Chapter 1

What Is a Delusion?

Delusions have always presented a particular challenge for psychiatry. It is not just that they are such an arresting phenomenon – patients with schizophrenia, the main but by no means the only disorder where they are seen, routinely make claims that are completely impossible but are narrated in a completely matter-of-fact way – it is also because they are central to the concepts of sanity and insanity in a way that other symptoms of mental illness are not. As the psychiatrist and philosopher Jaspers (1959) put it in a quote that has been repeated so many times it is in danger of becoming a cliché: 'Since time immemorial, delusion has been taken as the basic characteristic of madness. To be mad was to be deluded.'

The first step in understanding any phenomenon is to define it. However, in the case of delusions, this has not proved easy to do. Of course, like other psychiatric symptoms they have a textbook definition: they are false beliefs which are fixed, incorrigible and out of keeping with the individual's social and cultural background. Unfortunately, as Jaspers and a steady stream of later authors have pointed out, criteria of fixity and incorrigibility are not very helpful when it seems to be a universal human characteristic to hold on stubbornly to beliefs that are often self-evidently wrong. The part of the definition about the belief being out of keeping with the individual's social and cultural background might also be considered slightly suspect, given that it seems to leave a lot to the subjective judgement of the clinician. This and several other definitional problems were pithily summed up by David (1999):

> [D]espite the facade created by psychiatric textbooks, there is no acceptable (rather than accepted) definition of a delusion. Most attempted definitions begin with 'false belief', and this is swiftly amended to an unfounded belief to counter the circumstance where a person's belief turns out to be true. Then caveats accumulate concerning the person's culture and whether the beliefs are shared. Religious beliefs begin to cause problems here and religious delusions begin to create major conflicts. The beleaguered psychopathologist then falls back on the 'quality' of the belief – the strength of the conviction in the face of contradictory evidence, the 'incorrigibility', the personal commitment, etc. Here, the irrationality seen in 'normal' reasoning undermines the specificity of these characteristics for delusions as does the variable conviction and fluctuating insight seen in patients with chronic psychoses who everyone agrees are deluded. Finally we have the add-ons: the distress caused by the belief, its preoccupying quality, and its maladaptiveness generally, again, sometimes equally applicable to other beliefs held by non-psychotic fanatics of one sort or another. In the end we are left with a shambles.

Even if these problems are capable of resolution, simply defining delusions fails to do something at least as important, that of communicating what the experience of being deluded is like. This problem is easier to put right, since there is a reasonably substantial descriptive literature on the symptom. In fact, one needs to look no further than the

accounts of Kraepelin (1913a,b) and Bleuler (1911; 1924) to get a vivid and very detailed account of what deluded patients actually say. Later, Jaspers (1959) contributed additional important descriptions of his own. Beyond this, it is slightly surprising to realize that there is really one major contemporary source of original material. This had its origins in a drive that took place in the 1960s and 1970s to make the notoriously unreliable assessment of psychiatric symptoms more objective, which resulted in the development of a series of structured interviews for schizophrenia and other disorders. One of these stood out in terms of the broadness of its reach and sophistication of its psychopathological description. This was the Present State Examination (PSE) of Wing and co-workers (1974) and it had a particularly rich and detailed section on delusions.

Of course, it was never just a matter of description. Both Kraepelin and Bleuler had something to say about how and why delusions might arise. Jaspers became famous for trying to capture the essential nature of abnormal subjective experiences using a method called phenomenology. The conclusions he came to about delusions have had a lasting impact, although, as will be seen, they led to a disagreement with another phenomenologically minded author of the day, Schneider (1949). As Wing et al. (1974) refined their classification of delusions over nine editions of the PSE (there is now also a tenth), they also sometimes found themselves providing their own pragmatic solutions to a number of problems left over from the classical era.

This chapter describes the diverse clinical features of delusions, focusing on the contributions of the aforementioned authors. Their various attempts to go further and capture something of the essential nature of delusions, as well as the disputes that sometimes arose between them, provide a kind of parallel discourse that hopefully also allows something to be said about delusions beyond just defining them. Tricky questions about what is and is not a delusion are sidestepped for the time being by limiting the discussion to beliefs that everyone would agree are obviously delusional.

