guilt, fear and revelation contingent upon the differing ways voice-hearing is conceptualised" (p. 58). The various ways in which people interpret these kinds of phenomena have been said to affect their emotional responses to them, their help-seeking behaviour, involvement with mental health services, and so on (Perkins & Moodley, 1993). Each way of construing delusions and hallucinations may invite different kinds of actions and material consequences (Burr, 1995; Leudar, 2001). In light of such claims (that the ways in which delusions and hallucinations are conceptualised may have significant and far-reaching implications in terms of how people experience and respond to these kinds of
phenomena), it is important to re-examine and contest the customary ways in which delusions and hallucinations are construed.

My aim in this thesis is to question and disrupt conventional ways of conceptualising delusions and hallucinations. I set out, for instance, to query whether we ought to regard such phenomena as being necessarily pathological. Must delusions and hallucinations be construed as invariably distressing and harmful to those experiencing them? Should they be characterised as simply meaningless phenomena to be eliminated and/or ignored? How else might we make sense of them? Within this general task of rethinking the meaning of delusions and hallucinations, I focus specifically on mental health settings. I argue that even among those who have sought assistance from mental health services, it is possible - and important - to contest conventional ways of conceptualising delusions and hallucinations.

In the following chapter, I outline the clinical and theoretical background for this thesis and describe the epistemological and methodological approaches I have used to explore ways of rethinking the meaning of delusions and hallucinations. This incorporates a basic outline of the structure of the thesis. First, however, I wish to clarify my intended usage of the terms delusions and hallucinations, and explain why I am focusing on these specific phenomena rather than on a diagnostic category, such as schizophrenia.

**A caveat regarding terminology**

As Watkins (1998) notes, the terms delusions and hallucinations are regarded as unsatisfactory and pejorative by many clinicians, academics and members of the wider community. I have reservations about these terms, in line with the critiques
discussed above (that is, that the diagnostic criteria and assumptions underpinning these concepts are problematic). Nonetheless, I use the conventional terms throughout this thesis\(^3\), partly so that the research may be accessible to a wider audience, and partly for the sake of brevity. It would be cumbersome to repeatedly list the many specific phenomena that may be captured by these terms (e.g., highly implausible beliefs that are not shared by others, hearing voices, seeing visions, smelling odours that others cannot detect, and so on), and to do so might obscure commonalities shared by these kinds of phenomena. I use delusions and hallucinations as short-hand umbrella terms for this range of experiences. As yet, there do not appear to be any suitable (and succinct) alternatives to the terms delusions and hallucinations (Watkins, 1998), unless the discussion were to focus on a narrower range of experiences, such as exclusively on hearing voices, say, or seeing visions. I wish to make clear that when I use the terms delusions and hallucinations I am not assuming that the phenomena to which they refer are (necessarily) pathological. At times, I refer to this range of experiences as ‘the kinds of phenomena that might be characterised as delusions and hallucinations’, in order to provide some distance from the terms, and to attempt to open up, or increase the availability of, new ways of thinking (and talking) about these sorts of phenomena.

**A focus on phenomena rather than diagnostic categories**

Throughout this thesis, my focus is on the particular phenomena of delusions and hallucinations, rather than on diagnostic categories such as schizophrenia. This is

\(^3\) In Part Two of this thesis (which explores the accounts of women who have experienced the kinds of phenomena that might be regarded as delusions and hallucinations) the terms are used to refer to a slightly broader range of phenomena than might meet strict DSM-IV-TR (APA, 2000) criteria. That is, there may be plausible explanations (that appeal to extraneous factors) for some of the phenomena discussed in participants' accounts. For instance, some may have occurred while the person was under the influence of alcohol and/or other substances.
because my interest is in delusions and hallucinations per se, and I have therefore chosen to study them directly. Some people might argue that it is necessary to focus research attention at the level of diagnoses rather than specific phenomena; this would be a more conventional approach (see Persons, 1986). However, the diagnostic categories do not map directly onto the phenomena, therefore there is the potential for a participant group to include some people who do not experience the phenomena in question, while also failing to include other people who do (Persons, 1986). Although delusions and hallucinations are both listed as characteristic symptoms of schizophrenia, it is possible to receive a diagnosis of schizophrenia without experiencing either of them (e.g., a person exhibiting disorganised speech and grossly disorganised behaviour may also be assigned a diagnosis of schizophrenia) (APA, 2000). So, participants may share a diagnosis of schizophrenia yet be a heterogeneous group (Persons, 1986). Furthermore, the sorts of phenomena that might be characterised as delusions and hallucinations may be experienced by persons receiving various different psychiatric diagnoses (e.g., schizoaffective disorder, affective psychosis, etc), as well as by persons who do not meet the diagnostic criteria for any psychiatric disorder (Romme & Escher, 2000a). As noted above, it has been reported that it is "by no means exceptional" for persons in the general population to hear voices (Romme & Escher, 2000a, p. 14), and the diagnostic-category approach fails to recognise that psychological symptoms may be understood as being continuous with phenomena regarded as non-pathological (Persons, 1986).

