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Understanding Paranoia: Toward A Social Explanation

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ABSTRACT

In this paper we seek to offer an essentially sociological explanation of paranoia by way of a detailed examination of the case of an unmarried, ex-school-teacher who for the past 30 years has clung stubbornly to the belief that she is the victim of an ill-defined group of conspirators with the power to control her thoughts and actions. Taking as our starting point Lemert's seminal 1962 paper, we argue that paranoia is best understood, not as a disease in the accepted medical sense, but rather as a desperate attempt on the part of the sufferer to protect self from the consequences of a public identity at odds with self-image, and that its origins are to be sought in a combination of frustrated ambition, persistent failure and emotional isolation

In this paper we set out to account for one particular form of mental disorder—paranoia—using an explicitly sociological perspective. We argue that the tendency, of even the more sociologically sophisticated medical writers to view the phenomenon as a disease located primarily in the individual inevitably reduces the social to the biological or psychological, and

unhappily has obscured some important insights derived from clinical practice. Our intention is not simply to rescue social factors from the marginal position to which they have been consigned in so much of the psychiatric literature, but to reassert the power of sociological theorizing in the understanding of human behavior, including aberrant behavior.

Our explanation of paranoia does not assume an underlying disease. This is not to deny the presence, or possibility of bio-physical morbidity. We do, however, suggest that such morbidity is largely irrelevant to the events typically surrounding the "disease" and is unnecessary to any sociological explanation, except in so far as the concept of "disease" is used as a means of accounting for the paranoid behavior, both by the paranoiac and by various authorities (medical, legal etc.). Our explanation focusses on a social process emerging through time and space via behavioral and cognitive activity in which the use of language and symbols play a crucial part. We specifically address the account offered by the paranoiac (more commonly dismissed as "delusions"), as well as the accounts proffered, and preferred by others, doctors especially. Our interest is in the symbolic construction of paranoia—both by the paranoid person and by society at large.

In taking this position we should perhaps make it clear that we are not allying ourselves with the so-called "anti-psychiatry" movement. We do not believe that paranoia is merely a social category, invented by an authoritarian social system and deployed by the medical profession as a means of social control. Paranoid behavior is real enough, and to be drawn into the bizarre world of the paranoiac can be a frightening, or at least, extremely disconcerting experience. When they turn nasty—either physically or legally—as they often do, intervention is necessary, not, as we will argue, for authoritarian, but for humanitarian reasons; that is, generally with the best interests of the paranoiac, as well as others with whom s/he is engaged, in mind.

Psychiatry and the Concept of Paranoia.

The phenomenon which concerns us has been variously described as "paranoid disorder" (A.P.A., 1980), "paranoid reaction" (Batchelor, 1969; Cameron, 1959), "true paranoia" (Bonner, 1951), or "paranoid state" (Freedman, Kaplan, & Sadock, 1972). All refer to a disorder that is characterized by the appearance of chronic and intractable delusions of a grandiose, erotic, or persecutory nature, but in which other psychological functions, such as memory, consciousness, affect, intellect, and personality,

remain well preserved. Psychiatrists typically approach paranoiacs with a well-founded pessimism:

The prognosis of well-established systematized paranoid delusional states is extremely serious. It is very seldom that such cases ever make an adequate, or satisfactory adjustment, irrespective of any form of treatment which may be employed. A person so affected believes that he is right, that he is justified in his beliefs, and that anyone who opposes his point of view is behaving maliciously, or at least non-understandingly towards him. The illness in most cases runs a more or less autonomous course, with gradual worsening and increasing alienation from others. (Batchelor, 1969 p. 306)

Within psychiatry there is some reluctance to accord paranoia the status of a separate disease entity. In the nineteenth century, for example, dispute over the "paranoia question" divided German psychiatry. The French have never been happy with the term, while British psychiatrists, as Lewis (1970) has noted, prefer the more non-committal adjective "paranoid."

This uncertainty arises in part from the obvious presence of paranoid ideas and behavior in what are clearly other, well defined forms of illness or states, such as in paranoid schizophrenia or substance abuse. In DSM III, however, paranoid disorders are recognized as complete and separate entities quite distinct from paranoid schizophrenia (A.P.A., 1980). Batchelor (1969), too, argues that the paranoid psychoses can be distinguished from schizophrenia in terms of sex, age of onset, social class, personality, and the absence of many symptoms commonly found in the latter condition, such as incoherence of thought, incongruity of affect, volitional disorders, and catatonic symptoms.

