



Delusions:

Seeking epistemic justice for the most unusual of stories

by Hamilton Kennedy



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Abstract

The label of delusion can be so powerful that people so labelled are no longer believed or supported in preferred ways by those around them. This leads to a lack of meaningful and non-pathologising support for their significant, and at times unusual, beliefs. This phenomenon constitutes a form of epistemic injustice. To address this issue, this paper outlines specific approaches practitioners can adopt to better respond to such beliefs, illustrating these strategies with real-world examples from practice. By doing so, it aims to foster a form of epistemic justice that respects the knowledge and experience of people labelled as delusional and supports them to understand and lessen the impact of these often-distressing experiences. This paper is informed by research undertaken with people who had been labelled by psychiatry as “delusional”.

Key words: *delusion; paranoia; schizophrenia; hallucination; belief; epistemology; narrative practice*

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Narrative practitioners occupy a privileged position, allowing them to hear and engage with the stories of the individuals and communities they work with, irrespective of the specific work context. These narratives vary, with some being familiar and others more unusual. It is important to recognise that certain beliefs we hear may be very unusual, particularly when they diverge from our own beliefs or from cultural norms. Denying their unusual nature obscures their exceptionalness. Narrative practitioners are often aware of this, yet responding to such beliefs can be challenging when they significantly differ from what is commonly known or deemed appropriate.

During 2023 and 2024, I conducted a series of interviews aimed at understanding and documenting the experiences of individuals labelled as “delusional”. This formed the basis of a PhD thesis. It involved multiple conversations with people over several months in an attempt to explore the histories and origins of the experience that was labelled “delusional” as well as how they came to see this experience as true. Having their belief identified as delusional by someone else, even if this was done with “good intentions”, was frequently experienced by participants as a form of epistemic injustice. My research project sought to better understand these experiences, to identify their often-neglected features, and to identify potential improvements in practice. The research explored the significance, meaning, and utility of these “delusional” beliefs and the contexts that produced them.

This article presents the experiences and reflections of participants in relation to epistemic injustice.

Miranda Fricker’s (2007) concept of “epistemic injustice” refers to the delegitimisation of people’s capacity to “know”, which stems from an undermining of personhood. This article outlines strategies to resist and repair such injustices – to attempt to support epistemic justice. While unusual beliefs can pose challenges to practitioners, I demonstrate how these beliefs and experiences can be approached with the respect and consideration given to other beliefs. This approach recognises the problems these beliefs may present, the opportunities they offer, and the contexts they reflect. Such an approach can resist the epistemic injustice commonly experienced by individuals within the mental health system.

Background

Professionals in people-oriented services consistently encounter interesting stories from those they speak with. Whether these narratives emerge over coffee or within the confines of a therapist’s office, they can be truly remarkable. Occasionally, these stories challenge our perceptions of what is possible or real. In the mental health field, the most unusual of these narratives are sometimes labelled as delusions. This psychiatric label typically refers to a false, firmly held belief that remains unchanged despite conflicting evidence (Bortolotti, 2022a). However, such beliefs are not exclusive to clinical settings: a significant portion of the non-clinical population also holds beliefs that could be labelled delusional (Verdoux & van Os, 2002).

Through examples from my research, this paper explores approaches that avoid perpetuating epistemic injustice, which invalidates individuals’ experiences and negatively impact relationships with them. Instead, I focus on ways to offer meaningful and resonant support. Importantly, this work also includes the perspectives and reflections of those who have been labelled as delusional, emphasising their desires and needs in interactions with others.

Who was involved in this research?

The experiences of five participants are explored in this paper.¹ Detailed here is an overview of the participants’ beliefs, the impact of these beliefs, their responses to these beliefs, and the impact of these responses. For some individuals, the belief caused significant fear and distress, but for others it was experienced more as unusual. This illustrates the broad scope of what can be labelled as a delusion. It was common for participants to feel fearful or reserved about sharing their beliefs with others. This was largely due to the perceived or actual consequences of doing so, which for many included forced psychiatric treatment or stigmatisation and discrimination by those around them.

Janelle

Janelle is a Christian woman in her 30s who is married with children. She was initially diagnosed with depression with psychotic features and later with schizophrenia. This was in the context of Janelle’s belief that she was dead. Even while this belief emerged, she continued living a relatively normal life

until the psychiatric system forcibly intervened. She described this intervention as being worse than the initial belief she had. This belief persisted for a period and has returned periodically. Janelle's experiences arose from significant grief following the deaths of two children, one in utero and the other shortly after birth. She is fearful of future psychiatric intervention because of her previous experiences.

Bethany

Bethany is a woman in her 40s. She lives with chronic health conditions and has also been diagnosed with post-traumatic stress disorder. Bethany has been labelled delusional for expressing the belief that she is being surveilled by covert cameras at home, in public and specifically in bathrooms. She also believes that this surveillance extends to her child and to others more generally. This impacts her life as she is concerned about being observed at home and in public, and this evokes a spectre of fear in her day-to-day life. While she has been able to discuss this with some people, she is hesitant to discuss this fear with others as it has led to her being dismissed or seen as mentally ill.