For these reasons, my focus is on delusions and hallucinations rather than diagnostic categories such as schizophrenia. Having clarified this, I will now proceed, in the following chapter, to outline the rationale, theoretical framework and methodology of the thesis.
2: Epistemology and methodology: A call for new approaches to the study of delusions and hallucinations

My interest in delusions and hallucinations was sparked several years ago, while spending four months on clinical placement with a First Episode Psychosis service at a Community Mental Health Centre. Despite my very limited clinical experience at that stage, I began to develop the impression that there seemed to be some similarities among women, and some similarities among men, in the content of their delusions and hallucinations. Some of the women I encountered had experienced delusions and hallucinations that appeared to be of a romantic nature. For example, some women gave accounts of having conducted close personal relationships, and even 'fallen in love', with men who existed only in their delusions and hallucinations. For some of the male clients, the content appeared to have centred around concerns about their sexual orientation. For example, some men said that they had believed that strangers were broadcasting messages disputing their heterosexuality. These apparent similarities among at least some women, and among some men, caused me to begin questioning the orthodox ways of conceptualising delusions and hallucinations. At the least, they made me doubt whether delusions and hallucinations are necessarily meaningless and whether their content ought to be simply ignored. I started to wonder whether the content of delusions and hallucinations might reflect conventional notions about femininity and masculinity, and more generally, I became interested in how people might themselves make sense of these kinds of experiences.

When I began to search for literature that related to gender and the content of delusions and hallucinations, I was disappointed to find only a relatively small
number of papers addressing this topic directly. It seemed that when gender was discussed in relation to delusions and hallucinations, it tended to be within the context of more general research into sex differences in psychosis. A tremendous amount of energy appears to have been devoted to investigating sex differences in psychosis. Researchers have explored differences between women and men in the experience of psychosis, across a range of different dimensions (e.g., Goldstein & Tsuang, 1990; Seeman, 1982). For example, they have looked at possible differences in the pattern of symptoms with which women and men present, and sex differences in treatment response and outcome.

The most consistently-reported findings of sex differences in psychosis may be summarised, in broad terms, as follows. The onset of psychosis tends to be four to five years later for women than for men (e.g., Angermeyer & Kühn, 1988). As a group, women are said to display better premorbid functioning (e.g., Andia et al., 1995), and they tend to display more adaptive coping and social skills post-diagnosis (e.g., Andia et al., 1995; Shtasel et al., 1992), than men. Women are reported to respond better to pharmacotherapy (e.g., Seeman, 1997) and psychotherapy (specifically, family interventions) (e.g., Haas et al., 1990), and (the most accepted view is that) they have a milder course of psychosis (Shtasel et al., 1992) and a more favourable outcome (Navarro, van Os, Jones & Murray, 1996). Yet, the picture appears to be changing (e.g., Opjordsmoen, 1991; Seeman, 1998), and is certainly far more complex than this brief summary might suggest. Furthermore, the sex difference paradigm appears to have several serious limitations.

Included among the limitations is the ongoing, unresolved debate concerning the terms sex and gender (e.g., see Lewine, 1994), which has implications for the

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4 While this literature is discussed only briefly here, a more detailed critical review is presented in Appendix A.
presumed etiology of any reported differences (Kitzinger, 1994). Within this paradigm, sex is conceptualised as a dualism rather than as a continuum (Unger, 1990). However, to construe sex as an unproblematic dichotomous construct, based on such characteristics as a person’s sexual anatomy, is an oversimplification (Hamilton & Jensvold, 1995; Fausto-Sterling, 1993). Nonetheless, sex difference research relies on being able to make comparisons between two discrete groups. The use of a same/different framework itself oversimplifies the area of study (Pyke, 1988). In addition, there are significant problems associated with the statistical methods most commonly used in sex difference research (i.e., null hypothesis testing) (Favreau, 1997; Hare-Mustin & Marecek, 1990; Unger, 1990). There have also been claims of an editorial bias towards publishing significant findings, which leads to an exaggeration of difference (Unger, 1990; Hyde, 1994; Rosenthal, 1998). Some critics (e.g., Favreau, 1997; Yoder & Kahn, 2003) have argued that the context-dependency of findings continues to be largely ignored. In addition, a focus on sex differences takes attention away from sex similarities, and diverts research efforts away from other potentially important and interesting questions (Unger, 1990)

