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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 psychiatry 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 how 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

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\(^3\) 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
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 ideal⁶, 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

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.
Part One:

Survey of mental health practitioners and researchers
3: Is the content of delusions and hallucinations important?¹

As noted in the previous chapter, there is relatively little published research relating specifically to the content of delusions and hallucinations. This might be viewed as less than surprising given that these kinds of phenomena are conventionally understood within mainstream Western psychiatry as being merely surface manifestations of an underlying biological process (Kraepelin, 1913/1919; Huxley, Rendall & Sederer, 2000; Garety, 1992). The particular content of delusions and hallucinations have tended to be characterised as irrelevant (Read & Argyle, 1999), "incomprehensible, unreal and beyond our understanding" (Jasper, 1946, p. 98).

Boyle (1992) has questioned why there might be a relative paucity of literature regarding the content of delusions. She speculates that, to date, the form of delusions may have been regarded as more worthy of study than their content, because form is more amenable to systematic research oriented towards the scientific goal of identifying universal laws².

The conventional ways of conceptualising delusions and hallucinations not only influence the types of research that are conducted, but also have implications for clinical practice. For instance, Barker (1997) claims that mental health practitioners are often discouraged from attending to the content of their clients’ delusions and hallucinations. Many psychiatric texts warn that attending to content will make

¹ A version of this chapter has been published in Australasian Psychiatry (see Aschebrock, Gavey, McCreanor & Tippett, 2003).

² Please note that while it is theoretically possible to discriminate between the content and the form (i.e., features such as the duration of an hallucination, for example) of delusions and hallucinations, it is not always possible, practical, or appropriate, to do so (Nayani & David, 1996). For example, when considering "whether the voices are running commentaries or single expletives... it is not clear whether such attributes belong to form or content categories, or rather somewhere in between" (Nayani & David, 1996, p. 177). For these reasons, Chapters 3 and 4 contain references to the form of delusions and hallucinations, as well as the content, despite their particular focus on the content of delusions and hallucinations.
clients "even more confused, and reinforce a reality which is the result of a diseased and troubled mind" (Blackman, 2000, p. 59). Boyle (1992) cautions that "to pay too much attention to content might be professionally damaging" (p. 11).

The overall impression appears to be that the content of delusions and hallucinations receives relatively scant attention in research and clinical practice (Romme, 1998a; Musalek et al., 1989). In light of this, it seems important to canvass at least some measure of professional practice to determine the extent to which mental health practitioners and researchers do currently attend to content, as well as to investigate possible reasons why there appears to have been only limited interest in delusional and hallucinatory content up until now. In this chapter, I present the findings of the survey of mental health practitioners and researchers\(^3\), in which I explore their views concerning the importance of attending to the content of delusions and hallucinations. I investigate what participants identified as potential costs and benefits of attending to the content of delusions and hallucinations. This provides a glimpse of some of the ways in which contemporary mental health practitioners and researchers conceptualise delusions and hallucinations.

**Potential benefits and drawbacks of attending to the specific content of delusions and hallucinations**

In order to begin exploring researchers' and clinicians' thinking concerning whether it is important to engage with clients around the content of their delusions and hallucinations, respondents were asked to indicate what they saw as potential benefits and drawbacks of attending to the specific content of these experiences.

\(^3\) See Chapter 2 for a detailed account of the survey methodology.
While a small number of respondents saw little or no benefit in this practice, most (84%) listed both benefits and drawbacks, and these are discussed here.

Benefits

The potential benefits identified by participants generally fell into three main categories: heightened understanding of clients' difficulties; improvements in the nature of the therapeutic relationship; and enhanced ability to assess risk and/or address safety issues. The most frequently reported benefit of attending to content (identified by 41 participants [71%]) was that it provided useful information with which to understand and formulate clients' difficulties. This enhanced understanding and, in turn, informed treatment interventions:

This is absolutely basic. While delusions/hallucinations may assist diagnosis, treatment decisions and formulation of risk assessment/management plans are determined by a content analysis of the illness. No competent care can proceed without it (R18).

A common theme among these kinds of responses (evident for 28 of these 41 participants) was that the content of hallucinations and delusions were "understandable" within the particular contexts of clients' lives:

I can often find a lot of sense and 'meaning' behind people's psychotic experiences - and the content begins to make a lot of sense when you begin to explore the psychotic's [sic] life experiences enough (R19).

Twenty-two participants (38%) suggested that paying attention to content could be regarded as a strategic act to facilitate the development of good rapport with their clients. These respondents tended to suggest that exploring the content of hallucinations and delusions enhances the therapeutic relationship by signalling to
clients that clinicians are "taking them seriously" (R46) and "taking an interest in [them] rather than dismissing them" (R38):

Patients don’t really open up to you until you’re willing to actually talk about the specific content of their psychotic experiences (R19).

In addition, nine participants (16%) proposed that attending to content facilitates risk assessment.

Drawbacks

Participants' responses concerning the potential drawbacks of attending to content fell into four main categories: concern about being distracted from other, more useful, topics; the potential to inadvertently reinforce the content of hallucinations and delusions; fear of causing clients further distress; and the possibility of clinicians themselves losing touch with reality. Thirty-eight percent of respondents indicated that focusing on content could mean that clinicians become "too caught in the details" (R7) and so are distracted from other areas, such as the form of psychotic experiences, which may be more important therapeutically. These participants raised concern that such attention might be problem-focused, unfruitful, and unmanageable. It was common for these respondents to suggest that attending to content distracted clinicians from a solution focus (e.g., by "unduly focusing on [clients'] deficits" [R30]).

Paying attention to the content of delusions and hallucinations was sometimes represented as a "time waster" (R45) that might "lead [clinicians] in the wrong direction" (R53). Others felt that clinicians might become overwhelmed by excessive detail, leading them to become "bogged down" (R24) and "lost" (R52).
Sixteen participants (28%) were concerned that attending to the specific content may result in the “reinforcing of psychotic experiences” (R21), and “handled poorly, can seem to be colluding with the patient” (R23). Another concern, raised by (four) participants (7%), was that discussing the content of delusions and hallucinations “may be distressing” (R26) or “traumatic” (R34) for clients:

Patients feel ‘out of control’ when they are allowed to roam freely in their psychosis (R49).

Three further respondents cautioned that when clinicians attend to content, they may lose their own experiential reality:

You might ‘understand’ the psychosis so well that you miss the fact that the patient is psychotic (R53).

Respondents were asked to indicate how important it is, in their eyes, to attend to the specific content of clients’ hallucinations and delusions, respectively, on Likert scales ranging from 1 (‘not at all important’) to 7 (‘extremely important’). Although the median response was higher for delusions (median = 6) than for hallucinations (median = 5), the modal response was higher for hallucinations (i.e. mode = 7) than for delusions (mode = 6). A Wilcoxon signed ranks test failed to reveal any statistically significant difference between ratings for hallucinations and delusions, ($\chi^2$ (1, n = 57) = -1.524, p = 0.128). Responses ranged from 2 to 7 for both hallucinations and delusions. Yet, responses were skewed toward the ‘important’ end of the scale, with few participants indicating that the content of delusions and hallucinations was unimportant (see Figure 1).
Participants' ratings of the perceived importance of attending to the content of hallucinations and delusions, respectively, on a Likert scale ranging from 1 ('not at all important') to 7 ('extremely important')

Figure 1. The distribution of participants' ratings of the perceived importance of attending to the content of hallucinations and delusions.

Potential effects on clinical practice

When respondents were asked how aspects of their work might be affected if they were to attend to the specific content of clients' delusions and hallucinations, their responses were in line with the costs and benefits they had identified earlier. Thirty participants (52%) responded that information about content would enhance their formulations of clients' difficulties and facilitate appropriate decision-making regarding treatment interventions. Interestingly, approximately one-fifth of the respondents (21%) suggested that their work would be affected adversely should they attend to the content of clients' delusions and hallucinations. Some of these participants felt that they would “lose the[ir] sense of job satisfaction” (R15), that they might have difficulty maintaining a clear distinction between “what is psychotic and what is reality” (R21), or that they would suffer “ridicule from other professionals”
Other health-care professionals think I'm being un-therapeutic by paying too much attention to the content of people's delusions/psychosis... other health-care professionals believe that I'm crazy! (R19)

**Extent to which the specific content of delusions and hallucinations receives attention in current clinical practice**

Participants were asked to indicate, on a Likert scale, the proportion of clients experiencing delusions and hallucinations with whom they attend to specific content. Responses ranged from 1 (‘none’) to 7 (‘every patient’). However, the median (and modal) response was 7 because responses were skewed toward this end of the scale (see Figure 2).

![Figure 2](image-url)  
*Figure 2.* The distribution of participants' ratings of the proportion of clients (experiencing hallucinations and delusions) with whom they attend to the specific content of these experiences.
When asked how much of their work with a given client would involve attending to the specific content of her/his delusions and hallucinations, the median response was 4 (midway on a scale of 1 ['none'] to 7 ['all']), and the modal response to this item was 5 (see Figure 3).

![Figure 3](image-url)

Figure 3. The distribution of participants' ratings of how much of their work with a given client (e.g., the time spent) would involve attending to the specific content of her/his delusions and hallucinations.

Respondents identified a number of factors that might influence the extent to which they attend to the specific content of clients' delusions and hallucinations. The most frequent response (given by 27 participants [47%]) was that this would depend upon clinicians' judgements "as to [the] utility or efficacy of any such attention" (R4) for individual clients (i.e., clinician-driven). Another common response (given by 17 respondents [30%]) was that this decision would be influenced by each client's own wishes, goals and level of distress (i.e., client-driven). Participants tended to identify
factors that were either exclusively clinician-driven or exclusively client-driven; only six respondents suggested factors that fell within both categories. Twelve participants (21%) indicated that the risk of self-harm or harm to others would influence the degree to which they attend to the content of delusions and hallucinations. (As noted earlier, some respondents suggested that attending to delusional and hallucinatory content may facilitate risk assessment.) The amount of time available and current workload were also cited by four participants (7%) as important determining factors.

Clinicians' training regarding the content of delusions and hallucinations

Participants were surveyed about the training they had received (both in their initial training as clinicians and in their ongoing professional development) pertaining specifically to the content of delusions and hallucinations. Twenty-two respondents (38%) indicated that they had received little or no training in this area (five of these noted that they had to seek out information themselves, to enhance their clinical practice).

Among those who indicated that they had received little or no training concerning content were participants from each professional discipline. In this group of 22 respondents, there were 12 mental health nurses (44% of all mental health nurses in the survey), six clinical psychologists (55% of all clinical psychologists), two psychiatrists (15% of their group), and an occupational therapist. In contrast, three participants (two psychiatrists and one clinical psychologist) reported that they had extensive training in this area.
Participants' familiarity with the available literature pertaining to the content of delusions and hallucinations

Participants were asked to indicate their level of familiarity with the admittedly limited amount of literature available relating to the content of delusions and hallucinations. Approximately one-third of participants (31%) either indicated that they had little or no knowledge of this body of literature or left the question unanswered.

Discussion

The survey data suggest that mental health workers hold rather mixed views with regard to the importance of attending to the specific content of delusions and hallucinations, insofar as they listed both benefits and drawbacks to this practice. While a small number of respondents appeared to have unambiguously positive or negative views concerning the value of attending to content, most participants (84%) seemed to be somewhat ambivalent. Some respondents suggested that engaging with clients around the specific content of their delusions and hallucinations might heighten clinicians' understanding of clients' difficulties, enhance the therapeutic relationship, and improve practitioners' ability to assess risk and/or address safety issues. Others raised concerns that attending to content might be distracting and a time-waster that might cause further distress to clients and might even reinforce the content of clients' delusions and hallucinations. Overall, there was no significant difference between delusions and hallucinations in terms of the perceived importance of addressing their specific content.

While half of the participants indicated that aspects of their work (e.g.,
formulation, treatment planning) would be enhanced by attending to the content of delusions and hallucinations, approximately one-fifth suggested that their work would be affected adversely. Members of this latter group proposed that they would be ridiculed by their coworkers, their self-care would be compromised, or the distinction between reality and non-reality would become blurred for them, should they attend to content.

Despite ambivalence about exploring delusional and hallucinatory content, most participants indicated that they do routinely attend to content with every client, and indicated that they spend a moderate amount of time focusing on the specific content of clients' delusions and hallucinations. These findings are inconsistent with claims that content tends to be ignored in clinical practice (e.g., Musalek et al., 1989). Participants suggested that the extent to which they choose to attend to content is influenced by their own judgement as to the benefits of such attention and also by clients' goals and wishes. Risk management and pragmatic considerations (e.g., workload) were also identified as important influences affecting decision-making in this regard.

Although participants had high levels of experience in working with clients diagnosed with psychosis, in general they appeared to have received little formal training relating specifically to the content of delusions and hallucinations. A large number of the respondents were unfamiliar with the (admittedly limited amount of) literature published on this topic.

Interestingly, three participants remarked on what they regarded as the paucity of research pertaining to content. One of these respondents suggested that the lack of research interest in content may be due to the persisting belief that delusions and hallucinations are simply meaningless expressions of an underlying biological
illness. This view adheres to the traditional Kraepelinian model, which characterises delusions and hallucinations as part of a syndrome, as being surface symptoms with an underlying, presumably biological, cause (Kraepelin, 1913/1919; Jaspers, 1946/1946).

Bentall (1990a) has critiqued this way of construing delusions and hallucinations, noting that it involves what Ryle (1949) identified as a category error. For instance, instead of 'positive syndrome' being regarded simply as the term used to refer to a particular group of symptoms, the positive syndrome is taken to be the underlying, hidden, cause of these symptoms. This category error is avoided if a symptom approach (Chadwick, Birchwood & Trower, 1996) is adopted; as, for example, if the focus is on psychological phenomena (e.g., delusions and hallucinations per se) rather than on syndromes (e.g., diagnoses such as schizophrenia). However, it is important to recognise that this approach is not without problems either because the retention of the word symptom carries at least the implication that an underlying (biological) illness gives rise to these phenomena. Perhaps this difficulty might be lessened, to a degree, by referring to delusions and hallucinations as phenomena rather than as (biomedical) symptoms (Persons, 1986).

A consequence of continuing to adhere to a syndrome/diagnostic-category approach is that the content of delusions and hallucinations is conceptualised as being beyond our understanding (Jaspers, 1946/1963), as being merely a meaningless manifestation of a biological process. Yet, many participants in the current study indicated that, based on their experience, delusions and hallucinations are understandable, and when content is taken into consideration, rather than ignored, this can have benefits for therapeutic work. This challenges conventional ways of construing delusions and hallucinations.
Conclusions

Despite the limitations of the current study (e.g., a fairly small number of respondents and relatively low response rate)\(^4\), which preclude any claims of generalisability, this survey has enabled me to begin exploring the range of views held by mental health practitioners and researchers concerning the importance, or otherwise, of attending to the content of delusions and hallucinations. It has allowed a preliminary investigation of the extent to which delusional and hallucinatory content currently receives attention in clinical practice, and the reasoning involved in clinicians’ decision-making regarding whether or not to attend to content. These exploratory findings suggest that the paucity of research directly relating to delusional and hallucinatory content belies the frequency with which content is actually addressed in current clinical practice. Some of the participants’ responses challenged conventional ways of making sense of delusions and hallucinations. For example, some respondents characterised delusional and hallucinatory content as being understandable within the context of clients’ lives, as opposed to being meaningless.

Participants identified a number of factors that may contribute to a reluctance to attend to content. Some of these deterrents were pragmatic in nature (e.g., workload, limited provision of supervision) while others seemed to stem from the

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\(^4\) Limitations of the current study include the relatively small number of respondents and the fairly low response rate. It is probable that the length and detailed nature of the questionnaire discouraged some would-be participants. As the survey was international, with most respondents living overseas, it was not possible to supply them with pre-paid postage for the reply envelopes. Those who had been posted questionnaires were not sent reminder notices, and this may also have contributed to the low response rate. Also, there appeared to be relatively few practitioners, contactable via the internet, with suitable (and sufficient) clinical experience to enable them to complete the survey questionnaire. Therefore, the total population of those to be sampled was not particularly large. The postal survey format has certain inherent limitations. For example, self-selection bias results in gaining a non-representative sample, thereby severely limiting the generalisability of the findings. Some participants indicated that they would have liked to have given more in-depth responses, and pointed out that the issues they wished to discuss could not fit neatly into questionnaire boxes. When the questionnaire was designed, it was intended to be accessible to potential participants from diverse professional and epistemological backgrounds.
conventional way in which delusions and hallucinations are conceptualised (e.g., as meaningless phenomena, and the view that attending to them could compromise a clinician’s professionalism - in the eyes of colleagues - and perhaps even imperil her/his own sense of reality). Clearly, the ways in which delusions and hallucinations are construed have implications for clinical practice as well as for the kinds of research that are conducted.

Further research is needed to gain a more detailed understanding of clinicians’ and researchers’ views concerning the utility of attending to delusional and hallucinatory content. Given the relative lack of literature addressing content (Parker et al., 1995), there are numerous opportunities for further research in this area. For instance, how might various ways of conceptualising delusions and hallucinations enable/constrain/invite particular clinical practices? Of special importance would be an investigation of the implications for clients when practitioners attend, or fail to attend, to the content of their delusions and hallucinations. In the following chapter, I explore some of the ways in which mental health practitioners and researchers conceptualise delusional and hallucinatory content specifically in relation to gender.
4: Gender and the content of delusions and hallucinations

Are there similarities among women, and similarities among men, in the content of their delusions and hallucinations (that is, what their delusions and hallucinations are about)? If so, how might we account for these similarities? Does the content of delusions and hallucinations reflect conventional notions about femininity and masculinity, about what it is to be (or take oneself to be) a woman or a man?

The small number of studies that have investigated the specific content of delusions and hallucinations in relation to gender have tended to report differences between women and men in the content of their delusions (e.g., Rudden et al., 1983; Seeman, 1983; Allan & Hafner, 1989) and hallucinations (e.g., Allan & Hafner, 1989; Nayani & David, 1996). In this chapter, I provide an overview of this literature (notwithstanding the limitations of sex difference research; see Chapter 2 and Appendix A), and briefly outline explanations that have been offered to account for such differences. I then present data from the survey of mental health practitioners and researchers, exploring their views regarding gender and the content of delusions and hallucinations. This provides a further glimpse into the ways in which delusions and hallucinations are conceptualised by mental health professionals.

Reported sex differences in the content of delusions

More than a century ago, Kraepelin (cited in Goldstein, 1995) reported that women exhibited significantly more (hetero)sexual delusions than men. More contemporary studies (e.g., Menon, Cornelio & Saraswathy, 1980; Rudden et al., 1983; Galdos & van Os, 1995) concur with this finding. For example, nearly one third of the (44) female participants in an American study (Rudden et al., 1983) presented with delusions of an erotic, heterosexual nature, lending support to the authors' clinical impression that "in many women paranoid delusions may centre on
erotic subjects, particularly on the sense of being loved and erotically pursued by a man" (Rudden et al., 1983, p. 1575).

Delusions of fertility and sexual jealousy are also reported to be more common among women (Allan & Hafner, 1989). According to Seeman (1983), "sexual concerns, whether delusional, real, or transferential, are more in evidence in... [the delusions of women, and women experiencing delusions] are usually preoccupied with relationships, real, regretted, wished for, or delusional" (p. 146).

Men are reported to be significantly more likely than women to experience grandiose delusions (Allan & Hafner, 1989; Menon et al., 1980; Kazamias, 1970) involving status or personal power (Seeman & Fitzgerald, 2000). For example, Kazamias (1970) carried out research in a Greek psychiatric hospital, with 50 clients (25 women and 25 men) who had been experiencing delusions. He reported that 14 men presented with grandiose delusions (e.g., they believed they were great scientists, great politicians, or God) compared to only one woman (who believed she was the Virgin Mary).

Men are also reported to be more likely than women to present with erotic, homosexual delusions (Rudden et al., 1983), and delusions of homosexual persecution (Allan & Hafner, 1989). It has been claimed that issues concerning masculine identity and sexual orientation are more in evidence among men, while sexual role issues are reported to be more problematic for women (Rudden et al., 1983).

Allan and Hafner (1989) investigated both the content and form of delusions among 30 women and 30 men diagnosed with schizophrenic disorder. They reported that, in contrast to men, women were more likely to be the (passive) object rather than the (active) subject in their delusions. Allan and Hafner claimed that while women are less likely than men to present with delusions of grandeur, when women do present with delusions of grandeur, they tend to be the objects rather than the subjects of their delusions (e.g., being made pregnant by famous people rather than being famous people themselves). They (Allan & Hafner, 1989) also reported that when women do feature as the subjects in their grandiose delusions, they tend to hold
negative, rather than positive, attributes (e.g., are responsible for disasters such as earthquakes, floods and plagues).

It has been reported that both women and men are more likely to experience delusions about men, than delusions about women (Rudden et al., 1983; Allan & Hafner, 1989). Women are said to be more likely than men to have persecutors (in their delusions) who are personally known to them (Rudden et al., 1983; Allan & Hafner, 1989). It has also been claimed that women are more likely than men to experience immediate precipitants to the onset of their delusions (Rudden et al., 1983). Rudden and coworkers (1983) report that among all of their (female and male) participants who had precipitants recorded, family-related precipitants (e.g., arguments with family members) and precipitants such as first sexual encounters, rapes, and extramarital affairs were more common among women than men.

The vicissitudes of interpersonal relationships have been reported by many researchers (e.g., Seeman, 1983; Kitamura, Fujihara, Yuzuriha & Nakagawa, 1993; Childers & Harding, 1990; Salokangas, 1983) to be relevant to the onset of psychosis in women. According to Seeman (1983), the end of a close/intimate relationship is often considered to be the immediate precipitant to the manifestation of psychosis. It has been suggested that the loss or gain of relationships has an important influence on the ups and downs of women's long-term trajectories (Childers & Harding, 1990). Although women who experience delusions have been reported to be less socially-isolated than males similarly-diagnosed, family and marital conflict tends to be the prime environmental stress in these women's lives (Allan & Hafner, 1989).

A small-scale, exploratory study (Read & Argyle, 1999) found that for at least some of their sample (three of the five participants for whom delusional content had been recorded in their clinical notes), the content of delusions appeared to be related to earlier traumatic experiences. For example, one woman who experienced 'persecutory delusions' that men were intending to sexually harass and harm her had, in fact, been sexually abused by a man when she was a child (Read & Argyle, 1999). Group differences between women and men in the content of their delusions may
reflect the fact that, as groups, women and men tend to have different life circumstances, experiences, and roles, with women reported to be much more likely than men to have sustained violence and abuse (Stoppard, 2000).

**Reported sex differences in the content of hallucinations**

Although the literature pertaining to sex differences in the content of hallucinations is relatively scarce, it seems to parallel the literature concerning delusions. For example, both women and men are apparently more likely to hear male, rather than female, hallucinated voices (Allan & Hafner, 1989; Nayani & David, 1996).

Nayani and David (1996) questioned 100 individuals about the content of their auditory hallucinations, and found that while there was no sex difference in the number of participants who heard utterances that were abusive (60% of the entire sample), participants' gender influenced the types of words that were heard. Female participants tended to hear words of abuse that were conventionally directed at women (e.g., slut) while male participants tended to hear insults that were more specifically directed at men, such as those imputing homosexuality (Nayani & David, 1996). It is interesting that these (hallucinated) words of abuse intimate that the person at whom they are directed has contravened socially-prescribed norms of sexuality (e.g., women's reticent/chaste sexuality and men's potent (hetero)sexuality).

**Explanations offered to account for reported sex differences in the content of delusions and hallucinations**

Researchers have attributed sex differences in delusional and hallucinatory content to developmental/age-related (e.g., see Musalek et al., 1989; Seeman, 1983) and cultural (e.g., see Menon et al., 1980; Kazamias, 1970) factors. It has been claimed that, in general, "men talk about emancipation and dependency; women about sexual fantasies and inhibitions" (Seeman, 1983, p. 146), and the nature of these concerns (or 'conflicts') may be related to each person's developmental stage. As the
onset of psychosis tends to occur earlier for males than for females (Angermeyer & Kühn, 1988), the men are likely to still be at a stage in their lives when they are attempting to achieve independence from their parents/caregivers. The women, in contrast, have typically achieved autonomy by the time of onset, and their conflicts are said to relate more to sexuality and love (Seeman, 1983). Seeman (1983) has suggested that, for men diagnosed with schizophrenia, "these are problem areas as well but they are so profoundly problematical that they are usually avoided [i.e., in the sense of a psychodynamic 'defense mechanism'] and do not often surface as important psychotherapeutic themes" (p. 146).

Musalek and coworkers (1989) reported that, in general, certain delusional themes were more frequent among certain age groups, and they also noted more specific differences between women and men in the themes of their delusions and the ages at which these themes manifested. For instance, among their sample, the delusion of love was observed almost exclusively in women (i.e., in 91% of their sample), and never appeared later than age 50. The theme of persecution appeared most commonly in the 30-50-year-old age group, and this theme was observed in women at significantly older ages than in men.

To explain the different frequencies of delusional themes for different age periods, Musalek and colleagues (1989) hypothesised that delusional themes reflect the challenges associated with the developmental tasks of certain life periods. For example, they claimed that following early adulthood, the attainment and defence of a social position takes on importance, and this lends itself to delusions of persecution. "The contents of persecution in men are largely connected with the problems of professional success..., whereas in women persecution rather means a threat to hearth and home" (Musalek et al., 1989, p. 266). Others (e.g., Angermeyer & Kühn, 1988) have also suggested that relevant developmental tasks manifest in delusions and hallucinations, claiming that tasks such as leaving home, finding a job, and being competitive are especially relevant for men, while family conflict and childbirth are particularly salient for women.
A person's age may influence the content of her/his delusions, not only with regard to relevant developmental tasks, but also because some delusions require age-specific knowledge (Galdos & van Os, 1995). Galdos and van Os (1995) offer the example of a young person who might feel controlled, without being able to elaborate on the mechanism by which this control is being executed (e.g., electronic devices or telepathy). So sex differences between women and men in the content of delusions and hallucinations may, in part, reflect group differences in age (i.e., developmental stage), as the age-at-onset of psychosis is typically earlier for men than for women (e.g., Chaves, Seeman, Mari & Maluf, 1990).

Kazamias' (1970) finding, that delusions of grandeur were more common among men than among women in his sample of psychiatric inpatients in Greece, led him to propose that "the results could represent a pathological expression of characteristics normally found in Greek culture" (Kazamias, 1970, p. 230). He reported a striking differentiation of social roles for women and men in Greek culture, with "the superordinate role... reserved only for the male" [15, p. 230], while women are generally viewed in a negative light, with the role of mother being the only highly-respected female role. The subordinate role of women in this cultural context, therefore, made it less likely that they would experience delusions of grandeur, except perhaps if the delusion involved a maternal role (e.g., a woman who believes she is the mother of Christ).

Menon and coworkers (1980) have also proposed that the manifestation and course of psychosis is influenced by sex roles within a given cultural context, differences between women and men in occupational status and so on. Likewise, Allan and Hafner (1989) have suggested that the form and content of delusions "mirror with surprising accuracy aspects of prevailing sex-role stereotypes" (Allan & Hafner, 1989, p. 48). Indeed, it has been proposed that delusions and hallucinations are not categorically different from so-called normal experience (Kingdon & Turkington, 1994), but might be conceptualised more usefully as points on continua of
function (Strauss, 1969). “Delusions appear to be linked to people’s lives in very intricate ways.... they may be temporary exaggerations of prized normal ideas or themes” (Strauss, 1991, p. 60). Similarities in delusional and hallucinatory content among women, and among men, may simply reflect commonalities among women, and among men, in terms of their life circumstances and experiences.

Sociological, ethological and psychodynamic explanations have been offered to account for reports that representations of men occupy a dominant position in delusions and hallucinations. A sociological explanation might propose that men are more likely to feature in the delusions of both women and men, because men are more dominant in Western societies (Rudden et al., 1983). Being married and having children might be viewed as crucial for women in terms of their self-worth and self-definition, and so, they may be more concerned about (sexual) relationships with men (Rudden et al., 1983). From an ethological perspective, it might be argued that women may be more concerned with relationship issues, as they need to maintain ties with men throughout the period of child-rearing (which is prolonged among humans) (Rudden et al., 1983). A psychodynamic explanation might suggest that relationship issues have more importance for women because "the fear of loss of love is [supposedly] a greater one for them" (Rudden et al., 1983, p. 1577). Alternatively, "women's concern with relationships can be understood as a need to please others that arises from lack of power" (Hare-Mustin & Marecek, 1990, p. 38-39). It seems likely, however, that multiple explanations will need to be drawn upon in attempting to account for any observed sex differences in the content (and form) of delusions and hallucinations.

Below, I present data from the survey of mental health practitioners and researchers, exploring their views concerning gender and the content of delusions and hallucinations. The survey aimed to explore whether current practitioners had

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5 As discussed in Chapter 1, approaching delusions and hallucinations as phenomena, rather than as symptoms, allows them to be conceptualised as points on continua of function rather than as being categorically different from so-called normal experience (see Persons, 1986).
6 See Chapter 2 for a detailed account of the survey methodology.
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.

**Similarities among female clients in the content of their delusions and hallucinations, and explanations of these similarities**

Twenty-two participants (38%) reported that they had not observed any similarities among female clients in the content of their delusions and hallucinations, nor any content that was particular to female clients. A further 11 respondents (19%) did not answer this question. Among the remaining 25 respondents (43%) who reported that they had observed such similarities, the most frequent response (which was given by eight participants [32% of those who identified similarities and 14% of the entire sample]) was that women's delusions and hallucinations tend to reflect a concern with (hetero)sexual relationships and love:

- Love is central to most of the female patients I am in touch with (R15).
- Possibly more focus on relationships, and the power dynamics within them (R39).
- Special focus on relationships, delusions of love, [and] pregnancy (R8).

The second most commonly-identified similarity was content relating to “childhood trauma or present trauma” (R34). This theme was identified by seven respondents (28% of those who identified similarities and 12% of the entire sample), and included the client being a victim of physical violence, rape, or childhood sexual, physical or emotional abuse:

- I've only met female patients who believe they are being sexually abused by their 'voices' (R42).
- Only that it seems trauma related. E.g., the abuser appears offering food. There is magical meaning in random events that means she is bad/dirty (R57).
The derogatory nature of the content of women’s delusions and hallucinations was noted by three respondents (5% of the sample), with two of these explicitly contrasting this to a perceived tendency among men to present with grandiose delusions. One of these participants reported that women tend to experience “put downs” (R10) that are “cultural[ly] specific... e.g., ‘slut’, ‘whore’, ‘bitch’” (R10). A further three participants identified content of a religious/ritualistic nature as being a similarity among female clients.

Five of the eight participants who indicated that they had observed a focus on love and relationships in the content of women’s delusions and hallucinations, accounted for their observations in ways that emphasised clients’ cultural context:

Cultural upbringing may explain the difference. Our culture teaches us that female[s] must be loved and cared for by a man while a man must always be in control of everything (R15).