Michael

Michael is a man in his late 40s who has been diagnosed with schizophrenia and labelled delusional at various times throughout his life. Some of these beliefs include that he is being observed and assessed by the government and that he is capable of telepathy. At times this has been distressing and at other times enjoyable. He has been forcibly hospitalised more than 17 times and has been on near permanent compulsory treatment orders for nearly 20 years. He does not speak openly with mental health staff for fear of psychiatric intervention and also as he believes he will be ignored or dismissed.

Amanda

Amanda is a woman in her early 60s. Living with multiple chronic health conditions affecting her daily life and mobility, she frequently interacts with the health care system. She believes that she is the target of harassment orchestrated by a powerful family, with whom she had very real interactions in her earlier life. Amanda perceives the harassment extending into various facets of her life, including public housing, her day-to-day experiences and especially in health care. This causes ongoing fear and distress, which she chooses not to discuss with others for fear of the consequences of doing so.

Critical perspectives on delusion

The nature and experience of delusion vary significantly among those labelled as delusional (Ritunnano et al., 2022), as does its definition among academics (Rodrigues & Banzato, 2010). A discrete diagnostic category suggests that all beliefs can be categorised as either delusional or non-delusional. However, this binary approach fails to account for the nuanced spectrum of belief and the subjective meaning of experiences, ultimately rendering the experiences of those labelled as delusional as "false". As one participant astutely remarked, "It's just so reductive to reduce it to ticking boxes; that's not how any of this works".

While such unusual beliefs are typically considered features of mental illnesses, they are also common among the general population (Freeman, 2006). This was aptly summarised by another participant: "Maybe we should just relax a bit instead of pretending that we're all completely a hundred per cent sane and neurotypical a hundred per cent of the time." This flexible approach is crucial for practitioners to recognise, as it challenges the assumption that all beliefs and stories must fit neatly into categories of being entirely true or false thus dictating whether they are worthy of careful consideration.

Epistemic injustice

Labelling someone as delusional can be considered a unique form of injustice, despite its ostensibly benevolent intentions. This labelling occurs because people's sincere beliefs and expressions are deemed to be a combination of bizarre, fixed, irrational, resistant to counter-argument, and most notably, false. Regardless of the veracity of the claim, the experience of delusions can be jarring, confusing and extremely upsetting. This injustice can be best understood through the concept of epistemic injustice. According to Fricker (2007), epistemic injustice consists of two forms: testimonial injustice, where someone is discredited or not believed, and hermeneutical injustice, where a person is unable to express or make sense of their experience due to a lack of support or shared perspective.

When individuals' sincere stories of suffering or excitement are labelled as delusional, it typically renders their belief false and not worthy of further inquiry. Labelling someone as delusional is a form of "testimonial injustice" as it creates an identity marker

that leads them to be disbelieved on account of that label. It is not just a belief that comes to be labelled delusional but the person themselves. For Janelle, her belief “I am dead” was identified as delusional, and this also rendered Janelle herself as delusional. As a result, neither Janelle’s belief nor Janelle as a person are seen as warranting substantive engagement. The delusional label meant that she was ignored by those around her and was unable to discuss the matters that were most significant to her. However, Janelle considered her belief that she had died to be related to significant loss in her life, which would suggest a need for compassionate inquiry. This, however, was not explored. She explained:

Janelle: It was just having everybody against you and there wasn’t any care there. I’ve never done anything violent or I’ve never sworn anyone. I’m not that bad, but there just wasn’t like, “how are you going?” Or just care. Yeah.

Hamilton: There is a large amount of people who are hurt similarly. They don’t always get together to talk about how angry we are, but the anger is still there.

Janelle: I had my baby die in me full term, and I saw him. No one wanted to talk about that. No one wanted to talk about what it was like to pick your coffins for your babies ... No one wanted to hear me. It was like I was just crazy.

Here, Janelle expressed that she was only able to be seen through the lens of delusion and was “just crazy”. As an interviewer, in observing this testimonial injustice, offering specific questions was not my primary focus. Instead, in this moment I adopted a stance that recognised the injustices within the mental health system, and this allowed Janelle to further reflect on her personal experiences of injustice.

Bethany, who held the belief that she (and others) is under covert surveillance, reflected this too.

Hamilton: There was a kind of persistent disbelief of you inside of health systems, but also outside of health systems. Am I seeing that in the same way that you’ve experienced it?

Bethany: People go, oh, well you’re mentally ill, therefore nothing you say is true. You are hysterical or you are whatever. But even in other social situations, people don’t believe you.

