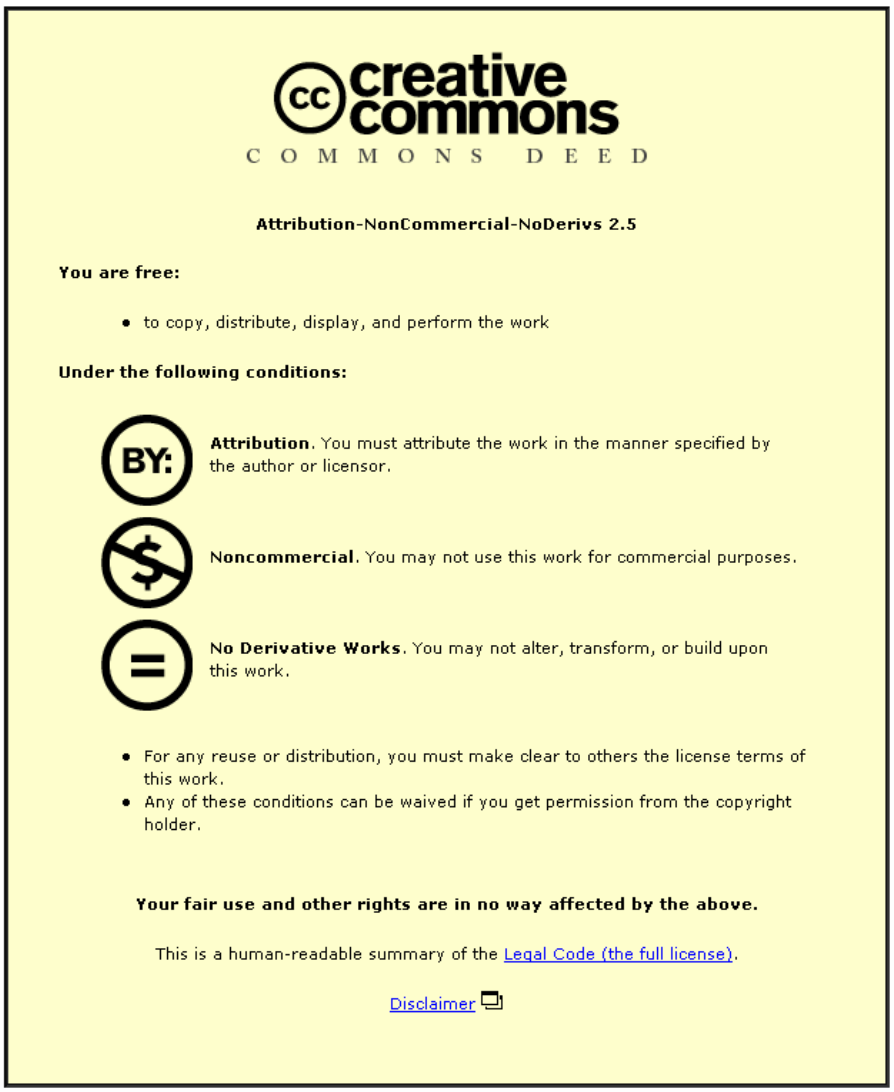

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Paranoia and Social Inequality

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Figures in square brackets in the text [p.xx] *give the page numbers for the published version*

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[p.17]

How might we make sense of the findings of epidemiological research showing the effects of social inequalities without accepting the validity of problematic diagnostic categories used by psychiatric epidemiologists (Rogers & Pilgrim, 2003)? How might we make sense of processes happening at a community and systemic level without neglecting individual experience? How should we conceptualise experiences which are embodied (i.e. felt and transmitted through our biological systems) without falling prey to dualistic or biologically reductionist thinking?

In this article, we hope to examine the links between social inequality and paranoia without falling into such traps. We use the term 'paranoia' broadly. Although single symptom research into psychosis has made great strides (e.g. Bentall, 2004) we feel there is benefit to be gained from taking the experience of paranoia as a starting point rather

than beginning with an unnecessarily narrow operational definition of, for example, the diagnostic criteria for persecutory delusions. Paranoia, of course, is well-represented in psychiatric diagnostic categories (e.g. paranoid schizophrenia, delusional and personality disorders) and is in some measure a feature of many people's everyday lives. However, focusing on such categories assumes that the differences between them are both valid and more important than the commonalities in the experiences they represent. Accordingly, we begin by presenting a brief critique of psychiatric thinking about paranoia, followed by a re-theorization that focuses on the social and material constitution of experience through feelings. We end by outlining some implications for intervention.

Psychiatry and Paranoia

Traditionally, psychiatric theorising assumes that experiences of paranoia are simply irrational and false, a sign of pathology whose context and content are meaningless (Harper, 1996, 2004). However, there are grounds for rejecting each of these assumptions.

