# Investigating Paranoia in a University Student Population

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**May 2016**

A thesis submitted in partial fulfilment of the requirements of the University of East London for the Professional Doctorate in Clinical Psychology

## ACKNOWLEDGEMENTS

I would like to thank Dr. David Harper for his support and guidance throughout the development and write-up of this study. I would also like to extend my thanks to my friends and family whose support and friendship made this journey an enjoyable one. I particularly want to thank Harry for his endless encouragement and reassurance while I conducted this research and for his support throughout the doctorate. Finally and perhaps most importantly, I would like to express my gratitude to all the individuals who participated in this study, and to those who generously gave their time to openly share their experiences with me for this research.

## ABSTRACT

A growing body of research demonstrates that paranoia is an experience best understood on a continuum and is common in the general population. Previous research suggests elevated levels of paranoia among student populations, yet subsequent qualitative investigation has been sparse. The aim of this study was to qualitatively explore the experiences of paranoia of students who scored highly on a measure of paranoid ideation. Participant perspectives on the causes of, effects of, and ways of managing paranoia in their daily lives were sought. The study also sought to provide a quantitative contextualisation of the incidence of paranoia in the student sample. A qualitative design was employed and quantitative measures were included to aid recruitment. London university students (n = 174) completed quantitative measures of paranoia via questionnaire. An experience of paranoia that involved a belief that others had intended to harm them was reported by 32.8% of the total sample. Seven individuals that reported comparable levels of paranoia to that of a clinical sample were subsequently interviewed regarding their experiences of paranoia. Interview data were analysed using grounded theory methodology. Two core categories were constructed; 'The Process of Becoming Paranoid' and 'Living with Paranoia'. The first core category captured the factors that participants felt might have shaped their tendency to become paranoid in the present, as well as outlining the contextual aspects of the situations that appear to trigger experiences of paranoia. The second core category, 'Living with Paranoia' represents a 'macro view' of how participants were negotiating paranoia in their daily lives. It is comprised of two subcategories that captured participant accounts of how their lives were being affected, as well as their attempts to cope with and manage paranoia. Attention was paid to both the intrapersonal and intrapersonal aspects of participant accounts. Implications for future research and practice are outlined.

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# CHAPTER ONE:
# INTRODUCTION

## 1.1. Overview of Introduction

The aim of this introduction is to give an overview of the landscape of paranoia research at the current time and provide a rationale for the current study. The chapter beings by considering how the term paranoia has been defined alongside an examination of the association of paranoia with abnormality. An overview of the continuum and categorical conceptualisations of mental health and illness will then be offered, with a focus on how paranoia can be viewed from a dimensional perspective. Several theoretical approaches to understanding paranoia will then be reviewed, before turning attention to more recent literature on paranoia in the nonclinical population, particularly in student populations. It will be argued that in order to advance our understanding of how paranoia is experienced in the nonclinical population we must go beyond epidemiological and survey studies and endeavour to build new theory from experiential perspectives. It will be argued that exploration of paranoia in the student population as a subsection of the nonclinical population would be particularly beneficial in light of research pointing toward elevated levels of paranoia among this group. The chapter will conclude with a summary of the research aims, and specific research questions.

## 1.2. Literature Search Strategy

A literature search was conducted using the following electronic databases: PsycINFO (2001-2016), PsycARTICLES (2001-2016), Science Direct (2001-2016), CINAHL (2001-2016), and Google Scholar (2001-2016). The following search terms were used: (i) general population OR nonclinical OR student OR college AND paranoi* OR persecutory OR delusion OR psychosis. Relevant papers were identified through title and abstract reviews and were included if there was a focus on paranoia or persecutory delusions in nonclinical or student populations. Searches were initially limited to the period 2001-2016 but snowball searches were conducted through the reference lists of relevant papers in order to identify other relevant papers. These follow-up searches sought to identify key papers outside this time

period, relevant studies conducted with clinical populations, and papers that focused on theoretical approaches to understanding paranoia/ persecutory delusions.

### 1.3. Defining Paranoia

The term paranoia is commonly used both in everyday life (i.e. within popular culture) and within psychiatric systems. Despite the common usage, however, it is still not fully understood as an experience, with researchers continuing to debate the various ways of understanding paranoia and its contributory factors. It is a complex construct that has had its definitions and conceptualisations shift over time. Oxford Dictionaries online (n.d) provide two definitions of paranoia. The first definition states that paranoia is "a mental condition characterized by delusions of persecution, unwarranted jealousy, or exaggerated self-importance, typically worked into an organized system" and the other definition states that paranoia is an "unjustified suspicion and mistrust of other people". Perhaps these two definitions reflect the different ways that the experience is understood, and the many meanings the term encapsulates. The contrast between defining paranoia as a 'mental condition' versus 'unjustified suspicious and mistrust' hints at a lack of clarity as to whether paranoia exists on a continuum, or is an experience reserved for those thought to be mentally unwell. Compounding the ambiguity of the term, Freeman (2008) highlights that 'paranoia' has been used in different ways within research literature, often being used interchangeably with other terms such as persecutory delusions and persecutory beliefs or ideation within the literature, as well as to denote different concepts.

In an effort to provide conceptual clarity, Freeman and Garety (2000) developed a more detailed set of criteria in an attempt to avoid some of the ambiguity around what 'counts' as a persecutory delusion. The criteria are reproduced from Freeman and Garety (2000):

Criterion A: The individual believes that harm is occurring, or is going to occur, to him or her

Criterion B: The individual believes that the persecutor has the intention to cause harm

While criteria A and B are said to be essential, a number of clarification points are also included in the definition:

I. Harm concerns any action that leads to the individual experiencing distress
II. Harm only to friends or relatives does not count as a persecutory belief unless the person believes that the persecutor also intends this to have a negative effect upon the individual
III. The individual must believe that the persecutor at present or in the future will attempt to harm him or her
IV. Delusions of reference do not count within the category of persecutory beliefs

Although no set of criteria is free from problematic assumptions, this thesis tentatively adopts the Freeman and Garety (2000) operational definition of paranoia as a basis for investigation. The definition has been used in paranoia research in both clinical (e.g. Startup, Freeman, & Garety, 2007) and nonclinical populations (e.g. Ellett, Lopes & Chadwick, 2003).

### 1.3.1. Association of Paranoia with Abnormality

Paranoia is listed as a symptom of many psychiatric diagnoses and therefore associated with abnormality and illness. The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) considers paranoia to be a symptom of several categories of mental illness such as paranoid personality disorder, psychotic disorders, schizophrenia and delusional disorder. Furthermore, paranoia is also referenced as a possible symptom of other conditions such as post-traumatic stress disorder, depression, and social phobia (Freeman & Garety, 2004).

The DSM-5 defines a persecutory delusion a “delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against” (p. 844). The DSM-5 definition of delusion is firstly that it is a “false belief” (American Psychiatric Association, 2013, p. 844) that has two characteristics; it is a belief based on incorrect interpretation of external reality, and

despite what almost everyone else believes, and undisputable evidence to the contrary, the belief remains firmly held. However, the diagnostic criteria for delusions are widely contested. On a conceptual level, it has been debated whether a delusion is *ever* falsifiable, and the subjectivity of the assessors' judgement of the belief's plausibility (David, 1999). Harper (2011) echoes such sentiment regarding the diagnostic criteria, suggesting that the notion that one might even be *able* to assess for the presence of a delusion (such as a belief that another person has the intent to cause you harm) represents a naively realist world view. Maher (1992) points out that a systematic evaluation and investigation of the plausibility of a belief is most often impossible (for example in the case of religious beliefs), and instead an assessment is based on the common sense of the assessor. This becomes somewhat of a reality battle in which as Heise (1988) contends that the most powerful person (invariably the mental health professional) is the one able to impose their view on the experience of another. A key question might be what exactly what constitutes 'obvious' and 'undisputable' proof that someone else's belief is unfounded (Harper, 1992; Heise, 1988).

These criticisms, along with more recent research into the validity of categorical ways of assessing and diagnosing what is thought to be mental illness has pointed toward the potential of continuum approaches to offering another way of conceptualising experiences such as persecutory delusions (Claridge, 1994; van Os et al., 1999).

### 1.3.2. Categorical vs Continuous Views of Psychotic Phenomena

Psychosis has been defined by Peters, Linney, Johns and Kuipers (2007) as a break from contact with reality involving negative symptoms such as low mood and withdrawal and positive symptoms such as hallucinations and delusional beliefs. This idea that psychosis is an extreme point on a continuum with healthy psychological functioning and human experience is not novel, and the last 20 years particularly has seen a rise in interest in and acceptance for continuum views. However, the Kraepelinian dichotomous approach (1904), or categorical view, of the traditional medical model still dominates in many ways, dictating how mental health problems are understood and classified (Johns and van Os, 2001). While the DSM (American Psychiatric Association, 2013) considered that psychotic symptoms may indeed exist on a continuum (Allardyce, Suppes & van Os, 2007), a categorical approach to

diagnosis remains. The categorical approach asserts that psychotic symptoms such as persecutory delusions are qualitatively different to normal beliefs, being discontinuous discrete entities that are not part of normal psychological functioning (Straus, 1969; van Os, 2003).

Van Os, Hanssen, Bijl, and Ravelli, (2000) built upon the work of Strauss (1969) in a landmark study whereby they interviewed a random sample of 7076 individuals using the Composite International Diagnostic Interview (CIDI). One finding was that of the 17.5% of participants that were found to have a positive psychosis rating, only 2.1% had a DSM-III-R diagnosis of non-affective psychosis. The authors concluded that the notion of continuity of psychotic phenomena in clinical samples could also be applied to the general population (van Os et al., 2000). This claim perhaps lends support for the suggestion of Oltmanns (1988) who called for a dimensional assessment of delusions. Oltmanns (1988) asserted that the presence of a delusion could be more usefully identified by considering an individual's increasing endorsement of items on a list of characteristics or dimensions such as degree of conviction, preoccupation, and distress. Indeed it is now widely agreed that delusions are better understood as multidimensional phenomena (Garety and Hemsley, 1994), differing quantitatively (on dimensions such as intrusiveness and frequency of thoughts) rather than qualitatively (Johns and van Os, 2001).

The idea that delusions should be normally distributed in the population along continual dimension has been termed the 'epidemiological view' (David, 2010). That is to say that persecutory delusions may represent the severe end of a continuum, but that paranoid thinking should be found to exist in a less severe, perhaps more transient and less debilitating but *not* qualitatively different form at the opposite end of the continuum, in people without psychiatric diagnosis in the general population. This conceptualisation of paranoid thinking has found empirical support (e.g. Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001; Ellett, Lopes, & Chadwick, 2003; Freeman, 2006; Freeman, 2007; Freeman & Garety, 2014).

While acceptance of a continuum approach has increased as mentioned, one might wonder why categorical assessments continue to dominate. Lawrie, Hall, McIntosh, Owens, and Johnstone (2010) argue that a lack of consensus exists about the best way to quantify the critical aspects of psychosis (or indeed what those critical aspects

are) and how such quantifications would be used in clinical practice. Where a particular consensus has been found, e.g. in the DSM, the concept of psychosis has been beset by poor reliability and validity. Freedman et al. (2013) highlight that the current inter-rater reliability for diagnoses of schizophrenia in the DSM-5 is 0.46, therefore falling quite short of the 0.7 considered to be a reliable agreement. Lawrie et al. (2010) argue that further research into the various dimensions of the paranoia experience from the individual's perspective is needed in order to remedy what is known to be a problematic reliance on categorical assessments.

Within the literature on continuum and dimensional views of psychosis, several schools of thought have emerged to represent different interpretations of how a continuum of mental health could be understood. A fully-dimensional view suggests that a line of continuity of experience exists, and as the frequency and level of symptoms increase, so does a need for care (Johns & Van Os, 2001). This view suggests that a psychotic trait is not pathological and can exist in any healthy personality as a matter of individual variation. Claridge, (1994) explains that a quasi-dimensional view, however, is rooted in the medical tradition, taking the state of abnormality as the point of reference, with the continuum being the levels of severity and frequency that the symptom is expressed or experienced.

These dimensional views, along with the disparity in diagnostic criteria have led to advocacy for a focus on single-symptom research (Bentall, 2006). Such an approach allows for the recognition of the continuum on which normal and clinical phenomena exist. This has meant an increase in studies focusing on particular symptoms as they occur, such as hallucinations, delusions of reference, and persecutory delusions. Single-symptom research enables investigation of phenomena along continual axes such as level of preoccupation, frequency of thoughts, and degree of associated distress, free from the constraints of disjunctive diagnoses. Freeman (2007) argues that paranoia is a phenomenon that warrants investigation in its own right outside of its association as a central symptom of psychosis.

This study views paranoia as a complex multidimensional experience (Garety & Hemsley, 1994) existing on a continuum, spanning the clinical to nonclinical populations, in line with recent research (e.g. Freeman et al., 2005). The study therefore adopts the understanding that paranoia and persecutory delusions are

closely related by their positions on a continuum, differing quantitatively rather than qualitatively. A major implication of taking a continuum view is that investigation into the nonclinical population can be useful in informing theory concerned with the development and maintenance of paranoid thinking. It may also help to inform our understanding of paranoia resulting in levels of distress where a person may be referred for professional help.

## 1.4. Conceptualising Paranoia: Theoretical Approaches

Theories concerning the development and maintenance of the paranoid experience have emerged from studies of both the clinical and nonclinical populations, yet the majority of research to date has focused on the former. However, if such a continuum of the paranoid experience does indeed exist, research carried out within the nonclinical population as well as the clinical population should prove mutually informative (Martinelli, Cavanagh, & Dudley, 2013). Various theoretical paradigms underpin research into the formation and maintenance of paranoia. Several theoretical approaches, as well as evidence for them, will now be reviewed to provide an overview of the literature informing current thinking about paranoia, and its clinical manifestation: persecutory delusions.

### 1.4.1. Cognitive Approaches

Much of the research into the paranoia experience has been focused on the application of cognitive frameworks in an attempt to explain the experience perhaps because of the apparent utility in helping to focus and refine cognitively based interventions for paranoia.

Cognitive models emphasise a variety of different psychological processes thought to be implicated in the development and maintenance of paranoia and persecutory delusions. They are concerned with how individuals arrive at explanations for salient events, with regard to biases in perception and reasoning. Affective processes have also been theorised within cognitive frameworks to differing degrees.

Maher (1974) put forward an ‘anomalous’ experience model of delusion formation, positing that delusions develop through an individual’s attempts to make sense of an

unusual internal experience. This is simply the idea that odd experiences, in turn, lead to odd ideas. Several studies have lent evidence to this theory (e.g. Buchanan et al., 1993; Freeman et al., 2004; Garety & Hemsley, 1994) and although Garety and Freeman (1999) note that there is much variability in groups considered delusional, the theory remains influential in current thinking about delusion formation. Yet it must be acknowledged that many people experience anomalous experiences in both clinical and nonclinical populations, but might not go on to develop what would be considered delusions. Therefore, a question remains as to what other factors, could illuminate our understanding of how odd experiences lead to odd explanations for some and not for others.

A deficit in 'theory of mind' (ToM) is potentially the most researched psychological process since being highlighted by Frith (1992) as having potential relevance in attempts to understand the formation of persecutory delusions. The theory suggests that those with impaired ToM (ability to attribute mental states to ourselves and others, using this ability to predict and explain their actions) become suspicious of the intention of others. In a recent review by Freeman and Garety (2014), they concluded that there is indeed strong evidence for ToM deficits in those diagnosed with schizophrenia (e.g. Brune, 2005; Bora & Pentelis, 2013) but argued that this finding has not been supported with regard to paranoia specifically. They suggest that a ToM deficit, when/if present, may exacerbate paranoia but that it has not been evidenced as a key factor in paranoia development.

Biases or deficits in reasoning processes have also been implicated in paranoia development. A probabilistic reasoning bias refers to the tendency for those holding delusional beliefs to 'jump to conclusions'. That is to say that the individual forms conclusions quickly, lacking adequate evidence for doing so. Hemsley and Garety (1986) originally investigated this using a task of probabilistic reasoning known as the 'bead task' which has since been supported by several other studies also finding evidence for a jumping to conclusion bias in paranoid individuals (e.g. Colbert & Peters, 2002; Garety, Hemsley, & Wessely, 1991; Dudley, John, Young, & Over, 1997a & b; Fear & Healy, 1997). However, a study investigating such a bias in the nonclinical population did not find evidence for a link between a tendency to jump to conclusions and paranoid thinking (Freeman et al., 2005). The authors concluded that perhaps the bias is more pronounced in acute delusional states. Furthermore,

how such a bias is modified by interactions with others, emotional state, and current goals needs to be examined (Freeman, 2007).

Attentional bias has also been cited as relevant to paranoia or delusion maintenance. Studies have found that people with paranoid delusions are more attentive to threat-related stimuli than depressed and normal controls, (Bentall & Kaney, 1989; Bentall, Kaney, & Bowen-Jones, 1995) as well as being more likely to recall more threat-related information than other details in a story task (Bentall, Kaney, & Bowen-Jones, 1995).

A bias in the attributional style of an individual has also been of interest in research concerning the development and maintenance of paranoia. Many studies have concluded that individuals experiencing paranoia tend to display an externalising bias for negative events following administration of questionnaire measures of attributional style (e.g. Fear, Sharp, & Healy, 1996; Kaney and Bentall, 1989). This refers to a tendency to essentially 'blame' others (excessively) for negative events (external-personal), as well as blaming the situation (external-situational), as opposed to blaming oneself. However, Freeman (2007) highlighted that only one of three studies that used nonclinical student groups found evidence for an association between a personalising bias and paranoid ideation (Kinderman & Bentall, 1996).

#### *1.4.1.1. Affective processes*

More recently, the role of affective processes in persecutory delusions has received more attention within cognitive research. Anxiety, depression, self-esteem and schemas have been the most researched constructs of interest, as well as shame to a lesser extent (Freeman, 2007).

Building on earlier work on attributional styles, Bentall, Kinderman, and Kaney (1994) put forward the attribution/self-representation cycle. This model that has some similarity with some psychodynamic approaches to understanding paranoia (Hingley, 1992), proposing that paranoia results from dysfunctional attempts to regulate self-esteem. It is thought that threat-related information may activate negative self-schemas leading one to make excessive external-personal attributions (a self-serving bias) during attempts to manage an uncomfortable discrepancy between the 'ideal' and 'actual' self. This self-serving bias is successful in reducing the discrepancy, but

it is posited that continual use of such a bias over time leads the person to develop a paranoid outlook (Bentall et al., 2001). This model is also referred to as the ‘paranoia as defence’ model, due to the assumption that these attributions occur to essentially defend against negative emotions especially low mood and low self-esteem. Research however paints a variable picture, with support for an association between paranoia and low self-esteem in some studies (e.g. Freeman et al., 1998), no support for an association in other studies (e.g. Drake et al., 2004), or indeed seemingly ‘good’ self-esteem in others (e.g. Lyon, Kaney & Bentall, 1994). The model has been updated to account for such mixed evidence, to suggest that something of an instability in self-esteem exists for paranoid individuals due to their attempts to defend against negative self-schemas only being successful some of the time (Bentall et al., 2001).

Further research into the relationship between paranoia and self-esteem has resulted in the proposition that two ‘types’ of paranoia exist, which have been named ‘poor me’ and ‘bad me’ paranoia (Trower & Chadwick, 1995). ‘Poor me’ paranoia is suggested to be an experience of persecution that is felt to be unjustified (thus serving as a defence against unwanted emotions), leaving the individual with higher self-esteem, as well as lower anxiety and depression, but potential anger. The ‘bad me’ subtype is where the paranoid individual is said to experience the persecution or threat as deserved in some way (perhaps as a reflection of negative beliefs about the self), damaging self-esteem and resulting in heightened anxiety and depression. Evidence has shown that ‘poor me’ paranoia is more common in clinical populations (e.g. Chadwick, Trower, Juusti-Butler, & Maguire, 2005; Fornells-Ambrojo & Garety, 2005) and it has also been found that self-esteem is relatively preserved in those considered to experience ‘poor me’ paranoia (Chadwick et al., 2005). However, evidence is mixed, with a study by Melo, Taylor, and Bentall (2006) finding that individuals considered ‘acutely ill’ can oscillate between ‘bad me’ and ‘poor me’ beliefs, somewhat similar to the ‘paranoia as defence’ model discussed above. They suggested that perhaps events throughout the person’s day dictated oscillations between the two types of paranoia. However, there have been no attempts to explore what types of social and interpersonal events or encounters might influence the paranoia experience of the individual with regard to such a ‘switching’ of paranoia types.