As an interviewer, checking to see if my understanding fits with Bethany’s experience enabled us to discern more about this concept and how it related to her specifically. These examples demonstrate that not only are people disbelieved about their specific “delusional” belief but that all their beliefs and expressions become subject to being viewed through a delusional lens when a person is positioned as uncredible.

The second concept Fricker (2007) offers is “hermeneutical injustice”, which refers to individuals lacking the support or opportunity to understand or express their own experiences. This form of injustice, along with testimonial injustice, is regularly experienced by people with unusual beliefs and those labelled as delusional. Despite often having a desire to explore their experiences, individuals are frequently denied the opportunity to do so. For instance, Michael had been labelled as delusional countless times over the past 20 years and was seldom given the chance to explore or understand his experiences. This lack of opportunity further marginalises and isolates individuals, preventing them from better understanding their own experiences.

Hamilton: You said that people didn’t really ask about your beliefs and experiences very much, which I find sad.

Michael: The question we should ask is not “what’s wrong with you?”, but “what happened to you?” What happened to you? And that’s a question that mental health authorities have not asked really carefully and caringly.

Michael’s reflection reveals a supposed truism of the “helping” professions: the importance of exploring an individual’s life and what has happened to them. However, Michael’s extensive experience shows that this exploration is often absent, even though it would be welcomed. My research found that any attempts to explore people’s beliefs were appreciated, and individuals frequently commented that in the past, they were either not asked questions about their beliefs, or they were asked the “wrong questions”. People overwhelmingly valued the opportunity to discuss their beliefs and found it to be useful.

Towards epistemic justice

The prevalence of epistemic injustice in psychiatry and mental health contexts has been extensively explored (Bueter, 2019; Crichton et al., 2017). While existing

literature suggests strategies to address this issue (such as participatory action research in Mooney et al., 2023 or the use of advocates in Newbigging & Ridley, 2018), there has been limited focus on specific practical strategies for supporting people with unusual beliefs or who are labelled as delusional. So how can we create possibilities for epistemic justice?

Epistemic justice involves recognising individuals as knowers, ensuring they are heard fairly, and supporting them in making sense of their experiences. Despite its fundamental importance, participants in this research and others (Grim et al., 2019) suggest that such practices are uncommon.

Skelton et al. (2024) have provided useful suggestions for addressing epistemic injustice. Their research sought to honour the contributions of people living in poverty who choose to offer support to their peers, whom they referred to as “activists”. I believe their approach can be adapted for mental health contexts. Skelton et al. (2024, p. 94) emphasise the importance of “breaking silence to speak about trauma in a way that frees activists to honour their own experiences and construct their own thoughts”. I propose that this is similarly relevant in a mental health context: we can support epistemic justice by creating contexts for people to break silences in ways that honour their own experience and support people to construct and explore their own thoughts. People with very unusual beliefs often lack opportunities to discuss them, and such opportunities are essential for achieving epistemic justice.

Allowing people to break silence and speak openly, while being genuinely listened to beyond the label of “delusional”, is foundational for doing testimonial justice. When individuals are listened to, it fosters opportunities for hermeneutic justice and creates an environment in which persons are not confined to a single label (delusional) but can freely share, discuss and make sense of their unusual and often distressing experiences.

It is also crucial to recognise that the label “delusional” is a constructed identity marker, which, while functional, often does not align with individuals’ perspectives or desires. This label can be totalising and limiting. Therefore, it is imperative to look beyond this label and to acknowledge the other identities individuals may hold, such as friend, worker, parent or artist.

Providing individuals with the opportunity to speak can be liberating. Conventional psychiatric practices often

avoid exploring or questioning beliefs (Zangrilli et al., 2014). However, in this research, individuals like Amanda expressed gratitude for the opportunity to break their silence. They found value in having a space where they could openly discuss their beliefs. This opportunity to speak and be heard is essential for addressing epistemic injustice.

Amanda: In an odd way, I’ve really enjoyed the process, and I think I’ve learned from it and perhaps got a better grip on what I’m going through, what I’ve been through, by thinking about it and taking it apart. Stepping outside of it and thinking about it has been really good.

What narrative ideas should we consider?

Narrative therapy, and its practices of valuing and exploring personal stories, provides further means to foster epistemic justice for individuals labelled as delusional or those with unusual beliefs. Specific practices include externalising the problem, situating beliefs within the broader contexts of people’s lives, offering people naming rights over their experiences, and listening from a position of not knowing. These practices are complemented by aspects of peer-support practices (as discussed in Kennedy, 2019), such as acknowledging one’s lack of expertise about a person’s experience or being willing to admit uncertainty as how to respond immediately. Together, these practices and principles form a foundation for honouring the stories we hear. Given the prevalence of epistemic injustice, it is crucial for narrative practitioners to actively reflect on and develop responses to unusual beliefs or those labelled as delusional.