Even though many "normal" everyday beliefs lack supporting evidence, psychiatry typically adopts a naively realist stance towards paranoia, and diagnosis rarely involves empirical investigation. Maher has argued that the assessment of the plausibility of beliefs is 'typically made by a clinician on the basis of "common sense," and not on the basis of a systematic evaluation of empirical data' (1992, p.261) and there appears to be some empirical evidence of this (McCabe et al., 2002).

The view that paranoid beliefs are simply pathological and irrational ignores evidence that people vary in the strength of conviction with which they express them (Garety, 1985), that irrational beliefs are highly prevalent in our culture – for example, with respect to the supernatural, and that "everyday" suspicion and mistrust are also more prevalent than might be expected (Social Surveys/Gallup Poll Ltd, 1995). Delusional beliefs, too, are more common than psychiatry presupposes (e.g. van Os, 2000; Poulton et al., 2000). The dimensions which seem to differentiate between those who do not come into contact with mental health services and those who do are not their beliefs *per se* but the levels of distress, conviction and preoccupation associated with them (Peters et al., 1999). Moreover, although mainstream psychiatry traditionally treats the content of paranoid [p.18]beliefs as meaningless, they often relate to purpose and meaning in a person's life and can be associated with life experience (Rhodes & Jakes, 2000) or wider societal influences (Mirowsky & Ross, 1983).

In sum, psychiatric theorizing reductively individualises and medicalises a complex phenomenon, obscuring its links with social conditions. To redress this problem we now offer an alternative understanding of paranoia, focusing on how social and material conditions produce feelings which, we suggest, are the primary cause of paranoia.

Re-theorising paranoia

Perhaps the most prominent component of human consciousness is language, the "inner voice" that provides a running commentary on our actions. But consciousness also has a non-verbal component which, to use Vygotsky's memorable terminology, our inner voice "completes". This non-verbal component consists of feelings. Feelings include emotions

of all kinds, motivational states such as hunger or thirst, and the more subtle feelings associated with inarticulate refusals or half-formed desires. Although feelings are fundamental to human consciousness, in our culture their contribution to action is frequently downplayed. When we reflect upon the reasons why we act as we do, we tend to attribute our decisions mainly to rational-discursive factors. Whilst such factors indeed contribute, the ever-present role of feelings as the ground upon which they are weighed and assessed is often ignored or under-emphasised. The alternative view (supported by most psychodynamic psychologies, cognitive psychologists like Zajonc and neuroscientists such as Panksepp and Damasio) is that feelings have a kind of nuanced primacy in human consciousness and are the *primary* determinants of motivation and choice.

Moreover, these feelings are not just biological drives or innate instincts - they are also *socialised.* There are many resources we can draw upon to understand this; limitations of space mean just two will be briefly addressed here. First, there is extensive evidence that emotions, the archetypal class of feelings, are thoroughly socialised. Whilst Ekman and others hold that there are biologically hardwired basic emotions, it has nevertheless proved difficult to determine precisely how many such emotions there are. Furthermore, even Ekman agrees that *all* emotions appear within local moral orders that determine the circumstances within which it is appropriate to experience them. Additionally, the "display rules" that regulate how emotion can permissibly be expressed show extensive cross-cultural variability. Further evidence for the socialisation of emotion is provided by evidence that some cultures have emotions that others do not.

Second, Damasio's (1994) neuroscientific work suggests that memories for events are not only auditory or visual: they also include memories of feelings, the body-state profiles that accompanied them. On future occasions when those events might be relevant, their accompanying feelings can be subtly reactivated and influence decision-making. When positive feelings previously associated with an option are reactivated, they serve both to focus our attention upon it and make it appear more desirable. Negative feelings do the opposite, encouraging neglect and unfavourable evaluation. Damasio calls these reconstituted feelings "somatic markers", and his work with brain-injured people suggests they play a critical role in decision-making in social settings.

Socialized feelings, then, provide the primary, pre-cognitive ground upon which we humans engage with the world, from which we assess it and make decisions. They are the evaluative terrain upon which cognitions and perceptions are already played out, the pre-reflective structure of meanings from within which thoughts and perceptions are always already textured (Merleau-Ponty, 1962/2002). It is not simply that feelings provide information about our evaluation of a situation, although they may. More importantly, before any conscious information processing occurs, feelings shape our reactions in two ways. First, because they focus our attention on some aspects of a situation rather than others they shape our perceptions. Second, because they shape our evaluations of what [p.19]we perceive, they inform our interpretations and choices.