Given the confusion over the definition, and even the existence, of paranoia, it is hardly surprising to find little consensus on matters of etiology. At one extreme are the psychoanalysts, who, although a diverse bunch, are at least agreed that the problem resides in intra-psychic processes originating in early childhood (see eg., Freud, 1927; Glover, 1949; Klein, 1932, 1948, 1961; Meissner, 1978; Winnicott, 1958). Their work, and that of their followers, has produced many detailed case studies that have yielded valuable insights, especially into the family dynamics involved. Yet too often couched in overly reductionist and opaque terms they frequently stand accused of explaining everything, and therefore, ultimately nothing. Quite different in both style and substance is a body of research that eschews theory for a more cautious listing of traits, characteristics or fac-

tors predisposing to, or in some way linked with, paranoia, but whose etiological significance remains for the most part associational. Between these extremes is a voluminous literature of varying ambition, theoretical sophistication and explanatory coherence (see especially, Cameron, 1943a & 1943b; Swanston, Bohnert, & Smith, 1970). A detailed review of this work is beyond the scope of this paper. Here we will content ourselves with a number of general observations, whose sweeping nature we freely acknowledge, but which we would argue apply, to a greater or lesser degree, to all (or perhaps more advisedly, since we are dealing with an extremely heterogeneous body of work, almost all) psychiatric writing on paranoia.

First is the tendency to locate the problem within the individual. Some writers intend this quite literally, while others imply a more metaphorical usage and take a wider view of causation and responsibility. But the appeal is ultimately and invariably to some unpleasant attribute or condition that in some way attaches itself to the individual. Whether the villain is a malfunctioning brain cell, some psycho-sexual trauma of early childhood, or a particular constellation of personality factors, the clues to the problem lie buried deep within the individual, recoverable only with professional assistance. It is this commitment to individualism that prevents a shift away from the medical model towards a more thoroughly social explanation. At the same time, it reinforces the tendency to view as disease, or at least as the symptoms of disease, what may more usefully be seen as strategic behavior.

Second, the body of work we refer to contains a highly deterministic model of human action. Paranoiacs, and by extension, human beings generally, are portrayed as creatures driven inexorably toward their destiny—by biological processes, inner psychic forces, or external circumstances. The particular variables and their precise relationship to each other in the causal chain are of little consequence compared with the general commitment to this principle of determinism. The possibility that men and women as essentially rational and purposeful actors might exercise a degree of control, not only over their environment but also over their own natures, and that action might involve choice from a variable range of options, is largely discounted.

Third is the assumption of pathology; that unpleasant conditions (in this case paranoia) must have equally unpleasant antecedents (such as a stunted or distorted personality, over-demanding or repressive parents, or a conflictual family life). Of course all this follows from the decision to treat paranoia as a disease or illness similar in all general respects to any other disease or illness known to medical science, with its own clearly defined and recognizable cluster of signs and symptoms, and located, in the final

analysis, whatever exogenous influences it may be subject to, within the individual sufferer. It is precisely this concept of paranoia which we regard as unhelpful and which we wish in this paper to challenge.

The account of paranoia that we advance rests on a fundamentally different model of human action and conceptualization of the phenomenon from the one that lies buried within so much of the literature on the topic. We hold that social action (or behavior) is an extraordinarily subtle and complex phenomenon which requires for its competent enactment a number of delicate skills. It is in the first instance oriented to its immediate social context. Above all, we believe that behavior cannot be understood without close inspection of its cognitive component, since it is in the process of defining and naming that human actions are given meaning, enabling us to classify them as of this or that type. Because, whatever else it is, paranoia is a form of social behavior, defined essentially in terms of deficient, or threatened, social relations, we would expect to locate its genesis and development in the network of relationships and interaction patterns that constitute the sufferer's social world.

The one author who has attempted to construct an explanation of paranoia in these terms is the American sociologist, Edwin Lemert, and his remains the classic—indeed virtually the only—sociological statement on the subject. Lemert (1967) insisted on the need to shift the focus of interest in the study of paranoia “away from the individual to a relationship and a process.” In doing so, he argued, “we make an explicit break with the conception of paranoia as a disease, a state, a condition or a syndrome of symptoms” (Lemert, 1967, p. 198).

Although Lemert makes some characteristically insightful comments on the genesis of paranoia, his paper focuses more narrowly on its development and persistence. This distinction, which is clear in his paper, serves to remind us that in much of the writing on paranoia there is a tendency to conflate what are essentially three related, but analytically separate, questions. First, what conditions (or social factors) trigger the behavior? Second, why, when faced with these conditions, do some individuals, but not others, respond in a paranoid fashion? Third, why does the behavior assume the form and course that it does?