Relating, viewing self in relation, might be relatively more significant for women than for men (R39).

Those who identified a theme of trauma (e.g., rape and childhood sexual abuse) in the content of women’s delusions and hallucinations, offered a range of explanations to account for this, although the explanations tended to recognise the importance of actual events in women’s lives and the circumstances (i.e., social conditions) in which they find themselves:

High incidence of past molestation or rape for women (R16).

1. It may be true - not psychotic.
2. It may be a psychotic distortion/exaggeration of [the] truth.
3. It may reflect fears.
4. It may reflect cultural awareness of this topic (R23).

To explain the observation (made by three respondents) that the content of women’s delusions and hallucinations tends to be derogatory rather than grandiose, it was
suggested that, as a group, women tend to view themselves in a predominantly negative light.

**Similarities among male clients in the content of their delusions and hallucinations, and explanations of these similarities**

When participants were asked whether they had noticed any similarities among male clients in the specific content of their delusions and hallucinations (or any content that was particular to male clients), 26 respondents (45% of the sample) either indicated that they had not observed any such similarities, or they left the question unanswered. Among the remaining 32 participants, 8 (14% of the entire sample) suggested that men are more aggressive/violent than women and this is reflected in the content of their delusions and hallucinations (i.e., the imagery tends to be more violent). Six respondents (10%) suggested that men tend to experience grandiose delusions:

Perhaps more often when delusional they believe they are male supreme being figures such as Jesus, the devil or God’s chosen... women don’t tend to do this as much (R57).

Five participants (9%) observed that male clients tend to experience content related to sexuality and masculinity:

Sexuality and sexual orientation among young men. Commonly believing that others are spreading rumours of [the] client being homosexual, or such like. Generally relates to homosexuality (R39).

Men are more preoccupied with their own masculinity (R22).

A further five participants (9%) noted that religious themes often emerge in the content of men’s delusions and hallucinations.
The explanations participants offered to account for these various observations, almost exclusively appealed to societal/cultural influences. Societal/cultural explanations of one form or another were given by 85% of those who offered an explanation:

I would say culturally determined - reflecting power relations, differential experiences of men and women (R26).

Sexual orientation is a more potent source of concern for men, more crucially related to what it means to be a man in western culture; homosexuality is more of a threat to men (R39).

Some kind of socialisation/gender role. Learnt influence on the ‘choices’ people unconsciously think they have to represent themselves. Ideal images of male power (R57).

A variety of other explanations were also given, however they tended to be highly idiosyncratic, being given by no more than one or two participants. A further two respondents indicated that they could not account for their observations at all (e.g., “I have no idea” [R32]).

Discussion

Who we are is crucially linked to what we think - psychotic and non-psychotic thinking alike. Gender is a crucial aspect of who we are, or rather, who we take ourselves to be (R39).

Less than half of the participants indicated that they had observed similarities among female clients in the content of their delusions and hallucinations. The theme most commonly identified in the content of women’s delusions and hallucinations related to (heterosexual) relationships and love. This was consistent with earlier research (e.g., Rudden et al., 1983; Seeman, 1983; Goldstein, 1995; Galdos & van Os, 1995; Menon et al., 1980). Trauma (e.g., being a victim of rape, childhood sexual
abuse, or physical violence) was the second most commonly-identified theme among those participants who reported having observed similarities in the content of women’s delusions and hallucinations.

Just over half of the clinicians and researchers who took part in the current survey reported having observed similarities among male clients in the specific content of their delusions and hallucinations, or content that was particular to male clients. Some, but not all, of the similarities reported by participants have previously been noted in the literature. In the current survey, the most-commonly reported similarity in content among male clients was content that was of an aggressive or violent nature. Some participants identified grandiose delusions as being another similarity, and this was consistent with reports from previous research (e.g., Kazamias, 1970; Menon et al., 1980; Allan & Hafner, 1989; Seeman & Fitzgerald, 2000). Content relating to sexuality (e.g., “inappropriate sexual material” (R34) and issues concerning sexual orientation and masculinity) was identified by some respondents as a similarity among male clients, and this too was consistent with reports from earlier studies (e.g., Rudden et al., 1983; Allan & Hafner, 1989). It should be noted, however, that the number of participants who identified each of these particular themes was not large.

Almost all of the explanations respondents offered to account for the similarities they had observed among women, and among men, in the content of their delusions and hallucinations, emphasised the importance of sociocultural context. For example, in an attempt to account for delusions of love among women and grandiose delusions among men, it was suggested that “our [Western] culture teaches us that female[s] must be loved and cared for by a man while a man must always be in control of everything” (R15). So, according to at least some participants, the specific content of some clients’ delusions and hallucinations does reflect conventional notions (within a given culture) about femininity and masculinity, about what it is to
be (or take oneself to be) a woman or a man. This view is consistent with early claims of the importance of "cultural expectations and role-learning experiences" (Forrest & Hay, 1971, p. 145) in determining the content of delusions and hallucinations. If we conceptualise delusions and hallucinations as being continuous with so-called normal experience, rather than being categorically different from it (e.g., see Strauss, 1969; 1991; Kingdon & Turkington, 1994) then we might regard delusions of love in women and grandiose delusions in men as exaggerated enactments of socially-prescribed gender roles.

In addition, some participants drew attention to the sociopolitical structure of Western society (e.g., the "political role of women in society" [R42] relative to men) in their explanations. Respondents did not, however, offer ethological or psychodynamic explanations to account for the similarities they had observed (c.f., Rudden et al., 1983), nor did they offer developmental/age-related explanations (c.f., Musalek et al., 1989; Seeman, 1983; Galdos & van Os, 1995). The kinds of explanations participants offered tended to be at the sociocultural, rather than individual, level of analysis.

Some respondents suggested that past events in clients' lives, particularly experiences of abuse, accounted for the presence of a trauma theme in the content of some clients' delusions and hallucinations. This was in line with earlier research that has proposed that there may be a relationship between the particular content of (some) people's delusions and hallucinations and traumatic events they have experienced earlier in their lives. For instance, Heins, Gray and Tennant (1990) suggest that the specific content of delusions and hallucinations may be shaped by previous experiences of childhood sexual abuse. In the first of three examples they provide, a woman who had been sexually violated repeatedly by her father since she was eight years of age (and later by other members of the extended family) reported hearing voices that called her a "slut" and a "whore" (Heins et al., 1990, p. 562). Another

Alternatively, participants who expressed these particular views may have been more likely to make sense of what they observed in these terms.

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[7] Alternatively, participants who expressed these particular views may have been more likely to make sense of what they observed in these terms.
woman who had been sexually assaulted by her father since she was very young, as
well as raped as a teenager, heard a voice accusing her of doing "dirty sexual things",
and believed that people were watching her because they regarded her as a "sexual
pervert" (Heins et al., 1990, p. 562). In the third example, a young man who had been
sexually abused by an uncle from the time he was seven years old saw creatures who
would appear to him and repeatedly tell him that he was "sleazy" and "no good"
(Heins et al., 1990, p. 563). A more recent paper (Read, Perry, Moskowitz &
Connolly, 2001) has gone further, claiming that experiences of abuse may actually
cause delusions and hallucinations, at least in some people. Read and colleagues
(2001) argue that "the pathway to adulthood hallucinations [and] delusions... may
begin with a predominantly dissociative response to traumatic events in childhood"
(p. 334).

There may be a number of reasons why approximately half of the sample did
not report having observed any similarities among women, or among men, in the
content of their delusions and hallucinations. It may be that there simply were no
such similarities for them to observe, or it may be that they have not been attending to
(i.e., focusing on) the content of delusions and hallucinations in their clinical work.
Mental health practitioners and researchers have expressed ambivalence towards the
practice of attending to content (see Chapter 3), and as noted above, some clinicians
are discouraged from attending to the content of clients' delusions and hallucinations
during their training (Barker, 1997). Some mental health practitioners and researchers
have expressed concern that they might be ridiculed by their colleagues, and criticised
as being un-therapeutic, should they attend to content (see Chapter 3).

Conclusions

Despite the limitations of the current study (as discussed earlier, in Chapter
3), this survey has enabled me to begin exploring the views of contemporary mental
health practitioners and researchers concerning gender and the content of delusions
and hallucinations. Just over half of the respondents identified similarities among
male clients in the content of their delusions and hallucinations, while less than half of participants identified similarities in content among female clients. Those respondents who had identified such similarities, attempted to account for these primarily by appealing to characteristics of the sociocultural context and adverse events that had occurred in clients' lives (which tended to be gender-related, as violence and abuse are most commonly directed towards women). In general, the similarities identified were congruent with the reports of previous research (even though some of the previous studies date back several decades) and were also in line with conventional notions of femininity and masculinity in contemporary Western societies. It should be emphasised, however, that the number of participants who identified similarities, and subsequently offered explanations to account for them, was not large.

Further research is required to investigate why approximately half of the respondents did not report any similarities among women, or among men, in delusional and hallucinatory content. Such research might involve surveying a more representative sample. It may be beneficial to conduct open-ended interviews with mental health practitioners and researchers, to avoid the constraints of the survey format, and potentially to allow participants to give more nuanced responses (i.e., those that do not fit neatly into questionnaire boxes). Interview data of this kind would lend itself to a more qualitative analysis. Despite my earlier comments on the limitations of sex difference research (see Chapter 2 and Appendix A), this survey (which focuses on similarities among women, and similarities among men, rather than sex differences) may be said to bear an uneasy resemblance to the sex difference paradigm. This dilemma might be avoided by the adoption of an alternative epistemological stance. As some of the respondents placed emphasis on clients' sociocultural circumstances and life events in their attempts to account for the similarities they had observed in content, it may be beneficial to carry out research in which the content of clients' delusions and hallucinations is explored within the context of their own lives. Strauss (1991) has advocated this sort of research,
highlighting the need to carry out detailed studies with individual clients. I adopt this kind of approach in the next three chapters, presenting analyses of interviews with women who have experienced delusions and hallucinations, in which they speak about their experiences of these phenomena, within the context of their lives. In the following chapter, I outline four main interpretative repertoires that seemed to resource the women’s accounts of their experiences. I discuss various positions that may be enabled or constrained through the deployment of these repertoires, and consider possible implications for how the women may come to understand and experience these phenomena and themselves.
Part Two:

Interviews with women who have experienced
delusions and hallucinations
5: Women talk about their experiences of delusions and hallucinations

As Harper (1992) notes, "perceptual phenomena often admit of more than one interpretation and hence different versions of reality may be plausible and valid" (p. 360). The meaning of phenomena such as hearing voices or seeing visions is mediated by the discourses drawn upon in order to make sense of them (Blackman, 2001). However, not all ways of interpreting such phenomena - and not all versions of reality - will have equal claims to authority. In the context of a community mental health (CMH) service, for instance, the (biomedical) repertoire of mainstream Western psychiatry is more dominant than, say, a repertoire of spirituality.

The dominant interpretative repertoire deployed by mainstream psychiatry limits the subject positions available to those whose behaviours, beliefs and conduct are being scrutinised (Parker et al., 1995). Typically, it individualises 'mental health problems', focusing on what is 'wrong' with individual people (Drewery & Winslade, 1997) by assigning them psychiatric diagnoses. At the same time, the deployment of technical knowledge and specialised jargon functions to maintain professional legitimacy, by allowing the clinician to take up the (privileged) position of expert (which in the past might have been held by priests or ministers) (Harper, 1992; 1994; Dickerson & Zimmerman, 1995; Honos-Webb & Leitner, 2001).

Honos-Webb and Leitner (2001) raise concern about the potential for psychiatric diagnoses to be damaging for those to whom they are applied. For instance, they claim that the use of psychiatric diagnoses may have a harmful effect on people's basic views of themselves, as diagnoses invite stigmatisation not only by members of the wider community, but also by clients themselves. In other words,
people who have been assigned psychiatric diagnoses may come to regard themselves in ways that subscribe to the same negative stereotypes as other members of society. Another concern is that psychiatric diagnoses may construct a person as being a ‘victim’ (Honos-Webb & Leitner, 2001):

The client is a victim of both the purported disorder and the process of diagnosis itself. The client believes that the diagnosis means that he or she has very little control over the course of the disorder and is therefore a victim of it. In addition, the client has no control over the labels that are applied to him or her that will in many ways determine the client’s fate. Both of these forms of ‘victimisation’ contradict the therapeutic aim of enabling clients to see themselves as active agents in constructing their worlds (Honos-Webb & Leitner, 2001, p. 44).

Honos-Webb and Leitner (2001) argue that psychiatric diagnoses impede the generation of alternative explanations, as a person’s behaviours and experiences are understood through the lens of her/his diagnosis. Diagnoses may cause clients to lose trust in their own perceptions, interpretations, emotions, and reactions, and may invalidate their own understandings of the phenomena they have been experiencing (Honos-Webb & Leitner, 2001). Further concerns raised by Honos-Webb and Leitner (2001) are that psychiatric diagnoses overlook the potential usefulness or meaningfulness of the phenomena that the person has been experiencing, and they focus only on areas of difficulty, ignoring the person’s strengths. In addition, psychiatric diagnoses imply that a person’s difficulties are static entities, thereby failing to convey a sense of hope that change is possible (Honos-Webb & Leitner, 2001). Despite such criticisms of their potentially harmful effects, psychiatric diagnoses continue to be routinely deployed as ways of describing, and making sense of, the kinds of phenomena that bring people to the attention of mental health services.
It has been argued that this particular historical moment has seen an extensive psychologisation - and pathologisation - of everyday life (Rose, 1986, 1999), in which psychiatry and related disciplines (e.g., psychology, psychotherapy, counselling and so on) arguably create as well as serve a need (Burr & Butt, 2000). Many of the terms, concepts and explanatory structures of these disciplines have been taken up by the general population. As Burr and Butt (2000) report, "therapeutic vocabularies have over-sensitised people to their faults and misfortunes - and helped them to be defined as such" (p. 195).

How, then, might those who experience delusions and hallucinations talk about their experiences of these kinds of phenomena? What are the interpretative repertoires available to them by which to make sense of delusions and hallucinations? Are those who seek assistance from CMH services constrained by the dominant repertoire of mainstream psychiatry? How accessible are competing/alternative repertoires in such settings? In this chapter, I analyse the accounts of the women I interviewed¹ who have experienced delusions and hallucinations. I identify five main interpretative repertoires that appeared to resource the women's accounts. I explore possible implications of drawing upon each of these repertoires for how those experiencing delusions and hallucinations might come to understand and experience these phenomena and themselves.

**Interpretative repertoires**

I identified a number of recurring patterns in participants' accounts of their experiences of delusions and hallucinations. Participants selectively combined a number of competing (although closely-aligned and often complementary)

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¹ See Chapter 2 for details of the research methodology.
interpretative repertoires. In the most common of these repertoires, participants characterised their experiences of these phenomena in terms of (a) a range of different psychiatric diagnoses, (b) being sick, ill or diseased, (c) being crazy, mad or insane, and (d) as being personally inadequate or flawed. In addition, participants also drew upon a less commonly used repertoire, in which delusions and hallucinations were described as relatively mundane phenomena\(^2\). In this chapter, I outline what I will refer to as the Diagnostic, Illness, Madness, Personal Inadequacy and Mundane repertoires, and discuss some of the possible ways in which the women I interviewed may position themselves when they deploy these ways of talking about their experiences of delusions and hallucinations.

**Diagnostic repertoire**

One of the interpretative repertoires that appeared to resource participants' accounts of their experiences of delusions and hallucinations was what I have termed the Diagnostic repertoire. Participants utilised a wide range of psychiatric diagnostic terminology, in idiosyncratic and flexible ways\(^3\). The use of technical- and scientific-

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\(^2\) In addition to these repertoires, some participants also characterised some of their experiences (that might be described within a psychiatric framework as delusions and hallucinations) as spiritual. While this might be viewed as another interpretative repertoire drawn upon when talking about delusions and hallucinations, participants in this study appeared to construe these particular experiences as ontologically different from those they constituted as delusions and hallucinations; they tended to place them in an entirely separate category from delusions and hallucinations. For instance, Anna characterised her experience of feeling a presence in her room one night as a spiritual experience, whereas she described her experience of hearing a voice speaking to her from outside her bedroom window at night as a delusion.

\(^3\) Most commonly, when diagnostic terminology was deployed, the specific terms used appeared to convey rather different meanings from the technical/professional definitions set out in diagnostic manuals. My impression was that participants were often unclear about (or unaware of) the technical meanings of the diagnostic terminology. For instance, some of the participants described experiences of hearing voices as delusions, whereas mental health practitioners would be more likely to categorise such experiences as hallucinations. It has been reported that delusions and hallucinations typically occur together, as many delusions arise as attempts to account for unusual perceptual experiences (Johns & van Os, 2001). Most of the women interviewed in this study had experienced both delusions and hallucinations. Whereas psychiatry and related disciplines draw a distinction between delusions and hallucinations, this demarcation appeared to be very blurred in participants' accounts.
sounding psychiatric diagnostic terms constructs delusions and hallucinations as being within the realms of professional rather than lay expertise:

Alice: I think when you are in that space, when you are like in the middle of a manic episode, breakdown, whatever you, whatever they call it, psychotic experience, I do believe they are hallucinations and delusions, because it’s not real.

Alice’s comment – “whatever they call it” – made as she chooses between a variety of diagnostic labels, suggests that she will defer to the authority of mental health practitioners whose expert status is legitimated by the deployment of psychiatric jargon. She refers to what is arguably the defining characteristic of delusions and hallucinations within the conceptual framework of mainstream psychiatry – that these phenomena are set apart from consensual, external reality – that they are not real.

Similarly, Hannah and Meg illustrate the abandonment of lay terms in favour of the (purportedly) correct diagnostic terminology used by experts:

Hannah: I suppose I would... use different terms [other than delusions and hallucinations] probably... and one it would be (laughing) completely out-of-it situations that I’ve been in but the mental health people refer to them as psychotic episodes so I’d probably use those terms now.

Meg: I have what is a mild case of.... it’s just very mild of schizophrenia.... it consists of paranoid thoughts... not seeing things but.... making up things sometimes and having dreams that I think are reality.... that’s the way... I’ve been told that I [have] to explain it to other people, that I’ve had [it] explained to myself, I just have paranoid.... thoughts, yeah paranoid.

Participants drew upon the Diagnostic repertoire even though it was common for them to indicate that they did not feel comfortable with the particular terms delusions and hallucinations (some preferring instead to speak about their experiences using other diagnostic terms such as “manic episode”, “anxiety attacks”, “obsessive
thoughts”, “depression” and so on). This attests to the availability (or dominance) of the Diagnostic repertoire in constructing these kinds of experiences, even if the specific terms delusions and hallucinations are not used. Within contemporary Western cultures, the Diagnostic repertoire is increasingly pervasive, as more and more aspects of life become constituted, scrutinised, and pathologised within a framework of psychiatry and related disciplines.

Participants’ use of a wide range of diagnostic terminology, might be seen as (psycho)pathologising their experiences, and positioning them as clients or patients in need of professional help. The deployment of language from the Diagnostic repertoire may legitimate and invite the input of mental health workers, by marking out delusions and hallucinations as being best understood, and responded to, by experts (positioned as having access to privileged, specialised knowledge). For instance, Emily spoke about feeling that there was “something wrong with [her]”, and that “the only people that... know how to help are psychologists”. Likewise, Kate talked about being “under the proper care of a psychiatrist”.

The positions that may be made available by the use of the Diagnostic repertoire appear to be relatively disempowering for those who experience delusions and hallucinations. Use of this repertoire seems to render them passive and dependent upon the specialised intervention of mental health practitioners. Yet, the position of client appeared to be readily taken up by participants in this study, perhaps because of the relative dominance of this repertoire in contemporary Western societies (and because the women I interviewed had all been, and most still were, clients of CMH services). In this cultural milieu, it has come to seem as only natural that a mental health practitioner should be consulted when a person’s experiences (such as delusions and hallucinations) are construed as pathological and beyond the
understanding of ordinary, lay people. To consult a mental health professional may also provide an explanatory framework for phenomena that can be used to make sense of delusions and hallucinations, and may offer hope or relief for those distressed by such experiences.

Participants' apparent reluctance to avoid applying the specific terms delusions and hallucinations to their own experiences (despite using a range of other diagnostic terms), may have been due to the unattractive identities that the terms set up. Although meaning is always in flux, there is arguably something very pejorative about describing someone as delusional. It would not be surprising to find that few people would be willing to characterise their experiences (or themselves) in this way. While the term hallucination does not seem to carry quite the same connotation as the term delusion, I would contend that neither are highly-valued within contemporary Western cultures.

Illness repertoire

Another interpretative repertoire that I identified in participants' accounts I labelled the Illness repertoire. Participants appeared to draw upon linguistic resources invoking notions of ill-health when talking about their experiences of delusions and hallucinations. By speaking about having "something wrong with [them]", being "really crook", "ill" or "unwell", and about eventually "getting better", and becoming "well" again, participants appeared to construct delusions and hallucinations in terms of being "sick". Although most of the women I interviewed drew upon this interpretative repertoire, I have chosen to focus on extracts from June's account, to provide a more detailed example of how this repertoire might be utilised.
The use of particular words and imagery that relate to ill-health may not only provide a means of describing and understanding delusions and hallucinations, but may also prescribe (and even necessitate) certain actions, such as seeking medical attention:

June I was very, very sick and I needed medical help.

Constructing delusions and hallucinations as part of an illness may serve to remove, or at least diminish, any potential responsibility or blame of the person experiencing them. Indeed, responsibility for the person’s wellbeing is likely to be assumed by the medical practitioner officially designated within mental health services as the (so-called) responsible clinician for that particular client.

Use of the Illness repertoire to talk about delusions and hallucinations might allow those experiencing these phenomena to avoid other ways of construing them which may be more unattractive and potentially frightening. For example, June expresses relief at being “set free” of the worry that she might be “crazy”.

Yasmin: How did you feel about getting diagnosed [as ‘having depression’]?
June: At the time I was relieved in a way. When he said that, the first thing he said to me, I said, “Am I going crazy or am I crazy?” He said, “You are not crazy, you are not crazy, June”. And that’s all I wanted to hear. That just set me free, yeah. And he put me on medication, put me on lithium to stabilise me, yeah, and all these other blimmin tablets, God, but it took me a while to come right.

 Construing delusions and hallucinations as merely surface symptoms of a biological illness, or epiphenomena, renders their content essentially meaningless; the focus is on eliminating and preventing them (most typically, by using psychotrophic medication) rather than attempting to make sense of them.
Descriptions of delusions and hallucinations that draw upon the Illness repertoire characterise these phenomena as being part of a biological disorder. The deployment of this repertoire might exclude other competing (and potentially more unattractive) ways of understanding delusions and hallucinations:

June: I had a relation [who] was a psychiatric nurse. She was [visiting].... and she came over to me and she said, “You are sick, mate”. And I said to her, “What do you mean ‘sick’? Mental? Am I mental?” . She said to me, “No, you’re depressed”. And I told her what was on my mind and she said, “Look”, she said, “I’m gonna work on it, I’ll get in touch with a doctor”. And it was only through that lady, she saved my life.

The pronouncement that June was “sick” allowed her to take up a position that was potentially less unattractive than the position of someone “mental”. It also sanctioned and invited the (life-saving) input of medical/mental health practitioners. In this way, the Illness repertoire shares commonalities with the Diagnostic repertoire. This is unsurprising as the dominant paradigm within psychiatry and related disciplines is the biomedical (or illness) model. The extract conveys a sense of relief that June was “sick”, as this potentially abrogated personal responsibility, and enabled her to take up a position as a patient (able) to be helped.

Talking about phenomena such as delusions and hallucinations as if they were part of an illness may enable those experiencing these phenomena to avoid being positioned as personally inadequate or at fault.

June: I don’t want some friends to know I have depression, especially with those ones that don’t want to, don’t understand it. There’s people that don’t understand it. They don’t want to know about it. They think oh it’s just, it’s the way you think. It’s not. It’s an illness.... Diabetes is an illness, depression is like diabetes. If you don’t take the insulin when you’re a diabetic [sic] you get sick. Well, it’s the same with depression. If you don’t take your meds when you’re depressed, you’ll get sick. It’s the same thing.
June positions herself alongside those diagnosed with the medical condition, diabetes (an analogy that is commonly invoked by mental health workers), appealing to biological processes that are beyond her control.

June:  My mum would say to me, “It’s the way you’re thinking, it’s your problem.” And that was terrible, I couldn’t stop thinking like that. How would I stop thinking like that when I had an illness?

June fends off the suggestion that she might be in some way to blame for the distress she has experienced (as a result of not thinking ‘correctly’). The rhetorical question she poses presents this competing (Personal Inadequacy) repertoire as patently unreasonable.

June:  I remember when I used to get those thoughts [about knives, blood and violent acts towards children]... and I would just break down and cry and then I'd want, then I'd sort of feel like I had to destroy myself you know.... I'd never kill anybody but myself, you know, I'm not a violent person. Nah, but it was the depression that was just fucking my brain up, mate.

June’s conclusion that it was “the depression” (that is, an illness) that was responsible for her distressing thoughts, allows her to continue to position herself as someone who is “not a violent person” (despite her concern about having had some thoughts with very violent content). When understandings of delusions and hallucinations are resourced by the Illness repertoire, any undesirable thoughts or behaviour that may occur when someone is ‘unwell’ can be attributed to the illness, and split off from the person as being ‘not-me’.
Madness repertoire

Another interpretative repertoire that appeared to resource participants’ accounts of their experiences of delusions and hallucinations was what I called the Madness repertoire. Within this repertoire, delusions and hallucinations are represented as “crazy”, “insane”, “nutty” or “mad”:

Alice: I put these blankets all round my head, wrapped them all round my head, and I even used to sleep with them. I put sunglasses on my eyes... oh, it was crazy, it was just insane, and wanting to hide my head in the wardrobe.... and being thirsty, being really thirsty, I was gonna drink out of the kids’ fish bowl one day. This must sound utterly crazy to you, but it was what I experienced, it was just so really nutto, eh.

Looking back, Alice characterises her actions as “crazy”, “insane”, and “nutto”, as they do not make sense, or seem rational, to her now. Within this repertoire, irrationality and incomprehensibility are constructed as synonymous with madness. Constituting delusions and hallucinations as crazy may invalidate these kinds of experiences and repudiate any serious attempt to make sense of them.

This repertoire also conflates madness with instability (and in turn, unpredictability), reproducing the notion that (in order to be normal) a person must be stable:

Iris: I’m not good with unstable people around me, it makes me unbalance [sic]. I need to be stable.

Most (but not all) participants’ accounts of their experiences of delusions and hallucinations characterised these phenomena as being inherently frightening (that is, in terms of their content). However, delusions and hallucinations were also
constructed as being frightening in another sense; they were depicted as signs that a person was "going insane":

Anna: It was pretty scary (laughs). I thought I was going insane .... I thought I was losing my mind (laughs).

Even though the male voice that Anna heard told her pleasant "things that [she] wanted to hear" (such as romantic messages), the experience of hearing the voice was still "scary" for her, because she feared that she was losing her sanity, and madness itself is constructed as something that is intrinsically frightening. Within the Madness repertoire, the mere presence of delusions and/or hallucinations is construed as signifying something frightening - that the person in question is crazy - irrespective of whether or not the content of these phenomena are characterised as frightening.

Claire stated that she did not find the experience of hearing voices frightening until she began to realise that the voices she heard were not real. Prior to this, she had simply "thought it was all normal", and that perhaps she just had special talents (such as being able to read other people's minds) that others did not share:

Yasmin: You said that when you realised what was going on, that's when it was scary. Was it not scary before that point?
Claire: Not scary .... it was making me do things, but I thought it was all normal. Like, I thought it was normal but I didn't understand .... I didn't actually find it scary, I just thought I was different....
Yasmin: That there was something special about you that you could do [certain things] and other people couldn't?
Claire: Yeah, that's it (laughing) that's exactly it.
Yasmin: So, how did it go from that to realising that maybe the voices weren't actually there?
Claire: When I got home [from overseas] and when I had to go to hospital, that's when I started to realise that I'm not right.
Yasmin: So, that was other people's reactions?
Claire: ....Yeah, other people's reactions, like when my family put their foot down sort of and said that something's not right.
It was only when other people’s reactions suggested to Claire that things were not as they had seemed, that she began to question her sanity and experience concomitant fear.

This extract also illustrates the way in which notions of madness and normality are set in opposition to one another within this repertoire. Participants’ accounts of their experiences tended to depict madness and normality as discrete, mutually exclusive categories (with normality underpinned by conformity of a person’s perceptions with inter-subjective reality).

Accounts of delusions and hallucinations that draw upon the Madness repertoire may position those experiencing these phenomena as abnormal:

Kate: One night.... I said to [my partner], “You’re going to think I’m crazy, you know, crazy, but I keep hearing these voices talking”.

For Kate, hearing voices is synonymous with being “crazy”, and she is reluctant to tell her partner that she has been hearing them, as she may then be positioned as mad. The material consequences of being positioned as a crazy person are generally unappealing and may even be quite frightening. For instance, a person may be forcibly admitted to hospital or her appeals for protection may be dismissed:

Emily: I didn’t want [my] mother-in-law to find out that I was talking to the voices.... because I thought she’d cart me off to a mental hospital.

Iris: I’ve been harassed.... I have contacted the police, I’ve contacted them and they seem to think that I’m mad or something I think, but nothing’s been done. I’ve contacted them and they know what I’ve been experiencing. I’ve contacted them and I’ve said well, I felt this bloke was trying to kill me.... because I told them what happened with the energy thing and that and oh I don’t know, perhaps they think it’s... I don’t know.
While accounts of the sorts of phenomena that may be described as delusions and hallucinations may be resourced by various different interpretative repertoires, certain ones are more available than others. Lucy makes this choice between competing repertoires explicit:

Lucy: When you have experience with mental illness, it's not healthy to talk about those kind of spiritual things because they want to lock you up straight away.

Even though Lucy construes some of the phenomena she experienced as spiritual, she is aware of the potential for others to position her as mad if she describes them in this way (as the Madness repertoire is a more dominant way of understanding these kinds of experiences in contemporary Western societies, at least in CMH settings).

Personal inadequacy repertoire

Language conveying notions of personal inadequacy or flaw was also evident in participants’ accounts. I termed this way of talking about delusions and hallucinations the Personal Inadequacy repertoire. Many of the participants readily identified deficits that they located within themselves. For example, some said that they were lacking self-confidence, had “low self-esteem”, were “too insecure”, got “worked up over nothing”, and had “stupid thoughts”.

The GROW (2001) self-help handbook locates responsibility for mental health exclusively within the (unitary, rational) individual, and attributes any break with reality to personal inadequacy or maladjustment (including immaturity – as the name of the movement implies). Those participants who had attended GROW
support groups identified ‘errors’ in their thought processes. For instance, Alice stated that she had been following “feelings and imagination instead of reason”.