Externalising the problem or experience

When we exclusively view these most unusual beliefs through the lens of pathology (as explored in Bortolotti, 2022a) or as products of faulty psychological mechanisms (as explored in Miyazono, 2015), we situate the experience or problem firmly within the brain and/or mind of the individual. However, as Fisher (2009, p. 37) has argued, “it goes without saying that all mental illnesses are neurologically instantiated, but this says nothing about their causation ... this requires a social and political explanation”. If we externalise experiences, we can acknowledge that beliefs are

generated by the mind but occur substantially in response to or in relationship with external factors. This perspective places the problem, at least in part, as external to the individual.

This perspective is supported by people's own experiences of unusual beliefs, as they recognise them as being internally experienced but necessarily informed by external factors. Externalising these beliefs in our response is crucial to avoid viewing individuals solely through the totalising lenses of "delusion" or "pathology".

Externalising conversations involve genuine explorations into the social conditions (external factors) that have supported the existence of problems. They are collaborative and often accompany people's own search for meaning. For instance:

Amanda: I say I've had bad luck, bad luck, bad luck. Don't just take my word for it. There are things that just simply do not make sense that I've got in my records that show that I've got a reason for saying it hasn't been great.

Amanda looked externally and queried why various and distressing events consistently happened to her. In doing so, she revealed a logic behind her beliefs, attributing ongoing difficulties to something unusual happening in her life. She at times called it "the conspiracy", but as above, at other times she called this "bad luck". This reflected how her relationship with this ongoing problem was in a constant flux. Our conversations about this also highlighted her proactive responses to the problem, such as keeping records to better understand and address these challenges. From here, we could further enquire about these specific challenges and how they might be addressed. This is radically different from assuming that this problem exists solely within Amanda's mind.

Externalising conversations resonated similarly with Michael, who had originally begun to develop beliefs that he was under observation and evaluation after attending acting school. Acknowledging the significance of these external factors was meaningful to Michael:

Hamilton: Sounds like something really important happened, not just like you remember it and it was a bit unusual, but something quite significant. Is that right?

Michael: It was the way that they assessed me and observed me that made me feel creeped out

... and so they carried on into my – when I left the workshop, they carried on into my everyday life where I thought that they were observing me. I thought that people were observing me and so on ... so if I hadn't attended acting school, if I hadn't worked with them for a couple of weeks, the whole story of my entire belief system might've been very different.

Michael explored his experience of being observed and assessed at an acting school, illustrating how his beliefs had been constructed in tandem with the developments in his environment. It's not just that Michael holds the unusual belief that he is under observation and assessment; rather, he is actually subject to observation and assessment, though the boundaries of this experience are unclear. When we invite discussions that consider the external context rather than solely focusing on the unusual nature of the belief, the situation becomes more understandable. These beliefs have a storied connection to the external that can be enquired about. In my research, people's unusual beliefs were found to be connected to true and meaningful events in people's lives. For Michael, it was the real challenges faced in the environment of near-constant observation, and for Amanda, it was the true and seemingly constant series of health care complications. If such external contexts are neglected or dismissed by others, I believe it limits the options for understanding.

Giving people naming rights over their experiences

Labelling individuals as delusional is correlated with increased stigmatisation compared to allowing individuals to name and describe their own experiences (Cuttler & Ryckman, 2019). Many participants in my research experienced this firsthand. Providing individuals with the opportunity to name and label their own experiences is crucial in addressing hermeneutical injustice. To address this, there must be a process of supporting people to define, name and articulate their experiences.

In my research, participants reported that being labelled as delusional often resulted in being perceived solely through the lens of delusion. This led to hesitancy in seeking support when needed. For instance, Michael found that health care workers were unable to view him as anything but delusional, which overshadowed other aspects of his identity and experiences. Similarly, Bethany refrained from

sharing her experiences due to fear of the stigma associated with being labelled delusional

Michael: My psychiatrist keeps on referring back to it, and I told him, "It's eight years old, it's more than eight years old".

Bethany: The social stigma around delusional thoughts stopped me from telling her. It stopped me from seeking help.

Supporting individuals in naming their own experiences is central to narrative practice. This approach emphasises the importance of supporting people "from the earliest possible moment ... to regain their sense of control over their lives ... To name is to regain a little control; naming is taking the initiative, imposing a chosen identification on something" (Payne, 2006, p. 42). While this practice is common in narrative therapy, it presents an additional challenge when participants have received a stigmatising label and the belief itself can seem unusual to the practitioner.

Offering individuals the direct opportunity to name their experience can be a simple yet powerful contribution to hermeneutic justice. Asking, "If it's not delusion, then what do you call it?" or "Do you have a name for this?" grants them explicit naming rights and the opportunity to express their own perspective, initiating a process of reflection and understanding of their experience.

