Gender and the Construction of Paranoid Experiences in the General Population

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ABSTRACT

Existing research has continued to demonstrate that experiences of paranoia are best understood as lying on a continuum, across both clinical and non-clinical populations. Within the non-clinical population, experiences of paranoia have been associated with gender, with the predominant pattern being a higher prevalence rate amongst males. The aim of this study was to further investigate this relationship, utilising a qualitative and discursive approach to data collection and analysis. This approach was chosen in order to address concerns with the predominantly reductive methodologies commonly utilised in investigations of both gender and paranoia.

The culturally available discourses of 'paranoia' and 'gender' were investigated through conducting semi-structured interviews with nine interviewees, recruited from a non-clinical, student population. Transcripts of interviews were subsequently analysed using Foucauldian Discourse Analysis (FDA).

The findings of the study demonstrated gendered aspects of discursive constructions of paranoia, as well as ways in which men and women are positioned differently within discourse, and the resultant potential consequences for individual subjective experience. Common constructions of paranoia in men were of an experience related to external and physical threats, expressed through an unpredictable and aggressive manner; whilst paranoia in women was constructed as more normalised and based in social and intimate relationships, expressed in an open manner, and shared with others. Implications of these findings suggest that considerations of gender should be brought more to the fore in both research and clinical practice, to provide a more nuanced understanding of the experience of paranoia.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

1.1. Overview of Chapter

This introduction chapter will aim to provide an overview of current and past research into the experience of paranoia, whilst also providing a rationale for the current study. The chapter will present the differing ways in which paranoia has come to be defined, critiquing traditional associations with abnormality and mental health. Following this, there will be an exploration of how thinking has moved on from this categorical view towards a continuum model and more single symptom approach, in which paranoia is investigated in the general population. A particular focus will then be given to the social and demographic factors which have been previously associated with experiences of paranoia, both in clinical and non-clinical contexts. The chapter will then move to focus more closely on the relatively under investigated associations between gender and paranoia. There will be a consideration of the potential flaws of a traditional empiricist exploration of gender and paranoia, before a more discursive approach is presented as an appropriate alternative. Finally, the current study, aims, approach and objectives will be introduced.

1.2. Literature Search Strategy

The literature search was conducted through the use of the following electronic databases: PsycINFO (2001-2017), PsycARTICLES (2001-2017), and Google Scholar (2001-2017). The search utilised the following terms: (i) general population OR nonclinical AND paranoi* OR persecutory OR delusion OR psychosis. Papers were screened for inclusion through an initial reading of the title and abstract, in order to identify papers with a focus on experiences of paranoia in the non-clinical population, as well as potential gender differences. Searches were initially limited to the period 2001-2017 but following the identification of specific papers, subsequent papers were found through snowball searches of the relevant reference lists.

1.3. Defining paranoia

'Paranoia' as a term has come to be widely used throughout everyday life, as well as within psychiatric and medical settings. This utilisation in multiple contexts appears to occur without a unified agreement on meaning. Within the Oxford English Dictionary two main definitions are provided, reflecting the varying ways in which the term has come to be used. The first of these defines the term as:

> "mental illness characterized by a persistent delusional system, usually on the theme of persecution, exaggerated personal importance, or sexual fantasy or jealousy, often as a manifestation of schizophrenia."

In contrast to this primarily medical and psychiatric construction of paranoia, the second definition appears to provide a broader and more generalised description.

> "any unjustified or excessive sense of fear; esp. an unreasonable fear of the actions or motives of others."

Examining these definitions highlights a distinction between two quite differing constructions of the term 'paranoia'. Paranoia is seemingly used both as abnormality or "mental illness", and to describe a more general although "unreasonable" fear. This distinction poses the question as to whether paranoia as a term describes a distinct abnormal experience, or whether the term represents more of a spectrum of experience, present both within general population and at more severe and 'clinically relevant' level. Within research literature and clinical practice, this question has historically been debated and explored through the categorical vs continuum debate (David, 2010; Van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009), which will be the focus of the early parts of this chapter.

1.3.1. The categorical approach to paranoia

In the field of psychiatry, paranoia has historically been largely viewed as a distinct and abnormal experience, and therefore as separate from reality or normal functioning. This categorical approach positions symptoms such as paranoia and delusional beliefs as qualitatively different to 'normal' experiences, and therefore part of discrete mental health diagnoses (Straus, 1969; van Os,

2003). This viewpoint can be retroactively traced and located within the original conception of the Dementia Praecox and Schizophrenia constructs at the turn of the twentieth century (Miller, 1986), within which paranoid experiences played a central role. Since this early part of psychiatry's history, the categorical view has continued to be the predominant approach in modern psychiatric practice. Until very recently, Paranoid Schizophrenia was a commonly used sub-type of the diagnosis of Schizophrenia within the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), since removed due to "poor description of the heterogeneity of schizophrenia" and "low diagnostic stability" (Tandon et al, 2013).

Within the currently used Diagnostic and Statistical Manual, Fifth Edition (DSM-V) (American Psychiatric Association, 2013), experiences of paranoia are now subsumed under the symptom constructs of Delusions and Paranoid Ideation. References to these symptoms can be found within several categories of psychiatric disorder, including Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders, Personality Disorders, and several others. The DSM-V provides a definition of a Delusion as "fixed beliefs that are not amenable to change in light of conflicting evidence", whilst a persecutory delusion is described as "belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group" (American Psychiatric Association, 2013, p. 87).

Separate from the construct of 'delusion', there are references to a less severe form of paranoia, or the existence of a spectrum of paranoid experiences. This can be found within the DSM-V definition of Paranoid Ideation which is defined as "Ideation, of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated" (American Psychiatric Association, 2013, p. 819). The inclusion of ideation points towards some acknowledgment of experiences of paranoia as lying more on a symptom continuum ranging from thoughts and ideation, up to a fixed belief held with a high level of certainty (Freeman, 2016). However, despite this nod towards a continuum approach, the DSM-V remains categorical in its requirement for distinction between 'delusion' and 'ideation'; "The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on

the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity" (American Psychiatric Association, 2013, p. 87).

1.3.2. Problems with a categorical approach

The placing of a categorical distinction between abnormal delusions of clinical significance and more general experiences of paranoid ideation or thinking can be seen as problematic in a number of ways. This section will aim to consider the most salient of these arguments, before considering the merit of a continuum approach, and presenting the definition or construction of paranoia that will be utilised throughout this thesis.

1.3.2.1. Variability in beliefs and experiences

The DSM-V emphasis of distinction based on the fixed nature of belief, conflicts with large amounts of research demonstrating the often fluctuating nature of individuals' level of conviction in their belief (Harper, 2004; Ross, 2014), even amongst those diagnosed with delusional beliefs (Appelbaum, Robbins & Vesselinov, 2004; Garety, 1985). Treatment of delusional beliefs through therapies such as Cognitive Behavioural Therapy (CBT) rely upon the notion that beliefs are not fixed, offering intervention in the form of exposure, reality testing, and cognitive therapy (van der Gaag, Valmaggia & Smit, 2014). In a small-scale study conducted by Chadwick and Lowe (1990) six participants diagnosed with delusional beliefs of a duration longer than two years, voluntarily participated in a reality testing intervention. Significant changes in conviction of belief were demonstrated in all but one of the participants. In a more recent study by Freeman et al (2016), 30 participants diagnosed with persecutory delusions were treated using a virtual reality form of exposure and cognitive therapy, leading to significant and large reductions in delusion conviction. When closely tracked over time, these changes in beliefs during therapy appear to occur in a fluctuating manner, with clients moving back and forth in their conviction, as opposed to a definitive moment of change that would be suggested by the more categorical construction of delusions as fixed (Messari & Hallam, 2003). The traditional categorical approach struggles to account for this evidence of this apparent

variable nature of strength of belief (Harper, 2004). At what point should a belief be considered a ‘strongly held idea’ or ‘paranoid ideation’ versus a ‘delusion’ or ‘fixed belief’, when movement can occur between the two, and there exists amenability to change?

1.3.2.2. Judging validity of beliefs and experiences

A further important critique of the categorical approach to delusions and paranoia, surrounds the criterion of falsity of beliefs (Harper, 2004). Both DSM-V and dictionary definitions of these experiences, point towards the requirement that beliefs are false, unjustified or contrary to evidence. This approach to distinguishing paranoid from non-paranoid beliefs requires us to take a naïve realist view of the world, in which we assume all belief systems are managed in this way (Georgaca, 2000; Harper, 2004; 1996). Harper (2004) critiques this assumption through considering how this expectation of evaluating beliefs based on evidence conflicts with what we know about how people manage their beliefs in general. Sharot and Garrett (2016) discuss how, contrary to the popular assumption of rationality and reality testing, decisions about beliefs are formed primarily through biases and systematic errors in reasoning, including a process of valence whereby particular attention is placed on desirable information, whilst undesirable is ignored. If this is the process by which ‘normal’ beliefs are formed, why is there an expectation placed on those who’s beliefs are constructed as paranoid to utilise evidence and logic (Harper, 2004)? Additionally, Georgaca (2004) argues that the plausibility of a belief is formed and judged through discursive processes, and not a form of logical or empirical reality testing. Therefore, the more categorical approach to paranoia and delusional beliefs appears flawed both in its expectation of drawing a clear distinction between true beliefs that reflect reality and those that are false, and in the assumption of logic and reasoning processes.

1.3.2.3. Paranoia in the general population

Perhaps the most significant challenge to the categorical approach, comes from research demonstrating the prevalence of paranoid and delusional experiences amongst non-clinical populations (Harper, 2004). In a large scale study in the Netherlands looking at experiences within the general population, 7076 people

were interviewed as part of the Netherlands Mental Health Survey and Incidence Study (NEMESIS). Within this randomised general population sample, a 17.5% overall incidence rate of symptoms associated with psychosis was reported, along with 8.7% meeting the criteria for delusional beliefs, despite only 2.1% of the sample having a formal DSM-III diagnosis (van Os, Hanssen, Bijl, & Ravelli, 2000). Again, looking at the experience of delusional beliefs in the general population, Freeman (2006) conducted a review of available epidemiological literature; across the included studies, it was found that up to 15% of the nonclinical population reported experiencing regular delusional ideation, with up to 6% presenting with a delusional belief but not at the severity warranting diagnosis.

Looking more specifically at experiences of paranoia, in a non-clinical population study, between 47% and 70% of a sample of 324 students reported experiences of paranoia that varied from concerns about the hostile intent of others, to more benign experiences of suspicion (Ellett, Lopes, & Chadwick, 2003). In a similar study conducted by Freeman (2005) around a third of 1202 internet surveyed participants reported paranoid thoughts, arranged on a hierarchy from suspiciousness up to persecutory delusions. Larger scale survey studies in the UK have also demonstrated paranoid experiences within the broader population. One such study looking at data available from a large scale psychiatric morbidity survey in the UK, demonstrated paranoid ideation in 20-30% of the population, with some variability according to types of ideation (Bebbington et al, 2013). In a similar study conducted by Freeman et al (2011) looking at large scale survey data, paranoid experiences were not only shown to be highly prevalent within the general population at 18.6%, but also to be associated with many markers of wellbeing, social functioning and other mental health difficulties.

Beyond purely survey based data, studies have shown how paranoia can be demonstrated in non-clinical individuals within an experimental situation. A virtual reality study measuring persecutory paranoia in 200 individuals from the general population, found that over 40% of participants endorsed paranoid thinking during a neutral virtual reality simulation (Freeman, et al, 2008). This research has been well replicated and expanded upon to further explore the spectrum of paranoia

experiences. A similar virtual reality study by Freeman, Pugh, Vorontsova, Antley and Slater (2010) demonstrated different levels of paranoid experiences within a sample from the general population, ranging from lower level paranoia to persecutory delusions, as well as linking these with experiences of anxiety, worry, trauma and interpersonal sensitivity.

Taking an overall view, in a systematic review of 47 studies investigating 'psychotic' phenomena in the general population, the median rate of prevalence of psychotic phenomena in broad terms, was found to be between 5% and 8%, compared with an average reported prevalence of psychosis diagnosis of 0.7% (Van Os, Linscott, Myin-Germeys, Delespaul, Krabbendam, 2009). Acknowledgement of the prevalence of these experiences within the non-clinical population on a spectrum of intensity, has led to calls for the abandonment of "outdated" categorical disease model and for a more continuum based approach to psychotic symptoms such as paranoia (Van Os, 2003).

1.3.3. The continuum approach to paranoia

Taken together, these arguments demonstrate the limitations of considering paranoia or delusional beliefs in a purely categorical manner, whilst also suggesting that a more continuum based conceptualisation would have greater validity and utility (van Os, Hanssen, Bijl, & Ravelli, 2000). One of the earliest proponents of a continuum based approach was Strauss (1969). Drawing upon research interviews that demonstrated the lack of diagnostic validity in symptoms of hallucinations and delusions, he proposed a continuum of functioning as opposed to a definitive categorical distinction. In this model, psychotic phenomena were understood to lie on a dimension with 'normal' experiences, as opposed to being considered either present or absent (Strauss, 1969). Van Os, Hanssen, Bijl, and Ravelli (2000) proposed that this notion of a continua of functioning be broadened beyond clinical populations to span the population in general. Expanding further on these ideas Johns and van Os (2001) reviewed the literature available at the time, proposing a continuum model understanding of the positive symptoms of psychosis, whereby as individuals move up the spectrum of experiences they also increase in need for care or support. This

contradicts a more categorical understanding, whereby need for care due to the presence of ‘illness’ or ‘disorder’ is predicated on the presence or lack of presence of distinct symptoms.

Critiques of the continuum approach have often focused on the viewpoint that they lack the validity and clinical utility that is provided by a diagnostic framework (Lawrie, Hall, McIntosh, Owens & Johnstone, 2010). However, this argument does not take into account the well replicated evidence demonstrating that categorical diagnostic frameworks themselves lack the level of validity and reliability that would render them clinical useful (Bentall, 2006). For example, taking the current DSM-V diagnostic framework for schizophrenia the kappa value for inter-rater reliability has been evaluated as 0.46, well below the recommended reliability level of 0.7 (Freedman et al, 2016). These critiques of the validity and reliability of diagnoses suggest an increased need for single symptom based research and clinical practice, whereby problems with diagnostic categories are circumvented, whilst preserving utility (Bentall, 2006). A single-symptom approach follows the continuum model, in which normal and clinical phenomena exist on a dimension with each other, however focuses on particular symptoms, such as hallucinations or paranoia. Single-symptom research can investigate paranoia phenomena away from the constraints of diagnoses, considering different aspects such as degree of functioning and severity of experience, as opposed to purely their presence or absence (Freeman, 2007).

David (2010) also considers some of the above criticism, providing a useful critique of overly simplified notions of a continuum approach to psychosis experiences. He called for an approach that recognises the separateness of the “epidemiology” continuum, acknowledging the prevalence across clinical and non-clinical populations, and the “phenomenological” continuum, recognising a separate spectrum of the type or severity of experience. This may therefore allow for a more nuanced understanding of the continuum, whereby we understand psychosis symptoms separately and as existing across the spectrum of population, but also across a spectrum of severity and phenomenology of experiences.

1.3.4. Cognitive models of paranoia

Cognitive models arguably provide a useful and more single symptom and continuum focused approach to conceptualising paranoid experiences (Bentall, Corcoran, Howard, Blackwood & Kinderman, 2001; Freeman & Garety, 2004). Several varying cognitive models have been proposed, each emphasising particular different psychological processes. An earlier such cognitive model of paranoia provided by Garety and Hemsley (1994) emphasised the roll of perception, judgment, and reasoning biases in the formation of delusional and paranoid beliefs. Within this framework, paranoid experiences are understood as resulting from initial anomalous experiences, and subsequent errors or biases in reasoning. However, in reviewing the evidence supporting such a model, researchers have found only limited evidence for an overall impairment in reasoning ability, and instead found that research more supported the presence of data-gathering biases, and 'jumping to conclusions', in that those with delusional beliefs showed a tendency to seek less information before reaching a conclusion (Garety & Freeman, 1999).

Taking a more affective approach to cognitive models, Bentall, Corcoran, Howard, Blackwood and Kinderman (2001) propose the Attribution Self-Representation Model. This model conceptualises paranoia as a dysfunctional attempt to manage low self-esteem, in which negative self-representations are thought to be avoided by attributing threatening events to the actions of another. Continuing to utilise these external attributions is thought to lead to an increase in paranoid thinking, through the consistent attribution of negative events to the hostile intentions of others. This model has been supported by evidence demonstrating the presence of attribution bias and low self-esteem within those reporting paranoid experiences, however has also been critiqued due to some inconsistencies in the association between paranoia and self-esteem (Garety & Freeman, 1999). However, inconsistencies may be a result of difficulties in reaching valid and reliable measuring of constructs such as 'self-esteem' (Bentall, Corcoran, Howard, Blackwood & Kinderman, 2001).

Perhaps the most commonly utilised cognitive model of paranoia is one outlined by Freeman, Garety, Kuipers, Fowler and Bebbington (2002). This model aims to be multifactorial in nature, incorporating many of the elements of other proposed models, however rejects the concept of paranoia as a defence against low self-esteem (Freeman, 2016). Paranoia is described within the model as related to the impact of a precipitator, such as a significant life event, interacting with a biological, psychological, or social vulnerability. The model outlines how these precipitators could lead to an anomalous experience and threat arousal, which in turn interact with cognitive bias's and pre-existing self/other beliefs, potentially leading to the formation of a paranoid belief. Further cognitive processes such as confirmatory and attentional biases, and safety-behaviours and reinforcement, are hypothesised to play a role in the maintenance of any subsequently formed belief (Freeman, 2007).

Overall, cognitive models of paranoia can provide a useful conceptualisation of the experience, taking into account a continuum based approach and offering a single symptom focus, whilst also contributing extensively to research in the area and the development of psychological interventions (Freeman, 2016; Freeman & Garety, 2004). However, they have been critiqued based on the lack of attention given to both the relational and interpersonal nature of paranoid experiences, and the importance of social context and environment (Cromby & Harper, 2009). These issues will be addressed in further detail later in this chapter, when the social and discursive model of paranoia is explored.

1.3.5. The definition of paranoia in the present study

Having outlined some of the problems inherent in the traditional categorical approach to paranoia, and outlined an alternative single-symptom continuum approach, this section of the chapter will go on to describe the definition of paranoia utilised in the present study. The present study adopts a conceptualisation of paranoia whereby it is understood to be a complex and interwoven experience, and therefore not fully separable from 'delusions'. This approach is supported by findings in research such as Freeman et al (2005), whereby the paranoid thoughts of respondents were found to fit into a

hierarchical distribution, ranging from socially evaluative concerns to delusions of severe persecutory threat. This viewpoint considers paranoia and delusions as different from each other quantitatively, in terms of relative rates of incidence, but similar qualitatively or phenomenologically, in terms of the core experience (David, 2010). To that end, a useful definition of the construct for the focus of the present study is that provided by Cromby and Harper (2009). They define paranoia as "a way of perceiving and relating to other people and to the world that is characterised by some degree of suspicion, mistrust, or hostility".

The presence of well replicated evidence of experiences of paranoia in the non-clinical population is important both as support for the continuum approach towards paranoia and delusional beliefs, and for revealing the relatively common nature of this type of emotional distress (van Os, Hanssen, Bijl, & Ravelli, 2000). In addition, further study of the phenomena of non-clinical paranoia can also potentially be of interest in increasing our understanding of the more severe and clinical end of the paranoia spectrum (Ellett & Wildschut, 2014; Freeman 2006). If experiences of paranoia lie on a continuum and are experienced within the general population, mental health services' reliance on diagnostic systems may lead to the overlooking of an important and prevalent distressing phenomena, deserving of investigation in its own right, separately from any associated diagnoses (Freeman, 2006; 2007).

1.4. Social and demographical factors associated with non-clinical paranoia

This section of the chapter will provide a review of the social and demographical factors that have been associated with the experience of non-clinical paranoia, before moving on to outline why gender was made the focus of the present study. Due to the presence of a relatively limited amount of research specifically taking a single symptom approach to paranoia, studies looking at broader 'psychotic' symptoms in non-clinical populations will also be considered in this brief review, where relevant. However, it is important to note critiques of the construct of 'psychosis' and 'schizophrenia' that demonstrate poor reliability and subsequent lack of validity, limiting the usefulness of these studies (Read, 2013).