A qualitative exploration of service users' experiences of paranoia also highlighted emotional components that are consistent to those cited above. Boyd and Gumley (2007) presented a core process of 'fear and vulnerability', along with sub-categories of 'confusion and uncertainty' (created by sleep deprivation, falling out with others, and drug use), and 'self under attack' (from internal and external sources), which both contributed to the core process. This led to the engaging of one's safety systems (e.g. blame others, denial, worry). The authors conclude that paranoia evolved as a self-protective mechanism. Hirschfeld, Smith, Trower and Griffin (2005) also explored male service users' experiences of paranoia, who named anger, stress and unhappiness as central emotions in the experience.

#### *1.4.1.2. A multifactorial cognitive model*

Freeman and Garety (2004) conclude that such varied evidence suggests that in fact no one factor can fully account for the development and maintenance of paranoia. They put forward that a multifactorial model may be more useful, highlighting the unlikelihood that there is a shared cause of paranoia beliefs. The Threat Anticipation Model was hence developed (Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002) to draw together existing factors thought to be important into a suggested pathway for paranoia development. A precipitant (such as a stressful life event, traumatic experience etc.) is thought to trigger anomalous experiences which the person attempts to appraise. Such anomalous experiences are then said to interact with cognitive deficits as well as emotions and existing schemas about the self, the world, and others, all contributing factors in the person's search for meaning. It is suggested that these processes interact to the point of an explanation being selected, but that the chosen explanation is further mediated by the person's beliefs about illness, as well as social factors (Freeman, 2007). With regard to these social factors, it is posited that isolation creates a situation in which the person has no opportunity to discuss their thoughts and ideas with others, therefore being more likely to adopt a threat belief, especially if they have limited ability to consider alternatives to the threat explanation (Freeman, 2007).

A qualitative investigation into the subjective experience of paranoia carried out by Campbell and Morrison (2007) aligns with the aforementioned cognitive understandings of paranoia. The authors found that the key difference between clinical and nonclinical participants' experiences was how controlled the person felt

by their ideas. The study generated four superordinate themes, one of which was ‘factors that influence paranoia’. Within this superordinate theme, sub-themes included ‘biased information processing’, ‘unusual perceptual experiences’ and ‘past experiences’. Factors that alleviated the experience included: ‘re-appraisal’, ‘safety’ (e.g. in one’s own home), ‘setting limits’ (e.g. to what one is willing to believe) and ‘medication’ (although medication was specific to the clinical group). This study gives a useful consideration of the factors that contributed to and alleviated paranoia from the participants’ own perspectives. However, these themes represent somewhat intrapersonal factors, rather than considering interpersonal factors that may have contributed to and alleviated the paranoia experience. Similarly, under the ‘consequences of paranoia’ superordinate theme, the sub-themes appeared to be focused on the intrapersonal consequences as indicated by titles such as ‘emotion’, ‘the self’ and ‘behaviour’.

#### *1.4.1.3. Limitations of cognitive approaches*

Whilst it must be acknowledged that cognitive lines of inquiry have proved useful in the development of practical cognitive behavioural interventions they are not without criticism. Advances have certainly been made in understanding what psychological processes are associated with paranoia, but a comprehensive understanding of the factors involved in the production of this experience has yet to be achieved, particularly with regard to the social and interpersonal nature of paranoia. Cromby and Harper (2009) argue that there is a lack of genuine recognition of the fundamentally relational nature of paranoia, as it is, after all, an interpersonal problem. They argue that cognitive processes are awarded a causal superiority over other factors, at the expense of considering important factors external to the experiencing individual, underplaying the impact of their material and social worlds.

With due acknowledgement that cognitive approaches have yielded a significant amount of research evidence to advance current thinking about the role of processes such as biases in reasoning and the importance of schemas, questions remain such as: in what contexts are such schemas activated? How or why are these biases occurring? Are these processes themselves a symptom of some other root cause of the person’s paranoia? What kinds of ‘precipitants’ influence the person, and how do they negotiate their threat concerns in interpersonal relationships? Freeman and Garety (2006) acknowledge that there can be no one answer or explanation of what

causes a paranoid belief and suggest that an understanding of the dimensions of the experience are more important, for example, what causes the degree of conviction, what has caused such content, or what influences resistance to change? If such questions are to be genuinely investigated, a more thorough exploration of social factors involved is warranted.

### 1.4.2. Approaches that Emphasize the Role of Social and/ or Environmental Factors

#### *1.4.2.1. A behavioural model of paranoia*

A literature search revealed a limited amount of behavioural approaches to the conceptualisation of paranoia, apart from a behavioural model proposed by Haynes (1986). The model has not been subject to empirical investigations and instead was arrived at from clinical inferences, behavioural conceptualisations of other psychopathology, and other existing models of paranoia. The model puts forth that paranoid experiences (including associated thoughts and behaviours) arise through social learning. Reciprocal determinism is seen as key in an interactive process between the person and their environment, as well as emphasis being placed on multiple and idiosyncratic causality. Causal factors are suggested to involve 'specific-nonspecific' and 'early learning-maintaining' aspects. 'Nonspecific' determinants are those thought to result in both paranoid and other behaviours and are suggested to include experiences such as having difficult early interactions with caregivers, having an insular family, as well as experiencing inconsistency in the behaviour of others. 'Specific' determinants refer to aspects of the learning experience which are specific in producing paranoid behaviour such as the impact of the paranoid behaviour of others. The 'early learning-maintaining' causal experiences are said to include early modelling of paranoid ways of behaving, as well as reinforcement of the same, coupled with an inadequate amount of reinforcement of non-paranoid ways of behaving and relating. Furthermore, learning from a history of confirmed suspicions is also thought to be a causal factor within this matrix. While it has not been subject to empirical investigation, this model highlights the importance of early learning environments in contributing to paranoid ways of behaving.

#### *1.4.2.2. Powerlessness and paranoia*

Substantial evidence has led researchers to conclude that paranoid individuals have experienced a high frequency of difficult experiences such as victimization and

discrimination and that such experiences may influence the onset of paranoia (e.g. Janssen et al., 2003; Mirowsky & Ross, 1983). Racial discrimination is an important social issue that has thought to be a possible cause of higher rates of psychosis in Asian and black people living in the UK (King, Coker, Leavey, Hoare, & Johnson-Sabine, 1994), particularly given the finding that black people living in predominantly white areas are more likely to receive a schizophrenia diagnosis (Boydell et al., 2001).

Generally speaking, in order to be subjected to chronic discrimination as Janssen et al. (2003) found, one most likely occupies a position of powerlessness. Mirowsky and Ross (1983) considered issues of powerlessness more directly in a study using data from a community mental health survey of adults living in Texas and Mexico. They found that factors such as low socioeconomic status, being female and having Mexican heritage were associated with paranoia. They argued that the real threats of victimization and exploitation faced by the women, coupled with the fact that they occupied social positions characterised by powerlessness led to them holding a belief in external control. The authors go on to describe what could be called a model of paranoia whereby low socioeconomic status and a belief that others are in control of one's life creates a tendency toward mistrust and suspicion, which, when exaggerated, develops into a paranoid response. This study places social context at the centre of a model of paranoia development, placing importance on the social world of the individual. This offers a stark contrast to cognitive approaches that tend to place an individual's internal processes at the centre of paranoia models.

Bentall and Fernyhough (2008) argue that the development of particular patterns of cognitive functioning are influenced by particular types of environmental adversity. They suggest a pathway from adversity to paranoia, whereby insecure attachment and experiences of victimization/powerlessness led to an individual developing negative self-esteem and an abnormal cognitive style (externalising explanatory bias, poor ToM skills, and JtC bias) which finally leads to threat anticipation and paranoid beliefs. This is supported by a qualitative exploration of childhood experiences and the development of persecutory delusions that found themes of early interpersonal adversity and victimization (Dickson, Barsky, Kinderman, King, & Taylor, 2016). Participant accounts led to the construction of an 'early experiences' theme that captured descriptions of problematic and inconsistent relationships in childhood, as

well as victimization experiences. Such experiences appeared to lead participants to develop negative perceptions of others, impaired social functioning, substance use and an inconsistent sense of self. Participant accounts also revealed that avoidant and proactive coping were engaged with in attempts to cope with adversity.

Another study that lends evidence to a relationship between powerlessness and paranoia is that of Wickham, Taylor, Shevlin and Bentall (2014) who examined associations between depression, psychotic symptoms, and deprivation, using the 2007 Adult Psychiatric Morbidity Survey which totalled a large sample of 7,253 participants. It was found that the participants' neighbourhood index of multiple deprivation (IMD) significantly predicted depression and psychosis, and with regard to specific symptoms, IMD predicted paranoia (Wickham et al., 2014). Furthermore, they also investigated the mediating role of discrimination, trust, stress and lack of social support, and found that trust and stress partially mediated the relationship between paranoid ideation and IMD.

#### *1.4.2.3. Culture and paranoia*

Freeman and Freeman (2008) speculate that paranoia is actually increasing in modern Western society, citing reasons such as migration, urbanisation, victimisation, trauma, and social isolation. They also draw attention to mistrust of authority and the effect of the media on people's perception of risk. Highlighting such factors represents a shift in focus from the paranoid individual to paranoia as a wider societal, cultural and even political issue. This normalising of paranoia leads to a conceptualisation of those who experience it as aware and alert individuals taking a critical stance toward knowledge (Knight, 2000) further loosening the association of paranoia as an experience reserved for the mentally ill.

Harper (2002) suggested that our society could be described as panoptical, with constant surveillance and regulation. It may be that such an environment has a large impact in shaping the sort of thinking that is considered paranoid and that paranoia is increasingly becoming a culturally available response to feelings of fear and threat. To suggest that a person is paranoid rather than an enlightened critical thinker when they question the government's motives becomes a judgement call.

While it could be argued that cognitive approaches do account for social and environmental factors, in the way of 'precipitating events' or schemas, it could also be argued that these factors need to be given more weight in conceptualisations of paranoia. Current cognitive theories include social and cultural factors but as something of a 'backdrop', placing psychological processes within the individual at the heart of the formulation, and therefore at the heart of paranoia interventions. While there is a need for interventions to be available at an individual level, the current dominance of cognitive approaches may be obscuring important changes that need to occur at a wider community and societal level.

The assertion that social, cultural, environmental and even political contexts can be key in the formation of paranoid thoughts and feelings in any individual lends further support to the continuum view of paranoia. Indeed studies of the prevalence of paranoia in the nonclinical population do highlight that paranoia is a phenomenon of interest in its own right, and may, in turn, enable us to understand more about the nature of paranoia experienced by those using mental health services (Freeman et al., 2005).

## 1.5. Prevalence and Phenomenology of Paranoia in the Nonclinical Population

As mentioned above, recent research into the nonclinical population (particularly the last ten years) has supported continuum views over categorical views of health and illness. Initially research into the general population was broad in focus, with many studies investigating the presence of psychotic-like phenomena in the general population (e.g. Stefanis et al., 2002; Johns et al, 2004), amongst those without diagnoses or attachment to mental health services. In fact, a meta-analysis of prevalence rates of sub-clinical psychosis in the general population found a median prevalence of between 5-8% for such symptoms (van Os et al., 2009). Interestingly, such psychotic-like experiences have been suggested as having higher rates in the adolescent population (Poulton et al., 2000; Laurens et al., 2007) as well as in the student population (Lincoln & Keller, 2008). More recently, the trend has been for research to investigate general population prevalence of 'single-symptoms' as mentioned above, so attention will be turned now to prevalence studies concerning the incidence of paranoia and persecutory delusions.

### 1.5.1. Cross-Sectional Survey Studies

In a UK-based study of the prevalence and correlates of psychotic symptoms, Johns et al. (2004) used data from the second UK National Survey of Psychiatric Morbidity. Interviews were carried out with all participants, with follow-up clinician-led interviews being carried out with those who endorsed one or more item on the Psychosis Screening Questionnaire (PSQ; Bebbington & Nayani, 1995). Measures were taken to exclude people with probable psychosis during the follow–up interview which used the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; World Health Organisation, 1992), leaving 8520 general population participants aged between 16-74 years. Of this sample, 20% had reported thinking that other people were against them in the previous year, 9.1% felt that there had been times when they felt people had acted to deliberately harm them, and a notable 1.5% felt that there were a group of people plotting to seriously harm them. A regression analysis revealed that experiences of victimization, being younger, male, of average IQ, and being alcohol dependent, as well as having had a recent stressful life event, and neurotic symptoms were independently associated with paranoid thoughts.

Another large-scale study attempted to extend the aforementioned work of Johns et al. (2004) using the second British National Psychiatric Morbidity Survey in an attempt to study structural relationships along a paranoia spectrum (Bebbington et al., 2013). The PSQ (Bebbington & Nayani, 1995) was used, but items from the Structured Clinical Interview for DSM-IV Axis II Disorders (SCID-II; First, Spitzer, Gibbon, & Williams, 1995) were included. The results showed that 2-30% of the sample endorsed paranoia items and a factor analysis suggested the presence of four subcategories of paranoia: ideas of reference, mistrust, interpersonal sensitivity and ideas of persecution. Bebbington et al., (2013) suggest that these subcategories corresponded with four groups of participants. One group of respondents demonstrated a high endorsement of all factors (a ‘severe but rare persecutory class’ of respondent), another group demonstrated a lack of endorsement of items related to persecutory ideas but some endorsement of the other three subcategories (a ‘quasi-normal class’ of respondent), and two intermediate groups who displayed somewhat high endorsement of items concerning ideas of reference, and mistrust. They suggest that a wide range of factors may be responsible for an individual’s movement along the continuum, including psychological factors and social factors.

Freeman et al. (2011) also carried out a large-scale study, using data from the third survey of Adult Psychiatric Morbidity which included items from the PSQ (Bebbington & Nayani, 1995) yielding paranoia data for 7281 individuals. They reported that paranoid thinking ranged from 1.8% who reporting thinking that there may be a plot to cause them serious harm in the last year, to 18.6% who reported thinking that other people were against them in the past year. The study found a great range of factors that were associated with paranoia including being single, being in poor physical health, poverty, being young, having lower IQ, work stress, less happiness and suicidal ideation, and less perceived social support. They concluded that even nonclinical paranoia has serious implications for a person's health and wellbeing as well as social functioning. Freeman (2006) however has highlighted the limitations of using the PSQ (Bebbington & Nayani, 1995) in that it does not allow for exploration of the dimensional nature of paranoia.

Olfsen et al. (2002) carried out a study of psychotic symptoms in a general practice of an urban area in the United States and administered the Mini International Neuropsychiatric Interview (Sheehan et al., 1998) to 1005 adults in the nonclinical population. With regard to the paranoia specific questions, it was reported that approximately 11% of the sample believed that they were being spied on, and 6.3% believed they were being plotted against or that others were trying to poison them. Olfsen et al. (2002) stated that individuals reporting such symptoms were more likely to be Hispanic, have eight or fewer years of education, be separated or divorced, and have a lower family income. In another study at a general medical practice in France, Verdoux et al. (1998) administered the Peters et al. Delusions Inventory (PDI; Peters, Joseph, & Garety, 1999) to a nonclinical sample of adults (*N* = 444) to assess the prevalence of delusional ideas. They found that 25% of the sample thought they were being persecuted, with 10% thinking that there may be a conspiracy against them.

### 1.5.2. Younger People, Students, and Paranoia

The majority of studies investigating paranoia (or psychotic symptoms more generally) in the nonclinical population have focused on adults, despite psychosis typically emerging in adolescence (e.g. Verdoux, & van Os, 2002). Even still, studies focusing on adults have found that younger participants have a higher endorsement

of paranoia items (e.g. Fonseca-Pedrero, Lemos-Giraldez, Muniz, Garcia-Cueto, Campillo-Alvarez, 2008; Freeman et al., 2011; Verdoux et al., 1998). Two studies carried out by Wigman et al. (2011) investigated psychotic symptoms in a sample of Dutch young people aged between 12 and 16 using a self-report dimensional measure of psychotic experiences. The results indicated that over 89% of the children experienced paranoid thoughts, with approximately 29% experiencing regular paranoid ideation. Wigman et al. (2011) concluded that paranoid experiences are higher among adolescents than the adult population. One hypothesis put forward about this finding is that younger people may be more self-conscious than an adult population, therefore being more prone to paranoid thoughts. Eldkind (1967) explains that adolescents may be more self-conscious due to their own attention being focused on themselves, leading them to believe other people are looking at them. Harrop and Trower (2001) suggest that such egocentricity peaks in college-age samples. However, it is as yet unclear why paranoid experiences are higher among younger people. Questionnaire-based studies are limited in the extent to which they can provide rich data, due to the pre-defined nature of the items, and in-depth qualitative interviews may be more appropriate for exploring the reasons for higher paranoia in this group.

A study by Freeman et al. (2005) used the Paranoia Checklist and the Paranoia Scale (PS; Fenigstein & Vanable, 1992) to investigate paranoia in a nonclinical population of 1201 London-based university students. The study endeavoured to present frequency data, as well as assessing the dimensions of conviction and distress. They reported that one-third of the sample experienced paranoid thoughts regularly. Interestingly, the study included a coping styles questionnaire and the authors concluded that higher paranoia levels were associated with the use of emotional coping (e.g. worry) and avoidant coping (e.g. distraction) but little use of detached (e.g. distancing from the situation) and rational coping (e.g. trying to find out more). Another study investigating coping with paranoia in a nonclinical population found that paranoid individuals tended to engage in rumination and the use of drugs and alcohol to manage their experiences (Melo & Bentall, 2010). Freeman et al. (2005) also found that higher paranoia levels were associated with lower social rank, negative attitudes to emotional expression, and submissive behaviours. Higher levels of paranoid ideation (experienced as more distressing and

frequent) were associated with an increase in social isolation, depression, and a feeling of powerlessness.

The overall conclusion of the Freeman et al. (2005) study was that paranoia is common, and hierarchically arranged. This hierarchical arrangement describes interpersonal threat beliefs as being ordered into five levels, whereby the lowest level represents the most common but least distressing type of belief and the highest represents the least common but most distressing and disabling type of belief. Freeman et al. (2005) propose the following levels of threat: social evaluative concerns (e.g. fears of rejection); ideas of reference (e.g. people watching you); mild threat (e.g. people trying to irritate you); moderate threat (e.g. people intentionally trying to harm you); and the top level being severe threat beliefs (e.g. people trying to cause you significant psychological, social or physical harm). This study used a sample of UK university students, and the authors acknowledge that it cannot be assumed that a student population is representative of the general population at large. As was discussed above, young people have been found to experience higher levels of paranoid ideation and as such may give an over-estimation of paranoia in the general population if taken as a proxy sample. Furthermore, a study by Lincoln and Keller (2008) compared students to the general population and found that delusional beliefs (including persecutory delusions) as measured by the PDI were higher in the student sample. This must be taken into account when considering findings from other studies using student samples (e.g. Martin & Penn, 2001; Pickering, Simpson, & Bentall, 2008).

Another study that used a student sample (from both a UK and an Italian university) is that of Cella, Sisti, Rocchi and Preti (2011). The PDI (Peters et al., 1999) was administered to 800 participants, and the most common type of delusion was found to be persecutory delusions. They found that 41% of the participants reported paranoid ideation, with no difference between the two university samples. This figure is similarly high the Ellett, Lopes and Chadwick (2003) study who investigated paranoia in UK university student population, which is of particular relevance to the current study. The questionnaire-based study investigated the incidence of paranoid ideation in a nonclinical sample of students from two UK universities, as well as including a measure endeavouring to assess the phenomenology of paranoia. The Paranoia Scale (PS; Fenigstein & Vanable, 1992) was used as the measure of

paranoid ideation having been specifically designed for use in a college population, and the Personal Experience of Paranoia Scale (PEPS; Ellett et al., 2003) was developed for the study to explore the person's experience of paranoia along certain cognitive, affective, and behavioural dimensions. Within the sample of 324 students, 47% reported an experience of paranoia in which they felt another person had the planned intention to harm them (psychological and/or physical harm). This figure was based on the individual first endorsing item one of the PEPS ('Have you ever had a feeling that people were deliberately trying to harm or upset you in some way?'), then going on to give an example of that situation (item two), before then endorsing item three which was 'In the above situation that you have described, at that time, did you feel that the other people involved actively intended to harm you?'. This question was included to increase confidence that the person was not reporting an incidence of social anxiety. A further 23% of the sample answered 'yes' to item one, but not item three i.e. the statement assessing their belief that others had the intent to harm them. Ellett et al. (2003) suggest that a more accurate representation of paranoia in the sample may be between 47-70%, had they not chosen to exclude those who had endorsed item one but not item three into their figure (in what they called a conservative step). This is an interesting finding given that the sample used ranged in age from 18-49 (mean age not reported) so it cannot be claimed that the elevated paranoia levels were due to the student sample being comprised of only young adults. However, the first item only requires the participant to recall if they have *ever* felt as though others were deliberately trying to harm or upset them. Utilising the endorsement of items relating to one experience of paranoia to arrive at a figure representing paranoia incidence in your sample may overestimate the number of people experiencing unwarranted or exaggerated suspicions. That said, the study attempts to provide an account of the phenomenology of paranoia which Freeman (2007) argues can be lacking from larger survey studies. Ellett et al. (2003) found that paranoia had a marked impact on participant wellbeing, in that it was preoccupying, evoked anger and frustration, and feelings of being judged and powerless. The study also indicated that participants were engaging in avoidant coping strategies to manage their paranoia. The study was somewhat limited however by the questionnaire design which prevented further exploration of the experiences of participants, and the fact that the focus was on cognitive, behavioural and affective dimensions which potentially neglected important interpersonal factors.

