Psychiatric Bulletin (2000), **24**,333–336

original papers

BIBA STANTON AND ANTHONY DAVID

First-person accounts of delusions

AIMS AND METHOD

In order to investigate cognitive aspects of the experience of delusions, including onset and recovery, autobiographical accounts of schizophrenia were reviewed.

RESULTS

The sample was self-selected and biased towards women and highly-educated patients. The delusions described were usually gradual in onset and often occurred in the context of an odd or fearful mood, which was accompanied by distorted reasoning. Recovery was also gradual with an intermediate stage of reality-testing or fluctuation between belief and disbelief. Many patients retained residual aspects of delusional thinking after recovery. Most attributed their recovery to a combination of medication, psychotherapy, social support and personal coping strategies; some felt that their illness had enhanced their self-awareness or spirituality.

CLINICAL IMPLICATIONS

Further exploration of spontaneous coping strategies in recovery from delusions through personal accounts of illness would be valuable.

Autobiographical accounts of the experience of psychiatric illness are ubiquitous (Sommer & Osmond, 1983). Despite this, their systematic use in research has been neglected. The recognition of the value of patients' perspectives on mental illness is, in itself, empowering to patients, and vivid descriptions of subjective accounts encourage empathy and reflection in health care professionals. In addition, autobiographical accounts provide a rich source of material for phenomenological and cognitive neuropsychiatric research (Freedman, 1974).

The use of first-person accounts of mental illness has disadvantages. Most importantly, the writers of such accounts are likely to be atypical of the general patient population in terms of demographic characteristics, personal qualities and their degree of recovery and insight. Such characteristics may lead these individuals to interpret their experiences in a different way. Despite these problems with subjective accounts of mental disorder, Chadwick (1997), a clinical psychologist who has described his own psychotic illness, argues strongly for learning more from patients' personal accounts, and highlights the individuality of patients' attributions for their illness and their perceived paths to recovery.

Since 1979, the journal, *Schizophrenia Bulletin*, has published a series of 'First Person Accounts' written by patients with schizophrenia and their families. We systematically reviewed all these articles in order to explore aspects of the onset, recovery and experience of delusions in patients with schizophrenia. We chose to focus on delusions and used the DSM–IV (American Psychiatric Association, 1994) definition where possible, as these are a core feature of psychosis and yet remain poorly understood (Mortimer *et al*, 1996; Jones & Watson, 1997; Kemp *et al*, 1997; David, 1999).

Results

Characteristics of authors

The gender of the author was ascertainable in 28 out of 29 cases. Twenty were female and eight were male (χ^2=5.14, d.f.=1, *P*=0.023). Information about the age of the author was available in only 10 out of 29 cases: mean age was 36.3 years (range 28–49).

Education of authors was classified into four categories; those who did not graduate from high school, high school graduates, college graduates and those with higher degrees. Information was available in 27 out of 29 cases. No subjects failed to graduate from high school; 13 (48%) were college graduates and eight (30%) had higher degrees. Four mentioned that they had started college but were unable to complete their course because of their illness.

Cognitive processes in delusions

Onset

The onset of delusional thinking was most often described as being gradual and insidious (Bockes, 1985; Anonymous, 1992). Bowden (1993) described an interest in psychic phenomena progressing to increasingly unusual preoccupations and then to bizarre beliefs "in which I believed wholeheartedly". Delusions occurring secondary to abnormal perceptual experiences (particularly auditory hallucinations) were frequently described. One author wrote of hallucinations "they deceive, derange and force me into a world of crippling paranoia" (Bayley, 1996). In many cases, the delusional beliefs could be seen as fairly rational explanations for abnormal experiences:

> "I increasingly heard voices (which I'd always call 'loud thoughts') . . . I concluded that other people were putting these loud thoughts into my head" (Bockes, 1985).

Bayley (1996) writes that delusions are:

> "reality to the individual, even if they appear to be unintelligible . . . there is often a link with an outwardly recognizable concept or event when time is given to try and interpret the thought processes involved".

However, it is possible that these explanations are partly retrospective rationalisations.