In the large-scale Netherlands survey study previously described, the experiences of psychosis symptoms found in the non-clinical population were associated with female gender, younger age, urbanicity, lower income, lower level of education, unemployment, and single marital status (van Os, Hanssen, Bijl, & Ravelli, 2000). In a similar survey study conducted by Subramaniam, Abdin, Vaingankar, Verma and Chong (2014), using data from 6616 participants in the Singapore Mental Health Study, non-clinical psychosis symptoms were found to be associated with female gender, lower-education, single marital status, and smoking. However, both studies did not explore whether this was also true of each subtype of psychotic symptom, and therefore specifically related to paranoia.

In a review of literature on non-clinical psychosis-like experiences (PLEs) conducted by Kelleher and Cannon (2011), convergences and similarities in the risk factors associated with non-clinical psychosis were found when compared with comparable research into clinical psychosis. The researchers highlighted studies that showed associations with urbanicity, ethnic minority background, low social-economic status, unemployment, adverse childhood experiences, substance use, and single marital status, as well as with familial and "genetic risk". Aiming for a similar overview, Van Os, Linscott, Myin-Germeys, Delespaul and Krabbendam (2009) conducted a more meta-analytic review of 47 studies attempting to pull together explorations of demographic features associated with non-clinical psychosis symptoms. A significant association was found between non-clinical 'PLEs' and male gender, adverse experiences in childhood, lower education, unemployment, substance misuse and migration. Results which the authors comment on as notably similar to results of comparable meta-analytic studies of clinical psychosis (McGrath, Saha, Welham, Saadi, El, MacCauley & Chant, 2004). Again however, these reviews did not differentiate between types of experiences.

A large-scale survey study, similar to the NEMESIS study, of 8580 participants was conducted in the UK by Johns et al (2004), using the UK National Survey of Psychiatric Morbidity to explore psychotic symptoms in the general population. Following a regression analysis of the data, symptoms of paranoia were found to

be more associated with average intelligence, alcohol dependency, younger age, and experiences of victimisation. Interestingly, in separating out experiences, paranoia was found to be associated with male gender, whilst hallucinatory experiences were more common in female participants. In a follow-up study, using a later version of the UK National Survey of Psychiatric Morbidity, conducted by Freeman et al (2011), non-clinical paranoia was investigated in 7281 participants. Similar results were found to those in the Johns et al (2004) study, with paranoid thinking found to be associated with single marital status, poor health, poverty, lower age, lower intelligence, stress, low happiness, and lower perceived levels of social support. Interestingly, they also found that low levels of paranoia (as differentiated by the Psychosis Screening Questionnaire) were more associated with women, whilst high levels of paranoia were associated with men.

When looked at overall, the research literature exploring 'non-clinical' symptoms of psychosis appear to show patterns in the associated factors and correlated demographic features. Factors related to lower socio-economic status and social disadvantage appear to be commonly correlated with non-clinical psychotic experiences, along with the perceived level of available social support and adverse childhood experiences (Kelleher & Cannon, 2011; Van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009; van Os, Hanssen, Bijl, & Ravelli, 2000). Looking more specifically at paranoia, similar patterns can be seen related to socio-economic status and social disadvantage, as well as experiences of victimisation (Freeman, 2011; Johns, 2004). These factors are well-known and well-evidenced correlates with a wide variety of experiences of mental health distress and have been demonstrated to increase the risk of a range of potential forms of emotional distress and mental health diagnoses (Harper, 2011; Longden, & Read, 2016; Pickett & Wilkinson, 2015).

In terms of gender, an interesting pattern is demonstrated in which studies appear conflicted between suggesting more women are affected by experiences (van Os, Hanssen, Bijl, & Ravelli, 2000), and others suggesting more men are (Van Os, Linscott, Myin-Germeys, Delespaul & Krabbendam, 2009). However, when looking at non-clinical experiences of paranoia specifically, there appears

to be more of a consensus towards more men reporting the experience (Freeman, 2011; Johns, 2004). Given this interesting pattern, the present thesis aims to take a closer look at this association, and further explore the apparent relationship between gender and experiences of paranoia.

1.5. Gender differences in clinical populations

Explorations of potential gender differences in experiences of mental health difficulties have a long history in psychiatric and psychological research, along with hypothesising and theorising about the causes or reasons for these (Rosenfield & Mouzon, 2013). As a result of the well-established difference in rates of schizophrenia diagnoses between genders, with on average 60% of patients being male (McGrath, Saha, Chant & Welham, 2008), differences between men and women's experiences have been extensively researched in clinical population psychosis and schizophrenia studies. However, this type of research is limited in non-clinical populations, or for paranoia specifically, beyond the incident rate research outlined in the previous section. This section of the chapter will therefore aim to offer a brief review of the literature available that further explores gender differences in clinical populations, as a way of gaining insight into the factors that may also contribute to differences at the more 'lower end' of the continuum. Again however, it is important to note the limiting nature of the use of these constructs (Read, 2013).

Reviews of the literature have found that in addition to receiving more diagnoses than women, males demonstrated earlier onset of psychosis, worse premorbid functioning (Falkenburg & Tracy, 2014; Leung & Chue, 2000), and more severe symptomatology at initial presentation to services (Marvin, Rosen, Reilly, Solari, & Sweeney, 2007). These well replicated findings of differences at onset has led to significant amounts of research considering gender differences in first episode psychosis. In a meta-analytic study of twenty-seven papers, conducted by Cascio, Cella, Preti, Meneghelli, and Cocchi (2012), differences in experiences in patients with a first episode of psychosis were explored. Males were found to be much more prevalent and on average presented to services at a significantly younger age (25.4 years compared with 27.5 years).

Differences have also been found between males and females in the types of experiences affecting patients diagnosed with psychosis. Rietschel et al (2015), interviewed 239 patients considered at high risk of psychosis. They found that male participant's experienced more pronounced negative symptoms, and higher rates of substance abuse disorders, as well as more severe deficits in social functioning, when compared to female interviewees. A finding also replicated in those experiencing symptoms, but not yet considered eligible for a diagnosis (Willhite, Niendam, Bearden, Zinberg, O'Brien & Cannon, 2008). In similar study conducted by Køster, Lajer, Lindhardt and Rosenbaum (2008) using a sample of 269 participants drawn from the Danish National Schizophrenia Project, women were found to present with significantly more affective symptoms, whilst men experienced more of the negative symptoms of psychosis, a finding commonly reported in other similar studies (Falkenburg & Tracy, 2014; Leung & Chue, 2000).

In addition to differences in the types of experiences, trends have also been found related to the impact of experiences on wellbeing. In a study conducted by Cotton et al (2009), a sample of 661 patients from an early intervention service in Melbourne, Australia. Males were found to be more likely to have a substance misuse disorder, more severe psychopathology (Clinical Global Impressions Severity of Illness Scale), lower levels of social functioning, higher unemployment, and higher 'treatment non-compliance'. In contrast, female patients were found to have a greater history of suicide attempts and depression, and presented with more depressive symptoms. Morgan, Chase and Jablensky (2008) randomly selected a sample of 1090 cases of schizophrenia, from a population sample of 1.1 million people as, part of the Australian Study of Low Prevalence Psychotic Disorders. Results demonstrated that women reported a less severe impact on interpersonal relationships and general social engagement, as well as a lower level of overall disability.

Amongst the clinical population, differences have also been explored in recovery from a diagnosis of psychosis. Thorup et al (2014), conducted a study in which 578 patients with first episode psychosis were included in a Danish trial early-intervention programme. Results from the study showed that female participants

had a greater level of social functioning (employment, education and relationships) at follow-up, when compared with males. Female participants were also more likely to have reached a better state of recovery, whilst males were more likely to live alone, and have greater substance misuse problems. A similar study reviewing the experiences of 700 patients treated by a first-episode psychosis treatment programme in Hong Kong, found that women were more likely to achieve a higher level of recovery, with greater levels of social functioning following treatment, and better levels of employment prospects (Chang et al, 2011).

Looking at gender differences specifically in delusional experiences, de Portugal, González, Vilaplana, Haro, Usall and Cervilla (2010) compared experiences in a sample of 106 individuals diagnosed with a delusional disorder, randomly selected from patients in five community mental health centres in Spain. In this study, it was found that women out numbered men on diagnoses of delusional disorder 1.6:1. However men were found to experience a greater severity of psychotic symptoms (Positive and Negative Syndrome Scale for Schizophrenia), specifically hallucinations, blunted affect, and emotional withdrawal, when compared to women. In addition, men were again found to experience a greater impact on general and social functioning, compared with women in the sample.

The above brief review of available literatures demonstrates the presence of some interesting gender differences in men and women diagnosed with a 'psychotic disorder'. When compared with women, men appear to experience symptoms and present at services earlier, to be more prone to 'negative' symptoms of schizophrenia, suffer a greater degree of impact on wellbeing, and have a worse prognosis in terms of recovery and social functioning. However, on review these results can be critiqued for demonstrating only small differences, or for the conflicted nature of findings between studies (Ochoa, Usall, Cobo, Labad & Kulkarni, 2012). Additionally, these studies are limited by their use of the construct of 'psychosis' and 'delusion', which can be considered flawed in the ways previously outlined in the earlier section of this chapter. Therefore, in terms of paranoia, no firm conclusions can be drawn, due to the lack of research specifically differentiating between experiences.

1.6. Explanations of male paranoia

Following on from the various explorations of gender differences in 'clinical' psychosis experiences outlined above, ideas for theoretical explanations have been proposed from biological, psychological and social perspectives (Falkenburg & Tracy, 2014). Whilst the predominant focus of these studies again is on the wider construct of psychosis, they can be theorised to offer an insight into possible explanations of the differences in experiences across the continuum of psychosis, and in the more specific experience of paranoia. Therefore, this section will offer a brief review of this literature.

One of the more primarily biological explanations given for gender differences in psychosis, surrounds the hypothesis that the sex hormone oestrogen is protective for women (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012; Falkenburg & Tracy, 2014). Evidence for this theory has primarily come from trends demonstrating that more women than men experience psychosis symptoms at a post-menopausal age. The hypothesis being that this difference may be accounted for by the reduced level of oestrogen in women post-menopause (Häfner et al, 1998). These ideas have led to trials of sex hormone treatments for schizophrenia, with mostly inconclusive evidence (da Silva & Ravindran, 2015), but some evidence of symptom reduction in women but not in men (Begemann, Dekker, van Lunenburg, & Sommer, 2012).

An alternative to this purely biological explanation relates to psychological experiences of trauma and adverse childhood experiences. Some evidence has appeared to suggest that women require a combination of more individual risk factors, in order to develop psychosis, when compared with men. Possibly indicating a reason for less women receiving a diagnosis (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). Conversely, it has been hypothesised that women's experiences may be more linked to childhood trauma and adverse childhood experiences than men's, leading to potentially different expression of symptoms. This has had limited support from evidence that women with a diagnosis of psychosis are twice as likely to report adverse childhood experiences than men (Fisher et al, 2009). However, these results are highly likely to be confounded by

the well-evidenced phenomena of men being significantly less likely to self-report traumatic experiences than women (O'Leary & Barber, 2008; Alaggia, 2005).

Proposed theories with more consideration of potential social factors have largely been inferred from examining trends of differences in levels of social support and social engagement. The apparent higher age of onset in women has been hypothesised as possibly protective for women, allowing for better social adjustment prior to the experiencing of symptoms (Ochoa, Usall, Cobo, Labad, & Kulkarni, 2012). In addition to this, evidence that women are more likely to be better socially integrated when compared with men, has been suggested to provide them with higher quality relationships and better familial support, potentially offsetting the negative impact of symptoms (Chang et al, 2011; Morgan, Castle & Jablensky, 2008; Preston, Orr, Date, Nolan & Castle, 2002). Jablensky and Cole (1997) propose that the apparent later age of onset for women, may be a result of the protective nature of long-term relationships and marriage, absent for many men diagnosed with psychosis. Additionally, more social support for women has been proposed as an explanation for higher incidence rates in men, due to a hypothesised greater degree of 'covering up' of women's symptoms within families (Scully et al, 2002).

Another area of focus for potential explanations surrounds differences in men and women's approach to help seeking. A particular focus has been given to the apparent trend that men have a longer duration of untreated psychosis (DUP) when compared with women, hypothesised to lead to the increase in the severity and impact of negative symptoms, and a greater overall impact on life and wellbeing (Chang et al, 2011). In addition to presenting for help later, evidence suggests that substance misuse is greater in men who experience psychosis symptoms, when compared with women experiencing similar difficulties. (Chang et al, 2011), leading to the hypothesis that this may reducing coping, levels of support, and increase intensity of both positive and negative symptoms (Arranz et al, 2015).

When considering causes of male paranoia, it is important to also draw attention to the evidence of increased rates of paranoia among black and ethnic minority

men receiving treatment in mental health services, when compared to their white peers (Whaley, 2004a; Whaley, 2004b). In addition to inpatient settings, trends of increased paranoia have been identified in non-clinical settings, amongst men who identified as black or bi-racial, linked to adverse life experiences and discrimination, as well as living in oppressive and racist contexts. (Mosley, Owen, Rostosky & Reese, 2016). Whaley (2004a) conducted a study on 116 black men of African descent, admitted for treatment at a state psychiatric inpatient unit in the U.S. They found that at the more 'mild' end of the paranoia continuum, significant elements of paranoia experiences correlated with levels of cultural mistrust, leading to hypotheses that the experiences of these men were related to negative associations with authority and experiences of state discrimination. Whaley (2004b) conducted a secondary analysis on data from 180 men from the general population who took part in an epidemiological study of risk factors for schizophrenia and depression. Results showed that black men with a level of paranoia at the 'mild' end of the continuum, were less likely to seek help from services that their white counterparts, further demonstrating the potential effects of mistrust. It has been theorised that experiences of paranoia in black men is of particular importance, due to the effects of justifiable or 'healthy paranoia' as a direct result of experiences of discrimination and racism (Sue, Capodilupo, & Holder, 2008).

Moving away from research focusing on gender differences in psychosis and schizophrenia, comparatively little attention has been given to explaining gender differences in nonclinical experiences of paranoia, and the apparent trend of increased prevalence in men. In order to hypothesise around potential mechanisms behind these differences, it is useful to briefly explore research surrounding men's psychological wellbeing in broader terms.

The potential impact of masculine norms on men's experiences of psychological distress has been extensively researched over the years. Some earlier attempts to theorise have focused on the socialisation of gender roles, hypothesising that male socialisation of detachment from emotions and high independence might foster a vulnerability to paranoia (Lewis, 1985). A strong adherence to perceived masculine norms such as emotional control has been linked to poorer mental

health (Burns, & Mahalik, 2006; Wong, Ho, Wang & Miller, 2017), increased psychological distress and aggression (Mahalik et al, 2003), experiences of depression in unemployment (Syzdek, & Addis, 2010), and is negatively associated with psychological help seeking (Wong, Ho, Wang & Miller, 2017). Research based on the 'Gender Role Strain' paradigm hypothesises that it is the degree of conflict between perceived masculine norms and own perception of achievement of those standards, that causes strain, conflict and increased psychological distress (Pleck, 1995). Level of gender role strain has been demonstrated to correlate with experiences of psychological distress in broader terms (Blazina & Watkins, 1996), as well as with experiences of paranoid thinking in men (Good, Robertson, Fitzgerald, Stevens & Bartels, 1996). However, these results do not appear to be universal. In a study conducted by Good, Heppner, DeBord and Fischer (2004), only 1% of the variance in men's psychological distress (from a sample of 260 male college students) could be accounted for by results on a measure of masculine gender role strain.

In summary, as a result of the evidence demonstrating a higher rate of psychosis diagnoses in men, extensive research has been conducted attempting to offer explanations. A variety of ideas have been hypothesised, including sex hormones, social support, help seeking, trauma, and racism and discrimination, as well as the broader impact of 'masculine' gender norms, with varying degrees of relevance and success. Again, this literature is open to critiques related to the use of constructs such as 'psychosis', and therefore offers only a limited amount of information related to the specific experience of paranoia. In addition, the body of research presented takes a very essentialised and non-critical or taken-for granted view of 'gender', failing to account for the socially-constructed nature of the term (Wodak, 1997). The next section of this chapter proposes that taking a qualitative and discursive approach to research could therefore offer a more useful perspective in this area.

1.7. Discursive approaches

So far, the literature reviewed in this chapter has presented research that takes a predominantly quantitative and reductive approach in exploring experiences of

paranoia and the role of gender. The following section will now propose arguments against purely researching these experiences in this manner, proposing that a qualitative and discursive approach will allow an investigation of the interrelatedness of gender and paranoia in a more socially contextualised manner.

1.7.1. Discursive approaches towards paranoia

In considering the reasoning for taking an alternative and more discursive approach to this research, it is important to return to and expand upon some of the arguments made earlier in this chapter. Beyond issues with the medical model taking a purely categorical approach to understanding paranoia, Harper (1996) highlights how the more medical definitions of paranoia individualise experiences of suspicion, constructing the phenomena as a form of disorder located within the individual. This process of individualisation has been criticised for leading to a disregarding of the impact of social context on experiences of paranoia (Cromby and Harper, 2009). Mary Boyle (2002) critiques the role of research in his process, describing how "Researchers de-emphasise the role of social context in 'delusions' in several ways, including providing little or no information on participants' backgrounds or circumstances and by using 'neutral' tasks which are not specifically related to the person's belief systems".

As well as ignoring the role of context, reductive and quantitative approaches to paranoia have been critiqued for ignoring the inherently social nature of the judgment of plausibility of beliefs (Harper 1996). This is most apparent in the way in which definitions within the DSM-V point to comparisons with "conflicting evidence", and for the experience to be "unfounded" (American Psychiatric Association, 2013). In this way paranoia is constructed as something whereupon the individual is compared with the 'normal' consensus within society, thus inherently a social process (Harper, 1996). In addition, the diagnosis or judgement of a delusional belief by professionals has been shown to rarely be based on evaluations against evidence, relying instead upon 'common sense', and judgements of plausibility (Maher, 1992). Again, pointing more to a social

and dialogical process, between individuals, as opposed to a process of empirical evaluation.

May and Kelly (1992) advocate the taking of a more social approach to understanding experiences of paranoia. They describe how it is revealed almost entirely in talk, is at a certain degree reasonably viewable as a functional part of everyday life, and is inherently relational in nature as “a desperate, and ultimately destructive, attempt to protect self from the consequences of a public identity at odds with self-image”. Viewing paranoia in relational and social terms, highlights how judgment of beliefs as ‘paranoid’ or ‘delusional’ occurs as an interactional process, as a judgement made by an other, and not as a direct comparison with a reality (Heise, 1988). Georgaca (2000) has further considered the social process of judgement of beliefs, stating that “The establishment of truth is an inter-subjective achievement which entails processes of validation, negotiation and persuasion in specific inter-subjective, social and cultural contexts”, and pointing to the need for a discursive approach to research in this area. Taking a more discursive approach, can be said to allow for considerations of the processes by which a belief is determined plausible, and ‘factualisation’ occurs, as well as why in ‘paranoid’ beliefs, this process breaks down (Georgaca, 2004).

Overall, these critiques point towards a need for research to turn away from considering individual dysfunction, and move towards more consideration and incorporation of the social context from within which these types of distress are experienced, and the interactional processes in which they are judged and formed (Cromby & Harper, 2009). A discursive approach to research, considers the role of language in constructing social reality, and therefore provides a critical perspective on more ‘cognitivist’ forms of psychology (Willig, 2013). In this way, social context, discourse and individual experiences are considered intrinsically linked (Wiggins & Potter, 2008). Psychological phenomena such as paranoia can therefore be considered as “discursive actions rather than cognitive processes” (Willig, 2013). In considering this approach to paranoia, Harper (1996) argues that it allows for the consideration of social and individual factors not as separate, but as intrinsically linked. This creates a perspective wherein the role of dominant

discourses in society and the ‘positioning’ of others as ‘paranoid’ can be unpicked.

In addition to allowing for a deconstruction of paranoia in context, it can be argued that taking a more discursive approach to researching paranoia and delusional beliefs can address the earlier made criticism that conventional approaches rely upon a naïve realist view of the world (Harper, 2004; Harper, 1996). In utilising discursive approaches, we can consider multiple perspectives and the constructed and co-constructed nature of ‘reality’ (Harper, 1996; Wiggins & Potter, 2008). As opposed to relying upon the limited perspective of attempting to separate a ‘false’ belief from one based in reality (Harper, 2004). This more critical perspective on the nature of reality also allows us to move towards focusing on the experiences of those whose paranoia has been pathologised or categorised through diagnosis, and consider the way in which experiences of paranoia are available to many through prevalent discourses (Harper, 1996). In this way a discursive approach provides a useful theoretical framework for investigating the phenomena in the broadest terms, without becoming fixed to either a ‘clinical’ or ‘non-clinical’ perspective.