Hannah: At the time it was totally irrational.... after I start to get well I know that it’s only for a period of time and I can think more rationally, but when I’m going through it, I don’t think rationally at all, not at all.

The notion of losing, or being out of, control, was also prominent in participants’ accounts of their experiences of delusions and hallucinations:

Sophie: I am constantly trying to be in control and not believe what [the voices] say because I know that when I believe, I give them power over my situation and the delusion carries on, but the moment I stop believing, the delusion stops and that’s when I can come to my senses, and I developed that over the years and I can have shorter delusions now than I used to, through not believing.

In this extract, Sophie describes her struggle to remain in control, by not believing what the voices tell her. This way of talking about delusions and hallucinations constructs them in such a way that it seems to be not only within her capacity to ward off these phenomena by remaining in control, but it is also her responsibility to do so. The task, then, is to stop, eliminate and/or resist them, with their mere presence signalling failure.

Presumably, this kind of responsibility is not always easy to fulfil. Some participants expressed disappointment in themselves, making statements such as, “I couldn’t cope”, “I felt that I was an absolute failure”, “I just hated myself”, and “I was utterly ashamed of myself”. Constructing delusions and hallucinations in a way that emphasises the personal responsibility of the individual diverts attention away from possible social and material causal factors in the context in which a person lives.
If delusions and hallucinations are discussed in terms of personal inadequacy, maladjustment, and error, this has serious implications for the positions available to those who experience these phenomena. By framing the presence of delusions and hallucinations as evidence of personal failure, the positions that may be taken up by those experiencing these phenomena may become particularly unattractive.

When the Personal Inadequacy repertoire is drawn upon to talk about delusions and hallucinations, it may invite blame upon those who experience these phenomena (by suggesting that it is their own fault that they are not thinking and/or perceiving stimuli correctly), possibly positioning them as failures. However, this repertoire also opens up a position in which those experiencing these phenomena may characterise themselves as being capable of having some agency and control over these sorts of experiences (rather than being reliant solely upon the professional help of experts):

Yasmin: Do you think perhaps you were a bit sceptical about [the voice] right from the beginning?
Anna: Definitely very sceptical about the whole thing, very sceptical indeed (laughs), yeah, I’d say that I realised that it wasn’t quite real but at the time it was still, I mean, it still seemed like it was happening anyway, but I mean you can sort of not believe in something and believe in it all at the same time so yeah (laughs).

Anna positions herself as someone discerning, rational, and capable of actively choosing whether or not to believe in something.

Mundane repertoire

An alternative interpretative repertoire, which participants appeared to draw upon less frequently than the Diagnostic, Illness, Madness and Personal Inadequacy repertoires, enabled them to talk about experiences that might be described as
delusions and hallucinations in terms of "hearing voices", "seeing things", "thinking things" and so on. Use of this kind of everyday language, rather than psychiatric jargon, potentially constructs these kinds of experiences as more commonplace:

Sophie: I see it's more like... a movie that you can't see but you're hearing the words and you get so engrossed in it that you can't break loose until you make a decision to not believe the story anymore and that will finish it.
Yasmin: Yeah, and you get so engrossed in it that you forget it's actually a movie?
Sophie: Yeah.... I mean when normal people, when you watch a movie you get involved don't you?
Yasmin: Oh yeah.
Sophie: You actually feel like you're in part of the movie.... and then when the movie's finished then you think, "Oh well, that was just a movie".

Sophie uses imagery that would be readily accessible to most people. By likening her experiences to a "normal" movie-goer being engrossed in a film, she constructs them as relatively innocuous illusions and potentially as less aberrant or pathological than would be implied by use of the Diagnostic repertoire. While this more mundane way of talking about the sorts of experiences that may be described as delusions and hallucinations offers an alternative means of constructing them, it was less frequently drawn upon by participants than the other repertoires outlined here, particularly the more hegemonic Diagnostic repertoire (which places these phenomena beyond the understanding of ordinary, lay people). Only some of the participants' accounts drew upon the Mundane repertoire, whereas use of the Diagnostic repertoire was evident in all of the women's accounts.

Talking about the sorts of experiences that might be described as delusions and hallucinations using commonplace, mundane language may avoid positioning those who experience these kinds of phenomena as having something wrong with them or being abnormal in some way. Constructing these sorts of phenomena as potentially being part of, or at least continuous with, so-called normal, everyday life,
may diminish the likelihood that those who experience them will be positioned as being in need of professional help, ill, mad, or personally deficient.

Discussion

Participants' accounts of their experiences of delusions and hallucinations appeared to be resourced primarily by Diagnostic, Illness, Madness, and Personal Inadequacy interpretative repertoires. These ways of talking about delusions and hallucinations constructed them as being pathological phenomena within the realms of professional rather than lay expertise, as being part of a biological illness, as signs of madness and abnormality, and as indicators of personal inadequacy and failure, respectively. An alternative interpretative repertoire, which participants appeared to draw upon somewhat less frequently, constructed the sorts of experiences that might be described as delusions and hallucinations as relatively commonplace phenomena, and not necessarily beyond the understanding of ordinary people.

The use of these interpretative repertoires appeared to allow participants to position themselves (and be positioned by others) in various ways. Use of the Diagnostic repertoire, for instance, may position those who experience delusions and hallucinations as able to be helped by mental health practitioners. It may also offer a position of relative powerlessness and inexpertise, as clients or patients reliant upon the privileged, specialised knowledge of mental health practitioners, and unqualified to make sense of their own experiences.

The current dominance of psychiatric constructions in contemporary Western societies made the Diagnostic repertoire a very available resource for participants to use when talking about delusions and hallucinations; its pervasiveness making it seem
a reasonable and appropriate way of talking about these kinds of phenomena. It is likely that the Diagnostic repertoire was even more salient for the women I interviewed, given that they had all been (and most still were) clients of CMH services. Boyle (2002) cautions that:

Highly specialised [psychiatric] language, used by those who claim the authority of science, may be accepted simply because we assume it must be true or meaningful (why would they talk like that otherwise?). This reluctance to question, however, allows one version of reality to become dominant and the less it is questioned, the less it seems to need to be questioned (p. 210).

The closely-aligned, Illness repertoire was also a highly available resource for participants to draw upon. It may enable those experiencing delusions and hallucinations to take up a position as someone who is sick rather than a potentially more unattractive position as someone who is crazy or inadequate. The notion that delusions and hallucinations are manifestations of a biological disease may exonerate those experiencing these phenomena, their family members, and society in general, of blame or responsibility (Boyle, 2002). People may receive more sympathy and support when they construct their difficulties as medical (Kitzinger & Perkins, 1993), they may be held less responsible for their actions (Leudar & Thomas, 2000), and they may be released from social and occupational expectations they would otherwise have been subject to if they were ‘well’ (White, 1995). Constituting delusions and hallucinations as part of an illness invites interventions that are primarily medical (typically involving the use of psychotropic drugs), and downplays the importance of

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4 The ‘Like Minds, Like Mine’ national destigmatisation campaign (e.g., see Ministry of Health, 2004) has increased the availability of biomedical understandings of ‘mental illness’ within the wider community in Aotearoa/New Zealand.
considering other aspects of a person’s life (such as social, cultural, political and economic conditions) (Kitzinger & Perkins, 1993; Leudar & Thomas, 2000).

According to House (2001), much of the fear and distress that people experience in relation to delusions and hallucinations arises due to a perceived mismatch between their own self-experience and what they conceptualise normality to be. Within the Madness repertoire, normality and madness are set in opposition to one another, increasing the likelihood that experiences deemed to be abnormal will be characterised as mad. Being positioned as a crazy person is unlikely to be an appealing prospect; often resulting in undesirable material consequences and a loss of credibility. For instance, Honos-Webb and Leitner (2001) report that claims by one of their clients that he was sexually molested while he was in an inpatient unit were dismissed as unreliable because he was regarded as “crazy”. The discursive resources the general population draws upon for understanding madness are overwhelmingly unpleasant and unattractive. For example, Wilson, Nairn, Coverdale and Panapa (1999) report that depictions of mental illness in television drama broadcast in Aotearoa/New Zealand are outstandingly negative, generating and sustaining fear of those judged to be mad. This fear is fed by the notion that mad people are unstable, and therefore, unpredictable and potentially dangerous.

The construction of delusions and hallucinations, within the Personal Inadequacy repertoire, as phenomena that a person can and should have control over, may serve to position those who continue to experience (and be troubled by) these phenomena as failures. As this repertoire promotes the notion that a person can have agency and control over delusions and hallucinations and do not need to be reliant solely upon the expertise of mental health practitioners, it has the potential to be both empowering and blaming. The Personal Inadequacy repertoire perpetuates the
'fiction of the autonomous self' (Rose, 1999) in contemporary Western cultures, whereby individuals are both encouraged and expected to exercise mastery and control over themselves and their lives, irrespective of whether or not this is indeed possible (Rimke, 2000). This illusion of control produces not only the desire for control but potentially also anxiety, guilt, shame and powerlessness for those who cannot live this fiction (Blackman, 1996). Rimke (2000) argues that our era is one characterised by hyper-individuality in which contemporary 'self-helping citizens' are "rendered entirely responsible for their failures as well as their successes, their despair as well as their happiness" (p. 63). Within this context, any personal flaws or failures are presented as opportunities for further change and self-transformation (Blackman, 1999). "In our culture, the opportunities to experience failure are boundless and are ever-available" (White, 1995, p. 145).

Talking about the kinds of experiences that might be called delusions and hallucinations using everyday, non-specialised language may allow those who experience these phenomena to position themselves in ways that are non-pathologising. As noted in Chapter 1, it is claimed that many people who hear voices do not seek (or require) assistance from mental health services at all, and actually report that their voices enrich their lives (Jackson & Fulford, 1997; Watkins, 1998; Romme and Escher, 2000a). Acceptance that these kinds of experiences are relatively common, and not necessarily indicative of mental illness, may allow people to speak more openly about their experiences of these phenomena and this, in turn, may decrease any distress that may be associated with them (Coleman, 1999; Leudar & Thomas, 2000).

The Diagnostic, Illness, Madness and Personal Inadequacy repertoires were the most consistently recurring patterns of language use I identified in participants'
accounts of their experiences of delusions and hallucinations. This suggests that they may be relatively dominant ways of understanding and accounting for these kinds of phenomena within contemporary mainstream Aotearoa/New Zealand culture. (However, as I have noted above, the women I interviewed had all been, and most still were, clients of CMH services.) If an interpretative repertoire becomes sufficiently dominant, it can come to seem so natural that it is difficult for people to know of any other way of talking about the topic in question (Boyle, 2002).

With the advent of the Hearing Voices Network (HVN) (e.g., see Coleman & Smith, 1997), alternative ways of talking about delusions and hallucinations are becoming increasingly accessible. As discussed in Chapter 2, members of the HVN encourage one another to acknowledge, accept and attend to their voices, rather than view them as just meaningless, surface expressions of an underlying biological illness (Blackman, 2002). By accepting, rather than denying, their experiences, they are able to transform their relation to the experience of hearing voices (Blackman, 2000). A workbook (Coleman & Smith, 1997) is available to assist and support those who hear voices to re-think and re-live their experience. In it, the authors affirm the right of voice-hearers to adopt whichever frame(s) of reference they find most helpful and appropriate. This contrasts sharply with the Diagnostic repertoire, by honouring, rather than marginalising, the knowledge of those who experience delusions and hallucinations. In their guide for mental health practitioners working with voice-hearers, Romme and Escher (2000a) assert that it is important for clinicians to accept the experience and belief systems of those who hear voices. They outline ways in which mental health practitioners may assist clients to change their relationship to their voices, by attempting to make sense of them within the context of their own lives (Romme & Escher, 2000a).
Presumably those who experience the kinds of phenomena that might be characterised as delusions and hallucinations, but who do not come into contact with CMH services, deploy alternative ways of making sense of these experiences that do not necessitate or legitimate expert interventions (e.g., see Romme & Escher, 1993, 2000a, 2000b; Romme, 1998a, 1998b). It has been reported that those who hear voices, yet do not seek help from CMH services, are more likely than clients with similar experiences to perceive their voices as positive (apparently, irrespective of the specific content of the voices), and are more able to ‘cope’ with and/or control them (Romme & Escher, 2000a, 2000b). Whether or not voice-hearers are able to cope with their voices is said to depend not on the specific content of the voice experience, but rather on the kind of relationship they have with the voices. If voice-hearers believe that the voices are in control then they will be less likely to cope, whereas if they believe that they are stronger than the voices, then they will be able to cope (Romme & Escher, 2000a, 2000b). I would argue that people experiencing these kinds of phenomena may be more likely to regard them as positive if they have a frame of reference in which these phenomena are not construed as signs that there is something wrong with them. It seems likely that it would be more difficult for persons who have had lengthy or intensive involvement with CMH services to adopt alternative (non-pathologising) ways of understanding delusions and hallucinations.

As “there is no ultimately correct way of construing anything” (Burr & Butt, 2000, p. 199), we cannot evaluate different ways of talking about delusions and hallucinations to determine which is the most true. We may, however, judge each repertoire/frame of reference according to how useful or helpful it is for those who experience these phenomena (Burr & Butt, 2000). We may question the usefulness of the dominant interpretative repertoires which (potentially) render those who
experience delusions and hallucinations helpless, dependent, fearful and/or deficient. How might thinking of themselves in these terms enable people who experience delusions and hallucinations to live their lives in satisfactory ways?

Rather than locating the ‘problem’ within the individual, as each of these dominant repertoires do, we may seek to open up and promote alternative (marginalised) ways of talking about delusions and hallucinations that do not require those who experience these phenomena to be positioned as having something wrong with them. This may, for instance, involve talking about delusions and hallucinations using everyday, commonplace language that enables people to experience and make sense of these kinds of phenomena in ways that are non-pathologising (e.g., the Mundane repertoire identified in the accounts of the women I interviewed). More widespread awareness that it is “by no means exceptional” to hear voices, even for members of the general population in Western societies (Romme & Escher, 2000a, p. 14), may serve to increase the availability of non-Diagnostic repertoires. I do not wish to deny or trivialise any distress that people may experience in relation to delusions and hallucinations, but merely to cast doubt over the assumption that these phenomena are necessarily/invariably experienced in a negative way.

The use of therapeutic approaches which view language as constitutive, such as narrative therapy (e.g., see White & Epston, 1990; White, 1995; Drewery & Winslade, 1997) may also allow those who experience delusions and hallucinations to resist debilitating ways of constructing themselves and their experiences. Rather than focusing on what is wrong with individual people, narrative therapy deliberately externalises clients’ presenting issues, emphasising that it is ‘the problem that is the problem’ and not the person (Harper, 1995).
The HVN (e.g., Coleman & Smith, 1997) provides an example of how making space for alternative ways of making sense of delusions and hallucinations (e.g., within a Spiritual framework) may allow people to redefine themselves and their experiences in potentially liberating and adaptive ways. Gagg (2002) encourages mental health practitioners to invite people to generate multiple explanations, or frames of reference, for their delusions and hallucinations, as a means of revising their relationships with these phenomena. This process may be facilitated by talking about these kinds of experiences in relation to a person’s life history (Coleman & Smith, 1997; Coleman, 1999; Leudar & Thomas, 2000; Romme & Escher, 2000a).

**Summary and conclusions**

In this chapter, I have described four main competing (although closely-related and often complementary) interpretative repertoires from participants’ accounts of delusions and hallucinations, that constitute the various meanings they give to their experiences of these phenomena. I argue that the continued deployment of these dominant repertoires - of Diagnostic, Illness, Madness, and Personal Inadequacy – may have potentially negative implications for how people relate to their experiences and themselves. I identified an alternative repertoire in participants’ accounts, in which experiences that might otherwise be described as delusions and hallucinations were characterised using more mundane, commonplace language. Potentially more helpful implications may be associated with this alternative way of talking about delusions and hallucinations. With the advent of movements such as the Hearing Voices Network (e.g, see Coleman & Smith, 1997), alternative ways of talking about delusions and hallucinations (such as the Mundane repertoire), are
becoming increasingly accessible. I endorse those alternative ways of making sense of delusions and hallucinations that do not require those who experience these phenomena to depict themselves as pathological, diseased, mad or deficient.

In the following chapter, I explore the ways in which different frames of reference might be deployed in order to account for delusions and hallucinations. Drawing upon the interviews I conducted with women who have experienced delusions and hallucinations, I show how the kinds of causal attributions that may be made are determined by the ways in which delusions and hallucinations are framed.
6: Frames of reference drawn upon in attempts to make sense of delusions and hallucinations

There is no one accepted way of explaining or accounting for delusions and hallucinations (Leudar, 2001). Just as people who experience delusions and hallucinations may draw upon a variety of frames of reference to make sense of them (e.g., see Coleman & Smith, 1997), so too mental health practitioners and researchers employ various ways of conceptualising these phenomena, in line with their particular theoretical orientation¹. Nonetheless, within mainstream Western psychiatry, certain (e.g., biomedical) ways of construing delusions and hallucinations are more dominant than others (e.g., psychodynamic conceptualisations) (Read & Argyle, 1999).

Mental health practitioners working within the dominant biomedical paradigm typically draw upon the notion of insight when considering the ways in which people make sense of phenomena that might be characterised as delusions and hallucinations. People are said to display insight when they appear to agree with clinicians that they are mentally ill, that their experiences are best understood within a psychiatric framework, and that they require psychiatric treatment (Perkins & Moodley, 1993). If clients’ personal explanations of delusions and hallucinations do not concur with psychiatric conceptualisations, their explanatory models may be regarded (and dismissed) as merely symptomatic of their illness (Perkins & Moodley, 1993).

¹ For example, mental health practitioners and researchers may draw upon biomedical (e.g., see Duncan, Sheitman & Lieberman, 1999; Johnstone, 1999; Lawrie, 1999a, 1999b; Sandler, 1999), psychodynamic (e.g., see Arieti, 1961, 1962, 1974a, 1974b; Freeman, 1982, 1989, 1990, 1994; Altman & Selzer, 1995; Silva, Kim, Hofmann & Loula, 2003), cognitive (e.g., Garety, 1992; Fowler, Garety & Kuipers, 1995; Bentall & Kaney, 1996; Chadwick et al., 1996; Garety & Freeman, 1999; Morrison, 2002; Rector & Beck, 2002) and other conceptualisations, depending upon their theoretical orientation.
Perkins and Moodley (1993) argue that the notion of insight is highly problematic, not least because it privileges one particular perspective (the biomedical model) above all other possible explanatory models. They suggest that “to persist in believing that one construction of problems is ‘correct’ means that those [persons] who do not hold this ‘correct’ perspective will be alienated from [mental health] services” (Perkins & Moodley, 1993, p. 234). Perkins and Moodley (1993) argue that mental health services must be sensitive to the varied ways in which people make sense of their experiences, in order for those services to be accessible, acceptable and effective.

It has been reported that when clients initially come into contact with mental health services, a significant number of them do not appear to agree with psychiatric explanations of their experiences and it is claimed that people tend not to limit themselves to only one explanatory framework, anyway (Perkins & Moodley, 1993). A person may simultaneously employ several different ways of making sense of their experiences (e.g., within religious, biological, spiritual and social frameworks) (Coleman & Smith, 1997), and these explanations may or may not be mutually compatible (Perkins & Moodley, 1993). 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:

I am impressed by the differences in the ways in which clients distinguish their experiences or interpretations of voices at different times and in different contexts, one minute describing ‘hallucinations’ to a nurse and the next offering me [a family psychotherapist] a ‘psychic’ or personal interpretation of their experiences (Gagg, 2002, p. 164, emphasis in original).

As discussed in Chapters 2 and 5, the Hearing Voices Network (HVN) (e.g., Coleman & Smith, 1997) encourages persons who experience delusions and
hallucinations to utilise their own frames of reference\textsuperscript{2} to account for their experiences of these kinds of phenomena. They affirm the right of voice-hearers to adopt whichever frame(s) of reference they find most helpful and appropriate, stating that they are just as valid as the ways in which mental health practitioners conceptualise these sorts of phenomena (Coleman & Smith, 1997).

While this approach (e.g., Coleman & Smith, 1997) might be regarded as potentially very empowering to those who experience delusions and hallucinations, it may also give rise to possible dilemmas. For instance, frames of reference in which delusions and hallucinations are construed as being benign or benevolent might be welcomed, but what if people adopt frames of reference that justify, for example, harm to themselves or others? Ron Coleman (1999) states that he makes sense of his own experiences of hearing voices by drawing upon what he terms a “psychological” model, in which his voices are characterised as understandable reactions to distressing life experiences (including childhood sexual abuse). What if a person who has shared similar life experiences blames her/himself for these events and conceptualises her/his voices as punishment for perceived wrongdoing? Just how relative are possible frames of reference? How comfortable would we be to regard all such frames of reference as being equally valid, given their various potential implications?

\textsuperscript{2} In the previous chapter, I used the term \textit{interpretative repertoire} (when analysing the ways in which the women I interviewed spoke about their experiences of delusions and hallucinations), whereas in this chapter, I use the term \textit{frame of reference} (when analysing the ways in which these women explained or accounted for their experiences of delusions and hallucinations). In other words, I have used the term interpretative repertoire when analysing participants’ accounts of ‘what kind of experiences’ they characterised their delusions and hallucinations to be, while I have used the term frame of reference when analysing participants’ accounts of ‘why or how’ they came to experience these kinds of phenomena. It is important to note, however, that there is no theoretical or methodological distinction between the terms interpretative repertoire and frame of reference. I have deliberately chosen to use the term frame of reference in this chapter, rather than interpretative repertoire, because it is the term used by the HVN (Coleman & Smith, 1997). The HVN encourages its members to make attributions about the possible causes of their voice-hearing experiences (e.g., by exploring characteristics of the voices in relation to their broader life experience) as a way of developing their own understandings of these phenomena (see Chapters 2 and 5). As the term frame of reference is already being used by the HVN, I have used it in this chapter, in the hope that it may make the ideas being discussed here more accessible to a wider audience.
As noted in the previous chapter, "there is no ultimately correct way of construing anything" (Burr & Butt, 2000, p. 199), so we cannot evaluate different ways of making sense of delusions and hallucinations to determine which is the most true. We may, however, judge each frame of reference according to how useful or helpful it is for those who experience these phenomena (Burr & Butt, 2000). We may question the implications of various ways of conceptualising the sorts of phenomena that might be characterised as delusions and hallucinations.

However, the question remains as to who might serve as the (final) arbiter to determine the degree to which a given frame of reference is helpful or useful? It is not difficult to imagine instances in which there might be considerable disagreement between people (e.g., between those who experience delusions and hallucinations and mental health practitioners employed to assist them) about how to make sense of, and respond to, these kinds of phenomena. Such disagreements are likely to involve unequal power relations. Furthermore, the ways in which people conceptualise delusions and hallucinations are also likely to be constrained by the relative availability of various frames of reference within a given sociocultural context. As certain frames of reference (such as the biomedical model of mainstream psychiatry) have more authority than others (e.g., a spiritual frame of reference) in Western societies, they are more likely to be drawn upon, particularly within a mental health context. As the discussion of the notion of insight illustrates, dominant frames of reference, which support and perpetuate existing power relations, are likely to be

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3 From a social constructionist perspective that it is epistemologically (and ontologically) impossible to determine the true nature of reality. As Taylor (2001) argues, "no single truth is possible because reality is neither single nor regular: there are multiple realities and therefore multiple truths.... furthermore, truth claims cannot be checked because accounts of the world are not simply reflections or records of what already exists. They themselves constitute and change what they purport to describe" (p. 12).
regarded as true. Competing ways of understanding delusions and hallucinations, however, are more likely to be dismissed as incorrect, irrelevant or even bizarre.

In this chapter, I explore some of the ways in which people attempt to make sense of their experiences of delusions and hallucinations. I analyse the frames of reference that the women I interviewed drew upon to account for their experiences of delusions and hallucinations, and the kinds of causal attributions made possible by these ways of framing these sorts of phenomena. I explore some possible implications of construing delusions and hallucinations in these particular ways.

Frames of reference

I identified a number of recurring patterns in how participants' accounted for their experiences of phenomena that might be characterised as delusions and hallucinations. Participants appeared to draw upon a range of competing (although often related and complementary) frames of reference, with all of the participants drawing upon more than one. Each frame of reference comprised a framework within which to attempt to make sense of the sorts of phenomena that might be regarded as delusions and hallucinations, entailing attributions about their causes. The various ways in which these kinds of phenomena were framed influenced the sorts of causal explanations that were sought.

Participants appeared to draw upon what I have referred to here as (a) Trauma/Stress, (b) Spiritual/Religious, (c) Psychoactive Substances, (d) Biological, and (e) Individual Psychology frames of reference. Within these frames of reference, delusions and hallucinations were attributed respectively to (a) adverse life events and deleterious interpersonal relationships (b) contact with a spiritual realm, and the

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4 See Chapter 2 for details of the research methodology.
influences of religious doctrine, (c) excessive intake of alcohol and other substances, (d) biological factors such as genetics and physical exhaustion, and (e) individual psychological characteristics. In this chapter, I outline each of these frames of reference, and discuss some of the possible implications of these ways of accounting for delusions and hallucinations.

Trauma/stress frame of reference

Participants appeared to draw most commonly upon a Trauma/Stress frame of reference, in which they attributed their experiences of delusions and hallucinations to having experienced life events and interpersonal relationships that were described as adverse and deleterious. All but one of the participants stated that they had experienced events that they characterised as traumatic. Typically, these events involved people with whom the participants had a significant relationship (that is, partners and/or family members). In their accounts, participants outlined a range of such experiences including what they described as emotional, physical and sexual abuse, and bereavement. They appeared to situate their experience of delusions and hallucinations firmly within the context of these broader life experiences:

Lucy: I have a personal belief that all mental illness is based on some kind of psychological trauma, somewhere in a person's life.

Lucy stated that she had been severely traumatised by the murder of a member of her family.

Lucy: I was traumatised.... my [family member] had come to me for sanctuary. She was making accusations [about another member of the family].... she and I ended up having a terrible argument. I kicked her out of my home. A week later she disappeared.
Lucy reported that some months after her family member’s disappearance, part of her “decomposed body” was found, and she was called upon to identify the body. Lucy said that she had thought that she was “only going to look at photographs of the clothing”, but as it was not possible to identify the body in this way, she “ended up at the morgue with a detective”. This experience was described by Lucy as being extremely unpleasant and distressing.

Lucy: Afterwards... I started talking about some of the things [i.e., accusations] she’d been telling me before she disappeared.... [but I was] silenced.... [I was told] that they were terrible, terrible things to be saying and [my family member] was crazy and I was never allowed to talk about it again, so eventually the only option was to suppress all the memories, and it was about... ten years after that I was re-traumatised. [My husband and I] found a young man, coming home one night, found a young man lying in the middle of the road bleeding to death. He’d been shot.... at close range.... we took him to hospital.... He died three hours later, and we were supposed to be witness[es] in the high court murder trial. So there was a lot more trauma and any unresolved issues from the first one resurfaced5.

Lucy: The trauma was so bad and I wasn’t allowed to talk to anybody about it. I had to escape somewhere inside my head. And you can only stay escaped in there for so long before they take the top of your head off, you know they’ve got to come out somehow, one way or another.

Lucy suggested that her experiences of delusions and hallucinations (which included believing that people were going to kill her and seeing visions of extremely violent acts being committed) were understandable, given the severity of some of the events she had experienced in her life. In particular, Lucy claimed that not being able to talk about, and resolve issues surrounding her family member’s murder, contributed to the development of delusions and hallucinations:

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5 Lucy said that she accepted that, due to the fairly low frequency with which murders occur in Aotearoa/New Zealand, the details of her account might be likely to compromise her anonymity and confidentiality. However, Lucy stated that this possibility did not cause her particular concern, as she has already been very open about her experiences with everyone she knows.
Lucy: I had years of intense guilt and grief that [my family member] had come to me for sanctuary with a real situation happening... and I, in my humanity, couldn't help her, didn’t help her, kicked her out, and maybe... there is a term for grief that turns into morbid grief, that was possibly a part of it, but.... I’ve never had auditory hallucinations or voices by themselves.... it was always to do with real people’s deaths.

She described her experience of delusions and hallucinations as a “normal reaction to an abnormal event”. This frame of reference incorporated the notion that a person can only withstand a certain amount of stress; when incidents in a person’s life are too traumatic, when several of these sorts of events occur within a short space of time, and/or when experiences of trauma are silenced/suppressed, it may become “too much” for a person to cope with.

Typically, participants listed numerous life events they had experienced which they characterised as adverse. For example, Kate referred to a large number of such life events, including: the deaths of a number of close family members in separate, unexpected incidents; attempted rape; and an abusive marriage which included physical abuse (and in which her husband “used to sit in the garage with a gun and say that he was going to blow his head off”). Kate commented that, by the time she left her husband, she felt that she was “on the verge of a nervous breakdown and.... couldn’t have taken any more”. Some years later, when Kate was discharged from hospital after having undergone a surgical procedure (and after having moved away to an isolated region), she began to hear voices:

Kate: It was like someone was saying.... “Oh you poor thing, look at her, the poor thing”, you know, and “She’s got nothing much going for her” and all that sort of stuff.

Kate appeared to try to make sense of the voices by placing them in the context of the stress she was under at the time and the cumulative effect of the many adverse things
that had happened to her over the years. She suggested that the things the voices said might have been consistent with what people were thinking and saying about her (i.e., feeling sorry for her and remarking that “she’s got nothing really going for her”), given her broader life experience.

Participants appeared to characterise life events they regarded as adverse as not only causing delusions and hallucinations, but often also as being causally-related to the specific content of these phenomena. Iris, for example, suggested that her previous experience of abuse may account for why she began to hear voices calling her a “slut” and saying that she was “dirty”:

Iris: When I was 18, they [the voices] were calling me horrible names like ‘slut’, things like that (laughs) dreadful things like that…. “She’s awful isn’t she?”…. real condescending it was, it was awful, yeah, horrible voices, nasty voices…. I thought, oh yes, this is what everyone around me thinks.

Iris: I think that was going right back in my childhood too though with Mum, those voices, they developed from there…. they’d say “She’s dirty” and stuff like that, it was probably the time when my mother was washing me in the bath and washing me there (points to pubic region) and I was bleeding…. when I was about four…. I started crying and complaining and I couldn’t walk properly…. She was calling me ‘dirty’ too, I think, as well… and when I’d tell her to stop it you know she used to go, “Shut up you dirty little bugger”, things like that she used to say to me.

