roar @UEL
research open access repository

ROAR, the University of East London Institutional Repository: http://roar.uel.ac.uk

This book chapter is made available online in accordance with publisher policies. Please scroll down to view the document itself. Please refer to the repository record for this item and our policy information available from the repository home page for further information.

Author(s): Cromby, J and Harper, D
Chapter Title: Paranoia: contested and contextualised
Year of publication: 2012
Citation: Cromby, J. and Harper, D. (2012) 'Paranoia: contested and contextualised' in Diamond, B., Coles, S. and Keenan, S. (eds.) *Madness contested: power and practice.* Ross-on-Wye: PCCS Books, forthcoming [In press].

Link to published version:
The book will be published by PCCS Books (website at http://www.pccs-books.co.uk/).

Publisher statement:

Information on how to cite items within roar@uel:
http://www.uel.ac.uk/roar/openaccess.htm#Citing

Paranoia: Contested and contextualised

In this chapter we discuss how paranoia might best be conceptualised and responded to. By paranoia we mean experiences of perceiving and relating to others that are characterised by suspicion, mistrust or hostility. Whilst such experiences are common in the general population, amongst people who receive clinical interventions they often include complex, self-insulating belief systems, distorted perceptions and marked distress. In psychiatry these experiences are usually associated with diagnoses of schizophrenia, delusional disorder and paranoid personality disorder. The problems with the reliability and validity of these diagnostic categories are well known (Bentall, 2004; Boyle, 2002; Pilgrim, 2001). One alternative approach is to focus on specific problematic experiences and behaviours (Boyle, 2002) or 'complaints' (Bentall (2004) rather than heterogeneous diagnostic categories. Doing so addresses the problem of heterogeneity – but how might we then conceptualise these experiences? Drawing on a discussion of Bleuler's notion of schizophrenia, we present an approach to paranoia that considers both its social context and its embodied character. We then investigate the notion of 'distress'. Given the well-established finding that many people have experiences similar in content to those of mental health service users but without any accompanying distress, we discuss the importance of context in the generation of distress – in particular how it may arise because of a lack of 'fit' in the way they negotiate their beliefs and unusual experiences with their social world. Finally, we discuss how one might offer help or support differently in relation to paranoia.

Conceptualising paranoia

Clinicians might usefully reflect upon what paranoia is, because how they conceptualise it will influence the interventions they offer. In recent writings we have proposed that paranoia can be understood as constituted most crucially from complex mixtures of feelings (Cromby & Harper, 2009). By feelings we mean embodied states that can be subjectively experienced: emotions fall into this category, as do states like pain and fatigue, alongside more subtle states such as 'feeling certain'. These states constantly reflect our social and material situation and are the basis of all of our more formal thought processes (Langer, 1967).

Here, we introduce this approach, contrasting it with one of the foundational accounts of schizophrenia: Eugene Bleuler's work, which also gave a prominent role to feelings. We are cautious not to over-extend this comparison, partly because interpretations even across such relatively short periods of historical time are fraught, and partly because there is evidence that the population studied by Bleuler (and Kraepelin, the other architect of schizophrenia) was fundamentally different from today's. Substantial numbers of these early patients probably suffered from undiagnosed encephalitis lethargica, the symptoms of which (e.g. cyanosis, disorders of balance and gait, tremors) were also recorded as symptoms of schizophrenia but which (excluding the Parkinsonian effects of medication) are rarely, if ever, seen today (Boyle, 2002). We also recognise that in examining Bleuler's concept we might appear to give it further legitimacy by reifying schizophrenia. However, many concepts in psychiatry are of this nature – reified categories that have become separated from the experiences they were originally designed to understand. Moreover, Bleuler's work is still cited by psychiatric textbooks to legitimate the schizophrenia diagnosis (e.g. Burton, 2006) and continues to inform research (Andreasen, 2000; Kraus & Keefe, 2007; Park & Thakkar, 2010). So it is both timely and appropriate to revisit Bleuler; having done so, we describe some differences between his account and ours, then identify some clinical implications of our discussion.

The Disease of Schizophrenia

The invention of schizophrenia is a seminal moment in the history of psychiatry, and the basics of the story are well known. In 1896 Emil Kraepelin claimed to have identified a subset of patients who shared similarities in the onset, course and outcome of their difficulties. He argued that these patients were reliably distinguishable from others (for example, those he described as having manic-depressive disorders) and concluded that all had the same disease, dementia praecox. Subsequently, Bleuler gave this disease its modern name: schizophrenia. The new name reflected two major differences from Kraepelin's conception. First, Bleuler's observation that – unlike in dementia – outcomes were not always negative, and deterioration was not inevitable and irreversible. Second, his view that the core symptom of this disease was a 'loosening of associations' between the various elements of thought, a 'weakening' of mental energy.