In a paper aiming to bring together many of these concepts Cromby and Harper (2009) propose a social account of the experience of paranoia. They argue that our inner experiences of ‘paranoid’ emotions and bodily sensations are co-constituted with discourse in a simultaneous and moment-by-moment process of embodied subjectivity. In this way, the social and the individual cannot be separated from each other, as each influences and affects the other. Discursive approaches to understanding paranoia can therefore be useful in considering this process of co-constituted feeling (Cromby & Harper, 2009), as well as the way in which discourse positions people as ‘paranoid’ (Harper, 2004).

1.7.2. Discursive approaches towards gender

In addition to being able to address the many issues surrounding explorations of paranoia experiences, discursive approaches have also been proposed as a solution to potential issues in the study of gender. Connell (2005) critiques the

amount of ‘sex differences’ research that is conducted, pointing out that despite sometimes seeming to reveal interesting differences in individual studies, the vast majority of large scale meta-analytic results conclude little to no significant difference. He further points out that our own biases may culturally cue us to exaggerate the importance of these relatively small differences. In addition, the commonly used empirical approach to studying gender differences reduces gender to two differing constructs (male and female), and then studies the differences between the two, in purely quantitative or numerical terms. This approach has been critiqued for ignoring evidence that gender is more nuanced and varied, and the socially constructed nature of these categories (Carrera, DePalma & Lameiras, 2012). Butler (1999) critiques the notion of gender, for appearing ‘socially based’ but actually maintaining the concepts of a ‘male’ and ‘female’ dichotomy. She goes on to deconstruct the fixed nature of these identities, and emphasises the socially constructed nature of both sex and gender.

In response to some of the above arguments, it can be proposed that taking a more discursive approach to research, and viewing gender as a social construct, allows for a more nuanced and contextualised understanding (Wodak, 1997). Discursive approaches to gender have their origins in post-structuralist perspectives, and understand gender in terms of multiple, shifting, and often contradictory positions within discourse, that individuals take up (Mehta & Bondi, (1999). Through this approach, the aim is often to explore how discursive patterns maintain existing gender constructions, as well as divisions and structural inequalities in society, so that they can be better understood (Litosseliti, 2014). In this way, there is an acknowledgment of a process of ‘doing gender’, where gender is understood to be acted and performed through behaviour and discourse, as opposed to being a more essentialised attribute possessed by individual people, by nature of their sex and biological attributes (Butler, 1999).

As outlined earlier in this chapter, much of the research exploring men’s mental health has focused on the concepts of masculinity and gender roles (Pleck, 1995). Wetherell and Edley (2014) argue strongly for a discursive approach to the study of men and masculinity, wherein masculinity is treated not as a something

of which its properties can or are to be revealed, but rather something that is being constructed. They argue that traditional research into the effects of masculinity, such as those utilising the gender role strain paradigm, risk treating masculinity as an essentialised property, thereby missing the multiple ways of constructing and 'doing masculinity'. Similarly, use of measures that aim to assess levels of adherence to masculine norms (Mahalik, 2003), reify and decontextualize the construct as it is described, stripping any space for critical analysis (Connell, 2005; Wetherell and Edley, 2014). In this way, constraining our understanding of gender to defined traits or roles, limits the ability to understand the context in which this occurs, as well as the ways in which individuals move in and out of transgressing norms and the circumstances that allow for or restrict this from happening (Addis, Mansfield, & Syzdek, 2010).

Connell (2005) emphasises the importance of considering intersectionality in masculinity research, whereby we can understand the different masculinities that are constructed in cultural settings, influenced by race, sexuality, class, culture, etc., as well as the dominance of 'hegemony' and oppression and marginalisation within masculinities (Hopkins & Noble, 2009; Connell 2005). Constructing men homogenously is potentially problematic in limiting the way we can explore how men experience their subjectivities, express and cope with distress, and how this relates to differing forms of gender discourse (Ridge, Emslie, & White, 2011). Intersectionality can be understood to be better accounted for in research utilising a more discursive approach, through the process of deconstructing single notions of gender and considering the multiple interplay with other constructs such as class, race, etc. (Litosselity, 2014). Additionally, it is then more possible to account for how the experience and subjectivity of men is changing, and the influence this has on psychological distress and mental health (Ridge, Emslie, & White, 2011)

1.8. The present study

1.8.1. Rationale

As outlined in this chapter so far, experiences of paranoia are common both within clinical and non-clinical populations (van Os, Hanssen, Bijl, & Ravelli, 2000). Therefore, further research into the experience of paranoia in non-clinical populations is important, in improving our understanding of the experiences across the board (Ellett & Wildschut, 2014; Freeman 2006). At the more general population 'non-clinical' end of the paranoia continuum, whilst there is some conflicting results, the overall trend appears to suggest that more men than women report paranoid experiences (Freeman, 2011; Johns, 2004). Research conducted so far aiming to explore gender differences in 'psychotic' experiences such as paranoia, have predominantly taken a more reductive and realist approach to both constructs. In this way, research can be critiqued for its reliance on unscientific diagnostic categories (Read, 2013), or when these are not used, for the decontextualising of experiences of paranoia (Cromby and Harper, 2009), and the reification of oversimplified notions of gender (Connell, 2005). In addition, purely focusing on numerical differences in the number of men or women reporting paranoia, gives little information about potential differences in how this is experienced. The taking of a qualitative and discursive approach may serve to address many of these issues (Willig, 2013), however discursive research exploring potential gender differences in experiences of distress is often lacking, with few studies exploring specific experiences (Ridge, Emslie, & White, 2011).

The current study therefore aimed to investigate the apparent relationship between gender and paranoia, taking a discursive psychology approach to the research. It explored how concepts of 'paranoid' men and women are constructed and how these constructions draw from wider culturally available discourses of gender and paranoia. Adopting a discursive approach was hoped to limit the potential for reification of traditional concepts of masculinity and femininity, whilst allowing for consideration of more nuanced and varied discourses, as well as the presence of intersectionality with class, race, and culture. (Wetherell and Edley, 2014). The study aimed to explore the experiences of both men and women, so

as not to risk reproducing notions of a dichotomous split in gender, through only investigating the experience of one 'gender' (Butler, 1999). The research was conducted utilising a student population due to the high prevalence of self-reported paranoia found within this population (Ellett, Lopes & Chadwick, 2003) and the resultant increased chance of individuals having direct or indirect experiences of which to speak.

It was hoped that further insights and understanding into the relationship between gender and paranoia could provide useful information for clinical practice. Within social constructionist approaches to therapy, such as systemic and narrative models, attention is paid to the storied nature of difficulties such as paranoia, how these constructions can arise, and how new stories can be co-constructed within the therapeutic relationship (Hedges, 2005). Having a greater understanding of the process in which discourse positions men and women as 'paranoid', could aid in this type of clinical work. Additionally, ideas drawn from this research was hoped to inform further studies and the development of psychological models of paranoia that can incorporate more consideration of the gendered nature of distress.

1.8.2. Research Questions

In light of the above aims, the current study aimed to address the following research questions;

1. What are the culturally available discourses around 'gender' and 'paranoia'?,
2. How do such discourses construct subjectivity and position paranoid men and women differently?, and
3. What is the role of intersectionality, in impacting constructions of paranoid men and women?

CHAPTER 2: METHOD

2.1. Chapter Overview

Having reviewed existing literature, and presented the research aims and rationale, this chapter will now outline the overall epistemological, methodological and procedural approach adopted by the present study, as well as the reasoning behind these decisions. The chapter begins by addressing the process behind the selection of a qualitative approach and research epistemology, before moving on to consider subsequent decisions around methods, and the reasoning behind the decision to utilise a Foucauldian Discourse Analysis (FDA) and individual interviews. The chapter will then move on to describing the procedures followed in recruitment, data collection, transcribing and analysis, before closing with a consideration of ethical and quality issues.

2.2. Choosing a Research Paradigm

In addressing the research questions outlined in the previous chapter, a qualitative research approach was taken. This approach was chosen in order to add to existing research literature in a way that addresses previously articulated concerns with more reductive and empiricist approaches towards investigating 'paranoia' (Harper, 2004) and 'gender' (Wetherell & Edley, 2014). Whilst a qualitative approach broadly enables an exploratory focus to research, there are enormous variations in epistemological foundations and methodologies, each useful for different types of research questions and data collection (Howitt, 2016).

Willig (2013) provides a useful description of the process behind which qualitative research projects should be developed. She outlines how research questions make important assumptions about knowledge, in terms of both what can be known, and how that knowledge can be approached. Therefore, it is necessary for researchers to consider what epistemological orientation best addresses their research questions, before moving through to the methodological and procedural designs that follow this decision. The following sections of this chapter will

therefore aim to describe the research paradigm utilised as a framework for the present study, whilst explaining the rationale behind these specific choices.

2.2.1. Epistemology

In asking what kind or type of knowledge is to be sought, we ask questions of epistemology or "what can be known and how?" (Willig, 2013). Harper (2012) described how this question is important in differentiating between different epistemological positions, which each inform the type of assumptions about knowledge that can be made, and then subsequently frame a study's methodology. He follows the work of Willig (2013) by outlining three main epistemological frameworks, realism, phenomenology, and social constructionism, each of which make differing claims about the nature of knowledge.

As outlined in the previous chapter, the research questions for the present study were;

1. What are the culturally available discourses around 'gender' and 'paranoia'?,
2. How do such discourses construct subjectivity and position paranoid men and women differently?, and
3. What is the role of intersectionality, in impacting constructions of paranoid men and women?

In order for an approach best suited to addressing the above research questions, a moderate social constructionist or critical realist social constructionist epistemology was chosen (Harper, 2012). A social constructionist epistemological framework takes a critical approach towards taken for granted knowledge, challenging the assumptions of reductive science (Burr, 2003). In this way, social constructionism considers how knowledge is generated and constructed, placing an emphasis on the discursive and social processes within which this occurs (Harper, 2012). Social constructionist research can vary between what has been termed the radical approach, and a more moderate viewpoint (Harper, 2012). At the more radical and relativist end, reality and

knowledge are viewed as entirely constructed through discourse. Therefore, a socially constructed reality cannot 'survive' beyond a specific context and make claims or inform us about a differing context, a position many feel makes research untenable (Willig, 2013). In contrast, at the more moderate or critical realist end of social constructionist epistemology there is often the aim of making connections between discursive constructions in a specific instance, and the wider social-cultural context in which this takes place (Willig, 2013). Taking this approach allows for an understanding that any 'reality' is made sense of through discursive construction and processes (Nightingale & Cromby, 1999), whilst also considering the pre-existence of material structures and practices, such as cultural and political power, that can influence discourse (Harper, 2012),

In taking this approach within the present study, the wider socio-cultural and political contexts can be considered in which gender and mental health discourse occurs, as opposed to a focus purely on one specific example of constructed reality (Willig, 2013). Additionally, taking this position allowed for an exploration of the role of discourse in forming gendered identities and creating 'subject positions' (Burr, 2003), acknowledging that there are multiple ways of "doing gender" (Wetherall & Edley, 2014) or of being positioned as 'paranoid', that create or limit possibilities for experiences and actions (Arribas-Ayllon & Walkerdine, 2008).

2.2.2. Methodology

Following on from decisions related to epistemology, qualitative researchers should consider the methodological and analytic strategies that both fit within this framework and allow for the generation of knowledge that best addresses the research questions (Willig, 2013). In the present study, Foucauldian Discourse Analysis (FDA) was chosen as the methodological approach. This section will aim to both conceptualise FDA and provide a rationale for the choice of this approach.

2.2.2.1. Foucauldian Discourse Analysis (FDA)

Like other forms of discourse analysis, Foucauldian Discourse Analysis is interested in the role of language in constructing the social world, however it goes beyond interpersonal communication to consider the relationship between discourse, subjectivity, and practice (Willig, 2013). Parker (1992) defines discourse as "a system of statements which constructs an object", the 'object' therefore being any noun or 'something' given a reality through its description. He goes on to describe how discourses do not just describe the social world, but construct and categorise it, along with the 'subjects' or individuals that inhabit the world and, in turn re-produce it through their own discursive 'talk'. Foucault conceptualised discourse as the objects, rules, and systems within a whole body of knowledge, such as medicine (Arribas-Ayllon, & Walkerdine, 2008). He considered discursive processes as creating 'subject positions' which if taken up have implications for an individual's experience or 'subjectivity' (Willig, 2013). He drew inherent links between this process and the practice of power, elucidating how there lies an inherent link between power and discourse, through the creating of possible positions of subjectivity and subsequent available ways of being and acting (Arribas-Ayllon, & Walkerdine, 2008). Parker (1992) gives the helpful example of the medical discourse, a body of knowledge and practices in which the subject positions of 'patient' and 'doctor' are created. As a 'patient' we are positioned in relation to power and therefore limited in what we can know, have the authority to speak about, and do.

Willig (2013) describes how, as an analytic method, Foucauldian Discourse Analysis aims to analyse the way in which a discursive object is constructed, along with the variety of wider socio-cultural discourses that are drawn upon and inform this process. Following this, there can be a consideration of how these constructions are deployed by individuals in talk, and how discourses create positions for subjects to 'take up' or be positioned into, as well as the subsequent impact this process has on an individual's experiences or subjectivity (van Langenhove & Harre, 1999). These concepts will be expanded upon later in this chapter, when the process of an FDA is outlined.

2.2.2.2. FDA and the Present Study

Foucauldian Discourse Analysis (FDA) was identified as the most appropriate methodological approach for this study, due to its usefulness in answering questions related to the discursive construction of subjects and objects such as paranoia and gender. Other methods were considered, but rejected based on their limited ability to address the research questions of the present study. For example, whilst interpretative Phenomenological Analysis (IPA) would allow for an exploration of individual's subjective experiences of paranoia, it would not account for the constructive nature of language, nor allow for an exploration of the wider discursive constructs and their impact on individuals' accounts of experiences (Willig, 2013). Similarly, whilst use of Discourse Analysis might allow for exploration of the constructive nature of language and the role of discourse, it would not allow for a consideration of the potential impact on subjectivity and the experience of those labelled paranoid (Willig, 2013). Hollway (1998) describes how femininity and masculinity cannot be considered as fixed features located in men and women, but are the products of prevalent gender discourses, and are re-produced through gendered subjectivity and practice. Therefore, utilising FDA in the present study will allow for both an exploration of prevalent gender and paranoia discourses, as well as a consideration for how these might intersect, and the resultant impact on experience or subjectivity of those positioned as a 'paranoid man' or 'paranoid woman'.

2.3. Method and Procedure

Having outlined the overall research paradigm utilised in the present study, this section will focus on the method and procedures used throughout data collection and analysis.

2.3.1. Recruitment and Participant Criteria

2.3.1.1. Participant Criteria

Participants were recruited from the student population at the University of East London. A student population was utilised due to the high prevalence of self-reported paranoia found within this population (Ellett, Lopes & Chadwick, 2003)

and the resultant increased chance of individuals having direct or indirect experiences about which they could speak. Due to the research interest in the culturally available discourses of gender, and the consequential effects for both women and men, participants of any gender identity were sought for participation in interviews.

The final criteria for participants in the present study were therefore as follows:

- to be able to communicate in English.
- to be a current student at the University of East London. and,
- to be aged 18 or over.

2.3.1.2. Recruitment Strategy

Participants were recruited using convenience sampling at the University of East London, through several means. Recruitment posters were displayed and leaflets handed out at different locations around the university campus, containing information about the study and the researcher's contact details. In addition, requests for participants were posted on several University of East London social networking groups, and sent out to all students in the School of Psychology.

The research aimed to recruit between eight and twelve individuals, with roughly equal numbers of male and females. Concepts of data saturation have been critiqued as difficult to operationalise, and inappropriate for time-limited post-graduate study (Mason, 2010). However, this number of participants was felt to be appropriate, offering a balance between answering the research questions, and the limits placed on time for interviewing, transcription and analysis, in professional doctorate study (Baker & Edwards, 2012).

2.3.1.3. Participants

Across the recruitment period, twenty potential participants contacted the researcher about taking part in the study, nine females and eleven males. Following this initial contact, three of the female and four of the male applicants did not respond to subsequent requests to arrange an interview. Of those interviews subsequently scheduled, four of the male participants did not attend their arranged interviews, and did not respond to subsequent contacts. The

recording of one interview with a female participant was lost, due to a faulty Dictaphone. Therefore, the final sample of interviews was made up of six female and three male participants. The mean age for participants was 29, with a range of 22; the youngest was 18, and the eldest 40. Table one describes the final interview sample, with assigned pseudonyms and approximate ages, in order to preserve anonymity.

Table 1.

Demographics of final interview sample.

Pseudonym	Approximate Age	Gender	Self-Identified Ethnicity	Area of Study
Adila	40	F	Mixed	Undergraduate Psychology
Sofia	40	F	Spanish	Post-Graduate Psychology
Sandra	20	F	Black British	Undergraduate Psychology
Lien	25	F	British Vietnamese	Undergraduate Psychology
Carlos	20	M	White Brazilian	Undergraduate Psychology
Bilal	30	M	British Mixed	Post-Graduate Psychology
Simon	30	M	White British	Undergraduate Psychology
Amy	25	F	White British	Post-Graduate Psychology
Becky	30	F	White British	Undergraduate Psychology

2.3.2. Data Collection

2.3.2.1. Interviews

Data was collected through the use of individual semi-structured interviews. This method was chosen due to the need for a flexible approach in which the researcher could follow up on interesting ideas or concepts raised by the participants (Smith, 1995). Interviews were carried out in research and library study rooms at the University of East London. Each interview lasted between 52 and 66 minutes, and was recorded through the use of a Dictaphone owned by the researcher. Interviews followed the structure of an interview schedule (Appendix A). The interview schedule aimed to broadly follow a 'funnelling' approach (Smith, 1995), in which the general topic of paranoia and any relevant experiences were explored, before moving on to asking about more specific examples. At the early part of each interview, after initial open reflections about the topic, there was a discussion around the definition of paranoia posed by Cromby and Harper (2009); that paranoia is "a way of perceiving and relating to other people and to the world that is characterized by some degree of suspicion, mistrust or hostility". This was utilised as a way of orienting to the topic and broadening ideas beyond purely clinical or mental health constructs (Howitt, 2016). A vignette was utilised towards the end of each interview, describing a young man experiencing paranoia, to gain participants' perspectives related to the experiences of another person (Appendix B). Following this, the researcher asked how the interviewees would feel about the vignette if it described a young woman, or someone of a different ethnicity, as a way gaining information related to the impact of intersectionality.

2.3.2.2. Transcription

Recordings of interviews were transcribed according to a word for word transcription method (Banister et al, 2011 pp. 49-69). This level of transcription was deemed appropriate as a greater level of detail (such as may be used for Conversation Analysis) was not required. All transcription was undertaken by the author. All personally identifiable information was altered to ensure anonymity, and pseudonyms were provided for all participants.

2.3.3. Analysis

Willig (2013) and Arribas-Ayllon and Walkerdine (2008) provide guidance on the process of conducting a Foucaldian Discourse Analysis in qualitative research projects, although both acknowledge that no formalised process exists. Before outlining the analytic procedure utilised in the present study, it is important to define some of the important terminology used.

- Discourse – As outlined earlier, discourse can be defined as any "system of statements which constructs an object" (Parker, 1992). This 'object' can therefore be any 'something' that is given a reality through its description. Discursive objects can be constructed in multiple different and often conflicting ways, dependent upon the broader discourses that are drawn upon (Willig, 2013).
- Subject Position – Arribas-Ayllon and Walkerdine (2008) state that "discourses do not only constitute objects in various and, sometimes, contradictory ways, but they also offer positions from which a person may speak the truth about objects". Different discourses therefore provide a variety of subject positions for individuals or 'subjects' to take up, each with limitations in terms of ways of speaking and acting (Willig, 2013). The positioning of self and others, within discourse, can be understood as "a dynamic alternative to the more static concept of role", in acknowledging that positions are created through discourse, as opposed to existing in a more fixed manner (van Langenhove & Harre, 1999).
- Practice and Subjectivity - As outlined by Willig (2013), practice concerns the way in which the discursive constructions and subject positions 'open up' and 'close down' opportunities for action, and limit or constrain what can be said and done. In turn, subjectivities are the subsequent consequences for individual subjective experience, and therefore the result of being positioned in these ways. Foucault linked this process with the practice of power, through describing how individuals or 'subjects' are produced within discourse, and therefore have limited or constrained agency (Kendall & Wickham, 1999).