Iris stated that in addition to maltreatment from her mother, her grandfather and brother had attempted to sexually abuse her, and a boyfriend had abused her when she was a teenager. Iris reported that these kinds of experiences had made her feel “grubby” and “yucky”, and this was later reflected in the sorts of “horrible names” the voices called her. She appeared to make sense of her delusions and hallucinations by placing them within the context of these kinds of life experiences. She noted that although she had “blocked out” things that had happened to her, eventually these kinds of life events “all became too much” for her to cope with.
Similarly, Alice attributed her experience of delusions and hallucinations to sexual abuse:

Alice: It was sexual abuse which actually brought a lot of this on, brought what happened to me on. I'd had experiences with sexual abuse, not by an adult but by another child who had been interfered with by an adult, and then my child was sexually abused at school, from other children. She was coming home and was displaying all sorts of... behaviour which was... obvious of sexual abuse and then I found out after 10, 11 years of marriage that my husband had been sexually abused as a child by a member of his own family... All this compounded... and just totally flipped me off the edge, I just could not cope.... I started having obsessive cleaning, seeing blood. I imagined that my child was dirty all the time. When she used to go to the toilet I used to always see like, I thought it was poo on the toilet but it wasn't, I'd always wipe it. It actually wasn't there but I was seeing it.

Alice: What was happening around me at the time was real.... it was just too much.... and I just couldn't cope, so... my mind just cracked under the strain.

Alice claimed that sexual abuse was responsible for bringing on her delusions and hallucinations (i.e., her “mind just cracked under the strain” of what was happening around her at the time), and also influenced their specific content (e.g., “I imagined that my child was dirty all the time”). It was common for participants to make these kinds of causal attributions (depicting adverse life events as causing delusions and hallucinations, and as being somehow expressed in the content of these phenomena).

Within this frame of reference, delusions and hallucinations appear to be construed as fairly understandable responses to life events and interpersonal relationships that are characterised as adverse and deleterious, especially when those life events are particularly traumatic, when several such events occur in a short period of time, or when such experiences are silenced/suppressed. This way of making sense of delusions and hallucinations also seems to characterise adverse events as often being causally-related to the content, as well as to the presence, of these kinds of phenomena.
Drawing upon this frame of reference may allow those who experience these kinds of phenomena to make sense of them in ways that are potentially less pathologising and frightening than other possible frames of reference. By characterising delusions and hallucinations as understandable reactions to traumatic and stressful life events, people who experience these phenomena need not position themselves as having something wrong with them, but rather as having an understandable reaction to significant trauma and stress. This may allow them to make sense of experiences that might otherwise potentially be regarded as random, inexplicable and frightening.

For instance, Alice said that she recognises that her mind can begin to "play tricks" on her (e.g., she starts to see things, such as blood) at times of stress:

Alice: Before I went for this operation.... it was the morning I was to go to hospital.... and I hadn’t had a very good sleep because I had a bit of anxiety that night, and I looked at the hair brush and I thought, ‘That’s not blood is it in the hair brush?”, and I looked again, ‘No, it’s just water’, you know, moisture and... I thought then, I thought ‘Oh-oh, something’s wrong’, and I thought ‘No, nothing is wrong, what’s happening now, that’s minor, it’s because of what you’re going to go through’.... my mind was starting to play tricks with me.... a bit of stress is coming on so those signs can come back, just slightly, but it’s still a sign that I’ve gotta [sic] think about why it’s happening and normally there is a reason why .... I’ve got to look at what is happening for me, what is going to happen or what is happening.

Contextualising these sorts of phenomena, and regarding them as understandable responses to stress, may enable Alice to relate to them in ways which are less likely to be characterised by fear and distress. It may also enable her to regard them as potentially helpful signs/warnings of stress, prompting her to consider, and seek to address, whatever challenges she might be facing around that time.

Construing delusions and hallucinations as understandable reactions to adverse life events, may enable people to experience these phenomena as less aberrant
and frightening. In addition, as will be discussed in the following chapter, some participants construed their experiences of delusions and hallucinations as in some ways enabling them to deal with adverse life events and circumstances and to bring about positive change in their lives.

**Spiritual/religious frame of reference**

In participants’ accounts of their experiences of phenomena that might be characterised as delusions and hallucinations, some appeared to draw upon a Spiritual/Religious frame of reference to make sense of these phenomena. This frame of reference seemed to be multifaceted; in some instances such phenomena were construed as being spiritual or supernatural experiences, whereas in others they were characterised as delusions and hallucinations arising from religious beliefs or intense religious experiences. These different ways of experiencing and construing these phenomena appeared to function in quite different ways (in general, participants were more inclined to regard the phenomena they described as spiritual experiences as being genuine, even in retrospect, than those which they framed as religious experiences). However, the boundaries between these different ways of making sense of these phenomena appeared to be rather blurred. The commonality within this frame of reference was the notion that the sorts of phenomena that might be regarded as delusions and hallucinations may be conceptualised as being associated with spiritual (i.e., non-material) dimensions of existence.

Some participants described many of their experiences as being spiritual in nature, differentiating them from others that they designated as delusions and
They appeared to construe the spiritual experiences as being quite distinct, at times involving contact with entities from spiritual realms. For example, Lucy reported that she experienced “spiritual haunting” after having contact with a young man who had been shot and later died. She described a range of such experiences:

Lucy: We had one night where I stood up on the bed to close the curtains and I could actually hear the glass crackling, but it wasn’t breaking, I could just hear the crackling and then I could feel a presence and another time, we were on the bed, two of us on the bed, and the bed was shaking, you know, really strange things like that.

Lucy made sense of these kinds of experiences by regarding them as the sorts of phenomena that might naturally be expected to occur following an unnatural death (thereby placing them in the context of her broader life experience):

Lucy: We interrupted his dying process and whenever there is an unnatural death like that, strange things happen.

This way of construing such phenomena offers an explanation of experiences that might otherwise seem inexplicable. It may enable people to accept these phenomena without having to position themselves as being mentally ill or mad. This frame of reference also offers guidelines about how to deal with such phenomena. For example, Lucy and her husband each sought out spiritual healers, and were advised to get rid of any objects that had been connected with the young man.

In the following extract, Alice illustrates how a particular experience (of smelling an odour that seemed like “the smell of death”) may be construed in various ways.

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6 A significant difference between the phenomena that participants described as being spiritual in nature and those they characterised as delusions and hallucinations is that when they look back on these sorts of experiences, they continue to regard the former as real, but not the latter.
different ways, either as a "warning sign" from another realm or as a sign of "getting sick" and/or being under significant pressure:

Alice: About two days before my dad died I went to the [local] hospital and he was laying there and all of a sudden that smell was there. I've never had it since but two days later he died and... it was really bad and it was really scary and I thought, 'Woah, I'm getting sick, the pressure of Dad dying is just too much' but... it was the warning sign, it was telling me.... I think when you're in that state, it can come back again, yeah, and the meaning is that it could be something, it could be something from a totally different realm even, that you and I will never totally understand.

Alice's account demonstrates how various frames of reference may be drawn upon to make sense of a particular experience. Although Alice suggested that the "offensive smell" might constitute a warning from another realm that her father was about to die, she expressed reluctance to employ this frame of reference, displaying flexibility in the process of making sense of such phenomena:

Alice: It could be something from a totally different realm.... it could be, but at the same time I don't want to play around (laughs) or know about it, it's too much, it's too heavy for me to deal with.

Although she suggested that a spiritual frame of reference might offer a plausible account of her experience, she appeared to construe anything from a "different realm" as being more than she could handle, preferring instead to make sense of her experiences by drawing upon more mundane kinds of explanations (e.g., the effects of stress).

Iris expressed ambivalence about experiencing spiritual phenomena, as she regarded some of these experiences as constituting interference from another realm. She reported that from the time she was a young child, she began to have these kinds of experiences, including being able to foresee the future:
Iris: I knew something was gonna [sic] happen and then it would happen.... I could feel things, like I could feel presences around me, like sometimes I'd feel really strong presences, do you know what I mean, like there's something around me but I couldn't see them, but then as I got older I started seeing them and I didn't really want to see them.

Iris: [My grandfather, who had sexually abused my mother] died when I was [in my early 20s], and he came to me after he died too. He came into, when I was asleep in my room, he came in, the presence was there and I could hear his voice was actually calling my name, but I didn't want to know, but it was an evilness there, there was a horrible smell, I smelt the smell and I just wanted it to go and it went, but I was frozen, I was locked in the presence, but it went, thank God.

Iris: I just wanted to get on with my life here, I didn't want to be interfered with by the other side.

Iris appeared to characterise these kinds of experiences as being largely beyond her control, uninvited, and often frightening. This way of construing these sorts of phenomena appeared to construct them as being external to her, but to which she was very sensitive. Iris stated that she would like to develop abilities to regulate her degree of sensitivity, so that she can have more control over these kinds of experiences (as opposed to having them cease altogether). In her account, Iris appeared to regard "spiritual experiences" as being potentially unproblematic (and even positive), provided that a person develops sufficient skill to control her/his level of sensitivity (so that these experiences do not become too intrusive or overwhelming). This seems to suggest that these kinds of phenomena may be under some degree of conscious control (in terms of being able to enhance or attenuate sensitivity to them) and may be positively valued (i.e., regarded as a "gift"), if the person experiencing them is able to control them.

Within this frame of reference, some phenomena that might be characterised as delusions and hallucinations were described as being associated with intense religious experience. For instance, Sophie associated the voice she heard (which she
thought was the voice of Jesus) with intense longing to communicate directly with Jesus:

Sophie: One of the prayers that I liked to pray at the time, what I was praying constantly for was a scripture that is written in the bible, and it says, 'My sheep, hear my voice' .... Jesus being the shepherd and his followers being the sheep. And I thought well his sheep hear his voice, so I figured that I could hear Jesus' voice, and so I started praying for this (clears throat) and I got quite passionate about it.... and then one day when I didn’t expect it, I was walking around the church.... and I remember hearing a voice say to me ‘Would you like to hear and see in the spirit?’ and I thought oh, this is my opportunity to talk to Jesus, so I said ‘I’d like to hear’.... and then a few days later I started hearing a voice.

Sophie appeared to make sense of the voice she heard within the framework of her broader religious experience. She seemed to construe the voice as having arisen from her “passionate” desire to hear the voice of Jesus. She reported that she went on to have theological discussions with the voice, but later also began to hear the voices of demons, and she eventually began to doubt the identity of all of the various voices she went on to hear (e.g., she said that she wondered whether a demon had posed as Jesus). Within this frame of reference, Sophie understood her experiences of these phenomena as being religious experiences, involving communication with another realm and, at first, as being very positive.

Like Sophie, Claire associated her experiences of these kinds of phenomena with her broader religious experience. She reported that she heard voices and had believed that she could “do the work that God does”. She said that the voices often instructed her to carry out particular tasks by a certain time, including “confessing” to her parents:

Claire: I guess a lot of it is when I was confessing.... to Mum and Dad and stuff like that.... it’s like the whole thing.... revolved around religion and relationships and how it’s supposed to work and how it’s not.
Claire: A lot of it was to do with religion and relationships and what's right and what's wrong.

Claire stated that the sorts of things she was confessing to her parents tended to pertain to transgressions of religious doctrine prohibiting sex before marriage:

Claire: I was going through my mind, sex before marriage and stuff like that, so it was relationship stuff again and I can't remember exactly what I said, but I was questioning it, and I said "Oh who said that? What's wrong - sex before marriage?" and then I thought, then I believed that I heard God say, "I did" and out of the sky (laughs).

Claire appeared to make sense of the content of these kinds of phenomena by appealing to her Catholic upbringing.

Prohibitions about sex outside of marriage also featured in Sophie’s account of her experiences. She proposed that schizophrenia may develop through sexual relationships conducted outside the sacrament of marriage:

Sophie: I think a lot of schizophrenia is developed through a sexual relationship with someone and you'll probably find that they have become one flesh and they don't know how to get away from them and that person they had sexual relationships with is the tormentor.

Sophie: I found that I.... needed to repent from all the sexual encounters that I've had in my life.... repenting from all [of].... them by name helped me get rid of certain voices.

In this account, sexual intercourse appears to be regarded as not just a physical act but also as involving a spiritual connection between persons, whereby each remains tied to the other, as if they are never able to fully separate from one another. This account seems to characterise phenomena such as hearing voices as being consequences of behaviour that transgresses religious doctrine. In this way, it appears to construct
these phenomena as a punishment for perceived wrongdoing. It seems to suggest that by confessing and repenting transgressions, a person may eliminate these kinds of phenomena. For instance, Sophie said that the voices "would bring up those past boyfriends", but that through repenting, she was able to "get rid of certain voices". So, while these sorts of experiences may be regarded as punishment for transgressions, guidelines are offered as to how people might redeem themselves (and thereby eliminate these kinds of experiences), and how a person might be expected to behave, more generally. This way of thinking about these kinds of phenomena may offer some comfort or reassurance, as they might appear to constitute evidence confirming existing religious beliefs.

Drawing upon a Spiritual/religious frame of reference may allow people to make sense of phenomena that might otherwise be characterised as delusions and hallucinations as being non-pathological and potentially even highly-valued experiences. Within this frame of reference, people who experience such phenomena may regard themselves as having a gift (which enhances their sensitivity to spiritual/non-material realms) as opposed to being mentally ill or mad. If experiences of these kinds of phenomena are construed in this way, they may also offer some sense of reassurance or certainty regarding the veracity of a person's spiritual/religious beliefs. However, construing the sorts of phenomena that might be regarded as delusions and hallucinations within a Spiritual/religious frame of reference may also be potentially frightening, particularly if a person feels out of her/his depth and at the mercy of forces greater than her/himself. Nonetheless, this frame of reference seems to offer guidelines about how to deal with such phenomena (e.g., to learn to control the degree of sensitivity to spiritual realms, to consult a
spiritual healer or member of the clergy, to behave in a way consistent with religious doctrine, and so on), and may therefore enhance a person's sense of agency.

Psychoactive substances frame of reference

Another frame of reference participants appeared to draw upon in their accounts of their experiences of delusions and hallucinations attributed these sorts of phenomena to excessive intake of alcohol and other psychoactive substances. For example, Claire suggested that many of her experiences of these kinds of phenomena were “drug-related and alcohol-related”:

Claire: I'd say the drugs had a lot of stuff, a lot to do with it. They made my thoughts out of control, made my thoughts run wild and start linking everything together and made me go off in all different angles and all different ways. I'd be here, there, and everywhere sort of thing. Like the experiences are still so real but had I not had the drugs I wouldn't have experienced it how I did. Like, I wouldn't have been, I wouldn't have dug up my past and gone through my whole life experience had I not taken it, that's what I believe. But I brought everything up again, like past things and started dwelling on past relationships and stuff which I never ever did previous to taking drugs, so yeah, a lot of it was drugs I think had a lot to do with it and stress and things.

Claire suggested that taking drugs “had a big impact” on her, as it “made [her] thoughts run wild”, thereby bringing about what might be referred to as delusions and hallucinations. Within this frame of reference, alcohol and other substances are understood as removing conventional controls/constraints on thinking, and that delusions and hallucinations may occur when such constraints are removed.

Like Claire, Meg characterised alcohol and drug use as adversely affecting a person’s thoughts:

Meg: I drunk just every day, every night, you know, I became an alcoholic. That wouldn't have helped with my thoughts and things... you can't blame it straight on all just marijuana, it's alcohol too that does it.
Meg suggested that excessive alcohol and drug intake compromises a person's cognitive ability and can lead to feelings of paranoia. She regarded her alcohol and drug use as having been causally-related to the delusions she experienced (which included believing that she had been kidnapped as a child and raised by a family that was not her "real" family), by affecting her thinking and making her "paranoid".

Within this frame of reference, delusions and hallucinations are attributed (largely, although not necessarily entirely) to the effects of alcohol and drugs, rather than to characteristics of the person experiencing these phenomena. Alcohol and drugs are characterised as being capable of eliciting and exacerbating these kinds of phenomena in virtually anyone. It is these extraneous psychoactive substances that are held responsible, rather than anything intrinsic to individual persons. So, within this frame of reference, a person who experiences delusions and hallucinations need not necessarily be regarded as being pathological. This frame of reference may also offer some reassurance, as it appears to provide a fairly concrete explanation of phenomena that might otherwise be regarded as puzzling and/or frightening.

In the following extract, Hannah illustrates how certain frames of reference may seem to be more attractive than others:

Hannah: I had aliens crawling through my body and basically they were like little, almost like little semen really (laughs) like little zig-zags and they started at my head and moved all the way down my body, hundreds and hundreds and hundreds of them just moving all the way down my body, I could feel them moving down my body.... through my body.... like [they] entered through my head, at the top of my head and just moved their way down.

Hannah: The psychiatrist thought it was more like a sensory type reaction to the medication that I was on.... If that was sensory, that's fine (laughs), I'd rather have a sensory reaction than have aliens crawling through my body.
In this account, Hannah describes a sensation she experienced that, at the time, she thought was caused by aliens crawling through her body. When her psychiatrist later suggested that this may have been a sensory reaction to medication, she seized upon this alternative frame of reference. Characterising the experience as a sensory reaction to medication might be less frightening and may offer a more attractive position than construing the experience as an hallucination, a sign of madness, or as an encounter with alien beings.

Within the Psychoactive substances frame of reference, delusions and hallucinations appear to be rendered fairly predictable; the likelihood of a person experiencing delusions and hallucinations is related to her/his consumption of these substances. This frame of reference seems to offer relatively clear guidelines as to how such phenomena might be controlled (i.e., they may be avoided by minimising alcohol and drug intake, or elicited by excessive consumption of such substances). This way of making sense of delusions and hallucinations may have potentially positive implications for how people who experience these kinds of phenomena regard their future.

Biological frame of reference

Another frame of reference that participants appeared to draw upon in attempts to make sense of their experiences of delusions and hallucinations attributed these kinds of phenomena to biological factors such as genetics and hormones. For example, Emily (who had been assigned a diagnosis of schizophrenia) characterised her delusions and hallucinations as being signs of an illness that has been passed from generation to generation in her family:
Emily: I think that runs in my family, the mental illness.

Emily: Schizophrenia, part of it's hereditary.

Some participants suggested that genetic factors might predispose a person to experience delusions and hallucinations, but that this genetic vulnerability was triggered by life events that were characterised as stressful and/or traumatic (i.e., a diathesis-stress model). For instance, Lucy speculated that, in her family, there was:

Lucy: Possibly a genetic vulnerability that's triggered by trauma.

Presumably, this vulnerability comprised an inherited biological predisposition. Participants suggested that a range of different sorts of triggers (drawn from other frames of reference) might act upon this biological vulnerability:

June: I guess I had an illness. I had an illness and it was triggered off by, just triggered off by having the miscarriage, maybe coming off the marijuana.... and lack of sleep as well I guess.

By conceptualising delusions and hallucinations as part of an illness, and attributing them to biological factors beyond a person's direct control (such as genetics), people who experience these phenomena may be absolved of potential blame. However, while this frame of reference suggests that it is not a person's fault if s/he is genetically predisposed to experience delusions and hallucinations, there is also little that s/he can do to rectify this vulnerability. It implies that the
predisposition will be life-long, which has implications for how a person might view her/his future.

Participants also suggested that delusions and hallucinations might be regarded as consequences of surpassing the physical limits of the body (e.g., exhaustion associated with stress, working exceedingly long hours, and sleep deprivation). For example, Claire and Alice characterised exhaustion and lack of sleep as being causally-related to their experiences of delusions and hallucinations:

Claire: There was a lot of stress involved because where I was working and stuff.... I worked in a [firm] overseas and I was working long hours, like 60 hours a week on top of going out and drugs and stuff as well, so my system just collapsed, so that’s how I make sense of the whole thing. Sort of doing too much and sort of, now I sort of know my body’s limits a lot better now.

Alice: If you have long periods.... without sleep, I mean, it’s like mental torture and.... it brings it on as well.

According to Claire, her “system just collapsed” because she had surpassed her body’s limits. Alice’s comment, that sleep deprivation is “like mental torture” implies that being under physical strain affects a person’s mind. This way of making sense of delusions and hallucinations seems to suggest that these phenomena are more likely to occur when people have been rendered vulnerable, due to physical (and mental) exhaustion. This concept of “doing too much”, and overtaxing oneself in a physical sense, is similar to the notion that a person can only cope with a certain amount of emotional or psychological stress (encountered in the trauma/stress frame of reference). A notion of human limitation or frailty seems to underlie these ways of

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7 Recovery approaches (e.g., Deegan, 1988; Kruger, 2000) offer alternative illness models which aim to promote hope. They encourage people to accept and overcome the challenge of ‘mental illness’ (Deegan, 1988).
construing delusions and hallucinations, such that humans are understood as having only a limited capacity to deal with emotional, psychological, and physical stress and strain. This has implications for how people who experience delusions and hallucinations might position themselves (e.g., as being ‘only human’). It may remove potential blame, by constructing these phenomena as understandable, natural consequences of exhaustion, sleep deprivation, and physical strain. It may offer a more optimistic view of the future than is afforded when delusions and hallucinations are understood as arising from genetic factors.

Individual psychology frame of reference

Another frame of reference participants appeared to draw upon appealed to individual psychological characteristics in order to account for experiences of delusions and hallucinations. Within this frame of reference, some participants identified personal qualities, such as being “insecure” or as having “low self-esteem”, which they regarded as giving rise to some experiences of delusions and hallucinations. For example, one participant, who had believed that her husband was going to dispose of her and replace her with another woman, accounted for this belief by appealing to what she described as her own “insecurity”, while another, who heard voices saying unfavourable things about her and believed that strangers in public places were making malicious comments about her, attributed this to her “low self-esteem”.

Within this frame of reference, various thought processes (e.g., having a “vivid imagination”, or allowing the mind to “exaggerate” on things) were offered to account for delusions and hallucinations. It was suggested that cognitive errors - in other words, incorrect or unhelpful thoughts – were sometimes (at least partly)
responsible for these kinds of phenomena. For instance, Alice spoke about what she saw as the pitfalls of “thinking stupid thoughts”:

Alice: You can believe that somebody’s persecuting you, you can really believe that if you want to, if you want to look at it that way, which you can... then you get into that frame of mind [and] it actually gets bigger and bigger and bigger and that’s what I used to do.... Nowadays I try not to think ‘Who’s doing this to me? Who’s out to hurt me?’ I’m not gonna let that negative thought even enter my head ‘cause that’s when I have those feelings of persecution.... I was only digging my own hole.

Alice’s account suggests that people may choose whether or not to believe things (e.g., that people are persecuting them). This implies that delusions of persecution are amenable to conscious control; they can be avoided or eradicated by simply choosing not to look at things in a certain way.

The Individual Psychology frame of reference appears to assign responsibility to those experiencing delusions and hallucinations. Not only is it seen as possible to ward off/eliminate these kinds of phenomena, it is each person’s responsibility to do so. When this frame of reference is drawn upon, it may invite blame upon those who experience delusions and hallucinations, by suggesting that it is their own fault that they are not thinking and/or perceiving stimuli correctly (or that they have failed to live up to an ideal of selfhood entailing confidence and self-esteem). This has implications for how they may position themselves (and be positioned by others).

Discussion

Participants each appeared to draw upon several different (but often related and complementary) frames of reference when attempting to account for their
experiences of phenomena that might be characterised as delusions and hallucinations. These included Trauma/Stress, Spiritual/Religious, Psychoactive Substances, Biological, and Individual Psychology frames of reference. As noted above, each of these frames of reference has a range of potential implications.

Within the frame of reference that participants appeared to draw upon most commonly, experiences of delusions and hallucinations were contextualised within each woman’s broader life experience. These kinds of phenomena seemed to be construed as fairly understandable responses to life events and interpersonal relationships that were characterised as adverse and deleterious. Increasingly, in recent years, researchers have also been suggesting that delusions and hallucinations may be related to life events that are construed as traumatic (e.g., Heins et al., 1990; Read, 1997; Honig et al., 1998; Romme & Escher, 2000a; Barker et al., 2001; Read et al., 2001; Read, Agar, Argyle & Aderhold, 2003). Coleman (1999) claims that “when we go through a major trauma, and refuse to deal with it we cannot successfully suppress our emotions forever, there comes a point where it must be dealt with” (p. 57); in effect, ‘something has to give’.

Drawing upon the Trauma/Stress frame of reference may render the kinds of phenomena that might be regarded as delusions and hallucinations as less frightening, as they are depicted as understandable (and perhaps even natural or fairly predictable) responses to life events and circumstances that are particularly challenging. This way of making sense of delusions and hallucinations diverts attention from the individual person to her/his social context. “It is the [life] event[s] which [are] outside the bounds of the normal and not the person” (Blackman, 2001, p. 28). Within this frame of reference, some delusions and hallucinations might even be regarded as helpful, as they may constitute signals/warnings of heightened stress and/or may enable people to
make changes to their life circumstances that they may not have otherwise felt able to make (e.g., see Chapter 7).

Within the Spiritual/Religious frame of reference, participants appeared to make sense of the sorts of phenomena that might be characterised as delusions and hallucinations by appealing to spiritual/non-material dimensions of existence. For instance, some of these kinds of experiences were regarded as encounters with entities from a spiritual realm, rather than as being delusions or hallucinations (i.e., as symptoms of an illness, for example). This way of construing these kinds of experiences may enable a person to take up a position as someone possessing a special gift rather than as someone who is mentally ill or mad. Jackson and Fulford (1997) have reported that spiritual experiences may not only be viewed as non-pathological, but also as commonplace, and they may enrich a person’s life. Such experiences may be deliberately sought, and they may be regarded as assisting a person to live her/his life more satisfactorily (e.g., by providing guidance, warnings of potential danger, and so on). The Spiritual/Religious frame of reference may offer an explanation of experiences that might otherwise seem inexplicable, and may serve as confirmation of spiritual/religious beliefs. It may also be somewhat empowering in the sense that it prescribes certain kinds of actions a person may take in order to eliminate or enhance her/his sense of control over such phenomena. For example, those members of the HVN who regard voice-hearing as a gift may engage in various practices (such as meditation and visualisation techniques) to heighten (or attenuate) their sensitivity to spiritual phenomena (Blackman, 2000). However, it is possible that some phenomena construed as spiritual experiences might potentially be used to justify various forms of harm to self or others. In addition, some of these kinds of phenomena may be experienced as malign rather than benign. These sorts of
experiences might potentially be very frightening, if a person regarded her/himself as being threatened/overwhelmed by forces greater than her/himself.

Within the Psychoactive Substances frame of reference, phenomena that might be characterised as delusions and hallucinations were attributed to excessive intake of certain kinds of extraneous substances (i.e., alcohol and drugs), rather than to any intrinsic feature of the person experiencing them. As such, persons who experience delusions and hallucinations need not be positioned as having something wrong with(in) them. The phenomena are simply regarded as fairly predictable outcomes of excessive consumption of alcohol and drugs. This way of making sense of delusions and hallucinations has potentially positive implications for how a person may view her/his future, as it offers clear guidelines as to how such phenomena might be avoided (or elicited) in future.

Within the Biological frame of reference, delusions and hallucinations were characterised as being symptoms of an illness that is biological in origin (e.g., due to genetics). While this frame of reference may remove potential blame from those who experience delusions and hallucinations, there is (currently) little that can be done to rectify an inherited predisposition. It may therefore offer a position of relative passivity and powerlessness, and may have potentially unfavourable implications for how a person might regard her/his future (as the biological vulnerability is presumably lifelong). Making sense of delusions and hallucinations within a Biological frame of reference may invite interventions from mental health practitioners that are primarily medical (typically involving the use of psychotropic drugs), and de-emphasises the importance of other aspects of a person’s life (such as social, cultural, political and economic conditions) (Kitzinger & Perkins, 1993; Leudar & Thomas, 2000).
Within the Biological frame of reference, delusions and hallucinations were also regarded as being natural consequences of surpassing the physical limits of the body (e.g., physical - and mental - exhaustion associated with stress, working exceedingly long hours, and sleep deprivation). This is consistent with reports that sleep deprivation may give rise to phenomena that might be described as hallucinations (e.g., Watkins, 1998). This way of making sense of these sorts of experiences may offer a more optimistic view of the future than is afforded when these phenomena are understood as arising from genetic factors. It prescribes certain kinds of actions (e.g., ensuring that a person has sufficient sleep and rest), that do not necessarily legitimate or invite the input of mental health practitioners. By characterising delusions and hallucinations as the sorts of phenomena that anyone might experience when under significant physical stress and strain, it may position those who experience these phenomena as 'only human' (and not as pathological).

Within the Individual Psychology frame of reference, delusions and hallucinations were attributed to an individual’s own psychological characteristics (e.g., insecurity or low self-esteem) and/or thought processes (e.g., making cognitive errors, allowing a vivid imagination to run wild, and so on). This way of making sense of delusions and hallucinations assigns responsibility to those experiencing them. This frame of reference promotes the notion that a person can have some agency and control over delusions and hallucinations, thereby having the potential to be blaming as well as empowering. As Gagg (2000) has noted, it may be demoralising for people to continue to be troubled by delusions and hallucinations despite trying to follow the advice of mental health practitioners.

The frames of reference discussed in this chapter illustrate diversity in the ways in which we may construe the sorts of phenomena that might be characterised as
delusions and hallucinations. Participants demonstrated multiple ways of making sense of these phenomena, and some of these might be regarded as positive/protective ways of framing their experiences. For instance, regarding oneself as having a special gift or as having an understandable reaction to adverse life events may have preferable consequences to believing oneself to have a mental illness. As the ontology of these phenomena is unknown (and, arguably, unknowable), their nature and meaning may be contested. A person may experience them differently (e.g., as positive or negative) according to the frames of reference s/he draws upon to make sense of them (Blackman, 2000). Identifying multiple frames of reference attests to the existence of diverse resources people may utilise, which has significance for the potential to change. If there had seemed to be no alternative frames of reference, it would be likely to make it very difficult to conceptualise how change might occur.

The question remains, however, as to how we might 'choose' between competing frames of reference. Is one way of making sense of the kinds of phenomena that might be characterised as delusions and hallucinations as good, or as valid, as any other? At the beginning of this chapter, I endorsed a pragmatic stance, which involved evaluating the potential implications of various ways of conceptualising these sorts of phenomena, in order to choose between them. Yet, not all frames of reference are equally available (to all persons, and in all circumstances). Also, the phenomena themselves may not always be the same kinds of phenomena, and so may not be equally open to various ways of construing them. Furthermore, who would be the arbiter to determine which frame of reference would be the most favourable?

Perhaps, rather than being limited to just one account of these kinds of phenomena, it might be preferable to entertain several competing (yet not necessarily
incompatible) frames of reference. I would argue that it would be beneficial for coexisting frames of reference to be subject to frequent questioning, in order to explore whose interests may be served by each way of making sense of delusions and hallucinations.

Gagg (2000) suggests that "freeing the imaginations" (p. 165) of persons who experience phenomena that might be characterised as delusions and hallucinations is far more desirable than merely promoting their compliance with the directives of mental health practitioners. Like the HVN (e.g., Coleman & Smith, 1997), she regards the process of each person making sense of her/his experiences in her/his own way(s) as markedly preferable to simply promoting insight (that is, adherence to the dominant (Biomedical) way of construing these phenomena).