A study by Allen-Crooks and Ellett (2014) investigated naturalistic change in paranoid thinking in a nonclinical population of students utilising qualitative methods, in order to provide a rich account of reasons for change. The study found that experiences of paranoia can indeed change naturally over time. One of the seven themes identified related to the importance of change in the individual's appraisal of their relationship with the perceived persecutor as crucial in alleviating the paranoia experience. This change in perception of the relationship took three forms: achieving a more positive view of the persecutor; a change in the power dynamic (i.e. viewing the person as having less influence on oneself); and a face-to-face resolution with the person. Another theme was the importance of not taking an event personally, which was said to occur through either seeing the persecutor as the problem or 'flawed' (resulting in the event being appraised as unimportant) or through normalising the event (i.e. realising many people go through the same experience). The other themes found to be important in alleviating the paranoia experience included 'acceptance and letting it go', 'social support' (e.g. getting other perspectives and emotional support from family and friends), 'reduction in current level of threat' (e.g. physical distance from perceived persecutor), 'positive outcomes' (e.g. being able to reflect on the paranoia-inducing event as a learning experience) and taking a 'wider perspective' (e.g. seeing the experience as less significant). This study provides an important insight into why some individuals may go on to develop paranoia that involves levels of distress that warrant support from services and some remain in the nonclinical domain without the need for professional support despite experiencing paranoia. Another qualitative exploration into the ways that eight participants with persecutory delusions in the clinical population coped with worry found some comparable themes; reporting that distraction, reality testing, interpersonal support and natural drift were important ways of managing worry (Startup, Pugh, Cordwell, Kingdon & Freeman, 2015).

Freeman (2007) suggests that studies using diagnostic measures may even be underestimating the prevalence of paranoia due to such measures not being sensitive to the everyday transitory manifestation of paranoia thoughts. It has therefore been said that a conservative estimate would be to suggest that 10-15% of the general population experience regular paranoid thoughts, with 1-3% estimated to experience persecutory delusions comparable to clinical cases (Freeman, 2007). The studies presented above represent part of a growing evidence base to suggest that paranoid thinking is common in the nonclinical population, appears to be more

common in young adults and students and is best viewed on a continuum of normal experience. However, it is still unclear as to how individuals in the nonclinical populations are managing their experiences without the support of services.

## 1.6. The Current Study

### 1.6.1. Rationale

Advances in understanding paranoia have as yet been mainly derived from research into the clinical population, and therefore a disorder-focussed conceptualisation. Research into nonclinical populations remains comparatively underexplored, with the majority of nonclinical research being carried out through survey studies. Furthermore, few qualitative explorations into the experience of paranoia in the nonclinical population exist.

A need has been identified for the construction of new theory from experiential perspectives, as a shift away from the current reliance in paranoia research on deducing hypotheses for testing based on existing theory (Boyd and Gumley, 2007). Additionally, the finding that students may have elevated levels of paranoia is of particular relevance to this study. As mentioned earlier, many studies have used students as a proxy for the general population, despite recognising this as a limitation. However, it is argued that investigation into a student population is important in its own right. Given that almost half (47%) the participants in a nonclinical UK student sample reported paranoid ideation in the Ellett, et al. (2003) study; further exploration appears warranted. The current research proposes that a partial replication and extension of the aforementioned study into paranoid ideation in a UK student sample by Ellett et al. (2003) would address a gap in the literature. This study firstly proposes to partially replicate the quantitative element of the Ellett et al. (2003) study by using quantitative measures to ascertain the incidence of paranoid ideation in a nonclinical student sample. It also proposes to extend the study by including a qualitative exploration of the experiences and perspectives of those who score highly on a measure of paranoia, by way of one-to-one interviews.

Building on understandings of the paranoid experience in the nonclinical population to include a model of social processes would contribute to both theory and clinical practice. Investigating how those reporting paranoid thoughts perceive the causes

and effects of their paranoia could uncover useful information which could be included in developing interventions for people experiencing paranoia-related distress. Exploring how people talk about coping with and negotiating paranoid thoughts in various contexts without support from services may also identify protective factors that have not been previously considered in research. Furthermore, by conducting research into the nonclinical population, the continuum understanding of mental health and distress can be further elaborated. This may in turn help to dissolve current stigma surrounding assertions that those experiencing paranoia as 'other' and 'abnormal' in some way.

The aim of this study, therefore, is to recruit participants who score highly on a measure of paranoid ideation, and then to qualitatively explore those individuals' *own* experiences of and perspectives on paranoia. The aim of this qualitative exploration will be to pay particular attention to how participants talk about perceived causes and effects of their paranoid thoughts as well as what they talk about in relation to coping or managing such thoughts, both intra-personally and inter-personally. Furthermore, descriptive statistics of the quantitative data gathered while recruiting participants will also be used to contextualise the sample by allowing the data to be compared to the Ellett et al. (2003) study as well as to other similar studies investigating paranoia in the nonclinical population.

### 1.6.2. Research Questions

With regard to individuals who score highly on a measure of paranoid ideation:

1. How do participants perceive the causes of their paranoid thoughts, and the effects of such thoughts on everyday life?
2. What do these participants talk about in relation to coping with paranoid thoughts in everyday life?

# CHAPTER TWO:
# METHODOLOGY

## 2.1. Chapter Overview

This chapter aims to outline the methodology and method that has been chosen to address the aforementioned questions. The chapter begins by providing a summary of the study's design. A rationale for the use of a qualitative research paradigm is then presented, before considering the critical realist epistemological position adopted by the current research. An overview of Grounded Theory and a rationale for its selection as the chosen methodology will be provided. The chapter will then move to an outline of the method of the study, including data collection, participants and the process of analysis.

## 2.2. Design

This study employed a qualitative design and included the use of quantitative measures to aid recruitment. In order to address the research questions shown above, the study incorporated two 'phases'. 'Phase One' involved recruiting a pool of participants to complete quantitative measures of paranoia via questionnaire. While it is acknowledged that reducing the experience of paranoia to a quantifiable construct is problematic, the inclusion of paranoia measures (described later in this chapter) enabled purposive sampling (Payne, 2007), by highlighting a sample of participants for whom paranoia appeared a more salient experience. These participants were then approached for participation in 'Phase Two' of the study.

Phase Two refers to the subsequent collection of qualitative data through interviews to form the core of this study. Furthermore, the inclusion of quantitative measures at Phase One enabled a contextualization of the study, providing a cross-sectional representation of paranoia scores for a sample of UK university students. This enabled comparisons to be made between the findings of this study and other similar studies attempting to describe the incidence of paranoia in student populations such as the aforementioned Ellett et al. (2003) study.

There exist several methods of data collection compatible with grounded theory as the selected method of qualitative inquiry, including focus groups, participant observation, and semi-structured interviews. This study chose to employ semi-structured interviews in order to collect data, as they would enable one-to-one in-depth discussion of the phenomenon of interest.

### 2.3. Choosing a Qualitative Research Paradigm

The aforementioned research questions are exploratory in nature as opposed to hypothetico-deductive, therefore being best suited to a qualitative approach. A qualitative approach can allow for complex ideas and experiences to be elaborated and reflected upon, as well as allowing space for the context of such experiences to be considered. Therefore this methodology appeared most appropriate in addressing the study's research questions as it would allow participants to discuss their perspectives on and experiences of paranoia (and indeed what they understand the term to mean) in such rich detail that the processes and contexts involved in the development of the experience, as well as the process by which they manage their experiences might be illuminated.

### 2.4. Epistemological Position

This study adopted a critical realist epistemological stance. Willig (2013) describes the stance as a combination of a realist desire to better understand what is 'really' going on in the world, whilst simultaneously recognising that any data the researcher gathers (qualitative or quantitative) is limited in its attempts to access any such reality. This position emphasizes the importance of social context on the production of knowledge, yet also retains the view that a reality exists independently of our construction of it (Cromby & Nightingale, 1999). Drawing on the critical realist perspective, in this study, paranoia is viewed as a way of thinking and being that is constructed through interactions with the person's environment, as well as their interactions with others within their social environment.

This position was adopted as it appeared important to acknowledge that there exists a 'reality' to the lived experience of the research participants with regard to what we

have come to define as paranoia, whilst acknowledging that the construction of this experience is influenced by social, cultural, and historical processes. In turn, any data gathered for this study was viewed as having value in telling us something about the participant's reality, but that it does not do this in an unmediated fashion and does not represent a complete reflection of what is going on (Willig, 2013).

### 2.5. Grounded Theory Outline and Rationale for Use

Grounded Theory is described as a methodological approach, accompanied by a set of inquiry methods or research procedures, culminating in the generation of theory (Charmaz and Henwood, 2007). This approach affords the researcher a systematic guide to data analysis through the use of coding procedures aiding the development of a core category with linking sub-categories that explain the phenomena of interest. The study employs Strauss and Corbin's (1990) description of 'theory' to guide the research. It is described as a collection of interrelated categories or concepts that are well-developed to the point of forming an explanatory theoretical framework for the phenomenon of interest whether it is social, psychological or otherwise.

The approach was originally developed by Glaser and Strauss (1967) as a response to their dissatisfaction about the dominance of existing theories forming the basis of sociological research. They outlined a set of methods (described in analysis section later in this chapter) that could serve as flexible analytic strategies allowing researchers to construct theories grounded in the data that could help to explain some aspect of how the social world 'operates' (Willig, 2013). Creswell (2009) summarises grounded theory as an inductive approach to inquiry whereby an abstract theory of action, interaction, or process is derived by the researcher, and grounded in the viewpoints of the study's participants.

Willig (2013) maintains that the development of grounded theory was an important shift away from a reliance on variables of pre-existing theories or constructs to the construction of new contextualised theories. This is a key reason for the decision to employ a grounded theory methodology in this study, having previously highlighted a need for the development of new theory based in experiential perspectives on paranoia. The previous chapter also highlighted that cognitive models of paranoia currently dominate the landscape of paranoia literature and that such a focus has

placed paranoia ideation and beliefs as phenomena best studied by a focus *within* an individual, somewhat obscuring the context. Grounded theory was felt to be a useful methodology to generate a theory that avoids such a tendency, given that it focuses on the identification and explanation of social processes within particular contexts, allowing the current study to develop an understanding of individual *and* social experience with regard to paranoia.

### 2.5.1. Approach to Grounded Theory

Grounded theory has undergone a series of revisions since its conception by Glaser and Strauss, particularly with reference to its use within different epistemological frameworks. However all grounded theory approaches share central characteristics and its procedures have retained a level of consistency (Oliver, 2011).

Madill, Jordan, and Shirley (2000) refer to the various epistemological frameworks that grounded theory study can be conducted within, namely realist, contextual constructionist, and radical constructionist. Neither realist nor radical constructionist approaches were felt to be appropriate to align this research with, and it was decided that a contextual constructionist approach to grounded theory would be most consistent with an epistemology of critical realism. This fits with the critical realist assertion of the study that knowledge inevitably involves the subjective interpretation of meaning. Madill et al. (2000) explain that the contextual constructionist position asserts that all findings are context specific. Jaeger and Rosnow (1988) suggest that contextualism is the stance that all knowledge is provisional, local, and situation dependent. This aligns well with the critical realist stance of this research in which the impact of social context on knowledge production is emphasized, while retaining the belief that there is a reality existing independently of our experience of it. Contextual constructionism and critical realism mutually assert that we can only access the relationship between discourse and reality, as they constantly shape one another.

Use of this approach to grounded theory necessitated an acknowledgement in the current study of the mutuality of participant and researcher in the research process, in the mutual construction of meanings. The notion that one can ‘discover data’ is rejected within the critical realist stance, and instead I assert that all data is constructed. A section is dedicated to reflexivity in chapter four in recognition that

theory is not only grounded in the experience of the participant but grounded in the experience of the researcher also.

#### *2.5.1.1. Abbreviated grounded theory*

A variation in the use of grounded theory is whether the researcher uses a 'full' implementation of the method or an 'abbreviated' version. Willig (2001) suggests that the abbreviated version contrasts with the full version in that it works with original data only. It is used as an alternative version, being particularly suited toward small-scale studies working with existing data. Data is analysed using a grounded theory approach by way of coding, constant comparative analysis and so on, but the researcher does not attempt to move back and forth between data collection and analysis (e.g. by leaving the data set to pursue new participants) for the purpose of negative case analysis and theoretical saturation. Such aspects are only able to be pursued *within* the existing data (Willig, 2013).

This study employed the 'abbreviated' version of the grounded theory method as described by Willig (2001) due to the time constraints imposed upon the research. Therefore, an opportunity was missed to broaden and refine the data by adding to the data set as analysis progressed. Whilst acknowledging that the methodology was used in a fashion more aligned with an abbreviated version, attempts were made to incorporate the aspects often lost by use of this version. The design of the study was theoretically informed hence the inclusion of a quantitative measure of paranoia, but theoretical sampling (the gathering of new data *during* analysis, informed by the emerging theory) was not possible beyond initial sampling, due to the time frame of the study. However, attempts were made to analyse transcripts prior to the next interview in order to use emerging categories to modify the subsequent interview schedule.

The current study did not endeavour to generate a theory that would be universally generalizable due to its small sample size. This study aimed to progressively identify and integrate categories grounded in participant data that would enable a logical explanatory system with regard to their experiences of paranoia, while staying close to the data. In this way the study aimed to produce a model that could shed light on the relationships between social processes and the development and management of paranoia for the participants.

## 2.6. Method: Phase One

### 2.6.1. Participant Inclusion Criteria

The primary aim of the study was to explore experiences of paranoia among the nonclinical student population. The purpose of Phase One was to enable purposive sampling (Payne, 2007), by highlighting a sample of participants for whom the paranoia experience appeared more salient. The inclusion criteria are as follows:

- Participants had to be able to communicate in English.
- Participants had to be a UK based university student at any level of study. As a number of individuals would be subsequently invited to participate in an interview, this criterion was refined to 'London-based university students' before recruitment began for ease of travelling to interview.
- Participants had to be 18 or over, with no upper age limit existing, in line with the Ellett et al. (2003) study of UK university students whose participants ranged from 18-49.

Those who were accessing professional mental health support for help with paranoid experiences at the time of data collection were excluded from the study; however, those who had accessed professional support in the past were not excluded. Those whose paranoid experiences were as a result of drug-taking were also excluded from the study. Questions were included in the questionnaire to address these criteria.

### 2.6.2. Recruitment Strategy

Participants were recruited via convenience sampling on the University of East London campus by approaching people in person, and distributing paper copies and slips containing the URL link to the study. The individuals who opted to fill in a paper copy (n= 44) were offered the use of a private room to fill in the study or to take it and return to me on the same day within the time frame that the 'completed questionnaire' box was in the library. Online recruitment strategies were also used, by posting the link on London university student forums on social media etc.
No statistical power was required for questionnaire data analysis as the measures were used for a 'screen and exclude' function, and to establish descriptive statistics

which were used to contextualise the sample. Therefore, the study initially endeavoured to recruit a minimum of 50 people for questionnaire completion.

### 2.6.3. Data Collection

Phase one of data collection involved gathering quantitative data via questionnaire distribution (Appendix 4), which included questions on demographic information (e.g. age, gender, ethnicity, level of study), the Paranoia Scale (PS; Fenigstein and Vanable, 1992), the first three items of the Personal Experience of Paranoia Scale (PEPS; Ellett et al., 2003) as well as the Green at al. Paranoid Thoughts Scales (GPTS; Green et al., 2008). Participants were also asked to supply a means of contacting them, and it was highlighted that this was because some participants would be invited to interview. Questionnaire completion, however, did not require the input of a form of contact. In order to complete the questionnaire, participants first had to read an information sheet (Appendix 2) and sign a consent form (Appendix 3).

#### *2.6.3.1. The PS*

The PS (Fenigstein and Vanable, 1992) was deemed useful to include in this study, having been included in the Ellett et al. (2003) study, therefore enabling a comparison of findings. The PS (see Appendix 4) was specifically designed to measure the incidence of paranoia in a university population. This self-report scale consists of 20 Likert-type items, ranging from 1 (not at all applicable) to 5 (extremely applicable). Individuals can score from 20-100 on the measure, with higher scores indicating greater paranoia. As Fenigstein and Vanable (1992) acknowledge, the scale uses a broad definition of paranoia, which results in some items relating to thoughts that are ‘reminiscent’ of paranoia. They define paranoia by the following characteristics: suspicion or mistrust of others' motives; a belief that people/external forces are trying to control one's thinking or influence behaviour; a belief that some people talk about/refer to/watch one; a belief that people are against one in some way; and feelings of ill will, resentment, or bitterness.

Freeman et al. (2005) suggest that the scale contains many items that are not considered clearly persecutory in nature for example ‘my parents and family find more fault in me than they should’ which is a potential limitation. However, the scale has an overall alpha of 0.84 implying good internal consistency ($\alpha = .084$) and a test-

retest correlation of 0.70. This indicates that the scale is a reliable measure to be employed in the nonclinical population. Fenigstein and Vanable (1992) also suggest that it demonstrates good convergent and divergent validity.

#### *2.6.3.2. The GPTS*

The GPTS (Green et al., 2008) was included as it is a standardised multi-dimensional measure of paranoid ideation that has been validated for use across clinical and nonclinical populations, which is an advantage it has over the PS. This further enabled comparisons to be made between the 'high scorers' of this sample and the mean total scores for Green et al.'s (2008) clinical sample. The GPTS is It is a self-report measure consisting of two 16-item subscales, assessing ideas of social reference (GPTS-A) and persecution (GPTS-B) over the last month. Higher scores indicate higher levels of paranoia, and individuals can score from 32-160. The Freeman and Garety (2000) definition of paranoia (outlined in the previous chapter) was consulted in the development of the GTPS. The measure has demonstrated good validity and reliability. It was demonstrated to have good internal consistency both in clinical ($\alpha = .90$) and nonclinical ($\alpha = .95$) samples (Green et al., 2008).

#### *2.6.3.3. The PEPS*

Only the first three items were elected for inclusion in this study, as these were used to determine the incidence of paranoia in the Ellett et al. (2003) study, and therefore, could be used to compare with the findings of this study. The subsequent PEPS questions were designed to assess phenomenology of paranoia across cognitive, behavioural and affective dimensions, which were felt to be unnecessary to include given that this study intended to carry out interviews which could gather richer data. Ellett et al. (2003) explain that the PEPS first offers a definition of paranoia as a perception of intention to harm by others, before asking participants to respond with a 'Yes' or 'No' (question one) to indicate whether or not that have had such an experience. If they indicate 'Yes' they are asked to give an example (question two). Question three asks if at the time of the example given the person felt as though the others involved were deliberately trying to harm them. Appendix 4 contains questions 1-3 along with the definition of paranoia given by Ellett et al. (2003).

### 2.6.4. Participants

One hundred and seventy-eight participants were recruited for the quantitative screening phase of the study. Four of these were subsequently excluded from the dataset as they were currently using professional mental health support which was an exclusion criterion, leaving 174 participants. There were 37 males and 137 females in the dataset. Participants average age was 27 (S.D. = 8.83) with a range of 18-57. Sample characteristics and mean total scores on the paranoia measures are shown in Table 1 below. The mean total scores on the paranoia measures will be put into context by comparison to other research in the following chapter.

With regard to the representativeness of the sample in relation to the general UK student population, the 174 participants recruited account for 0.007% of the 2,266,075 higher education student population in 2015 (HESA, 2016). Approximately 24% of the UK university population were engaged in postgraduate study at the time of the HESA (2016) survey while 76% were undergraduates, and approximately 54% of these students were female. The sample recruited for this study, therefore, has substantially more females and postgraduates than is representative of the UK student population in general.