Many authors gave clear descriptions of a prodromal state in which the development of delusional beliefs began. This delusional mood was described either as a sense of strangeness ("I felt distinctly different from my usual self", Payne, 1992) or of profound anxiety ("I first began to be anxious and fearful", Fortner & Steel, 1988;

https://doi.org/10.1192/pb.24.9.333 Published online by Cambridge University Press

original papers

"I sensed danger everywhere", Anonymous, 1983). The state was frequently described as being accompanied by a sense that "every single thing means something" or that "there is a connection to everything that happens" (Brundage, 1983).

Although some delusions appeared to be understandable explanations of abnormal perceptions (see Maher, 1988), a number of authors did not identify an antecedent. Nevertheless, there were few classical descriptions that arose in consciousness, fully formed. For instance, one author wrote:

> "One of my duties [at work] was to read information intended for military personnel . . . I became convinced that I was reading top secret information and that somebody would try to have me killed so that I couldn't talk".

Despite the fact that most delusions described had a gradual onset, there are very few descriptions which suggest that reality-testing or questioning of unusual beliefs occurs at an early stage. In contrast, many authors said that their beliefs always seemed perfectly reasonable to them ("I felt no surprise; it seemed natural to me"; Murphy, 1997) and that nothing caused them to question their ideas ("the world ticked like clockwork around me, never once protesting my assumptions"; Anonymous, 1997). One author described an attempt to rationalise her growing suspicions:

> "I am not alarmed. I attribute the signs to fatigue, and it makes sense to me that the FBI are following me since I am going to a high security [military] school" (Anonymous, 1990*a*).

But she does not seem to have considered the possibility that her fears may have been unfounded. Thus, while evidence apparently confirming a developing delusion is accepted ("Everything: billboards, radio, television, people, random sounds fed into this delusion"; Anonymous, 1989) evidence which could disconfirm it is ignored.

Recovery

Almost all authors who commented on the pace of their recovery from psychosis described it as gradual: "As the weeks passed . . . the world became saner. The voices stopped. Things started to seem ordinary" (Herrig, 1995); "My symptoms gradually subsided" (Payne, 1992). One account does describe an episode when delusional beliefs suddenly disappeared ("suddenly it dawned on me . . . everything seemed clear to me. It was as though a fog had lifted and I could think clearly again"; Anonymous, 1990*b*) but also describes more gradual recovery on another occasion ("the delusions seemed to fade away gradually").

There is support in these accounts for Sacks *et al*'s (1974) suggestion that there is an intermediate stage of "double-awareness" in the recovery from delusions. Ruocchio (1991) describes feeling that "a part of me wants to dispel the delusions whilst a part of me is frightened and resists". She feels that this is a particularly difficult stage in the illness: "the hardest part of beginning to recover from schizophrenia is passing back and forth from one part to another . . . the uncertainty is so painful and terrifying". Other authors describe this phase as an increasing willingness to question delusional beliefs and undertake reality-testing: "bit by bit my distrust faltered" (Lovejoy, 1982); "constant reality testing may be necessary to keep [my] mind in balance" (Anonymous, 1990*c*); "by thinking and writing in my journal [I concluded] that perhaps I'd noticed the strange incidents simply because I was already uneasy" (Bockes, 1985). Some authors emphasise that a conscious effort may be needed to achieve or maintain recovery: "the key is to be able to detect these false beliefs and reinforce them as fiction" (Fleshner, 1995). One account suggests that some patients may pass through a phase of fearfulness similar to that of delusional mood in the process of recovery: "at this stage of my illness, I was no longer imagining things, but I was afraid" (O'Neal, 1984).

Sacks *et al* (1974) also argued that the continuum of delusional and non-delusional thinking is reflected in "residua of formerly flagrant delusions". In some cases, delusional ideas were still present but were less bizarre ("presently, I believe that people can read my mind only if they are in my immediate vicinity. I do not believe, even if I am a psychic, that I am an agent of God"; Bowden, 1993), less firmly held ("I now know that this was either punishment at the hands of God's servants . . . or alternatively, but less likely, that I simply imagined these things"; Anonymous, 1996), or less prominent in the patient's thinking ("I have dispelled many delusions to the point where they are not primary in my thinking"; Ruocchio, 1989). Other authors describe a continuing duality between rational and delusional thinking (Fleshner, 1995) or occasional episodes of delusional beliefs ("I still have days when reality is distant"; Anonymous, 1992). Residua were described by about half of this sample (the remainder described full recovery) which are probably skewed towards good outcome. Interestingly, all patients whose delusional beliefs persisted, nevertheless recognised that they were suffering from a mental disorder.