Simply put, our argument is that paranoia is principally the outcome of such feelingful processes. It is therefore likely to afflict people whose safety, self-worth or competency

has continually been challenged, and who have received little respite or compensatory loving reassurance from others. Such people may acquire, in response to their experiences, an enduring, inchoate, habitually fearful way of being in the world, and a corresponding mode of perceiving and thinking. Feelings do not happen to the same rapid timescale as rational-discursive processes, and are not as neatly encapsulated as meanings in language. Moreover, the decisions and perceptions they regulate arise in human worlds where others will react to and interpret them. Feelings can therefore initiate and maintain trajectories of social interaction that have the unfortunate effect of stigmatising or isolating the person, further intensifying their fears and anxieties and "proving" their initial validity. Over successive interactions, fear and anxiety may thus come to structure people's perceptions and interpretations so thoroughly that they can barely be recognised as such. It can then seem mostly obvious that the threats, slights, insults and exclusions people perceive are simple, incontrovertible features of how the world actually *is*.

On a case-by-case basis such outcomes may be represented as attributional errors or individual cognitive processing biases. However, in our view this cognitive approach wrongly individualises experience, unjustly translating the acquired effects of adverse socialisation into information processing flaws. In contrast, we highlight the social and material conditions of social inequality, which can encourage relatively paranoid ways of being in the world.

For example, there is evidence that disadvantaged areas typically have increased risks of assault, burglary and theft, greater prevalence of graffiti, vandalism, derelict buildings and street gangs, and are characterised by powerlessness and low levels of trust (Ross et al 2001). People there are more likely to be unemployed or homeless, to have experienced social isolation, and to have fewer opportunities, more restrictive choices and fewer resources. There are synergistic associations between these social and material conditions and adverse socialisation (see Nightingale & Cromby, 2002), and ethnographic studies clearly demonstrate their painful impact upon individuals (Charlesworth, 1999). Perhaps unsurprisingly, then, there is evidence that paranoia is associated with immigration and low socio-economic status (Kendler 1982), refugee status (Westermeyer 1980), experience of victimisation and stressful life events (Johns et al 2004). People with a diagnosis of schizophrenia often have paranoid experiences, and research shows that people with fathers occupying low socio-economic status and who were born in a deprived area are 8.1 times more likely than others to receive such a diagnosis (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001); that Black and Asian people in the UK are 50% more likely to be diagnosed with schizophrenia than white people (King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994); and the prevalence of schizophrenia diagnoses is higher among Black people living in majority white areas (Boydell et al 2000).

It is perhaps no surprise that if you have been excluded, marginalised, discriminated against or have faced victimisation you may start to experience the world as a fearful place, although our ways of being in the world are also shaped by wider cultural forces and more local experiences like family relationships. For example, the possibility that paranoia is more common in men (Johns et al., 2004) and young people (Ellett, Lopes &

Chadwick, 2003) merits investigation. However, space does not permit further exploration here.

Implications for Intervention

How might an approach like this inform interventions? At an individual and family level we need to acknowledge the socially constructed nature of judgements about beliefs and not necessarily focus on their 'truth' or otherwise. Instead we should pay attention to the content of a person's para-[p.20]noid belief and be sensitive to its context in the light of their personal history. We should aim at enabling people to get a better 'fit' between their beliefs and the lives they wish to lead. Research on those who hear voices highlights the benefits for people of developing explanations which allow them to make sense of their experiences (and do not unduly distress them); which provide contact with a community which shares these meanings (e.g. spiritualist churches, hearing voices group etc); which involve certain helpful practices (e.g. meditation, political action etc.), and which allow them to continue living their lives in a relatively undisrupted manner (Romme & Escher, 2000). From our perspective, it is highly relevant that feelings of safety, security, warmth and even love, are likely to be integral to such groups and practices.

However, work at an individual and family level is not enough. We should support initiatives to combat the social isolation produced by the fragmentation of community life and the excessive individualism of Western culture. One approach is to help set up support groups for people experiencing paranoia, similar to those fostered by the Hearing Voices Network (James, 2003; Knight, 2004). There is also a need to build trust within neighbourhoods in order to combat victimization, and to support broader initiatives aimed at addressing social inequalities and fighting victimisation and racism (activities engendering feelings of solidarity and belonging and a sense of identity which may themselves be therapeutic). Finally, these approaches are unsustainable without national policies which consistently challenge discrimination and injustice. In a sense, we could view the received psychiatric view of paranoia as a form of 'false consciousness' which obscures the real causes of distress, locating it in faulty brain mechanisms, rather than out there in a sometimes hostile world. In contrast, we could draw on ideas from liberation social psychology (Burton, 2004) to facilitate a process Ignacio Martin-Baro called *conscientización* by which people can educate and liberate themselves from oppressive social conditions.