In providing a structure for analysis of the data collected in the present study, Willig's (2013, p.131) six stage procedure for Foucauldian Discourse Analysis was followed. Those stages are;

1. Discursive Constructions: Identify the different ways in which key discursive objects are constructed, utilising both explicit and implicit references. In the case of the present study, these would be any ways in which 'paranoia' or 'male' or 'female' etc. are constructed.
2. Discourses: Highlight the differences between constructions of each discursive object, whilst locating these within wider discourses.
3. Action Orientation: Examine the discursive context within which different constructions of the object are deployed, along with their possible functions or 'action orientation'. E.g. what is gained by constructing the object in that particular way, at that particular point?
4. Positionings: Identify the different subject positions offered by the varying constructions of the object.
5. Practice: Explore the ways in which the discursive constructions and subject positions open up or close down opportunities for action. How do discourses limit what can be said and done?
6. Subjectivity: Explore the consequences of taking up a subject position, in terms of individuals' subjective experiences. What is the relationship with subjectivity and the available ways of seeing, experiencing and being within the world?

Prior to following these stages, interview recordings were re-listened to, and the transcripts of interviews were read several times. This allowed for the accuracy of transcripts to be checked, whilst also allowing for familiarisation with the data. During this initial phase, notes were taken regarding initial thoughts and themes related to the data. Following these initial readings, transcripts were coded following the first of the stages, focusing on the varying ways in which paranoia and gender were constructed during talk. Key recurring constructions were then highlighted and mapped out, according to their varying associations and contradictions with other constructions.

At this stage, a meeting was held with the thesis supervisor, in order to discuss the analytic process. During this meeting, quotations and transcripts were reviewed, in order to explore ideas related to initial discursive themes, and a potential structure for the final analysis. Following this meeting each discursive construction was further analysed utilising the rest of the six stages. These more detailed ideas were then also shared with the supervisor, in order to receive feedback regarding the rigour and credibility of the analysis, as well as feedback on the type of interpretations made. Finally, in bringing together the data, the research questions were utilised as a way of managing and framing the analysis. This provided a structure to thinking, and maintained relevance to the study, preventing the analysis from becoming simply a list of each possible discursive feature. Following this process of structuring, the analysis report was written, utilising illustrative quotes and extracts throughout. This allowed for clarification of ideas, and a presentation of their relationship with the data, in way that addressed research questions.

2.4. Ethical Considerations

2.4.1. Ethical Approval

Ethical approval for this study was granted by the School of Psychology Research Ethics Sub-Committee at the University of East London (Appendix C). No other ethical approval was deemed necessary, as participants were recruited from a non-clinical population. As interview discussions were not oriented towards individual participants' own experiences, it was not anticipated that participants would find participation difficult or distressing.

2.4.2. Informed Consent

In order to gain informed consent, participants were required to read an information sheet (Appendix D), and then to sign a consent form (Appendix E). These forms outlined the purpose of the study, structure and content of the interviews, and participants' right to withdraw. Participants were informed that they were able to withdraw from interviews at any time and could request the

removal of their contributions, up until the point at which analysis began in March 2017. Following completion of the interviews, participants were debriefed and supplied with a debrief form detailing organisations from which they could seek support if required (Appendix F). Additionally, participants were reminded of their right to withdraw from the study. No participants requested for this to happen.

2.4.3. Confidentiality

In order to maintain confidentiality, participants' individual contributions to interviews were coded using pseudonyms in all transcriptions, analysis and interpretation, as well as throughout the report. All recordings will be erased upon completion of the thesis and viva examination, however anonymised transcripts were retained for further analysis and for the purposes of future publication.

2.5. Evaluating Quality

The evaluation of quality in all research is important, and qualitative research is no exception to this (Spencer and Ritchie, 2012). Madill, Jordan and Shirey (2000) state that to a greater extent than in quantitative research, qualitative research evaluation is influenced by the differing epistemological positions that can be taken up. Therefore, they argue that qualitative researchers should consider this, and specify their evaluative criteria. Spencer and Ritchie (2012) provide a useful set of guiding principles in the quality evaluation of qualitative research, which consider the role of epistemology, as well as the nature of this type of research. Those principles are:

- Contribution: To what extent does the research contribute to theory, policy, practice, methodological development, or the lives of individuals? Whether qualitative research can do this remains contested, however Spencer and Richie (2012) point to the ability of qualitative research to develop new hypotheses, and expand understanding of discursive processes and phenomenological experiences.

- Credibility: To what extent are the claims made by the research defensible and plausible? Does the research demonstrate a level of interpretive, and methodological validity? Has the process of interpretation been adequately presented, and are claims made by the researcher backed up by appropriate evidence? Readers of the project should be able to follow the thinking of the researcher, in order to evaluate the methods used in the generating of interpretations, and presenting of wider research claims.
- Rigour: Has the research been conducted and presented in such a way as to demonstrate a level of methodological validity and reliability? Whilst Spencer and Ritchie (2012) acknowledge that reliability in the sense of replicability is not possible in qualitative research, they advocate for studies to be evaluated in terms of a clear rationale and defensible approach to research design. In addition, has the researcher considered reflexivity, in the impact of their role, presence, and values on the research process?

The above criteria were utilised to evaluate the quality of the present study, and are presented in greater detail in the final chapter of this thesis.

2.6. Reflexivity

Harper & Thompson (2012) define reflexivity as “the ability to engage critically in understanding the contribution the researcher’s experiences and circumstances have had in shaping a given study (and its findings)”. In a Foucauldian Discourse Analysis, as all forms of knowledge are discursive practices, the work of the researcher is also viewed through the same framework (Willig, 2013). Therefore, it is important to take a reflexive approach to the research, considering what has contributed towards the construction of the knowledge claims of the thesis. In working towards reflexivity, a research reflective log was kept throughout the thesis, which was used to inform considerations of reflexivity in the final chapter.

CHAPTER 3: ANALYSIS

3.1. Chapter Overview

This chapter will present a report of the findings made during the analytic process. Firstly, there will be a presentation of the prevalent constructions of paranoia present within interviews, before then demonstrating how these intersected with discourses of gender. The chapter then considers what subject positions were made available within these discursive constructions, as well as how individuals took these up, or positioned others, and the subsequent consequences for individual subjectivity.

3.2. Discursive Constructions of Paranoia

This first section of the analysis will focus on outlining the ways in which paranoia was described by interviewees, highlighting the elements that comprised discursive constructions. Throughout interviews, participants gave descriptions of paranoia that appeared consistent with the continuum approach to paranoia discussed in the introduction. They did this primarily by drawing on discursive constructions of the opposite ends of the spectrum. For example, participants made reference to a discursive construction of paranoia which presented it as a normal and common experience with some basis in reality, as well as one which presented paranoia as more abnormal, more associated with mental health and with less basis in reality. Participants did not necessarily explicitly contrast these discursive constructions in the interviews. More often, the way in which an experience of paranoia was described could be seen as implicitly contrasting it with the construction of the opposite end. For example, descriptions of paranoia as abnormal included language which stressed how unusual and uncommon it was. This section will therefore present the prevalent discursive constructions at both end of this spectrum, along with the elements that comprised each. The decision was taken to group and present the constructions of paranoia in this way in order to reflect both the range of discursive resources drawn upon, and to highlight the differences between these conceptualisations of paranoia.

Table 2.

Summary of prevalent discursive constructions of common/normalised paranoia, and abnormal/clinical paranoia.

Common and Normalised Paranoia
"Just a phase"
Paranoia as a transient mood state
"it was this sense"
Paranoia as a sense or awareness
"Something might be happening"
An experience of suspicion
"It is a reasonable sort of fear"
Plausible experiences of paranoia
"That's a reason that allowed you to have the fear"
Paranoia with a basis in reality
"You have all these responsibilities"
Paranoia as a response to social pressures

Abnormal and Clinical Paranoia
"To you and I that would seem absurd"
Paranoia as absurd and insane
"that's in his head"
A paranoia not based in reality
"that's when we intervene"
Paranoia that is out of control, threatening, or has gone too far
"it becomes really intolerable"
Paranoia that builds up if not expressed
"they're not recognising that as an abnormal thing"
Paranoia that is hard to express

3.2.1. Common and normalised paranoia

This section of the analysis will outline how interviewees drew upon a construction of paranoia that appeared to represent a more common and

everyday experience, of a more normalised nature. This broader construction appeared to be comprised of various elements, portraying an experience based on ideas of a transient mood or feeling, related to suspicion, with a plausible basis in reality. Each element of this broader discursive construction will be presented in turn, along with illustrative quotes.

3.2.1.1. "Just a phase" – paranoia as a transient mood state

One way in which the wider construct of common or normalised paranoia was conveyed, was as a transient or temporary experience that passed over time and was not chronic. In this way interviewees appeared to draw on a construct of paranoia in which it was considered as more akin to an emotional state than to a symptom or diagnosable mental health condition.

> Carlos: You've got paranoia the mood and you feel a bit paranoid. You can have paranoia for like a couple of months or so, and it will eventually go away (70-71).

In the extract above, Carlos refers to "paranoia the mood", where a person might feel "a bit paranoid". This conveys to the listener a form of paranoia which feels akin to a mood or emotion, which is limited, or of minimal strength. In addition, his reference to time scales and "it will eventually go away" portrays a more transient and temporary experience. Constructing paranoia in this way can be seen to render the experience differently, when compared to a more stable and ongoing notion of a mental health symptom or diagnosis.

> Sandra: Yeah cause I've had anxiety, and then with, when I had it, cause I wasn't diagnosed with it or anything like that <Interviewer: Mmm hmm>, I just had a phase with it, and then, as I was going through it, I did feel paranoid (22-24).

In the extract above, Sandra acknowledges an experience of "anxiety", before appearing to separate this from something that you could be "diagnosed with". In this way, she describes an experience or feeling of anxiety that is constructed as not a diagnosable mental health condition. As a result, Sandra draws upon a

construct of a form of paranoia which again feels more like an emotional state, as opposed to a symptom. She goes on speak of the experiences as “just a phase”, again portraying to the listener the transient nature of the experience.

3.2.1.2. “it was this sense” – paranoia as a sense or awareness

Following on from the experience being described as a mood state, paranoia was at times also constructed as a sense or awareness, perhaps similar to an intuition. In describing experiences of paranoia in this way, it can be said that interviewees drew upon a construct of the experience as a more normalised or understandable one, related to a perceived awareness of others actions or intentions. This appears to contrast with the descriptions of abnormal or serious paranoia outlined later in this chapter, which construct it as something much more absurd in nature, and less understandable.

> Sofia: Yeah I think it was this sense that, people are not being completely honest <Interviewer: Mmm>. That somebody is not being completely honest, and you don’t have a proof about it (100-102).

In this example extract, Sofia draws on a construction of paranoia experiences as a “sense”, related to the actions of other people who are “not being completely honest”. In this way paranoia is constructed as an ineffable or inchoate experience, related to an awareness of the possible intentions of others.

3.2.1.3. “Something might be happening” – an experience of suspicion

In a similar way to framing paranoia as a sense, interviewees also spoke of paranoia in a way that constructed it as an experience related to ordinary mistrust and suspicion, along with a need for probing as to the truth of the experience. In addition, it was spoken of in a way that implied a function related to ordinary vigilance around the possibility of future threats.

> Sofia: So I certainly have had moments of, I would describe of paranoia, but not clinical paranoia. <Interviewer: Okay yes yes> and I have mistrust and suspicion and mistrust of something might be happening, and you need to prove (70-72).

In this extract, Sofia acknowledges an experience of paranoia, before contrasting this with “clinical paranoia”. This separation draws on constructions of paranoia as two different experiences, one of clinical significance, and one not. Sofia goes on to describe the non-clinical form as an experience of “mistrust and suspicion”. She speaks of a “need to prove”, suggesting a need to probe for the truth, and an implicit acknowledgement that it might not be true.

> Simon: So the suspicion is that either. For example it could be that they, or you think that something’s happened. <Interviewer: Mmm> erm for a reason, but it’s not apparent. So you’re trying to sort of. And then it can become your central focus of like, of your paranoia. In a kind of way <Interviewer: Mmm> because you’re trying to figure it out (25-29).

In a similar way to Sofia, Simon in this extract equates paranoia with “suspicion”, offering the example that “somethings happened” but it’s “not apparent”. In this way he appears to draw upon a construction of paranoia as a drive to work out some form of truth about a situation, either current or past. The use of “not apparent” suggests some truth behind the experience, and thus not a completely irrational experience set apart from reality.

> Lien: Something that could happen I think <Interviewer: okay> or that if you do things this happens, kind of thing. Erm predicting what can happen. Or maybe due to an experience or what other people have said, just assuming things as well (19-21).

In this extract, Lien appears to present the experience of suspicion in a slightly more conflicted way, using lots of qualifiers such as “could”, “can” and “assuming”. In this way paranoia is constructed as not a fact, but a potential truth. In addition, this conveys a function as a form of vigilance about possible future threats.

3.2.1.4. “It is a reasonable sort of fear” – plausible experiences of paranoia

A further aspect of the construction of a common or normalised experience of paranoia appeared to involve consideration of ideas of plausibility and

reasonableness. Interviewees at times commented on ideas of a reasonable or plausible amount of fear for a person to experience, drawing on ideas that there could be a threat, or a context of danger. A construction of a more normalised experience of paranoia was therefore drawn upon, in describing events and experiences as somewhat plausible, which appears to contrast with ideas of a more abnormal form of paranoia presented later in this chapter.

> Carlos: But, I think as I understand it is a reasonable, it is a reasonable sort of fear <Interviewer: Mmm>. His father left him and if he thinks he might be involved in gangs, especially in North East London, it's a very stereotypical thing, but you know, East London gangs. I think, you know, it's not a total irrational fear (437-440).

In this extract Carlos is responding to being presented with the vignette describing an experience of paranoia in a young man. Carlos interprets the person's experience as a "reasonable sort of fear", before giving the rationale that there might actually be a presence of "East London gangs". In this way, he draws on a discursive construct of a form of paranoia that is not totally irrational, but is an experience where there is a plausibility behind the fear, based on contextual information.

> Becky: Yeah I think that's true. Everybody must be paranoid to some degree. I think that it probably was adaptive… Sometimes people are talking about you [laughs]. Sometimes people are plotting to do you some kind of harm. So to be aware of that, I mean, I think maybe it's born out of the way that we are (42-45).

In this extract, Becky similarly appears to draw on ideas of a plausible form of paranoia, using several different methods to achieve this. She speaks of how "everybody must be paranoid to some degree", constructing the experience as universal. Becky then draws on evolutionary discourses in stating that a form of paranoia "probably was adaptive". In this way constructing the experience as related to normal adaptive vigilance against threat. She then goes on to speak to

the concepts of a justified level of fear, with a plausibility due to the possible reality of harm or negative intent from others.

3.2.1.5. "That's a reason that allowed you to have the fear" – paranoia with a basis in reality

An additional aspect of the construct of a common or normalised paranoia was that the experience has some form of a basis in reality. Interviewees framed many experiences of paranoia as having some form of connection to a real experience, and therefore not fully detached from reality. This contrasted strikingly with descriptions of other experiences that portrayed a more abnormal form of paranoia, which will be outlined later in this chapter.

> Carlos: You know, that person would have a reason, my friend got cheated on, I watched 'Mr. Robot' you know, that's a reason that allowed you to have that fear (127-129).

In this extract, Carlos is referring to his fear about internet security, and subsequent acts to protect himself. Carlos speaks of having "a reason that allowed you to have that fear", referencing having watched a series about hackers, and his friend's experiences of infidelity. Carlos therefore appears to draw upon a construction of a form of paranoia that has a basis in reality, implicitly separated from other experiences that might not, and may therefore be constructed as more abnormal.

> Amy: And I think that had a basis in truth as well. Because people are trying to save money, and they will take it where they can, kind of thing. But that's kind of the lower end of the spectrum I guess, because erm there's some paranoia within that, but it's harmless (69-72).

Here Amy is talking about a mental health client's belief that the government is removing benefits deliberately. Amy speaks of the belief as having "a basis in truth", portraying a similarly justified experience of paranoia. Interestingly, Amy then refers to this as "on the lower end of the spectrum", where there is "some

paranoia… but it's harmless". Here the paranoia is seen not only as reality-based, but also as not seriously distressing, as a more intense belief might be.

> Becky: Yeah okay yeah so, I mean, I guess like the idea of walking home by yourself, late at night. I think we are aware that there is a danger <Interviewer: Right>. It's just to what point that gets amplified, or muted, I guess (92-93).

Here is another example of paranoia constructed as having a basis in reality, in relation to a woman's experience of fear when walking home alone, and the judgment that "there is a danger". Becky then goes on to speak about a "point where that gets amplified, or muted", suggesting differences in the intensity of fear. In this way, paranoia appears to be portrayed as an experience of fear based in reality, but where one could over or under respond to or react.

3.2.1.6. "You have all these responsibilities" –paranoia as a response to social pressures

As well as relating it to an experience of fear with a basis in reality, interviewees spoke of some experiences of paranoia as a response to social pressures or expectations. This type of paranoid experience was conveyed in a way that suggested a form of negative self-talk, or self-evaluation. In addition, this form of experience was more likely to be attributed to the self as opposed to others. This form of paranoia also appeared to contrast with constructions of more abnormal or serious paranoia, in that they were related more to threatening and implausible experiences, as opposed to purely social pressures.

> Simon: Erm. Well it can easily be an overwhelming feeling, that you have all these responsibilities erm. And you that expectation leads to sort of erm a breakdown of functioning. So erm, and then that break down of functioning leads to a sort of paranoia, because you feel incompetent and unable to complete these tasks. (119-201).

In the extract above, Simon describes the impact of "responsibilities" as "overwhelming", with the potential to impair functioning and impact the ability to

fulfil these responsibilities. He appears to draw upon a construction of paranoia which is a consequence of feeling unable to meet these responsibilities, appearing to suggest that the experience of paranoia is equated with a form of self-criticism.

> Lien: Yeah and you don't want to do things wrong! So you're constantly questioning yourself, are you doing it wrong? Right? Etcetera. <Interviewer: Mmm mmm> and that could also build up as paranoia (130-131).

In a similar way to Simon, Lien here speaks of a process of "constantly questioning yourself" that could "build up as paranoia". In this way, she appears to also draw from this construction of paranoia as a form of self-doubt and internal dialogue, or negative self-talk.

In summary of the overall themes, interviewees at times drew upon different features of an overall construction of paranoia, in which it was portrayed or considered more as a common and normalised experience, in the form of a sense, a phase, a mood or experience of self-doubt. This type of paranoia was articulated as a more benign experience, related to feelings of mistrust, suspicion, and the anticipation of possible threats, or as a response to social pressures and expectations. An important element of the discursive construction related to there being some plausibility to others, and a basis in reality, as well as a low level of intensity.

3.2.2. Abnormal and clinical paranoia

In contrast to a more normalised and common form of paranoia, interviewees also at times drew upon a construction of a much more abnormal, irrational and clinically significant type of paranoid experience. This more serious or abnormal form of paranoia was discursively constructed both explicitly, through describing experiences with self and others, and implicitly by being contrasted with the previously outlined more normalised experiences. This section will aim to present the various ways in which this conceptualisation was drawn upon throughout

interviews, as well as the individual elements that made up this broader discursive construction. Later in the analysis, a particular focus will be placed on times where, within interviews participants positioned themselves and others across these two discourses.

3.2.2.1. "To you and I that would seem absurd" – paranoia as absurd and insane

An interesting way in which this more serious and irrational form of paranoia was constructed involved the use of vivid and extreme case examples and stories, as well as references to mental health. These appeared to convey to the listener a form of paranoia that was more out of the ordinary, unreasonable and implausible, as well as one where the person cannot distinguish between fantasy and the reality of the external world.

> Becky: Mmm yeah. I mean I had a boyfriend once who was insanely paranoid, that because he had tattoos, doctors, especially Asian doctors, would want to contaminate him with aids, if he was going to go their practice for anything. Which was obviously quite a paranoid belief. Which is quite a weird one as well (117-119).

In the above extract, Becky uses explicit markers such as "insane", "weird" and "paranoid", in a way that serves to convey to the listener a belief that stands out for its absurdity. Becky presents the experience of her boyfriend, pointing to the "obvious" nature of the belief as irrational. She highlights some of the idiosyncratic details of the belief, such as the connection with Asian doctors that presents the belief as having no obvious or logical rationale. In this way, she appears to draw upon a discursive construction of paranoia as an obviously weird or irrational experience.

> Amy: So quite recently we had a case of someone who believed their child who was 6 years old, was actually a spy… to you and I that would seem absurd. That child's a six year old. How could they be a spy? (72-76).

