The Ellard Collection

Strong beliefs and delusions

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'Strong beliefs and delusions' is an essay by the late Dr John Ellard reproduced from the book *The Anatomy of Mirages: a Psychiatrist Reflects on Life and the Mind*.*

Dr Ellard, revered former Editor of *Modern Medicine of Australia* and *Medicine Today* and a distinguished psychiatrist, wrote many essays in the 1970s, 1980s and 1990s on society's most controversial and vexing issues. These were published in various journals including *Modern Medicine of Australia*, and also collected together and published as books. The essay 'Strong beliefs and delusions' originally appeared in the March 1991 issue of *Modern Medicine of Australia*.

As an examiner in postgraduate psychiatry, for more than a score of years I heard my fellow examiners asking candidates to define the term delusion. I listened with great care, for I did not know the answer and hoped to discover it. I have decided to confess my state of ignorance and, as a sort of penance, try to put it right.

Some examples

Let us consider a procession of people with very strong beliefs. The first is a gentleman who strides imperiously before us shouting that, since he is King of the World, we are his slaves.

The second is an elderly lady, a little deaf, who explains that each night intruders enter her premises, even though she has a great array of bolts, bars, deadlocks and burglar alarms. They take nothing, but move her possessions about in a way that conveys a special meaning to her alone. She calls the police daily and is never satisfied by their reassurances. Her mother and her sister are troubled similarly.

Next is a quietly spoken man who states that he is convinced that he has AIDS even though every possible test has been done several times over several months, with negative results.

He is followed by a severely emaciated young woman. She assures us that she feels very well and is filled with energy; her only problem is her obesity.

Then we move to an operating theatre where there is a man having his appendix removed. He has declined an anaesthetic and requested hypnosis instead. He smiles and reassures us that he is relaxed and feels no discomfort at all. We note that his blood pressure is raised, his pulse is rapid and that he is pale and sweaty.

> **"... a gentleman... shouting that, since he is King of the World, we are his slaves."**

Next we receive a gentleman who undertakes to describe our several pasts, presents and futures provided that he is given the precise disposition of the planets at the moment of our respective births.

Finally, we are given audience by a woman who is the head of a system of religious belief with more than a million adherents. She converses with spirits and reaffirms her certain conviction that the universe will end with this millennium. When reminded

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* Ellard J. The anatomy of mirages: a psychiatrist reflects on life and the mind. Sydney: University of New South Wales Press; 1994. p. 207-217.

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that her predecessor made a similar prediction that did not come to pass, she smiles and explains that such matters are beyond our understanding.

What they have in common

All these people believe something very firmly on what most of us would regard as inadequate evidence. Incongruities and contradindications do not trouble them: the King of the World has holes in his socks and lines up for dinner with everyone else. The prophet is not dismayed by the failed prophecies of others because she alone has the true knowledge.

"All these people believe something very firmly on what most of us would regard as inadequate evidence."

If they have followers, they are equally persuaded: if we criticise the prophetess in public her disciples will be enraged, and if we reject the astrologer his followers will smile at our primitiveness as they turn to their pyramids and crystals.

Each seems to be achieving something, although in some cases it is not easy to say just what it is. Even though the astrologer is highly paid for his weekly column, and the religious leader is driven from her mansion to her television studio in her own Rolls Royce, I suspect that material gain is not the principal motivating force.

Nevertheless, we begin to surmise that one of the reasons behind all very strong beliefs of this kind is that, no matter how obscure the reason may be, there is an advantage to the person possessing them.

At this point a latecomer is ushered onto the stage. He is profoundly depressed, and in a slow and hopeless manner he tells us that he is responsible for all the wickedness and suffering in the world, as a consequence of which he should be tortured and then killed. He was late because of his marked psychomotor retardation.

Our hypothesis fades away; perhaps there are no general rules at all.

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What happens to the believers

Perhaps we shall understand better if we follow the careers of our examples.

The King of the World was persuaded to take some lithium; his mania subsided and his status went with it. Once more he is contented in his ordinary occupation.

The elderly lady beset by trespassers represents that form of paranoid schizophrenia called paraphrenia in the British literature. Phenothiazines diminished her distress and her beliefs no longer occupy the forefront of her mind. She suspects that the intruders still sneak in sometimes, for she has no doubt that they are real.