For Bleuler, this loosening or weakening causes a shattering of the psyche – a 'split mind'. The usual processes that link thinking, feeling, memory, identity and perception, enabling them to work together seamlessly, are pathologically impaired: consequently, these functions get dissociated or disconnected from each other. Bleuler describes how the product of this splitting is an excess of feeling that then gets associated in a relatively fixed way with a particular idea – an 'idea complex' – but that "behind this systematic splitting into definite idea-complexes, we have found a previous primary loosening of the associational structure which can lead to an irregular fragmentation of such solidly established elements as concrete ideas." (Bleuler 1950, p.362). Schizophrenia, then, impairs the usual power of rational thought to inhibit, control and regulate affect: "What is pathological in the organic psychoses, so far as the feelings are concerned, is that they dominate the thoughts more strongly than in healthy individuals. Their inhibitory and helping influence on associations is rendered stronger by the faultiness of intellectual function." (Bleuler, 1912 p.34).

Historically, at least, this is the sense in which schizophrenia is portrayed primarily as a cognitive disorder, a disease of thought. A weakening of cognitive processes, caused by an organic impairment, is seen as the fundamental cause of schizophrenia. The subsequent imbalance of thinking and feeling (for Bleuler, disorders of affect, autism and ambivalence), along with delusions and hallucinations, are merely derivative or secondary symptoms. As Andreasen (2000, p.107) puts it "For both Kraepelin and Bleuler, the most important defining feature was an impairment in the ability to think in a clear, fluent and logical way". To summarise, then: Bleuler proposed that in schizophrenia, an organic deficit impairs the ability to think. This causes an excess of feeling, which allows idea complexes to form; these idea-complexes are the basis of the delusions and hallucinations often associated with the diagnosis.

This very brief account of Bleuler's concept of schizophrenia allows us to make comparisons and contrasts with recent work of our own (Cromby & Harper, 2009). We have argued that experiences of paranoia for which a person might receive professional help are produced when complex mixtures of socialised feeling produce very high states of arousal. When a person is highly aroused in this way, perceptions – which are usually simply tinged by feelings – can become powerfully influenced by them. Proximally, these states of heightened arousal may happen as a consequence of feeling traps (Scheff, 2003): arrangements of social, relational and material circumstances which induce complex mixtures of feelings. This can cause the feelings involved to sustain, intensify and generalise, making it harder for the person to interpret or understand them or to recognise their origins or causes, and so – in turn – producing additional feelings of anxiety, confusion or excitement that further complicate the person's experience.

Scheff proposes that, because of its specific qualities, shame will often be a component of feeling traps. He also discusses evidence suggesting that experiences of shame are frequently 'disavowed' – that is, people simply avoid recognising them. Shame itself is shameful, and the feelings associated with it are highly toxic; as a consequence, people frequently avoid all reference to their own experiences of shame and try to act as though they did not happen (Lewis, 1971). Whilst for any specific individual very many different feelings might be involved, shame is frequently discussed in relation to paranoia, and our reading of the literature suggests that shame, fear and anger might all typically be important.

In paranoia, then, fear might cause shame (in men, for example, because of normative gender expectations); this in turn could lead to anger, especially if the shame is disavowed; and this anger could be frightening, so magnifying the initial state of fear. Importantly, though, this is a schematic summary: at every moment, the precise way such feeling dynamics are enacted will continuously be influenced by fluctuating social and material circumstances. Feelings also influence - and are reciprocally influenced by - the narratives we tell others and ourselves, the 'inner speech' we experience, and the discursive constructions of world and self that, in everyday life, we constantly construct, update and revise. In paranoia these narratives are often conspiratorial and may refer to security services, aliens, secret organisations, surveillance and military technologies, or obscure or extreme religious or political groups.

Paranoia is likely to be characterised both by complex, shifting mixtures of feeling and by obstacles to their interpretation: where people believe they are not allowed to have or express certain feelings; where having or being seen to have certain feelings is dangerous; where it is adaptive not to feel, or at least appear not to feel; where feelings are difficult to identify or acknowledge because they run counter to the expectations or strictures of powerful others, and so on. In such circumstances, personal narratives may become somewhat complex and convoluted, occasionally lacking in overt logical coherence whilst retaining a deeper metaphorical or affective structure. Some of the typical features of the narratives of people experiencing distressing forms of paranoia – rapid speech, and an obsessive concentration on particular themes – are often associated with the presence of disavowed feelings (Scheff, 2003), suggesting that these may be particularly important. Moreover, the well-documented associations between paranoia, poor attachment, victimisation, powerlessness and marginalisation mean that paranoid narratives may often be managing some degree of exclusion or disenfranchisement: consequently, they may frequently serve a compensatory function that would (if accurate) endow the speaker with arcane knowledge or privileged insight (Bentall 2004; Cromby & Harper 2009).

Beyond Notions of Disease

So there are similarities between our account and Bleuler's, since both are concerned with the relations between thinking and feeling, but there are also differences. Most fundamentally, Bleuler is explaining a putative disease, schizophrenia, whereas our aim is to understand an experience; consequently, our account is not confined to a single diagnostic category and recognises that paranoia is associated with numerous diagnoses (and with no diagnosis at all). Also, by comparison to our notion of feeling, Bleuler's conceptualisation of affect is on balance narrower, more sharply distinguished from cognition, and more interchangeable with emotion. But there are also other differences, and we will now explore three that are especially significant.