Describing Delusions: Kraepelin and Bleuler

Despite being written more than a century ago in another language, Kraepelin's descriptions of psychotic symptoms have an immediacy that has never been equalled. In the seventh edition of his textbook of psychiatry (Kraepelin, 1907), he began with what would now be regarded as a rather undifferentiated conception of *persecutory delusions*: patients would feel they were being watched, they would observe peculiar acts in public places that referred to them, children on the street would jeer and laugh at them wherever they went, all of which led them to believe that people were conspiring against them. *Hypochondriacal or somatic delusions* were another prominent type. Patients would express beliefs that their intestines were shrinking or that their organs had been removed, often bound up with the imagined persecution. *Expansive or grandiose delusions* were also seen and could be as varied as the ideas of persecution and bodily change. Patients would say that they had been awarded a prize for bravery, that they ruled the country, or that they were talented poets or the greatest inventor ever born; or alternatively that they had God-like attributes, had been transformed into Christ, would ascend to heaven and so on. What Kraepelin called ideas of spirit-possession often went hand in hand with these other kinds of delusions. Here the persecutor or persecutors would enter and take control of the body, causing the patient's bones to crack, his testicles to fall or his or her throat to dry up.

Kraepelin's multi-volume, eighth edition of his textbook (Kraepelin, 1913a,b) contained similar but more detailed descriptions. Where this later account really came into its own with respect to delusions, however, was in his account of paraphrenia and paranoia. Paraphrenia was the term he gave to a group of disorders closely related to schizophrenia, which were characterized by florid delusions and hallucinations but few if any other symptoms. His description of one of the subtypes of paraphrenia, paraphrenia systematica, is notable for how delusions, especially persecutory delusions, grew out of the experience of *referentiality*. At first:

> The patient notices that he is the object of general attention. On his appearance the neighbours put their heads together, turn round to look at him, watch him. On the street he is stared at; strange people follow him, look at one another, make signs to one another; policemen are standing about everywhere. In the restaurants to which he goes, his coming is already announced; in the newspapers there are allusions to him; the sermon is aimed at him; there must be something behind it all.

At the same time, people's motives would seem to be anything but friendly:

> [E]verything is done to spite him; people work systematically against him. The servants are incited against him, cannot endure him any longer; the children have no longer any respect for him; people are trying to remove him from his situation, to prevent him from marrying, to undermine his existence, to drive him into the night of insanity. Female patients perceive that people are trying to dishonour them, to seduce them, to bring them to shame.

Slowly, sometimes over the course of years, the reason for the persecution would become more and more tangible:

> Obviously there exists a regular conspiracy that carries on the persecution; sometimes it is the social democrats, the 'red guard', sometimes the Freemasons, sometimes the Jesuits, the Catholics, the spiritualists, the German Emperor, the 'central union', the members of the club, the neighbours, the relatives, the wife, but especially former mistresses, who cause all the mischief.

There was no such logical progression in what Kraepelin termed paraphrenia phantastica. As its name suggests, this was characterized by the spontaneous appearance of *fantastic delusions.* These could be persecutory, grandiose or hypochondriacal in nature, but their main feature was their wholly absurd content and the way in which they were produced in a seemingly inexhaustible supply. Patients would express the beliefs that there were multiple other people inside them or that they owned properties on other planets. One patient believed that a whole car had entered his body, with the steering wheel sticking out of his ears. Another talked about an international conspiracy that existed for getting rid of people by means of lifts in hotels, which took them down into subterranean vaults, where a sausage machine was waiting for them.

In a small group of cases ('paraphrenia confabulans'), the patients produced, in addition to other delusions and sometimes hallucinations, detailed accounts of fictitious events, something Kraepelin called pseudo-memories but are now referred as *delusional memories* and *delusional confabulations*. One patient related how, as a child, he had been taken to the Royal Palace where he was shown the room where he was born and later met one of the King's daughters who promised to marry him. Another patient went to the police and reported that he had dug up a human arm (which resulted in a police investigation). Sometimes the fictitious events would be repeated almost word for word on different occasions, but in other cases the tale would be continually embroidered. For example, the patient who stated he had dug up an arm later went on to recount how his mother and other individuals in the village

had disappeared, and that a woman in the neighbourhood had threatened him with a gun and said that it would be his turn next.