In this extract, Amy employs a similar discursive technique, utilising an extreme example to convey a form of paranoia that she calls "absurd". Interestingly her

use of “to you and I” seems to position her and the listener, inviting the listener to consensually evaluate the beliefs as odd. In both these extracts, a construct of an irrational form of paranoia is drawn upon, in which there is a lack of any plausibility to the beliefs, and it is hard to see within the bounds of possibility how someone would come to have such a belief. This appears to contrast with the constructions of a more normalised type of experience that were outlined in earlier sections of this chapter.

> Sofia: one of my friend’s brother is a schizophrenic and he has high levels of paranoia. <Interviewer: Mmm>. You know, he believes whatever’s in his mind is true (73-75).

Here in this extract, Sofia conveys her brother’s friends’ experiences within the discourse of mental health, as “schizophrenic”. She describes his experiences as “high levels” and therefore not low or harmless (as in the construction of more common and normalised paranoia), and points to an inability to distinguish between the external world or reality, and an internal fantasy.

3.2.2.2. “that’s in his head” – a paranoia not based in reality

In contrast to what was outlined previously in the construction of common or normalised paranoia, the discursive construction of more abnormal and irrational paranoia often comprised descriptions of an experience with no basis in reality (i.e. no situational context which would render it plausible) and where there is no real or present danger or threat, or of one where there is some plausible context but the fear is out of proportion to this.

> Sofia: What if? You know? Imagination goes wild. You know that sense of, you know, yes I mean I might be doing something that is not considered to be safe, but there’s no indication of danger around, and no danger around, and I’m actually feeling really scared…I should have taken the bus basically [laughs] (137-144).

In this example, Sofia has described an experience of fear when walking home alone, that she labelled as paranoid. In this extract, Sofia appears to justify that

labelling by stating that there was “no indication of danger around”, despite her “feeling really scared”. In this way, a construction of paranoia is drawn upon, where there is an experience of fear, however there is also a judgement by self or others that there is no real danger or basis for it.

> Simon: But maybe that’s his paranoia starting to show there. So then it escalates there. Cause you said there’s no actual physical violence as such, so that’s in his head (303-305).

In this example, Simon is responding to being presented with the vignette during the interview. Interestingly, the extract shows how Simon appears to have reached a point in the story where he no longer judges that account as acceptable, stating that “maybe that’s his paranoia starting to show there”. In this way, the experience is constructed as one lacking in plausible context, as well as one where the person is failing to differentiate between what’s “in his head” and what is reality.

> Bilal: Well my experience of why it’s tricky working with paranoia, sometimes it’s basis is like yeah, it’s got like a tiny <Interviewer: yeah> fraction of truth or foundation <Interviewer: Mmm mmm>. That can be what makes it complicated (187-189).

In some contrast to the above definitive split, Bilal acknowledges elements of truth in paranoid accounts, and describes the experience as not having quite so clear a divide. Thus, a construct of paranoia appears to be utilised, in which there is some level of plausible context, however there is an issue of proportionality, whereby the fear is judged as out of proportion to the amount of available evidence.

3.2.2.3. “that’s when we intervene” – paranoia that is out of control, threatening, or has gone too far

In addition to being portrayed as a more absurd or irrational experience, more abnormal forms of paranoia were often described as experiences that had

crossed a threshold into something others would consider out of control, threatening, or maladaptive.

> Amy: but it's when they start to voice any thoughts about acting, retaliation and becoming aroused or something like that, that's when we intervene (54-56).

In this extract, Amy is referring to her work in a mental health setting. She describes acting on paranoid thoughts as a key criterion for concern, whereby the belief has consequences in the real world, and possibly is no longer harmless. Her use of the word "retaliation" suggests an aggressive action, taken against perceived aggressors. In this way, Amy appears to draw upon a construction of paranoia as a potentially threatening or dangerous phenomena, requiring intervention from others.

> Becky: Most certainly once the paranoia goes too far, it again becomes maladaptive. Because me being spooked and running, is actually putting me in a more vulnerable situation, you know (96-98).

In this example above, Becky describes an experience of paranoia that has crossed a threshold from something judged as acceptable to something "maladaptive". In this way, a construction of paranoia is drawn upon, in which the experience has gone too far, and moved out of the range of normality and acceptability and into something counter-productive.

3.2.2.4. "it becomes really intolerable" – paranoia that builds up if not expressed

Many interviewees portrayed paranoia as an experience or emotion that in some way builds up or accumulates over time. Of particular interest, was how a discursive construction of a more abnormal form of paranoia was drawn upon, in which this build up had occurred too much, and there had been no form of cathartic release or expression.

> Adila: I think that it is something that it builds up, it doesn't stop <Interviewer: Right>. From time to time you will realise that what was [.] something that it was bearable at some point. It just <Interviewer: Mmm>. Everything is just something that it becomes really intolerable (59-62).

In this extract, paranoia is constructed as something that builds up, in a way that appears to draw upon hydraulic metaphors of emotional experiences, as an internal force or pressure that needs releasing. Adila described a movement from "bareable" to "something… really intolerable", suggesting that a paranoid experience is one where there has been a change in the ability of a person to manage or control the experience.

> Becky: Maybe it's when it snowballs into that, because for exactly that reason, because they haven't expressed it and talked it through, and come to understand that they were being paranoid or that it wasn't completely founded (269-271).

Becky describes something similar in this extract, a process of "snowballing", however she goes on to speak of this as "occurring because they haven't expressed it". This was a common construction of experiences of paranoia across the spectrum, that it is an experience that needed to be expressed, again drawing upon metaphors of emotion and concepts of cathartic release, as well as pointing to talking through experiences as a management strategy.

3.2.2.5. "they're not recognising that as an abnormal thing" – paranoia that is hard to express

In addition to being described as an experience that may build up if not expressed, experiences of paranoia were often described as something more inherently difficult or problematic to express or talk about, with connotations of craziness and negative judgement from others.

> Amy: Because they're not gonna call themselves [paranoid] and tell us "I'm having these beliefs" [laughs] because you know, they're not recognising that as an abnormal thing at that point (90-92).

In the extract above, Amy described paranoia as an experience a person would be unable to “recognise” or admit. She appears to draw from a construction of the paranoid person as both having an “abnormal” experience whilst simultaneously losing insight or perspective.

> Carlos: Cause it’s hard to you know, to open up to yourself and say ‘hey I’m paranoid. Cause the whole paranoia thing can be ‘oh my god the person is going crazy’ (300-301).

In the above example, Carlos portrays the experience of paranoia as difficult to admit or acknowledge, in a similar way to Amy. Additionally, he speaks of how another person might respond in a negative manner, whereby they judge the person as “going crazy”, and losing their rationality. Similarly, this appears to draw from a discursive construction of a more abnormal type of paranoia, whereby the person is unlikely to acknowledge their experience, or discuss it, due to connotations of craziness and abnormality.

Overall, and in contrast to a construction of more normalised and common experience of paranoia, interviewees also at times drew upon a construct of more abnormal and clinical experiences of paranoia. This discursive construct encompassed experiences that were judged as lacking a form of plausible context, and were based in idiosyncratic details, lacking in a rationale that could be considered clear or understandable to others. In addition, it was spoken of as something that to others seems weird, bizarre or irrational, and as reflecting an inability to distinguish between reality and the product of imagination, even when a kernel of truth is evident. It was described as disproportionate fear, or one that had passed a threshold of normality, that represents a loss of control, and may lead to inappropriate actions or those that are maladaptive and counter-productive. As well as something that could be diminished through talking through with others, and as something that builds-up over time particularly if not expressed. Lastly, these experiences were spoken of as something that someone would be fearful of acknowledging and that may not be recognised by a person, especially if given as an interpretation or judgment by another.

3.3. Discursive constructions of paranoia and gender

Following on from analysing the constructions of experiences of paranoia that were drawn upon and utilised within interviews, this section of the chapter will focus on how constructions of paranoia and gender appeared to intersect. The section will aim to describe how, within interviews, paranoia was spoken about in a gendered manner, constructing the experiences of paranoid men and women in different ways. In doing this, interviewees appeared to draw upon discourses of gender which were often consistent with hegemonic and stereotyped constructions of men and women. In presenting this particular part of the analysis, what was constructed as the more male form of paranoia and more female form will be presented separately, along with the elements and characteristics that appeared to form each discursive construct.

Table 3.

Summary of discursive constructions of male and female paranoia.

Paranoia associated with men
"somebody's coming to physically harm him" Paranoia in men and external threats
"you reflect on yourself and that can cause more paranoia" Paranoia and the male role
"he gets really paranoid and it's really scary" Paranoia and aggression in men
"there's that whole massive burst of emotion and fear" Paranoia in men as suppressed
"it might be hard to find men, men who would admit to it" Paranoia in men as not talked about
"far-fetched ideas" Conspiracy theories and paranoia in men

Paranoia associated with women

"women are more neurotic, and we just need to live with that"
Paranoia in women as normalised
"it feels lighter"
Paranoia in women as less serious
"You're not thinking so much about them hurting someone else"
Paranoia in women as internalised
"I don't think so and so likes me"
Paranoia in women as interpersonally focused
"that I guess is a female feeling"
Women, street harassment and paranoia
"we actually talk about it. And we then solve it!"
Paranoia in women as shared and discussed

3.3.1. Constructions of paranoia associated with men

This section will focus on the various ways in which paranoia in men was spoken about and constructed throughout the interviews, and the ways in which interviewees appeared to differentiate the experience from ideas of a more female experience of paranoia. Each element of the wider discursive construct will be presented separately, in order to highlight apparent differences when compared with descriptions that were given of female experiences.

3.3.1.1. "somebody's coming to physically harm him" – paranoia in men and external threats

A prevalent theme in the portrayal of male experiences of paranoia was of an externally directed experience and a perception of, or expectation of externalised threats, often more physical in nature. In addition, there were also references made to a need to act on or defend against these perceived threats.

> Bilal: The instant image for a man would be like, somebody's coming to physically harm him, and [2] yeah he's figuring out what to do (155-156).

In this extract, Bilal describes his expectation of a man's experience of paranoia, as an experience of vigilance against a perceived external and physical threat. His use of "he's figuring out what to do" suggests an active experience, wherein there is a focus or a plan of action. In this way, there appears to be a possible drawing on of discourses related to both paranoia, and what is expected of in the primary concerns or behaviour of men. This broadly appeared to differ from the descriptions of paranoid experiences in women given later in this chapter, in which there was a much more relational focus.

3.3.1.2. "you reflect on yourself and that can cause more paranoia" – paranoia and the male role

As well as being related specifically to external threats, paranoia in men was at times described in a way that related it to normative gender roles, or to the presence of external social pressures. Paranoia was spoken of as both an experience that resulted from men failing to meet these standards, or as a worry of the possibility of not meeting them.

> Lien: My brother probably has more paranoia regards to like his role, his image, as the male lead, how he is doing as the male, if he's doing the right thing etcetera (121-123).

In this extract, Lien speaks of her brother's experiences in a way that suggests to the listener that the primary concern is "how he is doing" as a "male lead". Here, his experience of paranoia are firmly constructed as primarily related to the male role and the image that is potentially portrayed to others. There appears to be a drawing from of gender discourses in relation to the stereotypical roles of men, and to the expectation of concern in relation to meeting these.

> Simon: There's quite a large array of hoops <Interviewer: right> that men have to go through. If you get them wrong, you know it doesn't work. And that is quite challenging because you reflect on yourself and that can cause more paranoia and depression (133-135).

Here, Simon speaks of the expectations placed on men, in a slightly different way to Lien. Rather than focusing on awareness of role expectations, Simon describes paranoia as a response to having failed to meet them. Thus, a construction is drawn on, in which paranoia in men is constructed as related to not measuring up to a perceived normative standard, and possible subsequent experience of negative self-evaluations.

3.3.1.3. "he gets really paranoid and it's really scary" – paranoia and aggression in men

Throughout the interviews, paranoia in men was frequently constructed in a manner that conveyed a threatening, aggressive, or controlling experience, likely to lead to others responding with fear. This appeared present only in description of male experiences of paranoia, and did not feature when women's experiences were discussed.

> Sofia: So I have friend [laughs] he doesn't drink much anymore, because when he drinks he gets really paranoid and it's really scary, because this kind of like. Yeah if he thinks we are talking about him he gets really, I mean, yeah, it's that sense that he's not really comfortable. Nothing in him is going to listen at that point (378-381).

Here, Sofia describes her experience and impression of her friend, constructing his experiences as paranoia. Sofia speaks of her response to the friend, describing him as "really scary". Her description of the experience appears to draw upon a construction of paranoia that is scary, unpredictable, and where the person refuses to listen or recognise and acknowledge their experience as paranoid. In addition, Sofia associated the experience with alcohol, and a lack of inhibition or control. These ideas appear to differ from descriptions of paranoia experiences in women, given elsewhere in interviews and outlined later in this chapter, where a perceived potential for harm was absent.

3.3.1.4. "there's that whole massive burst of emotion and fear" – paranoia in men as suppressed

In addition to being constructed as an intimidating or aggressive experience, paranoia in men was frequently described as suppressed and unexpressed, often with quite negative connotations to this. These ideas appear to draw heavily on common discourses around hegemonic masculinity (Connell, 2005) and the pressure for men to remain in control of and not express emotions. The extracts below demonstrate how this discourse in some way intersects with the constructions of paranoia analysed earlier in this chapter, of an experience that 'builds up' and becomes dangerous if not released or expressed.

> Sofia: I think by the time you notice that a man is paranoid it has all this strength behind it.

In this short extract, Sophia describes male paranoia in a way that suggests a hidden or suppressed experience that has "strength behind it". Her use of "by the time you notice", also appears to suggest something that may have built up over time.

> Carlos: So I guess it's because men don't act on it, as much, and then they just let that build up happen, until it explodes, and then there's that whole massive burst of emotion and fear (228-229).

Here, men are described as not acting on their experiences, and as letting it happen. In addition, Carlos portrays paranoia in men as an experience that explodes or bursts, in an unpredictable and dangerous manner. These descriptions appear to draw upon discursive constructions both of paranoia as needing to be expressed, and gendered discourses of men as not expressing emotions, and of male emotions as dangerous and problematised.

3.3.1.5. "it might be hard to find men, men who would admit to it" – paranoia in men as not talked about

Following on from the above, paranoia in men was often constructed as an experience that is not recognised or talked about, or is difficult to talk about. This

was also at times presented as a contrast to paranoia in women, which was constructed as easy to recognise and as more open or shared experience.

> Lien: it might be hard to find men, men who would admit to it. <Interviewer: Okay> Whereas women would be like "Yeah I'm always thinking like this!" you know, talk to someone about it (164-165).

In this extract, Lien constructs men as not able to "admit" to paranoid experiences, contrasting this with women, who she conveys in a humorous manner, as "always thinking like this" and able to "talk".

> Carlos: So if a man will have a fear that 'I'm scared that I'm not enough, and my girlfriend might leave me for someone else' <Interviewer: Mmm> you know, they might not want to see that weakness, they might not want to see themselves as you know, having that weak spot in them (237-240).

Here Carlos speaks in a similar way about men finding it hard to admit experiences of paranoia. He constructs the experience of paranoia in men as "that weakness" and "having that weak spot". In this way, Carlos draws on discourses of masculinity and strength, suggesting that the reason men might not admit these experiences relates to a conflict between these two discourses. Interestingly whilst this connection between paranoia and weakness was mentioned by several interviewees, the connotation was only made in reference to male experiences, and never those of females.

3.3.1.6. "far-fetched ideas" – conspiracy theories and paranoia in men

A final theme prevalent throughout constructions of male paranoia concerned links with conspiracy theory. Experiences of paranoia related to conspiracy theory were described as a primarily male interest, and as something women would be less interested in, or would not likely experience paranoia around. Interestingly, conspiracy theories were often spoken about as if a relatively harmless experience, in contrast to the constructions of male paranoia and aggression outlined earlier in this section.

> Bilal: Boys are more into like cars, gadgets, computers, technology. You can just see how if you like turn the amplifier volume up on that <Interviewer: Mmm> it would lead to more far-fetched ideas about aliens and UFO and that sort of things, and wider conspiracy theories (394-397).

Here, Bilal describes the experience an exacerbation of several stereotypically male interests. He then goes on to equate conspiracy theory with “far-fetched ideas”, demonstrating a form of devaluation of these ideas which was present throughout interviews.

> Simon: They are fighting against something. They are angry and they’re fighting against something. And, when they come out of it, when you stop using drugs and you start like “okay let’s figure out the world” and looking for your place in it, and how things work out 9389-392).

In this example, Simon is following on from talking somewhat about men’s interest in conspiracy theories. He constructs male interest in conspiracy theory as a struggle for understanding in the world. He conveys an angry experience, and a fight, but it is unclear what this is about and to whom it is directed. Both of these extracts appear to draw upon an idea that conspiracy theory would be a primarily male interest, and that it is a form of paranoia that is less dangerous or concerning to others.

In summary, paranoia in men was described as an experience based in vigilance regarding external, and primarily physical threats, as well as something related to status and a perceived failure to ‘measure up’ to societal norms. It was portrayed as a build-up of supressed emotion that could lead to an explosion of unpredictable and uncontrollable force and anger, especially if disinhibited by alcohol. This appeared to contrast significantly with the construction of emotional openness in women, who were said to acknowledge how common feelings of paranoia were. Male paranoia was additionally constructed as synonymous with insecurity and an admission of self-doubt, connected with connotations of weakness and shame.

3.3.2. Constructions of paranoia associated with women

Following on from presenting the common constructions of paranoia associated with men, this section will outline the various ways in which women's experiences of paranoia were spoken about by interviewees, as well as the discursive constructions drawn upon. Again, each element of the wider discursive construct will be presented separately, in order to highlight differences when compared with the way in which male experiences of paranoia were talked about.

3.3.2.1. "women are more neurotic, and we just need to live with that" – paranoia in women as normalised

Somewhat in contrast to paranoia in men, female experiences of paranoia were often spoken of in a way that portrayed a more common or normalised type of experience. This contrasted with the descriptions of paranoia in men described earlier in this chapter, where it was constructed as a more abnormal or unacceptable, unspoken or suppressed experience. Interestingly, these ideas were spoken about by both male and female interviewees.

> Becky: Like I say, I think a lot of paranoia is accepted for women. It's kind of seen as quite normal, as women are more neurotic, and we just need to live with that [laughs] (420-421).

In this extract, Becky described paranoia in women as "accepted" and "normal". She goes on to link this with ideas of women as neurotic, drawing on the discourse of women as the emotional gender (Fischer, 1993), or as more common worriers, however with some negative connotations to this, as an inferior quality, perhaps implicitly in comparison with discourses of the rational non-emotional nature of men. Becky's laughter may imply some irony in her statement, where she may recognise this as a somewhat stereotyped description.

3.3.2.2. "it feels lighter" – paranoia in women as less serious

Following on from being described as a normalised experienced, paranoia in women was also often spoken of in way that portrayed a lesser or lighter experience. This contrasts with the descriptions of experiences of paranoia in

men, outlined earlier in the chapter, where the constructions were of a much more dangerous experience.

> Sofia: Well I feel that when I have talked to women about it, it's kind of yeah. I have this feeling I have this sense "oh I'm being paranoid" type of thing, but it feels lighter. Yeah I haven't come across anybody that was so paranoid that, it becomes as scary, yeah. (398-400).

In this extract, Sophia is talking about her impression of experiences of paranoia in women. She speaks in an acknowledgment of experiences of paranoia occurring, whilst also describing them as feeling "lighter", and not "scary". In this way, female experiences of paranoia are implicitly constructed as less dangerous or threatening, in comparison with paranoia in men.

> Carlos: The male version is a way more physical like manifestation of the paranoia, like 'I need to check up on them' and 'I need to take care of my family', 'I need to, you know, protect them'. While a woman's is more of a lesser manifestation, where it's like 'I need to prove myself, do well at school' and stuff like that (476-479).

Here, Carlos describes women's experiences of paranoia as a "lesser manifestation", comparing it with the more male construction of action against a perceived threat. In this way, the paranoia is conveyed as a more internal experience, more akin to worries about proving oneself and day-to-day pursuits, whilst paranoia in men is spoken of as external, related to threats. Interestingly, these worries related to status were also attributed to male experiences of paranoia (as described earlier in the analysis) although here are constructed as "lesser".