For example, when I asked Michael if he had a name for his experience, he responded with, "Have you heard of *pronoia*?" *Pronoia* is the belief that people are conspiring to support you (as opposed to harm you). Here, we learn that unusual belief and experience might at times be useful! If I had not given Michael this opportunity to name the experience, we would not know of its actual impact. These experiences, however, can seldom be confined to being either positive or negative. While Michael at times experienced periods of *pronoia*, he also named experiences of *monitoring* and *surveillance*, which provoked periods of *paranoia*. In discovering this, further questions could then be asked to learn about the context of the beliefs and what might contribute to them being supportive or challenging. For instance, by asking Michael, "What was happening to you, what was occurring at the time?" both in relation to experiences of *pronoia* and *paranoia* we may be able to uncover what supports preferred experiences.

Situating the beliefs in the broader context of the person's life

Some traditional approaches to responding to unusual beliefs or delusions downplay the importance of the content of these beliefs and may avoid exploring their background altogether (Aschebrock et al., 2003; Federico et al., 2013). This dismissal implies that the content of beliefs is irrelevant, contributing to epistemic injustice.

In contrast, narrative therapy places emphasis on the social, cultural, political and economic contexts that shape individuals' lives, recognising their profound influence on identity and experiences. This recognition is crucial, as these contexts significantly contribute to the formation of individuals' beliefs. Doing so not only promotes understanding but also establishes a foundation for individuals to resist the challenges they face. This approach aims to deepen comprehension of experiences and beliefs, alleviating shame and suffering. Further, it enables individuals to articulate and contextualise their experiences within a broader framework that is resonant for them, addressing both testimonial and hermeneutical injustices.

In Janelle's case, her beliefs were influenced by a religious context that shaped what she considered possible. This involved discussions of epistemology and theories of knowledge. This is a complex topic, as it considers questions such as whether we know things, and if we do, how we came to know them. However, within research and/or therapeutic conversations, such ideas can be readily understood by people through questions such as "how did you come to learn or know this?" As I sought to understand how Janelle had formed theories about her life, I asked whether and how religious ideas had contributed to her life.

Hamilton: Did you have a faith at the time?

Janelle: I had finished a degree in Anglican theology, and I had grown up in a very religious environment, and my husband [did] as well. My faith always comes and goes, but I would say we were part of religious community. At the time both of my babies died was around Passover, Easter time. So, we had celebrated both and they are about death, and they're about – the Easter is rising from the dead. And I just remember that it would've contributed to it ... Growing up in religious communities, they didn't have that

barrier of death as permanent, because death you keep, your soul keeps on living, and there's the concept of the afterlife. It's not you die and that's it. I had grown up with that my whole life, so I guess that would contribute to my development of this.

When a person lives in a context where “they didn't have that barrier of death as permanent”, it opens the possibility that being dead is not the end of someone's life. Such attention to cultural and religious contexts also opens possibilities for bringing other religious ideas to bear in responding to the beliefs. However, without exploring the context of the person's life, this context is lost, leaving the belief almost incomprehensible and difficult to respond to. Inquiring about context is essential to addressing hermeneutical injustice as it provides individuals with the opportunity to make sense of and understand their own experiences.

Understanding the context of Amanda's unusual beliefs about the influence of a particular family over her life involved a more rigorous approach. Amanda and I agreed to conduct independent research in between our meetings on the family she believed exerted significant power over her. This acted as an informal secondary research project, asking

- Who is the family?
- What do they do?
- What specifically is informing this belief?

Our discussions between sessions involved sharing our findings.

Through her independent research, Amanda uncovered compelling evidence that highlighted the significant political and media influence wielded by this family. Soon after, we both discovered further evidence confirming that this family was among the most influential in Australia. The capacity of such a small yet powerful group to exert disproportionate control over many lives became evident. This was a broader social reality that could be confirmed by research. Joining with Amanda in conducting this research was an attempt to redress the hermeneutic injustice of Amanda having to hold on to these beliefs alone with limited to no support in making sense of them. Rather than assume an internal faulty psychological mechanism, we looked externally. What we found demonstrated the role context has in the development of beliefs and how enquiring about this context can be significant.

The process of co-investigation was considered useful by Amanda and participants. Michael reflected on this and hoped others might join in this shared curiosity:

If they had good conversations like we're doing, it would level the playing field a lot, and it would make things much more comfortable for me ...
If you're asking really good questions and you try to understand the person's point of view, that to me is a really good sign.

Listening from a position of not knowing

Foundations of narrative therapy emphasise “ethical particularism” (Byers, 2019), which involves tailoring actions and responses to the specific individuals involved. This approach contrasts with more generalisable forms of ethics and therapeutic responses. In practice, this means responding to each person uniquely, taking into account their individual context and needs. This principle applies equally to beliefs that may appear similar to those of others and to those that are markedly different. It also applies when a belief is held with significant intensity or conviction.