**Table 1.** Sample Characteristics

| Variable | Total sample (*n*= 174) | Approached for interview (*n*=31) | Final interview sample (*n*=7) |
|---|---|---|---|
| Age (years) M (SD) | 27.35 (8.83) | 39.82 (10.94) | 28.14 (6.12) |
| Sex N (%) | | | |
| Male | 37 (21.3) | 5 (16.1) | 1 (14.3) |
| Female | 137 (78.7) | 26 (83.9) | 6 (85.7) |
| Ethnicity N (%) | | | |
| White British/ Irish/Other | 115(66.1) | 18 (56.4) | 5 (71.4) |
| Black British/Caribbean/African | 22 (12.6) | 4 (12.9) | 1 (14.3) |
| Asian British/ Asian/Other | 21 (12.1) | 5 (16.1) | 1 (14.3) |
| Mixed | 7(4.0) | 3 (6.1) | 0 (0) |
| Other | 9 (5.2) | 1 (3.2) | 0 (0) |
| Level of Study N (%) | | | |
| Undergraduate | 84 (48.3) | 23 (74.2) | 3 (42.9) |
| Postgraduate | 89 (51.1) | 8 (16.1) | 4 (57.1) |
| Use of Professional MH support N (%) | | | |
| Historical | 22 (12.6) | 13 (41.9) | 1 (14.3) |
| Paranoia Scale Scores M (SD) | | | |
| GPTS-A | 29.99 (11.71) | 48.0 (9.21) | 46.34 (7.31) |
| GPTS-B | 26.06 (13.99) | 51.48 (11.93) | 55.0 (12.65) |
| Total GPTS[1] | 55.92 (24.04) | 99.48 (15.46) | 101.0 (11.67) |
| Paranoia Scale[2] | 39.25 (15.44) | 56.77 (16.69) | 51 (15.13) |

[1]GPTS scores can range from 32-160
[2]PS scores can range from 20-100

## 2.7. Method: Phase Two

### 2.7.1. Recruitment Strategy

It was decided that participants would be invited to participate in an interview on the basis of their GPTS scores. This is because it was developed for use across the general population-clinical population continuum, and as such enabled a more valid comparison between this study's population, and the data presented for a clinical

population in the Green et al. (2008) study. Beginning with highest scorers on the GPTS (which denotes higher levels of paranoia) and working down until enough individuals agreed to participate, participants were contacted and invited to participate in an interview. They had received prior indication of the possibility of being contacted when filling out the questionnaire (Appendix 4).

### 2.7.2. Data Collection

Phase two of the study represents the core of the study, entailing the gathering of qualitative data by way of one-to-one, semi-structured interviews. These were carried out in research rooms at the University of East London, and lasted 45-70 minutes. A semi-structured interview schedule (Appendix 7) was constructed to serve as a prompt for areas of conversation in line with the natural flow rather than be asked in as a sequence of questions. Efforts were made to ensure questions were open-ended to avoid 'leading' the participant's answer.

The first line of questioning on the interview schedule is regarding the person's own understanding of the development and nature of paranoia and explores a recent scenario where they felt others might want to harm or upset them deliberately, the circumstances of that scenario and other times that they had felt that way etc. The second theme centred around the effects of such concerns on the person's life, with regard to the ways in which their life had been impacted, whether their concerns had changed over time and the effect of such concerns on their social relationships. The final line of questioning revolves around the theme of coping with or managing the paranoia experience. Question areas here included how they manage their concerns in relationships, how others have responded, and what stops the worry from getting worse.

### 2.7.3. Participants

Thirty-one individuals were approached for an interview on the basis of their GPTS scores as can be seen in Table 1 above. Approximately 12 of the 31 people approached responded to the email or message left, seven of whom agreed to take part, and eight of whom declined to take part. All of those who responded but declined gave a busy schedule as the reason they could not take part. The overall

sample, the subsample approached for an interview, and the final interview sample is described by their demographic and other variables of interest in Table 1 above.

The final sample of participants totalled seven individuals that agreed to be interviewed. The mean age was 28.14 (S.D. = 6.12). There were one male and six females. Table two below describes the final sample using pseudonyms.

**Table 2.** Final Interview Sample

| Name* | Age | Sex | Ethnicity | Level of Study | Previous MH Service Use | Total GPTS score |
|---|---|---|---|---|---|---|
| James | 36 | M | White British | Postgrad | No | 111 |
| Sukhi | 26 | F | Indian | Undergrad | No | 116 |
| Sarah | 25 | F | White British | Postgrad | No | 99 |
| Lisa | 36 | F | White British | Postgrad | Yes | 103 |
| Marsha | 30 | F | White British | Postgrad | No | 96 |
| Kemi | 20 | F | Black African | Undergrad | No | 83 |
| Katrina | 24 | F | White Other | Undergrad | Yes | 113 |

### 2.7.4. Process of Interviewing and Analysis

Participants were given time to ask any questions after they had read the information sheet (Appendix 5), however, no questions were asked. A preamble was given before the interviews regarding previous research findings that paranoia is a common experience in the nonclinical population (see Appendix 7). This was given in an attempt to allay any fears about appearing ‘abnormal’, holding in mind that paranoia is still a stigmatized experience. They were then asked to sign a consent form (Appendix 6), reminded of confidentiality limits, and asked if it was ok to begin audio-recording.

Each interview was transcribed verbatim shortly after taking place. This enabled attempts at initial coding to be performed on the transcripts prior to the next interview so as to adapt the interview schedule. This was to allow for inquiry about any emerging ideas that had not previously been considered as is suggested by Starks and Trinidad (2007). This occurred after the first interview, where the theme of 'maleness' arose (briefly) despite not having been asked about. This prompted an adaptation to the interview schedule to include a question about gender so that the relationship between gender and paranoia could be considered. However, due to the time frame, this was not possible for all interviews, and theoretical sampling was therefore not pursued in light of emerging categories.

Coding is a feature common to all version of grounded theory, as is the process of categorising of data. Line-by-line coding was performed on each transcript in turn, which involved assigning descriptive labels to instances of phenomena in order to begin identifying categories (Willig, 2013). Codes were then interrogated for other possible interpretations. Efforts were made to use the participant's own words to ground the data and refrain from imposing my own language where in vivo codes could be used. In order to facilitate coding that was orientated toward the actions and processes in the data, gerunds were found to be useful, as suggested by Charmaz (2006).

The second stage of analysis involved focused coding, which aimed to capture the more frequent or seemingly significant codes to develop meaningful categories. This stage of coding tended to move from a descriptive to more analytical or interpretative level, as codes were grouped together based on their common features and the relationships between them were tentatively theorised. Focused codes were in turn grouped together to form two core categories and respective subcategories.

Constant comparative analysis, as a characteristic of grounded theory, took place at each level of analysis but particularly aided the movement from open coding to focused coding. This involved searching through and comparing the data, making links between codes, and looking for differences and similarities within and across transcripts (known as theoretical sensitivity) therefore capturing instances of variation within the emerging theory. This allowed categories to be refined and made more robust. For example, I initially had a group of codes that pertained to a process of

‘engaging in an inner dialogue with oneself’ thus receiving that label as a focused code. I originally thought this might be a variation of the subcategory ‘Investigating the Concern’, but on comparing those codes with codes relating to coping mechanisms, I realised that two variations of ‘engaging in an inner dialogue’ existed: times when the participant did so to help themselves form a conclusion, and other times when they wanted to reassure themselves. Those codes that related to reassurance were subsequently moved to a category that related to coping while the rest remained in ‘Investigating the Concern’. Differences within a category prompted consideration of whether a subcategory could be useful to extend the theoretical idea, displaying the complexity of the paranoia experience.

As an important characteristic of grounded theory, detailed memos were kept (see examples in Appendix 11) during the processes of interviewing, transcribing, and analysis. This meant keeping a written record of ideas and reflections during the process of data collection and analysis (Willig, 2013), aiding the process of constant comparative analysis. Any personal reflections, coding ideas, theoretical concepts that were coming to mind, or thoughts on emerging categories were captured in the memo.

Finally, the point of category saturation was reached, where no further refinement of categories could be made within the dataset, and it was not possible to leave the dataset to pursue new data due to time constraints. The notion of progressive abstraction guided analysis and as such, the process continued until as few as possible categories satisfactorily accounted for the data.

The final stage of analysis involved theoretical integration. This referred to the process of organising the codes and categories into a ‘hierarchy’. The aim here was to develop a consistent ‘story’ that would have explanatory power and depth, accounting for the complexity of participant experience.

## 2.8. Ethical Considerations

Ethical approval for this study was granted by the School of Psychology Research Ethics Sub-Committee at the University of East London (Appendix 1). As participants

were recruited from the non-clinical population, no other ethical approval was necessary.

### 2.8.1. Informed Consent

To enable participation in either phase of the study (quantitative or qualitative) participants were asked to read a study information sheet (Appendix 2 and 5), and then to sign a consent form (Appendix 3 and 6). It was made clear that by completing the questionnaire, participants were in no way committing themselves to subsequent participation in an interview, but that they might be contacted should they supply contact information. All participants who responded to the initial invitation for interview were informed that they were being invited because their responses on the questionnaire suggested that they had experienced suspicion about others or paranoia which was the interest of the study. However, they were assured that research would suggest such experiences are common, and not necessarily a cause for concern. Participants were also routinely debriefed following interviews and supplied with details of organisations from which they could seek support (Appendix 8) for concerns such as paranoia if wanted. Additionally, participants were made aware of their right to withdraw from the study at any point.

### 2.8.2. Confidentiality

Participant confidentiality was ensured by assigning identification numbers to participants and storing contact details separately and securely until they were destroyed. Questionnaires were stored in a locked cabinet and contact information and audio recordings were stored in separate password protected documents, on a password protected computer. All interviews were anonymously transcribed.
As part of the preamble to the interview I advised participants that I would have to break confidentiality only if I was worried about a risk to them or others. The study supervisor was in the building at interview times, and available to consult with (as planned) in any potential risk situation e.g. if it appeared a participant was in such distress that simply supplying a list of organisation for support seemed insufficient, and another measure seemed appropriate, such as advising the participant to attend A&E. No such scenario arose however, and all participants indicated afterwards that they had found it helpful to share their experiences.

## 2.9. Evaluating the Quality of the Study

Madill et al. (2000) argue for the need for qualitative researchers to make explicit their epistemological positions, conduct their study in line with their position, and outline their findings in such a way that their readers may evaluate them. Furthermore, while Henwood and Pigeon (1992) suggest that research can never be unbiased due to the role of the researcher's unique interactions with the data, they suggest the research should still display internal coherence i.e. developing our understanding whilst accounting for and explaining any contradictions in the data.

Care has been taken to include adequate information throughout the write-up of this study, to enable a reader to evaluate its quality. Concurrently, steps were taken to remain reflexive throughout the research process, acknowledging my role in the process. As such, a section is dedicated to reflexivity in chapter four.

Yardley's (2000) evaluative criteria for qualitative approaches were drawn upon, which can be used as a framework to consider the validity of this research. The criteria are briefly described below, however, evaluation of the quality of this study is considered in detail in chapter four.

- *Sensitivity to context:* This refers to having a good awareness of the relevant literature, the ethical consideration of the participants, as well as acknowledgement of one's own assumptions and views (Harding & Gantley, 1998).
- *Commitment and rigour:* This is regarding commitment to the topic and methods of analysis as well as the researcher's engagement in the research. This principle is considered particularly important in demonstrating validity in qualitative studies (Yardley, 2008).
- *Transparency and coherence:* This principle refers to the study's presentation, as well as the consistency between the study aims, methodology, and methods.
- *Impact and importance:* This principle refers to whether or not the study evokes new understandings of the topic, and is of impact and utility (Yardley, 2000).

# CHAPTER THREE:
# RESULTS

## 3.1. Chapter Overview

This chapter begins by presenting the quantitative data gathered in Phase One of the research. In an effort to contextualise this data, comparisons to previous research will be made. Following presentation of quantitative data, a short profile summary will be provided for each interview participant, to give context to the qualitative analysis. The chapter will then move to a presentation of a grounded theory generated from the interview data gathered. Participant quotes will be included to illustrate the categories that have been constructed.

## 3.2. Phase One: Quantitative Results

### 3.2.1. The Green et al Paranoid Thoughts Scales (GPTS)

As described in the previous chapter, higher scores on the GPTS indicate higher levels of paranoia. Total GPTS scores range from 32-160. Table 3 below provides GPTS data for the current study's overall and interviewed samples which can be compared to data in the Green et al. (2008) study. As can be seen, the mean total GPTS score for the overall sample in this study (*M* = 55.92) is only slightly higher than the nonclinical (student) sample means provided in the Green et al. (2008) study (*M* = 48.8). The mean total GPTS score for the interviewed sample (*M* = 101.0) in the current study is also very comparable to the mean total GPTS score (*M* = 101.9) for the clinical sample in the Green et al. (2008) study. Five of the seven participants interviewed for this study scored above the mean total GPTS score for a clinical population sample, with one participant scoring within one standard deviation below, and the final participant scoring within two standard deviations below. This demonstrates that the sample interviewed for the present study are highly comparable to the clinical population sample in the Green et al. (2008) study based on their GPTS total scores.

**Table 3.** GPTS score comparisons

| | **Present Study Overall Sample** | **Present Study Sample Interviewed** | **Green et al (2008) Nonclinical Sample** | **Green et al (2008) Clinical Sample** |
|---|---|---|---|---|
| | (n = 174) | (n = 7) | (n = 353) | (n = 50) |
| | Mean (SD) Range | Mean (SD) Range | Mean (SD) Range | Mean (SD) Range |
| **GPTS A ref**[1] | 29.99 (11.71)16-68 | 46.34 (7.31)35-55 | 26.8 (10.4) 16–72 | 46.4 (16.4) 16–80 |
| **GPTS B pers**[2] | 26.06 (13.99)16-73 | 55.0 (12.65)35-70 | 22.1 (9.2) 16–77 | 55.4 (15.7) 16–80 |
| **GPTS Total** | 55.92 (24.04)32-141 | 101.0 (11.67)83-116 | 48.8 (18.7) 32–149 | 101.9 (29.8) 32–160 |

[1]Social reference subscale
[2]Persecution subscale

3.2.2. The Paranoia Scale

Higher scores on the Fenigstein and Vanable (1992) Paranoia Scale (PS) indicate higher levels of paranoia. Participant scores on the PS can range from 20-100. Table 4 below provides PS data for current study's overall and interviewed samples that can be compared to data in the Ellett et al. (2003) study, the Green et al. (2008) study, as well as the original normative data published by Fenigstein and Vanable (1992) which was generated from a student sample. As is displayed below, the mean total PS score for the overall sample in this study (*M* = 39.25) is consistent with the findings from the Ellett et al. (2003) sample of students (*M* = 39.5), which are both only slightly lower than the Fenigstein and Vanable (1992) mean total score (*M*= 42.7). The mean total PS score for the nonclinical sample (comprised of students) in the Green et al. (2008) study (*M* = 35.4) is also similar to the mean total PS score of the current study. As is displayed below, the sample interviewed in the current study were experiencing comparable levels of paranoia to the service user participants included in the clinical sample of the Green et al. (2008) study, with the mean total PS score of the current study being within one standard deviation of the mean total PS score of the Green et al. (2008) study.

**Table 4.** Paranoia Scale Score Comparisons

| | **Present Study Overall Sample**<br><br>(n=174)<br><br>Mean<br>(SD)<br>Range | **Present Study Sample Interviewed**<br><br>(n=7)<br><br>Mean<br>(SD)<br>Range | **Ellett et al. (2003)**<br><br>(n=324)<br><br>Mean<br>(SD)<br>Range | **Fenigstein &Vanable (1992)**<br><br>(n = 214)<br><br>Mean<br>(SD)<br>Range | **Green et al (2008) Nonclinical Sample**<br><br>(n=353)<br><br>Mean<br>(SD)<br>Range | **Green et al (2008) Clinical Sample**<br><br>(n=50)<br><br>Mean<br>(SD)<br>Range |
|---|---|---|---|---|---|---|
| **Paranoia Scale** | 39.25<br>(15.44)<br>20-91 | 51.0<br>(15.13)<br>30-71 | 39.5<br>(10.8)<br>20-77 | 42.7<br>(10.2)<br>20-100 | 35.4<br>(13.2)<br>20–89 | 63.8<br>(20.5)<br>21–100 |

3.2.3. Inclusion of Items from the PEPS Questionnaire

In the total sample of 174 participants in the current study, 32.8% (n = 57) responded ‘yes’ to both questions 1 and question 3, with 56.3% (n = 98) responding with a ‘yes’ to question 1 only. That is to say that 32.8% reported an episode of paranoid ideation, including a statement of belief that another person had the intention to harm them while 56.3% reported an experience they identified as paranoia but did not include a statement of planned intention to harm. The final 43.7% (n = 76) indicated that they had never experienced a situation in which they felt another person was deliberately trying to harm or upset them. These results are presented in Table 5 below where they can be compared to the responses to questions 1 and 3 in the Ellet et al. (2003) study.

**Table 5.** PEPS Responses to Questions 1 and 3

| | Yes<br>N (%) | No<br>N (%) | N/A<br>N (%) |
|---|---|---|---|
| **Current Study** | | | |
| Q.1. Have you ever had a feeling that people were deliberately trying to harm or upset you in some way? | 98 (56.3) | 76 (43.7) | 0 (0) |
| Q.3. In the above situation that you have described, at that time did you feel that the other people involved actively intended to harm you? | 57 (32.8) | 39 (22.4) | 73 (42) |
| **Ellett et al. (2003) Study** | | | |
| Q.1. Have you ever had a feeling that people were deliberately trying to harm or upset you in some way? | 73 (70) | 98 (30) | 0 (0) |
| Q.3. In the above situation that you have described, at that time did you feel that the other people involved actively intended to harm you? | 153 (47) | 73 (23) | 98 (30 |

The responses in this study differ to those reported in the Ellett et al. (2003) study wherein 47% (n = 153) of their sample reported an episode of paranoid ideation in which they felt another person had the intention to harm them, compared to 32.8% in this study. Only 30% (n = 98) of the sample in the Ellett et al. (2003) study reported not having an experience of paranoia, compared to 43.7% in this study. This is surprising given that the mean total PS scores for both studies are so similar. One might expect that if the PEPS questions 1 and 3 do accurately assess for the incidence of paranoia that our findings on these questions would be more closely aligned given that consistency of our mean total scores on the PS.

Consistent with the Ellett et al. (2003) study, participant responses to question two ('please describe an example of the situation where you felt someone was deliberately trying to harm/upset you') were allocated to three categories: *unexpected event* (n=50), e.g. 'Someone ignoring what I am saying on purpose, being not interested', *victimization and injustice* (n=20 ), e.g. 'in employment, people ganging up and removing support and singling me out', and *exclusion* (n=9 ), e.g. 'friends

conspiring to exclude me from invitations/meet-ups'. However, in addition to these three categories, it was felt necessary to add a fourth *ambiguous* (n= 13) category to account for responses that did not directly answer the question such as the following example where the person gave an opinion rather than describing a situation e.g. 'people tend to have such a behaviour when they're experiencing feelings of jealousy of some kind'. It was noted that many responses were describing actual events whereby the person had experienced deliberate harm (either psychological or physical) from another. Examples responses to question two in this study include 'A man shouted at me on the bus and called me four-eyes', and 'A lecturer wouldn't let me return to the classroom having left to pray', which highlight a potential problem of participant comprehension perhaps due to the paranoid definition offered being unclear, and the questions not clearly asking about paranoia. A remedy to this could be to add on 'in the absence of clear evidence' to the two questions as Allen-Crooks (2012) suggests.

### 3.3. Interview Participant Profiles

A brief summary of the general concerns that participants described as paranoia during interviews are presented in Table 6 below to give context to the following grounded theory analysis.

**Table 6.** Participant Profiles

| Participant Pseudonym | Summary of Concerns Identified as Paranoia |
|---|---|
| **James** | At the time of interview was particularly concerned about a work situation in which he worried that a particular person may have been conspiring against him for an unknown reason |
| **Sukhi** | Sukhi described feeling paranoid in many situations throughout her life, saying that she has a paranoid thinking style. However at the time of the interview she had fallen out with a family member leading her to become particularly paranoid about her close relationships. She worried about what others were saying and thinking. |
| **Sarah** | Sarah had fallen out with a friend just before the interview. She was concerned that the friend was deliberately turning people against her. She described occasionally experiencing paranoia with regard to strangers (such as on public transport), but most usually in situations with known others. |
| **Lisa** | Lisa was concerned about being excluded and plotted against in her work context at the time of interview. She identified that experienced paranoia in most social contexts, mostly around known others such as colleagues. |
| **Marsha** | Marsha identified struggling with paranoia in relation to peer groups. She was concerned about being intentionally excluded or talked about in a malicious way. She also reported the occasional thought that she could be in an altered reality where everything around her was purposely set up for her (i.e. the Truman show). When she was younger Marsha recalled thinking that she was being followed by cartoon characters and dangerous people that she had seen on the news. |
| **Kemi** | Kemi reported that she only experienced paranoia with regard to strangers while out in public, but never in relation to friends or family. Her concerns were mostly with regard to being physically harmed in a random attack. Kemi described that she felt much less distressed in recent times since she started regularly hearing the voice of God, who she felt would keep her safe and give her life meaning. |

| | |
|---|---|
| **Katrina** | Katrina described experiencing paranoia in relation to strangers in public as an on-going problem since her early teenage years. Her concerns about strangers ranged from being harmed psychologically (e.g. discovering she was being harshly judged) to being physically harmed. At age 16, she described a period of living in her own world, seeing and hearing 'things' and speaking to herself alone for hours at a time. |

## 3.4. Phase Two: Grounded Theory

This section outlines the two theoretical models (or core categories) developed following analysis of the qualitative data. Two core categories were constructed; 'The Process of Becoming Paranoid' and 'Living with Paranoia'. These categories appeared to encapsulate the overall processes that were emerging from the data, and reflect the original aims of the research; to investigate participants' perceptions of the causes of, effects of, and ways of managing paranoia in their lives.