3.3.2.3. "You're not thinking so much about them hurting someone else" – paranoia in women as internalised

A further common construction of female experiences of paranoia was one of an internalised experience. Interviewees often portrayed women as more likely to respond in an emotional way, withdraw and retreat, or harm themselves. This

was often spoken of in a way that appeared to contrast with descriptions of paranoia in men, and the externalised experience outlined earlier in this chapter, related more to threatening explosions of anger.

> Carlos: While if he was a woman, it might have been on the other side. The 'oh my god I'm scared, I need to lay down and cry, because I'm scared' (463-464).

Here, Carlos is speaking about his impression of the young man described in the vignette, responding to a question about any differences if the person was a young woman. Carlos describes how he would expect a woman to respond very differently to a man. His use of "scared" and "lay down and cry", draw on discourses of women as vulnerable (Hollander, 2001), and suggest a more internalised, emotional experience, where the woman responds in a vulnerable way, as opposed to reacting by directly addressing the threat.

> Amy: I think with women it's more a case of the response being us wondering if they would hurt themselves <Interviewer: Right>. You're not thinking so much about them hurting someone else <Interviewer: Okay>. You know, women are more likely to harm themselves (209-201).

In this extract, Amy talks about her work in mental health, she described how the primary concern for women is "if they will hurt themselves", before going on to say that you would worry less about "hurting someone else". In this way, paranoia in women is constructed again as an internalised experience, as well as being primarily a concern with a risk to self, as opposed to a risk to others.

3.3.2.4. "I don't think so and so likes me" – paranoia in women as interpersonally focused

Paranoia in women was often constructed as a socially focused experience, wherein the primary concern related to relationships. Again, this appeared to contrast with the constructions of paranoia in men outlined earlier in the chapter, where the experiences were described as more related to external and primarily physical threats.

> Becky: I think it's usually "So and so is talking about me. I don't think so and so likes me". You know, kind of like second guessing people. Overthinking things a little bit (254-255).

Here, Becky constructs paranoia in women as a relational experience, relating it to concerns about the intentions of others and insecurity in social relationships. She describes this as "overthinking things a little bit", suggesting an exacerbated experience of relational worries. Again this is appears to draw heavily from apparent discursive constructions of women as primarily concerned with relationships.

3.3.2.5. "that I guess is a female feeling" – street harassment and paranoia in women

Somewhat in contrast to the construction of paranoia in women as socially related and internally directed, it was also spoken of in relation to street harassment and an implied risk of violence from men. Interestingly, this construction was only present in interviews with female participants and was not spoken about by male interviewees.

> Sofia: but that I guess is a female feeling as well <Interviewer: Okay> to feel danger at night and when there might not be danger (133-134).

In this extract, Sofia has just talked about some of her experiences of paranoia when walking alone at night. She describes "fear of danger at night" as "a female feeling" "when there might not be danger". In portraying the experience in this way, Sofia appears to draw on ideas of women as vulnerable, and as likely to feel fear.

> Becky: Because I think for a female, walking home alone in the dark, then there is a risk. You know (94).

Becky here comments on a similar experience, however also states that "there is a risk". This appears to construct this experience as a form of paranoia in women

where it is more acceptable or expected for there to be more of an external threat focus.

> Amy: Women are constantly on guard anyway, throughout their lives…you feel like you're being surveilled constantly <Interviewer: Right>, and it is based in reality. So you know, when you've got street harassment and you're constantly on your guard, as a woman (30-34).

In this extract, Amy speaks of this fear as "based in reality", similarly constructing the experience as more acceptable. Amy describes woman as "constantly on guard", linking the experience to harassment and being to being "surveilled". In this way, Amy appears to describe a gendered experience for women in public space, as under the surveillance, scrutiny or gaze of men (Brown, 1998).

3.3.2.6. "we actually talk about it. And we then solve it!" – paranoia in women as shared and discussed

In sharp contrast to descriptions of men's experiences of paranoia as not talked about, paranoia in women was consistently described as an open and expressed experience. In addition, these ideas were linked to discourses around women as the emotional sex, openness and the sharing of emotions, and were frequently commented on as something helpful.

> Sofia: Certainly I speak more of feelings of paranoia, anxiety, whatever it is, with women. Cause we tend to speak more about those things? <Interviewer: Mmm mmm>. I mean maybe the reason we are less paranoid is because we actually talk about it. And we then solve it! (156-159).

In this extract, Sofia presents herself as able to speak about paranoia with other women, before linking this to women in general. She comments on how this leads to women being able to "solve it', implying a pragmatic solution to the problem. This presents an interesting intersection of gender discourse and the construction of paranoia presented earlier, whereby expressing or talking about paranoia was presented as curative or preventative. In addition, this may also represent an

implicit drawing on of notions of paranoia as the result of a build-up of something unexpressed, as described earlier in the chapter. Here however, women are described as able to express it and so prevent any build-up.

> Becky: So perhaps it's a case that when a woman is mildly paranoid, she feels more able to express that paranoia, without looking weak or kind of like deviating from the stereotype of what it is that she is allowed to do (265-267).

Here, Becky similarly speaks of women as able to "express that paranoia", linking to discourses of femininity and the ability to express emotions without connotations of weakness (Lutz, 1990). This provides an interesting example of how gendered discourses appear to allow for women to manage paranoid experiences or feelings in a more emotionally open way.

In summary, female experiences of paranoia were constructed as related to neurosis, and were positioned as an expected or normalised experience for a woman to have. Women's experiences of paranoia were described in a way that contrasted with the externalised, supressed and dangerousness of male paranoia, in being constructed as internalised, emotionally open, and not dangerous to others. It was spoken of as related to thinking about one's status in intimate and social relationships, as well as how one is seen or judged by others. The experience of street harassment was equated with a female experience of paranoia, despite also being positioned as based in reality. Lastly, paranoia in women was linked with constructions of women as open, and discussed as something that can be shared with others, preventing a build-up and facilitating problem solving and reality testing.

3.4. Subject Positions and Action Orientation

Having outlined the various constructions of gender and paranoia prevalent within interviews, the analysis will now consider how these discursive constructions were deployed, and what subject positions were subsequently made available. The positioning of self and others can be understood as "a dynamic alternative to

the more static concept of role", in which discourses present a variety of 'positions' for a 'subject' or person to take up (van Langenhove & Harre, 1999). Following on from this, action orientation will be considered, this refers to how discursive constructions are utilised by individuals within talk, and subsequently what is achieved by the constructing or positioning of a subject in that way (Willig, 2013).

3.4.1. Positioning self as acceptably paranoid

Having available two different constructions of paranoia, at opposing ends of the continuum, as either a normalised and rational experience or as an abnormal and irrational one, offered two different and quite opposing subject positions. Interviewees frequently allowed themselves to adopt the position of acknowledging a normalised experience of paranoia, whilst positioning others within the abnormal or serious paranoia position. This discursive action appeared to function in a way that rendered their own experiences as more acceptable or understandable. Several different discursive practices were utilised in the taking up of one position over another (Davies & Harre, 1999), which will be described in turn in this section of the analysis.

3.4.1.1. "but not clinical paranoia" – positioning one's own experiences in relation to the discourse of mental health

One way in which interviewees appeared to position their own experiences as within the more acceptable construct of paranoia, was through the making of a direct comparison with concepts of abnormal or clinical paranoia, and drawing from available discourses of mental health.

> Sofia: So I certainly have had moments of, I would describe of paranoia, but not clinical paranoia (70-71).

In this example, Sofia acknowledges and shares her own experience of paranoia, whilst also positioning this within the wider discourse of paranoia as "not clinical", and therefore within the bounds of a more normalised or common experience. In this way, Sofia has differentiated her experiences by anticipating the potential for

an alternative and more pathological interpretation, and then subsequently rejecting this.

3.4.1.2. "It's not necessarily gonna harm me" – positioning self as rationally paranoid

A further method utilised by interviewees in positioning their own experiences as acceptably paranoid, concerned the drawing upon of the construction that normalised paranoia is a rational and plausible experience, as previously outlined in section *3.2.1.4*. Interviewees at times appeared to utilise this element of the wider discursive construction, by outlining to the listener how their experience could be judged as 'rational'.

> Carlos: I go out of my way to do certain things to protect it. It's not necessarily gonna harm me, it's doing some sort of good, it's protecting my things (45-46).

In this example, Carlos constructs and positions himself and his experiences as a plausible and useful form of paranoia, and as a rational vigilance against possible threats. He acknowledges but also dismisses the potential for harm, suggesting a drawing on of discourses at both ends of the continuum, before positioning himself within the none harmful end.

3.4.1.3. "and then your life's pretty much over" – establishing that there is a real risk

Interviewees also positioned their experiences as more acceptable through drawing upon and utilising the construction presented in section *3.2.2.2*, wherein more normalised paranoia experiences have a basis in real risk or potential for harm. Interviewees at times described experiences in a way that attempted to portray to the listener that there was a real threat or risk, and that the paranoia experience therefore has a basis within reality.

> Carlos: Someone can pay a deep-web hacker five hundred euros and he can plant some, you know, he can plant some really nasty evidence in your computer, without you even knowing, and then send an anonymous tip, and then your life's pretty much over <Interviewer: Right> just because you didn't have control of your own security (107-110).

In this extract, Carlos refers to his experiences as related to fears about the security of his personal information. Carlos conveys to the listener that there is a threat based in reality, with severe consequences, "your life's pretty much over". In this way, his experiences are positioned within the construct of normalised or common paranoia, through an implicit cost-benefit analysis of the potential cost of vigilance versus the cost or impact of being hacked.

3.4.1.4. "obviously when I had my child, I had anxiety" – positioning self as having a reason for the paranoia

Through drawing on the construction of more normalised paranoia as experiences that have a reason or basis in reality (section 3.2.1.5), interviewees were also able to position their own experiences as more acceptable.

> Sandra: As I was going through it, I did feel paranoid I did feel like. Cause I have a child, so obviously when I had my child, I had anxiety (23-24).

In this example, Sandra is following on from talking about her fears that others judge her as a bad mum, labelling this as paranoia. Sandra acknowledges this as being "paranoid", before saying that her having a child would "obviously" make her have this anxiety, drawing upon cultural constructions of mothers as needing to be vigilant and responsible for protecting their children, and positioning her experiences as thus having a reason or justification.

3.4.1.5. "never to the level that has hindered my capacity" - positioning self as not impacted by experiences

A final way in which interviewees positioned their experiences within the more acceptable end of the paranoia continuum, was through describing themselves as not impacted by experiences, or by positioning the experiences as

manageable and within the bounds of what can be considered normal. In this way, some of the earlier described constructions of paranoia are drawn upon, of paranoid experiences being evaluated against the potential impact and disruption to functioning.

> Sofia: But never to the level that has hindered my capacity to have a life in society (72-73).

In this extract, Sofia positions herself through describing how her "capacity to have a life" has not been "hindered". In this way, Sofia can acknowledge paranoid experiences, without conveying that these had strayed over into something that could be judged as more abnormal, are 'intolerable', require support from others, or prevent her from meeting the culturally determined requirements of a normal life.

3.4.2. Positioning self and others in relation to 'reality'

A further way in which interviewees positioned themselves and others within discursive constructions, related to comparisons made with a notion of 'reality' or 'truth'. These examples of discursive positioning occurred both in terms of appraising one's own experiences, and the experiences of others, in terms of alignment to the 'real world'.

3.4.2.1. "was something really going on?" – positioning self within internal dialogues

When discussing their own experiences, interviewees often alluded to engaging in a form of internal dialogue at the time of having paranoid thoughts or experiences. Within descriptions of these processes, interviewees took the position of multiple selves engaging in a form of internal dialogue (Hallam & O'Connor, 2002) about the truth or reality of fears. Reality was in this way appeared to be constructed through partly an ongoing process of questioning and engaging in "what if's".

> Carlos: Because it sounds like if you're arguing with yourself "should I drop this?" the reason will always be the thing, the reason why you shouldn't. There's always that "what if" you know <Interviewer: Yeah>? So I guess that's the main point, yeah (129-132).

In this extract, Carlos talks about "arguing with yourself" in relation to a reason why a fear shouldn't be dropped, and "what if"s. In this way, Carlos conveys to the listener a process of internal dialogue around the fear and if it should be dropped. Carlos appears to position himself within the dialogue as having a "reason" to not drop the fear, subsequently justifying to himself the continuing of paranoid experiences or the subsequent behaviours.

> Sofia: I couldn't see anybody following me, and there was nobody, but I had this sense that, I was really scared, and was something really going on? (123-125).

A similar process is conveyed in this extract, where Sofia speaks of her thoughts at the time of experiencing fear when walking home alone. She describes on one hand not being able to see "anybody following me", but on the other hand wondering "was something really going on?". She appears to be engaging in a process of positioning herself between these two dialogical poles, as a way of considering the justification for feeling "really scared". In addition, this extract provides an example of paranoid subjectivity serving a function, wherein Sofia can engage in this time of thinking, possibly as a way of experiencing a sense of control in this ambiguous situation.

3.4.2.2. "a moment to check your own thoughts" – dialogical reality testing with others.

An alternative way in which participants appeared to position themselves in relation to reality, involved entering dialogue with others and co-constructing an understanding of the truth. Interestingly, this form of reality testing was constructed as a primarily 'female' ability, linked to the discourses of paranoia in women as more spoken about, and paranoia in men as unrecognised, unacknowledged, and supressed.

> Becky: And then that opportunity gives you a moment to check your own thoughts. You know “Am I being a bit silly there?” Maybe they could say “oh you’re being silly, she was in a bad mood. She missed the bus, she probably wasn’t looking at you like that”. Then you could say “Oh okay” (295-298).

In this extract, Becky describes engaging in a process of reality testing with friends, concerning socially related paranoia. There appears to be an acknowledgment that one’s own view may be impaired, and a subsequent engaging in a dialogical process with others in order to share perception, and generate alternative interpretations.

3.4.2.3. “yeah people aren’t out to get them” - positioning the paranoid person as needing to see reality

An interesting way in which others were at timed positioned by interviewees, was as needing to be convinced of reality. This process of reality testing another person was often suggested as a way of stopping the other person from being paranoid, along with simultaneously being constructed as something very hard to accomplish, suggesting a drawing on of ideas of ‘paranoid’ people as irrational.

> Adila: Does the person acknowledge? No they don’t, they don’t. They have an excuse. They find an excuse. They think they are the normal <Interviewer: Mmm>. You are not the one <Interviewer: Mmm>. So it’s very hard to try to explain them the difference (71-73).

Here, Adila speaks generally of paranoid others, commenting that they don’t “acknowledge” and instead “find an excuse”. In this way, the discourse of irrational paranoia as not acknowledged is drawn upon, and the paranoid other is quite firmly positioned as both needing to see “the difference”, and as not being able to, suggesting a quite powerless subject position.

> Bilal: because you want to support people but also what they are saying isn't true necessarily. <Interviewer: Mmm> Yeah people aren't out to get them. So you're trying to do this sort of version of reassurance that is hopefully not kind of also just missing what they're saying. (28-30).

In this extract, Bilal positions the paranoid other's experiences as not "true necessarily" and the person subsequently as needing "reassurance". This suggests a slightly less confrontational position as in Adila's extract, however still places the other person in the subject position of 'isn't true' in relation to a notion of reality.

3.5. Practice and Subjectivity

In the final section of this chapter the focus will be placed on the relationship between discourse and practice, and the resulting consequences for subjectivity. As outlined by Willig (2013), practice concerns the way in which the discursive constructions and subject positions described in previous sections 'open up' and 'close down' opportunities for action, and limit or constrain what can be said and done. In turn, subjectivities are the subsequent consequences for individual's subjective experience, and therefore the result of being positioned in these ways. Foucault linked this process with the practice of power, through describing how individuals or 'subjects' are produced within discourse, and therefore have limited or constrained agency (Kendall & Wickham, 1999). For this study, the importance is in considering the consequences for individual subjectivity, of being positioned in terms of the discourses of 'paranoid man' and 'paranoid women'.

3.5.1. Who can express paranoia, and how?

The discursive constructions of paranoia and gender outlined so far in this chapter have several potential consequences for practice and subjectivity, in terms of how they limit the expressions and actions of an individual judged as paranoid.

3.5.1.1. It is hard for some guys to, you know, to cross some barriers – men as unable to speak about their experiences

As outlined previously, paranoia was often constructed broadly as an experience which should be shared before becoming 'intolerable', whilst paranoid experiences in men specifically, were constructed as a potential expression of weakness. These discursive constructions can be seen to intersect and interact with each other, as well as with the wider gender discourses of hegemonic masculinity that espouse the control of emotion, and privilege rationality (Connell, 2005). As a result, a 'paranoid man' might find themselves problematised within multiple subject positions, having to maintain emotional control and rationality, whilst simultaneously being positioned as irrational and weak.

> Carlos: Yeah. I mean it is hard for some guys to, you know, to cross some barriers, to say 'hey I'm worried that I'm not enough and my girlfriend might leave me', 'hey I'm worried that, you know, my parent might pass away if they're ill'. <Interviewer: Mmm> Erm you know, 'I'm terrified of dying' (332-334).

In this example, Carlos suggests several possible fears, which he states would be "hard for some guys" to talk about, describing this as having to "cross some barriers". Interestingly, these fears are all described in quite embodied and emotional terms, as being "worried" and "terrified", and thus do appear to contradict ideas of strength, control, and rationality, that are frequent elements of construction of masculinity (Connell, 2005).

This limit on men expressing paranoia appears to link to the discourse of paranoia in men discussed earlier in section 3.3.1.4, where it is portrayed as an experience suppressed until exploding. The subject position of 'paranoid man' appears to allow more for these forms of expression of paranoia, as a strong burst of aggression, rather than as something more akin to a calm expression of doubt. In this way, paranoia can be expressed by a man, without the connotations of weakness or emotionality that are commonly rejected from hegemonic masculinity.

3.5.1.2. "I mean they're less like aggressive than men" - Women as unable to be aggressively paranoid

In a similar way to the limits placed on 'male' expressions of paranoia, the subject position of 'paranoid woman' appears to place restrictions on the expression of paranoia by women. Within the interviews, as outlined previously, there was a common construction of women as vulnerable and less aggressive, compared with the aggressive and scary male (Hollander, 2001). These discourses appeared to limit what behaviour was expected and permitted of a woman experiencing paranoia, in that she would have to break gendered norms of behaviour constructed as part of gendered subjectivity.

> Simon: Women. Yeah. They do talk more about their issues and stuff like that. They seem to have better, they have more empathy… I mean they're less like aggressive than men. So that sort of, that testosterone I know leads to aggression (154-157).

In this extract, Simon directly constructs women as having "more empathy" and being "less aggressive". He draws on these ideas to position women as talking more about their issues. In this way, a paranoid woman is positioned in such a way as to render expressions of aggression as less expected or understandable, potentially problematising any women who expressed a form of paranoia in this way.

> Adila: I think women are more sly sort of a thing in that sense. I think they observe more quietly. More on the sly. [laughs]. They do their research. They do their homework [laughs] (191-192).

Here Adila also constructs and positions women as expressing paranoia in a different way to men. She positions the paranoid women as "more sly" and "observ[ing] more quietly". This interestingly portrays a women as acting quite intelligently and rationally, traits commonly constructed more as 'masculine', however in Adila's description these are expressed in a way that is more hidden. This suggests a way of a woman navigating around the discourses of paranoia

and gender that normally prevent and restrict expressions of paranoia in a more 'male' way.

3.5.1.3. "that kinda like urban black youth" – positioning of young black men

A final consideration of practice and subjectivity, concerns the impact of intersectionality. When interviewees were asked about how expectations or opinions related to the vignette might change if the subject was a young black man, the answers given gave interesting insights into the potential impact of discourse on subjectivity. Young black men were spoken of as likely to experience paranoia, and were positioned as having more reasons to be paranoid, due to experiences of discrimination and police victimisation.

> Bilal: [2] I think you know, if I were to just pull out the like, you know, the stereotypical paranoid male sufferer in my head, he's definitely like, he's definitely, John is in my mind black <Interviewer: Right mmm>. Erm you know. That's what you know, that kinda like urban black youth is who I think struggles most with paranoia (260-264).

In this extract, Bilal states that a young black man is for him the "stereotypical paranoid male sufferer". He positions "black youth" as those who "struggles most with paranoia". The positioning of young black men in this way, as likely to suffer from paranoia, appears contradictory in terms of on one hand acknowledging the reality of discrimination, but on the other still framing subsequent experiences as 'paranoid'.

> Adila: It's my perception is that erm black people have toughened up themselves … So they don't fear when it's one to one. But they would fear obviously if it would be in a large sort of a scale (299-302).