First, our account does not presuppose an organic impairment which gives rise to a cognitive deficit. Since Bleuler proposed this, more than a hundred years of generously funded research, using ever more sophisticated technologies, has failed to find consistent evidence for any such pathology. As eminent biological psychiatrist Kenneth Kendler (2005, p.434-5)

puts it: "We have hunted for big, simple, neuropathological explanations for psychiatric disorders and have not found them. We have hunted for big, simple, neurochemical explanations for psychiatric disorders and have not found them. We have hunted for big, simple genetic explanations for psychiatric disorders, and have not found them." Importantly, though, whilst our account does not presume an organic deficit, nor does it *ignore* the body, as social science and cognitive psychology so often do: instead, we emphasise embodied feelings as the medium through which paranoia is primarily constituted.

Second, Bleuler's account posits an imbalance between thinking and feeling, arising as a consequence of weakened cognitive function. However, not only is the organic impairment purported to cause this initial weakening still elusive, we also question whether there can actually be an 'imbalance' of this kind. There is a contemporary movement within the humanities and social sciences known as the 'affective turn' (e.g. Athanasiou, Hantzaroula, & Yannakopoulos, 2008; Clough & Halley, 2007). Whilst the diversity of this work is such that even the basic terms affect, emotion and feeling are disputed, scholars associated with this movement agree that affective phenomena are hugely significant in human life; cannot sensibly be reduced to language, discourse or representation; and, conversely, cannot simply be treated as separable biological causes. From the perspective of the affective turn, *no* cognition is free of affect. Every thought is simultaneously both a movement of feeling and an associated fragment of inner speech that, to borrow Vygotsky's terminology, 'completes' it, making it fully sensible and available for reflection upon by ourselves, and (if we speak it aloud) by others (Cromby, 2007; Johnson, 2007; Vygotsky, 1962).

Frequently, the experiences associated with psychiatric diagnoses get related to neural structures and processes. Notwithstanding the well-documented dangers of individualism, reductionism and reification of diagnostic categories associated with such inferences (Bennett & Hacker, 2003), neuroscience itself provides evidence suggesting that thinking and feeling are not actually separable. Panksepp's (1998) studies of the mammalian brain identify a set of evolutionary older affect structures that he calls 'basic operating system circuits' that, once engaged, set the imperative and tone of cognitive processing. Similarly, Damasio (1999) proposes that feelings – feedback from the body – are the raw stuff of consciousness itself, which he suggests is generated in pulses that consist of the *difference* between the body in one somatic state and then, momentarily later, in another. Both of these neuroscientists (and others e.g. Le Doux, 1999) provide arguments and evidence indicating that thinking and feeling are always thoroughly intertwined. On the basis of this evidence, *all* thinking – whether or not it is associated with mental health difficulties - is already *felt thinking*.

This evidence suggests that, rather than being capable of getting stuck in a state of imbalance, feeling and thinking are in a continuous, dialectical relation, each with the other. Additionally, both are constantly open to external influence, so experiences of paranoia ebb and flow according to circumstance and situation. Even during intensely distressing episodes (so-called florid paranoia), when sustained, complex mixtures of feeling have temporarily generated highly aroused states, it does not seem that thinking somehow stops: on the contrary, individuals continue to generate narratives by which to understand their experience. These narratives may become rapid (so called 'pressure of speech') as the person strives to keep toxic feelings out of awareness (cf. Scheff, 2003). They may become disjointed as the person struggles to make sense of their multiple, fluctuating feelings and the fragments of meaning they are able to attach to them (so-called 'thought disorder'). Likewise, their logic – reflecting the complex, mobile, partially unspeakable mix of feelings within it – may defy some everyday conventions whilst entirely according with others, and indeed whilst reflecting in important ways the events, people and circumstances with which the person is currently preoccupied. But even during these intensely distressing episodes, feeling does not simply prevent or overwhelm thinking. In fact, it seems equally plausible to suggest that these are experiences where people are thinking *too much*: one way of

4

understanding paranoia is to see it as a determined search for meanings and significances where none may actually exist.

A third difference between Bleuler's account and ours is that we do not see the origin of paranoia as a cognitive deficit within the individual. Instead, we propose that toxic social and material circumstances combine to produce feeling traps which position individuals in ways that engender self-amplifying mixtures of shame, fear, anger and other feelings, mixtures that - if they persist - can induce extreme levels of arousal. Arguably, Bleuler's view that paranoia (at least in association with diagnoses of schizophrenia) is caused by individual cognitive deficits is mirrored by recent innovations in clinical psychology which emphasise the role of cognitive processes (e.g. attentional biases and jumping to conclusions) in producing experiences such as voice-hearing and delusional beliefs (Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001; Bentall, Kinderman, & Kaney, 1994). This work is a valuable advance upon Bleuler's because it emphasises experiences that can be identified relatively reliably, rather than being dependent upon unreliable diagnostic categories, and also because it is associated with psychological rather than pharmaceutical interventions. Nevertheless, it is conceptually similar in that it posits a cognitive disorder as the root cause of these problems.