Experience of illness

The most common factor that authors felt had contributed to their recovery was medication (mentioned by 23 patients), but few felt that they had been helped by medication alone. Fourteen highlighted psychotherapy, either in helping to deal with specific symptoms or as a means of personal support. Many (n=14) also identified social support (from family, friends, other patients or formal support groups) as a significant factor in their rehabilitation. Anonymous (1989) writes that "a secure, stable, friendly environment around me reduced the paranoia". Psychosocial factors were perceived by most patients as very important in recovery, despite the fact that they almost always attributed their problems to a biological disorder.

Many patients (n=11) emphasised the role they had played in their own recovery. A number commented on developing personal coping strategies: "I have tried very hard to find ways to cope better with my disease" (Molta, 1997); "I must look inside myself to find ways to handle it" (McGrath, 1984). Strategies discussed include structuring of time, developing a support network, writing journals and acceptance of illness. Some authors mention specific methods for combating delusional thinking: "I am able to fight the delusional thinking better

https://doi.org/10.1192/pb.24.9.333 Published online by Cambridge University Press

original papers

by discussing it with people" (Anonymous, 1990*c*). Other writers do not mention practical strategies, but nevertheless perceive their recovery as a personal struggle against illness: "I began to fight an all out war against my paranoid and other fearful and/or bizarre ideas" (Gallo, 1994); "medication made it possible, if I fought very hard, to stay in reality" (Anonymous, 1992).

Although the experience of psychosis is often frightening and disturbing, some patients may perceive something positive to have come out of their illness. A number in this sample commented that they had gained a greater insight into themselves as a result: "my illness has caused me to grow in my inner self to discover who I really am" (Anonymous, 1990*c*); "I reflect back on the pains of the past and consider them as a learning experience" (O'Neal, 1984). Fleshner (1995) writes: "this illness enriches my imagination". Other authors felt that they could find meaning in their illness by using their experiences to help other sufferers or increase awareness of mental health issues (Brundage, 1983; Anonymous, 1990*a*). Several patients felt that their illness had increased their spirituality (Anonymous, 1992; Murphy, 1997), a factor frequently ignored by professionals (see Chadwick, 1997).

Discussion

The delusions described in these first-person accounts were most often gradual in onset. Many delusions occurred secondary to an abnormal perception (apparently rationally) or in the context of an odd or fearful mood, which was often accompanied by altered reasoning. Apparently primary delusions were also described, but were not necessarily sudden in onset. Reality-testing was not usually part of the process of the development of delusions. It seems that people usually feel no need to question their developing beliefs, and that evidence which might disconfirm them is ignored.

Recovery from delusions is almost always a gradual process, during which the individual passes through an intermediate stage of willingness to question delusions or duality of belief and disbelief. Reality-testing and other strategies to combat delusional thinking may play an important part in promoting and maintaining recovery (e.g. Falloon & Talbot, 1981). This could be actively enhanced by clinicians to promote recovery. It is likely that the emphasis placed by these authors on the importance of a personal role in recovery is a reflection of the well-educated and well-motivated nature of this group, and perhaps the views of journal editors. In many cases, some aspects of delusional thinking appear to persist despite insight into illness generally (see Jørgensen, 1995). This supports a multi-dimensional conceptualisation of insight (David, 1990; Amador & David, 1998).

Most authors of first-person accounts identified several factors as contributing to their path to recovery, including medication, psychotherapy and social support. Many perceived recovery as a personal struggle against illness and developed individual strategies for coping. Positive aspects of experiences were often identified, including enhanced insight and spirituality. There is evidence to suggest that psychotic illness often increases the strength of religious belief and that this may assist coping in these individuals (Kirov *et al*, 1998).

The observational nature of this study and the atypicality of the patients represented make it hard to draw firm and generalisable conclusions. The reasons for the gender difference are unclear. It is possible that women are more introspective about their illness, that they more often wish to share their experience with others, or that they are more likely to see writing as a useful form of personal expression. Alternatively, professionals or families may perceive women differently and hence encourage them to write articles for publication. Nevertheless, autobiographical accounts such as these can make an important contribution to understanding the cognitive processes and personal views of patients with a psychotic illness.