Here Adila speaks of her opinion that "black people have toughened up", subsequently suggesting a form of higher tolerance for fear. Positioning a black person in this way raises potential questions in terms of the impact on subjectivity, through possibly increasing the threshold of what could be considered an 'understandable fear' and an acceptable expression of paranoia.

CHAPTER 4: DISCUSSION

4.1. Chapter Overview

This chapter will discuss the findings of the analytic process, presenting these within the framework of the original research questions and wider gender and paranoia literature. Following this, the quality of the present study will be evaluated, along with a critical review of the methodological and analytical choices made. The chapter will then conclude with a discussion of implications, both in terms of research and clinical practice.

4.2. Research Questions and Analysis Summary

The overall aims of the present study were to explore discursive constructions of paranoia and gender, the resultant availability of subject positions, and subsequent consequences for subjectivity and practice. This section of the thesis will further explore and discuss the findings of the analysis, in relation to these aims and the research questions, and in the context of existing research literature.

4.2.1. What are the culturally available discourses around gender and paranoia?

'Psychosis like' experiences, including paranoia, can be considered to lie across a continuum from normal phenomena, to those that can be considered highly distressing and of clinical severity (van Os, Hanssen, Bijl, & Ravelli, 2000). This appeared to manifest within the discursive constructions apparent in the interviews of the present study, in the distinction between constructions of more normalised experiences and those of a more severe and abnormal nature. However, as opposed to being constructed by interviewees as an acceptable experience across the continuum, severe and abnormal paranoia appeared to reflect a point in which experiences had crossed over into being considered 'too much', or judged as unacceptable. These judgments appeared to be made based on the perceived plausibility of beliefs, the perceived basis in reality, and level and intensity of fear. Experiences of paranoia considered as having passed this

point of normality, appeared to be subsequently judged as out of control, scary, maladaptive, and bizarre. These findings provide further support for discursive models of fear and threat, that identify the socially constructed nature of acceptable fear (Lupton & Tulloch, 1999), and the processes by which others judge fear as unwarranted or paranoid (Simpson, 1996).

In further consideration of discursive constructions of experiences, analysis of interviews highlighted an intersecting with gender discourses of masculinity and femininity. These intersections were most apparent in the way that paranoid experiences could potentially be constructed differently for men and women, leading to differing judgements of when paranoia was considered to have progressed up the continuum of experiences. For experiences of paranoia in men, the most prevalent constructions were of an experience based in vigilance for external and physical threats, or related to status, that manifested as an uncontrollable and unpredictable expression, judged by others as scary or aggressive. In contrast, paranoid experiences in women were constructed in a more normalising way, as related to expectations of women as worriers and as concerned about intimate and social relationships, or to experiences of street harassment, likely to be expressed in an open manner and easily shared with others. These differences in constructions draw heavily upon culturally familiar discourses of masculinity as controlled and unemotional (Connell, 2005), and as aggressive (Hollander, 2001), and of femininity as more emotional (Barrett, Robin, Pietromonaco, & Eyssell, 1998; Lutz, 1990), and socially expressive (Coates, 1997).

In contrast to this more gendered notion of paranoia, constructions found and utilised in Clinical Psychology research and practice are commonly more ungendered in nature, or appear to draw more broadly from what has been identified here as the more ‘male’ construction, with a predominant focus on the potential for harm. For example, the definition provided by Freeman and Garety (2000) refers to how the “individual believes that harm is occurring”, throughout each of its criteria, along with how “Harm only to friends or relatives does not count”. Similarly, within the DSM-5 the definition of persecutory delusions is given as “belief that one is going to be harmed, harassed, and so forth by an individual,

organization, or other group" (American Psychiatric Association, 2013, p. 87). The DSM-5 defines paranoid ideation as experiences "involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated", representing some consideration of forms of suspicion not related directly to harm. However, this serves to construct the experience as 'ideation' in a way that suggests a lesser or more normalised experience. Broadly speaking therefore, it can be hypothesised that defining paranoia in terms of what has been identified in the present study as the more male discursive construction of paranoid experiences, may lead to experiences of paranoia in line with the more female construction as potentially becoming more normalised or disregarded within both research and clinical practice.

A further finding relates to the prevalence of constructions of paranoia as a 'sense' or feeling, linked to anxiety, and as transient and temporary in nature. These ideas were most associated with constructions of paranoid experiences that were normalised in nature, contrasting with constructions of a more persistent and out of control or abnormal experience of paranoia. In addition, interviewees reported these experiences as occurring along with an engaging in a process of "what if?" and "is this real?" style thinking. This experience of paranoid subjectivity, as a pairing of embodied experiences with an element of inner speech, has previously been articulated by Cromby and Harper (2009). They describe paranoid subjectivity as "a constant iteration between socialised feelings and socially derived inner speech", emphasising how this movement between the two occurs within and in relation to social context. Within Cognitive approaches, the process of inner speech has been considered in terms of a reappraisal of thoughts, and a process of reality testing (Taylor, Graves & Stopa, 2009). The beneficial or adversarial nature of this inner speech is contested, with some studies demonstrating this as a helpful process, and others describing it as part of the paranoid subjectivity itself, or associating it with an increase in the severity of experiences of paranoia (Aggelidou & Georgaca, 2017), pointing to area potentially needing future research.

Following on from the above, experiences of paranoia that were constructed as more severe and abnormal, were described within interviews as in some way a

product of failing to express oneself, and subsequently a resultant build up or snowball of associated emotions. In this way, the construction of paranoia drew upon common discourses and metaphors of emotions, as a hydraulic like system that requires a form of venting. These ideas are commonly found within the discourse of anger, and within psychoanalytic and cognitive therapies (Lutz & White, 1986). A suppression of paranoid thoughts, especially in the context of high anxiety, has been associated with increased severity of experiences (Jones & Fernyhough, 2008), whilst acceptance of paranoid thinking and expression of emotions are considered helpful and adaptive coping strategies (Aggelidou & Georgaca, 2017). Interestingly however, these metaphors have been critiqued for narrowing focus purely to the releasing of emotional experiences, and thus neglecting the social and communicative aspects or functions (Lutz & White, 1986). Analysis of interviews in the present study suggest that whereas in the construction of experiences of paranoia considered more acceptable or normalised interviewees gave some consideration to the potentially communicative nature of the experience, this was rendered less so when paranoia was judged as abnormal or severe. Constructing more severe experiences of paranoia in this way may potentially obscure and mystify the meaning within individual experiences.

In addition to being described as an emotional experience requiring expression, paranoia was also constructed as an experience to be spoken about and checked out with others. More severe or abnormal experiences of paranoia were subsequently implicated as a failure to do this. This appears to draw upon discourses of reality testing, in which a further behavioural norm is constructed of a willingness to share and evaluate one's own experiences. Within psychological discourses, this would commonly be considered the use of disconfirmatory evidence, to modify beliefs, a component of Cognitive Behavioural Therapy for paranoia (Freeman, Garety, Kuipers, Fowler & Bebbington, 2002). However, critics of this notion, such as Georgaca (2004), describe how this process more reflects the co-construction of 'reality' in interpersonal dialogue, as opposed to a process of reality testing, wherein "not only the plausibility of the account, but also the rationality, integrity, and accountability of the participants is at stake". Taking this view would suggest that further research could be useful in expanding

existing knowledge in how this process occurs, and to what extent discussing beliefs with others influences the paranoid experience.

4.2.2. How do such discourses construct subjectivity and position 'paranoid' men and women differently?

Following on from the first research question, this second question considers how the discursive constructions of paranoia and gender are deployed and make available the subject positions of 'paranoid man' and 'paranoid woman'. Additionally, it considers the consequences of these for subjectivity or the experience and practice of men and women positioned as paranoid.

The discursive construction of abnormal or severe paranoia as an experience that had built up and not been expressed, appeared to intersect with gender discourses, constructing male paranoia as an experience difficult to express and associated with self-doubt and weakness. Contrary to this, female experiences of paranoia were spoken of as expressed more freely. In addition, male paranoia was felt to build up and then be released in an angry or aggressive manner, whilst female paranoia was constructed as a more open experience, released at a lower-level. These constructions appear to draw upon intersections of the discourses of hegemonic masculinity (Connell, 2005), female emotionality (Lutz, 1990), and that of paranoia. The constructions position men and women differently, in terms of their ability to express and speak about paranoid experiences. Within these discourses, logic and rationality is constructed as masculine, whilst emotionality is constructed as feminine and subsequently rejected from hegemony (Connell, 2005), subsequently positioning women as the emotional and irrational sex (Lutz, 1990). As a result, men who express or acknowledge emotion, or self-doubt, in a non-masculine way, can find themselves as Connell (2005) says, "expelled from the circle of legitimacy", or in more Foucauldian terms as problematised.

In terms of consequences for the subjectivity of paranoid men, use of more interpersonal and emotional coping strategies is likely to necessitate a process of renegotiating one's masculine identity around these problematisations (Wetherell

& Edley, 2014). This potentially limits the ability for men to utilise interpersonal and social coping strategies, identified as helpful in reducing paranoid experiences (Freeman, Garety & Kuipers, 2001; Yamauchi, Sudo, & Tanno, 2009), as well as increasing the likelihood of suppression or avoidance, shown to be correlated with increased experiences (Jones & Fernyhough, 2008). Additionally, analysis of interviews demonstrated how experiences of paranoia in men could be constructed as an unpredictable, explosion of anger. It can be hypothesised that this results from the limiting, within discourse, of men's ability to express paranoia in what would be considered a more female manner, resulting in an expectation for this to be expressed in a way more consistent with the construction of men as aggressive (Hollander, 2001). When considering the consequences for women of being positioned in this way, it may be that there is an increase in the ability to utilise social and relational coping strategies, identified potentially as protective for women (Morgan, Castle & Jablensky, 2008), without the negative connotations experienced by men. However, there also appears to be an element of normalisation of women's experiences, leading a certain level of dismissal of the possible impact, as well as a potential problematisation of women who use 'male' ways of expressing paranoia, such as through aggressive of controlling acts.

Intersections between gender, and paranoia discourses also occurred in that different fears were constructed as primarily the concern of either men or women. This process of positioning fears as more male or more female raises interesting considerations for the subjectivity of the 'paranoid man' and 'paranoid woman'. An example of this concerned the description of fear of street harassment as a "female feeling", positioning this as something women experience and men would only experience in more obviously or severely dangerous situations. Gender discourses commonly position people in this way, with women as positioned as vulnerable, and men as dangerous (Hollander, 2001). Brown (1998) describes the apparent disparity between women's fear of public space, and the relatively higher risk of violence towards men. She points out the subtler consequences of harassment, and more embodied effects of gendered experiences in public space, describing women's experiences of always being seen or as under the gaze of men. Mehta and Bondi (1999) highlight how these discrepancies lead to

women adopting a position of “being sensible” in which there is an awareness of threat and some adjustment to behaviour, without this becoming something judged or positioned as irrational. It appears therefore that the intersecting of discourse creates a subject position for women to take up, in which there can be acknowledgement of fear in public space, however straying into too much fear or an irrational response, leads to being positioned more as ‘paranoid’.

This concept of ‘too much’ fear also appeared relevant for the subjectivity of men experiencing paranoia. Constructions of paranoia in men portrayed the experience as having a potential to cross a threshold from something considered more acceptable, into a more dangerous or scary experience, as a consequence of a form of build-up, or related to the presence of external threats. Men were positioned as likely to express paranoia of this nature in a dangerous, unpredictable and out of control manner, with connotations of aggression. The discourse of men as violent or aggressive has been well documented previously, with violence constructed as something ‘men do’ and as ‘fact of life’ (Hollander, 2001). Seymour (2011) follows on from this in pointing out the cultural acceptance of men’s violence towards men in some circumstances, and the problematisation of men’s violence in others. They quote Hearn and McKie (2010) “Men are supposed to know when and where, and to whom they may be violent”. This appears to be important to the subjectivity of men, whereby some expression of awareness of external threats is considered acceptable and within the common constructions of masculine norms. However, experiencing ‘too much’ external threat can lead to being judged as irrational and paranoid.

A further interesting finding related to the subjectivity of paranoia, concerns associated emotional experiences. Paranoia was frequently constructed as an experience related to the effect of social pressures, as well as a result of a failure to meet these expectations. This was presented as especially the case for paranoia in men, which was felt to be related to the effect of gendered expectations, status, and the impact of the ‘male role’. In this way, paranoia was constructed as related feelings of inferiority or inadequacy, and subsequent experiences of shame. As an emotional experience, ‘external shame’ related to belief of being held negatively in the minds of others, has been shown to

correlate with experiences of paranoia (Matos, Pinto-Gouveia, & Gilbert, 2013). Cromby and Harper (2009) point to the nature of shame as an emotion related to evaluation of self in relation to others, as well as an experience that for men is in itself shaming as a consequent of prohibition by cultural norms. They further posit that experiences of shame may be 'bypassed' and projected into 'paranoia' oriented towards the hostile intentions of an other.

4.2.3. What is the role of intersectionality, in impacting constructions of paranoid men and women?

Shields (2008) defines intersectionality in terms of how "one category of identity, such as gender, takes its meaning as a category in relation to another category". In this way, the discourse of gender can be described as unavoidably involved with other social practices and structures, and can only be understood in terms of other forms of discourse, such as race and culture. Therefore, in answering this research question, this section will discuss the effects of intersectionality on the discursive constructions of paranoia and gender drawn upon in interviews.

Within interviews, participants described a view that young black men might experience more paranoia than young white men, due to the impact of racial discrimination, and associations with crime and 'urban' culture. The notion of a link between experiences of racism and paranoia is supported within the literature. In a general population study conducted in America by Combs, Penn and Fenigstein (2002), it was found that black Americans scored higher on a paranoia scale than non-Hispanic white Americans. Paranoia has been associated with racial microagressions, in creating what has been described as a 'healthy paranoia' amongst black Americans, wherein racism is anticipated (Sue, Capodilupo, & Holder, 2008). Evidence of interviewees drawing on these ideas within interviews is interesting, as experiences were still often framed as paranoid, as opposed to being explicitly described as justified by experiences of racism and discrimination. Whilst this positioning may be a consequence of participant orientation towards the interview topic of paranoia (Potter & Hepburn, 2005), it may also be a consequence of the cultureless nature of the construct of paranoia (Harper, 2014).

In addition to the above, young black men were constructed at times during interviews as “tough” and “fearless”. Connell (2005) points to how masculinity is constructed in intersection with race, culture and class, creating a multiplicity of forms of ‘white masculinity’ and ‘black masculinity’. The construction of black men as tough appears to point towards this element of intersectionality, and raises questions about the subjectivity of black men. In being constructed as tough and fearless, a higher threshold of acceptable fear is formed, wherein a greater threat level is needed to justify a fear, potentially influencing the possibility of an experience being judged as paranoid in nature. This notion is supported by the work of Lupton and Tullock (1999), who describe fear of crime as a product of subjectivity and as “constituted through the discourses of a number of subcultures or social collectives of which individuals are members”. They point to how disparities between subjectivities can lead to judgments of irrational fear from others.

A final element of intersectionality present during the analysis concerned the impact of gender roles and expectations. Participants from different cultural backgrounds constructed the gendered roles of men and women in subtly different ways, raising questions related to the resulting effects of subjectivity. For example, a female interviewee from a Muslim background spoke of women as oppressed in relationships by men and male jealously, whilst a female interviewee from a white British background constructed women as more jealous than men. Whilst these disparities may reflect individual and more subtle differences, they also may be reflected of broader differences in the cultural construction of gender. These ideas are however based on small numbers of comments within interviews, from specific interviewees, and are therefore speculative in nature. Future research related to this area is therefore needed.

4.3. Critical Review and Research Evaluation

This section of the discussion chapter will now critically review and evaluate the research presented in this thesis. In order to do this, the guiding principles outlined by Spencer and Richie (2012) will be drawn upon, in considering the credibility, rigour, contribution, and reflexivity of the research.

4.3.1. Credibility

Credibility refers to “the defensibility and plausibility of claims made by the research”, concerning the “believability” of findings as well as “the ability to see how claims have been reached” (Spencer and Richie, 2012). In this way, the credibility of qualitative research could also be considered its interpretive validity. To maintain credibility, the analytic process has been described in detail throughout, along with examples of coded transcripts provided in the appendices (Appendix G). Throughout the analysis chapter, analytic comments have been presented alongside example quotations, in order to provide transparency and to support the interpretive claims made (Yardley, 2008). The plausibility of the claims made has been demonstrated by discussing interpretations in the context of existing research (Spencer and Richie, 2012). Lastly, in order to maintain interpretive validity, conflicting or contrasting discursive constructions were presented where indicated, acknowledging the often contradictory nature of discourse (Parker, 1992).

4.3.2. Rigour

In qualitative research evaluation, rigour can be seen as synonymous with methodological validity, concerning the appropriateness of research decisions, dependability of evidence and the overall conduct of research (Spencer & Richie, 2012). In order to maintain and demonstrate vigour, efforts have been made throughout the thesis to present each stage of the research process, as well as to detail the rationale behind key decisions. Additional consideration of methodological limitations is giving in a separate section later in this chapter.

4.3.3. Contribution

Contribution refers to the extent to which the study addresses the research questions and contributes towards wider knowledge and understanding, as well as clinical practice (Spencer & Richie (2012). A full discussion of the contributions made by this study towards wider knowledge and understanding are presented in the implications section later in this chapter.

In terms of addressing the research questions, data collected during interview provided more limited information regarding intersectionality than was expected during the design of the study. Whilst some interesting information was gathered related to the positioning of black men, and cultural differences in constructions of gender roles, these were somewhat limited in depth. It could be hypothesised that issues of race and class are harder to discuss within an interview setting, wherein the interaction is more formalised and the researcher is positioned in terms of 'footing' as more powerful than the interviewee (Potter & Hepburn, 2005).

4.3.4. Reflexivity

Reflexivity refers to an awareness of the influence that the researcher has in the shaping of the research process, both personally, and as a theorist or thinker (Willig, 2013). It acknowledges that the research process is open to a number of potential influences, and asks questions of the values and assumptions that guided the project throughout (Spencer & Richie (2012). In terms of my own interest in this subject, as a man myself I have an interest in the impact discourses of masculinity have on men's experiences of psychological distress. My initial interest in this specific project came from knowledge of research that pointed towards men reporting more experiences of paranoia in the general population. However, upon reading further into associated literature, and engaging in conversations with my thesis supervisor, my standpoint on the topic moved beyond considering these experiences in relation solely to masculine norms, and towards considering the more nuanced aspects of gender discourses in the broader sense (e.g. Wetherell & Edley, 2014), as well as the experiences of women, and the role of intersectionality.

In terms of the data collection and analytic process, it is important to consider the impact my being a white, middle class man may have had on the process. As interviews are inherently dialogical encounters (Potter & Hepburn, 2005), the context of both participants and researcher is important. It may be that my context unintentionally limited what could be said within interviews, in that conversations with an interviewer of different class, race, or gender, may have

opened different avenues of conversation. For example, male interviewees may have felt cautious around speaking contrary to stereotypically masculine ideas or discourses, due to concerns about judgment from me as the interviewer. Likewise, female interviewees may have potentially opened up more about personal experiences to a fellow female interviewer. Additionally, whilst throughout analysis I endeavoured to maintain awareness of my context, and how this had the potential to influence my interpretations, it is important to consider how my gender may have influenced the analytic process. Being male potentially may have limited the range of interpretations considered during the analytic process, through biasing towards certain discourses of gender and constructions of masculinity and femininity, leaving other potentially more subordinated ideas less visible.

4.4. Research Limitations

A number of potential methodological limitations arose during the conducting of the research, and will be discussed below in the context of decisions taken in the overall design of the research.

4.4.1. The use of interviews in data collection

The use of semi-structured interviews was deemed the most appropriate way to, in a general population study, collect data pertaining to discursive constructions of paranoia and gender and processes of subjectification. Semi-structured interviews do however present limitations, as outlined by Potter and Hepburn (2005). Interviews are themselves dialogical interactions, in which both participants have a ‘stake’, and therefore cannot be considered discursively neutral or free from bias. Interviews can be critiqued for implicit ‘cognitivist’ assumptions that reports provided by interviewees can provide a transparent reflection of the experiences, events and emotional responses under discussion (Potter & Hepburn, 2005). In the present study, this was felt to be unavoidable, as naturally occurring text or dialogue was not practicable as a data collection method. However, this potential limitation was considered throughout the discussion of findings and implications.