Some readers may raise concern that this might lead to potentially serious implications (e.g., involving the risk of violence). However, there is no a priori reason to assume that people who draw upon a Spiritual/Religious frame of reference (e.g., believing that they are receiving instructions from demons), for instance, would offer any more threats to safety than people who adhere to a Biomedical frame of reference (e.g., regarding themselves as exempt from the consequences of their actions due to their illness). Along with others (e.g., Clarke, 1998; Romme & Escher, 2000a), Coleman (2002) claims that it is crucial for people to be able to explore and discuss their own understandings of their experiences of the kinds of phenomena that might be regarded as delusions and hallucinations:

Many people can actually understand why they hear voices but they're never given the opportunity to really talk about that.... For me, understanding my experience was much more important than any medication (Coleman, 2002).
This view has implications for clinical practice. It encourages mental health practitioners to enter into discussions with their clients of the diverse ways in which delusions and hallucinations may be construed. It also encourages acceptance of the notion “that there might be different realities for different people” (Romme & Escher, 2000a, p. 14).

**Summary and conclusions**

In this chapter, I have described five main competing (although closely-related and often complementary) frames of reference from participants’ accounts of their experiences of phenomena that might be described as delusions and hallucinations. Each of these frames of reference comprised a framework within which to attempt to make sense of these sorts of phenomena, entailing attributions about their causes. By describing several different frames of reference – Trauma/Stress, Spiritual/Religious, Psychoactive Substances, Biological and Individual Psychology – I have sought to illustrate diversity in the ways in which these kinds of experiences may be conceptualised. This is significant given claims that a person may experience these phenomena in various different ways depending upon how s/he construes them (Blackman, 2000).

I would argue that as there is no one correct way of making sense of the sorts of phenomena that might be described as delusions and hallucinations, it is necessary to question the implications of each frame of reference, to determine how enabling/helpful it may be. Rather than settling upon only one way of framing these kinds of phenomena, we might tentatively consider entertaining a number of competing (yet not necessarily incompatible) frames of reference. This
ambiguity/uncertainty over just how to construe these phenomena is likely to serve as a valuable reminder that all ways of making sense of these kinds of experiences are contingent and open to re-interpretation. This may open up opportunities for people who experience delusions and hallucinations to understand them in ways that best enable them to live their lives in ways that they regard as satisfactory.

In the next chapter, I illustrate some of the challenges to orthodox ways of conceptualising delusions and hallucinations by focusing, in particular, on the accounts of two of the women I interviewed. Their accounts show that, contrary to conventional understandings, delusions and hallucinations are not necessarily experienced as meaningless, distressing and harmful.
7: Illustrating challenges to conventional ways of construing delusions and hallucinations

Like many others who work in the mental health field I had long believed that hearing voices must invariably be a frightening, disturbing and essentially negative experience. This is certainly what I had been taught. I also imagined that most people who hear voices would be desperate to get rid of them,... many mental health professionals are quite oblivious to the fact that human beings generally – including some who have [been diagnosed as having] a psychiatric disorder – are capable of having voice experiences which are positive and beneficial (Watkins, 1998, p. 263).

As Watkins (1998) points out, experiences of delusions and hallucinations do not necessarily conform to conventional understandings of these phenomena. As I have noted throughout this thesis, although delusions and hallucinations are typically construed in contemporary Western societies as being meaningless phenomena to be eliminated and/or ignored, and as being almost invariably distressing and harmful, such conceptualisations are increasingly being challenged. One such challenge comes from an Australian discussion group established by Michael White (a psychologist working within the narrative therapy framework) (e.g., see White & Epston, 1990; White, 1995; Drewery & Winslade, 1997), for women who are/have been clients of community mental health (CMH) services (Brigitte et al., 1998). Most of the group members have, at some time, been assigned a diagnosis of schizophrenia. The women describe the group, entitled Power to Our Journeys, as follows:

We get together as a group once per month, and invite Michael White to join us to keep a special record of our conversation and to ask questions that assist us to express our thoughts on various issues. After each of these meetings, Michael puts together our ideas in a document which serves as a record of our evolving knowledge (Brigitte et al., 1998, p. 203-204).
The women of the Power to Our Journeys group contest the assumption that the sorts of phenomena that may be characterised as delusions and hallucinations are necessarily experienced as distressing and harmful. Indeed, they describe some of their experiences of voices and visions as "helpful" and "supportive":

Over the many years of our different connections with psychiatric services, we have found little opportunity to speak openly of our day-to-day experiences of the voices and visions that have been so troublesome to us, or, for that matter, the voices and visions that have been helpful to our lives. We have been silenced time and again by many psychiatric professionals who have consistently refused to acknowledge our experiences of these voices and visions. At times we have been bewildered by this, at a loss to understand it. At times we have linked this silencing to the fear we see in the eyes of others. Perhaps they experience this fear because we put them in touch with how vulnerable they might be in their own struggles in life, and with a realisation of how thin the line is between where they stand in life and where we stand in life. At other times we understand that others believe that to make space for us to talk more openly about our experiences of troublesome voices and visions is counterproductive. We know that still others are caught up in weird theories about our experiences, and talk about our lives in ways that subtract from our sense of self-respect and make it impossible for them to hear what we have to say about our experiences of voices and visions... Needless to say, this silencing has profoundly negative consequences for all of our lives. All of us have felt abandoned because of this. We have not felt joined with by others at those times in our lives when this was what we have longed for most. At times this very silencing contributed to a sense that we might be going mad. And it has made it virtually impossible for us to change our relationship with the troublesome voices and visions that have been so dominating of our lives, and, as well, with the voices and visions that have been supportive of us (Brigitte et al., 1998, p. 204-205).

According to the members of the Power to our Journeys group (Brigitte et al., 1998), it may be the failure of some mental health practitioners to "make space" for clients to talk about delusions and hallucinations that gives rise to harm and distress in those experiencing them. Watkins (1998) also reports that "people who hear voices are often given little opportunity to discuss their experiences in detail with the mental health professionals who are responsible for providing care and treatment" (p. 272). The failure of mental health practitioners to attend to the content of their clients’
delusions and hallucinations may have potentially negative implications, as Blackman (2001) points out:

Within modern psychiatric discourse, a particular relation is engendered towards the voices or visions, where the voice-hearer is required to deny their existence and view them as meaningless epiphenomena, having no other function than as signifiers of disease and illness. One of the maxims operating within psychiatric practice, congruent with this mode of denial, is that talking to voice-hearers about their experiences will make them even more confused, and reinforce a reality which is the result of a diseased and troubled mind.... this relation to the voices has certain consequences for the way the voices are embodied or lived by the voice-hearer, creating feelings of shame, fear, guilt, anxiety, terror and confusion (Blackman, 2001, p. 187, italics in original).

Hassett (1998) encourages clinicians to engage with clients around the content of their delusions and hallucinations, pointing out that such phenomena may be fulfilling particular functions in people’s lives. As an example, she relates the story of “Miss S”, a 74-year-old woman whose “life was bereft of any interpersonal closeness” (Hassett, 1998, p. 310). Miss S believed that a plumber who had come to her house to carry out some work had subsequently become romantically/sexually attracted to her, and had since been living in her roof, watching her and listening to her continuously. This story highlights the potential for delusions and hallucinations to serve a function, such as filling a void, or providing a sense of meaning, in a person’s life (Hassett, 1998). It stands in contrast to notions that delusions and hallucinations are necessarily meaningless and distressing.

In this chapter, I illustrate some of the challenges to conventional ways of understanding delusions and hallucinations by detailing the accounts of two of the women I interviewed1 who have experienced the sorts of phenomena that might be characterised as delusions and hallucinations. Extracts from the accounts of a further

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1 See Chapter 2 for details of the research methodology.
three women are also discussed, albeit more briefly. I have chosen these examples specifically because they contravene the assumption that these sorts of phenomena ought to be construed as meaningless and the view that they are almost inevitably distressing and harmful. While not intending to deny that delusions and hallucinations are frequently experienced as distressing, I am proposing that it need not be taken for granted that these sorts of phenomena are always experienced in this way. I do not wish to argue that the sorts of phenomena that may be characterised as delusions and hallucinations ought to be construed in any particular way. I merely aim to further illustrate the need to open up a wider range of ways of construing and talking about these sorts of experiences.

**Accounts of delusions and hallucinations that challenge conventional understandings of these phenomena**

The descriptions and analyses that follow are based primarily on interviews with two women. In addition, there is a briefer discussion of extracts from three of the other participants. By the time they were interviewed, the two women whose accounts are summarised in this chapter had both been discharged from CMH services; they no longer experienced phenomena that might be regarded as delusions or hallucinations. The other three women, whose accounts are discussed more briefly, had not yet been discharged from CMH services by the time they were interviewed. These three women reported that they were still occasionally experiencing phenomena that might be regarded as delusions and hallucinations.

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2 I make no claims regarding whether these particular accounts are representative in any way of those in the wider population who experience delusions and hallucinations.
The particular accounts detailed in this chapter were chosen specifically because they appeared to provide the strongest counter-examples to the conventional notion of delusions and hallucinations as being meaningless phenomena to be eliminated and/or ignored, and as being almost invariably harmful and distressing to the person experiencing them. The accounts of the other six women interviewed in the study varied in terms of the degree to which they were consistent with conventional ways of thinking about delusions and hallucinations. However, in general, these accounts were largely consistent with the notion of delusions and hallucinations as being distressing and harmful.

The two stories presented in this chapter are summarised versions of participants’ accounts. They have been simplified (by omitting some of the details) for the sake of brevity, but adhere as closely as possible to participants’ actual accounts of their experiences. Although the stories have been edited in such a way as to address the specific aims of this chapter (that is, to establish instances of hallucinations and delusions in which these phenomena are not construed in negative terms, etc), every attempt has been made to ensure that they are congruent with participants’ accounts. The brief discussion of extracts from three of the other participants provides only a selected glimpse of their accounts of their experiences. The material discussed from these three participants was chosen, again, specifically to address the aims of the chapter.

**Summary of Anna’s account**

At the time of the interview, Anna was 23 years old. She told me that, approximately one year earlier, she had begun hearing a voice. She heard the voice, on average, about twice a week, over a two to three month period. Anna stated that
this was during a time when she was using cannabis fairly regularly. The voice appeared to speak to her from outside her bedroom at night. She was then living with a boyfriend, and the voice she heard seemed to belong to another young man she had also become romantically involved with around that time. She said that she was “pretty in love with this [other] guy” even though she was still living with her boyfriend.

Anna reported that, early on, her relationship with her boyfriend had deteriorated. She said that he “was quite heavily into alcohol and drugs”. Within a few months of entering into the relationship, Anna noted, she had begun to feel “frightened” of her boyfriend:

Anna: I felt like I was being controlled and manipulated [by my boyfriend] and I was really unhappy and I was frightened of him.... it was a pretty rocky relationship.... he had a very violent, explosive temper and would make general threats towards not necessarily me but other people that I knew and... things to do with general situations which I sort of found myself in (laughs) yeah, hard to explain. He used to have a violent temper and punched a hole in the wall on one occasion, kept guns and knives and things in the house and talked about how he was gonna kill people and things (laughs)

Yasmin: Did you think he was capable of that?
Anna: Yes, I did. I think I probably still do actually (laughs) yeah.

Anna characterised this period of her life as a “very unhappy time”. It was after she had been in this relationship for about nine months that she began to hear the voice. She said that this was “probably about the time when things started to get particularly bad and when I started to get particularly unhappy”.

Anna: [The voice said] things like... that he was in love with me and wanted to be with me.

Anna: [The sorts of things the voice said] definitely fitted with how I was feeling at that time... perhaps now I sort of think that my subconscious mind.... was almost trying to tell me through that sort of... medium, I guess.... [The voice was] basically just
telling me that I was in a bad situation and that I should just leave and you know, go live with him (laughs), pretty much just what I wanted to hear.

Anna stated that she had attempted to leave her boyfriend on a number of occasions; she had packed her belongings into her car, only to eventually bring them back into the house again. Anna said that she found that she “couldn’t just up and leave”, partly attributing this to difficulties she had experienced when ending previous relationships. For instance, Anna reported that her first boyfriend had threatened that he would commit suicide if she left him. According to Anna, she had “had quite a pattern of... bad relationships”, and this made it more difficult for her to extricate herself from this most recent relationship. Anna characterised the things that the voice said as (in some way) enabling her to eventually leave her boyfriend:

Anna: [Hearing the voice] gave me something to hang on for, some sort of hope for the future when I really didn’t have any at that point (laughs) yeah, things were really quite bad and sometimes I think you need to believe that there’s something to continue on for, just so that you can and I mean that it’s not necessarily that things are going to end up that way but it’s just that that’s another way that things can be, yeah.

Yasmin: So it opens up some possibilities for you?
Anna: Yeah, it opens up a whole new world.

This is not to say that Anna reported her experience of hearing the voice as being entirely positive. Even though she said that the messages the voice had conveyed to her were generally “romantic” and “comforting”, she described the voice-hearing experience itself as frightening. Anna seemed to regard the hearing of voices as being associated with madness:

Anna: It was pretty scary [to be hearing a voice] (laughs), I thought I was going insane.... I thought I was losing my mind.
Anna consulted her general practitioner, who prescribed her antidepressants and referred her to the local CMH service. Anna reported that her contact with this service was helpful, as she found that voice-hearing was more common than she had previously thought, and this lessened her fear that she might be losing her mind. Anna expressed the view that it is important for mental health practitioners to ask about what a voice has been saying, in order to facilitate understanding:

Anna: [The things the voice said] related to things that were happening at the time.... perhaps that was driven by my real experience.

Looking back, Anna characterised her voice-hearing experience as something that happened “for a reason”, namely to enable her to leave a situation she had come to regard as detrimental to her.

Anna: [I have learned] to never get back into that situation again (laughs). I think I’ve learned quite a few things.... I think that I’m a lot more wary now about relationships than I was before.... how I approach them, how I get into them and why I get into them (laughs).

Throughout Anna’s account, she appeared to draw upon various coexisting ways of making sense of her voice-hearing experience. For example, she characterised her experience of hearing the voice as being: drug-induced; a reflection of her “vivid imagination”; a sign of insanity; the provision of comfort and support during a difficult time; a “delusion”; messages from her subconscious mind; a guide to decision making; encouragement to leave an adverse situation; and as something that happened for a reason:
Anna: I think the voice that I was hearing and the things it said to me were something that I needed at the time just to help me through a rough period in my life.

Anna: Sometimes you need... something pretty major to make you realise that you do need to change.

Anna’s narrative provides a counter-example to the conventional way of conceptualising what might be termed verbal auditory hallucinations. The things the voice said did not appear to be meaningless to Anna, as she reported that they were directly related to life circumstances in which she found herself at that time. Anna suggested that her experience of hearing the voice enabled her to leave a relationship that she regarded as being detrimental to her (e.g., by telling her that she should leave the relationship and by giving her some “hope for the future”), and from which she had previously found it difficult to extricate herself. In this sense, she indicated that the implications of hearing the voice might be regarded as helpful rather than harmful. Although the mere presence of the voice appeared to make Anna question her own sanity (which she experienced as distressing), in general, she said that she experienced the voice as “comforting”.

Anna reported that the mental health practitioners she consulted asked her specifically about what the voice had been saying, and related this content directly to her life circumstances. She said that the clinicians also alleviated her fears that she may have been losing her mind, by characterising voice-hearing as being quite common. How might the implications of hearing the voice have varied for Anna, had the mental health practitioners simply prescribed her psychotropic medication, and advised her to ignore the voice she heard?

Anna reported that after she finally left her boyfriend, she ceased hearing the voice, and has not heard any subsequent voices, or experienced any other phenomena
that might be characterised as delusions or hallucinations. She described her voice-hearing experience as something that "definitely served its purpose" insofar as she construes it as having enabled her to make positive changes to her life.

**Summary of Emily's account**

Emily was 32 years old at the time of the interview. She stated that, seven years earlier, she had begun believing that psychologists were observing her via electronic surveillance, and two years after that she began to hear voices. Emily said that she was experiencing difficulties in her job when she first began to feel convinced that psychologists were watching her:

Emily: I think I just started thinking (cough) that there was something wrong with me. I think now it was probably just [that] I lacked self-confidence at the school that I was working at, and I was.... scared to use a firm voice with children in front of the teachers, and I couldn’t remember things and I thought ‘Oh God, there’s something wrong with me’ (laughs).... and then I thought that [the teachers] started to talk to psychologists (laughs) and then I thought the... psychologists thought ‘Oh, we should observe her behaviour without her knowing’.

Emily: I started thinking there were video cameras in the room, and after school, when all of the teachers were out of the room, I’d be looking for hidden video cameras (laughs) and *microphones* too.... I thought it was just in the school.... it wasn’t until I lost my job that I started thinking oh, they’ve put them in my home.

As well as having faced difficulties at work, Emily also reported that things were "really stressful" at home. Emily and her husband, John, had been living with his parents for several years, which Emily said she had been finding challenging. She reported that she was also being subjected to sexual abuse in her marriage:

Emily: I think too it might have been from how John treated me, from when he raped me and things like that... and I never went down without a fight and that’s what made it worse ‘cause you know if I’d just laid down and taken it, it would’ve been a lot easier but I wouldn’t, I *fought* all the time, kicked, pinched him.
According to Emily, John had treated her in this way since before they were even married:

Emily: But I was too insecure to leave, I didn’t wanna leave him (laughs) no, I loved him too, that was another reason why I didn’t leave him.... I had low self-esteem and everything, so I thought I wouldn’t find another [partner], so I put up with it and then got married [to him].

Emily reported that she did not experience any distress at the thought that psychologists might be observing her, to determine what was “wrong” with her:

Emily said that when she began to hear voices, she regarded this as confirmation that psychologists had indeed been observing her.

Emily reported hearing three distinct voices – a young female voice, a young male voice, and an older male voice. As Emily stated, she experienced hearing the voices as pleasant, as they tended to say positive things about her. She came to regard the older male voice as being “like a father figure”, saying that he was her “favourite because he was the one [who] said the nicest things”.

Emily: [My family] was a dysfunctional family and.... maybe I just didn’t get the emotional needs [met], and so when I heard these voices it was almost like getting the emotional needs met.... They were making me feel really nice inside, making me feel special.

3 Emily said that she suspected that she might be “autistic”, and reported hearing the voices debate whether she was “autistic” or “schizophrenic”.
Emily: I just felt wanted and needed and loved.... what I thought [was].... oh gosh, someone cares enough about me (laughs).

Emily noted that she gradually became attracted to the young male voice, who gave her compliments such as, “You’re beautiful”:

Emily: I did sort of... like... the... young male voice.... I thought he was gonna be really nice looking.

Emily said that one night, after hearing the voices for several months, she heard the young male voice call her “a stupid idiot”:

Emily: And then the young female voice went “Oh, I thought you loved her”, and he said, “Nah, she’s too stupid for me, eh”, and then that was it.... I was angry that he had said to this voice that I was a stupid idiot.... and then of course the moment he said it John had just walked up the stairs.... and I just said to John, “Who is observing me, you know, I want to know now”.... He burst out laughing and said... there was no one observing me.

Emily said that she invited the voices to meet with her, to talk things through, but eventually realised that they would not turn up. Her attempts to locate the people to whom the voices belonged were fruitless, which she characterised as very frustrating.

Emily stated that she eventually decided to leave her husband and go to live with her parents:

Emily: It was just a spur of the moment thing, I didn’t even really think about it, and... I got all my clothes out of the wardrobe.... all the stuff that I could take, I put it in my car, turned up at my parents’ doorstep and said, “I’m coming here to live”.

Emily noted that she eventually decided to leave her husband and go to live with her parents:
Emily said that she consulted her general practitioner, following her father’s advice. She told her doctor, “This is gonna sound really crazy, but I’m hearing voices”. She was referred to the local CMH centre, where she was seen by a psychiatrist and prescribed antipsychotic medication:

Emily: It took about four or five weeks [after beginning to take the medication] for the voices to go, but they went dimmer and dimmer. Now I was getting really annoyed because then I couldn’t hear what they were saying.... and then they just went away, yeah. In some ways it was a relief.... before [she “confronted” the voices following the incident in which the young male voice called her “a stupid idiot”] it wasn’t 24 hours a day and you could put up with it, once it was 24 hours a day it was just... it gets on your wick (both laugh).

Emily reported experiencing a sense of loss once the voices disappeared:

Yasmin: What was it like when the voices actually went away? How was that?
Emily: Oh, it was terrible. I really missed them, like even though I knew and understood that they weren’t real it was still horrible because it’s like a real emptiness and all of a sudden when I’d been hearing these voices more like company, all of a sudden they just, you know, gradually they just went away.

Emily described the mental health practitioners she encountered at the CMH centre as being “really good”. She reported that their input was helpful, and that she particularly enjoyed attending weekly outings with the social group (for clients of the CMH service) which was run by an occupational therapist and a family worker.

Emily said that she was not certain whether the mental health practitioners had asked her specifically about what the voices were saying, but she indicated that she regarded this information as being important in facilitating their understanding:

Emily: I think I’d rather they did ask me what the voices were saying ‘cause then I’d know that at least they sort of were interested in what I had to say.... I think it would.... make them really understand where we’re coming from.
Emily stated that she lived on her own for a couple of years after leaving her husband (and while still being involved with CMH services). She reported that ever since she had been assigned a diagnosis of schizophrenia, John had stopped sexually assaulting her:

Emily: It was only when I was diagnosed with schizophrenia that he stopped [raping me].... and he said to me, “Oh, I feel so guilty, I feel that what I’ve done has caused your schizophrenia”.... I felt sad for him really. I said to him, “Schizophrenia, part of it’s hereditary anyway, it’s not, I don’t think it’s the whole cause of it”.

At the time of the interview Emily was living with John again. However, she said that she was not sure that they have a future together, and are now “just more [like] friends than husband and wife”.

Emily suggested that her experience of believing that she was being observed by psychologists and hearing voices may have provided something “positive” in her life at a time when she particularly needed it:

Emily: Things that happened, especially in my adult [life], were very negative, so when the voices came it was almost... [the] extreme opposite, it was something really positive.

Emily: Maybe it’s what I needed to hear at the time, I don’t know.

She reported that she no longer believes that she is under surveillance or hears any voices.

In her account of her experience of hearing voices and believing that she was being observed, Emily appeared to characterise these phenomena in various different ways, such as: signs that she was “special”; “delusions” and “hallucinations”; phenomena that were “really positive”; confirmation that there was “something wrong” with her; pleasant “company”; ways of providing a sense of “security”; signs
that she was “crazy”; means of meeting various “emotional needs”; things that were “not real”; objects of affection; hereditary symptoms; and phenomena that are associated with “abuse”.

Like Anna, Emily provides an account that serves as a counter-example to the conventional way of conceptualising delusions and hallucinations. The particular beliefs that Emily had, and the things the voices said to her, did not appear to be random or meaningless to her; she noted that they related to experiences she had had in her life, and her underlying feeling that there was something wrong with her. Rather than regarding them as distressing, Emily described the voices and the notion of being observed as pleasant. Emily suggested that her experience of hearing voices and believing she was under surveillance may have contributed to the loss of her job. In this way, she characterised her experience of these phenomena as being somewhat harmful. However, she also suggested that due to these experiences, and her subsequent diagnosis of schizophrenia, her husband finally stopped sexually assaulting her. She regarded this as being one of the positive implications of her experience of hearing voices and believing she was being observed. Like Anna, Emily claimed that it is important for mental health practitioners to attend to what a person’s specific beliefs are, and to what voices actually say.

**Further challenges to conventional understandings of delusions and hallucinations from the accounts of three other participants**

The accounts of Anna and Emily provided the strongest illustrations of challenges to conventional ways of construing delusions and hallucinations.

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4 It may well have been relevant for mental health practitioners involved with Emily to be aware that she had believed that psychologists had been observing her, to assist them in their therapeutic work with her.
However, the accounts of some of the other participants in the interview study can also be read as posing challenges to orthodox understandings of these phenomena. They can be regarded as causing some doubt over whether delusions and hallucinations ought to be construed as meaningless and whether they are necessarily harmful and distressing to those experiencing them. For instance, Claire (who was 27 years old at the time of the interview) characterised her experience of hearing voices and believing that she “knew other people’s thoughts” as having sometimes enabled her to work through issues related to life events:

Claire: The majority was all linked to my life history and it was all linked to previous relationships or previous things that I’ve done.... Sometimes it helped me deal with things that had happened to me or what was happening but yeah it was all life-experience related, like in family, mainly family relationships.

Claire appeared to construe her experiences of hearing voices and believing that she could read other people’s minds as having been at least partially beneficial to her, in the sense that these experiences enabled her to address issues of personal relevance. Claire reported that she heard several distinct voices including family members, her partner, her CMH nurse, and two other voices which she named “the helper” and “the demon”. She characterised “the helper” in positive terms:

Claire: I named the helper helpful because all the time that was helpful.

Claire: The helper.... gave me sort of advice and made sense sort of to me.

This illustrates that not all voices are (necessarily) construed as being harmful or distressing, even if the person also hears other voices that are construed in those terms. Claire’s claim, that the things “the helper” said “made sense” to her, challenges the notion that the content of hallucinations is essentially meaningless.
Claire said that when she first began to experience the sorts of phenomena that might be characterised as delusions and hallucinations, she was alone on an overseas holiday. In her account, Claire described a “spiritual” encounter she experienced during this period of time:

Claire: My grandfather walked up towards me and shook my hand and said something to me, but I can’t remember what exactly, but I knew that he knew who I was, and I smiled. It was a very nice meeting and then he walked off and I watched him walk up the road and then I turned again and then he just sort of disappeared and I, at the time, I didn’t think anything of it, I just thought, oh, this is a nice meeting.... I just see it as they’re watching out for us, watching over us, ‘cause.... I don’t know if I mentioned my grandfather passed away [several years earlier] and I guess I don’t know, I just see it as a nice “hello” and I was just being looked after because I was on my own and I think I was just being looked after when I needed some help (laughs).

Claire characterised this experience as being pleasant and reassuring, at a time when she particularly needed some assistance. Claire’s account illustrates that delusions and hallucinations may be regarded as being (at least partially) meaningful, enabling, and pleasant.

Iris (who was aged 42 at the time of the interview) described having a range of experiences that might be characterised as delusions (e.g., “sometimes I think yeah people are doing things to me, they’re trying to harm me and they’re not”) and hallucinations (e.g., hearing voices calling her names). Her account included descriptions of numerous experiences that she termed “spiritual” (involving seeing and hearing “spirits”, knowing that “something was gonna happen and then it would happen”, and so on). Iris said that, following an incident in which she “read another person’s mind”, she had been told that she has “a gift”. She reported that, at times, this “gift” has helped to keep her safe:
Iris: It’s an extra sense... I think it was there for a safeguard when I was little and that and yeah it developed. It’s just a safeguard thing, because I got a lot of warnings too... sometimes warnings about things and people.... I didn’t really understand them, but now I’m starting to understand that they are warnings, as soon as I start seeing things around people it’s a warning, ‘Be careful’ (laughs).

Iris construed these sorts of phenomena as valid “warnings” assisting her to avoid potential harm. In this way, she appeared to regard them as serving a useful function and being helpful to her.

Sophie (who was 42 years of age at the time of the interview) described experiences involving believing that she was having an intimate relationship with her pastor and hearing his voice (in addition to hearing numerous other voices also). She characterised the relationships she had had with men previously in her life as being unsatisfying. She said that she was drawn to her pastor because he appeared to have more “depth” than any of her boyfriends had appeared to have had:

Sophie: One boyfriend, he went off and got another girlfriend behind my back... ‘cause she had bigger breasts (both laugh)... there was no depth to our relationship anyway, no personal depth, so I thought maybe it was just a sexual thing anyway...[the pastor] was very... good at explaining life and the way we think and he was a great philosopher.... he was the only man I ever related to.... He [had] more depth, so that’s why I fell in love with him.

Sophie: I loved to listen to my pastor, so I developed a love relationship from the audience.

According to Sophie, she became “deluded because of [her] passion.... [for] the relationship that [she] wanted”. She reported that she believed that she was conducting an intimate relationship with the pastor “in the spirit” realm. Sophie said, “Looking back, I think no, that was just the make-believe story”. Nonetheless:

Sophie: At the time [when I hear the pastor’s voice] it’s quite a nice thing, it sort of keeps me company and gives me a nice feeling so I feel happy about that for the rest of the day, and it puts me in a good mood.
Sophie said that although her romance with the pastor was only "make-believe", at times, it still made her feel "nice" and "happy". She stated that she regarded the pastor's voice as providing company, and in some ways compensating for previous, unsatisfying relationships with men. Although Sophie also spoke about other experiences of delusions and hallucinations which she characterised as being very distressing (such as hearing the voices of "demons"), she did appear to construe some of these sorts of experiences (i.e., those in which she seemed to be having an intimate relationship with the pastor) as having been pleasant.

The extracts from Claire, Iris and Sophie further illustrate some of the challenges to conventional notions of delusions and hallucinations as being meaningless phenomena to be eliminated and/or ignored, and as almost invariably being distressing and harmful to those experiencing them. While the accounts of these three participants did not provide unambiguous challenges to the orthodox view of these phenomena, they did illustrate that even though a person may regard some (even most) of their delusions and hallucinations as distressing and harmful, it is not inevitable that all such phenomena will be characterised in this way. Even amidst a range of experiences in which some are described in very negative terms, others may be characterised as beneficial, pleasant and offering assistance.

Summary

The two summarised accounts presented in this chapter, and the brief discussion of the accounts of three of the other women I interviewed, illustrate some of the challenges to the conventional view of delusions and hallucinations as being meaningless phenomena to be eliminated and/or ignored, and as almost invariably distressing and harmful to those experiencing them. Each of the participants
described and accounted for their experiences of these kinds of phenomena in diverse ways.

None of the women cited in this chapter characterised the content of their delusions and hallucinations as meaningless. For instance, Anna and Emily spoke about the content as being meaningful for them within the broader context of their lives. Indeed, their descriptions of their experiences of delusions and hallucinations were firmly situated within the context of their life events and life circumstances. It might perhaps be unsurprising for people who are still experiencing delusions and hallucinations to regard these phenomena as meaningful. Yet, Anna and Emily indicated that they regarded the content of their delusions and hallucinations as being meaningful, even though they were at a point where they were no longer experiencing these sorts of phenomena. Romme and Escher (2000a) claim that what voices say is “always highly pertinent to the hearers” (p. 33). Rather than advocating that delusions and hallucinations ought to be eliminated and/or ignored, Anna and Emily spoke about the content of these as being something to which mental health practitioners ought to attend.