Delusions were not just a feature of schizophrenia and paraphrenia. They also occurred in the states that Kraepelin (1913a, b) brought together as manic-depressive insanity (a term which would now cover bipolar disorder and unipolar major depression). In the mildest form of mania, hypomania, it was more a case of exaggerations and distortions than delusions: patients boasted about their aristocratic acquaintances and prospects of marriage, gave themselves non-existent titles, and had visiting cards printed with a crown on them. These ideas gave way to fully fledged delusions in more severely affected cases – the patients were geniuses, were of noble or royal descent, possessed great riches, were saints, Jesus or God – although the beliefs could still sometimes be fleeting or expressed in half-joking way.

In depression, the same range of abnormal beliefs was seen in mirror image, from unfounded gloomy and self-depreciatory thoughts in what he called 'melancholia simplex', through to undoubted delusions playing on the same themes. In these latter cases, patients would say things like they were the most wicked person, an abomination, or had committed fraud and would be imprisoned for 10 years. Others believed they were incurably ill with cancer or syphilis and/or they were making people around them ill. A heartrending example of what are now referred to as *depressive delusions* is given in Box 1.1.

Box 1.1 Extract from a Letter by a Female Patient with Depressive Delusions to Her Sister (Kraepelin, 1913b)

I wish to inform you that I have received the cake. Many thanks, but I am not worthy. You sent it on the anniversary of my child's death, for I am not worthy of my birthday; I must weep myself to death; I cannot live and I cannot die, because I have failed so much, I shall bring my husband and children to hell. We are all lost; we won't see each other any more; I shall go to the convict prison and my two girls as well, if they do not make away with themselves, because they were borne in my body. If I had only remained single! I shall bring all my children into damnation, five children! Not far enough cut in my throat, nothing but unworthy confessions and communion; I have fallen and it never in my life occurred to me; I am to blame that my husband died and many others. God caused the fire in our village on my account; I shall bring many people into the institution. My good, honest John was so pious and has to take his life; he got nineteen marks on Low Sunday, and at the age of nineteen his life came to an end. My two girls are there, no father, no mother, no brother, and no one will take them because of their wicked mother. God puts everything into my mind; I can write to you a whole sheet full of nothing but significance; you have not seen it, what signs it has made. I have heard that we need nothing more, we are lost.

Note: 'Not far enough cut in my throat' referred to a suicide attempt the patient had made. John, her husband, was in fact alive.

Kraepelin was not quite finished with delusions yet. He argued that a small number of patients showed insidiously developing delusions in the absence of any other psychotic (or mood) symptoms and with little if any change in other areas of thinking. In this disorder, paranoia, the beliefs often, though not always, took a persecutory form and in many cases they followed a long period of suspiciousness and referentiality. The central delusion itself was also

different from delusions in other disorders, in that it did not show gross internal contradictions and, despite its usual extreme unlikeliness, did 'not usually contain any apparent absolute impossibilities'. This idea survives to the present day as the concept of *non-bizarre delusions*.

Bleuler, Kraepelin's contemporary and the other towering psychiatric figure of the day, generally had less to say about delusions. In his book on schizophrenia (Bleuler, 1911), he described persecutory delusions as being particularly common, and emphasized the wide variety of organizations that were alleged to be involved, including the patients' fellow-employees, the Freemasons, the Jesuits, mind-readers and spiritualists, among others. In his experience, grandiose delusions were also common and usually occurred alongside persecutory delusions. He also noted that depressive delusions could be seen which were very similar to those described by Kraepelin in delusional forms of melancholia; sometimes they seemed to be related to the patient's current mood state, but this was by no means always the case.