4.4.2. Choice of participants

As discussed in earlier chapters of the thesis, a student population was chosen for this study, due to the high prevalence of paranoid experiences reported in this population (Ellett, Lopes & Chadwick, 2003). However, the choice of this group as an example of the 'general population' is not without potential criticisms. Whilst this study was not aiming for generalisability to wider populations in the more quantitative sense (Willig, 2013), it is important to note that student populations are a slightly more homogenised population, in comparison with samples of general population (Peterson, 2001). Additionally, it is important to consider the impact of all participants being Psychology students. This may have occurred due to the recruitment strategy, and high proportion of Psychology students on the campus in which recruitment occurred, or as a result of more Psychology students being aware of and willing to discuss the construct of paranoia. Potter and Hepburn (2005) point to the need to consider the 'stake' of interviewer and interviewees. With the researcher as a Doctorate of Clinical Psychology student, and the participants as Psychology post-graduate and undergraduates, both can be said to have a stake in the use of psychological language and constructs, potentially limiting the discourses drawn upon, or risking the reproduction of psychological constructs within interviews. Despite being drawn from a student population, the age range of interviewees was broader than expected, ranging from 18 to 40. However, utilising participants of this age range limits the discourses of gender drawn upon in interviews. Individuals of an older and younger age than this range are likely to draw upon generationally different ideas and discourses around gender, masculinity and femininity, as well as different attitudes and understandings around mental health difficulties. Additionally, as outlined in the method chapter of this thesis, there was a difficulty in recruiting male participants to interviews, resulting in fewer male than female participants. This difference limits the potential examples of paranoia in men drawn upon in the analytic process, as well as potentially narrowing the discourses of masculinity considered. Finally, it is important to note that the number of interviewees who agreed to participate was relatively small, meaning a certain level of caution is required regarding broader interpretations.

4.4.3. Choice of epistemology and analytic method

The decision to utilise a moderate or critical realist social constructionist epistemology was taken in order to allow for a consideration of connections between discursive constructions of paranoia and gender within interviews, and the wider social-cultural discourses that are drawn upon, and exist independent of what is said (Parker, 1992; Willig, 2013). In accordance with this position, and with the research questions, Foucauldian Discourse Analysis (FDA) (Arribas-Ayllon, & Walkerdine, 2008; Willig, 2013) was chosen as the analytic method, due to its use in going beyond identifying discursive constructions, and answering questions related to subjectification and subjectivity (van Langenhove & Harre, 1999). Willig (2013) highlights debates around to the extent to which subjectivity can be said to relate to discourse alone, and whether other theoretical considerations are needed to account for the investments individuals place in adopting particular discursive positions. Within the present study, this can be seen in discussions around the ways in which individuals position themselves and others in relation to the discourse of paranoia, as 'acceptably paranoid' or as 'abnormally paranoid', as well as in terms of gender, as 'male' and as 'female'. To what extent can be this be said to occur due to availability of positions alone? To this end, Henriques, Hollway, Urwin, Venn and Walkerdine (1984 pp.203) advocate the incorporation of Psychoanalytic theory into discursive psychology and the investigation of subjectivity, a possible focus for future discursive studies exploring paranoia.

4.5. Research Implications

The findings of the present study point towards several important clinical and research implications. This section of the thesis will present areas for potential exploration in future research, as well as broader implications for research in this topic area. In addition, clinical implications will be considered in regard to the clinical practice of psychologists and therapists working in this area.

4.5.1. Implications for further research

4.5.1.1. Paranoid subjectivity and emotional/dialogical processes

The research presented in this thesis provides further support for the continued exploration of the role of internal dialogues in experiences of paranoia (Cromby & Harper, 2009; Georgaca, 2004). The present study demonstrated some examples of dialogues, both internal and external, involved in the experience of paranoia. These dialogues appear to be important to the overall phenomena of paranoia, however are not commonly a feature of the dominant cognitive models. It appears unclear whether these processes occur as a part of the subjective experience of paranoia in a potentially unhelpful way, or as part of an adaptive coping strategy (Aggelidou & Georgaca, 2017). Further research is needed to explore in more detail dialogical processes and paranoid experiences, as well as any potential interactions with associated embodied experiences, such as the extent to which dialogues occur along with emotional or embodied experiences of shame, anxiety, and threat.

4.5.2.2. Gendered forms of distress

The present research highlights several ways in which discursive constructions of paranoia are potentially gendered in nature, as well as possible effects on subjectivity for those positioned as a 'paranoid man' or 'paranoid woman'. However, dominant constructs and models of paranoia utilised in research are broadly ungendered in nature, or predominantly focus on what this study has highlighted as the more 'male' construct of paranoid subjectivity (Freeman & Garety, 2000), in which there is a primary focus on ideas such as perceived harm from others. This may present potential consequences through the normalising or dismissing of other more relational, interpersonal and affective aspects of the experience, associated within this research with constructions of paranoid experiences in women. Further research should consider broadening the understanding of paranoia beyond purely focusing on perceived harm, giving an increased focus on the role of gender and the meaning of the experience for different groups. For example, researchers may wish to consider the type of measures utilised in measuring experiences of paranoia, and whether these

potentially capture only a narrow representation of experiences or ignore the gendered nature of the experience.

4.5.3.4. Intersectionality, gender and paranoia

One of the aims of the present study was to explore the role of intersectionality in gendered constructions of paranoia. However, whilst findings indicated some interesting points related to the potential differences in experiences of black men, and some variety in cultural constructions of gendered roles, due to the limitations discussed earlier this was not fully explored to the level hoped for. Further research may wish to consider alternative ways of investigating intersectionality in experiences of paranoia, through a more specifically designed study. Furthermore, whilst the present study elicited some discursive constructions of paranoia which were considered within interviews as more associated with either male or female experiences, future research should consider unpacking these constructions more. It may be important to consider the more nuanced aspects of gender, and the multiple forms of femininity and masculinity, intersected with class, race, and culture.

4.5.2. Clinical implications

4.5.2.1. Implications in psychological therapies for paranoia

The dominant psychological models of paranoia continue to be those based in a Cognitive Behavioural Therapy (CBT) model, such as in that posed by Freeman, Garety, Kuipers Fowler and Bebbington (2002). These models, whilst useful, have been previously critiqued for inadequately considering the relational, emotional, social and embodied aspects of the experience (Cromby & Harper, 2009). The present study, whilst small in scale, provides some additional support for the notion of bringing interpersonal, affective and social factors more to the fore in clinical work. This may be achieved though adapting cognitive models and formulations to include more socially based or systemic factors, such as what has been proposed in work with children and families (Dummett, 2006), which may be a potential focus for further research. Additionally, further research could consider the potential utility of alternative models of intervention, such as Compassion Focused Therapy (CFT), wherein the embodied and emotional experiences

associated with paranoia becomes the primary target for intervention (Lincoln, Hohenhaus & Hartmann, 2013); or Narrative Therapy, where attention is given more to how discourse impacts upon personal narratives, meanings and understandings of paranoid experiences (Rhodes & Jakes, 2009).

4.5.2.2. Reconstructing masculinity

The findings of the present study point towards potential ways in which the culturally available discourses of masculinity may limit both the expression of paranoid experiences in men, and the use of more relational, and emotionally expressive coping strategies. Whilst the impact of constructions of masculinity on help seeking is well known (Connell, 2005; Wong, Ho, Wang, & Miller, 2017), further research may wish to consider this more specifically in relation to experiences of paranoia. In terms of work clinically, Brooks (2010) proposes the development of transtheoretical and integrative approaches to therapeutic work with men, as a way of countering "strong aversion in males for any consideration of psychotherapy". However, further work is needed to better consider the varied and intersecting nature of constructions of masculinity (Wetherell & Edley, 2014), and to develop ways of working that may increase the accessibility of therapeutic approaches to men.

4.5.2.3. Public health implications

Whilst the research presented in this thesis is based on interviews with a relatively small number of individuals, some important preventative and public health implications can be drawn from the analysis. Results of the present study provide some indication that gender based discourses related to masculinity and femininity may contribute to how a person's experiences may be understood, as well as individual ways of expressing or responding, and subsequent likelihood or method of help seeking. In a recent British Psychological Society (BPS) Division of Clinical Psychology report on Psychosis and Schizophrenia (Cooke, 2014), several recommendations were made related to working at a preventative and public health level. Amongst these recommendations, the report suggested work was needed in order to promote equality and reduce discrimination related to gender. Similarly, a World Health Organisation (WHO, 2002) report recommends that gender disparities in mental health be addressed through targeting gender

discrimination, gender-based violence and gender-role stereotyping, though legislation, policies, and programmes of intervention. Further work is needed to explore the potential format of such interventions, and how to tailor specifically to experiences of paranoia. Existing programmes which may provide examples of such work include the Campaign Against Living Miserably (CALM), and the Movember Foundation in relation to men's mental health, and the Women's Mental Health Network which campaigns for more gender specific legislation and policy.

4.6. Conclusion

The present study was undertaken in response to existing research suggesting that more men than women experience paranoia in the general population. As opposed to taking a reductive approach, this study aimed to approach the topic from the perspective of discursive psychology, and investigate the culturally available discourses of 'paranoia' and 'gender'. This was undertaken through conducting semi-structured interviews, analysed utilising Foucauldian Discourse Analysis (FDA). The findings of the study demonstrated ways in which discourses of paranoia can reflect opposing ends of a continuum of experiences, as well as how these discourses can be gendered in nature. The study also demonstrated ways in which men and women can be positioned differently within the intersecting discourses of paranoia and gender, along with highlighting the gendered nature of paranoid subjectivity. Implications of these findings suggest that considerations of gender should be brought more to the fore in research and clinical practice, in order to provide a more nuanced understanding of the experience of paranoia.

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6. APPENDICES

Appendix A – Interview Schedule

Appendix B – Interview Vignette

Appendix C – Confirmation of Ethnical Approval

Appendix D – Participant Information Sheet

Appendix E – Participant Consent Form

Appendix F – Participant Debrief Sheet

Appendix G – Example Coded Transcript

Appendix A – Interview Schedule

1) Understanding:

- Have you heard the term 'paranoia' used? What does it mean to you? Can you think of any examples of it?
- (Working definition for study: Paranoia has been defined as "a way of perceiving and relating to other people and to the world that is characterized by some degree of suspicion, mistrust or hostility").
- Briefly discuss continuum: from everyday experiences >> more distressing/interfering with life

2) Gender:

- Some studies suggest that men score higher on measures of paranoia than women.
    - Do you think this is true? If so, what might explain it?
    - What comes to mind when you think about a 'paranoid' man? Or 'paranoid' woman?
- Do you think men and women might just experience paranoia differently?
    - Can you think of examples of men being paranoid?
    - Can you think of examples of women being paranoid?
    - If different, what might be the reasons their experiences might be different?

2) Share vignette:

- What do you think about this person's experiences?
    - Do you feel this person's experience was in any way affected by their gender, race, culture, social status etc?
    - Could their experience be different if they were a young black man/woman/from a richer/poorer family?
    - Would your impression/interpretation of their experiences be any different?

3) Are there ever any times where paranoia/suspiciousness in a man is appropriate or warranted?

- Would this be the same or different for women?
- What would be a sign things had tipped over into something where the feelings might interfere with one's life and cause problems with mental health?

4) Some studies suggest more men than women are interested in conspiracy theories.

- Do you think this is true? If so, why do you think this is?
- Do you think there is anything about being a man, about masculinity that makes men more prone to feeling paranoid or women less prone?

Appendix B – Interview Vignette

John is 18 and lives at home in North East London with his mum and younger sister. John remembers his parents always arguing when he was a child, and his dad eventually left the family when he was 9. John's mum has since struggled to get by, due to problems with money, the family have had to move frequently and are currently living in temporary accommodation. John has always found school difficult and has been labeled 'disruptive' and excluded on a number of occasions. He often has argued with his teachers, and constantly felt 'got at by them'.

Since John was a teenager, he has often worried about his family being unsafe or in danger. John believed the family might be being targeted by gangs in the local area, and that his father might have caused this. John would spend a lot of time watching people walking past the flat and around the area, taking note if he had seen them before and noticing that they would often stare at him. When he was around 16, John started to find it more anxiety provoking and threatening to be out, worrying that people had been tasked to attack or kidnap him. More recently, John feels that his family could be all under surveillance by the government, gangs, or both. He feels people could have installed surveillance equipment to monitor his phone, and cameras in the flat before they moved in. John also strongly suspects that the police are also involved, he has been stopped and searched several times and remembers how this even used to happen when he was younger.

Appendix C – Confirmation of Ethical Approval

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Jenni Brown

SUPERVISOR: David Harper

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Elliot Huggins

TITLE OF PROPOSED STUDY: Gender and the Construction of Paranoid Experiences in the General Population

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is <u>not</u> required but the student must confirm with their supervisor that all minor amendments have been made <u>before</u> the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

Approved with minor amendment

Minor amendments required *(for reviewer)*:

It would be better to give the participants a cut-off point to withdraw their data if they choose (e.g. within 2 weeks of taking part) as they will not know when analysis has started

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

	HIGH
	MEDIUM
x	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Jennie Brown

Date: 11/05/16

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Elliot Huggins
Student number: u1438308

Date: 20/05/2016

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

Appendix D – Participant Information Sheet

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
Elliot Huggins
u1438308@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this research study. The study is being conducted as part of my Doctorate in Clinical Psychology at the University of East London.

What is this study called?

"Suspicious Minds: a study about gender and paranoia"

What is it about?

The term 'paranoia' is used a lot in everyday talk. Sometimes people use it to refer to ordinary everyday experiences of wariness when there might be a good reason for this. At other times it may be used to refer to someone who is convinced others are out to get them in some way even if there doesn't seem to be strong evidence of this. If severe this could affect their mental health. There is some evidence that, although both men and women can experience these feelings, that it might be more common in men. I am interested in your views about this. The study is open to all whether they have experienced these feelings themselves or not.

What will happen if I decide to take part?

If you choose to participate in this study you will be invited to take part in an interview, to discuss how paranoia is understood and what people think about possible gender differences. You will not be asked to share any personal experiences (e.g. whether you have ever felt paranoid yourself) but you will be asked to share your views about the topic (e.g. what you understand by it? What you think might be the reasons for possible gender differences etc). Interviews will take place at UEL Stratford campus and will last approximately 60-90 minutes.

It is unlikely that taking part in an interview will be upsetting but, if it is, you are free to take a break or leave the interview at any time. The researcher will be available to answer any questions or queries that you may have.

Will what I say be confidential?

Recordings of interviews will be stored, typed up and saved in password-protected files on a password protected computer. No details which might identify you (eg your name) will be included in the transcript of the discussion. A pseudonym will be used in place of participants' names in order to protect confidentiality. Following completion of the study and submission of the project, audio recordings will be erased. Anonymised transcripts may be kept beyond this point, in order for further analysis and publication of the research.

Where will the study take place?

The study will take place at the Stratford campus of the University of East London.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. Should you withdraw once analysis has started, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ. D.harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Elliot Huggins

Appendix E – Participant Consent Form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

"Suspicious Minds: a study about gender and paranoia"

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data.

It has been explained to me what will happen once the research study has been completed. I understand that the researcher will use quotes from interviews in the write up of this study, but that all names and identifying details will be replaced with pseudonyms.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw once analysis has begun, the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher.

Participant's Name (BLOCK CAPITALS)

……

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

……..

Researcher's Signature

……

Date: ……..……

Appendix F – Participant Debrief Sheet

Debrief Information Sheet

"Suspicious Minds: a study about gender and paranoia"

Thank you for participating in this research study. Your contributions during the interview were very much appreciated.

This research project aimed to explore whether there was a relationship between gender and paranoia. We were interested in the way in which paranoia might be talked about and discussed within an interview setting. Analysis of the discussion will aim to make links between what was said and wider ideas about gender and paranoia.

Where can I go for further support?

If you feel affected by any issues raised during the interview today and would like further support, treatment or guidance, you can contact your local GP.
Additional support, advice or information may be found at the following locations.

Samaritans
Free helpline - 116 123

Saneline
National out-of-hours mental health helpline – 0300 304 7000

Mind
www.mind.org.uk
Mental Health Info Line – Call: 0300 123 3393, Text: 86463

www.nationalparanoianetwork.org

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr David Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ. D.Harper@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Thank you again.

Yours sincerely,

Elliot Huggins

aware, you know. If I heard something in the bush, I would be hyper sensitive to it and I would be quite readily aware of it, probably a normal level of paranoia. If I'm walking home drunk, ahhh! You know! There could be herd of elephants behind me and I'm not gonna notice. I would walk home wearing probably not enough clothes, probably I would take the short cut that I wouldn't usually take <I: Mmm>. And I have this decreased sense of paranoia, I'm not even am aware of the danger that in fact I am in. Whereas for instance if you were taking cannabis, there would be a heightened sense of paranoia. You would over emphasise. I mean I can remember one time I ran home because of some rustle in the bush [laughs] and that was it, I was off. Like something's gonna get me and that when fight or flight just kinda kicked in. <I: Yeah yeah> So quickly. So I think that's just one example of how and external force can really impact on your own level of paranoia.

I: Mmm yeah yeah. I think that's interesting. So it sounds like there's a few times for yourself then, that particularly when you are on your own out, you have experiences some kind of worry or paranoia.

B: Yeah I think so. I guess as well it's probably quite culturally constructed, that we believe walking home in the dark is actually more dangerous that walking home in the light. You know, whether it's evolutionary, or I'm not entirely sure. It is interesting how it can be dampened and heightened in one person. I would consider myself to be quite normal and not particularly paranoid, you know, but so yeah I guess that other social or psychological aspects could do the same.

I: Yeah, and there's some sense that, from what you were saying, that there might be an actual danger as well <B: Mmm>. I wonder if you could say a bit more about that.

B: Yeah okay yeah so, I mean, I guess like the idea of walking home by yourself, late at night. I think we are aware that there is a danger <I: right>. It's just to what point that gets amplified, or muted, I guess. Erm, because I think for a female, walking home alone in the dark, then there is a risk. You know I guess just there's less people about, so you're less likely to be discovered if something did happen. So there is a risk to be aware of. Most certainly once the paranoia goes too far, it again becomes maladaptive. Because me being spooked and running, is actually putting me in a more vulnerable situation, you know <I: Right>. I'm out of breath, I'm quick on my feet, I'm not taking note of my environment in the same way you would be if you were just steadily walking. So yeah I don't know.

I: So there can be a, sort of almost a fine line between adaptive responses or not one?

Positioning self
"Normal"
"Not particularly"

concept of 'norm paranoia

'useful' para

drugs and par

fight or flig

reasonable/vs unreasonable

paranoia as danger when t is no

Paranoia as abnorma

'Actual' leve danger vs amplifi du

A Female risk when alone ri

Maladaptive adaptive Para

based on n to self

B: Yeah definitely. And I guess if that can be altered on an individual basis, through some substances in quite a transient state, you could imagine it could be altered within individuals based upon other things, but maybe in more of a fixed way. I guess. I guess in another way you know, obviously the feeling of paranoia is like punishment, then the running away is like a reward, and so in some way that could reinforce the running away behaviours. Then therefore it makes somebody more paranoid <I: Mmm mmm>. Whereas sort of maybe the facing of the fears, could then work to make somebody less paranoia. So I think that actually, you know, I walked home ten times in a row and nobody jumped out at me, it's probably quite safe, you know. But if you always ran home, or you always avoided it by taking a taxi, or something like that, it would just reinforce that it's not safe and I have to choose a different behaviour.

I: Mmm yeah. Thinking about it now, are there any other examples of paranoia in people you know or have worked with or?

B: Mmm yeah. I mean I had a boyfriend once who was insanely paranoid, that because he had tattoos, doctors, especially Asian doctors, would want to contaminate him with aids, if he was going to go their practice for anything. Which was obviously quite a paranoid belief. Which is quite a weird one as well. Because it doesn't fit with what I was saying before about it being born out of something and reinforced. Cause there was no, like that never happened [laughs]. There was no way for that to be reinforced. So <I: mmm> that's quite an odd delusion, I guess, in that respect.

I: Mmm right. And did he find that, was that difficult for him, or was he, did he let it affect things?

B: Erm only just in as much as he didn't seek medical treatment, where he should you know <I: Right mmm>. So I guess you know, most, like the worst example of that was that he had a mole that was giving him some kind of trouble, so instead of going to see the doctor he kind of dug it out with a potato peeler [laughs]. Which you know is quite an extreme action to take, to avoid having to go and see a doctor, because you think they are going to give you aids <I: mmm>, yeah. Again I'm not quite sure where the fear of the aids came from, and it didn't seem to be like a blanket thing. He wasn't afraid of germs or anything else. It only seemed to be the doctor that he was afraid. I don't know, maybe there was a position of authority there, or something like that, and distrust for authority.

I: And it was very specific then?