By contrast, we propose that the cause of intrensely distressing episodes of paranoia is not an individual disorder or deficit, whether cognitive or organic, but a set of circumstances in the world itself. By virtue of their immersion in environments, individuals acquire habits of feeling, alongside habits of making sense both of their feelings and of the circumstances which generated them. If acquired in toxic circumstances, or alternately if acquired in benign environments but subsequently transferred to toxic ones, these habits may themselves become unhelpful. But even where this occurs, the origin of these habits is the social and material circumstances which gave rise to them, not some intrinsic cognitive flaw. As Jacqui Dillon, chair of the UK Hearing Voices Network puts it "instead of asking people – what is wrong with you? We ask people – what has happened to you?" (2011, p.155).

So it is not necessarily that these habits of thinking and feeling are themselves unhelpful, so much as that their 'goodness of fit' with the situations within which they are now enacted is not optimal. Strikingly, however, this issue of fit is rarely discussed, even though the context of experience is hugely influential on whether distress is associated with it.

Context, 'fit' and paranoia

One of the problems facing clinicians is that the vast majority of people they see because of paranoia are either in distress themselves or causing distress to others. Consequently, they might fall prey to the clinician's fallacy: the assumption that unusual experiences are necessarily associated with distress. A number of studies challenge this assumption, notably those using the PDI (*Peters et al Delusions Inventory*), a self-report questionnaire which asks questions about beliefs drawn from schedules of psychiatric symptoms but uses everyday rather than psychiatric language. Items include questions like 'do you ever feel as if people seem to drop hints about you or say things with a double meaning?' and 'do you ever feel as if you are being persecuted in some way?'. The PDI provides a total score – the number of unusual beliefs the person is said to hold -- and, for each belief, ratings of the conviction with which it is held, the level of preoccupation the person has with the belief, and the level of distress they feel it causes. Whilst this method takes a cognitive approach to beliefs (which can themselves be seen as both structures of feeling and components of thinking - Cromby, in press), it nevertheless provides a useful perspective. Peters, *et al* (2004), using a 21 item version of the PDI, compared the scores of a large general population sample with the scores of people who were psychiatric patients and diagnosed as having delusions. The authors used the shorthand labels of 'healthy' and 'deluded' for the

two samples. In figure 1 we can see how many beliefs were held by people in each of the samples.   If we look at the general population ('healthy') sample we can see that relatively few people endorsed none of the beliefs – indeed, the vast majority of this sample endorsed at least some of the beliefs. The authors reported that the difference between the two samples was not the existence of unusual beliefs *per se* but the levels of conviction, preoccupation and distress associated with them. Another study compared members of New Religious Movements (NRMs: Druids and Hare Krishnas), non-religious people, Christians and 'deluded people' (their term for the same in-patient sample), and reported no differences between NRMs and 'deluded people' in numbers of beliefs or the conviction with which they were held. Rather, the key differences were in the preoccupation and distress associated with them (Peters *et al*, 1999).

Figure 1 about here

In the Netherlands, van Os, *et al* (2000) conducted a survey of 7,076 Dutch people from the general population using a structured interview schedule with follow-up telephone interviews by psychiatrists for anyone where there was at least one rating on an item relating to psychosis. They reported that 3.3% had 'true' delusions (i.e. beliefs which met the diagnostic criteria for delusional belief), whilst an additional 8.7% had delusions that were 'not clinically relevant' – that is, they were 'not bothered by it and not seeking help for it' (van Os, *et al.*, 2000, p.13). This raises the intriguing possibility that, in addition to mental health service users, there may be twice that number of people in the wider population who have unusual experiences or beliefs, but who are not in distress or causing distress to others, and are living outwardly conventional everyday lives.

Whilst it can be hard for us to fully accept this, there are numerous accounts of people living with extraordinary experiences (Romme, Escher, Dillon, Corstens & Morris, 2009). There are also high-profile people who might not have been given psychiatric diagnoses who live apparently functional lives, who do not appear to have either experienced distress because of their beliefs or to have received mental health services. Harper (2011a) discusses Sun Ra (a black American avant garde jazz musician) and David Icke: here, we will briefly consider David Icke's views.

Icke was a professional footballer who became a BBC TV sports presenter in the 1980s. He was involved in the Green Party in the late 1980s, but parted company with them following a number of spiritual experiences. A week after resigning from the Green Party he held a press conference to announce that he had become a "channel for the Christ spirit" and predicted that the world would end in 1997 after a series of natural disasters. Icke subsequently began wearing only turquoise because he considered it a conduit of positive energy. Although the audience on Terry Wogan's BBC chat show appeared to laugh when they heard his views, according to journalist Jon Ronson Icke is 'a global sensation' who "lectures to packed houses all over the world, riveting his audiences for six hours at a time with extraordinary revelations" (Ronson, 2001, p.151). He has a website (www.davidicke.com) which announced a second live date at the O2 Brixton academy in London in September 2010 to meet excess demand following a previous sell-out lecture in May 2010, and has written numerous books about his ideas, in particular that the world is run by a race of shape-shifting alien lizards who have inter-bred with humans.