There was no shortage of fantastic delusions in Bleuler's (1911) account. Patients could be animals, a frog, a dog, a shark, or even an inanimate object. Women gave birth to 150 children every night. A patient had human beings in her fingers who wanted to kill her and drink her blood. Hypochondriacal delusions, often with a bizarre or fantastic quality, were also common: patients would say things like there was a growth in their heads, their bones had turned to liquid, or that their bone marrow was running out in their sperm. He also drew attention to the occurrence of *sexual delusions*, as in male patients who felt they were female, and vice-versa.

Bleuler additionally highlighted a phenomenon, ideas of influence, that had only been noted in passing by Kraepelin:

> [T]hese hostile forces observe and note his every action and thought by means of 'mountain-mirrors', or by electrical instruments and influence him by means of mysterious apparatus and magic. They make the voices; they cause him every conceivable, unbearable sensation. They cause him to go stiff, deprive him of his thoughts or make him think certain thoughts … The bodily 'influencing' constitutes an especially unbearable torture for these patients. The physician stabs their eyes with a 'knife voice'. They are dissected, beaten, electrocuted; their brain is sawn in pieces, their muscles are stiffened. A constantly operating machine has been installed in their heads.

This class of delusions would go on to become a focus of much subsequent interest as one of the so-called first-rank symptoms of schizophrenia, *passivity* or *delusions of control.*

Like Kraepelin, Bleuler (1911; 1924) considered that delusions of reference could be an important starting point for the development of persecutory delusions. Patients with grandiose delusions had also often had vague and undefined great hopes and ambitions at the start of their illnesses, which then later assumed a more definite form. However, he did not feel that this mode of development could be established as a general principle. In some cases, the sudden appearance of sharply formulated ideas was the first symptom of the illness; in others, delusions appeared in consciousness all at once, as it were as finished products.

The Phenomenology of Delusions: Jaspers versus Schneider

Memorable though they were, Kraepelin's and Bleuler's descriptions of delusions were just that – descriptions. Neither author spent much time deliberating over the nature or limits of the phenomenon, or on features such as fixity and incorrigibility. It was Jaspers who more than anyone else shouldered this responsibility. He was the first and, it is probably fair to say,

the only author to seriously grapple with the definition of delusion. He also formulated a theory of delusions whose influence rightly or wrongly is still felt today. Along the way he also contributed some fine descriptions of the symptom, especially with respect to referentiality.

Jaspers' thinking about delusions appeared in successive editions of his book *General Psychopathology*, the last of which was published in 1959. This version is long and mostly very dense (the only way the present author has ever been able to approach it is to look up topics in the index and read the relevant pages). Fortunately, his views on delusions have been lucidly summarized and explained by Walker (1991) in an article with the title 'Delusions: what did Jaspers really say?', and this will be drawn on repeatedly in what follows.

Jaspers started by exposing the deficiencies in the standard definition of delusions. He noted that the term tended to be applied to false judgements which showed the following external characteristics: (1) they are held with extraordinary conviction, an incomparable subjective certainty; (2) there is an imperviousness to other experiences and to compelling counter-argument; and (3) their content is impossible. He dismissed the first two features out of hand. Intensity of conviction neither distinguished delusions from normal strongly held scientific, political or ethical convictions, nor from the overvalued idea (a symptom that is discussed in detail in the next chapter). Nor was incorrigibility a good criterion, since normal wrong beliefs are also notoriously difficult to correct and are often clung on to tenaciously. This point was nicely made by Walker (1991):

> Imagine John Major and Neil Kinnock [the Prime Minister and leader of the opposition at the time] in full flow at the dispatch box of the House of Commons. Both hold views with an 'extraordinary conviction' and 'an incomparable subjective certainty'. Both show a very definite 'imperviousness to other experiences and to compelling counter-argument'. For each, the judgements of the other are 'false' and 'their content impossible'. Obviously, neither is deluded.

Jaspers also made the point that beliefs which otherwise showed all the characteristics of delusions were not necessarily held with full conviction. Patients' attitudes to their beliefs could range from a mere play with possibilities, through a 'double reality' where the real and the delusional existed side by side, to full conviction ('unequivocal attitudes in which the delusional content reigns as the sole and absolute reality').