Overwhelmingly, the concern in the psychiatric literature has been limited to the second of these three questions—why do certain individuals, but not others, behave in a paranoid fashion—a preoccupation that neatly incorporates the twin features of individualism and determinism. But, we contend, not only does this fatally distort the phenomenon being investigated, it also presents an inappropriate and misleading model of explanation that ignores the fact that “patterns of behavior develop in orderly

sequence....(and that) what may operate as a cause at one step in the sequence may be of negligible importance at another step." What is required is a form of explanation that combines "objective facts of social structure and changes in the perspectives, motivations, and desires of the individual" (Becker, 1963, p. 23), and in so doing fully reflects the emergent character of paranoia.

Method: The Case Study

Our argument in this paper proceeds from a detailed examination of a single case history. The case in question is that of an unmarried former school-teacher (whom we shall call Ms. Tennant) who in 1978 was admitted to the psychiatric unit of a large general hospital with a diagnosis of paranoid psychosis. She was then in her early 50s, and with both parents deceased, living alone. In appearance she was very much the stereotypical "old maid": she wore no make-up, and with her greying hair always severely pulled back in a bun, she had at times a rather imperious look. Her clothes were drab and old-fashioned, and seemingly deliberately designed to deny her sexuality; she wore "sensible," lace-up shoes, thick woollen stockings, voluminous, ill-fitting skirts, and usually two or three sweaters or cardigans—"a walking yard-sale" was how one junior doctor, perhaps unkindly, but not inaccurately, described her.

This lady maintained (and continues to maintain) that she was the victim of a malicious, yet ill-defined conspiracy, which destroyed her career and ruined her life. The details of this "plot" are not easily grasped, as the contents of the delusions seem to assume different forms at different times, probably reflecting her current concerns and worries. The essential elements, however, remain unchanged. The conspiracy is organized by a shadowy group of nameless individuals, whose identity is uncertain—even, apparently, to Ms. Tennant herself. It is not clear whether she has ever seen them, or indeed would recognize them if she were to encounter them. All her talk, however, implies that they do assume an incarnate form, which does at least lend her story an immediate plausibility. Acting, wittingly or unwittingly, as agents of the main conspirators is a vast, and again ill-defined, army of "proles" (a term borrowed from Orwell to suggest the nightmarish quality of her situation). The "proles" are recruited from the very real people she meets in her daily life—neighbors, colleagues, tradesmen, doctors, etc. Ms. Tennant firmly believes that the conspirators, and perhaps their agents, have the power to monitor her actions, private conversations, and even her thoughts. To guard against this and its terrifying

implications she must exercise a constant vigilance and resort to all manner of devious, and outwardly bizarre, stratagems.

The case first came to our attention upon Ms. Tennant's admission to the hospital. In the course of her stay, she struck up a relationship with one of the present authors (DM). This relationship, which continued long after her discharge from the hospital and, later on, from psychiatric treatment altogether, was to prove more intensive and enduring than any she had previously experienced (excepting, perhaps, that with her parents). For the six years, the two met on a weekly basis. Later, following a six month sabbatical break, the meetings were reduced to one a month. In total, DM has spent more than 300 hours talking with Ms. Tennant. Detailed notes were kept of their conversations, especially in the early years. Tape-recording was, for obvious reasons, not possible, and note-taking generally had to proceed circumspectly. Ms. Tennant's talk assumes a repetitive, circuitous, frequently allusive, and always guarded character, which makes it difficult at times to follow or immediately grasp its meaning. For this reason, an attempt to produce a chronological account of what was said during the course of each session was soon abandoned as it proved too time-consuming and confusing. Instead, notes were organized around particular topics that had arisen in the course of the discussion.

The meetings with Ms. Tennant were initially prompted by a more general, if somewhat vague, interest in patient perceptions of psychiatric treatment. While sociological concerns remain at the center of what is a continuing involvement,—and we offer this paper as some proof of that claim—the relationship (inevitably so, given the lady's preoccupations and our methodology) has been transformed into a quasi-therapeutic one. This, of course, raises important ethical and methodological issues that we cannot deal with here beyond acknowledging their existence. We do, however, wish to point out that while we have never discussed the nature of our sociological concerns with Ms. Tennant—in part because she has not shown the slightest interest in them, and in part, too, because these concerns have genuinely evolved over time and have not therefore been wholly accessible even to us—she is under no illusion that she is speaking to anyone other than a sociologist, who lays no claim to any psychiatric expertise or therapeutic competence.

Whether or not Ms. Tennant is a typical paranoiac is not relevant to our purpose or our method. Indeed, whether in fact she is "really" paranoid at all (whatever that might mean) does not particularly concern us. It is sufficient for our purposes that two highly competent psychiatrists on separate occasions came to the conclusion that she is. As Mitchell (1983, p. 190)

has convincingly argued, in case studies “extrapolation is in fact based on the validity of the analysis rather than the representativeness of the events.”