The limitations inherent in this body of research are of sufficient importance to warrant serious debate about the future of the sex difference paradigm. Adherence to an epistemological (or theoretical and methodological) position that concentrates on quantitative methodologies that are oriented towards difference (i.e., the search for statistically significant results), limits the research questions which may be addressed (Swann & Ussher, 1995). Epistemology is defined as “the study of the nature of knowledge and the methods of obtaining it” (Burr, 1995, p. 184). A researcher’s epistemological stance will determine the sorts of questions that may be asked, the ways in which s/he would go about exploring them, the types of analyses used, and
the kinds of interpretative claims that may be made. Adopting an alternative epistemological stance (e.g., see Gergen, 1985) would transform “not just how one might look for, and where to find, answers” (Kitzinger, 1994, p. 504), but would also give voice to, as yet, unspoken questions.

In this thesis, I use a variety of methods to enable me to explore different aspects of how delusions and hallucinations might be construed (these methods are aligned to different epistemological positions). I present analyses from two separate studies. The first is a survey of mental health practitioners and researchers, and the second, a series of interviews with women who have experienced the sorts of phenomena that might be characterised as delusions and hallucinations. They are discussed in Parts One and Two of the thesis, respectively. The survey and the interview study each utilised different epistemological approaches, but they both aimed to investigate and challenge conventional ways of conceptualising delusions and hallucinations. Before providing details of the rationale and methodology for each of these studies, I will first outline the epistemological positions adopted. It is necessary for me to explain the theoretical tools I have utilised in approaching questions about the meaning of delusions and hallucinations, particularly for those who may be unfamiliar with the particular frameworks I have drawn upon.

**Epistemological approaches**

The epistemological stance adopted for the survey was consistent with a *critical realist* position, whereas the approach taken for the interview study might be described as broadly *social constructionist*, and influenced by *feminist poststructuralist* theory (discussed below).
Critical realism affirms the existence of reality (that is, an external world that exists independently of being perceived or thought about), but also recognises that representations of reality are “mediated by culture, language and political interests” (Ussher, 1999, p. 221). For instance, from a critical realist stance, the existence of phenomena such as delusions and hallucinations is acknowledged, but within a framework that explicitly recognises that they do not exist independently of the historical, sociocultural and political context in which they occur (Ussher, 1999). The kind of critical realist approach outlined by Ussher (1999) allows the utilisation of a range of different research methodologies. For example, the questionnaire used in the survey included closed- and open-ended questions, to elicit both quantitative and qualitative data (e.g., respondents’ ratings of the perceived importance of attending to the content of delusions and hallucinations as well as what they identified as potential advantages and disadvantages of this practice). The ways in which I make sense of survey participants’ responses are consistent with a critical realist position as I interpret them within their particular historical and sociocultural context. By using a (critical) realist stance for the survey, I have sought to communicate to a range of different audiences (including those working within mainstream Western psychiatry).

The epistemological position I adopted for the interview study falls under the general umbrella of social constructionism. Burr (1995) argues that there is no adequate definition of social constructionism, as this general approach may take various forms. However, they do tend to share several common features. Social constructionist approaches are critical of taken-for-granted knowledge, they recognise that knowledge is historically and culturally specific, they regard knowledge as resulting from social processes, and they recognise that knowledge and social action are tied together (Burr, 1995). My epistemological position has been influenced by
feminist poststructuralist theory, because I found it offered useful theoretical tools with which to challenge conventional ways of conceptualising delusions and hallucinations.

In poststructuralist theory, language is not regarded as a transparent, neutral medium for the transmission of information; language does not merely reflect and describe the world, but rather constitutes reality as we know it (Gavey, 1989; Weedon, 1987).

There is always more than one way of describing something and our choice of how to use words... gives rise to particular versions of events and of reality (Willig, 1999, p. 2).

This view may be taken further to suggest that perceptions and experiences are themselves (to some extent, at least) formed by language, before we ever come to describe them to others. People's understandings of themselves and their worlds are constructed, limited, and guided by the language they use (Weatherall, 2002). As meaning is produced through language (Potter & Wetherell, 1987; Weedon, 1987), the meanings associated with delusions and hallucinations, for example, are not fixed, stable or essential. Understandings of delusions and hallucinations are ever-shifting and contextually-specific.