As Blackman (2002) argues, phenomena such as hearing voices or seeing visions may be experienced in very different ways depending upon the discourses that are deployed. An experience of voice-hearing may be interpreted as a sign of mental illness, or perhaps as a message from the dead, depending on whichever interpretative repertoire is drawn upon. In line with this argument, the degree to which a person experiences delusions and hallucinations as distressing will vary according to how s/he makes sense of them. Reports from Romme and Escher (2000a, 2000b) suggest that a person may construe voice-hearing experiences as positive, irrespective of the specific content of these phenomena.
Each of the women cited in this chapter, including Anna and Emily, described their experience of delusions and hallucinations as being negative in some ways (e.g., Anna indicated that she felt frightened because she associated voice-hearing with madness, and Emily said that the voices became annoying once she began hearing them “24 hours a day”) yet they also appeared to construe their delusions and hallucinations as having been positive in various ways. For instance, Anna and Emily described their voices (and the things the voices said) as being generally comforting and pleasant. These two women appeared to construe their delusions and hallucinations as having been purposeful insofar as they characterised them as having helped to bring about (what they described as) favourable changes in their lives. Similarly, a recent study in which eight people (two women and six men) who had been assigned a diagnosis of schizophrenia were interviewed, reported that “all clients mentioned that their ‘illness’ experiences had been beneficial in some ways” (Barker et al., 2001, p. 207). In particular, they suggested that their experiences of delusions and hallucinations had enabled them to develop their own identities as individuals and become “more ‘themselves’” (Barker et al., 2001, p. 207).

I do not wish to romanticise delusions and hallucinations, as I acknowledge that the majority of the participants in this study did characterise their experiences of these kinds of phenomena in negative terms (most commonly as frightening). However, the accounts of the women cited in this chapter, particularly those of Anna and Emily, show that we need not necessarily adhere to the assumption that delusions and hallucinations are meaningless or that they are almost invariably distressing and harmful to those experiencing them. In the following section, I outline some approaches aimed at rethinking the meaning of delusions and hallucinations, including particular techniques such as normalising and focusing, and support groups such as
the Hearing Voices Network (HVN) (e.g., Coleman & Smith, 1997; Coleman, 1999) and the Power to our Journeys group (Brigette et al., 1998).

Some possible approaches to rethinking the meaning of delusions and hallucinations

As discussed in Chapter 5, House (2001) argues that much of the distress and fear that people may experience in relation to delusions and hallucinations arises due to a perceived mismatch between their own self-experience and what they conceptualise normality to be. "The persistent but erroneous belief that 'normal' people never have such experiences contributes significantly to this fear" (Watkins, 1998, p. 230, emphasis in original). If a person construes the kinds of phenomena that might be characterised as delusions and hallucinations as signs of serious, incurable, mental illness, then this is likely to invite feelings of distress (Romme & Escher, 2000a). It is not inevitable, however, for such phenomena to be construed in this way. Watkins (1998) claims that "if an attitude of non-judgemental and tolerant acceptance is adopted by voice hearers and others — including any mental health professionals who may be involved — sometimes even quite frightening experiences may be remarkably transformed" (p. 231-232).

A strategy known as normalising may assist persons who experience delusions and hallucinations to construe such phenomena in ways that are less likely to invite feelings of distress (Kingdon & Turkington, 1994; Morrison, 2004). Normalising involves providing information about the prevalence of delusions and hallucinations in the general population, drawing attention to the large number of people who never have contact with CMH services despite experiencing these kinds of phenomena (Morrison, 2004). Information is offered about the wide range of
circumstances in which people may hear voices or see visions and yet not be regarded as having a mental illness (Kingdon & Turkington, 1994). As discussed in Chapter 1, such circumstances include sleep deprivation, hostage situations, sensory deprivation, bereavement, and so on (Kingdon & Turkington, 1994). Morrison (2004) suggests that discussing possible links between life events and specific delusions and hallucinations may also be beneficial in reducing any feelings of distress. Normalising may assist people to revise how they make sense of these kinds of phenomena (Romme & Escher, 2000a; Morrison, 2004).

In recent years, there has been a move among some cognitive-behavioural therapists (e.g., Haddock & Slade, 1996) towards encouraging voice-hearers to accept and listen to their voices, rather than ignore them. This strategy, termed focusing, involves paying careful attention to the physical characteristics (e.g., the number of voices, their gender, accent, loudness etc) and content of the voices, any related thoughts and feelings, and the possible meaning of the voices (Haddock & Slade, 1996). The aim of the strategy is for people to make sense of their experiences by trying to determine the meaning and function of the voices. It has been claimed that this approach enables people to live their lives more satisfactorily than asking them to try to ignore the voices they hear (Romme & Escher, 2000a). Davies, Thomas and Leudar (1999) suggest that it is beneficial to attend to the content and meaning of hallucinations, even though it is "contrary to perceived wisdom" (p. 186).

As noted in previous chapters, the HVN (e.g., see Coleman & Smith, 1997; Coleman, 1999) exemplifies attempts to open up a wider range of ways of thinking and talking about the sorts of phenomena that may be characterised as delusions and hallucinations. By accepting, rather than denying, their experiences, members of the HVN are able to transform their relation to the experience of hearing voices, so that it
need not necessarily be distressing or harmful to them (Blackman, 2000). Members of the HVN characterise voice-hearing as simply another variant of behaviour; just as someone may be right- or left-handed, so too someone may, or may not, hear voices (Blackman, 2001). A workbook (Coleman & Smith, 1997) is available to assist those who hear voices to focus on their voice-hearing experiences and gradually revise/deepen their understanding of them. Although there are similarities with the cognitive-behavioural approach of focusing, the HVN appears to go further in its insistence on the validity of whichever frame(s) of reference voice-hearers find most appropriate. While I endorse the rights of people who experience delusions and hallucinations to make sense of them in whichever way(s) they find most helpful, I also believe that it is important to consider the implications of various ways of construing these sorts of phenomena. What sorts of things might be made possible (or impossible) by speaking about delusions and hallucinations in a particular way?

Members of the HVN typically support one another in a group context (that is, in support group meetings) which aims to foster a sense of fellowship and acceptance (Blackman, 2000). The Power to Our Journeys group (Brigitte et al., 1998) also provides a forum in which people who experience delusions and hallucinations may come together to discuss their diverse understandings of these kinds of phenomena. Narrative therapist, Michael White aims to assist members of the group to revise their relationship with their voices, by encouraging them to personify and ‘suss out’ the voices, and piece together an exposé on them (White, 1995). For example, someone who hears voices may be asked to consider the following sorts of questions:

What is it the voices are trying to convince you of at this time? What are they trying to talk you into? How does this fit with their overall plans for your life?... If they
succeed in forcing their will on your life, how do you imagine this might influence the direction of your life? (White, 1995, p. 131-132).

This kind of questioning is aimed at making the purposes of the voices transparent, thereby revising a person’s relationship with them (White, 1995). Through this process, it is claimed that even voices regarded as distressing may be rendered less “troublesome” (Brigitte et al., 1998, p. 206). As this is achieved within a group context, a sense of solidarity between the members is also fostered:

In developing an exposé of the purposes and operations of these voices and visions, we become clearer about the extent to which what they want for our lives is not in our interests, and we become increasingly knowledgeable about the strategies that they utilise to achieve their purposes. This exposé disempowers them and opens up the possibilities for us to become much more aware of the knowledge and skills that we have that we can put to work to frustrate the attempts of the voices and visions to capture our lives. By meeting together to extend this exposé and to further pool our knowledge and skills, we all have been able to further change our relationships with the troublesome voices and visions so they become less dominant in our lives (Brigitte et al., 1998, p. 205).

It is not that we still don’t have hard times. We do. But, in revising our relationships with the troublesome voices and visions, and through our work together in the Power to Our Journeys group, we have also stepped into an experience of life that we could never have predicted. We know that it probably sounds strange, but we have achieved a quality of life, a richness, when living with the voices, that would be difficult for many to understand (Brigitte et al., 1998, p. 207).

We are together in solidarity. We are secure in each other’s company, knowing that we have coped with lots of changes in our lives, and that we have gained knowledge through successfully managing the difficulties we have experienced at these times (Brigitte et al., 1998, p. 208).

Such deliberate attempts to personify voices have been criticised as merely serving to reinforce hallucinations. “It has been argued that the problem with auditory hallucinations is that they are already externalised and that people need to own them, to integrate them” (White, 1995, p. 134). However, White (1995) disputes these criticisms, noting that they spring from unsustainable liberal humanist notions of an
essential and unitary self. Likewise, Leudar and Thomas (2000) voice scepticism about (cognitive-behavioural) attempts to instruct clients to construe voices as emanating from the self, given that conventional notions of the unitary self are highly problematic.

It seems likely that few people who experience delusions and hallucinations would have access to the level of assistance offered by the Power to Our Journeys group (Brigitte et al., 1998). Notably, the women cited in this chapter were not in such a highly supportive context, yet they were still able to experience and make sense of some (aspects) of their delusions and hallucinations in non-conventional ways.

It has been claimed that people who hear voices often develop relationships with the voices that share many of the qualities of ordinary person-to-person relationships (Watkins, 1998). Noting that it takes more than one party to create and sustain conflict, Watkins (1998) suggests that “hostility and anger directed at critical voices can [merely] have the effect of ‘adding fuel to the fire’” (Watkins, 1998, p. 250). Instead, he recommends that people who hear such voices attempt to be compassionate towards them (in line with Eastern and other religious traditions). Watkins (1998) refers to a woman who reported that “developing a loving attitude toward the voices which tormented her eventually brought about a total transformation in her situation” (p. 251). This approach may be yet another which may assist persons who experience delusions and hallucinations to revise their relationships with these phenomena.
Conclusions

Movements such as the Hearing Voices Network (e.g., see Coleman & Smith, 1997; Coleman, 1999) and the Power to Our Journeys group (Brigitte et al., 1998), and the promotion of strategies such as normalising and focusing, encourage the opening up of a broader range of ways of making sense of delusions and hallucinations. These approaches advocate the need for people to accept and discuss their experiences of delusions and hallucinations, to assist them to revise their relationships with these phenomena. Making space for diverse ways of construing and talking about delusions and hallucinations (rather than simply attempting to eliminate and/or ignore them) may reduce the likelihood of such phenomena being experienced as distressing and harmful.
8: Rethinking the meaning of delusions and hallucinations

My aim in this thesis has been to challenge conventional ways of conceptualising delusions and hallucinations. In mainstream Western psychiatry, delusions and hallucinations are typically regarded as pathological (i.e., as signs of serious mental illness) (Thomas & Leudar, 1996; Leudar, Thomas, McNally & Glinski, 1997; Watkins, 1998; Clarke, 1998; Romme & Escher, 2000a; Leudar, 2001; Leudar & David, 2001), as essentially meaningless (Read & Argyle, 1999; Leudar & David, 2001), and as almost invariably distressing and harmful to those experiencing them (e.g., Clarke, 1998). However, these ways of thinking about delusions and hallucinations are increasingly being contested. For example, as noted in Chapter 1, it has been claimed that it is not uncommon for members of the general population to experience delusions and hallucinations without seeking (or requiring) psychiatric intervention (e.g., see Posey & Losch, 1983; Tien, 1991; Watkins, 1998; Romme & Escher, 2000a; Johns & van Os, 2001; Verdoux & van Os, 2002). There have also been reports that many people who hear voices are not particularly distressed by this, and some people actually describe the voices as being a positive part of their lives (Romme & Escher, 1989, 2000a; Jackson & Fulford, 1997; Watkins, 1998). Even some of those who have sought assistance from community mental health (CMH) services describe some of their experiences of hearing voices and seeing visions as having been “helpful” and “supportive” (e.g., Brigitte et al., 1998, p. 204). In light of such claims, I have argued for the need to rethink the meaning of delusions and hallucinations. This is an important task because the ways in which delusions and hallucinations are conceptualised, and spoken about, have significant implications in terms of the kinds of actions and consequences they invite (Leudar, 2001). As Burr
(2003) emphasises, “our descriptions and accounts of events have consequences in the world and... language is therefore a site of struggle (p. 24-25).

In Part One of this thesis, I presented data from the survey I conducted with mental health practitioners and researchers to explore their views regarding the content of delusions and hallucinations. I reported, in Chapter 3, that participants appeared to express some ambivalence towards engaging with clients around delusional and hallucinatory content. Although respondents identified several possible benefits of attending to content (such as potentially enhancing the therapeutic relationship, heightening clinicians’ understanding, and facilitating risk assessment), they also suggested a number of potential drawbacks (e.g., it might be a waste of time, it might inadvertently reinforce the content of delusions and hallucinations, and it might invite ridicule from colleagues). Nevertheless, most respondents indicated that they do routinely attend to content with every client, and indicated that they spend a moderate amount of time focusing on the specific content of clients’ delusions and hallucinations.

Some survey participants’ responses showed how conventional understandings of delusions and hallucinations might constrain clinical practice, by discouraging clinicians from attending to delusional and hallucinatory content. For instance, if delusions and hallucinations are regarded as meaningless expressions of an underlying biological illness, then it would make little sense to engage with clients around the specific content of these phenomena, and it might even seem unprofessional to do so. Despite the dominance of the biomedical model (within contemporary mainstream Western psychiatry), some participants’ responses in this survey challenged orthodox views concerning delusions and hallucinations, insofar as they suggested that the content of these phenomena is not necessarily meaningless and
indeed may be intelligible within the context of clients’ lives. The diversity in the survey participants’ responses illustrates the potential for change (although it should be noted that the responses of those who participated in this survey cannot be taken to suggest that such change is already happening).

In Chapter 4, I presented further data from the survey of mental health practitioners and researchers, aimed at exploring their views regarding the content of delusions and hallucinations specifically in relation to gender. Just over two-fifths of the participants indicated that they had observed similarities among female clients in the content of these phenomena, and just over half noted that they had observed similarities in the content of male clients’ delusions and hallucinations. The theme most commonly identified in the content of women’s delusions and hallucinations related to (hetero)sexual relationships and love (although it should be noted that this was identified by only 8 of the 25 participants who reported that they had observed similarities among women in the content of their delusions and hallucinations). A theme of trauma was also identified as a commonality among female clients in the content of their delusions and hallucinations (by 7 of the 25 respondents who indicated that they had observed such similarities). Commonalities participants identified in the content of male clients’ delusions and hallucinations included content of an aggressive or violent nature, grandiose delusions, and content relating to sexuality (including issues concerning sexual orientation and masculinity). (Again, it should be noted that of the 32 participants who reported having observed similarities among men in the content of their delusions and hallucinations, these particular commonalities were reported by only 8, 6 and 5 participants, respectively.)

Almost all of the explanations offered by respondents to account for the similarities they had observed emphasised the importance of the person’s previous life
events and the sociocultural context in which the delusions and hallucinations had occurred. For instance, some participants suggested that adverse events that had occurred in clients' lives (particularly experiences of abuse) might account for the presence of a trauma theme in the content of some (female) clients' delusions and hallucinations. As Stoppard (2000) reports, women are more likely than men to have sustained violence and abuse, and this may go some way to account for why a theme of trauma was also identified as a similarity among female clients in the content of their delusions and hallucinations. According to some of the respondents, the specific content of some clients' delusions and hallucinations seemed to reflect conventional notions (within a given culture) about femininity and masculinity. So, at least some of the respondents seemed to conceptualise delusional and hallucinatory content as being related to people's life experience and sociocultural context in meaningful ways. These participants' views contrasted with the notion of delusions and hallucinations as being simply meaningless epiphenomena. Based upon the responses of participants in this survey, I advocated further research to explore the content of people's delusions and hallucinations within the context of their own lives and sociocultural milieu, and to examine how they themselves make sense of their experiences of delusions and hallucinations. This was the line of inquiry I set out to pursue in Part Two of this thesis, in which I presented analyses from the series of interviews I conducted with women who have experienced delusions and hallucinations.

In Chapter 5, I explored the ways in which the women I interviewed talked about their experiences of delusions and hallucinations, identifying five main interpretative repertoires that appeared to be resourcing their accounts. In the most common of these – the Diagnostic, Illness, Madness and Personal Inadequacy
repertoires – the women characterised their experiences of these kinds of phenomena in terms of: a range of different psychiatric diagnoses; being sick, ill or diseased; being crazy, mad or insane; and as being personally inadequate or flawed, respectively. These ways of talking about delusions and hallucinations seemed to have some potentially negative implications for how people may experience these phenomena and themselves. For example, the Personal Inadequacy repertoire might invite feelings of self-blame and/or a sense of failure for those who experience delusions and hallucinations. An alternative repertoire was also identified, in which delusions and hallucinations were characterised using more mundane, commonplace language. While this repertoire appeared to have potentially more helpful implications, among the women interviewed, it also seemed to be less accessible than other ways of talking about these kinds of phenomena.

With the advent of organisations such as the Hearing Voices Network (HVN) (e.g., see Coleman & Smith, 1997), marginalised ways of talking about delusions and hallucinations are becoming increasingly accessible. Such movements challenge the taken-for-grantedness of conventional (dominant) understandings of these sorts of phenomena, and encourage people to conceptualise them in whichever ways they find most enabling or helpful to them. As it has been claimed that these kinds of phenomena may be embodied very differently according to how they are construed (Blackman, 2000), it is important to open up alternative ways of understanding them, so that those who experience delusions and hallucinations need not depict themselves in (unduly) negative ways (that is, as pathological, diseased, mad or deficient).

In Chapter 6, I described five main frames of reference that participants appeared to draw upon in their attempts to account for their experiences of delusions
and hallucinations\(^1\). Each of these frames of reference – Trauma/Stress, Spiritual/Religious, Psychoactive Substances, Biological and Individual Psychology – entailed attributions about the causes of these phenomena, and was associated with various potential implications for those who experience delusions and hallucinations (e.g., in terms of the subject positions they may be called into). The HVN (Coleman & Smith, 1997) asserts the right of those experiencing delusions and hallucinations to make sense of these phenomena in whichever ways they find most appropriate and acceptable. While I support this philosophy, I see that there is a need to consider (and critically examine) the practical and moral implications of a range of possible ways of conceptualising delusions and hallucinations. However, the process of interpreting such experiences will be constrained by the relative availability of competing frames of reference in a given context. Possible dilemmas may also arise, as there may be the potential for certain frames of reference to justify harmful actions (e.g., acts of violence) or otherwise lead to undesirable consequences (e.g., someone who has been subjected to abuse might construe delusions and hallucinations as punishment for her/his own perceived wrongdoing). Furthermore, there may be disagreement between people (e.g., between those experiencing delusions and hallucinations and the mental health practitioners employed to assist them) about how best to make sense of, and respond to, delusions and hallucinations, and in such situations, unequal power relations are likely to be involved. While it seems impossible to safeguard against all such possible pitfalls, I would suggest that the adoption of a stance of scepticism may allow us (i.e., those who experience delusions and hallucinations, their family members, mental health practitioners and the wider community) to critically examine

\(^1\) As noted in Chapter 6, when analysing the accounts of the women I interviewed, I have used the term interpretative repertoire when exploring what kind of phenomena the women construed their delusions and hallucinations to be, whereas I have used the term frame of reference when analysing participants' attributions about the causes of such phenomena.
and weigh-up competing frames of reference (with respect to their relative merits). This approach would involve treating frames of reference as provisional theories, always open to reappraisal, and would demand an acceptance of uncertainty and ambiguity.

It was of interest to note some convergence between data from the survey and the interview study with regards to suggestions of a possible relation between traumatic life experiences and delusions and hallucinations. Some of the mental health practitioners and researchers I surveyed identified adverse life events (such as sexual abuse) as being reflected in the content of some delusions and hallucinations, and all but one of the women I interviewed attributed their experiences of delusions and hallucinations to having experienced life events that they characterised as stressful and traumatic. Although the number of participants in each of these studies was relatively small, the data are consistent with a growing body of literature implicating trauma in precipitating hallucinations and possibly also 'paranoid' delusions (e.g., see review of this literature by Read, Goodman, Morrison, Ross & Aderhold, 2004). It has been suggested that delusions and hallucinations may manifest in response to any life challenges which seem overwhelming (Romme & Escher, 2000a, 2000b). Given the potentially deleterious effects of violence and abuse, their prevention is obviously a matter of considerable importance and urgency.

In Chapter 7, I illustrated some of the challenges to conventional ways of conceptualising delusions and hallucinations, by drawing upon the accounts of five of the women who took part in the interview study (focusing on two, in particular). The accounts of these women provided counter-examples to the orthodox view of delusions and hallucinations as being meaningless phenomena to be eliminated and/or ignored, and as being almost invariably distressing and harmful to those experiencing
them. They each described their experiences of these kinds of phenomena as being meaningful to them and as being in some way positive (e.g., as being pleasant, comforting, and even helpful). Their accounts were congruent with reports that many people who hear voices describe some of them as providing guidance and support (Blackman, 2001). While not wishing to romanticise delusions and hallucinations, these women’s accounts do illustrate the need for broader, more flexible ways of conceptualising these phenomena. They demonstrate the possibility of rethinking the meaning of delusions and hallucinations.

Each of the women whose accounts were drawn upon in Chapter 7 appeared to utilise multiple different ways of making sense of delusions and hallucinations. While it seems unnecessary (and unwarranted) to adhere to the conventional view of these phenomena as being inevitably negative experiences, I would also argue that it is unnecessary to adhere to any one particular alternative conceptualisation. As I have suggested above, a stance of scepticism towards all possible ways of construing these phenomena may allow us to recognise that all such accounts are socially constructed. Simply recognising that particular discourses are influencing our subjectivity may be beneficial (Burr, 2003):

Change is possible because human agents, given the right circumstances, are capable of critically analysing the discourses which frame their lives, and to claim or resist them according to the effects they wish to bring about. Foucault proposed that change is possible through opening up marginalised and repressed discourses, making them available as alternatives from which we may fashion alternative identities (Burr, 2003, p. 122).

Critically examining diverse ways of making sense of delusions and hallucinations may open up a wider range of possible subject positions for those who experience these kinds of phenomena, including positions that are potentially more
enabling than those made available by conventional ways of conceptualising delusions and hallucinations. While it may not be a straightforward matter of simply ‘choosing’ to draw upon (a) particular interpretative repertoire(s) and eschew others - to argue so would be to perpetuate the fiction of the autonomous self (Rose, 1999) - there is, nonetheless, the potential for change. The existence of diverse ways of interpreting delusions and hallucinations opens up possibilities to think about, and experience, these kinds of phenomena in new, non-conventional ways. According to Burr (2003), the view that “we both actively produce and manipulate, and are the products of discourse allows us the possibility of personal and social change through our capacity to identify, understand and resist the discourses to which we are subject” (p. 125, italics in original).

If we are to accept the notion that language is a precondition for thought, with language making certain kinds of thought possible (Burr, 2003), then it becomes crucial to explore new ways of describing the kinds of experiences that might be regarded as delusions and hallucinations. As discussed in Chapter 1, the terms delusions and hallucinations are widely regarded as pejorative (e.g., Watkins, 1998). In addition, the concepts of delusions and hallucinations are themselves claimed to be highly problematic (e.g., see Harper, 1992, 1994, 1996; Georgaca, 2000; Boyle, 2002). As I have noted, in recent years, certain phenomena have begun to be described as hearing voices rather than as verbal auditory hallucinations. This kind of change in language, in favour of everyday terminology, may open up less restrictive ways of conceptualising these phenomena. (However, unless the focus is on very specific categories of experience, such as seeing visions or hearing voices, then the language that is currently available is still inadequate, as there is no suitable (sufficiently-broad) term, as yet, to replace either hallucinations or delusions.) The
use of everyday, mundane terms may allow people who experience these phenomena to embody them in ways that are less likely to be frightening or distressing (e.g., as not uncommon), and to position themselves (and be positioned by others) in ways that are relatively more favourable.

There are numerous opportunities for further research concerning delusions and hallucinations. In my view, it would be of particular interest to carry out research with those who experience these sorts of phenomena, yet never come to the attention of mental health services. As I noted in Chapter 5, Romme and his colleagues (e.g., Romme & Escher, 1989, 1993, 2000a; Honig et al., 1998) have begun investigations of this kind with people who hear voices. They have reported that there do not appear to be any significant group differences between those who seek psychiatric help and those who do not, with regards to the characteristics of the voices they hear (Romme & Escher, 1993, 2000a). The difference between these groups is reported to be in the ways in which the voices are construed (that is, according to whether they are regarded as being positive or negative experiences\(^2\), and depending on the degree to which voice-hearers feel that they are in control). Such reports are consistent with the claim that “the emotional responses to the voices are produced out of the lived relations to the voices, rather than the voices per se” (Blackman, 2001, p. 236). How do people who experience the types of phenomena that might be characterised as delusions and hallucinations, yet do not seek assistance from mental health services, make sense of these experiences? What sorts of interpretative repertoires might they draw upon? What kinds of practices might be enabled or constrained by the use of these repertoires? How might their accounts of their experiences challenge dominant ways of conceptualising delusions and hallucinations? Claims that delusions and

\(^2\text{Presumably some experiences of this kind might be regarded as neutral, rather than as positive or negative.}\)
hallucinations may serve potentially useful functions (e.g., Hassett, 1998) and may enrich people’s lives (Romme & Escher, 1989, 2000a; Jackson & Fulford, 1997; Watkins, 1998) signpost other potential research questions. For instance, in what ways, and in what circumstances, might delusions and hallucinations be experienced as enhancing a person’s quality of life?

In the interviews I conducted, women spoke about their experiences of delusions and hallucinations in retrospect. It is possible that the kinds of interpretative repertoires they drew upon may have been rather different at the time when the delusions and hallucinations were initially occurring, as opposed to when the women were making sense of them at a later time (in most cases, once they had ceased occurring). It would be interesting to explore the various ways in which people might construe delusions and hallucinations over time. It would also be informative to investigate variability in the ways in which people construct and account for their experiences of delusions and hallucinations, according to the social context. The HVN (Coleman & Smith, 1997) and the Power to Our Journeys group (Brigitte et al., 1998) exemplify social contexts in which there is a high level of acceptance of, and support for, non-conventional ways of construing delusions and hallucinations. How easy would it be to access and adopt alternative understandings of delusions and hallucinations in contexts that are less open to these kinds of conceptualisations, and in which non-conventional understandings of delusions and hallucinations may be much less available? Recognition of how highly situated and contingent our conceptualisations of delusions and hallucinations are may serve as a reminder that the ways in which we make sense of them are always open to re-interpretation.
In this thesis, I have questioned conventional understandings of delusions and hallucinations in an attempt to open up, or increase the availability of, new ways of thinking (and talking) about these kinds of phenomena. I have argued that the ways in which delusions and hallucinations are construed is crucially important in determining how such phenomena are experienced and responded to. I have advocated a pragmatic approach in which competing ways of conceptualising delusions and hallucinations are evaluated in terms of their potential (practical and moral) implications for those experiencing these phenomena, and for those with whom they interact. It is hoped that, by critically examining various different ways of making sense of delusions and hallucinations, those who experience these kinds of phenomena may work towards occupying subject positions that enable them to live their lives in ways that they regard as satisfactory, and we may all develop a greater appreciation of the rich diversity of human experience.
References


Burr, V., & Butt, T. (2000). Psychological distress and postmodern thought. In D. Fee (Ed.), *Pathology and the Postmodern: Mental Illness as Discourse*


Predicting the long-term outcome of schizophrenia. *Psychological Medicine*, 26, 697-705.


Brunner-Routledge.


McCreanor, T., & Nairn, R. (2002). Tauitiwi general practitioners’ explanations of Maori health: Colonial relations in primary healthcare in Aotearoa/


Appendix A

Critical review of reported sex differences in psychosis

Over the past two decades, there has been a “spurt of interest” (Thara & Rajkumar, 1992, p. 65) in sex differences in psychosis. Researchers (e.g., Goldstein & Tsuang, 1990; Seeman, 1982) have explored differences between women and men in the experience of psychosis, across a range of different dimensions. 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. Although this research has been reviewed previously (e.g., Andia & Zisook, 1991; Flor-Henry, 1985; Häfner et al., 1991; Lewis, 1992; Seeman, 1982; Tamminga, 1997; Leung & Chue, 2000), in this appendix, I will extend this work, by drawing upon a wider body of literature. I will show not only that some of the conclusions concerning sex differences in psychosis are less stable than they were once regarded, but will highlight many of the serious limitations of this area of research. In this appendix, I argue that continued attention to sex differences diverts attention from other potentially-valuable research questions concerning gender, which cannot be addressed adequately within the parameters of the current sex difference paradigm.

The term psychosis is used in this context as an umbrella term, as it subsumes schizophrenia, schizoaffective disorder, affective psychosis, etc. Although this is (in this case, deliberately) inexact, so too are the diagnostic categories for each of the more specific disorders listed here. Indeed, Bertelsen (1999) has referred to divisions between subtypes of psychosis as “arbitrary and unsatisfactory” (p. 170). The studies reviewed in this chapter have utilised differing diagnostic criteria, and each study has differed with regard to the breadth or narrowness of their population of interest, so the term psychosis is used here with intended generality. The term schizophrenia is used when researchers have referred only to those with this specific diagnosis.
Reported sex differences in psychosis

"Men and women experience and manifest psychosis differently" (Grigoriadis & Seeman, 2002, p. 437).

The above quotation offers a simplification of research findings of sex differences in psychosis. A critical reading of the research evidence supports an interpretation which is far more complex and nuanced. Reports of sex differences in psychosis can be broken into a number of subcategories of research interest (e.g., incidence and prevalence, age at onset, phenomenology and so on). This review will consider each of these in turn, as a way of delineating the scope of the topic, before proceeding to elaborate a critique of sex difference research.

Incidence and prevalence

The "conventional belief" (Iacono & Beiser, 1992a, p. 1073) among mental health workers has been that "schizophrenia does not show marked gender preferences" (Seeman, 1982, p. 107) - that it has equal prevalence and incidence among women and men (Andia et al., 1995; Angermeyer & Kühn, 1988). Yet, research in the past decade (e.g., Iacono & Beiser, 1992a, 1992b; Nicole, Lesage & Lalonde, 1992) has suggested that the incidence of schizophrenia is, in fact, higher for men than it is for women (assuming that hospitalisation is a direct measure of the presence of psychosis). For example, a Canadian study (Nicole et al., 1992) of 891 individuals admitted to a psychiatric hospital between 1983 and 1987, reported the incidence of schizophrenia to be 39.8 per 100,000 for men, compared to only 22.4 per 100,000 for women (using
criteria from the Diagnostic and Statistical Manual of Mental Disorders (third edition, revised) [DSM-III-R] (APA, 1987)). Likewise, Iacono and Beiser (1992a) reported that the incidence rates of schizophrenia were two to three times higher for men than for women, “regardless of the breadth or narrowness of the [five sets of] diagnostic criteria” (p. 1073) that were used in their study.

**Age at onset**

A difference in age at onset is the most often-reported, and most widely-accepted, sex difference in psychosis (Hambrecht, Maurer & Häfner, 1992, p. 117). There has reputedly been “worldwide agreement” (Seeman, 1982, p. 107) that psychosis manifests earlier in males than in females, and indeed, this sex difference has been found across cultures (e.g., Gureje, 1991; Çetingök, Chu & Park, 1990).