The man who believes that he has AIDS has had several more tests, all negative. He has studied the literature closely and can offer some very implausible theories about why, in his opinions, the tests are consistently invalid.

The family of the young lady with severe anorexia nervosa came to see that the problem involved them all and that her struggle for autonomy might be handled better. She is no longer emaciated but very concerned lest she become plump.

The appendicectomised young man is now in training as a hypnotist, the astrologer's column has become syndicated and the religious leader has departed because of a sexual scandal. Her successor is undeterred.

Our severely depressed man had some ECT and is now back to normal, without guilt.

Some qualities of these strong beliefs

Firmness and constancy

These beliefs attracted our attention because of the firmness with which they were held; ordinary reasonable argument made

no impression upon them. However, looking about we find that this rule is neither absolute nor invariable.

For example, some patients with paranoid schizophrenia on occasion will resile a little, and confess to some uncertainty. This state of mind does not often last (unless there is a progression to full recovery) but it can be observed.

Approaching the same point from the other direction, occasionally someone suffering from an obsessional neurosis who fears that by misadventure he has placed slivers of glass in someone else's food, will become convinced that he has – belief replaces apprehension. Once more this is not a permanent state of affairs, but it happens.

There is, then, a tendency for firm beliefs of the kind that interest us to be fixed, but there is no rule about it.

"Many people believe... that to discuss their beliefs publicly may lead to derision and being thought mad..."

Insight

Once more there are difficulties. Some of our examples will argue that we lack insight, not them. This argument may be difficult to resolve; for example, we shall have to wait until the end of the millennium to settle the dispute between the prophetess and ourselves. Should we all survive, then no doubt we shall be offered the same explanation as on the last occasion; the wrong conclusion was reached from the auguries and we shall be given another date for the End.

There are partial insights. Many people believe, correctly enough, that to discuss their beliefs publicly may lead to derision and being thought mad: they say nothing or speak only to those whom they trust. Others can see that to hire all the detectives, cameras and microphones that record their daily lives would cost someone a fortune. They reflect upon it and explain that this is an additional reason for their mystification, for they know of no one who could afford it and yet someone does.

Finally, a gentleman who is quite certain that he is being observed from flying saucers is very likely to believe that someone else being persecuted by Martians is quite mad to think so.

Why do the beliefs develop?

Now that we have made some observations we can begin to ask how strong beliefs of the kind that interest us come about.

Major psychosis

We have encountered them in manic, depressed and schizophrenic patients. Modern investigatory techniques leave no doubt that these conditions reflect underlying neurophysiological and structural disturbances of the brain. Some are genetically transmitted and perhaps some of the others are due to such things as minor birth injuries or occult slow infections. Infections of this nature have been demonstrated to exist in Kreuzfeldt–Jakob's disease (in the news recently) and Kuru, in New Guinea.

The essential point is that the presence of the strong beliefs almost certainly can be attributed to the underlying organic disturbance. The same can be said of our next two categories.

Metabolic or structural brain disease

Here we have the conditions commonly regarded as neurological and to be found in textbooks of neurology. The list of diseases that can give rise to such a state of affairs is very large. Those who wish to acquire it should consult Dr Cummings' article on this topic.[1] To put it simply, it is difficult to think of a brain disease that has not been complicated in this way. Infections, degenerations, metabolic disorders, endocrinopathies and a host of other conditions have been implicated.

Drugs and medications

Both therapeutic and recreational drugs can produce a variety of psychological abnormalities with strong illogical beliefs amongst them.

Social pressure

This has already been mentioned. It may amount to no more than acculturation – if one is reared amongst snake worshippers one is likely to attribute special powers to snakes. It may be more than this: there have been times when not to acknowledge a particular belief meant to be burned at the stake. Many would find this argument quite persuasive. Nowadays one is more likely to be burned embedded in rubber tyres, for there are still communities in which there are savage forces requiring conformity.

"At one end... those in whom there is no doubt at all that both the presence and the content of the very strong belief are totally, or at least substantially, due to physical disease."

Family pressure

Folie à deux is the most striking manifestation here. Person A has psychotic beliefs and imposes them upon B. In some cases the removal of A (or of A's illness) will permit B to recover but sometimes B does not, suggesting that there is a common aetiology rather than one imposed by one person on another.

Lesser manifestations of the same mechanisms are so commonplace that there is no need to describe them.