Proponents of poststructuralist theory do not aim to reveal the truth, uncover the facts, or discover reality, by applying (supposedly) objective scientific methods. They reject the possibility of neutral and value-free knowledge, arguing that knowledge is socially constructed; that it reflects, incorporates and relies upon the assumptions and values of the researchers (Gavey, 1989).
In poststructuralist theory, the term *discourse* is used to refer to a shared set of interrelated cultural linguistic resources and other practices that people draw upon in their everyday lives in order to construct meaning and subjectivity (Gavey, 1989). As discourses are multiple, they can compete with one another. These contradictory ways of making sense of the world, potentially create “distinct and incompatible versions of reality” (Davies & Harré, 1990, p. 45).

Certain functions may be served by articulating particular discourses, and in this sense, discourse is a form of social action (Potter & Wetherell, 1987; Harper, 1994). This performative aspect of language use may be explored by looking at what is being achieved (often unintentionally) when someone uses language in a particular way (Weatherall, 2002).

The term *interpretative repertoire* has been employed to refer to the ‘building blocks’ people use to construct versions of actions, thought processes or other phenomena (Wetherell & Potter, 1988). Each repertoire consists of a restricted range of terms or descriptions that cluster around a particular metaphor or image and often involves characteristic figures of speech (Wetherell & Potter, 1988). Some theorists (e.g., Potter, Wetherell, Gill & Edwards, 2002) prefer this term to discourse as they believe that it allows us to capture the action orientation of language use (Wetherell, 1998). They argue that to describe discourses as being simply sets of statements, runs the risk of objectifying or reifying them, whereas the term interpretative repertoire “encompasses the way that different... (terms, tropes, metaphors) from the repertoire may be invoked according to their suitability to an immediate context” (Potter et al., 2002, p. 169). In this thesis, I utilise the term interpretative repertoire to refer to the resources that the women I interviewed appeared to be drawing upon in their accounts of their experiences of delusions and
hallucinations. However, at times throughout the thesis, I also use the term discourse, when it is the term that has been used by the theorist(s) to whose work I am referring.

Poststructuralist perspectives reject the conventional, liberal-humanist view of individuals as unified subjects who have an essence or a core self that is coherent, rational and stable over time (Gavey, 1989). Instead, it is argued that, through language and discourse, people are able to take up various subject positions. A subject position is "what is created in and through talk as the speakers and hearers take themselves up as persons" (Davies & Harré, 1990, p. 62). The subject positions taken up facilitate or constrain particular experiences and actions (Willig, 1999).

Subjectivity (that is, people's sense of themselves and their understandings of how they relate to the world) is understood as being multiple, fragmentary, inconsistent and contradictory (Gavey, 1989). Subjectivity is produced through the various discursive practices in which people participate. Their social identity and sense of self is constituted and reconstituted as they are positioned within particular discursive practices (Davies & Harré, 1990):

Who one is is always an open question with a shifting answer depending upon the positions made available within one's own and others' discursive practices and within those practices, the stories through which we make sense of our own and others' lives (Davies & Harré, 1990, p. 46).

Blackman (2002) argues that, for poststructuralist approaches to be useful, they must also incorporate the notion of *embodiment*. This term draws attention to the ways in which somatic and neurological experiences (that impinge on the senses), such as hearing voices or seeing visions (which would traditionally be viewed as symptoms of biological illness), are experienced in a form that is mediated by discursive practices (Blackman, 2002). In this view, the phenomena come to be
constructed in certain ways depending upon the discourses that are deployed. A person who hears a voice may interpret it as a symptom of mental illness or s/he may experience it quite differently as, say, telepathy, or as a message from the dead, depending on whichever discourse is drawn upon (Blackman, 2002). The implications of hearing a voice would vary greatly depending upon how the phenomena are spoken about (e.g., as a sign that there is something wrong with someone or as a gift), and this is why it is so important to look at the language people use to construct these kinds of experiences.

As certain interpretative repertoires have more authority than others in Western societies, they are more likely to be drawn upon. For instance, within the context of a community mental health service, the repertoire of mainstream psychiatry is more dominant than a repertoire of spirituality. Those interpretative repertoires supporting and perpetuating existing power relations maintain their dominance by appearing to be natural and/or common sense (Gavey, 1989). Dominant repertoires come to be accepted as true, while competing repertoires may be marginalised as incorrect, irrelevant or bizarre (Gavey, 1989).