Next, Jaspers went on to explore the nature of delusions. He did this using phenomenology, his own partly clinical, partly philosophical method for grasping the nature of psychotic and other psychiatric symptoms. The important features of the approach are summarized in Box 1.2, but ultimately it boiled down to abstracting the essential features of a particular abnormal subjective experience from the very varied descriptions that patients gave, while at the same time taking care not to impose unwarranted theoretical interpretations on the results of the exercise.

Box 1.2 Jaspers on Phenomenology (Jaspers, 1912, reproduced with permission from the British Journal of Psychiatry)

We must begin with a clear representation of what is actually going on in the patient, what he is really experiencing, how things arise in his consciousness, what are his own feelings, and so forth; and at this stage we must put aside altogether such considerations as the relationships between experiences, or their summation as a whole, and more especially we must avoid trying to supply any basic constructs or frames of reference. We should picture only what is really present in the patient's consciousness; anything that has not really presented itself to his

consciousness is outside our consideration. We must set aside all outmoded theories, psychological constructs or materialist mythologies of cerebral processes; we must turn our attention only to that which we can understand as having real existence, and which we can differentiate and describe. This, as experience has shown, is in itself a very difficult task …

The methods by which we carry out a phenomenological analysis and determine what patients really experience are of three kinds: (1) one immerses oneself, so to speak, in their gestures, behaviour, expressive movements; (2) exploration, by direct questioning of the patients and by means of accounts which they themselves, under our guidance, give of their own experiences; (3) written self-descriptions – seldom really good, but then all the more valuable; they can, in fact, be made use of even if one has not known the writer personally …

So before real inquiry can begin it is necessary to identify the specific psychic phenomena which are to be its subject, and form a clear picture of the resemblances and differences between them and other phenomena with which they must not be confused. This preliminary work of representing, defining, and classifying psychic phenomena, pursued as an independent activity, constitutes phenomenology. The difficult and comprehensive nature of this preliminary work makes it inevitable that it should become for the time being an end in itself.

Psychopathological phenomena seem to call for just such an approach, one which will isolate, will make abstractions from related observations, will present as realities only the data themselves without attempting to understand how they have arisen; an approach which only wants to see, not to explain.

On phenomenological grounds, what Jaspers felt set delusions apart from other beliefs was a single, fundamental property: they were un-understandable. What he meant by un-understandability, however, turned out to be quite complicated. In one sense it simply meant that delusions – true delusions or delusions proper, as opposed to overvalued and other 'delusion-like' ideas – were psychologically irreducible; they did not emerge comprehensibly from anything else in the patient's current or past mental life, either normal ('shattering, mortifying, guilt-provoking or other such experiences') or pathological ('false-perception or from the experience of derealization in states of altered consciousness etc.'). As Walker (1991) later put it, Jaspers felt that delusions were not understandable in the sense of the normal empathic access that one has to another person's subjective experience using the analogy of one's own experience.

Un-understandability also included a dimension of being unmediated. As Walker (1991) explained, cutting through Jaspers' whole concept of phenomenology was the distinction between unmediated or immediate experiences and those that are the product of reflection. Unmediated experiences are elementary or irreducible, and are characterized by an immediate certainty of reality. In contrast, mediated experiences are judgements about the reality of these experiences which involve processes of thinking and working through. For Jaspers, delusions were not a product of reflection, and in a way they could even be considered to be an experience, although not in the perceptual sense of the term. This sense of un-understandable lay behind his use of phrases like 'the primary delusional experience', and delusion as something that 'comes before thought, although it becomes clear to itself only in thought'.

Could the nature of delusions be defined further? Jaspers thought that it could, although in doing so he went some way beyond the strict rules he himself had laid down for phenomenology. He proposed that delusions ultimately reflected a change in the way in which

meaning is attached to events. The experience of events was, he argued, not just a mechanical perceptual process, there was always an accompanying sense of meaning: a house is seen as something that people inhabit, a knife as a tool for cutting and so on. In the case of delusions, perception itself remained normal, but the process of seeing of meaning underwent a radical transformation, so that it became immediate and intrusive. This altered sense of meaning was clearly evident in a symptom Jaspers described in the early stages of psychotic disorders, where the patient has an indefinable sensation that the world is changing or something suspicious is afoot, *delusional mood*:

> The environment is somehow different – not to a gross degree – perception is unaltered in itself but there is some change which envelops everything with a subtle, pervasive and strangely uncertain light. A living-room which formerly was felt as neutral or friendly now becomes dominated by some indefinable atmosphere. Something seems in the air which the patient cannot account for, a distrustful, uncomfortable, uncanny tension invades him.

