



On two kinds of delusion of reference

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Abstract

Although delusions of reference are one of the most common psychotic symptoms, they have been the focus of little research. The aims of the present research were, first, to determine whether it is possible to identify different kinds of referential delusions reliably and, if so, to investigate associations among them and between these delusions and other positive psychotic symptoms. Participants with a diagnosis of schizophrenia ($n=57$) were recruited from a volunteer register ($n=26$) and from inpatient psychiatric wards ($n=31$). They were interviewed with the Scale for the Assessment of Positive Symptoms (SAPS) except that the questions about ideas and delusions of reference were replaced with questions targeted at seven particular delusions and three content areas. Ratings were made independently by two assessors. Agreement between the assessors was high for all of the delusions of reference and other psychotic symptoms. A factor analysis of these ratings revealed two factors that represent delusions of communication and delusions of observation. Only delusions of observation were associated with hallucinations and persecutory ideation. Delusions of communication showed few significant correlations with other symptoms and therefore appear to require different explanations.

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1. Introduction

Use of the single-symptom approach has led to significant advances in the theoretical understanding of psychotic symptoms such as persecutory delusions (Bentall et al., 2001), auditory hallucinations (David and Cutting, 1994) and passivity experiences (e.g. Blake-

more, 2003). However, this approach appears not to have been applied to delusions of reference. That is surprising because these delusions are one of the most common psychotic symptoms. For example, 55% of the 811 patients in the International Pilot Study of Schizophrenia had this symptom (World Health Organization, 1973) and, among the 306 patients in the ‘concordant group’ from this study (those who met all criteria for a diagnosis of schizophrenia), 67% had delusions of reference.

One possible explanation for the lack of attention to these types of delusions is that they are often regarded as integral to persecutory delusions. The statement by Leon

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et al. (1989), that “Delusions of persecution. . .include delusions of self-reference” (p. 458), is typical. However, a clear distinction can be made on conceptual grounds in that only persecutory delusions concern the threat of harm, as Freeman and Garety (2000) have noted. Other authors maintain that delusions of reference may also relate to grandiose or reassuring themes (e.g., Gelder et al., 1989). Phillips et al. (1993) found them to be common in body dysmorphic disorder. Clinical experience suggests that these delusions sometimes occur in isolation, that is, without any other delusions. However, the degree of association between particular delusions of reference and other psychotic symptoms has not, to the authors’ knowledge, been investigated nor does there appear to have been any research to determine whether all the experiences and beliefs that are referred to as delusions of reference really occur together.

The term ‘delusions of reference’ is said to refer to beliefs that a wide variety of neutral events have special significance and refer to the individual personally (e.g. Gelder et al., 1989; McKenna, 1997). However, within this variety there appears to be a fundamental distinction to be made between experiences of communication and beliefs about observation. According to psychiatric textbooks (e.g. McKenna, 1997), some patients frequently have the mistaken sense that others are communicating with them by subtle and oblique verbal means, such as hints or innuendos, or through non-verbal channels such as gestures, stances or clothing. They may also believe that they are being referred to in the public media or that objects or situations have been purposely arranged to convey a message. Some even have the sense that animals are communicating implausibly complex messages. These kinds of delusions appear to be misinterpretations of perceivable events. However, other kinds of beliefs that are also referred to as delusions of reference are concerned with being kept under observation. Thus, some patients entertain the false belief that others are surreptitiously observing them, perhaps by using surveillance equipment or by following them, or are gossiping and spreading rumours about them. Since patients usually believe that those who are observing them are at pains to keep their activities secret, they may not believe there is an intention to communicate. Thus, it seems quite possible that referential experiences of communication and beliefs about observations might be quite distinct symptoms.

The aims of the present research were, first, to determine whether it is possible to identify different kinds of referential delusion reliably and, if so, to investigate associations among different referential delusions and between those delusions and other kinds of positive psychotic symptoms.

2. Methods

2.1. Participants

Participants with a diagnosis of schizophrenia were recruited from two sources. Some were approached by administrators of the Schizophrenia Research Register of the Neuroscience Institute of Schizophrenia and Allied Disorders (NISAD: Loughland et al., 2001). This is a register of volunteers who are willing to consider participating in research projects and whose diagnosis of schizophrenia has been confirmed with the Diagnostic Interview for Psychosis (Jablensky et al., 1999). Invitations were accepted by 12 men and 14 women, with a mean age of 38.9 years (S.D.=12.9). The other participants were inpatients from three acute wards of a psychiatric hospital. They all had a chart diagnosis of schizophrenia and were invited to participate when their psychiatrists declared them to be capable of informed consent and able to tolerate a 1-h interview. Invitations were accepted by 15 men and 16 women, with a mean age of 32.4 years (S.D.=8.8). The combined sample of 57 had the following mean characteristics: school leaving age, 16.9 years (S.D.=3.4); age at onset of schizophrenia, 25.0 years (S.D.=7.9); and number of admissions to psychiatric hospital, 5.3 (S.D.=7.3). Only three, all volunteers, were employed. Only four were cohabiting or married; the rest were never married, divorced, separated or widowed. The two samples did not differ significantly on any of these characteristics except that the inpatients had been admitted to hospital more times (mean=7.85, S.D.=9.5) than the volunteers (mean=3.2, S.D.=3.6), $t [31.0]=2.4$, $P=0.024$.

2.2. Measures

Participants were interviewed by trained assessors using the questions and probes of the Scale for the Assessment of Positive Symptoms (SAPS: Andreasen,

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