Having sketched out the theoretical tools I have drawn upon to rethink conventional understandings of delusions and hallucinations, I will now outline the rationale and methodology for the survey and the interview study.

**Part One: Survey of mental health practitioners and researchers**

In psychiatric clinical practice, scant attention is often paid to the content of delusions and hallucinations (Romme, 1998a; Musalek, Berner & Katschnig, 1989). Even some psychological approaches to the treatment of psychosis, such as cognitive-behavioural therapy (CBT) (Adams, Malatesta, Brantley & Turkat, 1981), have
tended to be more process-oriented than content-oriented. According to Gagg (2002), those undergoing traditional psychiatric training are discouraged from attending to content, ostensibly to avoid any potential encouragement of delusional thinking. Even contemporary guides for mental health practitioners (e.g., Rosenbaum, 2002) reiterate the maxim, "No collusion with delusion" (p. 5). When clients volunteer information about the voices they hear, they are usually told that the voices are 'only the illness', they are encouraged to ignore them, and are distracted from talking about them (Gagg, 2002). While psychodynamic theorists (e.g., Arieti, 1962, 1974a, 1974b) have long been interested in the content and symbolic meaning of delusions and hallucinations, there appears to have been relatively little interest in the content of delusions and hallucinations within mainstream (biomedical) psychiatry (Musalek et al., 1989; Boyle, 1992; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Watkins, 1998; Read & Argyle, 1999), as evidenced by the relative dearth of literature on the topic. This raises questions about why there appears to have been such a lack of interest in the content of delusions and hallucinations.

I conducted an international survey of mental health practitioners and researchers to explore their views concerning the importance of attending to content and to canvass the extent to which they currently engage with clients around the specific content of their delusions and hallucinations. What do those currently working in the field regard as potential advantages and disadvantages of engaging with clients around the content of their delusions and hallucinations? What might affect the extent to which clinicians and researchers attend to delusional and hallucinatory content? What might this tell us about how mental health practitioners and researchers conceptualise delusions and hallucinations? This facet of the survey is discussed in Chapter 3 (which is the first chapter of Part One). In Chapter 4, I
explore survey respondents' views concerning the content of delusions and hallucinations specifically in relation to gender.

It was noted by Lewine (1994) over a decade ago that issues concerning gender are often reflected in the content of delusions, but that relatively little research has been conducted investigating any possible relationship between gender and the content of delusions. The small number of studies that have explored content in relation to gender have tended to report differences between women and men in the content of their delusions (e.g., Rudden, Sweeney, Frances & Gilmore, 1983; Seeman, 1983; Allan & Hafner, 1989) and hallucinations (Allan & Hafner, 1989; Nayani & David, 1996). In the second part of the survey, I explore whether contemporary mental health practitioners and researchers had observed similarities among women, and similarities among men, in the content of their delusions and hallucinations, and sought to elicit their explanations for any such observations.

Both facets of the survey provide challenges to conventional understandings of delusions and hallucinations. The methodology of the survey is detailed below.

Method

Questionnaire

The first part of the questionnaire was constructed to investigate clinicians' and researchers' beliefs about (i) the costs and benefits of attending to the content of delusions and hallucinations; (ii) the possible effects on clinical practice of attending to content; (iii) the extent to which they currently attend to content; (iv) their training regarding content; and (v) their familiarity with the literature concerning content. This section of the questionnaire included both closed (e.g. using Likert scale) and open-ended questions, to allow for the collection of both quantitative and qualitative
data.

The second part of the questionnaire sought to investigate (i) whether clinicians and researchers had observed any similarities among female clients, and similarities among male clients, in the content of their delusions and hallucinations, and (ii) respondents' explanations of any such similarities. This section of the questionnaire comprised open-ended questions to allow for the collection of qualitative data.

Procedure

Potential participants were identified as follows. A PsycLit search was conducted, in 2000, to locate articles relating to both psychosis and gender, published in the preceding 5 years. All authors of these articles were contacted by e-mail (except in cases in which it was not possible to find their e-mail addresses). Publicly available lists of members of professional associations (e.g., American Psychological Association, international associations for mental health nurses, psychiatrists etc) were also sought via the internet, and e-mails were then sent to these members. I also visited as many websites of psychology, psychiatry, behavioural science, nursing, and social work departments of universities throughout the world as I could find on the internet (including Australasia, North America, South America, Europe, Africa, Scandinavia, Asia etc), and identified staff members of these departments whose interests seemed relevant to this research project. Other participants included colleagues at Northland Health and mental health practitioners who were members of a psychosis interest group in Auckland. In short, I attempted to contact as many potential participants as practicable who would have clinical experience and/or academic interest in this area. Following the initial contact, some respondents
requested that information about the study (see Appendix B) and the questionnaire form (see Appendix C) be posted to them. Others who wished to participate in the study accessed identical versions of these documents, available on the internet, and submitted their completed questionnaire forms online. In total, 142 questionnaires were distributed by post (to clinicians and researchers who had expressed an interest in taking part in the survey), including 46 when the survey was piloted.