Individual objects and events also started to signify something, although still nothing definite; they were simply eerie, horrifying, peculiar, or alternatively remarkable, mystifying or transcendental:

> A patient noticed the waiter in the coffee-house; he skipped past him so quickly and uncannily. He noticed odd behaviour in an acquaintance which made him feel strange; everything in the street was so different, something was bound to be happening. A passer-by gave such a penetrating glance, he could be a detective. Then there was a dog who seemed hypnotised, a kind of mechanical dog made of rubber. There were such a lot of people walking about, something must surely be starting up against the patient. All the umbrellas were rattling as if some apparatus was hidden inside them.

In what Jaspers implied was the next stage in this process, the patient arrived at defining these events as more clearly having some obvious relationship to him or her, or in other words as delusions of reference:

> Gestures, ambiguous words provide 'tacit intimations'. All sorts of things are being conveyed to the patient. People imply quite different things in such harmless remarks as 'the carnations are lovely' or 'the blouse fits all right' and understand these meanings very well among themselves. People look at the patient as if they had something special to say to him. – 'It was as if everything was being done to spite me; everything that happened in Mannheim happened in order to take it out of me.' People in the street are obviously discussing the patient. Odd words picked up in passing refer to him. In the papers, books, everywhere there are things which are specially meant for the patient, concern his own personal life and carry warnings or insults.

What Jaspers then went on to propose involved a conceptual leap: all other types of delusions were also characterized by the same changed awareness of meaning. In support of this view, he gave the example of a girl who was reading about Lazarus being woken from the dead in the Bible and immediately felt herself to be the Virgin Mary. She vividly experienced the events she had just read about as if they were her own experience, although this vividness did not have sensory qualities. However, while the belief that Jaspers described in this example was certainly sudden and intrusive, how it specifically involved a changed awareness of meaning was not made clear. The only further clarification Jaspers gave concerned another patient who suddenly had the notion that a fire had broken out in a faraway town. 'This', he argued 'surely happens only through the meaning he draws from inner visions that

crowd in on him with the character of reality'. Walker (1991) was not overly impressed by this argument, describing it as lame.

Someone else who was not impressed was Schneider, the psychiatrist who delineated the first rank symptoms of schizophrenia. He (Schneider, 1949) distinguished between two types of delusion: on the one hand there were delusional perceptions (a term that broadly corresponded to delusions of reference, though he excluded delusional mood), where abnormal significance becomes attached to a real event without any cause that is understandable in rational or emotional terms. On the other hand were what he referred to as delusional ideas and intuitions, which covered virtually all other types of delusions, including grandiose, religious and persecutory convictions and at least some beliefs about ill-health. He did not see how the concept of abnormal meaning could be extended to cover these latter delusions. In his slightly overcomplicated way of describing it:

> Delusional intuition does not consist in attributing unfounded significance to an actual percept: it is purely ideational … If it comes into someone's head that he is Christ, that is a single process involving both the person and the intuition. There is no second part, extending from the perceived object (which includes normal comprehension and understandable interpretation) to the abnormal significance attached to it which goes with a delusional perception.

Nor did Schneider feel it was credible to argue that this latter class of delusion had a component of significance by virtue of the fact that the beliefs were often of momentous importance to the patient. This was to use the word significance in a very different sense from that of abnormal meaning being attached to a perceived event.