Thus it would seem that unusual beliefs, or experiences like hearing voices and seeing visions, are not necessarily associated with distress: other kinds of feelings can be implicated. Indeed, the category of eccentric is frequently ascribed to those who are open about these experiences (Weeks & James, 1997). Whilst people are usually described as eccentric when their views are idiosyncratic, sometimes whole groups of people profess beliefs that many consider unusual. Shaw (1995) describes his experiences with a number of new religious groups, including the Aetherius Society which believes that their founder

was in telepathic communication with UFOs. Of course, particularly when discussing religious, philosophical, political or moral claims, assertions about whether a belief is unusual can be problematic (Harper, 2011a). It seems that it is the *fit* between particular beliefs and experiences and other aspects of people's lives that powerfully influences whether distress (their own, or that of others) is associated with them.

Clinical Implications

We have suggested that intensely distressing episodes of paranoia should be seen as habits of felt thinking and action acquired in response to events in the social world. We have also argued that it is the context of beliefs and experiences and their 'fit' in a person's life which may be important in determining whether they might cause problems for them. How might these observations be of use to those and those seeking to help people referred to mental health services? Firstly, it is important to consider the wider context within which distress is identified (for either the person or others). Secondly, it is important to consider how the person's biographical context may give metaphorical meaning to the belief or experience, since this may suggest how habits of felt thinking and action are linked to prior adverse experiences.

<u>Wider context</u>

It is important not to assume the experience or belief is necessarily distressing. One needs to consider the source of the referral: did it come from the person, a relative, or an agency as a result of requests by neighbours etc? If the person is not in distress then maybe, rather than trying to change the person's relationship with their experience (e.g. through trying to alter their appraisal of it), what may be needed is help with relating that experience to the wider world, devising practical strategies to manage and negotiate their feelings in a world which may find them disturbing. There could be a range of tacit skills deployed by those in the general population with similar experiences – for example, people might carefully consider those with whom to discuss their unusual beliefs.

If the person is not distressed it may help to direct them to groups who share similar beliefs or experiences, since social isolation seems to accentuate distress (Read & Bentall, in press).These groups may also offer protocols, practices and rituals which enable even a person preoccupied with a belief to set it in a context, reducing its immediacy and personal salience by sharing with the group, and locating it within a narrative with broader meanings. Thus, Hearing Voices Network groups embrace an agnostic approach to causality, enabling people to develop their own conceptual frameworks. Similarly, UFO abduction groups have developed complex belief systems setting these experiences in a wider historical and cultural context of the possibilities of human-alien communication (Clancy, 2005).

If the person themselves is not distressed by their experience or belief, but their family (for example) are disturbed or concerned, it may help to closely examine how this concern arises. It may be that simply talking to their family less about their beliefs and/or experiences will be helpful. Indeed, this is a common strategy deployed by those in hospital who wish to be discharged (Dillon, 2011). Frequently, a person's ability to talk less to those close to them is facilitated by engagement with a group – like those mentioned above – where experiences *can* be freely discussed.

Equally, it is important not to assume that these experiences or beliefs aren't distressing. Indeed, it is easy to romanticise those who hold beliefs which are seen as unusual as cognitive dissidents, to view their experiences in solely libertarian terms. If the person *is* distressed it is still important to investigate the context in which these feelings arise, though. Is it the belief or experience *per se*, the nature of their relationship with it, or the way they

negotiate it with the wider world? It may help to clarify criteria by which the person would judge whether their relationship with -- and negotiation of -- the belief or experience had improved. Following Michael White's approach to helping service users clarify their position in relation to psychiatric medication (Stewart, 1995), therapists could consider how they might help service users determine whether their relationship with their beliefs contributes to -- or subtracts from -- their quality of life, ways in which their beliefs might be enabling and disabling, and how their effects (on themselves, and others) might best be monitored.

<u>Biographical context</u>

It may also help to explore the metaphorical meaning of a person's feelings in relation to their biography – for example, does it convey something about how they have made sense of aversive events earlier in life? Read and Bentall (in press) provide various examples of such links from the mental health literature, including this from Heins et al (1990):

> A woman, who had been sexually assaulted by her father from a very young age and raped as a teenager, had the delusion that 'people were watching her as they thought she was a sexual pervert and auditory hallucinations accusing her of doing "dirty sexy things"' (cited in Read & Bentall, in press)

Of course, such explorations need to be conducted in a therapeutically safe and containing manner, setting problematic feelings in a meaningful context.

Even if a service user does not wish or is not able to leave their belief behind, it may be important to discuss how they might revise their relationship with it or its role in their life. Recently, cognitive behavioural approaches have begun to move in this direction, particularly concerning beliefs which seem hard to shift. Tamasin Knight, who received Cognitive Behavioural Therapy but did not find that approach a good fit for her, explains how this kind of revision might occur:

> Some years ago I became very distressed as I believed I had a physical illness that would kill me in the not too distant future. I later became able to cope with this by thinking that if this was the case, then I should do the things I felt were important and enjoyed right away, rather than leave them to the future. By getting involved in activities I felt were important and worthwhile and building up my social network, the unpleasant beliefs I experienced became less central and troublesome in my life.
>
> Knight (2004, p.13)

This is a pragmatic approach, focusing on a person's life goals rather than whether their beliefs are true. Given that final and convincing proof in relation to some beliefs may be impossible to acquire, the question becomes: how do we move forward? This might involve activities with which the person wishes to be involved but which fear has prevented. Such involvement might increase self-confidence and reduce social isolation, both factors which appear to be implicated in the development of unusual beliefs and experiences (Read & Bentall, in press). In the next section we discuss a range of interventions which are consistent with the approach we have outlined.