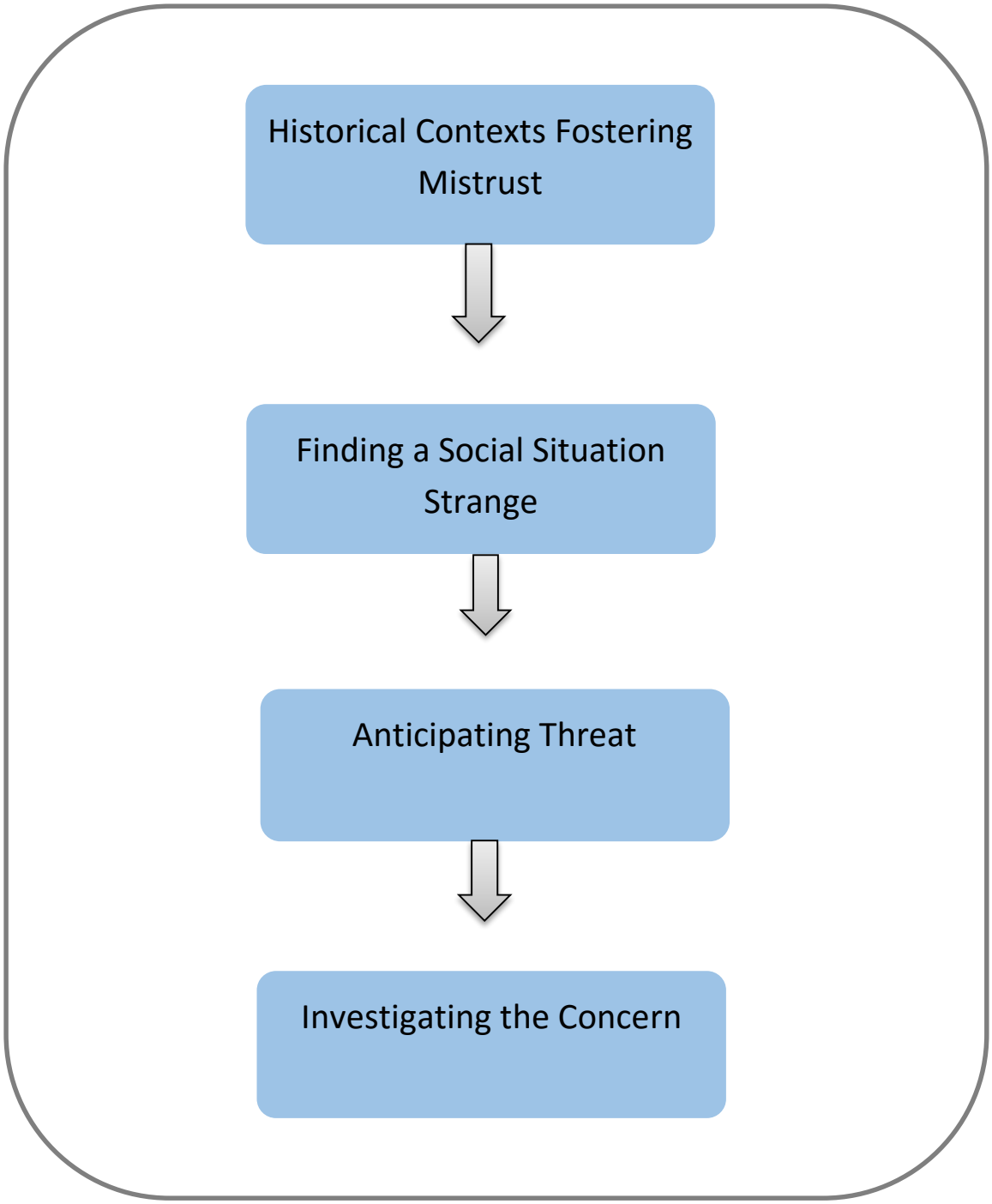
These core categories and subcategories will be described, elaborated upon, and supported by the inclusion of quotations from interviews with participants. Focused codes which were used in the construction of subcategories will also be used to organise material where variations within a subcategory exist. Participant quotes are included in headings where suitable.

## 3.5. Core Category 1: The Process of Becoming Paranoid

This category represents participants' perceptions of how and why they came to experience paranoia in their lives. It captures the historical aspects that that they felt may have shaped a tendency toward mistrust, before outlining the specific situations in which paranoia emerged, including participants' reactions to feeling at risk from another person.

This core category is illustrated in *Figure 1* below. It is elucidated through the subcategories 'Historical Contexts Fostering Mistrust', 'Finding a Social Situation Strange', 'Anticipating Threat', and 'Investigating the Concern'.

**Figure 1.** The Process of Becoming Paranoid



### 3.5.1. Historical Contexts Fostering Mistrust

This category pertains to participant perceptions of causal factors or contexts that may have shaped their tendency to be mistrustful of others.

Each participant made reference to reasons why they believed that they might be more susceptible to experiencing paranoia than others such as being bullied in their school context, being from a high crime neighbourhood etc. which are outlined below.

#### *3.5.1.1. 'I've seen my mum being suspicious': Family context*

Four of the seven participants spoke of their family contexts as being relevant in thinking about causal influences on their current day experiences of paranoia. While it was acknowledged that having good family relationships was a support for many participants, it was also felt that one's family could have fostered a mistrustful interpersonal style. Three participants had also described difficult family dynamics and inconsistent parenting, with two participants losing a parent in tragic circumstances. Three of the four participants felt that a paranoid interactional style was unintentionally modelled to them, and the other participant felt it was consciously modelled by her parents as a way of keeping her safe from 'stranger danger', leading her to believe it was a healthy and important attitude toward others.

One participant, for example, spoke about growing up with a parent who had been diagnosed as having paranoid schizophrenia, and felt that her mother's tendency toward suspicion and withdrawal influenced her own tendency toward "putting up the barriers". Lisa's extract below echoes this experience of being shaped by parental behaviour and thinking styles, consistent with Bandura's (1977) social learning theory.

> Lisa: I mean sometimes my parents are very suspicious people. Yeah, I'm starting to learn when not to talk to them about stuff and when and who to talk to. I do think you know I got particular ways of thinking from my parents I think yeah… nobody's perfect. And I guess that's sort of a less welcome legacy from them. (p.20)

*3.5.1.2. 'They're looking at us, what are they thinking': School context*

Five participants spoke about difficult school environments that may have impacted their ways of relating to others. Four of these reported being bullied at school. Three of which also spoke about falling out with friends which left them feeling paranoid, alone, and anxious. One of the five participants explained that she felt particularly prone to paranoid ways of thinking during school, due to adolescence being an emotional period of "turmoil", "growth", and "change", in which she strived to develop an identity and cement a peer group. Lisa's extract below demonstrates something she later termed a "self-fulfilling prophecy" whereby difficult peer dynamics affected her social skills, in turn meaning that she came across as "creepy", creating a cycle of paranoia and isolation in her teenage years. She said she felt that she was vulnerable to paranoia, and the extract below was her response to being asked why she believed that she was vulnerable.

> Lisa: Sort of past events that kind of predisposed me or shaped me to be not trusting and not confident; which affected my ability to interact socially for fairly long. And then kind of different things… but there's a later thing that happened [friend's betrayal and mocking] that really fucked everything up for secondary school, sorry about my language. So yeah I was just vulnerable probably to not interacting necessarily in the healthiest way and then not being resilient when things went wrong I guess. (p.10)

*3.5.1.3. 'It could be anyone': Neighbourhood context*

Neighbourhood context appeared to be another important factor that three participants perceived as important in fostering a mistrust of others. In Katrina's extract, she linked her sense of being constantly watched by others to being raised in a small village, where she felt constantly observed.

> Katrina: I was raised up by a very strict family in a very small I would say village…like okay, you have to be careful because if the neighbour sees this they will talk about it or at school be the best because people will talk about it and stuff like that. And I think at the back of my head I've got that in my head like every time I do something. (p.5)

Conversely, Kemi felt her experience of growing up in a dangerous London neighbourhood had made her very aware that "normal people" can hurt others and that it "could be anyone", leading her to feel unsafe when out in public. She seemed to view paranoia as a sensible adaptive way of being, entirely influenced by her environment.

> Kemi: And also people's levels of conscience, like people don't have as much guilt, remorse or they don't see another human being as precious; and obviously with my background I'm from [country where crime is high] and my parents have always told me about the people there they kill and they don't really see it as a big deal […later in transcript…] those people that do commit crimes, they also have people that they value, love and they also have normal relationships which in a way makes you realize that if you think like that it could be anyone. (p.4, 6)

Further to the aforementioned contexts being referenced as factors that led to a tendency toward mistrust, three participants also felt that being a woman contributed to feeling unsafe. A need to protect the self against men appeared to be an aspect of their experience as females. One participant described a sense of a "male gaze" whereby she felt judged and observed by men, who might prey upon the more vulnerable female. Kemi's quote below relates to her feeling vulnerable as a woman, and how it played on her mind.

> Kemi: …so you know I think it's mostly men as well; I just find them really strange and they do make me feel uncomfortable…I'll often just think ok he is just going to drag me in the car and see it just playing out in my mind. (p.14)

The next subcategory outlines the findings in relation to present day contexts for paranoia development as perceived by the participants.

### 3.5.2. Finding a Social Situation Strange

This subcategory weaves together participant commonalities regarding the social contexts that had caused paranoia to become a salient experience. It represents the situational characteristics across participant descriptions that appeared to act as 'triggers' for paranoia.

Participants had given examples of situations when they felt paranoia was 'active' and gave examples of the types of behaviour noticed in others that had given rise to concern about being at risk in some way. Within and across interviews there appeared to be two broad variations to a social situation being judged as strange; when the behaviour was judged as unusual for the context, and/or when something was perceived as 'unknown' about the situation.

*3.5.2.1. 'They look at me and it makes me feel uncertain': Finding behaviour unusual*

Participants appeared to compare the behaviours that they were observing in various situations with idealised norms of behaviour. When behaviour did not match up with their implicit expectations of how people 'should' behave in a particular context, they experienced discomfort and suspicion. While participants all appeared to be quite observant individuals who were highly aware of what the people around them were doing, they simultaneously experienced attention from others (e.g. another staring) as unusual and unwelcome. Kemi spoke about feeling "paranoid" and "uncertain" around anyone who was not focused enough on 'their own thing' which she felt they ought to be. Sarah's extract demonstrates such an experience.

> Sarah: Generally on the tube people sit on phone and reading the paper, so people talking anyways is a bit unusual. And their speech wasn't like friends kind of catching up or killing time. (p.23)

Further to the behaviour of others being judged with reference to idealised norms of behaviour, three participants highlighted the role of the media in influencing such judgements. Three participants directly implicated the media in generating needless paranoia, suggesting that they encourage inaccurate perceptions of crime risk due to biased reporting.

> Kemi: I've kind of shut out the news and stuff. I don't really read the media because to be honest it's not truthful and all it's going to do is get you in a state where you're constantly paranoid about other people; constantly suspicious of other people's motives. […later in transcript…] I think with me that the only reason I get suspicious or paranoid is because of the media and what they portray. (p.3, 12)

*3.5.2.2. Pondering the 'unknowns' of a situation*

Participants also described paranoia triggering situations as ones in which they felt 'in the dark' about the thoughts, feelings, or motivations of another person. The ambiguity of a situation appeared to leave the participant with many questions to ponder over, sometimes creating rumination cycles. In the following extract, James reflects on the concern he had about a co-worker conspiring against him, though interestingly he showed an awareness of the potential for other more mundane and innocent explanations for the person's behaviour.

> James: …every time I see him talking and he sort of looks, and they sort of walk further away so they can't hear me. He might be talking about his lunch I don't know…but I start thinking to myself… (p.3)

Linking to the discomfort at being paid undue attention that several participants experienced, Marsha also referred to staring as a "banal" piece of interaction that still holds the power to rob her of her sense of safety. It appeared that participants were able to consider other explanations for a person's behaviour, yet were unable to control the emergence of paranoia, suggesting that at times it was beyond their ability to rationalise.

> James: So it's *obvious* that they have had a conversation… I say it's obvious… to *me* I am now thinking to myself 'okay, you know, it's come around again what's he doing, what's he saying to her? Has he now said something to someone else?' (p.10)

The next subcategory represents an apparent pathway that participants moved through, from findings a situation strange to feeling threatened.

### 3.5.3. Anticipating Threat

This subcategory represents participants' attempts to describe what 'being paranoid' meant to them, with regard to the various characteristics of the experience such as the emotional and cognitive processes involved, as well as describing the type of threat being anticipated.

Participants seemed just as concerned about the threat of psychological harm, as that of physical harm. Some threats mentioned were that someone was conspiring with others to get the participant fired; that friends or others were talking about the participant in a derogatory way or purposely excluding them; and that strangers were staring at or following the participant with potential intent to cause physical harm.

Each participant named anxiety, fear, and low mood as emotional components that came together to form a period of heightened paranoia. Lisa spoke about a self-perpetuating cycle in which she 'acted weird' because she is feeling "frozen, paralyzed and not able to do anything". This sense of uncertainty, paralysis and fear during a period of heightened paranoia led to participants feeling vulnerable in that context.

Participants also spoke about various mental processes that comprised the paranoia experience, such as constant questioning of the motivations of another person. The extract below represents Marsha's attempt to explain her experience of paranoia, where she drew attention to the spiraling nature that makes it difficult to control.

> Marsha: …it [paranoia] makes you feel really bad; it makes you feel really… I found that if I felt particularly suspicious or paranoid about something that if you're left to your own devices in thinking, being stuck in your head, it can become really poisonous and it's really hard to control. I've been in positions when I was younger where I've managed to let spiral massively with no grounding whatsoever and it's been yeah just… got a bit out of hand really. (p.2)

James talked at length about the nature of 'feeling paranoid', explaining how he experienced as different from other emotions, or perhaps represents a combination of emotional and cognitive processes. Similar to other participants, he emphasized the importance of 'control', or lack of control, as a concept that was important to understanding paranoia. He appeared to feel that paranoia was essentially feeling powerless while faced with painful uncertainty about a potential threat. He explained that without this knowledge, he was unable to take appropriate action to keep himself safe, meaning that he had no control over his fate.

> James: I felt like there was some kind of threat to me, but I didn't know what the threat was. I didn't know why there was a threat, I didn't know where the threat was coming from… but I felt on edge. For me personally, paranoia is when I'm feeling scared... I'm feeling worried about something I'm scared or upset or whatever. And I'm not in control of what the issue is, and I don't even know for certain how to deal with it. (p.11)

While feeling paranoid, or anticipating threat, participants went on to attempt to make sense of how they were feeling, as is explained in the subsequent subcategory.

### 3.5.4. Investigating the Concern

This subcategory represents a process whereby participants tried to make sense of their concerns. It outlines their attempts to process and evaluate the validity of their concerns both intra and interpersonally.

Following identification of the paranoid feeling, participants went on to consciously ask themselves key questions in a deliberate effort to make sense of their emotions, as well as recruiting others in their quest for answers. This 'investigating' often led them to notice even more 'strange' things about social situations, therefore feeding back into and reinforcing the process of becoming paranoid. A sense of uncertainty about threat appeared to be an important aspect of the paranoia experience for each person, which resulted in a struggle to reconcile a conflicting inner dialogue inner with regard to their own 'rationality' and 'irrationality'.

*3.5.4.1. Wrestling with one's inner dialogue*

In identifying as 'paranoid', each participant held a sense of doubt about the accuracy of their own fears. James' extract below demonstrates an inner dialogue that was always experienced during a time of paranoia. He reported experiencing rational and irrational sides that were separate and un-integrated.

> James: I have like always got my rational head, and I've always got my irrational head going 'Oh my god! Why she just ignored me?' And my rational head is like, 'she's a kid I don't care it's nothing to… just like she is just with her friends' (p.10)

Participants engaged with their inner dialogue in an attempt to form a conclusion about the appropriateness of their feeling of concern, drawing on discourses of rationality and reason in a realist search for the 'truth'. Another way participants' tried to evaluate their concerns was to place their feeling of paranoia into a wider context, taking a wider perspective. This included considering one's own potential reasons for arriving at a particular suspicion, such as Kemi does below. Two other participants spoke about being able to see the rationale for another person's behaviour as imperative in judging whether they were being reasonable, and not being able to ascertain a rationale seemed to 'fuel the paranoia fire'.

> Kemi: Yeah so it's like I don't straight away think like this person is out to get me; I kind of think like okay you could be paranoid because of this and because of that. So I try and balance it out because I know that my views on people will be different to someone who has never maybe studied [subject mentioned] or someone who grew up in a different area. (p.14)

Three participants also described a 'rule of thumb' they had developed as a heuristic technique to investigating the validity of their concerns which they turned over in their

minds upon encountering a situation perceived as strange. James spoke about a rule for when a person does something that made him feel uncomfortable (e.g. staring) thinking that once was a mistake, twice is a habit and three times is a reason to be paranoia. Marsha describes her 'rule' in the extract below.

> Marsha: Sometimes I've made myself a clause like… 'If they look at me again then I know they're looking at me' and then if it has happened which is extremely rare I'm like 'wow that's just a coincidence'. (p.19)

*3.5.4.2. 'He completely denied it': Confronting the person*

Along with the aforementioned intrapersonal ways of investigating the concern, participants also drew on interpersonal methods of investigation. Three participants went as far as to confront the person being suspected of having a malevolent motive. The other participants, however, felt that confrontation would be pointless as they perceived the other person as unlikely to be truthful about their actions or intentions.

> Lisa: … I tried to rectify things with her [a colleague] but she was really controlling and had kind of power in her and her ability could never be questioned. (p.2)

*3.5.4.3. Getting others' perspectives*

As part of their attempts to form an 'accurate' conclusion about the concern, all participants described telling friends, family or colleagues pieces of information to gauge their reactions, which could then be used to inform their own thinking about the issue. Rather than confiding in others as a form of relief or support (which could be thought of as a way of coping), there appeared to be a clear distinction whereby some participants confided as a means to gather more information to aid their decision-making, such as in the extract below.

> Sarah: Like in situations with other people; 'oh blah blah told me this' and see how they react; kind of using different people, people who didn't know the situation and seeing their reactions and gauging from them. And seeing actually they didn't react that badly; so thinking 'ok maybe it is this one person'…so kind of testing out with different people. (p.6)

Participants' various attempts to investigate the concern had differing outcomes. Sometimes the information gathered from others would relieve them as it would be deemed insufficient to support their fear of threat from another. Even managing to

gather some knowledge of the threat was helpful, even if the threat was not disconfirmed as can be seen in James' extract below which refers to his boss having given him important information about his concerns having gone to him to elicit his views.

> James: It sort of got better when I had some answers… so my paranoia was building when I didn't know it was this particular work colleague… when I *did* know it was John, and when I could answer the questions it dropped yeah. So it wasn't as bad because I thought, alright ok I know who it is now there's one of the boxes… if you know who it is then ok fine, I know who it is to worry about or who to avoid or who to deal with whatever, I know what the cause is, who the cause is. (p.19)

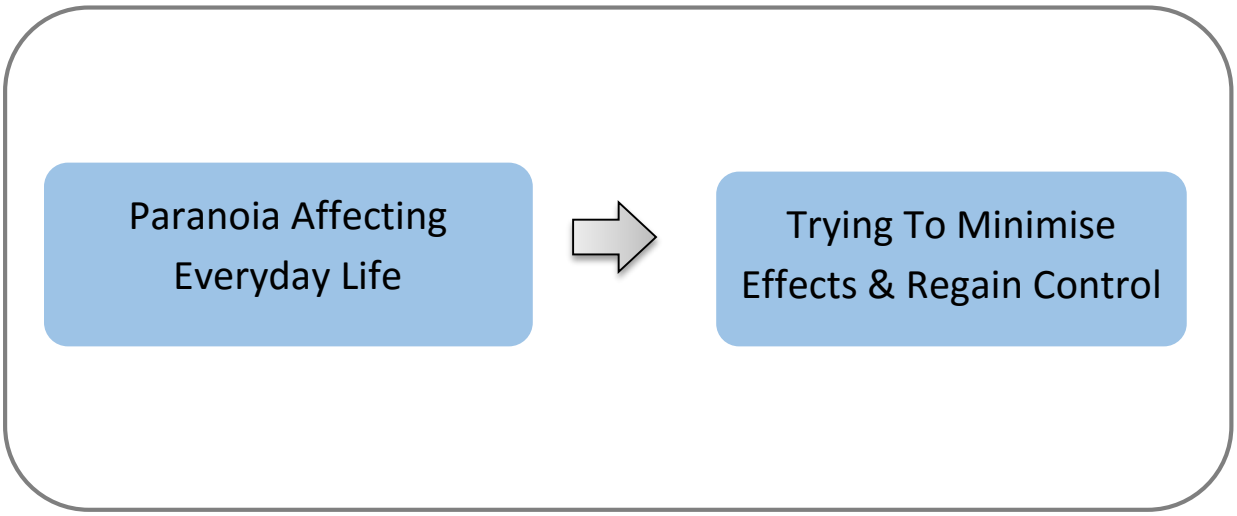
However, participants all reflected on a continuing inner conflict, whereby even when they found it unlikely that another person had malicious plans to harm them in some way; they found that the feeling of paranoia remained. Therefore, the concern was rarely 'resolved', and the period of investigation sometimes fed back into a cycle whereby they were more likely to find subsequent situations strange, as they judged them with an assumption of threat. The way in which they went on to 'live with paranoia' is explicated in the next core category.