However, there is a generalisable stance or position that practitioners can adopt: listening from a position of not knowing and refraining from positioning themselves as experts on someone else's experience. This is informed by the work of Harry Goolishian, who describes how “the therapist exercises an expertise in asking questions from a position of not knowing rather than asking questions that are informed by method and that demand specific answers” (Anderson & Goolishian, 1992, p. 28). This approach positions the person/client/participant as the “knower” in relation to their experience, and positions practitioners as observers and enquirers.

We look to support people from the position that we are not the experts on their experience; they are the experts on their own experience. This means resisting making assumptions or conclusions about the meaning of what is shared. This can help to shed light on the gap between our understanding and the person's perspective. This concept is similar to “listening from a position of not knowing” (Mead, 2014), a skill drawn from Intentional Peer Support that is often quoted but insufficiently documented. Through either approach, we listen as though we genuinely do not know about what is being shared. By resisting assumptions, we can remain open to radical possibilities for making meaning and sense.

The question below attempts to resist the assumed knowledge that a delusion is always fixed, and allows for reflecting on the experience in general.

Hamilton: Do you sometimes doubt what you believe or do you not doubt it at all?

Amanda: Yeah. Oh yeah, I doubt it. And in an odd way ... you think, is it bad for my mental health or isn't it? On the one hand, yes, it is bad ... especially if you say it is really happening. But even ... if it is purely a delusion, yes. But then on the other hand, having someone to blame everything on – it really does free up your mind.

Bethany and I initially discussed the purpose of our meetings, and she wondered whether our conversations would “fix” the distressing beliefs. Listening (and responding) from a position of not knowing, I let her know that I wasn't certain what specifically needed fixing, and that even if we knew what that was, I wasn't certain we could. Months later, towards the end of our conversations, Bethany reflected on the notion of fixing her experience:

Bethany: Some part of me wanted the experience to fix me. Do you know what I mean? Because my thoughts make my life hard in some ways. There's situations that I avoid or it's unpleasant to feel surveilled in some ways. It makes my life hard. Participating has forced me to think about my thoughts, to examine them. Previously, I just accepted them, and that has made me realise that in some way, I actually don't want to be fixed.

While it may seem counterintuitive to approach unusual beliefs from a non-expert/not-knowing perspective, it creates the conditions for reflection that would be suppressed by more rigid approaches that assume certain meta-considerations such as that the belief is always fixed, always bad or requires repair. If we approach people without these assumptions, and refrain from asking questions “that demand specific answers” (Anderson & Goolishian, 1992, p. 28), we can create opportunities for people to make sense of their own experience in ways that are consistent with their own desires. This is a further example of working in a way that supports hermeneutic justice.

The effects

This kind of practice has led to a number of positive effects for the research participants. For some, it provided an environment where they were able to discuss their beliefs in depth for the first time ever. Some effects were general, such as the appreciation of being able to discuss their beliefs, while others were more specific, such as finding strength and perseverance through their resistance and realising new ways of responding to and accepting their beliefs. There were also positive effects for me.

In the most general sense, participants appreciated the opportunity to discuss their beliefs and experiences with me. This is significant in the context of seeking epistemic injustice. Having the opportunity to discuss their experiences without them being denied or dismissed was valuable for people. This was exemplified by Amanda who, as seen earlier, now feels she has “got a better grip on what I'm going through”.

The conversations uncovered “sparkling moments” or unique outcomes (Gonçalves et al., 2009) that reflected both old and new skills. People were able to demonstrate these skills in the face of the impacts of these beliefs and the impacts of psychiatry. Amanda said, “You're not going to get me to crack, back off”, demonstrating her renewed efforts to keep living life despite her experiences with unusual beliefs. It may not be possible to eliminate the fear that these beliefs can cause, but Bethany demonstrated her commitment to living life despite that fear. She highlighted this by saying, “It doesn't stop me from having a road trip because the overall benefit of that road trip to my child and I for our life experience and mental wellbeing overrides my knowledge that there are cameras everywhere”. These moments of resistance were uncovered by enquiring about how participants' beliefs affected their lives. Because our conversations resisted an assumption of total disability or impairment and avoided questions that demand a specific answer, Amanda, Bethany and others were able to articulate the effects of the beliefs themselves.

For Michael, whose beliefs and experiences with psychiatry are ongoing, we discussed how he would continue to cope. Demonstrating an acceptance that exceeds what many might think possible, he said, “I'm not going to complain about my life because I'm going to live it within the constraints that I've been given”.

The conversations in this research have made a significant impact on me as a researcher and worker. Although I attempted to position myself as non-judgemental, I still held assumptions about the experience of delusion. They were informed by my past work and personal experiences. However, after spending so much time learning from people, the differing experiences of delusion seem to have little inherently in common. What unifies them appears to be the label and the often-unhelpful responses of others, including in the mental health system. It confirmed to me that delusion is a construct that encompasses many different phenomena.