References

Bentall, R.P. (2004). *Madness Explained: Psychosis and Human Nature.* Penguin: Harmondsworth.

Boydell, J., van Os, J., McKenzie, K., Allardyce, J., Goel, R., McGreadie, R.G. & Murray, R.M. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal*, **323**, 1336-1338.

Burton, M. (2004). Liberating psychology in Latin America. The Psychologist: Bulletin of the British Psychological Society, **17**, 584-587.

Charlesworth, S. (1999). *A Phenomenology of working class experience*. Cambridge: Cambridge University Press.

Damasio, A. R. (1994). *Descartes Error: emotion, reason and the human brain*. London: Picador.

Ellett, L., Lopes, B. & Chadwick, P. (2003). Paranoia in a nonclinical population of college students. *Journal of Nervous and Mental Disease*, **191**, 425-430.

Garety, P. (1985). Delusions: Problems in definition and measurement. *British Journal of Medical Psychology*, **58**, 25-34.

Harper, D.J. (1996). Deconstructing 'paranoia': Towards a discursive understanding of apparently unwarranted suspicion. *Theory & Psychology*, **6**, 423-448.

Harper, D.J. (2004). Delusions and discourse: Moving beyond the constraints of the rationalist paradigm. *Philosophy, Psychiatry & Psychology*, **11**, 55-64.

Harrison, G., Gunnell, D., Glazebrook, C., Page, K., & Kwiecinski, R. (2001). Association between schizophrenia and social inequality at birth: case-control study. *British Journal of Psychiatry, 179*, 346-350.

James, A. (2003). Voices of reason. *The Guardian*, 10 December.

Johns, L.C., Cannon, M., Singleton, N., Murray, R.M., Farrell, M., Brugha, T., Bebbington, P., Jenkins, R. & Meltzer, H. (2004). Prevalence and correlates of self-reported psychotic symptoms in the British population. *British Journal of Psychiatry*, **185**, 298-305.

Kendler, K.S. (1982). Demography of paranoid psychosis (delusional disorder): A review and comparison with schizophrenia and affective illness. *Archives of General Psychiatry*, **39**, 890-902.

King, M., Coker, E., Leavey, A., Hoare, A., & Johnson-Sabine, D. (1994). Incidence of psychotic illness in London: comparison of ethnic groups. *British Medical Journal, 309*, 1115-1119.

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

Maher, B.A. (1992). Delusions: Contemporary etiological hypotheses. *Psychiatric Annals*, **22**, 260-268.

McCabe, R., Heath, C., Burns, T. & Priebe, S. (2002). Engagement of patients with psychosis in the consultation: Conversation analytic study. *British Medical Journal*, **325**, 1148-1151.

Merleau-Ponty, M. (1962/2002). *Phenomenology of Perception*. London: Routledge.

Mirowsky, J. & Ross, C.E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, **48**, 228-239.

Nightingale, D. J., & Cromby, J. (2002). Social Constructionism as Ontology: exposition and example. *Theory and Psychology, 12*(5), 701-713.

Peters, E.R., Joseph, S.A. & Garety, P. (1999). Measurement of delusional ideation in the normal population: Introducing the PDI (Peters et al. Delusions Inventory). *Schizophrenia Bulletin*, **25**, 553-576.

Poulton, R., Caspi, A., Moffitt, T.E., Cannon, M., Murray, R. & Harrington, H. (2000). Children's self-reported psychotic symptoms and adult schizophreniform disorder: A 15 year longitudinal study. *Archives of General Psychiatry*, **57**, 1053-1058.

Rhodes, J.E. & Jakes, S. (2000). Correspondence between delusions and personal goals: A qualitative analysis. *British Journal of Medical Psychology*, **73**, 211-225.

Romme M. & Escher, S. (eds) (2000). *Making Sense of Voices.* London: Mind publications.

Rogers, A. & Pilgrim, D. (2003). *Mental Health and Inequality*. Basingstoke, Hampshire: Palgrave MacMillan.

Ross, C.E., Mirowsky, J. & Pribesh, S. (2001). Powerlessness and the amplification of threat: Neighbourhood disadvantage, disorder and mistrust. *American Sociological Review*, **66**, 568-591.

Social Surveys/Gallup Poll Ltd. (1995). Paranormal behaviour. *Gallup Political Index*, **415**, 24.

Van Os, J., Hanssen, M., Bijl, R.V. & Ravelli, A. (2000). Strauss (1969) revisited: A psychosis continuum in the normal population? *Social Psychiatry & Psychiatric Epidemiology*, **26**, 287-292.

Westermeyer, J. (1989). Paranoid symptoms and disorders among 100 Hmong refugees: a longitudinal study. *Acta Psychiatrica Scandinavica*, **80**, 47-59.