Alternative interventions

Interventions from a range of theoretical traditions would be consistent with our approach. However, given the dominance of individual psychotherapeutic approaches and the relative neglect of a more collective and contextualised approach, here we will focus mainly on

interventions with groups and wider networks. We will begin by focusing on the Hearing Voices Movement, as it has led the way in developing collective, alternatives but we will then look at paranoia self help groups, the Open Dialogue approach and, finally, community psychology. Following reports that many in the general population heard voices, the Hearing Voices Movement attempted to de-pathologise this experience. In the UK, the Hearing Voices Network follows this approach, welcoming a diversity of causal explanations, and voice hearers are encouraged to find their own ways of understanding and managing their experiences (Romme et al., 2009). Often this involves meeting with others who have similar experiences. How might such groups be helpful? One important factor may be that they help people develop explanations for their experiences which make sense to them *and* fit with the way they and others see the world. Of course, some explanations may be distressing, so groups might also help people to develop explanations which do not unduly distress them. Groups may also put people in contact with communities of others who share similar meanings – for example, Spiritualist church groups which see voices as having religious significance: this can help reduce social isolation. In addition, groups often engage in routine collective activities which ground the person in a community, for example the regular meetings of Hearing Voices groups or the rituals and services of religious groups (Clarke, 2010).

In recent years, these insights have led to the development of paranoia support groups (Bullimore, 2010; James, 2003). Knight (2009) describes the process of setting up the 'Better believe it!' support group at the Joan of Arc project in Exeter and also includes the findings of an evaluation after the group had been meeting for two years. The founding conference of the Paranoia Network in Manchester in 2004 was attended by over 100 people; accounts of it can be found in Hornstein (2009) and Jacobson and Zavos (2007), whilst the Romme et al (2009) volume includes accounts by some of the presenters.

The family is an important social context for some service users but, a continual challenge in psychotherapeutic work is to avoid colonising service users' experience with a monological interpretation (e.g. biomedical, cognitive etc). Seikkula, Alakare and Aaltonen's (2001a,b) 'Open Dialogue' approach explicitly involves the elaboration of multiple perspectives on distress, utilising the reflecting team tradition within systemic therapy. Here a small team of professionals meet with service users and their families with the specific aim of generating a range of explanations in a safe and containing manner, with the aim of placing problematic feelings in a meaningful context, rather than simply offering one explanation and one treatment.

Community psychology is another approach to engaging with the social context. May (2007) has discussed the development of community-based approaches for people having experiences considered psychotic – for example the work of Evolving Minds in Yorkshire (http://www.evolving-minds.co.uk/). Holland's (1991) White City project is also a useful model. Holland adopted a social action psychotherapy approach focused on women in West London's White City area, offered sessions of individual therapy which led into group work and then into collective social action. Holmes' (2010) approach to group work draws on Holland's approach. Narrative therapists offer another approach to working with communities and groups (e.g.Freedman & Combs, 2009). One issue which is often neglected is the need for societal changes, since environments are consistently shown to be strong causal factors in the development and maintenance of distress. Consequently, policy recommendations also flow from our approach, and these may become especially important in a so-called 'Age of Austerity' that seems likely to fuel increased social fragmentation and decreased trust in communities (Harper, 2011a,b).

Conclusion

Paranoia, like other terms used to describe mental health difficulties, is contested. In this chapter, we have tried to show how this term need not be understood in the context of a disease. Instead, we have argued, paranoia can be understood in the multiple contexts of everyday life and the unique contexts of personal biographies. This understanding of paranoia begins to distance it from the stigma that is inevitably associated with biomedical explanations for such experiences. It directs our attention to social and material circumstances, to the fit between beliefs, experiences and their contexts; it also directs our attention to personal biographies, and the habits of feeling they produce. Various research questions flow from our approach, and we have elaborated these elsewhere (Cromby & Harper, 2009). Here, we have explored some ways in which clinicians might help people who experience paranoia, and examined some of the ways in which people who experience paranoia are already helping themselves. However, since paranoia is a socially and materially constituted embodied experience, a way of being in the world, it necessarily reflects the circumstances and contingencies *of* that world. Consequently, its amelioration will always be a matter of political, economic and social policy, as well as therapeutic intervention.