A meta-analysis (Angermeyer & Kühn, 1988) of 53 relevant studies highlighted the consistency with which this sex difference has been found - most studies reported the age at onset of psychosis to be four to five years later for women than for men. The findings of numerous, more recent studies (e.g., Faraone, Chen, Goldstein & Tsuang, 1994; Häfner, Maurer, Löffler & Riecher-Rössler, 1993) concur with this trend. The peak period of onset tends to be between 18 and 25 years of age for men, and between 23 and 35 years of age for women (Gorwood, Leboyer, Jay, Payan & Feingold, 1995).

Earlier researchers (e.g., Tudor, Tudor & Gove, 1977) proposed that within so-called Western society (at least), unusual behaviour is less tolerated in men, as it is further removed from the role expectations for men than those held for women. They
suggested that men are brought to the attention of mental health workers sooner than women:

A poor performance by a housewife does not threaten the family in the way a husband’s loss of job would and is thus more likely to be tolerated.... the house may provide a “sheltered workshop” for housewives, insulating them within a legitimate asylum unavailable to men employed outside the home.... Mental disorders among housewives are likely to be defined as less disruptive than similar disorders among working males.... The housewife’s role is defined as less “demanding” in several respects, and as less important (Tudor et al., 1977, p. 98-100).

The underlying sentiment expressed in this statement has persisted (at least until the late 1980s; e.g., see Angermeyer & Kühn, 1988), even though the argument itself has strong historical and class limitations². Parents are said to react more strongly to the manifestation of psychotic experiences in their sons than in their daughters (Flaherty & Jobe, 1990; Goldstein & Kriesman, 1988), a pattern which appears to be congruent with the reactions of members of the wider community (e.g., see Farina, 1981).

Despite the argument that the sex difference in age at onset may be merely an artifact which can be accounted for by a shorter period of time between the onset of psychotic experiences and first admission for men, relative to women, other research has indicated that there is no significant difference between women and men in the period of time between onset and first admission (e.g., Angermeyer & Kühn, 1988; Castle, Wessely & Murray, 1993; Hafner et al., 1998; Mayer, Kelterborn & Naber, 1993). On this basis, it

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² For example, the phenomenon of housewives, as women who do not work outside of the home, is a middle-class phenomenon, particular to certain societies in the mid-20th century (and lessening in the late-20th century).
has been concluded that "men really do show first symptoms of schizophrenia earlier than women" (Angermeyer & Kühn, 1988, p. 357).

However, it is important to remain skeptical of this body of research, as it relies upon a dichotomous, now-you-have-it, now-you-don’t understanding of psychosis. Current diagnostic systems (e.g., DSM-IV-TR [APA, 2000]) are based upon the view that "psychopathological processes constitute discrete entities" (Jablensky, 1999, p. 140). It has been argued that a dimensional approach would be more appropriate (Jablensky, 1999; cf., Meehl, 1995), as there does appear to be a continuum between experiences deemed to be psychotic and those viewed as normal (e.g., see Bentall, 1990b; Posey & Losch, 1983; Young, Bentall, Slade & Dewey, 1986). For example, although hallucinations are generally viewed as first-rank symptoms of schizophrenia, they are reported to be experienced by approximately 10% of the general population of "otherwise normal individuals" (Bentall, 1990b, p. 82) in countries characterised as Western. Hallucinations and delusions are increasingly being regarded by researchers as extreme points on continua, rather than as constituting discrete abnormalities (Rector & Beck, 2002).

**Level of premorbid functioning**

Sex difference research investigating premorbid functioning (i.e., the level of psychosocial functioning displayed before the onset [or diagnosis] of symptoms) has tended to report that, as a group, women display better premorbid functioning than men (e.g., Andia et al., 1995; Childers & Harding, 1990; McGlashan & Bardenstein, 1990; Shtasel, Gur, Gallacher, Heimberg & Gur, 1992. For example, a study (Shtasel et al.,
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1992) of 74 men and 33 women diagnosed with schizophrenia, reported that prior to the onset of psychotic experiences, the women were typically less impaired in social role functioning, and had a greater “sense of life involvement” (p. 230), than the men. It has been suggested that if psychotic experiences do manifest at later ages for women than for men, this may allow them additional time (relative to men) in which to develop/consolidate their social skills, prior to the onset of psychosis (Chaves, Seeman, Mari & Maluf, 1993).

Whether people become married prior to the onset of psychotic experiences has been taken as an indicator of their level of premorbid functioning. Numerous studies (e.g., Andia et al., 1995; Chaves et al., 1993; Riecher-Rössler, Fätkenheuer, Lößler, Maurer & Häfner, 1992) have found that the majority of individuals with a diagnosis of schizophrenia are unmarried. Yet, women diagnosed with schizophrenia are more likely to be married than their male counterparts (e.g., Çetingök et al., 1990; Gureje, 1991; Forrest & Hay, 1971; McGlashan & Bardenstein, 1990). This finding would appear to be complicated by the reported sex difference in age at onset.

Sex difference research typically treats constructs such as premorbid functioning as unproblematic - as fixed, stable, and representing real phenomena (Hare-Mustin & Marecek, 1994). Nearly all studies reporting sex differences in premorbid functioning in those diagnosed with schizophrenia (e.g., Andia et al., 1995; Childers & Harding, 1990; McGlashan & Bardenstein, 1990; Shtasel, Gur, Gallacher, Heimberg & Gur, 1992) fail to critically examine the construct of premorbid functioning itself. A welcome exception is

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3 Entering into marriage has become less normative over recent decades, in at least some Western countries, and so perhaps marital status will no longer be seen as quite so indicative of appropriate social functioning.

4 See the 1992 study, by Riecher-Rössler and colleagues, which tested possible explanations to account for the high percentage of unmarried persons among those with a diagnosis of schizophrenia.
a paper by Riecher-Rössler and coworkers (1992), which recommended that the construct of premorbidity be reconceptualised. They found that the prodromal phase of psychosis\(^5\) may extend well back into the period that other researchers regard as premorbid. For their sample, psychotic symptoms became manifest, on average, 1.9 years before first admission, and early "signs of a mental disturbance" (p. 126) were evident, on average, at 4.5 years of age. Other studies (e.g., Foerster, Lewis, Owen & Murray, 1991) have reported similar findings. Even so, the retention of the construct of premorbid functioning maintains an understanding of psychosis as a discrete entity. This way of construing psychosis precludes any recognition of continuity between so-called psychotic and normal experiences (e.g., see Bentall, 1990b; Rector & Beck, 2002; Young et al., 1986), ignoring the debate concerning whether psychosis (in its various forms) constitutes a discrete entity or should rather be conceptualised in dimensional terms (see above; Jablensky, 1999).

**Phenomenology**

The symptoms of psychosis include delusions, hallucinations, disorganised speech, disorganised behaviour and flattened affect (APA, 2000). The specific diagnosis (say, schizophrenia as opposed to schizophreniform disorder) assigned to a given person is dependent upon not only the particular constellation of symptoms, but also the length of time they have been experienced by the person (APA, 2000).

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\(^5\) The prodromal phase is defined as the period in which the first signs of psychosis appear, but which is prior to diagnosis and the commencement of 'treatment' (McGlashan & Johannessen, 1996). As the concept is retrospective, it has been critiqued as being limited in its usefulness (e.g., Johannessen, 2004).
It has been reported that women and men do not differ in either the type, or severity, of the psychotic symptoms they experience during acute episodes (Tamminga, 1997), or at first admission (Häfner et al., 1991). However, it has been claimed that, as a group, men are more likely to display signs of social withdrawal and blunted affect (so-called negative symptoms), while women are more likely to exhibit signs of paranoid delusions and dysphoria (i.e., positive symptoms) (Lewis, 1992; Goldstein & Link, 1988; Opjordsmoen, 1991; Ring et al., 1991; Tamminga, 1997; Thara & Rajkumar, 1992).

These phenomenological differences between women and men (regarding positive and negative symptoms) have been said to constitute a role reversal (Al-Issa, 1982), such that “men are thought to become more passive, apathetic, and socially withdrawn while women, in contrast, become more impulsive, outgoing, and domineering” (Angermeyer & Kühn, 1988, p. 354). In both cases, their behaviour could be seen to contravene social norms regarding appropriate behaviour for women and men in Western societies.

Phenomenological differences between women and men may not be as clear-cut or reliable as the negative-versus-positive-symptoms heuristic suggests. For example, a North American study (Fennig, Putnam, Bromet & Galambos, 1995) of 52 individuals with a diagnosis of schizophrenia, found that although men were more likely than women to display flattened affect, overall, they did not exhibit more negative symptoms than women. Likewise, Rector and Seeman (1992) have reported that while auditory hallucinations are more common among women than men (i.e., 78% of the (37) women in their study experienced auditory hallucinations compared to only 54% of the (57) men), hallucinations involving other modalities (i.e., visual, tactile, olfactory and gustatory hallucinations) were found to occur with equal frequency in both groups.
Çetingök and colleagues (1990) have noted that a person’s culture influences her/his clinical presentation. In their study of Turkish and North American individuals diagnosed with schizophrenia, they found that “patients of another culture, i.e., Turkish, can be more severe on all of the symptoms... regardless of their gender; and secondly, some symptoms [e.g., affective symptoms] reported to be more severe for females in one culture may in fact be more intense for males in another” (p. 278). Hambrecht and coworkers (1992) have also highlighted the influence of culture on the phenomenology of psychosis, reporting different patterns of sex differences in symptom profiles across three different cultures - Western European, Balkan, and Islamic. The finding that sex differences in phenomenology do not remain constant across cultures reiterates that such differences are neither essential nor immutable. Indeed, even within Western culture there is little consistency in findings of sex differences in phenomenology.

**Coping and social skills**

It is frequently reported (e.g., Haas, Glick, Clarkin, Spencer & Lewis, 1990; Hambrecht et al., 1992; Shtasel et al., 1992) that males with the diagnosis of schizophrenia demonstrate a higher level of antisocial behaviour (e.g., substance abuse, violence) and poorer coping skills (e.g., self-neglect) than their female counterparts. “Despite comparable illness severity, women manage to maintain better social functioning than men” (Andia et al., 1995, p. 526; see also Hintikka, Saarinen, Tanskanen, Koivumaa-Honkanen & Viinamäki, 1999). According to Seeman (1983), both women and men diagnosed with schizophrenia are affected by poverty, yet women
are more able to stretch their finances, and they perform their daily tasks (e.g., self-care, cooking etc) in a more satisfactory manner, than men.

**Cognitive functioning**

“There is little consensus regarding sex differences in neuropsychological functioning” (Lewine, Walker, Shurett, Caudle & Haden, 1996, p. 1178) in psychosis. Perlick, Mattis, Stastny and Teresi (1992) reported that among their sample of 26 ‘inpatients’ and 26 ‘outpatients’ diagnosed with schizophrenia, women displayed greater impairment than men on tasks of attention and conceptualisation. Conversely, other researchers (e.g., Andia et al., 1995; Hoff et al., 1998) have found no significant sex differences in cognitive functioning.

Lewine and colleagues (1996) found that women with the diagnosis of schizophrenia displayed more severe memory impairment and more difficulty in visual processing than men with the same diagnosis. In contrast, Goldstein and coworkers (1998) reported that women diagnosed with schizophrenia were less vulnerable than their male counterparts to impairment in visuospatial ability and verbal processing (including verbal memory).

As Hoff and colleagues (1998) have noted, sex differences in cognitive functioning in persons diagnosed with schizophrenia “are not robust findings” (p. 1437). Furthermore, neuropsychological impairments observed in this population may be largely functional (i.e., not due to organic brain dysfunction), as memory function has been found to improve with the resolution of psychotic symptoms (Gruzelier, Wilson, Liddiard, Peters & Pusavat, 1999). Therefore, if any sex differences in cognitive functioning are
observed, they may reflect sex differences in the phenomenology and course of psychosis.

A difficulty with sex difference research in general is that researchers often fail to report effect sizes which results in very small differences being given far more attention than is actually merited (Hyde, 1994). When effect sizes are considered, the findings often appear less dramatic. For example, Perlick and colleagues (1992) reported that women diagnosed with schizophrenia displayed significantly greater impairment of attention than men with the same diagnosis. Yet, upon closer examination, the difference in scores on the test of attention (the attention subscale of the Dementia Rating Scale) (Mattis, 1989, cited in Perlick et al., 1992) was found to be small (35.6/37 for men compared to 34.6/37 for women), and the reported p-value (p<0.10) did not even reach the conventional level of significance (i.e., 0.05).

**Brain structure/morphology and function**

A number of researchers (e.g., Andia et al., 1995; Hoff, Neal, Kushner & DeLisi, 1994) have attempted to find neurological differences between women and men with the diagnosis of schizophrenia. Various structures of the brain (e.g., the ventricles, temporal lobes, and corpus callosum) and indicators of brain function (e.g., event-related potentials, and regional cerebral blood flow) have been examined, using various neuroimaging (e.g., magnetic resonance imaging [MRI], and computed tomography [CT]) and functional-imaging (e.g., positron emission tomography [PET]) techniques (e.g., see Lewine & Seeman, 1995). Although the reports from such studies are "inconsistent, when gender differences are found, there is usually greater brain
morphological and functional divergence from control subjects in men [rather than women] with schizophrenia” (Lewine & Seeman, 1995, p. 140; see also Flaum, Arndt & Andreason, 1991). However, this pattern only tends to be found in studies with large sample sizes. Flaum, Arndt and Andreason (1990) conclude that “if a gender effect does exist, it is subtle” (p. 1330), which may go some way in explaining why the literature has inconsistent findings (Nopoulos, Flaum & Andreason, 1997).

Response to treatment

Women and men diagnosed with psychosis are reported to display differences in their response to pharmacotherapy (e.g., Seeman, 1997) and psychotherapy (specifically, family interventions) (e.g., Haas et al., 1990). Women show a better treatment response to antipsychotic medication than men, as they require lower doses of these drugs than men, “to get over an acute episode and to ward off future episodes” (Seeman, 1997, p. 1642). This sex difference has been attributed, in part, to women’s higher propensity to comply with treatment (Seeman, 1997). Women may also respond better to antipsychotic medication than men, due to the antidopaminergic effects of estrogens⁶, including synthetic hormones such as oral contraceptives as well as those associated with the menstrual cycle (Hamilton & Jensvold, 1995; Seeman, 1997). Furthermore, women apparently have greater bioavailability and slower clearance of such medications than men (Hamilton & Jensvold, 1995) (see van Os, Walsh, Tattan, Bale and Thompson

⁶ The dopamine theory of schizophrenia (e.g., see Krieckhaus, Donahoe & Morgan, 1992) (or dopamine idea of schizophrenia - see Ross, 1995a) posits that psychotic symptoms are caused by excessive overactivity at dopaminergic synapses. Therefore, antipsychotic medications work by decreasing dopaminergic activity (i.e., they are dopamine antagonists) thereby attempting to inhibit delusions and hallucinations. Estrogens also function as dopamine antagonists.
(1999) for a discussion of women's and men's (apparently) differential vulnerability to the side-effects of neuroleptic medications).

Women with a diagnosis of schizophrenia are reported to respond better to family therapy than their male counterparts (e.g., Haas et al., 1990; Seeman, 1983, 1995). For example, a study (Haas et al., 1990) of 43 women and 49 men diagnosed with schizophrenia, reported that family therapy was not as beneficial for men, because their families tended to be more critical of them, and were less engaged in the therapeutic process (e.g., missing sessions and arriving late) than the families of female inpatients. The authors advanced four possible explanations of their findings. Firstly, it may be easier for family members to hold more 'appropriate' expectations for the person's readjustment to community living, when the social and occupational role demands are less (as they are purported to be for women) (Haas et al., 1990; see also Goldstein & Kriesman, 1988; Hien, Haas & Cook, 1998; Seeman, 1983, 1995):

Gender role differences in our culture allow families to harbour educational and achievement expectations of their schizophrenic [sic] sons long after they have resigned themselves to a more modest future for their schizophrenic [sic] daughters (Seeman, 1983, p.143).

Secondly, it may be more difficult for men in Western cultures to engage fully in the cooperation and shared decision-making that are important components of family interventions (Hien et al., 1998; Seeman, 1995), particularly when this "runs counter to socialisation practices that discourage dependency and verbal disclosure of feelings among males" (Haas et al., 1990, p. 289). Thirdly, the females in the study (Haas et al., 1990) were reported to have had superior social skills to the men, and this may have
enabled them to interact more appropriately and beneficially during family therapy. Lastly, the higher level of antisocial behaviour among men may have led to the negative response to family intervention.

Davis, Goldstein and Nuechterlein (1996) also found that family members were more critical of male relatives diagnosed with schizophrenia than they were of female relatives with the same diagnosis. They speculated that this may have been due to the more significant improvement in symptomatology observed in women. Another possible reason why women might benefit more from family therapy may be that their families blame themselves less, because the onset of psychosis is generally later for women, and so it is likely that the psychosis emerged after the daughter had left the family home (Seeman, 1983).

It has been reported that the issues that families bring to therapy tend to differ depending upon whether their relative is female or male (Seeman, 1983):

Families of male schizophrenics [sic] are primarily concerned with impulsive sexuality in their relative (public masturbation, exhibitionism, fetishism), with violence, drugs, alcohol.... Families with schizophrenic [sic] daughters worry most lest their relative be sexually abused and/or become pregnant (Seeman, 1983, p. 143).

This statement suggests that families of individuals diagnosed with schizophrenia tend to be concerned about what male relatives might do, whereas they are worried about what might be done to female relatives. This trend is consistent with a (conventional) view of men as active agents in the world, while women are merely passive objects, waiting to be acted upon (e.g., see Hare-Mustin & Marecek, 1990).
Course and outcome

Although the early course of psychosis does not differ between women and men (Häfner et al., 1993), women are generally believed to experience a “more benign form” of psychosis (Shatsel et al., 1992, p. 225). Indeed, women are said to have a better outcome than men, regardless of diagnosis (e.g., schizophrenia, schizoaffective disorder, affective psychosis etc) or outcome dimension (e.g., readmission rate, degree of social impairment, time in remission, time living independently etc) (Navarro et al., 1996). For example, in a ten-year follow-up of 90 individuals with the diagnosis of schizophrenia, Goldstein (1988) found that women were hospitalised for less time, and experienced fewer rehospitalisations, than men. Other researchers have also found this pattern (e.g., Angermeyer, Kühn & Goldstein, 1990; Harrison, Croudace, Mason, Glazebrook & Medley, 1996; Munk-Jørgensen & Mortensen, 1992; Nyman & Jonsson, 1983; Salokangas, 1983; Thara and Rajkumar, 1992).

In a Finnish study (Salokangas, 1983) of 175 individuals diagnosed with schizophrenia, 32% of women, but only 18% of men, were rated as symptom-free at the end of the eight-year follow-up period. Men in this study rated poorly on functional capacity (i.e., the ability to live independently and perform self-care tasks), and working ability, in comparison to women.

A two-year follow-up study (Test, Burke & Wallisch, 1990) of 122 young adults diagnosed with schizophrenia or related disorders, found that women were significantly more likely than men to be involved in parenting children, and they were also more likely
to be living with a partner of the opposite sex or to be heterosexually active. These findings are likely to be confounded by the sex difference in age at onset (Angermeyer & Kühn, 1988), and they echo the reported sex difference in premorbid marital status (in which being married, or here, being in a heterosexual relationship, is taken as an indicator of a high (or appropriate) level of functioning).

Among those diagnosed with schizophrenia, men are said to be more likely to become homeless and to become estranged from their families (Seeman, 1995); they are also reported to be more likely than women to commit suicide (Seeman, 1983; Test et al., 1990). In the general population, men are at greater risk for unnatural deaths than women (Goldstein, Santangelo, Simpson & Tsuang, 1993). However, having a diagnosis of schizophrenia elevates the risk for both women and men, such that men diagnosed with schizophrenia have a particularly high risk, and the risk for women with a diagnosis of schizophrenia is on a par with the risk for men in the general population (Goldstein et al., 1993).

More recent research (e.g., Seeman, 1997) has, however, begun to challenge the view that women have a better outcome in psychosis. Although women are found to have a better outcome than men when the follow-up period is less than 15 years, longer-term follow-up studies find no such sex difference (Seeman, 1997). Following a 20-30-year follow-up of 20 clients diagnosed with schizophrenia, Seeman (1998) reported that in general, for men, the clinical picture during the first decade following diagnosis is the most severe, and it is followed by a gradual improvement in clinical status. In contrast, it

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7 Unfortunately, the information provided by this study (Test et al., 1990) is incomplete, as the researchers failed to inquire about homosexual relationships.
has been said that for women, the first decade of psychosis is relatively mild, but the clinical picture tends to worsen with increasing age.

Similarly, Opjordsmoen (1991) found that although there was no significant difference in outcome between women (n=62) and men (n=77) 10 years after they had been diagnosed with schizophrenia, the men displayed a stable clinical course, while the women's clinical status tended to deteriorate over time. Interestingly, "marriage tended to be associated with a small change to the worse in the long run in women, but not in men" (Opjordsmoen, 1991, p. 308). A more recent study (Röder-Wanner, Oliver & Priebe, 1997) has reported that while women were objectively found to have a better quality of life than men (i.e., as indicated by social integration, living situation, finances and partnership), women and men diagnosed with schizophrenia did not differ in their subjective quality of life. So while the weight of evidence at present supports the accepted view that women have a better outcome than men (particularly when mortality rates are considered), this may not necessarily be the case, particularly when the follow-up period is 20 years or more (see Seeman, 1998).

It has been suggested that any sex difference in the course and outcome of psychosis favouring women (i.e., in line with the conventional view) may be partly due to differences in coping strategies and illness behaviour (e.g., Navarro et al., 1996), and may be partially attributed to supposed differences in phenomenology (i.e., that men experience more negative symptoms) (e.g., Gur, Petty, Turetsky & Gur, 1996; Ring et al., 1991). As mentioned above, maladaptive illness behaviours (which contribute to a poor outcome), such as alcohol abuse and social withdrawal, are more common among men than among women (Hambrecht et al., 1992). It is still a matter of conjecture, however,
as to whether men do experience more negative symptoms than women (e.g., see Addington, Addington & Pattern, 1996; Fennig et al., 1995). Furthermore, negative symptoms themselves are associated with other factors which are believed to predict a poor outcome, such as poor premorbid social adjustment and cognitive impairment (Ring et al., 1991). Indeed, Chaves and coworkers (1993) found that a high level of negative symptoms was associated with impaired social role performance (e.g., self-care, level of activity, social withdrawal, etc) for both women and men.

A further hypothesis offered to account for the conventional view that men have a poorer outcome in psychosis suggests that failure to reach employment and achievement expectations (which are purported to be higher for men than for women) is particularly damaging for men, and contributes to their less favourable outcome (e.g., Thara & Rajkumar, 1992). According to Salokangas (1983), there may be "relatively more severe damage to self-esteem for men than for women, in whom the gap between personal goals and the level of psychological functioning does not become as wide" (p. 150). The assumption that a woman's role is less demanding than that of a man has led some researchers (e.g., Salokangas, 1983) to trivialise/undermine the (more typical) finding that women have a more favourable outcome in psychosis - "a certain number of female patients are able to fulfil their functions as housewives and mothers, but would hardly succeed in the free labour market" (Salokangas, 1983, p. 150). Yet, "conventional definitions of independence and autonomy [e.g., success in the free labour market] conceal the extent to which men depend on women for material and emotional sustenance, as well as the extent to which women cannot rely on men in return" (Hare-Mustin & Marecek, 1994, p. 533). Men may appear to fulfil higher role expectations than
women (in general), because their roles are more public and because they have substantial (usually unacknowledged) assistance from women, which enables them to do so. “Women carry the burden of family welfare and household maintenance in addition to generating income.... a burden that men by and large do not share; moreover, they often lack the skills to do so” (Hare-Mustin & Marecek, 1990, p. 187).

Furthermore, a recent study (Srinivasan & Thara, 1999) has reported that long-term home-making functioning is compromised by psychotic symptoms as much as is occupational functioning. Like paid competitive employment, home-making too demands “at least a moderate degree of functional capacity” (Srinivasan & Thara, 1999, p. 98). Although the home has been represented as a “benign environment.... women’s roles associated with the home are not free of undue stress” (Hare-Mustin & Marecek, 1990, p. 50) - stress which “is often marginalised or overlooked” (Hare-Mustin & Marecek, 1990, p. 50).

Explanatory theories of sex differences in psychosis

A limitation of sex difference research is that it tends to be merely descriptive - falling short of elucidating the actual mechanisms responsible for producing any such differences (Unger, 1990; Hare-Mustin & Marecek, 1994). While there have been reports of various sex differences in psychosis, as yet, the literature fails to explain (adequately) how these differences came to be. To date, two main explanations have been offered to account for the reported sex differences in psychosis - the estrogen hypothesis (e.g., see Seeman, 1997) and the subtype model (e.g., Castle & Murray, 1991).
According to the estrogen hypothesis (e.g., see Häfner et al., 1998; Seeman, 1997), women (in their reproductive years) are “protected by the antidopaminergic action of estrogens” (Castle, Abel, Takei & Murray, 1995, p. 2). In this (suppressor) model (see Lewine, 1981), estrogens are thought to delay the onset of psychosis in women, and this confers a further advantage, by allowing women additional time, relative to men, in which to complete their formal education, enter the workforce, and consolidate important social skills (Seeman, 1997). Castle and coworkers (1995) have reported a significant negative correlation between women’s estrogen levels and psychotic symptomatology. Likewise, psychosis has been linked with “a decrease in estrogen levels, as shown by premenstrual exacerbation of schizophrenia, the decrease in relapse during pregnancy, and increased vulnerability in the postpartum period and after menopause” (Gorwood et al., 1995). However, the age-at-onset curve does not mirror the changes in estrogen levels associated with puberty and menopause (Loranger, 1984), and it has been suggested that “social life events that coincide with menopause play a greater role in psychiatric disturbances at this time than do biological factors” (Castle et al., 1995, p. 3).

An alternative explanation of the observed sex differences in psychosis calls upon different (hypothetical) subtypes of schizophrenia, to which women and men are differentially at risk (e.g., see Castle & Murray, 1991). Castle and colleagues (1995) have proposed that women are more likely to experience a milder, later-onset form of schizophrenia, while men are more likely to experience a more severe, early-onset form. Ostensibly, men are more likely to express a subtype characterised by flat affect and poor premorbid history, while women more commonly experience a subtype characterised by dysphoria and delusions of persecution (Goldstein, Santangelo, Simpson & Tsuang,
The subtype model arises from particular etiological assumptions (e.g., see Foerster et al., 1991; Wolyniec, Pulver, McGrath & Tam, 1992) which tend to allude to the “underlying biological nature” (DeLisi, 1997, p. 188) of psychosis. Yet, some authors (e.g., Galdos & van Os, 1995; Lewine, 1981) have speculated that psychosocial factors may be causally-relevant. Lewine (1981) has suggested that “psychosocial demands of dynamic importance” (p. 441) occur earlier for men than for women, which may account for the earlier age at onset of psychosis among men. “Young men are stressed by the need to establish themselves in work and to become independent of their parents; women perhaps suffer the major stress later when they are pressured by the demands of home, children and husband” (Forrest & Hay, 1971, p. 145). If this assertion were correct, then in the intervening decades since this statement was written, a change in the sex difference in age at onset would have been expected, given that women are increasingly expected to have careers also. Yet, no such change has been reported in the literature.

**Some limitations of sex difference research**

That humans come in at least two sexes coincides conveniently with psychology’s orientation towards difference (Favreau, 1997, p. 64).

The distinction between sex and gender is central to any critique of sex difference research. Until the late 1960s, gender was merely a term used in linguistics to denote feminine or masculine forms within a given language (Nicholson, 1995). The meaning of gender was then extended, however, and it began to be used in contrast to the term sex.
Whereas sex was taken as referring to that which is biologically given, gender came to refer to that which is socially constructed (Nicholson, 1995). The concept of gender was intended to supplement sex, such that sex was regarded as providing the physiological basis on which gender was superimposed, through the process of socialisation (Nicholson, 1995). Nicholson (1995) has described this way of understanding the relationship between biology and socialisation as a ‘biological foundationalist’ or ‘coat rack’ model (i.e., the garments of socialisation hang on the rail of biological reality), and it continues to underpin much thinking about sex and gender (e.g., see Oakley, 2000). Yet, the meanings of these terms have not remained fixed (Nicholson, 1995).

In sex difference research, there is ongoing, unresolved debate regarding sex and gender (e.g., see Lewine, 1994), with some researchers reporting sex differences in psychosis, and others reporting gender differences. While some researchers (e.g., Lewine, 1994) have raised concern that sex and gender are often used interchangeably (presumably because this represents a lack of terminological precision), others (e.g., Hamilton & Jensvold, 1995) have cast a more critical eye over this practice. Hamilton and Jensvold (1995), for example, have argued that many researchers appear to use the term gender as a euphemism for sex, reporting gender differences in psychosis, even though they have not actually assessed their participants’ gender role orientation.

The usage of the terms sex and gender has implications beyond mere issues of nomenclature. Sex implies a presumed biological cause of a reported difference, while gender implies a putative environmental (cultural, social, or political) cause (Lewine, 1994). The distinction between sex and gender, therefore, presupposes the etiology of any observed differences, and precludes interactionist explanations (Kitzinger, 1994).
"The terminology becomes impossible" (Hyde, 1994, p. 511), because researchers generally do not know what causes an observed difference (Hyde, 1994), yet by electing to use either sex or gender they are implying that an observed difference can be accounted for by biological or environmental factors, respectively.

Furthermore, the term gender may be utilised in many ways - for example, as an intrapsychic variable or as a scheme for social categorisation (Unger, 1992), and differing definitions may operate simultaneously (Unger, 1990). Use of the same word conceals the fact that different levels of analysis are being referred to (Unger, 1992). When gender is used merely as a proxy for sex, more complex and subtle meanings of the term are obscured, which, in turn, constrains the complexity and appropriateness of research endeavours.

Perhaps a more fundamental difficulty with investigations into sex differences is that, within such research, sex is "constructed as a dualism rather than as a continuum" (Unger, 1990, p. 111). Construing sex as an (unproblematic) dichotomous construct, based on such characteristics as a person's sexual anatomy, is an oversimplification. For example, even sexual anatomy "is imperfectly linked to genetic sex" (Hamilton & Jensvold, 1995, p. 15; see also Fausto-Sterling, 1993). Yet, the sex difference literature relies upon being able to make comparisons between two discrete groups, even if the absolute distinction between these (female and male) groups is somewhat artificial.