The version of Ms. Tennant’s life that we present in this paper has been derived almost exclusively from what she alone has told us (although that does not necessarily make it her account), supplemented with data taken from her case notes. We have made no attempt to seek out the views of those—family, friends, neighbors, colleagues, doctors, social workers, and others (although we have talked extensively to her psychiatrists)—who, over the years, have been drawn into Ms. Tennant’s world. We acknowledge this as a serious weakness, but plead sound practical and ethical reasons for our decision. In the end the validity of our account rests largely on appeals to plausibility, and in crucial places to the internal consistency of the evidence. We do, however, contend that our explanation accounts for most of the known ‘facts’ in this case, enables us to predict how Ms. Tennant is likely to act, and provides a basis for her continuing management. We are not sure that in practice more can be asked of explanations than this.

Case

Origins

Ms. Tennant was an only child of elderly parents. Her mother, who had had a number of miscarriages, was aged 40 when she was born. Her father, having spent some time in the British army, was then serving as an officer in one of Scotland’s more forbidding pre-war prisons. Her childhood and adolescence coincided with the “Depression” years and World War II, and some of the austerity of that period seems to have rubbed off on her. Her family was fairly comfortably placed, however, and there is no evidence that she suffered particular hardship or, more generally, that her upbringing differed markedly from that of any other girl of her time or place. While difficult to judge from this distance, her parents seem to have possessed all the virtues, and faults, of the Scottish middle classes: hard-working and self-reliant; strong on discipline and self-control; overly concerned with appearance and respectability; and above all, possessing a well-defined sense of what is right and proper. Her father, especially, appears to have been somewhat aloof and authoritarian, but again no more so than any man of his generation and background. Not unnaturally, Ms. Tennant developed a closer relationship with her mother. While neither parent was much given to open displays of emotion, they seem, nonetheless, to have cared deeply

for their daughter. However, when her paranoia first manifested itself in symptoms that could no longer be ignored (a necessary circumlocution because it is in the nature of paranoia that its onset cannot be precisely identified), both were then in their seventies; and, although clearly distressed and bewildered by what was happening, they no longer had the intellectual or physical powers to offer much practical help.

Ms. Tennant apparently was an intelligent child and much was expected of her, not least by her parents. But upon leaving school at age 17, having done reasonably well in her examinations, she drifted rather aimlessly for a time, much to their disapproval. There was a succession of mostly "dead-end" jobs, and at least two periods working and living away from home. However, she seemed to have put all of that behind her when at the age of 21, and much to her mother's satisfaction, she gained a place at the University.

The picture that emerges of Ms. Tennant at the University is an ambiguous one. Although she continued to live at home, her circle of acquaintances widened and her social life took on a new depth. She even appears to have "dated" occasionally, although not on a regular basis; photographs taken at the time show her to have been a not unattractive young woman. On the other hand, there is some evidence that even then her behavior was regarded as somewhat strange by her contemporaries and that she remained a marginal, socially isolated figure.

All of us from time to time are prone to misconceptions about the nature of the world around us and our place in that world. For the most part this is not too disastrous because as we tentatively test our interpretations in the company of close friends and family, we are encouraged and enabled, usually without too much fuss or mortification, to revise them and bring them into line with the views of others. This is such a subtle process that we are rarely conscious of it, but as Berger (1963) has noted, it is crucial to the construction and maintenance of a viable sense of self:

Identities are socially bestowed. They must be socially sustained and fairly steadily so. One cannot be human all by oneself, and apparently one cannot hold onto any particular identity all by oneself. (Berger, 1963, p. 118)

Lacking close, confiding relationships, Ms. Tennant turned instead to 19th century literature and the cinema for her role models. In these circumstances, it is hardly surprising that the persona that emerged as she entered adulthood was both distorted and deficient, concealing a highly romantic, yet unrealizable self-image.

Failure

Lemert has suggested that the origins of paranoia are to be found in "...persistent interpersonal difficulties between the individual and his family, or his work associates and superiors, or neighbours, or other persons in the community." In turn, these difficulties frequently center on some actual, or perceived, status loss or failure, "which may appear unimportant to others," but whose "unendurability...is a function of an intensified commitment, in some cases born of an awareness that there is a quota placed on failures in our society." (Lemert, 1967, p. 201)

Ms. Tennant was soon brought face to face with failure in both her professional and private life. At the University, after some initial success, things quickly began to go wrong. She failed her examinations, was forced to change courses, and struggled to get her degree. This was a bitter blow. Intellectual ability is for Ms. Tennant an important source of self-esteem. While she might not possess the charm or social graces of other women, she had always considered herself more clever than most. Her university experience made it increasingly difficult to sustain that illusion.