### 3.6. Core Category 2: Living with Paranoia

This core category concerns participants' perceptions of how paranoia affected their daily lives and how they managed these effects, having identified it as a regular experience for them.

The second core category is illustrated in Figure 2 below. The process of living with paranoia is explicated through the subcategories 'Paranoia Affecting Everyday Life', and 'Trying to Minimize Effects and Regain Control.' This represents a 'macro view' of how participants were negotiating their daily lives in spite of the presence of paranoia.

**Figure 2.** Living with Paranoia




### 3.6.1. Paranoia Affecting Everyday Life

This subcategory captures participants' descriptions of the various ways in which their life was affected by the tendency to become paranoid, as well as considering the ways in which paranoia fluctuated, and their perceptions about why fluctuations were experienced.

Each participant offered examples of how paranoia had affected their lives in the past and present, with reference to intrapersonal and relational effects. Paranoia affected participants' abilities to be effective in their work, and their relationships with others. Furthermore, daily activities such as engaging in student life, tended to effect the tendency to become paranoid.

Lisa had spoken about how her past experiences of bullying shaped a tendency to become paranoid and introverted. She believed that this way of being affected her ability to be effective in her work, and in turn affected her relationships.

> Lisa: … because I was so anxious about it… it becomes itself a self-fulfilling prophecy because I'm not able to interact with people. I actually lose the ability to converse; I can't sustain a conversation anymore. So you know it becomes self-fulfilling in the sense that it's going to be hard to build a relationship with you because I'm like a like a rabbit in headlights… and less able to make good decisions professionally and that kind of thing. (p.5)

Like Lisa, Katrina gave many examples of how paranoia had negatively affected her relationships, such as in the extract below. She later went on to explain that her friends had openly told her that they did not want to be seen with her due to her noticeable paranoia. This appeared to be a common experience as several participants described having limited social circles.

> Katrina: I came up to a point where I would go home and just sit on my bed and cry for hours because I wouldn't understand why I'm thinking all these thoughts why just why. I lost a lot of friends actually because I would go a bit paranoid. They couldn't understand what was going on. (p.9)

A commonality across participant experiences was that paranoia laid on a continuum, varying in intensity, duration, and frequency of occurrence, rather than a constant and static experience or way of being. While some effects were short-term, such as being negatively emotionally affected on a particular day, some effects were described as more pervasive such as restricting one's social circle due to paranoia. It appeared to be an experience that varied in intensity from day to day but also over time and was mediated by factors such as how much sleep they had had, how confident they were feeling on a certain day etc. Participants reflected on the aspects of their lives that may be affecting their tendency to become paranoid more often, such as their position as a university student, therefore regularly being immersed in a socially intense experience.

Katrina has described losing friends and struggling in life due to her experiences of paranoia. Like other participants, she felt that the experience has changed in intensity over time, but the below extract is an example of a time when she felt quite controlled by the power of the paranoid experience, and it began to significantly affect her functioning and quality of life.

> Katrina: …Then I went into drugs but then the drugs actually make it worse. And I could actually realize that okay I'm just being paranoid. So that 10 minute burst [of paranoia] became hours of just seeing things, imagining things and then I would actually kind of make a daily thing of my life; like I thought 'okay since I'm having these reactions I might just have them all the time and live in my own world.' (p.11)

#### *3.6.1.1. 'It's a bit infantilising': Student Life*

All participants were asked about their status as a student, and whether they felt it had any relevance in thinking about the causes, effects, or ways of managing paranoia. Responses were mixed. Several participants felt that student life was a positive and protective factor for them, which will be discussed in the next subcategory. However, it was also thought that the experience was akin to being in school (which was previously discussed), and as such had the power to be infantilising, returning the student to the concerns associated with adolescence, such as finding a safe peer group and being accepted. In that respect, it was found to be an experience that heightened social anxiety, which could then lead to paranoia.

> Marsha: I remember finding the first semester of university, the undergraduate, really tough and doing the same thing not wanting to kind of go out and see people, for it being too overwhelming being in a group of people not knowing where I stood. (p.5)

All participants identified paranoia as a negative experience that was affecting their lives in various ways as has been illuminated through the use of extracts. However, they all had ways of managing these effects which are considered in the following subcategory.

### 3.6.2. Trying to Minimise Effects and Regain Control

This subcategory pays attention to the ways that participants were attempting to manage and cope with the impact that paranoia was having on their lives. It refers to both intrapersonal and interpersonal strategies that were employed.

Given that participants were recruited based on them having scored highly on a measure of paranoia, yet were not using mental health services for support, much time was dedicated to hearing about their ways of coping. Each participant was functioning at a high level for example performing well at university, having a job in some cases, and maintaining social relationships. In this respect, it could be said they were managing to keep the experience 'at bay'. Participants had various ways of managing the experience in an effort to get on with their life; both individual and relational ways of coping. They also commented on what they felt were the key

reasons they managed to keep the experience from escalating, reducing preoccupation and distress associated with paranoid experiences.

*3.6.2.1. Considering one's own importance in context of the world*

A strategy that four participants used to reassure themselves that it was unlikely that their fears were correct was to draw in perspective on a large scale, seeing themselves as 'unimportant' in the grand scheme of the world. Remembering that the world 'doesn't revolve around you' was experienced as comforting and reassuring that 'not everyone is out to harm you'. While this way of coping shares commonality with the process of investigating whereby Kemi tried to draw in context, it is thought to be distinct in that participants exclusively used this strategy to 'feel better' rather than to form a conclusion. Lisa's extract below arguably reflects her low self-esteem and a sense of painful worthlessness, yet in many respects, her own sense of unimportance actually aided her in feeling safe.

> Lisa: But beyond that I don't think that they're going to go out of their way to hurt me because… I'm not worth it. They might be bitchy because it's some help for them or they might tell tales because it makes them feel better about themselves. But I don't think I'm going to figure significantly enough about people lives that they would want to do anything *serious* to me. (p.16)

Participants seemed to find useful to reflect on their concerns as somewhat self-absorbed and therefore unrealistic as shown in Marsha's extract below.

> Marsha: When I look back I'm like 'wow I'm really self-involved. They are cartoon characters [that she believed were following her] they must have loads of better things to do than follow me'. I used to collect them [in own mind] and really be on edge. (p.11)

*3.6.2.2. Engaging in reassuring internal dialogue*

While the above strategy could be said to be a form of reassuring self-talk, each participant appeared to more broadly engage in a reassuring internal dialogue to help alleviate their anxiety. This is a similar process to the process of inner dialoguing that the participants engaged in during the 'investigation phase' captured at the end of the previous core category, but a key difference is that there were times when participants engaged in inner dialogue only as a way to comfort their mind, rather than in a search for the 'truth', or 'reality' of the situation. Marsha's extract below is an example of such an internal dialogue.

> Marsha: Sometimes my imagination might get the better of me….like I'm on the Truman Show… 'is it today or something?' and then I try to rationalize about the all the logistics involved in that… sometimes like when I'm on my way into uni and then I think 'you can't plan this around me this is ridiculous; there are too many people here'. (p.20)

Sometimes participants engaged in a reassuring inner dialogue about their past experiences of feeling paranoid, reminding themselves that all had ended well. Two participants talked about 'coming out the other side' of a time of heightened paranoia, and the value of remembering that 'it won't last forever'. This seemed to be an important way of managing the emotional impact of paranoia as shown in the extract below.

> Kemi: So from experience, there have been times where I've been paranoid and it's come down to nothing. So through thinking about those prior experiences I'm just thinking to myself 'you've been through so many things where you thought things would happen and it, in fact, didn't happen. So what are the chances of something happening now?' I used to kind of put to myself to kind of combat the paranoia and stuff. (p.30)

*3.6.2.3. Brushing it off*

Five participants described the usefulness of simply 'brushing it off' with regard to feelings of paranoia. Ignoring the thoughts and feelings and even withdrawing from the situation where concern was raised was a conscious strategy some participants described. However, two participants also acknowledge that some attempts to cope were likely to be less useful than others. The extract below shows Sukhi talking about deliberately withdrawing as a way of coping with and ignoring the concerns.

> Sukhi: I think that's my coping mechanism is withdrawing from certain people and just kind of isolating myself. Maybe it's a good thing. Maybe it's a bad thing, I don't know, but the way I see it is like when I do that I focus myself on more positive things. Well, I try to anyway. (p.8)

*3.6.2.4. 'I got busier so that helped': Turning attention to other things*

Linked to 'brushing it off', participant's decided to turn their attention to other things to allow them to ignore the paranoia, and wait until it passed. Participants found that being busy reduced preoccupation and distress. They would distract themselves from their worries by purposely focus on important and valued things in their life.

> Katrina: I used to let it go into a big scenario; into a huge scenario in my head and go on and on. Now I might think that… but I'll just won't sit and let get to that extent of where it will get into a huge story. Say that will happen now and then usually, I just call my best friend like okay talk to me… keep my brain busy. So when I feel that is coming to something I can't control, I usually try and keep myself busy. (p.25)

Further to just serving a purpose to distract them, several participants also pointed out the importance of having valued roles and responsibilities, as providing meaning in life. Participants made direct links between 'staying well' and having meaning in their lives, for example being a student working toward a qualification, or having good relationships.

> Sukhi: Whereas, I do feel paranoid sometimes and suspicious, but I have other responsibilities. For example, uni, now that takes my mind of personal issues at home, worrying, you know, paranoia and stress and all the rest of it. Erm, because I know that I'm working towards something, that lifts me up and that makes me go, you know… Get on with day-to-day life. (p.43)

For Kemi, belief in God gave her a sense of higher purpose and meaning in life. She explained that before God started speaking to her, she experienced paranoia much more intensely and more frequently, but had been finding life much easier now that God spoke to her. She felt able to put her trust in God, relieving her of a need to protect herself, as her fate lay in God's hands which the below extract is referring to.

> Kemi: the only thing that keeps me I guess sane and not afraid of other people's motives as much is my faith in God and that's the only thing. The fact that then…without that then I'd probably be hiring a car to take me from this place and that place and boarding my doors… I don't know how. There was a point where I was feeling extremely unsafe because I was living alone last year. (p.8)

Like all of the participants, Sarah's extract below highlights that there was no 'one way' to deal with paranoia, and that different strategies were needed and at different times. Some participants reflected on why they sometimes chose one technique, such as engaging in a reassuring self-dialogue over other techniques such as distraction. They highlighted some potential reasons that affected the coping mechanism adopted on any given day such as how confident they were feeling, how convinced they were of the accuracy of their fears, and how much mental energy they had. Sarah talks below about distraction being more helpful when she felt more

convinced about the possibility of threat, whereas she would try to challenge the beliefs when feeling more confident.

> Sarah: I probably try and do both, to be honest. I think the more empowered I feel; the more I'm going to look for exceptions versus trying to distract myself. I think the more I'm worried about the situation, the more I try to distract because that's when I'm more convinced that actually there is a problem. (p.15)

*3.6.2.5. 'If you accept your demons you can fight them': Viewing it as controllable*

The way that participants thought about paranoia and their perception of how much power the experience had over them, appeared relevant to how easy the found it to manage. Kemi spoke about how paranoia would only have an effect 'if you let it have an effect'. The extract below refers to how 'controllable' Katrina viewed paranoia to be. For her, accepting that paranoia was in her life allowed her to begin managing it better.

> Katrina: I just think the fact that I have accepted it because I strongly believe that if you accept your demons you can fight them. Do you know what I mean? Like if I just kept on saying 'why me? Why is this happening to me? Why don't I understand what is going on? Why? Why? Why?' It would never pass… it still hasn't passed but I think I would still need that extra hand of helping and I do think the fact that I've got my friend help me a lot. (p.34)

*3.6.2.6. Confiding (versus not confiding)*

Five of the seven participants spoke about the importance of having good relationships where they could confide in a trusted other about their concerns and experiences.

These trusted others allowed participants to "rant" and offload concerns allowing for emotional relief or 'emotion-focused coping'. At other times they divulged their concerns about threat to the other person to get another perspective (as discussed in the previous core category), more consistent with the notion of 'problem-focused coping'. Lisa said that simply just having the knowledge that she was unconditionally loved by family helped her to stay well, similar to Katrina's opinion in the extract below.

> Katrina: I think it's [the fact that things had not got worse] because I've had someone next to me all the time. I don't know how I would react if I was alone. I think if people don't have anyone to talk to about it, it's actually when they do get to extent when they can't control what's going on […later in extract…] Now I know that if I go out of my normal stage I have someone there. And I think that counts a lot that if I do go mentally crazy someone will be there to listen to me. (p.11)

While most participants had *someone* that they felt able to talk to, it was also suggested that coping with the experience sometimes meant protecting the self by keeping their experiences to themselves, therefore not risking rejection or being viewed as 'crazy'. This is linked to paranoia still being a stigmatized experience, which one participant said suggested is because of paranoia's association with mental illness. The extract below demonstrates one reason that Marsha had for choosing not to confide.

> Marsha: Oh yeah fear of being judged. I wouldn't want to [tell others]. And my experience has been like I can normally soothe it eventually […later in extract…] Just knowing it will pass is quite powerful. (p7, 8)

Sukhi spoke about how her difficulty trusting others and tendency toward suspicion had impacted her ability to confide in others for support. She described not wanting to be an "open book", perhaps as that would increase a sense of vulnerability. She remarked that it had been much easier to speak with me as a researcher about her experiences than it would be to speak about them with a friend. Lisa's extract below echoes Sukhi's concerns about confiding in others.

> Lisa: … so I'm really extremely wary about people and trust; I've got trust issues. And if I don't feel like I can trust people, I'm instantly uncomfortable around them…On any level, I just don't like being around them. But if I'm going to talk to someone like that I have to be fairly confident that they are a decent human being; that they are well disposed towards me, that I can rely on their maybe strength of character as well. So yeah I guess this sort of the judgment of trustworthiness and also actually of who they're connected with and who their loyalty lies with as well. (p.9)

The following chapter considers these findings in the context of existing literature on paranoia, the limitations of these findings, and their potential research and clinical implications.

# CHAPTER FOUR:
# DISCUSSION

## 4.1. Chapter Overview

This chapter will consider the results of the analysis in the context of the original research questions, and existing paranoia literature. The quality of the study will then be evaluated and commented upon, before reflecting on the limitations. The chapter will conclude with a discussion of the research and clinical implications of the study.

## 4.2. Discussion of Findings

Two models were constructed from the qualitative data gathered: 'The Process of Becoming Paranoid', and 'Trying to Minimize Effects and Regain Control'. These models provide a useful insight into perspectives of those who experience paranoia at a comparable level to those in a clinical population; yet manage without the use of services.

### 4.2.1. Research Question One

*How do participants perceive the causes of their paranoid thoughts, and the effects of such thoughts on everyday life?*

Participants spoke of historical factors they deemed relevant to the manifestation of paranoia in their lives. Five participants felt that bullying had negatively impacted them throughout their teenage years, resulting in anxiety, fear, and worries about going to school. This experience may have resulted in a tendency to be suspicious toward others as a self-protective mechanism that has carried on into adult life. This is consistent with the literature on powerlessness and paranoia suggesting that experiences such as on-going victimization and discrimination may influence the onset of paranoia (e.g. Janssen et al., 2003; Mirowsky & Ross, 1983). A study of the psychological consequences of bullying by Campbell and Morrison (2007) found that bullying in school was significantly associated with predisposition to psychotic experiences, as well as the development of positive beliefs about paranoia (e.g. viewing paranoia as an important survival strategy). Similarly, a study by Van Dam et al. (2012) investigated the association between childhood bullying and psychosis in

clinical and nonclinical samples and concluded that school bullying was related to the development of psychotic symptoms in the nonclinical sample. Two participants drew comparisons between the contexts of school and university, suggesting that university can be an infantilising experience that re-creates the anxiety that was experienced while attending school in one's teenage years. While social factors such as victimization have been much recognised as contributing to paranoia development, the finding that bullying, in particular, was perceived to be a relevant causal factor in paranoia is less well documented and represents an important addition to paranoia literature.

Participants also spoke of their families as relevant in fostering mistrust in others. It appeared that a cautious and mistrustful way of behaving could be encouraged by parents as a way of keeping safe, as well as parents' generally modelling suspicious ways of being. Haynes' (1986) behavioural model of paranoia offers a useful theoretical framework to consider this finding whereby hypothesized determinants of paranoia included early modelling and prompting of paranoid behaviours, an insular family, and insufficient reinforcement of non-paranoid behaviours. It may be that parents were rewarding cautious behaviour (being pleased to see that their child was internalising ideas about 'stranger danger') and reinforcing such behaviour. Furthermore, difficult early interactions with caregivers and inconsistency in others' behaviour were also thought to be a determinant of future paranoid behaviour. Four participants in this study spoke about difficult parental relationships and parental inconsistency, two of whom lost a parent in tragic circumstances. One of the four participants expressed the belief that she and her brother had been neglected as children. Literature concerning poor early attachment and paranoia is relevant in considering this finding. For example, in a sample of UK university students, it was found that insecure attachment predicted paranoia (Pickering, Simpson, & Bentall, 2008). In another study, Bentall et al. (2014) investigated pathways from specific adversities to particular psychotic symptoms and concluded that attachment-disrupting events, such as neglect or death of a parent, may be particularly relevant to the development of paranoia. The findings of the current study lend some support to such research that has demonstrated links between attachment disrupting events and paranoia development.

Studies investigating the relationship between paranoia and gender have had mixed results. While paranoia has been found to be associated with males (e.g. Johns et al., 2004), as well as with females (e.g. Forsell & Henderson, 1998), other research has found no difference between genders such as Freeman et al. (2005). Females were overrepresented in the overall sample of the current study, as well as the qualitative sample of six women and one man. An interesting finding was that three participants believed that being a woman was a causal factor to their paranoid experiences. They felt subjected to a 'male gaze' (e.g. Mulvey, 1989) whereby paranoia seemed to serve a protective function from men who posed threats such as castings judgement or physical harm such as a random attack. This again is consistent with research that captures issues of powerlessness by Mirowsky and Ross (1983) who found that being female was associated with a belief in external control, due to them occupying positions characterised by powerlessness, facing real threats of victimization.

Another finding of this study regarding participant perspectives on causal factors of their paranoia was one's neighbourhood context. One participant spoke about growing up in a dangerous neighbourhood and was keen to emphasise the very real threats that were faced by someone living in her area. This finding parallels studies that have cited urban living as a risk factor for the development of psychosis (e.g. van Os et al., 2000). A study by Ross, Mirowsky and Pribesh (2001) demonstrated that individuals living in neighbourhoods with high crime levels had high levels of mistrust. Similarly, it has been found that people residing in dangerous neighbourhoods are more likely to demonstrate paranoid thinking and overestimate threat (Jack and Egan, 2015). Another study investigating the link between paranoia and neighbourhood crime concluded that paranoia represented a realistic and adaptive response to one's environment and stressed the importance of considering context when conducting risk screens for psychosis (Wilson et al., 2016). These findings may aid discussions in considering when paranoia is adaptive as opposed to an indication of a mental health problem, and how that distinction is made. Another participant found that growing up in a small village had been an important factor that led to her developing distressing levels of paranoia. She described a sense of being watched and talked about which is interesting to consider in light of research that has found high social anxiety (Trower & Chadwick, 1995), and attention to public aspects of the self (Bodner & Mikulineer, 1998) to be associated with paranoia. While growing up in

a dangerous urban area has received attention in paranoia literature, this study suggests that small rural areas could also be an area of important consideration in thinking about contexts that evoke a paranoia response. Of course, many people live in both dangerous urban areas and small villages and do not go on to develop paranoia so one possibility is that an intersection between one's neighbourhood and factors such as gender, class, and race increases the likelihood that one will develop paranoia.