Intrapsychic pressure

If you have severe anxieties about public speaking then you will do all you can to avoid it. If you have severe anxieties about sexual behaviour you are very likely to do the same. It may assist you if you join up with other like-minded persons and form an organisation with the avowed purpose of making sexual activity something to be denigrated and avoided, so that those who do so will be able to claim special merit. Should someone question your beliefs they may well find you immovable.

There are, then, very strongly held beliefs that seem to be based

upon psychological need without any evidence of brain disorder. Having a brain disorder may facilitate the process, but it is not essential.

Making sense of it all

Let us arrange our cases – and others we have encountered in other places – along a dimension. At one end we shall place those in whom there is no doubt at all that both the presence and the content of the very strong belief are totally, or at least substantially, due to physical disease. It is not difficult to find an example; consider a man who has had a stroke that has left him hemiplegic. Everyone can see his disability except him: he insists that there is no problem at all with his limbs.

"At the other end of the dimension we have those whose strong beliefs can be understood psychologically, and there is no reason to suspect or require the presence of brain disorder."

Then we come to the very large number in which there is strong belief and there is also unequivocal evidence of brain disorder, or of a condition certainly or almost certainly so caused. The evidence may range from the presence of several neurological signs to clear abnormalities on a CT scan, or the symptoms of a major psychosis. Needless to say, the content may be psychologically determined. No one in the nineteenth century believed themselves to be observed by hidden TV cameras and microphones, and few now have the religious preoccupations so common then.

Another example of this mixture is to be found in the natural history of the 'delusional mood'. Some people with schizophrenia go through a phase in which they know beyond doubt that something peculiar is going on about them, but they cannot discover what it is. Kafka's novels convey the atmosphere exactly. Then, suddenly, on a particular day, everything falls into place and they develop a firm belief that – in a psychotic way – makes sense out of it all. A patient notices that on my desk there is a red pen, a red telephone and a red clock – incontrovertible evidence that I am a member of the KGB and that that organisation is behind his present experiences. I am not a member of the KGB, he can give no reason why that organisation should take an interest in him, the evidence is unpersuasive – his belief is immovable nevertheless. Sometimes one can make a reasonable hypothesis about why a patient's belief may take a particular form, but psychogenesis cannot account for the primary break in logic.

At the other end of the dimension we have those whose strong beliefs can be understood psychologically, and there is no reason to suspect or require the presence of brain disorder. Our sexually anxious person who has joined the organisation devoted to stamping out sexual activity fits there.

In the middle we have those for whom we can advance no reasonable mechanism. There we must locate our man persuaded that he has AIDS, the anorectic who sees herself as obese and the obsessional who for a while believes that he has put glass in other people's food. We have some understanding of some of them: thus there is no great difficulty in understanding why the anorectic is preoccupied with food and thinness, but why she should distort reality to this extent remains unclear.

If this dimension is acceptable, it is possible to suggest a nomenclature that has one significant difference from that usually advanced.

"Strong beliefs, held unshakeably or almost unshakeably, and not part of a person's cultural equipment, can be called delusions provided there is evidence of a brain disorder, whether structural or biochemical."

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The middle group – the most obscure – has already been named by Wernicke; those in it have the 'syndrome of the over valued idea'. There is no good reason for changing the established nomenclature.

I doubt that we need a term for those at the other end of the dimension. Those who do not share their beliefs are likely to use something pejorative; those who do share them will regard themselves as the enlightened ones. Perhaps it is better to describe them as strongly adherent to a particular belief or set of beliefs and leave it at that, offering a more careful dissection only when there is a firm need for it.

"Cerebral pathology is present until proved otherwise."

Has this discussion any practical use?

Yes it has. In 1896, Joseph Babinski made a most important observation. In well people, if one strokes the sole of the foot from behind forwards with a small blunt object, the toes flex towards the sole of the foot. If on the contrary the big toes extends – points up – then there is certainly something wrong in the upper reaches of the central nervous system. This response had been known as Bainski's sign since then.

If the definition of delusion suggested in this essay is accepted then the presence of a delusion has exactly the same significance as Babinski's sign. Cerebral pathology is present until proved otherwise. MT

Reference

1. Cummings JL. Organic delusions: phenomenology, anatomical correlations and review. Br J Psychiatry 1966; 146: 184-197.