She left the University as a qualified teacher, but could only get a job in the City's primary schools (for children aged 5-12 years), which at that time attracted few graduate teachers. Yet even in this less demanding environment, she conspicuously failed to make progress. Despite being better qualified than the majority of her colleagues and, despite her uninterrupted service (many were married women who came and went), she was not promoted, but instead continued to be assigned the less important, and less taxing, junior classes. The implications of this, for both her ambition and reputation, were not lost on her.

While she denies it when it is put directly to her, all the evidence, going right back to her teaching days, suggests that she found the work a great strain, which intensified as her incompetence and failure became increasingly manifest. Certainly, it is very difficult to imagine such a withdrawn and essentially private woman enjoying teaching, or being very good at it, since it is a job that can punish the introvert in many ways.

Nor was Ms. Tennant's perception of failure restricted to her professional life. For Ms. Tennant, the normal pattern of a woman's life is to marry and raise a family. Her mother had apparently encouraged her to go to the University in the hope that there she might "make a good match." Indeed, Ms. Tennant seems to regard the ability to attract men as constituting the visible, public proof of one's standing as a woman. Now as she entered middle-age, still unmarried, this too was a fast receding ambition.

The Crisis

Matters came to a head for Ms. Tennant early in 1961. She was then aged 34, and had been teaching for some 10 years. While it is difficult to piece together the precise chronology of events—the intensity of the experience is reflected in the opacity and incoherence of Ms. Tennant's accounts—the problem seems to have manifested itself initially in difficulties at work. Teaching, as Willis has noted, is an occupation all too likely to give rise to paranoid fantasies:

Teachers are adept conspiracy theorists. They have to be. It partly explains their devotion to finding out "the truth" from suspected culprits. They live surrounded by conspiracy in its most obvious—though often verbally unexpressed—forms. It can easily become a paranoid conviction of enormous proportions. (Willis, 1977)

The chain of events that would eventually lead to Ms. Tennant's breakdown began with the sudden departure of one of her colleagues midway through the spring term. Ms. Tennant was required to absorb part her former colleague's class into her own, exacerbating the problems of order and control she was already experiencing. Some weeks later she heard that she had again been passed over for promotion. It was about this time that she seems to have first experienced the "monitoring" and "dialogue" which so unnerved her.

Returning to school in the fall, her classroom problems continued. She was, moreover, becoming increasingly isolated from her colleagues. It is suggested that she was the object of much gossip. Some staff, in fact, even complained about her to the headmaster. Certainly by this time she had become the subject of comment and concern. She responded by withdrawing more and more from contact with her fellow teachers. She avoided the staff-room, remaining in her own room at break-time. This only increased her alienation, and no doubt strengthened her colleagues' view of her as someone who, to say the least, was a little strange.

As the weeks and months passed, Ms. Tennant's paranoid symptoms became increasingly florid. The winter of 1962-63 was particularly difficult. The weather was bad, and just getting to and from school was not easy. She became ill with the flu and felt wretched as she struggled to hold down her job as well as look after the house and her aging and ailing parents. She was unwilling to take time off from work for fear that the authorities might seize the opportunity to dismiss her. She describes her life at this time as a "nightmare." It was at this point that she took her complaints

to the headmaster and demanded that he act to put a halt to what she perceived as the malicious behavior of her colleagues.

Allocation to Paranoid Status

Crude labelling theory notwithstanding, social groups can show a remarkable tolerance for deviant or norm-violating behavior. As Lemert (1967) has observed, the typical response to paranoia is avoidance. Moreover, what brings about formal intervention is not the content of the paranoiac's story as such, but the persistence, and indeed the insistence, with which it is pressed. This is particularly the case where the paranoiac goes to the legal authorities, writes to government departments, or invokes the formal complaints procedures available to a citizen. Once this stage is reached, the paranoiac's accusations can no longer be ignored, evaded, or deliberately misinterpreted for appearance's sake; they must be taken at face value and dealt with accordingly.

In Ms. Tennant's case there is evidence, extending over a period of at least 18 months, of increasingly bizarre behavior and an inability to discharge her duties effectively. For example, she describes how during this period her problems would so completely overwhelm her that she would break down in class, weeping uncontrollably at her desk, while the children were left to their own devices. It is inconceivable that reports of this behavior did not get back to the headmaster, or to the parents. While this seems to have prompted closer surveillance of her activities by senior school staff, a move that of course fueled her paranoia, it brought no formal intervention; it was, ironically, left to her to initiate that.

Once she had taken this step, events moved with bewildering speed. She was referred, via the school doctor and her general practitioner, to a consultant psychiatrist, who diagnosed "a paranoid reaction with secondary depression," a label she sought, if not openly to challenge, then at least to resist. She refused even to have the phrase "nervous exhaustion" on her sick-note, eventually persuading her general practitioner to substitute the diagnosis of "anaemia." She attempted to conceal the identity of the psychiatrist from her parents by telling them that he had come to see her about her varicose veins. Throughout her first period of sick leave she declined to accept the state benefits to which she was entitled because she simply did not concur with the definition of herself as sick.