This research has also reinforced the importance of not succumbing to the nihilism that sometimes accompanies experiences that are called delusions, psychosis or schizophrenia. These experiences are not “paradigmatic instances of incomprehensibility and meaninglessness” as they are sometimes considered (Ritunnano & Bortolotti, 2022). Or at least, it cannot be presumed that they are. There is value in listening to and asking about these experiences.

While it is uncommon in conventional mental health services, some contexts such as peer-support work or practice informed by narrative therapy acknowledge that delusions are a construct and consider that these experiences can be real and significant for people. However, it is different to embed this concept into practice. It is challenging to suspend judgement because some of the beliefs are very unusual, and we may have immediate emotional or cognitive reactions to them. We might even think “that doesn’t make any sense”. In response to this, I might say, “Yes, it doesn’t make any sense, so we will ask about it and listen to what the person has to say”.

Reflections

Some beliefs may stretch what we consider possible; however, this alone is not a reason for us to abandon narrative principles or disregard the real significance of these beliefs. Currently, the definition of delusion is so broad that it could seemingly apply to any belief that is novel, genius, revolutionary or lacking universal consensus (Kapusta, 2014). Notably, we rarely share the same beliefs and contexts as the people we work with. This serves as a reminder of the importance of particularism, whereby we recognise that the people we work with necessarily believe differently from us. It is

this recognition of difference that allows us to respond uniquely, thoughtfully and respectfully. This underscores the necessity of understanding each person within their specific context. By acknowledging and respecting these specificities, we can create an environment in which people can speak openly, feel heard and understand experiences, which is crucial for fostering epistemic justice.

While it may be appealing to engage in discussions about whether specific beliefs are literally “true” or not, doing so can reduce our conversations to arguments and obscure the impact and importance of the person’s belief. As Amanda noted, “Sadly, it’s a very human tendency to just not believe because it’s outside of their realm of [one’s] own experience”. This does not mean abandoning rational inquiry altogether, but it requires acknowledgment that some expressions resist clearly defined epistemologies. Some beliefs and expressions contain degrees of truth, they resist a binary true/false conclusion. Further, some beliefs are enmeshed with feelings, and it makes little sense to consider someone’s feelings as either true or false.

For example, the deeply held beliefs “I am a bad person” or “I feel something bad is going to happen” may be considered true by someone, but these beliefs themselves, their origins and their impacts resist neat categorisation as “true” or “false” because they are more experiential. Even with more specific claims or beliefs, elements of them may be true, creating a belief informed by both subjective and objective experiences. Understanding the origins and impacts of these beliefs has proven more useful in this research than focusing on their epistemological status.

We may wish to be non-judgemental but may find ourselves drawn into wanting to negate or dismiss some beliefs because of their perceived unusualness or inappropriateness. Conversely, we might entirely abstain from commenting in pursuit of being non-judgemental but may risk being non-influential. I have said to many people, “I don’t know”, “I don’t believe that to be true”, “I don’t understand where you are coming from”, “That doesn’t make immediate sense to me”. Yet this can be coupled with an attempt to understand, saying “I don’t know, BUT can you help me understand why you feel that is occurring” or “I don’t believe that to be true, BUT it seems like it is evident for you. When did this first become apparent?” Unusualness is not a sufficient reason not to enquire about someone’s experience. Certainly, the most significant events in people’s lives are often unusual. Resisting assumption-

making, or worse – a nihilism in which the beliefs are considered to have no value whatsoever, resists epistemic injustice. There is an opportunity to provide people with an environment to discuss and attempt to understand their own beliefs. Of the participants in my research, few, if any, had previously experienced this.

Conclusion

While individuals' experiences are idiosyncratic, people are not alone in their experiences. Many people both suffer from similar fear or sadness. Many resist this and find a way to thrive in the face of such significant beliefs. This realisation underscores the potential opportunity to connect individuals with shared experiences in future work. Peter Bullimore's National Paranoia Network² provides a model for such connections, which could be extended beyond paranoia

to encompass other beliefs and experiences. Despite the extraordinary nature of stories about unusual beliefs that have been labelled delusional, there is no need to treat them as fundamentally different to other stories. All storytellers are entitled to epistemic justice. This is the right to be heard and to be supported to understand one's experience. It may be the case that beliefs or mental states are "neurologically instantiated" (Fisher, 2009, p. 37). However, their causation and explanation remain far less certain. Joining with people in explorations of the histories, contexts and explanations of unusual beliefs can create possibilities for understanding, hope and change.

Notes

¹ Pseudonyms are used throughout.