References

AMADOR, X. F. & DAVID, A. S. (1998) *Insight and Psychosis*. New York: Oxford University Press.

AMERICAN PSYCHIATRIC ASSOCIATION (1994) *Diagnostic and Statistical Manual of Mental Disorders* (4th edn) (DSM–IV). Washington, DC: APA.

ANONYMOUS (1983) Schizophrenia – a pharmacy student's view. *Schizophrenia Bulletin*, **9**, 152–155.

— (1989) How I've managed chronic mental illness. *Schizophrenia Bulletin*, **15**, 635–640.

— (1990*a*) Birds of a psychic feather. *Schizophrenia Bulletin*, **16**, 165–168.

— (1990*b*) A pit of confusion. *Schizophrenia Bulletin*, **16**, 355–359.

— (1990*c*) Behind the mask: a functional schizophrenic copes. *Schizophrenia Bulletin*, **16**, 547–549.

— (1992) Portrait of a schizophrenic. *Schizophrenia Bulletin*, **18**, 333–336.

— (1996) Social, economic and medical effects of schizophrenia. *Schizophrenia Bulletin*, **22**, 183–185.

— (1997) The end of two roads. *Schizophrenia Bulletin*, **23**, 163–164.

BAYLEY, R. (1996) Schizophrenia. *Schizophrenia Bulletin*, **22**, 727–729.

BOCKES, Z. (1985) Freedom means knowing you have a choice. *Schizophrenia Bulletin*, **11**, 487–489.

BOWDEN, W. D. (1993) The onset of paranoia. *Schizophrenia Bulletin*, **19**, 165–167.

BRUNDAGE, B. E. (1983) What I wanted to know but was afraid to ask. *Schizophrenia Bulletin*, **9**, 583–585.

CHADWICK, P. K. (1997) Recovery from psychosis: learning more from patients. *Journal of Mental Health*, **6**, 577–588.

DAVID, A. S. (1990) Insight and psychosis. *British Journal of Psychiatry*, **156**, 798–808.

— (1999) On the impossibility of defining delusions. *Philosophy, Psychiatry & Psychology*, **6**, 17–20.

FALLOON, I. R. & TALBOT, R. E. (1981) Persistent auditory hallucinations: coping mechanisms and implications for management. *Psychological Medicine*, **11**, 329–339.

FLESHNER, C. L. (1995) Insight from a schizophrenic patient with depression. *Schizophrenia Bulletin*, **21**, 703–707.

FORTNER, R. B. & STEEL, C. (1988) The history and outcome of my encounter with schizophrenia. *Schizophrenia Bulletin*, **14**, 701–706.

FREEDMAN, B. J. (1974) The subjective experience of perceptual and cognitive disturbances in schizophrenia. *Archives of General Psychiatry*, **30**, 333–340.

GALLO, K. M. (1994) Self-stigmatization. *Schizophrenia Bulletin*, **20**, 407–410.

HERRIG E. (1995) A personal experience. *Schizophrenia Bulletin*, **21**, 339–342.

JONES, E. & WATSON, J. P. (1997) Delusion, the overvalued idea and religious beliefs: a comparative analysis of their characteristics. *British Journal of Psychiatry*, **170**, 381–386.

JØRGENSEN, P. (1995) Recovery and insight in schizophrenia. *Acta Psychiatrica Scandinavica*, **92**, 436–440.

https://doi.org/10.1192/pb.24.9.333 Published online by Cambridge University Press

original papers

KEMP, R., CHUA, S., McKENNA, P., *et al* (1997) Reasoning and delusions. *British Journal of Psychiatry*, **170**, 398–405.

KIROV, G., KEMP, R. & DAVID, A. S. (1998) Religious faith after psychotic illness. *Psychopathology*, **31**, 234–245.

LOVEJOY, M. (1982) Expectations and the recovery process. *Schizophrenia Bulletin*, **8**, 605–609.

McGRATH, M. E. (1984) Where did I go? *Schizophrenia Bulletin*, **10**, 638–640.