Figure 1: Range of scores and distributions of PDI Yes/No scores in the "healthy" and "deluded" groups (Peters et al, 2004)
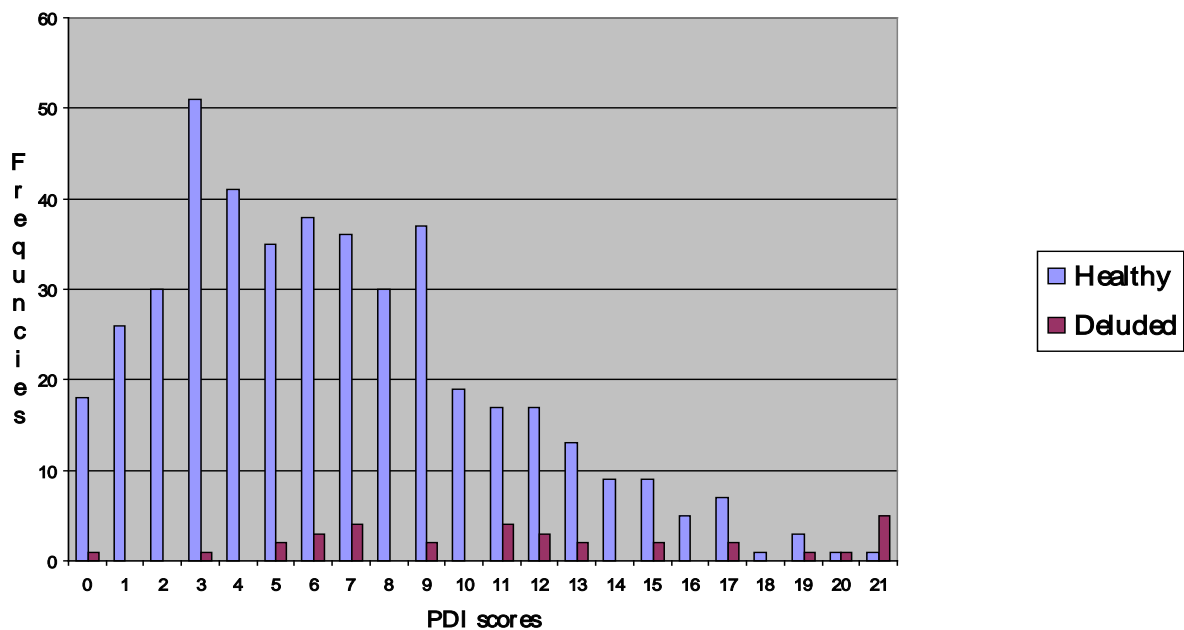
Andreasen, N. (2000). Schizophrenia: the fundamental questions. *Brain Research Reviews, 31,* 106-112.

Athanasiou, A., Hantzaroula, P., & Yannakopoulos, Y. (2008). Towards a New Epistemology: the "affective turn". *Historein, 8,* 5-16.

Bennett, M. R., & Hacker, P. M. S. (2003). *Philosophical Foundations of Neuroscience.* Oxford: Blackwells.

Bentall, R., Corcoran, R., Howard, R., Blackwood, R., & Kinderman, P. (2001). Persecutory delusions: a review and theoretical integration. *Clinical Psychology Review, 21*, 1143-1192.

Bentall, R., Kinderman, P., & Kaney, S. (1994). The self, attributional processes and abnormal beliefs: towards a model of persecutory delusions. *Behaviour Research and Therapy, 32*, 331-341.

Bentall, R.P. (2004). *Madness explained: Psychosis and human nature.* London: Allen Lane/Penguin.

Bleuler, E. (1912). *Affectivity, Suggestibility, Paranoia* (C. Ricksher, Trans.). Utica: State Hospitals Press.

Bleuler, E. (1950). *Dementia Praecox or the Group of Schizophrenias* (J.Zitkin, Trans.). New York: International Universities Press.

Boyle, M. (2002). *Schizophrenia: A scientific delusion?* Second edition. London: Routledge.

Bullimore, P. (2010) 'The paranoia group' *Asylum: The Magazine for Democratic Psychiatry* 17(1): 26.

Burton, N. (2006). *Psychiatry*. Oxford: Blackwells.

Clancy, S.A. (2005). Abducted: How People Come to Believe They Were Kidnapped by Aliens. London: Harvard University Press.

Clarke, I. (ed) (2010) *Psychosis and spirituality: Consolidating the new paradigm. Second edition.* Chichester: Wiley.

Clough, P., & Halley, J. (Eds.). (2007). *The Affective Turn: theorising the social.* Durham NC: Duke University Press.

Cromby, J. (2007). Toward a Psychology of Feeling. *International Journal of Critical Psychology, 21*, 94-118. Retrieved from http://www-staff.lboro.ac.uk/~hujc4/

Cromby, J. (in press). Beyond Belief. *Journal of Health Psychology*.

Cromby, J., & Harper, D. (2009). Paranoia: a social account. *Theory and Psychology, 19*(3), 335-361.

Damasio, A. R. (1999). *The Feeling of What Happens: body, emotion and the making of consciousness.* London: William Heinemann.

Dillon, J. (2011). The personal *is* the political. In M.Rapley, J. Dillon & J. Moncrieff (eds) *De-medicalising misery*. London: Palgrave Macmillan.