Whether she was genuinely bewildered, or simply engaged in a futile attempt to compel others to accept her definition of the situation, the true nature of her position was starkly and embarrassingly revealed to her not long after the psychiatrist's visit. A letter from him, in which he set out his

diagnosis, was delivered, not to the general practitioner for whom it was intended, but to Ms. Tennant herself. Until this point, those who had been dealing with her had merely hinted at what they really thought was the matter: she was "ill," "under strain," "experiencing difficulties at school," and "heading for a nervous breakdown." No one had yet said to her (understandably enough) that she was "mad," "deluded," or "paranoid." Receipt of the psychiatrist's letter presented Ms. Tennant with a version of herself that was difficult to avoid. It also provided her with proof of her suspicions regarding the duplicity of the authorities. Her belief in a conspiracy was reinforced.

From Diagnosis to Hospitalization

Following an extended period of sick leave, Ms. Tennant returned to her teaching job, but at a new school. Her reputation and problems followed her, however, and she was soon as estranged from her colleagues there as she had been in her previous position. Intermittently, over the next 15 years, she continued medical treatment, alternating between her own general practitioner and the psychiatric outpatient clinic. While this offered temporary alleviation, it failed to reverse the inexorable deterioration in her situation and personality. Doctor and patient remained forever at cross purposes as this "cri de coeur" from her GP reveals only too well:

...[S]he kept breaking into denunciations of the staff at her former school with detailed, pointless stories about the way they had treated her. All I could do was to advise her to forget the unhappy past and concentrate on the present and future. I also offered her some tranquilizers, which she refused.

A medical diagnosis offered much more than an explanation for Ms. Tennant's behavior, or a way out of an increasingly uncomfortable situation for the school authorities. By assigning her to the category of patient, it effectively denied her other forms of redress and resolution, since (except in cases thought to require an exceptional public and symbolic response) medical definitions have primacy over all others and are virtually unchallengeable (Bittner, 1967). Yet, while doctors were trying, and failing, to reach her, Ms. Tennant sought a resolution to her problems on her own terms, taking her case to (among others): her minister, lawyer, member of Parliament, local and national union officers, Director of Education, Social Work Department, Citizens Advice Bureau, Ombudsman, Scottish Office, and the Home Secretary. While always politely and sympathetically

received, she invariably found herself back in the arms of an increasingly despairing medical profession.

There is a discernible pattern to her life in this period: a recurring cycle of illness, remission to barely tolerable levels, then illness once again. With each attack, her position worsened and became, in her own words, increasingly "untenable," and less and less amenable to medical, or indeed any other kind of help. Moreover, the strategy which she had fashioned to cope with her difficulties, namely progressive withdrawal from social contact, served only to exacerbate the very problem it was intended to control, speeding up the next attack, and ensuring that when the attack did come, its effects were all the more devastating.

The crisis which finally precipitated her hospitalization came in 1978, 16 years after the public onset of the paranoia. She was then in her early fifties. By this time her situation had indeed become desperate. Her isolation was virtually total. She had dropped her few remaining friends. Her mother, who had suffered a stroke in 1960 and was thereafter a semi-invalid, died in 1968, and her father 3 years later, although by that time he too had long since been consigned to the army of "proles." She had no television. Her radio was rarely on; her daily newspaper went unread. She had withdrawn into one room of her old house, where she kept the curtains tightly drawn to prevent those who were "monitoring" her from spying. She took little food, and was on the verge of a complete physical break-down. It was at this point that she was persuaded to accept a visit from another psychiatrist. The diagnosis of paranoid psychosis was reaffirmed. Very reluctantly, she agreed to submit to further outpatient treatment, and even to accept medication. Six months later, as her condition deteriorated further, she was admitted to the psychiatric unit of the local hospital.

Conclusion: The Sociological Dimensions of Paranoia.

Two features of paranoia make it an especially interesting subject for sociologists. First, it is revealed almost wholly in talk. It is not simply that talk provides the evidence (symptoms) for the illness, but that the illness itself is talk, and, moreover, talk that is unacceptable in content rather than form (unlike, for example, schizophrenia). Certainly the paranoiac will frequently manifest eccentric, even bizarre behavior, but, as Lemert (1967) has convincingly argued and we have tried to show, this is better understood as epiphenomena, the consequences of inhabiting a social world in which one is defined as paranoid.