MAHER, B. A. (1988) Anomalous experiences and delusional thinking: the logic of explanations. In *Delusional Beliefs* (eds T. F. Oltmanns & B. A. Maher), pp. 15–33. Wiley: New York.

MOLTA, V. E. (1997). Living with mental illness. *Schizophrenia Bulletin*, **23**, 349–351.

MORTIMER, A. M., BENTHAM, P., McKAY, A. P., *et al* (1996) Delusions in schizophrenia: a phenomenological and psychological exploration. *Cognitive Neuropsychiatry*, **1**, 289–304.

MURPHY, M. A. (1997). Meaning of psychoses. *Schizophrenia Bulletin*, **23**, 541–543.

O'NEAL, J. M. (1984) Finding myself and loving it. *Schizophrenia Bulletin*, **10**, 109–110.

PAYNE, R. L. (1992) My schizophrenia. *Schizophrenia Bulletin*, **18**, 725–727.

RUOCCHIO, P. J. (1989) The schizophrenic's nightmare. *Schizophrenia Bulletin*, **15**, 163–166.

— (1991) The schizophrenic inside. *Schizophrenia Bulletin*, **17**, 357–360.

SACKS, M. H., CARPENTER, W. T. & STRAUSS, J. S. (1974) Recovery from delusions: three phases documented by patient's interpretation of research procedures. *Archives of General Psychiatry*, **43**, 117–120.

SOMMER, R. & OSMOND, H. (1983) A bibliography of mental patients' autobiographies, 1960–1982. *American Journal of Psychiatry*, **110**, 1051–1054.

Biba Stanton Medical Student, University of Newcastle, Newcastle, ***Anthony S. David** Professor of Cognitive Neuropsychiatry, Institute of Psychiatry, London SE5 8AF

Psychiatric Bulletin (2000), **24**, 336–338

ROWAN WILSON, CATHERINE L. CORBY, MARIA ATKINS AND GEOFF MARSTON

Trainee views on active problems and issues in UK psychiatry

Collegiate Trainees' Committee survey of three UK training regions

AIMS AND METHOD

A questionnaire sent to trainees in three regions of the UK asked them which current issues they felt were most important in psychiatry. Comments were invited of ways to improve the UK practice of psychiatry.

RESULTS

Trainees from each of the regions were concerned about inadequate resourcing, public expectations, manpower and quality of training. Solutions to these problems were collated.

CLINICAL IMPLICATIONS

The opinion of trainees reflects the recent initiatives undertaken by the Royal College of Psychiatrists to improve recruitment and retention. Consultants and trainees have similar concerns, which need to be addressed and monitored at a local and national level.

There have been suggestions that there are significant problems in the recruitment and retention of psychiatrists (Storer, 1996; Sims, 1997; Jenkins & Scott, 1998). A survey of psychiatrists who retired prematurely revealed significant dissatisfaction with current practice of psychiatry in the UK (Kendell & Pearce, 1997). Trainee morale has anecdotally been reported as low (Milton, 1998; Thompson, 1998), particularly in general psychiatry (Deahl & Turner, 1997), although for a significant number of trainees this is still a career choice (Davies & Schlich, 1999). To provide objective information about trainees' views on training and service conditions the Collegiate Trainees' Committee (CTC) surveyed trainees in three regions representative of the UK in 1998. Such data have been lacking in the literature to date (Milton, 1998).

The study

Members of the CTC, an elected committee of the Royal College of Psychiatrists representing trainees (Sullivan, 1997), devised a questionnaire for all grades of trainee. Information was gathered on demographic details, career choices and local working conditions, including items related to stress at work. Trainees were specifically asked to respond to the statement, "The following factors are active problems or issues in psychiatry, with a major impact on quality and/or safety of the practice of psychiatry". Ten specific issues felt by the CTC to be important areas in UK psychiatry were then listed:

(a) bureaucracy;
(b) excessive on-call;
(c) excessive clinical workload;
(d) general understaffing;
(e) inadequate resourcing;
(f) in-patient bed numbers;
(g) patient expectations;
(h) professional isolation;
(i) public expectations;
(j) violence to staff.

A five-point Likert scale, from 'strongly agree' to 'strongly disagree', was used to rate responses. Responses to the

https://doi.org/10.1192/pb.24.9.333 Published online by Cambridge University Press