Freedman, J. & Combs, G. (2009). Narrative ideas for consulting with communities and organizations: Ripples from the gatherings. *Family Process*, 48, 347–362.Harper, D. (2011a). The social context of 'paranoia'. In M.Rapley, J. Dillon & J. Moncrieff (eds) *De-medicalising misery*. London: Palgrave Macmillan.

Harper, D. (2011b). Social inequality and the diagnosis of paranoia. *Health Sociology Review*, 20, 420-433.

Heins, T., Gray, A., & Tennant, M. (1990). Persisting hallucinations following childhood sexual abuse. *Australian and New Zealand Journal of Psychiatry, 24*, 561-565.

Holland, S. (1991). From private symptom to public action. *Feminism & Psychology*, **1**, 58-62.

Holmes, G. (2010). *Psychology in the real world: Community-based groupwork.* Ross-on-Wye: PCCS books.

Hornstein, G.A. (2009) *Agnes's Jacket: A Psychologist's Search For The Meanings Of Madness* Rodale Press: New York.

Jacobson, M. and Zavos, A. (2007). Paranoia Network and conference: Alternative communities and the disruption of pathology' *Journal of Critical Psychology, Counselling and Psychotherapy* 7: 28-39.

James, A. (2003) 'Voices of reason' *The Guardian* 10 December. http://society.guardian.co.uk/societyguardian/story/0,7843,1103141,00.html, accessed 8 February 2010.

Johnson, M. (2007). *The Meaning of the Body: aesthetics of human understanding*. Chicago: University of Chicago Press.

Kendler, K. (2005). Towards a philosophical structure for psychiatry. *American Journal of Psychiatry, 162*, 433-440.

Knight, T. (2004) 'You'd better believe it' *Open Mind* **128**: 12-13.

Knight, T. (2009) Beyond Belief: Alternative Ways Of Working With Delusions, Obsessions And Unusual Experiences Peter Lehmann Publishing: Berlin. http://www.peter-lehmann-publishing.com/beyond-belief.htm, accessed 15 January, 2010.

Kraus, M. & Keefe, R. (2007). Cognition as an outcome measure in schizophrenia. *British Journal of Psychiatry 191 (suppl 50)* s46-s51

Langer, S. (1967). *Mind: an essay on human feeling* (Vol. 1). Baltimore: The Johns Hopkins University Press.

Le Doux, J. (1999). *The Emotional Brain*. London: Phoenix.

Lewis, H. B. (1971). *Shame and guilt in neurosis*. New York: International Universities Press.

May, R. (2007). Working outside the diagnostic frame. *The Psychologist*, 20, 300-1.

Panksepp, J. (1998). *Affective Neuroscience*. Oxford: Oxford University Press.

Park, S., & Thakkar, K. (2010). 'Splitting of the Mind' revisited: recent neuroimaging evidence for functional dysconnection in schizophrenia and its relation to symptoms. *American Journal of Psychiatry, 174*(4), 366-368.

Peters, E., Day, S., McKenna, J. & Orbach, G. (1999). Delusional ideation in religious and psychotic populations. *British Journal of Clinical Psychology*, 38, 83-96.

Peters, E., Joseph, S., Day, S. & Garety, P. (2004). Measuring delusional ideation: The 21-Item Peters et al Delusions Inventory (PDI). *Schizophrenia Bulletin*, 30, 1005-22.

Pilgrim, D. (2001). Disordered personalities and disordered concepts. *Journal of Mental Health*, 10, 253-265.

Read, J. & Bentall, R. (in press). Madness. In J. Cromby, D. Harper & P. Reavey, *Psychology, mental health and distress*. London: Palgrave.

Romme, M., Escher, S., Dillon, J., Corstens, D. and Morris, M. (eds) (2009) *Living with Voices: 50 Stories of Recovery* PCCS: Ross-on-Wye.

Ronson, J. (2001). *Them: Adventures with extremists*. London: Picador.

Scheff, T. (2003). Male emotions/relations and violence: a case study. *Human Relations, 56*(6), 727-749.

Seikkula, J., Alakare, B. and Aaltonen, J. (2001a) 'Open Dialogue in psychosis I: An introduction and case illustration' *Journal of Constructivist Psychology* **14**: 247-265.

Seikkula, J., Alakare, B. and Aaltonen, J. (2001b) 'Open Dialogue in psychosis II: A comparison of good and poor outcome cases' *Journal of Constructivist Psychology* **14**: 267-284.

Shaw, W. (1995). *Spying in Guru land: Inside Britain's cults*. London: Fourth Estate.

Stewart, K. (1995). On pathologising discourse and psychiatric illness: an interview within an interview. In M. White, *Re-authoring lives: Interviews and essays*. Adelaide: Dulwich Centre Publications.

van Os, J., Hanssen, M., Bijl, R.V. & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the general population? *Schizophrenia Research*, 45, 11-20.

Vygotsky, L. S. (1962). *Thought and Language* (E. Hanfmann & G. Vakar, Trans.). Cambridge, Mass.: M.I.T. Press.

Weeks, D. & James, J. (1997). *Eccentrics*. London: Phoenix.