Fifty-eight completed questionnaires (21 online questionnaires and 37 hard copy questionnaires) were received, which constituted an overall response rate of 26% for the hard copy questionnaires. There was a 15% response rate for the pilot survey and a 31% response rate for the survey proper. The final questionnaire (see Appendix C) differed only slightly from the pilot questionnaire (see Appendix D), as there were some minor changes to the wording of a small number of questions. For example, whereas the pilot questionnaire asked participants whether they had noticed any similarities among female, and among male, clients in the specific content of their delusions and hallucinations, the later version of the questionnaire also asked whether they had noticed any content that is particular to female, or male, clients. Responses to both versions of the questionnaire are included in the analyses and discussion. There were no obvious differences between responses to the two versions of the items that had been slightly amended.

Participants

A total of 58 people participated in the survey. Respondents ranged from 30 to 71 years of age, with the mean (and median) age being 44 years. Sixty-two percent of participants were men. Respondents were primarily from: Aotearoa/New Zealand
(33%); United Kingdom (24%); United States (12%); Australia (10%); Canada (9%); and South Africa (5%).

Nearly half of all participants (47%) were mental health nurses, just over a fifth (22%) were psychiatrists, and 19% were clinical psychologists. The remaining respondents identified themselves as belonging to other disciplines (e.g., occupational therapists). Thirty-six percent of participants identified as primarily clinicians and 26% identified as primarily academics, while 38% identified as both. Most respondents indicated that their clinical orientation was either eclectic (50%) or cognitive-behavioural (CBT) (22%). (Respondents were designated as eclectic in their clinical orientation if they endorsed the category eclectic as applying to them, or endorsed two or more paradigms.) Less common paradigms were biomedical (10%), psychodynamic (5%), or other paradigms (e.g., constructivist) (12%) (see Appendix E for details regarding each respondent's discipline and clinical orientation).

Please note that participants' responses to the Likert scale items did not differ for discipline, professional identification, chosen paradigm, or gender (Wilcoxon signed ranks). Likewise, qualitative analysis of the results did not suggest that there were any systematic differences in participants' responses to the open-ended questions, based upon their group membership (i.e., their discipline, professional identification, paradigm or gender).

As a group, the participants were highly experienced in working with clients who had been diagnosed with psychosis, 35 (60%) having had 10 or more years of experience, of whom three had more than 30 years' experience. Individual respondents were identified by number (e.g., R23).
Part Two: Interviews with women who have experienced delusions and hallucinations

As noted in Chapter 1, it is conventional in contemporary Western societies to conceptualise delusions and hallucinations as symptoms of serious mental illness (e.g., as first-rank symptoms of schizophrenia, Schneider, 1959; Thomas & Leudar, 1996; Leudar et al., 1997; Watkins, 1998; Romme & Escher, 2000a; Leudar, 2001; Leudar & David, 2001), as meaningless surface expressions of an underlying biological illness (following Kraepelin, 1913/1919; Jaspers, 1946/1963), and as phenomena that are almost invariably distressing and harmful to those experiencing them (Clarke, 1998). Recent years have seen not only a mounting body of literature that is critical of these ways of making sense of delusions and hallucinations (e.g., Harper, 1992, 1994, 1996; Georgaca, 2000; Boyle, 2002), but also the emergence of groups such as the Hearing Voices Network (HVN) (see Coleman & Smith, 1997), which directly challenge us to rethink the meaning of delusions and hallucinations.

The HVN is a movement of people who hear voices and who are attempting to experience, manage, and make sense of their voices outside a psychiatric framework (Blackman, 2002). The HVN encourages persons who experience delusions and hallucinations to utilise their own frames of reference to account for their experiences of these kinds of phenomena, defining a frame of reference as the process of explaining such experiences within one’s own belief system (Coleman & Smith, 1997). The HVN asserts that the frames of reference of people who experience delusions and hallucinations are just as valid as those of anyone else, including mental health practitioners (Coleman & Smith, 1997). Indeed, they claim that those who hear voices "know better than any of the people paid to 'help'" them (Coleman & Smith, 1997, p. 21). They affirm the right of voice-hearers to adopt
whichever frame(s) of reference they find most helpful and appropriate (Coleman & Smith, 1997).