This study illuminated the various situations in which participants judged the behaviour of others as strange, leading them to become suspicious. Participants seemed to compare observed behaviour to internalised norms about appropriate behaviour in particular social contexts. When another person 'broke' this norm, (e.g. by staring at them) they became suspicious of their motives. It may be that these internalised norms were developed through strict family scripts about appropriate ways of acting in public, or perhaps were influenced by one's cultural norms and were then used as reference points for keeping oneself safe. It appeared that each participant was quite vigilant in social situations, often watching others and noticing 'odd' behaviour or 'norm-breaking', yet simultaneously expecting others not to look at them. In chapter one the various hypothesized cognitive biases in individuals that experience paranoia were reviewed, one of which was attentional bias. Indeed studies have found that people experiencing paranoia are more attentive to threat-related stimuli than normal controls (Bentall & Kaney, 1989). However, it is important to ask *why* the participants in this study were seemingly vigilant to threat, and avoid an exclusive focus on the cognitive process itself. It may be that the earlier contexts that fostered mistrust (such as bullying, attachment disrupting events, and neighbourhood context) resulted in an expectation of threat from others, similar to the concept of a 'working model' as proposed by Bowlby (1980). Bowlby suggested that early interpersonal experiences influence future methods of distress regulation, expectations of the self and others, and interpersonal functioning. Furthermore, Berry, Barrowclough, and Wearden (2008) highlight the possibility that individuals may have different attachment working models that are influenced by fluctuations in mood or emotion.

This study consistently found that fear and anxiety were central emotions to the paranoia experiences described by participants. Vulnerability and uncertainty were

also important themes that were common to their descriptions of how it feels to be paranoid. These findings are very consistent with other studies that have found fear and anxiety to be central in one's experience of paranoia (Freeman, 2007). There has particularly been a wealth of evidence implicating fear and anxiety in the development of paranoid content in bothy qualitative (Campbell & Morrison, 2007) and quantitative studies (Freeman et al., 2005). Facing an unknown threat meant that participants felt powerless and out of control. It could be that such emotional experiences were influencing participants' cognition, leading to the cognitive biases that have been associated with paranoia such as a jumping to conclusions bias (e.g. Hemsley and Garety, 1986). Said more simply, it may be that participants were jumping to conclusions as a response to feeling threatened and anxious.

With regard to the nature of the threat, many participants described feeling paranoid about physical harm and being conspired against, but it appeared that social evaluative concerns, ideas of reference, and concerns about mild threat were more common. This is consistent with the notion of a paranoia hierarchy of as described by Freeman et al. (2005). In keeping with a continuum view, Freeman and colleagues posited that the levels of threat belief build upon more common social evaluative concerns associated with social phobia and this study lends evidence to that notion based on participant accounts.

Each participant's life was in some way negatively affected by paranoia. The experience of paranoia appeared to force them into a cycle of investigation where they would engage in an uncomfortable inner dialogue in an effort to make sense of their experience. Perhaps unsurprisingly given the nature of paranoia as a belief about interpersonal threat, participants' believed that their relationships had been affected. What's more, the notion of a 'self-fulfilling prophecy' emerged at interview when discussing the deterioration of a participant's relationships with others. It appeared that the fear and anxiety that characterised paranoia meant that one's social skills were compromised, resulting in a cycle whereby they found it difficult to sustain relationships, leading to further isolation and increased paranoia. Despite believing that their relationships had been affected, however, all participants described having a number of valued relationships, whether friends or family. They were also all able to engage with others in their daily life, for example, doing group work at university. This is interesting given that Freeman and Garety (2004) found

that feelings of isolation and a lack of social support were mediating factors development of persecutory delusions. In a qualitative comparison of psychotic-like phenomena in nonclinical and clinical populations, it was found that 'validation' from others distinguished the consequences of the person's experience, with nonclinical participants getting more validation and acceptance from others than the clinical participants (Heriot-Maitland, Knight, & Peters, 2012). They conclude that it is the wider interpersonal contexts of the person's life that determine the effects of the person's experience, rather than the experience itself. One speculation based on the findings of this study would be that perhaps the supportive relationships that participants were able to maintain enabled them to avoid the levels of distress that might lead them to mental health services for support.

### 4.2.2. Research Question Two

*What do these participants talk about in relation to coping with paranoid thoughts in everyday life?*

Each participant had found ways of staying well despite the ongoing presence of paranoia in their lives. An interesting finding was that four participants used a strategy whereby they tried to consider their own importance in the context of the world, to reassure themselves that they were unlikely to be a target for threat. This is similar to a qualitative investigation into reasons for change in paranoia in a nonclinical student population by Allen-Crooks and Ellett (2014) whereby a 'wider perspective' theme captured how participants came to see the experience as less significant or relevant than previously thought. It differs slightly however in that the participants in this study only came to see their concern as less significant because they acknowledged their relative lack of importance in the world and therefore is a useful and novel finding.

Another way of coping with their experiences was described by participants as 'brushing it off' and disengaging from the worries (e.g. by withdrawing from the situation). This is consistent with the notion of 'detached coping' which Freeman and colleagues (2005) found to be associated with lower levels of paranoia. Participants also described that engaging in a reassuring inner dialogue was helpful, often to remind themselves that the paranoia would pass which was experienced as a powerful way of coping. Linked to this was the helpfulness of viewing the paranoia as

controllable, whereby acceptance of the experience aided participants in waiting for it to pass. Allen-Crooks and Ellett (2014) also found that their student participants described accepting and letting go of their paranoid concerns as important in creating change.

As mentioned above, each participant had found a trusted social circle. While some participants felt their social circles were quite small because of their paranoia, each person had nonetheless found a confidante. This social support seemed to be key in allowing participants to cope with and minimize the effects that paranoia had on them. Two participants went as far as to cite good relationships as what had stopped the paranoia from getting worse in their lives. This finding supports research that has emphasized the importance of social support in managing experiences of paranoia (Allen-Crooks & Ellett, 2014; Brett, Heriot-Maitland, McGuire and Peters, 2014). Given that Freeman et al. (2005) found that negative attitudes to emotional expression were linked to higher paranoia, it might be that the participants had mainly positive attitudes toward emotional expression in that they each confided in people, enabling them to keep distress levels at bay.

Another important finding concerning how participants were managing their experience of paranoia was regarding how they spent their time. Being busy and engaged in valued activities in their daily life was perceived by participants as imperative in maintaining mental health. Each participant felt their life had meaning, and that they occupied valued roles and had responsibilities, for example, being a busy student working toward a degree, or being a friend. While several coping strategies have been reviewed and compared with previous research, the findings of this study demonstrates that ‘managing paranoia’ goes beyond employing particular coping strategies that an individual has developed. Having life meaning, valued roles, and responsibilities and being occupied in daily life were vital characteristics of participants’ lives that they perceived as crucial in staying well. It is hoped that these findings broaden how ‘coping’ in thought about, and instead achieving quality of life can be extended to thinking about the overall context of the person’s life, rather than the techniques that they are using to manage paranoia.

## 4.3. Critical Review and Research Evaluation

As highlighted in chapter two, Yardley's (2000) evaluative criteria for qualitative approaches were consulted throughout the process of this research in an attempt to enhance the quality of the study.

### 4.3.1. Sensitivity to Context

One aspect of sensitivity to context is ethical consideration of the participants. I considered how paranoia is thought about in the social context that participants exist within to hypothesise how participation in this study might be received. As was highlighted by one of the interview participants, paranoia is a stigmatized experience, perhaps due to its association with abnormality and illness. I ensured that every attempt was made to normalise the experience by making reference to literature that has concluded that paranoia exists on a continuum, given that it has been found to be common in the nonclinical population. I tried to balance this normalising with a thorough debrief to ensure that participants were not distressed by speaking about their experiences during interview, and knew where to get support if wanted.

Another aspect of sensitivity to context is regarding the need to situate the study within the relevant literature. While some grounded theory writers suggest that a literature should be delayed until after analysis is complete (Charmaz, 1995), this study engaged with the review in advance which enabled greater sensitivity to context. It was therefore ensured that the rationale for this study would be arrived at through consideration of gaps in the literature. I deliberately carried out a broad literature review in line with Yardley's (2000) suggestion that extensive grounding in the complex arguments relevant to the topic is important to develop one's analysis and become aware of one's own assumptions on the topic. For example, as research on cognitive approaches to understanding paranoia currently dominates the landscape of literature, I may have fallen foul to unintentionally paying more attention to such ways of understanding the data, but by actively seeking out a breath of literature I remained alive to the various ways in which each line of data could be understood.

### 4.3.2. Commitment and Rigour

Commitment to the methods of analysis was addressed by engaging in discussion with a supervisor who had grounded theory expertise, and engaging in reading in grounded theory methods. Memo writing aided reflection on the use of the methods of analysis, as well as tracking the development of grounded theory research skills. Furthermore, line by line coding was opted for in an effort to keep close to the data and to participants' own words. Constant comparative analysis was practiced on every interaction with the data, and I tried to ensure that final categories closely represented the original data, with clear connections between different levels of abstraction as suggested by Henwood and Pidgeon (1992). Use of a memo again aided this process, as justifications for the codes and categories chosen were captured, as well as how they were understood to be linked.

### 4.3.3. Transparency and Coherence

The processes of data collection and analysis were outlined in chapter two to aid the reader in understanding progression of the grounded theory method, adhering to the transparency criterion. Furthermore, extracts were given throughout the fourth chapter, as well as excerpts from coding being included in Appendix 9 and 10. In order to address internal coherence of the research, thought was given to the consistency of the study aims, the critical realist epistemological position, and grounded theory methods. For example, in order to ensure that the aims and methods were congruent with and the critical realist stance, it was decided that a contextual constructionist approach to the grounded theory would be most appropriate as described by Madill et al. (2000). Feedback on the coherence of the arguments put forward was also sought in supervision.

### 4.3.4. Impact and importance

The design of the study was the product of consideration of under-researched areas in paranoia literature and sought to offer novel insights into the phenomenon. A section on implications of this research is offered later in this chapter which aims to ensure this criterion has been thoroughly considered.

### 4.3.5. Researcher Reflexivity

Detailed memos were kept to record the analytic process as theory emerged, which included my reflections on my potential contributions to the construction of meaning. As suggested by Willig (2001), reflexivity will be considered with regard to epistemological reflexivity and personal reflexivity. By offering these accounts it is hoped that transparency of my perspectives and position as the researcher is somewhat achieved so that it is clearer how the research may have been shaped by my own unique lenses. That is to say, I hope to give context to the construction of this knowledge.

#### *4.3.5.1. Epistemological reflexivity*

While the methodological framework and specific methods of inquiry of this study were purposely chosen as it was felt they best answered the research question, they would also have limited what could be 'found'. For example, a discourse analysis would have focused underlying assumptions of the language used by participants and uncovered more about how people talk about experience of paranoia drawing upon the discourses that are available to them. Had a different epistemological stance such as social constructionist been taken, the resulting theory would be viewed as one of multiple realities of what might be happening, rejecting the critical realist notion of a single reality with multiple interpretations.

#### *4.3.5.2. Personal reflexivity*

I considered several of my identities and lenses during the process of the research and how they may have impacted the way in which participants received me, or how I interacted with the data, such as being young, white, Irish, a woman, or a trainee clinical psychologist. For example, being a psychologist could have raised concerns about my ability to 'judge' the person's mental state, potentially affecting the detail they were willing to give at interview. Furthermore, only seven of 31 individuals approached agreed to participate at interview. It may have been that my status as trainee psychologist disinclined people toward interview participation, given the stigma of paranoia and its association with abnormality.

Invisible differences also made an impact in the interviews. For example, one participant began to tell me about the role of faith in her life and commented that she was unsure how much I knew about Christianity, sounding tentative. I made the decision to reveal that I was raised a Christian, to enable to her to feel understood, and comfortable enough to share more about how her faith was important. This appeared to be useful at the time, however for another person, it could have 'shut down' conversation or a misunderstanding may have arisen by assuming shared understandings. When that participant revealed that she regularly heard the voice of God, my identity as a psychologist became more salient, as I considered how a clinician might interpret her experiences as voice hearing, rather than the voice of God. It seemed important to reflect on how my own religious views and identity as psychologist interacted at that time to influence how I was making sense of what was being said.

### 4.3.6. Study Limitations

The grounded theory constructed in this study is based on a small sample of seven participants, meaning it is not possible to generalise the findings with confidence. This sample was predominately female, at Phase One and Phase Two. As stated in chapter two, approximately 54% of UK university students are female. Therefore, the samples recruited at each phase of this study underrepresents males. The total sample was also comprised of 51% postgraduate students, as compared to the figure of 24% of UK students that are thought to be in postgraduate study (HESA, 2016).

This study presented the findings from the quantitative data gathered to contextualise the final interview sample in relation to the wider student population. The data were collected by self-report which should be considered in light of a number of limitations. Social desirability (Paulhus & Reid, 1991) and distorted self-perceptions (John & Robins, 1994) can both affect the responses provided. Additionally, Freeman (2008) suggests that self-report measures may overestimate the presence of paranoid thinking despite their apparent correlation with interviewer assessments (Watson, Chilton, Fairchild, & Whewell, 2006). While seven high-scoring participants did agree to be interviewed, van Os et al. (1999) suggest that individuals currently experiencing psychiatric difficulties may be less likely to respond to such a study. This may mean that the overall sample represents a particular 'sub-set' of individuals experiencing

paranoia, for example, people who are less distressed by their experiences and therefore more willing to fill in the questionnaire (and subsequently agree to interview).

As stated previously, the abbreviated version of grounded theory was utilised in this study due to time limitations. While measures were taken to ensure that quality was maintained such as engaging in line by line coding as recommended by Willig (2013) when using an abbreviated version, use of the full version would have allowed more in-depth exploration of the paranoia experience, and allow for a more elaborated theory to be constructed. It was only possible to account for theoretical saturation within the data, rather than leaving the data to engage in theoretical sampling. Nonetheless, attempts were made to adapt the interview schedule slightly in light of the themes that had emerged in each preceding interview.

### 4.4. Research Implications

The findings of this study have generated lines of inquiry for future research, particularly in relation to causal factors, effects of, and ways of managing paranoid experiences as were the foci of the current study.

Rich data was generated that offered an explanation of how participants were managing their experiences. Future research that focuses on the ways of managing paranoia in a nonclinical population (both in students and nonstudents) in a more detailed way is warranted, both qualitatively and quantitatively. Such research might elaborate the existing theory. The inclusion of quantitative measures that assess coping styles in student samples could prove useful and allow data to be gathered from a larger number or participants. Additionally, research that compares ways of managing paranoid experiences in clinical and nonclinical populations may highlight any differences in coping styles. Knowledge of how people are managing without the support of services can only be speculated upon in isolation whereas firmer conclusions could be drawn from a comparative study. Additionally, qualitative (and quantitative) comparison study of the experiences of students and nonstudents in the nonclinical population, as well as students and non-student young people would be interesting to assess whether there are differences in how paranoia develops, is maintained, and is coped with.

With regard to historical contexts that were named as relevant to the development of participants' paranoia, further more detailed qualitative exploration would be useful specifically into the relationships between experiences of bullying and paranoia, as well as attachment and paranoia. It might also be useful to interview family members or close friends alongside the person experiencing paranoia, to get a broader range of perspectives. While participant perspectives were captured in this study, it was not possible to comment more definitively on causal relationships, and another interesting line of further study would be to quantitatively test causal relationships suggested in this study such as bullying and early attachments.

This study interviewed six females and one male, so was limited in its ability to even speculate on differences in the experience of paranoia between men and women, for example whether there exist qualitative differences in the content of paranoid thinking. A study that uses a larger sample of men and women could engage in a comparison of their experiences. It would also be interesting to record data pertaining to socioeconomic status or class to investigate any intersectional effects.

Finally, qualitative research that utilises a discourse analysis would be useful in teasing out the discourses underlying the language used by participants and might help to uncover more about how people talk about paranoia as an experience.

## 4.5. Clinical Implications

Whilst this study was exploratory in nature, some speculative implications for clinical practice and service provision are offered.

### 4.5.1. Implications for Schools and Universities

This study theorises that such schooling experiences fostered mistrust leading participants to be more cautious and likely to suspect harm from others as adults. While bullying has been highlighted as an important issue that can lead to poor mental health in those who experience it (e.g. Sharp & Smith, 1991), this study adds to evidence that bullying can have long-term negative effects, such as paranoia. Anti-

bullying programmes do exist in many schools but there still exist many schools where no such initiatives are in place. Where they do exist, it is suggested that a strand of the programme should include individual and group work for those who been affected by bullying that includes strategies to manage feeling at risk from threat.

Universities could also facilitate the setting-up of peer support groups that focus specifically on paranoia but also related emotional aspects such as for sharing experiences of fear and anxiety which would, in turn, address the risks of social isolation. The distribution of self-help material could also prove useful to students whose paranoid concerns are preventing them from seeking help.

### 4.5.2. Implications for Mental Health Services

The findings of this study suggest collaborative working with the person and their network should be made a priority. Given that many participants felt their family members and friends had shaped their tendency to become suspicious in certain contexts, systemic views of the problem of paranoia are important. Furthermore, as participants all spoke of the importance of having good relationships, working with people and their networks seems imperative. Where the person is isolated or no social network exists, emphasis could be placed on helping them to explore avenues where they might build a social network such as mental health specific support groups but also non mental health associated avenues.

All participants had found ‘being busy’ helped them to stay well, particularly where they felt they had meaningful goals to work towards. This lends support to approaches that incorporate behavioural activation such as cognitive behavioural approaches and particularly Acceptance and Commitment Therapy (ACT) (e.g. Smith & Hayes, 2005). ACT philosophy encourages acceptance of the inevitability of distressing experiences arising and puts the focus on changing one’s relationship to distressing thoughts, images, feelings, and sensations instead. Several participant’s mentioned that ‘knowing it would pass’ and ‘accepting your demons’ were powerful ways of combating the negative effects of paranoia on their lives, stances that an ACT approach would advocate.

Fear, uncertainty, and anxiety were three central emotional experiences associated with paranoia which point to a need for clinicians to work with the person to find strategies for managing these emotional experiences. The two models proposed in this study could be used as formulation guides as alternative to more commonly used approaches such as cognitive behavioural formulations (see Freeman et al., 2002), which may help to highlight the social contexts in which the person tends to become paranoid, pointing toward things they could do differently in such situations, shifting emphasis away from thought biases and onto the context of the person's experiences. Many of the coping strategies that were outlined in the findings of this study would be useful to consider when helping an individual develop their own ways of minimizing the effects of paranoia.

There are also some broader societal implications with regard to increasing awareness and understanding of paranoia and the portrayal of risk by the media. A recent study by Schomerus et al. (2016) showed that an online intervention on the mental health-illness continuum reduced stigma toward people experiencing mental distress. Similar campaigns specifically concerning paranoia may achieve similar results. Furthermore providing information in such campaigns on the societal factors involved in paranoia production may normalise the experience for those experiencing paranoia.

## 4.6. Conclusion

This study has investigated paranoia in a nonclinical population of students. The findings highlight both the historical and current contexts that can serve to increase the likelihood of an individual feeling threatened. Participants' ways of trying to make sense of what they were feeling was explored, uncovering both intrapersonal and interpersonal ways of investigating their concerns. The study also explored the ways in which the participants' lives were affected by paranoia, and how they were managing the experiences. While the participants' interviewed had all scored close to the mean for a clinical population on a measure of paranoia, they were not using mental health services. The finding that these individuals were managing well in the community supports a move toward freeing paranoia from an association with diagnostic categories. This finding is further supported given the data on the overall

sample which suggests that paranoia is a common experience in a nonclinical sample of students.

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## 6. APPENDICES

**Appendix 1.** Ethical Approval

# NOTICE OF ETHICS REVIEW DECISION

**For research involving human participants**

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

**SUPERVISOR**: David Harper **REVIEWER:** Chanelle Myrie

**STUDENT:** Caoilfhionn Timmons

**Title of proposed study**: Worries about Others in Everyday Life: Investigating Paranoia in the Non-clinical Population

**Course**: Professional Doctorate in Clinical Psychology

**DECISION** *(Delete as necessary)***:**

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

**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.

**APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before 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.

**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.

**Minor amendments required** *(for reviewer)*:

1) Could you clarify where participants will complete the questionnaires e.g. in a private space, with or without the researcher present?
2) Withholding information from participants (e.g. scores on the GPTS) may be seen as deception and participants should be thoroughly debriefed on the aims of your study and why they were selected for interview (e.g. obtaining a high score).
3) Please specify a plan for if you have concerns about a participant's mental health during the course of the interview and what you would do afterwards.