The use of a same/different framework (intrinsic to sex difference research) oversimplifies the area of study (Pyke, 1988). Humans have a "predilection for construing events on the basis of hierarchically organised dichotomous constructs (e.g., same/different; male/female; good/bad)" (Pyke, 1988, p. 56). The use of such dualisms
conceals complexity. For example, "the idea of masculinity and femininity as counterparts implies their symmetry and equivalence and thus obscures gender differences in power and social value" (Hare-Mustin & Marecek, 1990, p. 35).

Typically, sex difference research relies upon null hypothesis testing (Favreau, 1997). Yet, null hypothesis tests cannot support inferences to general group differences (e.g., sex differences), although, ironically perhaps, these are the kinds of inferences for which null hypothesis tests tend to be used (see Favreau, 1997; Hare-Mustin & Marecek, 1990; Unger, 1990; for detailed discussions of the limitations of null hypothesis testing).

Furthermore, as there is an editorial bias towards publishing significant findings (i.e., studies in which the null hypothesis has been rejected), studies which find no significant difference between women and men are less likely to be published (Unger, 1990; Hyde, 1994). Rosenthal (1998) has termed this difficulty the "file drawer problem", in that studies which have not achieved statistical significance end up being "squirreled away in... file drawers" (p. 783). It has also been claimed that "significant findings that are ideologically offensive [i.e., inconsistent with the dominant ideology] are more difficult to publish than insignificant results on favoured and acceptable topics" (Ross, 1995b, p. 143).

A further limitation is that sex difference research does not investigate behaviours which have an extremely low rate among one of the sexes - Unger (1990) gives the example of rape. So, "paradoxically, studies of sex differences concentrate on those areas in which males and females are seen as least different" (Unger, 1990, p. 104).

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8 Equivalency testing (e.g., see Rogers, Howard & Vessey, 1993) constitutes a more rigorous, sophisticated, alternative to null hypothesis testing. However, null hypothesis testing remains the most commonly-used statistical method employed in sex difference research.
A focus on sex differences diverts attention from sex similarities (Unger, 1990). "The fact that the sexes are more similar than they are different is not considered noteworthy either by psychology as a discipline or by society as a whole" (Unger, 1990, p. 104). The popularity of such titles as 'Men Are From Mars, Women Are From Venus' (Gray, 1992) attests to the high level of interest and/or investment among the general public (in Western societies) in descriptions (and prescriptions) of (essential) points of difference between women and men.

As Halpern (1994) has noted, "research on sex differences is front-page news... the bold headlines that proclaim these differences are based on the belief that news of sex differences, like sex itself, sells" (p. 523). This point does not appear to have been lost on researchers investigating sex differences in psychosis. For example, when referring to a study (Addington et al., 1996) investigating "gender and affect in schizophrenia", Seeman (1996, p. 263) commented that "the topic... could not be more provocative: sex and emotion!". As Lewis (1992) has wryly observed, "schizophrenia research has, belatedly, discovered sex" (p. 447).

It has been argued that sex difference research acts as a "red herring" (Unger, 1990, p. 102) - it diverts research efforts away from other potentially important and interesting questions. Many feminists have been drawn into sex difference research - some attempting to establish the similarity between women and men (minimising any differences as a means to attaining equality) and others attempting to establish the difference between women and men (maximising any differences to reaffirm and celebrate women's difference from men) (Hare-Mustin & Marecek, 1990; Kitzinger, 1994). Continued attention to debates concerning sex differences not only draws
attention away from other potentially valuable research questions, but also lends credence to, and heightens the importance of, those debates (Hare-Mustin & Marecek, 1990). Furthermore, it is important to consider the "consequences of representing gender in ways that either emphasise or minimise male-female differences" (Hare-Mustin & Marecek, 1990).

Reports of sex differences invite the differential treatment of the sexes (Hare-Mustin & Marecek, 1990), and therefore may be used in ways that benefit or harm women or men (Eagly, 1996). For instance, Seeman (1997) has advocated differential treatment (interventions) for women and men on the basis of reported sex differences in treatment response; this is just one example of the potential practical and political implications of sex difference research. Yet, "gender roles are not totalising" (Hare-Mustin & Marecek, 1990, p. 16), so conclusions about sex differences in psychosis, and decisions arising from these conclusions (e.g., affecting service provision) are premature if they do not also consider other relevant factors, such as social class, ethnicity, age, geographic region (Hare-Mustin & Marecek, 1990), and so forth.

When considering sex differences in psychosis, it is essential to be mindful of the context-dependency of research findings. "What we think of as gender is a complex mixture of traits, roles, and behavioural preferences influenced by situational demands" (Unger, 1990, p. 104) (as well as a complex mix of various biological dimensions). As such, it is futile to investigate sex differences in the absence of other contextual information (Favreau, 1997).

Eagly (1994) has defended studies of sex differences, arguing that contemporary sex difference research does recognise that findings are context-dependent. However, the
literature relating to sex differences in psychosis continues to largely ignore contextual factors. Indeed, Unger (1992) argues that "theoretical and methodological critiques seem to have had little impact upon the field" (p. 232).

**Conclusions**

Research investigating sex differences in psychosis has flourished in recent years. The most consistently-reported findings to date 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 display better premorbid functioning (e.g., Andia et al., 1995), and they tend to display more adaptive coping and social skills (e.g., Andia et al., 1995; Shtasel et al., 1992), than men. Women 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 et al., 1996). Yet, the picture appears to be changing, and is certainly far more complex than this brief summary might suggest. Given the problematic assumptions and methodology of the sex difference paradigm, one might question the extent to which our understanding of psychosis has been furthered as a result of this (heightened) attention to sex differences in psychosis. How has this research influenced the way in which psychosis is conceptualised? What implications has this research had?

The limitations inherent in this research are of sufficient importance to warrant serious debate about the future (nature) of the sex difference paradigm. Those who
continue to conduct sex difference research must examine critically the assumptions underlying their work. Adherence to an epistemological 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). 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.
Appendix B

The nature of psychotic experiences

Participant Information Sheet

Principal Investigator: Ms. Yasmin Aschebrock, a PhD student at the University of Auckland, Private Bag 92019, Auckland, New Zealand
Tel: +649 409 8556 (home); E-mail: yasmin@ihug.co.nz

Supervisors/co-investigators: Dr. Nicola Gavey, a Senior Lecturer in the Department of Psychology, University of Auckland, New Zealand
Tel: +649 373 7599 ext. 6877; E-mail: n.gavey@auckland.ac.nz
Dr. Lynette Tippett, a Senior Lecturer in the Department of Psychology, University of Auckland, New Zealand
Tel: +649 373 7599 ext. 8551; E-mail: lj.tippett@auckland.ac.nz

Request for participation

You are invited to participate in a survey which will investigate factors affecting the nature of psychotic experiences (that is, delusions and hallucinations). Participation in the study is voluntary. You do not have to take part in this study, and you may decline to participate without giving a reason.

Description of the study

The aim of this study is to investigate the views of mental health practitioners regarding factors affecting the nature of psychotic experiences. Participants in the study are practitioners who work with individuals who have been diagnosed with psychosis (e.g., diagnoses of schizophrenia, schizoaffective disorder, affective psychosis etc) in clinical and/or academic/research settings. You have been asked to volunteer because of your experience in working with these patients. Approximately 100 practitioners, from a number of different countries (e.g., United Kingdom, United States, Australia, New Zealand, and Germany), will take part in the survey. The sample will include researchers who have published articles relating to psychosis in the last five years, and practitioners currently working in the field. The study is being partly funded by a University of Auckland PhD Scholarship.

Participation

If you agree to take part in this research, your participation will involve completing a questionnaire. The questionnaire form will take approximately one hour to complete. If you do decide to participate in the survey, you should know that it will not be possible to withdraw information, once the completed form has been returned. This is because the survey data are anonymous, and so data cannot be traced in order to be withdrawn. Completed questionnaire forms may be returned to the researchers up until 30 June 2001.
Anonymity and confidentiality
No material which could personally identify you will be used in any reports on this study. To ensure privacy and confidentiality, all original documents will be numbered, and all data collected from participants will be identified only by this code number.

Research findings
It is believed that a greater understanding of the factors influencing psychotic experiences will ultimately be of benefit to mental health practitioners, individuals diagnosed with psychosis, and the wider community. The results of this research will be reported within a PhD thesis, a copy of which will be available in the General Library of the University of Auckland. It is also hoped that the results will be available for public dissemination in a published paper. Should you wish to receive a summary of the findings of the study, please record your name and contact details on the form enclosed, and return it to the researchers in the additional addressed envelope enclosed. Posting this form in an envelope, separate from your completed questionnaire, will preserve the anonymity of your questionnaire responses.

Contact addresses
Thank you very much for your time. If you have any queries, or simply wish to know more about the study, please feel free to contact the investigators. You may also contact the Head of the Department of Psychology at the University of Auckland.

The Head of Department is: Professor Dianne McCarthy
Department of Psychology
The University of Auckland
Private Bag 92019
Auckland.

Tel. 373 7999 extn 8555
E-mail: d.mccarthy@auckland.ac.nz

For any queries regarding ethical concerns please contact:

The Chair, The University of Auckland Human Subjects Ethics Committee,
The University of Auckland, Research Office - Office of the Vice Chancellor, Private Bag 92019, Auckland. Tel. 373 7999 extn 7830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE on 16/08/00 for a period of three years, from 16/08/00 Reference 2000/Q/042.
Appendix C

QUESTIONNAIRE:
THE NATURE OF PSYCHOTIC EXPERIENCES

The questions in this survey ask about your opinions regarding factors which may affect the particular nature of psychotic experiences (that is, delusions and hallucinations). Please answer the questions based on your clinical experience. For each question, please circle your desired response, or fill in the space provided. Thank you for completing this questionnaire.

SECTION 1: FACTORS WHICH MAY AFFECT THE NATURE OF PSYCHOTIC EXPERIENCES

1. How important are the following factors in understanding the particular way in which psychosis manifests in people?

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2. Please list the three factors which you believe are the *most important* in understanding the *particular* way in which psychosis manifests in people.  
*The factors you list do not need to be taken from the list above*

Factor 1:  
Factor 2:  
Factor 3:  

a. For each of these three factors, please explain briefly the way in which it is important in understanding the *particular* way in which psychosis manifests in people.  

Factor 1:  

Factor 2:  

Factor 3:  

3. "Schizophrenia seems to be a different sort of experience for men and women"  
(Forrest & Hay, 1971, p. 147).  

a. Please describe your reaction to the above quotation based upon your clinical experience.
b. Please describe your reaction to the above quotation based upon your knowledge of what has been reported in the research and clinical literature.

c. If there is a difference in your responses to Questions 3a and 3b, please explain why you believe this is.

4. How, if at all, might a patient's sex affect any of the following aspects of your own work?
   [e.g., initial assessment, diagnosis, formulation/conceptualisation, choice of intervention, delivery of therapeutic intervention, evaluation of outcome, etc]

a. How, if at all, does a patient's sex affect aspects of other clinicians' work?
   [i.e., based upon your observations of the work of other mental health practitioners]
5. What might be the benefits of taking a patient’s sex into account, when working with someone who has been diagnosed with psychosis?

6. What might be the drawbacks of taking a patient’s sex into account, when working with someone who has been diagnosed with psychosis?

7. In your initial training as a clinician and in your ongoing professional development, what sort of training have you had regarding gender and psychosis?
   a. What has been the extent of this training?

SECTION 2: THE CONTENT OF PSYCHOTIC EXPERIENCES

The questions in the following two sections relate specifically to those patients diagnosed with psychosis who experience delusions and hallucinations.

8. What might be the benefits of attending to the specific content of patients’ psychotic experiences (i.e., what the hallucinations and/or delusions are about)?
9. What might be the drawbacks of attending to the specific content of patients' psychotic experiences (i.e., what the hallucinations and/or delusions are about)?

10. How, if at all, might the following aspects of your work be affected, if you attend to the specific content of patients' psychotic experiences? [e.g., initial assessment, diagnosis, formulation/conceptualisation, choice of intervention, delivery of therapeutic intervention, evaluation of outcome, etc]

11. This question relates specifically to your work with patients diagnosed with psychosis, who experience delusions and/or hallucinations.

   a. With how many of your patients do you attend to the specific content of their psychotic experiences?

      1 2 3 4 5 6 7
      None  2 3 4 5 6 7
      Every patient

   b. How much of your work with a particular patient would involve attending to the specific content of his/her psychotic experiences (e.g., proportion of time spent addressing content in therapy sessions or in planning treatment)?

      1 2 3 4 5 6 7
      None  2 3 4 5 6 7
      All

   c. Which factors might influence the extent to which you attend to the specific content of patients' psychotic experiences?
12. a. How important is it to attend to the specific content of patients' hallucinations?

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b. How important is it to attend to the specific content of patients' delusions?

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c. If there is a difference between your responses to Questions 12a and 12b, please explain why you believe this is.

13. Which factors might be important in shaping the specific content of psychotic experiences a person presents with?

a. How might each of these factors shape/influence/determine the specific content of psychotic experiences?

14. In your initial training as a clinician and in your ongoing professional development, what sort of training have you had regarding the content of psychotic experiences?

a. What has been the extent of this training?
15. Please outline briefly your knowledge of what has been reported in the research and clinical literature regarding the content of psychotic experiences.

16. Are you aware of any discrepancy between what the research and clinical literature suggest, and what your clinical experience suggests, regarding the content of psychotic experiences?

   a. If so, please explain.

SECTION 3: SEX AND THE CONTENT OF PSYCHOTIC EXPERIENCES

17. Have you noticed any similarities among male patients in the specific content of their psychotic experiences and/or have you noticed any content that is particular to male patients?

   a. If yes, please gives examples/details.

   b. How might you account for the observations in Question 17a?
18. Have you noticed any similarities among female patients in the specific content of their psychotic experiences and/or have you noticed any content that is particular to female patients?

a. If yes, please give examples/details.

b. How might you account for the observations in Question 18a?

19. Is the specific content of psychotic experiences influenced by whether a person is male or female?

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a. Please explain your answer to Question 19.

20. If you have any further comments you wish to add, relating to any of the topics touched upon in this questionnaire, please do so in the space below.
SECTION 4: BIOGRAPHICAL INFORMATION

21. Which country do you live in?

22. Which of the following best describes your professional discipline? [please choose one only]
   
   Clinical Psychologist  Counselor
   Psychiatrist  Social Worker
   Psychiatric/Mental Health Nurse  Other (please specify)

23. Please outline briefly your clinical experience in working with patients diagnosed with psychosis.

24. Which of the following best describes your orientation to your clinical work?
   
   Biomedical  Cognitive/behavioural
   Eclectic  Family systems
   Psychodynamic  Other (please specify)

25. Are you male or female?

26. What is your age?

27. What is your primary professional identification?
   
   Academic  Clinician
   Both  Neither

THANK YOU, ONCE AGAIN, FOR YOUR PARTICIPATION.
Appendix D

PILOT QUESTIONNAIRE: FACTORS INFLUENCING PSYCHOTIC EXPERIENCES

The questions in this survey ask about your opinions regarding factors influencing psychosis (i.e., schizophrenia, schizoaffective disorder, affective psychosis, etc). Please answer the questions based on your clinical experience. For each question, please circle your desired response, or fill in the space provided. Thank you for completing this questionnaire.

SECTION 1: VARIABLES WHICH MAY INFLUENCE PSYCHOSIS

1. How important are the following factors in understanding the way in which psychosis manifests?

   a. **Family dynamics**

      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |---|---|---|---|---|---|---|---|
      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |   | Not at all |  |  |  |  |  | Extremely important |

   b. **Trauma**

      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |---|---|---|---|---|---|---|---|
      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |   | Not at all |  |  |  |  |  | Extremely important |

   c. **Alcohol and drug abuse**

      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |---|---|---|---|---|---|---|---|
      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |   | Not at all |  |  |  |  |  | Extremely important |

   d. **Sex (i.e., whether a patient is male or female)**

      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |---|---|---|---|---|---|---|---|
      |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
      |   | Not at all |  |  |  |  |  | Extremely important |

   e. **Genetics (e.g., family history of psychosis)**

<pre><code>  |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
  |---|---|---|---|---|---|---|---|
  |   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
  |   | Not at all |  |  |  |  |  | Extremely important |
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Please note: The response categories range from 1 (Not at all important) to 7 (Extremely important).
2. Please list the three factors which you believe are the most important in understanding the way in which psychosis manifests. 
   [The factors you list do not need to be taken from the list above]

   a. For each of these three factors, please explain briefly the way in which it is important in understanding the way in which psychosis manifests.

3. "Schizophrenia seems to be a different sort of experience for men and women" (Forrest & Hay, 1971, p. 147).

   a. Please describe your reaction to the above quotation based upon your clinical experience.

   b. Please describe your reaction to the above quotation based upon your knowledge of what has been reported in the research and clinical literature.

   c. If there is a difference in your responses to Questions 3a and 3b, please explain why you believe this is.
4. How, if at all, might a patient’s sex affect any of the following aspects of your work?
   a. Initial assessment
   b. Diagnosis
   c. Formulation
   d. Choice of intervention
   e. Delivery of therapeutic intervention
   f. Evaluation of outcome
   g. Other aspects of your work [please give details]

5. What might be the benefits of taking a patient’s sex into account, when working with someone who has been diagnosed with psychosis?
6. What might be the **drawbacks** of taking a patient's sex into account, when working with someone who has been diagnosed with psychosis?

7. In your initial training as a clinician and in your ongoing professional development, what sort of training have you had regarding gender and psychosis?

   a. What has been the extent of this training?

**SECTION 2: THE CONTENT OF PSYCHOTIC EXPERIENCES**

The questions in the following two sections relate specifically to those patients diagnosed with psychosis who experience delusions and hallucinations.

8. What might be the **benefits** of attending to the specific content of patients' psychotic experiences (i.e., what the hallucinations and/or delusions are about)?

9. What might be the **drawbacks** of attending to the specific content of patients' psychotic experiences (i.e., what the hallucinations and/or delusions are about)?
10. How, if at all, might the following aspects of your work be affected, if you attend to the specific content of patients’ psychotic experiences?

   a. Initial assessment

   b. Diagnosis

   c. Formulation

   d. Choice of intervention

   e. Delivery of therapeutic intervention

   f. Evaluation of outcome

   g. Other aspects of your work [please give details]

11. This question relates specifically to your work with patients diagnosed with psychosis, who experience delusions and/or hallucinations.

   a. With how many of your patients do you attend to the specific content of their psychotic experiences?

   1 2 3 4 5 6 7
   None

   Every patient
b. How much of your work with a particular patient would involve attending to the specific content of his/her psychotic experiences (e.g., proportion of time spent addressing content in therapy sessions or in planning treatment)?

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c. Which factors might influence the extent to which you attend to the specific content of patients’ psychotic experiences?

12. a. How important is it to attend to the specific content of patients’ hallucinations?

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b. How important is it to attend to the specific content of patients’ delusions?

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c. If there is a difference between your responses to Questions 12a and 12b, please explain why you believe this is.

13. Which factors might be important in influencing/determining the specific content of psychotic experiences?

a. How might each of these factors influence/determine the content of psychotic experiences?
14. In your initial training as a clinician and in your ongoing professional development, what sort of training have you had regarding the content of psychotic experiences?

a. What has been the extent of this training?

15. Please outline briefly your knowledge of what has been reported in the research and clinical literature regarding the content of psychotic experiences.

16. Are you aware of any discrepancy between what the research and clinical literature suggest, and what your clinical experience suggests, regarding the content of psychotic experiences?

a. If so, please explain.

SECTION 3: SEX AND THE CONTENT OF PSYCHOTIC EXPERIENCES

17. Have you noticed any similarities among male patients in the specific content of their psychotic experiences?

a. If yes, please gives examples/details.
b. How might you account for any similarities among male patients in the specific content of their psychotic experiences?

18. Have you noticed any similarities among female patients in the specific content of their psychotic experiences?

a. If yes, please give examples/details.

b. How might you account for any similarities among female patients in the specific content of their psychotic experiences?

19. Is the specific content of psychotic experiences influenced by whether a person is male or female?

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</table>

a. Please explain your answer to Question 19.

20. If you have any further comments you wish to add, relating to any of the topics touched upon in this questionnaire, please do so in the space below.
SECTION 4: BIOGRAPHICAL INFORMATION

21. Which country do you live in?

22. Which of the following best describes your professional discipline?
   [please choose one only]
   
   - Clinical Psychologist
   - Psychiatrist
   - Psychiatric/Mental Health Nurse
   - Counsellor
   - Social Worker
   - Other (please specify)

23. Please outline briefly your clinical experience in working with patients diagnosed with psychosis.

24. Which of the following best describes your orientation to your clinical work?
   
   - Biomedical
   - Eclectic
   - Psychodynamic
   - Cognitive/behavioural
   - Family systems
   - Other (please specify)

25. Are you male or female?

26. What is your age?

27. What is your primary professional identification?
   
   - Academic
   - Both
   - Clinician
   - Neither

THANK YOU, ONCE AGAIN, FOR YOUR PARTICIPATION.
## Appendix E

### Details of the discipline and clinical orientation of each participant in the survey

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Appendix F

Making sense of ‘delusions’ and ‘hallucinations’ within the context of women’s lives

Participant Information Sheet

Principal Investigator: Ms. Yasmin Aschebrock, a PhD candidate in the Department of Psychology, University of Auckland, Private Bag 92019, Auckland, and Assistant Psychologist, Adult Psychology Service, Northland Health, PO Box 256, Kaitaia
Tel: 09 408 0011 ext. 4756 or 4749 (work) 09 409 8556 (home);
E-mail: yasmin@ihug.co.nz

Supervisors/co-investigators: Dr. Nicola Gavey, a Senior Lecturer in the Department of Psychology, University of Auckland, Private Bag 92019, Auckland
Tel: 09 373 7599 ext. 6877; E-mail: n.gavey@auckland.ac.nz
Dr. Tim McCreanor, Independent Researcher, 0.5 FTE Lecturer, Department of Psychology, University of Auckland, Private Bag 92019, Auckland
Tel: 09 373 7599; E-mail: t.mccreanor@auckland.ac.nz

Request for participation

You are invited to take part in a study exploring the life stories of Pakeha (New Zealand European) women who have had experiences characterised as delusions and/or hallucinations, and their experiences of mental health services. Participation in the study is voluntary. You do not have to take part in this study, and you may decline to participate without giving a reason.

You have two weeks to consider whether or not you would like to take part in the study. Please let the person who gave you this information sheet know within two weeks whether or not you would like to be contacted by Yasmin Aschebrock to arrange for you to participate in the study. Alternately, you may contact Yasmin directly.

Description of the study

The aim of the study is to explore the ways in which the events and circumstances of a person’s life may be reflected in the content of their delusions and hallucinations – that is, what their delusions and hallucinations ‘are about’. It also aims to investigate how people who have had these sorts of experiences make sense/meaning of them, and what it is like to seek assistance from mental health services.

Potential participants in the study are Pakeha women who have had, or continue to have experiences characterised as delusions and/or hallucinations. All those who take part in the study have either been discharged from mental health services, or they have not been admitted to hospital (i.e., they have been ‘well’) for at least the last three years. We aim to interview 10-15 women. All those who take part in the study will live in the Northland or Auckland regions. Participants will be selected for the study by their former/current mental health key workers from Northland Health/Auckland Healthcare (A+). You have been asked to consider taking part in the study because your former/current key worker has identified you as someone who has had experiences that have been labelled as delusions and/or hallucinations.
If you agree to take part in this research, your participation will involve taking part in an interview, which will take 2 - 3 hours to complete. The interview will include questions about your life, your experience of delusions and/or hallucinations, and about what it was like to seek assistance from mental health services. The interview will be arranged to suit you, and will be carried out in your own home or in another suitable place that we agree upon. The interview will be tape recorded, and then a written transcript will be typed up. You will be given a copy of this transcript (unless you prefer not to have one), and you will be able to make changes to it, if you choose to. If you choose to make changes to the transcript, you will have two weeks to do so. The data collected will be stored securely in a locked filing cabinet in Yasmin Aschebrock's office.

**Benefits, risks and safety**

You may find the study interesting and you may enjoy the opportunity to speak with someone about your life experiences. Taking part in the study would allow you an opportunity to provide feedback about what it is like to be a consumer of mental health services.

You may find that by talking about your life story or your experience of delusions and/or hallucinations, uncomfortable or unpleasant feelings arise. The possibility of this will be minimised as much as possible by the interviewer, Yasmin Aschebrock (who is employed as an assistant psychologist). However, if you do feel in any way distressed by speaking about these topics, there will be assistance available. You will be able to discuss any issues arising from taking part in the study with a clinician from Northland Health/Auckland Healthcare (A+). This assistance will be provided free of charge.

Within one week of the interview you will be contacted by Yasmin to talk through any issues which may have arisen as a result of taking part in the research. At the time of the interview, you will be given the contact details of the clinician(s) in your region, so that you can contact them to arrange an appointment, if you would like to discuss your reaction to taking part in the study. Alternatively, when Yasmin telephones you within the week following the interview, she can arrange for you to be contacted by a clinician, who will then schedule an appointment for you. Once you have requested an appointment, it is expected that you will not have to wait more than 1 - 2 weeks to meet with a clinician. Should you need more urgent assistance, then an after-hours service (24 hours, 7 days a week) is available in your region (and you will be given the relevant contact details for this service at the time of the interview). The level of assistance offered will vary according to each person's particular needs at the time. It is likely that one session with the clinician would be sufficient to talk through any issues associated with taking part in the study. However, if the clinician believes that further assistance is required, then further sessions will be offered, or s/he may refer you to other appropriate clinicians in the area, who will also provide services free of charge.

**Participation**

Your participation is entirely voluntary (your choice). You do not have to take part in this study, and if you choose not to take part, this will not affect any future care or treatment. If you do agree to take part, but later decide to withdraw from the study, you may do so within one month of receiving the written transcript of your interview. If you choose to withdraw from the study, you will not have to give a reason, and your decision to withdraw will in no way affect your future health care.

If you have any queries, or simply wish to know more about the study, please feel free to contact the researchers. If you have any queries or concerns about your rights as a participant in this study you may wish to contact the Health Advocates Trust, on 0800 555 050.

**Anonymity and confidentiality**

No material which could personally identify you will be used in any reports on this study. To protect your identity, an alternative/made-up name will be used when referring to information from your interview. Care will be taken to ensure that no information will be
included which could be used to identify you. The interviews may be transcribed by someone who is not one of the researchers. However, that person would be required to sign an agreement that they would keep all of the information confidential. All records will be stored securely so that all details and information given in interviews will be kept confidential throughout the duration of the study. At the completion of the study, the information will be kept in a locked filing cabinet.

**Results**
Each participant will be given a summary of the results, unless she prefers not to receive one. The results of the research will be part of a PhD thesis, a copy of which will be available in the General Library of the University of Auckland. The results will also be written up into a number of articles, which will be submitted for publication with appropriate academic journals. They may also be used in seminar and conference presentations. Please note that there will be a delay between data collection and publication of results.

This study has received ethical approval from the Auckland Ethics Committee.

**Please feel free to contact the researcher if you have any questions about this study.**
Appendix G

Consent Form

Making sense of ‘delusions’ and ‘hallucinations’ within the context of women’s lives

I have read and I understand the information sheet dated ____________ for volunteers taking part in the study designed to explore the life stories of Pakeha (New Zealand European) women who have had experiences characterised as delusions or hallucinations, and their experiences of mental health services. I have had the opportunity to discuss this study. I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary (my choice), and that I may withdraw from the study within one month of receiving the transcript of my interview, and this will in no way affect my future health care. I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study. I understand the compensation provisions for this study. I have had time to consider whether to take part. I know whom to contact if any issues arise for me as a result of taking part in the study. I know whom to contact if I have any questions about the study.

I give consent to my interview being audio-taped YES/NO
I wish to receive a copy of the transcript of my interview YES/NO
I wish to receive a copy of the results YES/NO

I ____________________________ (full name) hereby consent to take part in this study.

Date: __________________________ Signature of witness: __________________________

Signature: __________________________ Name of witness: __________________________

Researchers: Ms. Yasmin Aschebrock, Tel: 09 408 0011 ext. 4756 or 4749 (work); 09 409 8556 (home)
Dr. Nicola Gavey, Tel: 09 373 7599 ext. 6877
Dr. Tim McCreanor, Tel: 09 373 7599

Project explained by: Yasmin Aschebrock (principal researcher)

Signature: __________________________
Date: __________________________

Consent Form, Version 2, 30/05/02
Appendix H

Thank you for taking part in this study.

I will contact you within one week of the interview to talk through any issues which may have arisen as a result of taking part in the research.

If you feel that would like to meet with a clinician to discuss your reaction to taking part in the study then you can phone:

Tanya Goosen of the Adult Psychology Service on 09 408 8658 ext. 8338
or the 24 hour Crisis (DAO) Service on 09 408 0011

If you have any queries or concerns about your rights as a participant in this research, then you may wish to contact:

the Health Advocates Trust, on 0800 555 050

Thanks again!
Appendix I

Thank you for taking part in this study.

I will contact you within one week of the interview to talk through any issues which may have arisen as a result of taking part in the research.

If you feel that you would like to meet with a clinician in your area to discuss your reaction to taking part in the study then you can phone:

the FEP team at St Lukes Community Mental Health Centre, on 09 846 4116

or the 24 hour Crisis Service, on 0800 800 717

If you have any queries or concerns about your rights as a participant in this research, then you may wish to contact:

the Health Advocates Trust, on 0800 555 050

Thanks again!
Appendix J

Interview Schedule

Thank you for agreeing to take part in this interview. I am going to ask you some questions about your life, about your experiences of 'hearing voices' (change as appropriate depending on the nature of the person's experiences), and about what it has been like to have contact with mental health services. Please ask me to clarify if you are unsure about what some of the questions are asking. If you feel uncomfortable about answering any of the questions, please let me know. You do not have to discuss anything that you find too difficult or uncomfortable to talk about.

You have been invited to participate in this study because of experiences you have had that are referred to, in mental health settings, as delusions and/or hallucinations. To begin with, I am wondering whether you think of them in those terms or do you have other names for them?

What do you call the experiences that in mental health settings are referred to as delusions and hallucinations?

Can you tell me about your 'voices' (change as appropriate according to each person's experiences)?

How and when did they begin?

Can you tell me what they were about? For instance, if they were voices, what were the voices saying to you?

What was it like for you to hear voices (change as appropriate)?

Do those ideas/messages (change as appropriate) have particular meaning for you, that you can relate to your life more generally?

How do you understand or make sense of these experiences (i.e., how do you think about them)?

How would you explain them?

Is there anything about your voices (change as appropriate) that reminds you of things that have happened to you in your life?

Can you tell me about your experiences of seeking help from mental health services?

What was that like for you?

How well do you think the responses of mental health workers fitted with what you needed at that time?

Did the mental health workers ask you specifically about what the voices were saying etc (change as appropriate)?

When you look back now, how do you understand what happened?

What have you learned from those experiences (e.g., of hearing voices, etc, as appropriate for each participant’s experiences)?

How do you see your future now?