Delusions Today: Wing, Cooper and Sartorius

How has psychiatric thinking about delusions changed in the half-century or so since Jaspers and Schneider crossed swords over the role of meaning? On the face of it, not much. Textbooks and review articles continue to rehearse the standard definition that they are fixed, incorrigible beliefs which are out of keeping with the individual's culture and background. Two British authors, Sims (1988; 1995) and Cutting (1985), who wrote books on psychopathology with chapters on delusions, also did not stray far from the fold in this respect (and were duly chastised by Walker (1991) for this). But nowhere was the steadfast adherence to dogma more apparent than in the landmark *American Diagnostic and Clinical Manual of Mental Disorders, Third Edition*, (DSM-III). Its terse and superficial definition of delusions in the glossary gave the distinct impression that deep thinking about phenomenological issues was not welcome.

DSM-III itself was a response to a series of scandals about the loose way in which schizophrenia was being diagnosed, particularly in America. This led to the adoption of a criterion-based approach to diagnosis, something that is now routinely employed all over the world. According to this, psychiatric disorders are defined by the presence of a certain number of symptoms in certain combinations, together with the absence of other symptoms. Schizophrenia, for example, is diagnosed on the basis of the patient showing multiple delusions, or both delusions and hallucinations, or having pathognomonic symptoms (i.e. Schneiderian first rank symptoms), with the additional requirements that there are insufficient symptoms to diagnose a full affective disorder, and there is no evidence of organic brain disease.

Another response to the problem was the development of a series of so-called structured psychiatric interviews designed to elicit psychiatric symptoms in an unequivocal way.

The idea was that by asking patients a comprehensive set of precisely formulated questions, diagnostic practice in psychiatry could be placed on an equal footing with that in the rest of medicine. Most of these structured interviews were rather turgid affairs, plodding through a long series of questions covering in turn the symptoms of schizophrenia, mania, major depression and in some cases other disorders as well. One, however, was different; this was the Present State Examination (PSE) developed by Wing and his co-workers Cooper and Sartorius over more than ten years to emerge in its final form as its ninth edition in 1974 (Wing et al., 1974) (a tenth edition has since been released which is similar but covers a broader range of disorders). For a start, it was an order of magnitude more detailed than other structured interviews – rather than simply eliciting the symptoms necessary to make a diagnosis, its aim was to give a detailed picture of the patient's current symptomatology (or in its 'lifetime' form, the symptoms experienced over a period of months or years). Its section on delusions was particularly rich, including some forms of the symptom that would probably be unfamiliar to many clinicians. There was also a glossary of symptoms in the accompanying manual which, in sharp contrast to that provided at the end of DSM-III and its successors, provided useful practical information on every symptom rated. This additionally offered solutions to a number of phenomenological debates and uncertainties which, while typically pragmatic, often betrayed a sophisticated knowledge of the currents of historical thought.

Wing et al.'s (1974) classification of delusions in the ninth edition of the PSE is summarized in Box 1.3. It can be seen that those where neutral events have significance for the patient are multiply represented, as delusional mood and delusions of reference, misinterpretation and misidentification (this use of misidentification is different from that used to refer to the Capgras and related syndromes discussed in Chapter 7). A special case of this type of delusion is what the PSE calls primary delusions. This refers to an experience where a patient suddenly becomes convinced that a particular set of events has a special but also highly specific meaning. The example Wing et al. (1974) gave was of a patient undergoing a liver biopsy who, as the needle was being inserted, felt that he had been chosen by God. This symptom is more commonly known as *delusional perception*, although this usage is quite different (specifically much narrower) than the way Schneider originally intended.

Box 1.3 The PSE Classification of Delusions (Wing, Cooper and Sartorius, 1974)

Delusions of Control

The subject's will is replaced by that of some external agency. He feels under the control of some force or power other than himself, as though he is a robot or a zombie or possessed. It makes his movements for him without him willing it, or uses his voice or his handwriting, or replaces his personality.

Delusional Mood

The subject feels that his familiar environment has changed in a way which puzzles him and which he may not be able to describe clearly. Everything feels odd, strange and uncanny, something suspicious is afoot, events are charged with new meaning. The state typically precedes the development of full delusions: the patient may fluctuate between acceptance and rejection of various delusional explanations, or the experience may suddenly crystallize into a clear, fully formed delusional idea.