Secondly, despite its clinical rarity, paranoia is endemic to our modern world. We are all a little paranoid at times. Indeed, we would go further: feelings of persecution, self-reference, suspicion, and jealousy can reasonably be viewed as both normal and to some degree functionally useful. To be skeptical of the motives and claims of others is one way of preserving personal and territorial integrity, and at the very least protects us from charges of naivety. A certain amount of egocentrism is essential for normal social intercourse and the fashioning of a sense of self. But in the normal course of events, skepticism rarely turns into blanket and unremitting suspicion of everyone, and self-reference generally stops short of grandiosity. Sooner rather than later we are rescued from whatever delusions might momentarily grip us by our connectedness to the social world. Such transient paranoid episodes generally leave us unmarked, our psychic structures intact and our status unaltered.

Sociologically speaking, the underlying "causes" or "reasons" why certain individuals go on to exhibit paranoid behavior of the clinical variety are unknowable since they lie buried in early experiences and relationships not readily amenable to sociological enquiry. The existing psychoanalytic literature and the family-dynamics approach to paranoia, as well as many clinical reports are strongly suggestive of an etiological process having its genesis within the family. It would seem that certain types of family life create in children and adults habitual ways of thinking about, and acting upon, the world, which seem to predispose them to paranoid behavior. These characteristics include behavior which is dominated by uncertainty and ambiguity, and ambivalent relationships. Where family members neither say what they mean nor mean what they say, and where, therefore, hidden meanings and unstated assumptions abound, mistrust is engendered and coping involves a constant search for the hidden meanings underlying external appearances. In a slightly different vein, authoritarian and rigid families produce lowered self-esteem, fear, and high degrees of self-reference. Both sets of conditions form the seed-bed in which "delusions" of persecution, grandiosity and jealousy all thrive. Families which exhibit these varying characteristics populate the literature on paranoia (Anthony, 1981; Bonner, 1951; Kaffman, 1981a, 1981b; 1983; Kaplan & Sadock, 1971; Polatin, 1975). Put someone who has learned to think in these ways in an environment beyond the immediate family which is relatively stable, where meaning can be taken-for-granted, where threat is not ever-present, and the result is likely to be a marked disjunction between self and the external world: enter Lemert and Ms. Tennant.

In this article we have suggested that paranoia arises out of a combination of frustrated ambition, persistent failure, and emotional isolation, all of

which, we believe, are present in the case of Ms. Tennant. Fading adolescent dreams and the general failure of performance to match ambition are not easy to come to terms with. Given that paranoiacs are likely to have been socially and emotionally isolated from an early age, they remain largely unaware of the near universality of that experience; their tragedy is to think of themselves as special. The paranoia not only accounts for their failure, it confirms their specialness. Abandoning the role of participant for that of observer, the paranoiac's frustrated ambitions are redirected to the production and validation of a world view at whose center they are themselves located. Cut off by inclination and behavior from everyday social interaction, the delusions become more firmly entrenched, the commitment to them (both of time and self) the greater, provoking in turn an increasingly systematized response from those groups and individuals with whom the paranoiac comes into contact and leading to further exclusion and isolation.

This is the point at which self and identity intersect. In Ms. Tennant's case, her experiences at school, the failure to be promoted, suspension from her teaching duties, the medical diagnosis, and admission to the hospital, all constitute critical events in the process of negative identity construction. The record of her experience contained in her hospital notes and in the letters written about her by the school authorities and her doctors reveal the labelling process in which her public identity as a mentally ill person was articulated. But while she recognized the social reality of this process, she refused to accord it legitimacy. The irony is that in so doing, she only furnished further proof of her illness.

Our argument proceeds from a rejection of paranoia as a disease or condition that is in some way independent of the social context in which it arises. Far from being a manifestation of a pathological process or an altered psychic state, paranoia may be better understood as a desperate, and ultimately destructive, attempt to protect self from the consequences of a public identity at odds with self-image. Ms. Tennant's paranoia was, we maintain, a response to the problems she experienced in her work as a teacher. It was subsequently exacerbated by a series of perceived failures and crises, by no means confined to her career, that extended over much of her adult life, but which came to a head in early middle age (as such generalized failure is wont to do). Her "illness" functioned to excuse those failures by explaining, at least to her own satisfaction, why she had not achieved all that she and others might have expected. At the same time it legitimated her refusal to do anything about those "failures," for how could she be expected to deal with such problems when all her energies must be directed at the immediate and overriding task of surviving the persecution?

More conventionally we may also view Ms. Tennant's paranoid behavior as "a cry for help." A central dilemma which she faced—and one which may go some way to explain her peculiar resistance to treatment—is that only apparently as a "mad" woman was she taken seriously; sane, no one seemed to care very much about her. It is surely no coincidence that she exhibited few paranoid symptoms during her time in the hospital, a time when she was receiving a great deal of care and attention. Yet less than a week after discharge, an event the symbolic significance of which was underlined by unintended signals from several key figures involved in her treatment (her ward sister, psychiatrist, research sociologist) suggesting that they too had lost interest in her, she sent off a highly paranoid letter to the Home Secretary.