**Major amendments required** *(for reviewer):*

| |
|---|
| |

**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.<br><br>Student's name *(Typed name to act as signature): Caoilfhionn Timmons*<br><br>Student number: u1331819<br><br>Date: 30/03/2015 |

**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 |
| ✓ | LOW |

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

**Reviewer** Chanelle Myrie

**Date**: 09/03/2015

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)*

**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 2.** Phase One: Information Sheet

**UNIVERSITY OF EAST LONDON**

School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

### CONSENT TO PARTICIPATE IN A RESEARCH STUDY

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

### PROJECT TITLE

Exploring Feelings of Suspicion about Others

### PROJECT DESCRIPTION

This study aims to investigate suspicious thoughts about others in the student population. This questionnaire is to help us to find out more about how common it is for people in the student population experience suspicion about others and will ask you on a scale of 1-5 to rate the extent to which you agree with the statements about such worries. It should take you 10-15 minutes to complete. A small number of people who fill in this questionnaire may be contacted for invitation to follow-up interview to find out more about the experiences mentioned in the questionnaire. This is to get a richer understanding of their experiences. By completing this questionnaire however you are in no way committing yourself to attend any follow-up interview.

#### CONFIDENTIALITY/ANONYMITY

- All names and other identifying information will be anonymised through coding procedures, which will be held securely and separately from data and on a password protected file.
- Your contact information will not be stored with the questionnaire, to further ensure confidentiality.
- Data will be kept securely for possible research publication at a later date (which will also be strictly anonymous) but all data will be destroyed after 3 years.

### 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. I understand that I will also be able to request to have any data I have supplied destroyed up to December 2015.

#### FOR FUTHER INFORMATION ABOUT THIS RESEARCH STUDY:

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr Dave Harper **OR** Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn.

Thank you in anticipation.
Yours sincerely,

Caoilfhionn Timmons

**Appendix 3.** Phase One: Consent Form

**UNIVERSITY OF EAST LONDON**

School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

**THE PRINCIPAL INVESTIGATOR**
Caoilfhionn Timmons

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**
Exploring Feelings of Suspicion about Others

**PARTICIPANT UNDERSTANDING & CONSENT**

☐ 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 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 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 understand that I will also be able to request to have any data I have supplied destroyed up to December 2015.

**PARTICPANT'S PRINTED NAME:** _____

**PARTICIPANT'S SIGNATURE:** _____

**RESEARCHER'S SIGNATURE:** _____

**DATE SIGNED:** _____

**Appendix 4.** Phase One: Questionnaire

## Exploring Feelings of Suspicion about Others

**Demographic Information**

**Age:** _____

**Gender:** Male □ Female □

**Where do you study?** e.g. UEL _____

**Level of study:** Postgraduate □ Undergraduate □

**Ethnicity:**

□ White – British
□ White – Irish
□ White - Turkish/ Turkish Cypriot
□ White - Any other White background
□ Mixed – White and Black Caribbean
□ Mixed – White and Black African
□ Mixed – White and Asian
□ Mixed - Any other Mixed background
□ Asian or Asian British – Indian
□ Asian or Asian British – Pakistani
□ Asian or Asian British – Bangladeshi
□ Asian or Asian British - Any other Asian background
□ Black or Black British – Caribbean
□ Black or Black British – African
□ Black or Black British - Somali
□ Black or Black British - Any other Black background
□ Other ethnic groups – Chinese
□ Other ethnic groups - Any other ethnic group
□ I do not wish to give my ethnic group

A small number of people who fill in this questionnaire may be contacted for a follow-up interview to ask about experiences of such worries.

Please ensure you have supplied at least one form of contact information (asked for below) for this purpose. By filling in this questionnaire, you are in no way committing yourself to participating in a follow-up interview, but the researcher will contact several people about this possibility. Please leave blank if you do not wish to be contacted.

**Contact information:** (Please provide at least one form of contact)

**Email address** _____

**Contact Number** _____

**Part 1.**

Research shows that it is quite normal to sometimes believe that someone is trying to deliberately harm or upset you, or that others are in some way working together against you. For example, you may get a lower mark than you expected in an essay and conclude that the lecturer gave you that mark because they don't like you. Or you may believe that others have deliberately excluded or rejected you as a way of trying to cause harm or upset.

- Have you ever had a feeling that people were deliberately trying to harm or upset you in some way?

  Yes □ No □

- Q.2 Please briefly describe an example of the situation where you felt someone deliberately trying to harm/upset you

_____

_____

- In the above situation that you have described, **at that time** did you feel that the other people involved actively intended to harm you?

  Yes □ No □

## Part 2.

Please read each of the statements carefully.

They refer to thoughts and feelings you may have had about others over the last month**.**

Think about **the last month** and indicate the extent of these feelings from 1 (Not at all) to 5 (Totally). Please complete all questions.

(N.B. Please do not rate items according to any experiences you may have had under the influence of drugs.)

| **A.** | **Not at all** | | **Somewhat** | | **Totally** |
|---|---|---|---|---|---|
| 1. I spent time thinking about friends gossiping about me | **1** | **2** | **3** | **4** | **5** |
| 2. I often heard people referring to me | **1** | **2** | **3** | **4** | **5** |
| 3. I have been upset by friends and colleagues judging me critically | **1** | **2** | **3** | **4** | **5** |
| 4. People definitely laughed at me behind my back | **1** | **2** | **3** | **4** | **5** |
| 5. I have been thinking a lot about people avoiding me | **1** | **2** | **3** | **4** | **5** |
| 6. People have been dropping hints for me | **1** | **2** | **3** | **4** | **5** |
| 7. I believed that certain people were not what they seemed | **1** | **2** | **3** | **4** | **5** |
| 8. People talking about me behind my back upset me | **1** | **2** | **3** | **4** | **5** |
| 9. I was convinced that people were singling me out | **1** | **2** | **3** | **4** | **5** |
| 10. I was certain that people have followed me | **1** | **2** | **3** | **4** | **5** |
| 11. Certain people were hostile towards me personally | **1** | **2** | **3** | **4** | **5** |
| 12. People have been checking up on me | **1** | **2** | **3** | **4** | **5** |
| 13. I was stressed out by people watching me | **1** | **2** | **3** | **4** | **5** |
| 14. I was frustrated by people laughing at me | **1** | **2** | **3** | **4** | **5** |
| 15. I was worried by people's undue interest in me | **1** | **2** | **3** | **4** | **5** |
| 16. It was hard to stop thinking about people talking about me behind my back | **1** | **2** | **3** | **4** | **5** |

| B. | Not at all | | Somewhat | | Totally |
|---|---|---|---|---|---|
| 1. Certain individuals have had it in for me | **1** | **2** | **3** | **4** | **5** |
| 2. I have definitely been persecuted | **1** | **2** | **3** | **4** | **5** |
| 3. People have intended me harm | **1** | **2** | **3** | **4** | **5** |
| 4. People wanted me to feel threatened, so they stared at me | **1** | **2** | **3** | **4** | **5** |
| 5. I was sure certain people did things in order to annoy me | **1** | **2** | **3** | **4** | **5** |
| 6. I was convinced there was a conspiracy against me | **1** | **2** | **3** | **4** | **5** |
| 7. I was sure someone wanted to hurt me | **1** | **2** | **3** | **4** | **5** |
| 8. I was distressed by people wanting to harm me in some way | **1** | **2** | **3** | **4** | **5** |
| 9. I was preoccupied with thoughts of people trying to upset me deliberately | **1** | **2** | **3** | **4** | **5** |
| 10. I couldn't stop thinking about people wanting to confuse me | **1** | **2** | **3** | **4** | **5** |
| 11. I was distressed by being persecuted | **1** | **2** | **3** | **4** | **5** |
| 12. I was annoyed because others wanted to deliberately upset me | **1** | **2** | **3** | **4** | **5** |
| 13. The thought that people were persecuting me played on my mind | **1** | **2** | **3** | **4** | **5** |
| 14. It was difficult to stop thinking about people wanting to make me feel bad | **1** | **2** | **3** | **4** | **5** |
| 15. People have been hostile towards me on purpose | **1** | **2** | **3** | **4** | **5** |
| 16. I was angry that someone wanted to hurt me | **1** | **2** | **3** | **4** | **5** |

**Part 3.**

**How much the following statements are applicable to you? Please mark with a tick.**

(Please do not rate items according to any experiences you may have had under the influence of drugs.)

| | Not at all applicable to me | Slightly applicable to me | Somewhat applicable to me | Applicable to me | Extremely applicable to me |
|---|---|---|---|---|---|
| **1.** Someone has it in for me. | | | | | |
| **2.** I sometimes feel as if I am being followed. | | | | | |
| **3.** I believe that I have often been punished without cause. | | | | | |
| **4.** Some people have tried to steal my ideas and take credit for them. | | | | | |
| **5.** My parents and family find more fault with me then they should. | | | | | |
| **6.** No one really cares much what happens to you. | | | | | |
| **7.** I am sure I get a raw deal from life. | | | | | |
| **8.** Most people will use somewhat unfair means to gain profit or an advantage rather than lose it. | | | | | |
| **9.** I often wonder what hidden reasons another person may have for doing something nice for you. | | | | | |
| **10.** It is safer to trust no one. | | | | | |
| **11.** I have often felt that strangers were looking at me critically. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **12.** Most people make friends because friends are likely to be helpful to them. | | | | | |
| **13.** Someone has been trying to influence my mind. | | | | | |
| **14.** I am sure I have been talked about behind my back. | | | | | |
| **15.** Most people inwardly dislike putting themselves out to help other people. | | | | | |
| **16.** I tend to be on guard with people who are somewhat more friendly then I expect. | | | | | |
| **17.** People have said insulting and unkind things about me. | | | | | |
| **18.** People often disappoint me. | | | | | |
| **19.** I am bothered by people outside, in cars, in store, etc. watching me. | | | | | |
| **20.** I have often found people jealous of my good ideas just because they have not thought of them first | | | | | |

- Have you ever had professional support regarding the worries described in this questionnaire? Yes □ No □

- Are you currently receiving professional support regarding the worries described in this questionnaire? Yes □ No □

**Thank you for your participation!**

**Appendix 5.** Phase Two: Information Sheet

**UNIVERSITY OF EAST LONDON**

School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

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

**PROJECT TITLE**

Exploring Feelings of Suspicion about Others

**PROJECT DESCRIPTION**

This study aims to better understand students' experiences of having suspicions about others in their everyday life. You will be asked to discuss such experiences during a one-to-one interview with me as the researcher. Interviews will last for approximately 60 minutes and will be audio recorded for transcription.

**CONFIDENTIALITY/ANONYMITY**

- All names and other identifying information will be anonymised through coding procedures, which will be held securely and separately from securely and separately from transcribed data.
- Following completion, audio recordings will be deleted.
- Electronic copies of the anonymised transcripts will be kept securely for possible research publication at a later date but all data will be deleted after 3 years.

**Location**

The interviews will be held in a private research room at UEL's Stratford campus.

**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. You will also be able to request to have any data I have supplied destroyed up to December 2015.

**FOR FUTHER INFORMATION ABOUT THIS RESEARCH STUDY:**

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr Dave Harper **OR** Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn.

Thank you in anticipation.
Yours sincerely,

Caoilfhionn Timmons

**Appendix 6.** Phase Two: Consent Form

**UNIVERSITY OF EAST LONDON**

School of Psychology, Stratford Campus, Water Lane, London E15 4LZ

**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**
Exploring Feelings of Suspicion about Others

**PARTICIPANT UNDERSTANDING & CONSENT**

☐ 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 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 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 understand that I will also be able to request to have any data I have supplied destroyed up to December 2015.

**PARTICPANT'S PRINTED NAME:** _____

**PARTICIPANT'S SIGNATURE:** _____

**RESEARCHER'S SIGNATURE:** _____

**DATE SIGNED:** _____

**Appendix 7:** Interview Guide and Debrief Sheet

**Preamble example:**

Thanks for coming along today, and for filling out that questionnaire recently. As you saw in the information sheet, the purpose of today is to ask about some of the experiences mentioned in the questionnaire. Research shows that such worries about others are very common in everyday life so I want to explore that a bit more. In fact one study found that 47% of UK university students who filled out a questionnaire indicated that they felt that people were deliberately trying to harm or upset them in some way….

In the questionnaire you filled in, you indicated that such experiences of suspicion are somewhat common for you, and as I said on the phone/email that's why I invited you along for a follow-up interview, to explore this further and get a better understanding of your experiences. However, as I said, studies are finding that such worries about others are actually quite common in the general population and as such your scores are not necessarily anything to be concerned about

Check information sheet and consent forms are signed

Opportunity to ask questions here

**Semi-structured interview schedule:**

(These topics will serve as a guide for discussion but may not follow this order)

- <u>Causes of worries about others</u>

- Can you tell me about a recent example/ scenario when you felt worried about others wanting to upset or harm you?
- What have you noticed about the circumstances giving rise to a scenario such as that, or other times you've felt this way? Prompts: What seems to generate an experience like this? Can you tell me more about that? What did you first notice?
- Are some incidents worse than others? Can you tell me about that?
- Have worries like this been around for a long while in your life?
- What sense do you make of these experiences you've mentioned?
- How do others make you feel this way?
- Do you think your position as a student has been a factor relevant to these feelings of suspicion?
- How has student life contributed to these worries or perhaps alleviated these worries in any way?

- Effects of such worries

- How much do you feel your life is impacted by these concerns? In what ways?
- Do your worries change how you interact with people?
- Do the extent of your concerns about others change over time?

- Coping with/managing these worries about others

- Have you discussed these concerns with others? Who? What did you tell them? If yes, does this help?
- How have people responded to you when you've shared these worries?
- What do you make of such responses?

- What stops these worries from getting worse?
- How do you manage in your everyday life to cope with these concerns?
- Have you ever tested your ideas out? E.g. confronted someone you're feeling worried about?

Extra question added after interview 1 – do you feel being a woman/man is at all relevant to your experiences?

## Appendix 8. Debrief Material

### Verbal debrief:

- Thank you…how was it for you to speak about these experiences today?
- Questions?
- Reminder of study aim
- Although research says many people have such feelings of suspicion and it's not necessarily a problem, if you do ever decide you want to talk to a professional, or get some sort of support for the types of things we have discussed today, then I have some information here that might be of use.
- Reminder of where to contact if want to withdraw data or answer questions at a later date…

### Debrief Sheet given to participants:

Thank you for taking part in my study!

As I have already mentioned, such experiences are thought to be common in the general population and don't necessarily mean the person needs help or support from professionals /support organisations. However, if you do decide to seek support with the types of experiences discussed during this study, here is some information on support sources:

- Your GP should be able to make an appropriate referral for you based on the information you give them about the support you are seeking and the services available in your area.

- For useful information on suspicious/paranoid thoughts, as well as self-help material see: http://www.paranoidthoughts.com/

- For information about primary care mental health support in the UK using psychological therapies see: http://www.iapt.nhs.uk/

- The PICuP Clinic is a specialist psychological therapies service providing CBT for paranoia and other distressing unusual experiences. 91% of people who have had CBT with PICuP report that they are satisfied with the therapy they received. PICuP takes referrals from GPs and community mental health teams throughout London and the South East1, and the clinic also accepts self-funded referrals.
  Web site: http://www.national.slam.nhs.uk/services/adult-services/picup/
  Booklet: https://www.national.slam.nhs.uk/wp-content/uploads/2011/08/PICuP-Service-Booklets.pdf

- Paranoia & Beliefs Groups are safe, supportive spaces where people meet to share their experiences and learn from one another. They provide opportunity to learn to cope with the distress related to beliefs – both where the belief itself is inherently distressing, and also where the distress can be a result of how those beliefs are viewed by others. For information on paranoia and beliefs groups see: http://www.mindincamden.org.uk/services/paranoia and for information on the national paranoia network see: http://www.nationalparanoianetwork.org/

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor, Dr Dave Harper (email address removed) **OR** Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn. (contact details removed)

**Appendix 9.** Example of Initial Coding

| | |
|---|---|
| I've got like a bit of a vivid imagination and I've watched a lot of movies. So I thought he was just going to drag me in the car and you know I was very… I could see it just playing out in my mind what's going to happen and I haven't spoken to my parents since yesterday so you know. But then I did find comfort in the fact that I am pretty; like I have a close relationship with God and at that time I knew that nothing would happen to me. So that's kind of like the only thing that… that's the only reason I didn't completely panic because I knew that God would see what could happen and nothing would happen to me. But at the same time just being in that situation where someone is like stop the car like 3-4 times after you've told them no, it's obvious that your response to them doesn't really matter because if someone says no and you carry on pursuing that it's disrespectful to the person because I'm a young girl walking home. And actually on that same night there was like 3 or probably 2 other cars that did something very similar. So that made me very cautious about going out late at night. And you know like a van went past and did something kind of similar. And the fact that the person literally was driving past me; so he would've had to detour and go out of his way to come back and for me that was really scary. In those situations I just felt like yeah; especially with the guy today because I was told recently by my friend that there was a guy in London that something happened and he attacked people that he didn't know. Today with that guy I just thought oh my days... I guess like the news like I said with my relationship with God, I've kind of shut out the news and stuff. I don't really read the media because to be honest it's not truthful and all it's going to do is get | *Having a vivid imagination*<br>*Watched a lot of movies*<br>*Thinking he would drag her into car /worried about man's motives*<br><br>*Imagining the feared situation*<br><br>*Hadn't spoken to parents*<br><br>*Finding comfort in relationship with God*<br><br>*Knowing nothing would happen*<br><br>*Not panicking because of relationship with God*<br><br>*Knowing god would protect her*<br>*Nothing would happen*<br>*Being in interpersonal situation*<br>*Stopping the car several times*<br>*Not being listened to*<br>*Feeling that your response doesn't matter*<br>*Person being persistent*<br>*Viewing behaviour as disrespectful*<br>*Disrespectful given her status as young girl walking home*<br>*Others cars did the same thing*<br>*Became cautious*<br>*Cautious late at night*<br><br>*Another car behaving same way/ receiving unwanted attention*<br><br>*The person was driving past*<br><br>*Driver making a detour for her*<br><br>*Perceiving situation as scary*<br><br>*Recalling situation with guy today*<br><br>*Friend told story recently*<br><br>*Story about a guy attacking strangers*<br><br>*Being affected by a story that was heard*<br>*Relationship with God*<br>*Shutting out the news*<br>*Not reading media*<br>*Viewing media as untruthful*<br><br>*Media creating a state of paranoia* |

**Appendix 10.** Example of Focused Coding

Initial codes were labelled using participants own words where possible to keep close to the data. Codes were cut out and grouped with other codes that appeared to share a common meaning or characteristic. Some focused codes were comprised of as many as 40 initial codes. See examples below:

*Focused code:* Family context (fostering mistrust)

*Examples of several initial (line-by-line) codes:*

Sukhi, p.38: witnessing mum being suspicious

Lisa, p. 20: my parents are suspicious people

Katrina, p.3: Being taught how to act by family

Marsha, p.14: being taught about stranger danger

Lisa, p. 22: unwelcome legacies from parents

*Focused code:* Finding behaviour unusual

*Examples of several initial (line-by-line) codes:*

James, p.21: Being looked at specifically

Sarah, p.23: Talking on tube as strange

Marsha, p.19: Being stared at is odd

Kemi, p.6: Car turned around specifically

Kemi, p.10: Not focused on themselves

**Appendix 11.** Memo Examples

Date: 29.10.15

Initial reflections on interview with James

What stands out to me was the way that James described paranoia. It seemed important to him that I understand that the context of threat is key for him in feeling okay versus feeling paranoid. Knowing versus not knowing was really important – he spent time explaining that if he knew what the threat was and why it was being directed at him then he could manage it and feel okay about that but it's the situations where he can't see a motive that evoke intense fear and vulnerability. He also seemed to be talking about anxiety and paranoia as inseparable – can't have paranoia without anxiety. He drew on context to consider the appropriateness of a person's behaviour and this seems to be something that was both helpful and unhelpful e.g. if a person is hostile in the workplace then it's ok as he views it as part of the business world (i.e. cut throat?) and therefore appropriate to context… but if the behaviour happens somewhere else – like the charity he works at he can't see a motive so in this instance comparing the behaviour to a norm he holds is not as helpful as it evokes paranoia (in that being hostile in the context of working for a charity is viewed as inappropriate/strange)

In terms of how James might have received me it is hard to tell but I wonder whether being a young woman of a similar age affected what he told me e.g. preserving his image? He did mention stigma as related to paranoia so it's difficult to know how open he felt able to be? Maybe I should be asking questions about gender given that it briefly came up in interview – come back to this after initial coding is done and check – potentially should adapt interview schedule.

Date: March 2016

Note on 'Investigating' subcategory

I'm not sure whether 'investigating' should stay in the 'Process of Becoming Paranoid' core category or whether it would be best incorporated into the subcategory on coping in the second core category. Going back through each code and checking the extracts there seems to be some overlaps whereby sometimes people were asking friends for

their thoughts as a way of coping, but that this was also a way of generally getting more information about the threat…and forming conclusions… are they doing both? Is investigating a way of trying to take control and minimize the effects of the paranoia – like problem focused/active coping?? What is the function and is more about coping than gathering knowledge? Need to keep going through to see if both subcategories are distinct enough to keep them as separate subcategories in their respective core categories or if I need to collapse them. If they are overlapping but still retain something distinct from each other it's worth leaving them as they are – come back to this tomorrow.