² <https://nationalparanoianetwork.org/>

References

- Anderson, H., & Goolishian, H. (1992). The client is the expert: A not-knowing approach to therapy. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 25–39). Sage.
- Aschebrock, Y., Gavey, N., McCreanor, T., & Tippett, L. (2003). Is the content of delusions and hallucinations important? *Australasian Psychiatry*, 11(3), 306–311. <https://doi.org/10.1046/j.1440-1665.2003.00560.x>
- Bortolotti, L. (2022a). Are delusions pathological beliefs? *Asian Journal of Philosophy*, 1(1), 31. <https://doi.org/10.1007/s44204-022-00033-3>
- Bortolotti, L. (2022b, May 4). Delusion. In E. N. Zalta (Ed.), *Stanford encyclopedia of philosophy*. <https://plato.stanford.edu/archives/sum2022/entries/delusion/>
- Byers, P. (2019). Michael White's particularist ethics in a biological age. *International Journal of Narrative Therapy and Community Work*, (3), 106–115.
- Bueter, A. (2019). Epistemic Injustice and psychiatric classification. *Philosophy of Science*, 86(5), 1064–1074. <https://doi.org/10.1086/705443>
- Cuttler, C., & Ryckman, M. (2019). Don't call me delusional: Stigmatizing effects of noun labels on people with mental disorders. *Stigma and Health*, 4(2), 118–125. <https://doi.org/10.1037/sah0000132>
- Federico, M. T., Priebe, S., Fusco, C., Strapelli, N., Singh, R., & McCabe, R. (2013). Communication about psychotic symptoms in long-term psychiatric illness. *Psychopathology*, 46, 233–240.
- Fisher, M. (2009). *Capitalist realism: Is there no alternative?* John Hunt Publishing.
- Freeman, D. (2006). Delusions in the nonclinical population. *Current Psychiatry Reports*, 8(3), 191–204. <https://doi.org/10.1007/s11920-006-0023-1>
- Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press. <https://doi.org/10.1093/acprof:oso/9780198237907.001.0001>
- Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, 22(1), 1–23. <https://doi.org/10.1080/10720530802500748>
- Grim, K., Tistad, M., Schön, U.-K., & Rosenberg, D. (2019). The legitimacy of user knowledge in decision-making processes in mental health care: An analysis of epistemic injustice. *Journal of Psychosocial Rehabilitation and Mental Health*, 6(2), 157–173. <https://doi.org/10.1007/s40737-019-00145-9>
- Kennedy, H. (2019). Narrative practice and peer support. *International Journal of Narrative Therapy and Community Work*, (4), 42–49.
- Kapusta, A. (2014). Delusions in the phenomenological perspective. *AVANT*, 5(3), 113–125. <https://doi.org/10.26913/50302014.0112.0006>
- Mead, S. (2014). *Intentional peer support: An alternative approach*. Intentional Peer Support.

- Miyazono, K. (2015). Delusions as harmful malfunctioning beliefs. *Consciousness and Cognition*, 33, 561–573. <https://doi.org/10.1016/j.concog.2014.10.008>
- Newbigging, K., & Ridley, J. (2018). Epistemic struggles: The role of advocacy in promoting epistemic justice and rights in mental health. *Social Science and Medicine*, 219, 36–44. <https://doi.org/10.1016/j.socscimed.2018.10.003>
- Payne, M. (2006). *Narrative therapy: An introduction for counsellors* (2nd ed.). Sage.
- Ritunnano, R., & Bortolotti, L. (2022). Do delusions have and give meaning? *Phenomenology and the cognitive sciences*, 21(4), 949–968. <https://doi.org/10.1007/s11097-021-09764-9>
- Ritunnano, R., Kleinman, J., Oshodi, D. W., Michail, M., Nelson, B., Humpston, C. S., & Broome, M. R. (2022). Subjective experience and meaning of delusions in psychosis: A systematic review and qualitative evidence synthesis. *The Lancet Psychiatry*, 9(6), 458–476. [https://doi.org/10.1016/S2215-0366\(22\)00104-3](https://doi.org/10.1016/S2215-0366(22)00104-3)
- Rodrigues, A. C., & Banzato, C. E. (2010). Construct representation and definitions in psychopathology: The case of delusion. *Philosophy, Ethics, and Humanities in Medicine*, 5(1), 5. <https://doi.org/10.1186/1747-5341-5-5>
- Skelton, D., Coyne, B., Monje Barón, B., & Blunski Ackermann, M.-R. (2024). “Taking knowledge on a journey”: Creating conditions for epistemic justice. *Action Research*, 22(1), 86–103. <https://doi.org/10.1177/14767503231205235>
- Verdoux, H., & van Os, J. (2002). Psychotic symptoms in non-clinical populations and the continuum of psychosis. *Schizophrenia Research*, 54(1), 59–65. [https://doi.org/10.1016/S0920-9964\(01\)00352-8](https://doi.org/10.1016/S0920-9964(01)00352-8)
- Zangrilli, A., Ducci, G., Bandinelli, P. L., Dooley, J., McCabe, R., & Priebe, S. (2014). How do psychiatrists address delusions in first meetings in acute care? A qualitative study. *BMC Psychiatry*, 14, 178. <https://doi.org/10.1186/1471-244X-14-178>