Despite claims that the ways in which delusions and hallucinations are conceptualised have significant implications (that is, they invite particular kinds of actions and consequences) (Leudar, 2001), to date there has been relatively little attention to the ways in which people construe these kinds of experiences (Perkins & Moodley, 1993). The HVN constitutes a notable exception. More typically, the ways in which people make sense of their own experiences of delusions and hallucinations are marginalised in relation to conventional psychiatric understandings, at least in clinical settings and in the research literature (Geekie, 2004).

In Part Two of this thesis, I present analyses from a series of interviews with women who have experienced the kinds of phenomena that might be characterised as delusions and hallucinations. The interviews were conducted to explore how people describe and make sense of these sorts of phenomena. I was interested in the interpretative repertoires available to the participants when talking about delusions and hallucinations, and how these might influence the ways in which these kinds of phenomena are experienced (see Chapter 5). I examined how these interpretative repertoires might be applied in participants’ attempts to make sense of their experiences of delusions and hallucinations (see Chapter 6). I also sought to broaden understandings of delusions and hallucinations by exploring how the accounts of some of the participants challenged conventional ways of conceptualising these kinds of phenomena (see Chapter 7). The methodology for the interview study is set out below.
Method

Participants

Eleven women were interviewed. They ranged in age from 21 to 48 years. All of the participants were current or former clients of community mental health (CMH) services (provided by Northland Health or Auckland Healthcare), who had been identified within those services as having experienced delusions and/or hallucinations. Only two of the women had been formally discharged from CMH services, while the remaining nine were still engaged with those services (that is, they were still receiving periodic follow-up in the community from mental health practitioners). Two of the participants were also members of a ‘GROW’ mental health support group (see GROW, 2001). Some of the women were still experiencing delusions and hallucinations around the time the interviews were conducted.

All but one of the participants identified as Pakeha (non-Maori New Zealanders of European descent); the other woman identified as both Pakeha and Maori. As I am Pakeha, it is likely that it would have been culturally inappropriate for me to attempt to analyse the accounts of members of non-Pakeha cultures. The misreadings and misrepresentations that may occur when Pakeha researchers (mis)interpret the accounts of Maori have been well-documented (e.g., see Johnson & Pihama, 1995; McKinley, 1995; Smith, 1999; Cram, 2001). I decided to work within my cultural milieu, as pragmatic constraints (e.g., limited resources and time) did not allow me to adopt a collaborative, partnership approach with Maori researchers (e.g., see Cram, 1997; Smith, 1999; McCleanor & Nairn, 2002).

5 The GROW community mental health movement began in Australia in 1957. It has since spread to six other Western countries, including Aotearoa/New Zealand. GROW provides anonymous mental health support groups. Its programme advocates personal ‘growth to maturity’ through belonging to a ‘caring and sharing’ community (GROW, 2001).
While gender matching was possible in this project (and I also happened to be matched to participants according to other dimensions such as residence in a remote, rural setting), it was not possible to match according to personal experiences of the phenomena being studied. While this might be regarded as less than ideal, the analyses are primarily concerned with identifying the linguistic resources available to people who experience delusions and hallucinations, within contemporary mainstream Aotearoa/New Zealand culture, and the influences on subjectivity, rather than wishing or claiming to 'speak the truth' of the women's experience (Weatherall, Gavey & Potts, 2002). Any possible concerns about being 'Other' to those with whom the research has been conducted are mitigated by the focus on broader (cultural) systems of meaning. I acknowledge that the study explores how participants construct their experiences of delusions and hallucinations in a particular social context (that is, within a fairly neutral, supportive, research context, in an interview with someone who has not experienced delusions and hallucinations). Gagg (2002) has noted that there may be considerable variability in the ways in which people construct and account for their experiences of delusions and hallucinations, according to the social context. The ways in which I was perceived by the women I interviewed are likely to have influenced the kinds of accounts they gave of their experiences. It is relevant to note, therefore, that at the time I conducted the interviews for this study, I was employed as an assistant psychologist by Northland Health's Adult Psychology Service, as well as being a (postgraduate) student.