All of this merely illustrates the secondary gains which attach to any occupant of the sick role (Parsons, 1951). Appealing to illness as a means of solving problems, gaining attention, being cosseted, or to escape reality is well documented (Gerhardt 1979; Herzlich, 1973; Lipowski, 1970). Such "tactics" are by no means confined to paranoiacs or to the mentally ill. They have, of course, profound treatment implications, suggesting as they do good reasons why the sick person might acquire a considerable investment in the continuation of his/her illness (Scott, 1973). In this sense medical definitions are not neutral, for though they promise treatment and care, they do so only on the basis of the continued existence of that condition which the treatment is intended to eliminate.

Central to our analysis is the status of the account offered by Ms. Tennant. In a paper which considers some of the methodological issues associated with the validity of accounts produced and used qualitatively, West (1990), following Cornwell (1984), draws a distinction between public and private accounts. Public accounts are those produced by subjects which affirm or reproduce the moral order or dominant ideology. These are "ought" types of expressions of an approved or acceptable kind. Private accounts, on the other hand, refer to meanings derived from the experiential world—a reality often at odds with the public account of things. As West notes, with reference to people with long-term, non-psychiatric illness, such subjects are "eminently capable of talking about an issue in different, and apparently contradictory ways," and shifting from private to public accounts as the situation demands. What distinguishes Ms. Tennant's account of her "illness" from those produced by other chronically ill people (see, e.g., Kelly, 1991, 1992a, 1992b) is that it only has the private quality. She is unable to shift into a personal account which incorporates a public social order. While she clearly recognizes that social order—her identity as "sick"—she is unable (or unwilling) to incorporate it to any sig-

nificant degree in what she says or does. It is this "monotonous" nature of the account which distinguishes the paranoid person from others.

Language and action reflect each other. Both unfold in space and time, inextricably bound together. In this sense language is representative, not of some other underlying phenomena (biological or behavioral), but of the sense of self and the social identity the person doing the accounting is laying claim to. In this sense the form and content of the account is an important element in emergent social action. The sociological enterprise is therefore (at least in part) not to ask why paranoid behavior occurs in the first place; it is to explore and elaborate the unfolding social processes of which language is a crucial part by focussing on the situational and context specific circumstances in which useful social skills become translated into unrealistic fears. Looking for the origins of such thoughts and skills in an earlier developmental phase is simply not on the sociological agenda.

Postscript

Ms. Tennant was in the hospital for 3 months. She left in much better physical condition than when she came in, but with her delusional system intact, indeed untouched. It was not that she offered any great resistance to treatment. Quite the reverse. She was at all times a "good" patient. She never caused trouble or made demands on staff. She always appeared to listen respectfully when advice was offered. She was ever ready to join in conversations, and to mix with her fellow patients, even though she found many of them coarse and uncongenial. She was, in fact, prepared to do all that was demanded of her without demur or complaint. Yet, like her earlier acceptance of psychiatric help, this never involved her in legitimating the treatment she received or the basis on which it rested. She even went so far as to deny the existence of any continuing problem, much to the frustration of nursing and medical staff.

A short period of outpatient treatment followed her discharge from the hospital, but this was discontinued as her life returned to an acceptable level of normality. The contact with the research sociologist continued, but it was at times difficult to see what purpose their meetings served, other than to keep Ms. Tennant in some kind of contact, however tenuous, with a reality beyond her own world. There is a decidedly instrumental quality to all of Ms. Tennant's dealings with the wider world, and suspicious though she was of others' intentions, she was also well aware of the dangers of complete social isolation. From time to time she seemed ready to

concede that her story might lack credibility, but she never went so far as to abandon her claims or the behavior they supported.

In 1989 there was a noticeable deterioration in her appearance and behavior. She turned up for meetings with the sociologist looking particularly unkempt, in clothes that were torn, dirty and ill-fitting. It was clear, too, that she was not eating properly or taking care of herself, and her paranoid symptoms, for so long concealed under an outward show of deference, were becoming increasingly florid and open. Her general practitioner was informed, and closer monitoring of her condition was instituted. Matters came to a head early in 1991. Her varicose veins ruptured necessitating emergency hospitalization. All professionals involved agreed that, under the circumstances, return to her own home was impossible. An alternative place was found for her in a residential home for the elderly. Shortly after her transfer there the sociologist wrote to her offering to reinstitute their meetings. So far that letter has gone unanswered. Reports from the Home suggest that she has settled down well and has so far shown no signs of bizarre or paranoid behavior.

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