While the participants came from a variety of socioeconomic backgrounds, in general they appeared to have limited incomes. None of the women were

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6 For example, see Taylor's (2001) comments concerning the relevance of a researcher's identity to data collection and Wilkinson and Kitzinger's (1996) detailed discussion of the complex issues involved in representing the 'Other'.
employed in full-time positions outside of the home. All but one of the participants lived in remote rural areas, where there were few employment opportunities. Seven of the women were in long-term (heterosexual) relationships. Of the six participants who were mothers, five had children or grandchildren living with them, and three had adult children who had left home.

Procedure

Potential participants were Pakeha women who had been identified by mental health practitioners as having experienced delusions and/or hallucinations, and who were currently ‘well’ (i.e., they had not been admitted to an inpatient mental health unit within the preceding three years). To minimise any risk of harm, the potential participants were approached about the study by their former or current key worker within the mental health system (e.g., CMH nurse) or via a consumer representative, who had identified them as meeting the inclusion criteria.

Potential participants who were considering taking part in the study gave verbal consent, to the CMH worker or consumer representative, for their contact details to be passed on to me. I then made telephone contact with potential participants and provided them with information about the interview study (see Appendix F for Participant Information Sheet). All those who subsequently agreed to take part in the research completed a written Consent Form (see Appendix G) prior to participation in the study.

It was initially hoped that approximately 15 women would participate in this study. However, it was very difficult to recruit participants. The narrowness of the inclusion criteria meant that there was only a relatively small population from which to sample. This was somewhat unavoidable, as ethical constraints required the
inclusion criteria to be rather narrow. For instance, I had to be certain that any potential risk of harm was minimised and that potential participants would be fully able to give informed consent. It was necessary to rely upon third parties (mostly CMH nurses) to identify and approach potential participants. Many of these clinicians seemed concerned that it might be counter-therapeutic for clients to talk about their experiences of delusions and hallucinations, as it might serve to reinforce/encourage these phenomena. Some expressed reluctance to allow their clients to take part in the interview study, in case it might cause clients distress and lead to a deterioration in their mental state. In addition, most of the mental health practitioners had large case loads and very limited time in which to consider whether any of their current or former clients might be suitable as participants in the study.

Participants were all interviewed individually. The interviews were conducted within the Northland and Auckland regions of Aotearoa/New Zealand. Two of the interviews took place in CMH centres. The rest of the interviews were carried out in participants' homes. I conducted all of the interviews.

I contacted each participant by telephone within one week of the interview to talk through any issues that may have arisen as a result of taking part in the research. In the event that participants might be distressed by talking about their experience of delusions and hallucinations, clinicians were also available to meet with them, free of charge, should they have wished to discuss their reactions to taking part in the study. (Each participant was given contact details of a clinician in her area immediately following the interview; see Appendices H and I.) However, none of the participants took up this offer, and all indicated that they had not been distressed by speaking about their experiences of delusions and hallucinations.
The interviews were audiotaped and transcribed verbatim. Each participant was given a copy of the transcript and invited to make any changes she felt necessary or desirable (i.e., to remove, add or alter any of the information). None of the participants asked for any amendments to be made to the transcripts.

I read and re-read the transcripts for the language used to describe and make sense of delusions and hallucinations. Through repeated, detailed reading of the transcripts, I identified recurring patterns in participants' accounts.

Interview format

A semi-structured interview format was used. The interview schedule (see Appendix J) was designed to elicit participants' accounts of their own experience of delusions and hallucinations, and what it was like for them to seek assistance from mental health services.

In line with the theoretical orientation of this particular study, the interviews were conducted in an open-ended, interactive style. This was in preference to attempting to 'extract information' from participants in a supposedly-objective, efficient and distanced manner (Franklin, 1997).

In order to preserve anonymity, participants (but not the interviewer) were assigned pseudonyms. Extracts from the interview transcripts are included in this thesis in a slightly-modified form. Wherever quotation marks (i.e., "") are used, this denotes a direct quotation from one or more participants. Words and phrases that were emphasised by participants during the interviews are printed in italics. Pauses in speech are indicated by the presence of three consecutive dots. Wherever a section of the transcript has been omitted, this is represented by four consecutive dots. Speech hesitations (e.g., "um") and word repetitions have been omitted, as their inclusion is
not required for the type of analysis being conducted, and their omission makes the extracts easier to read (Taylor, 2001).

**Varied understandings of delusions and hallucinations**

In the next two chapters, I report on the survey I carried out to explore the ways in which mental health practitioners and researchers construe delusions and hallucinations. I then go on to present analyses of women’s accounts of their own experiences of these kinds of phenomena. By examining some of the varied ways of making sense of delusions and hallucinations, and possible implications of conceptualising them in these particular ways, I seek to challenge conventional understandings of these sorts of phenomena.